# COMMUNITY CONNECTEDNESS AND INTERNALIZING SYMPTOMS AMONG GAY MEN

by

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(Under the Direction of Justin A. Lavner)

## ABSTRACT

Sexual minorities are exposed to various gay-related and general stressors by virtue of their minority status that increase risk for negative mental and physical health problems. Yet, positive gay-related factors such as ameliorative coping strategies and social supports that may serve promotive functions for sexual minorities' functioning have largely been overlooked. The current study sought to address this gap by examining the association between gay community connectedness and internalizing symptoms over eight weeks within a sample of self-identified gay men, as well as the conditions under which gay community connectedness is associated with more positive functioning. Findings were generally consistent with minority stress theory and other work examining the benefits of community coping resources in suggesting that gay community connectedness is associated with more positive outcomes among gay men. Theoretical and practical implications are discussed.

INDEX WORDS: Community Connectedness, Internalizing Symptoms, Gay Men, Depression, Anxiety, Identity

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# CHAPTER 1

# INTRODUCTION

Sexual minorities are exposed to various gay-related (e.g., experiences of discrimination based on one's sexual orientation) and general (e.g., occupational and relational) stressors by virtue of their minority status that increase risk for negative mental and physical health problems (Lick, Durso, & Johnson, 2013; Meyer, 2003). Over the past few years, a growing body of work examining gay-related distal and proximal minority stressors, such as experiences of discrimination (Hatzenbuehler et al., 2014; McCabe, Bostwick, Hughes, West, & Boyd, 2010), rejection sensitivity (Pachankis, Goldfried, & Ramrattan, 2008; Wang & Pachankis, 2016), and internalized stigma (Cox, Dewaele, Van Houtte, & Vincke, 2010; Herek, Gillis, & Cogan, 2009), has consistently supported the idea that minority stressors are associated with negative outcomes (Moody, Starks, Grov, & Parsons, 2017; Sattler & Christiansen, 2017). Yet, research has tended to overlook other gay-related factors such as ameliorative coping strategies and social supports that may serve *promotive* functions for sexual minorities' functioning. The current study aims to address this gap by examining the association between gay community connectedness and internalizing symptoms over eight weeks within a sample of self-identified gay men, as well as the conditions under which gay community connectedness is associated with more positive functioning. Doing so will serve to enhance theoretical understanding of how gay-specific factors may be associated with positive outcomes and could ultimately inform interventions to prevent or ameliorate the experiences of minority stress.

**Community Connectedness and Gay Men's Psychological Functioning**

A sense of in-group status or belongingness is important and generally associated with positive outcomes (Baumeister & Leary, 1995). Gay community connectedness refers to a sense of in-group status or belongingness to a broader gay community, an affiliative subgroup of the community (e.g., bear community or LGBT communities of color), or other sexual minorities (Frost & Meyer, 2012; Meyer, 2003). Notably, this cognitive/affective construct is separate from involvement or participation in the gay community, such as frequenting a local gay bar (Frost & Meyer, 2012). These concepts are related, however, as increased connectedness may elicit, result from, or coincide with (though not require) more active behavioral participation in one's community (e.g., frequenting a local gay bar and joining LGBT organizations). Despite increased societal acceptance over the past few decades (Andersen & Fetner, 2008), gay men often self-segregate and frequent gay venues rather than integrating into broader, predominantly heterosexual communities, likely to ensure safety, acquire social support, or fulfill social or intimacy needs.

Few studies have examined the relations between gay community connectedness and mental health outcomes (Meyer, 2003). Kertzner and colleagues (2009) found strong associations between community connectedness and social and psychological well-being. Gay men who reported higher levels of community connectedness were more likely to report greater social (e.g., integration, contribution, and actualization) and psychological (e.g., self-acceptance, personal growth, and autonomy) well-being. Community connectedness was not, however, associated with depressive symptom severity. More recently, Puckett and colleagues (2015) examined community connectedness, internalized heterosexism, and psychological distress, finding that low levels of community connectedness were associated with increased levels of

psychological distress. Moreover, community connectedness mediated the association between internalized heterosexism and psychological distress, such that individuals with greater internalized heterosexism reported lower levels of community connectedness, thereby disposing them to greater psychological distress (e.g., depression and social anxiety). The authors argue that connectedness may result in increased opportunities to engage in positive relationships with other gay men and experiences to challenge internalized stigma or other preconceived negative notions of the gay community (e.g., negative self-image related to one's sexual orientation; Puckett et al., 2015), resulting in lower levels of psychological distress. Together, these findings highlight the potential importance of community connectedness serving promotive functions (i.e., increasing social and psychological resources).

The first aim of the current study was to examine whether community connectedness is associated with internalizing symptoms cross-sectionally and over time using data from an eight-week diary study of self-identified gay men. This aim was consistent with minority stress theory, which states that community connectedness is an ameliorative group-level coping resource for gay men (Meyer, 2003). In line with this theory, we predicted that individuals who report higher levels of community connectedness should demonstrate lower levels of internalizing symptoms. The use of longitudinal data is a strength of the current study, as longitudinal data 1) allow for greater, more flexible interpretations than cross-sectional data alone, 2) address issues of directionality, and 3) reduce the effects of unobserved time-invariant individual differences, such as personality factors, or time-variant states, such as low mood while completing questionnaires (Affleck, Zautra, Tennen, & Armeli, 1999; Bolger, Davis, & Rafaeli, 2003; Fraley & Hudson, 2014).

**Moderators of Community Connectedness**

The second aim of the study was to examine whether the relations between community connectedness and internalizing symptoms were moderated by demographic and other individual factors. Prior studies have primarily examined mean associations between community connectedness and other aspects of psychological functioning, without considering the possibility that these associations may differ for different individuals, such that community connectedness shows strong associations with internalizing symptoms for some subgroups within the gay community and weak to no association with outcomes for others. For instance, community connectedness may not be as strongly associated with mental health problems for gay men who possess alternative coping strategies and other protective factors. To test these possibilities, we considered several demographic and individual moderators of the association between community connectedness and internalizing symptoms, including age, identity centrality, masculinity, femininity, and race/ethnicity.

Age may play a significant role in how community connectedness is associated with health outcomes. Attendance at specific venues, affiliation with gay organizations, and integration into heteronormative society can vary across the lifespan and by age cohort (Hammack & Cohler, 2011; Wight, Harig, Aneshensel, & Detels, 2016), suggesting that gay community connectedness may serve more or less prominent roles in individuals' lives at different ages. Older gay men in particular may feel excluded or unwelcomed in gay venues or even in the broader community given the gay community's tendency to value youth (Grant, 2010), thus reducing the importance of gay community connectedness in their lives. Consistent with this idea, Lelutiu-Weinberger and colleagues (2013) found that identification with the gay community protected against HIV risk only for younger gay men, which might suggest that

middle-aged and older gay men benefit less from community connectedness. Variable definitions and meanings of the gay community may also explain the differential impact of connectedness. For older gay men, connection to one's gay community served as a survival strategy during the HIV/AIDS crisis (i.e., in the 1980's and 1990's) or a necessary coping resource following family rejection. With the advent of antiretroviral medications and increased societal acceptance of sexual minorities, younger gay men may understand the gay community to be an opportunity for identity exploration and social interactions (Hammack, Frost, Meyer, & Pletta, 2017; Rosario, Schrimshaw, & Hunter, 2011). As such, community connectedness may matter less for older gay men, who likely have acquired additional coping strategies (e.g., to cope with social or familial rejection). Specifically, we expected the relation between community connectedness and internalizing symptoms would be stronger among younger men than among older men.

Identity centrality is the extent to which an aspect of one's identity is central to the self. Most research examining identity centrality has explored its associations to psychological outcomes in groups with visible identities, such as race (Sellers, Caldwell, Schmeelk-Cone, & Zimmerman, 2003), gender (Settles, 2004), and occupation (Murnieks, Mosakowski, & Cardon, 2014). For these visible identities, increased levels of identity centrality have been associated with lower mental health problems (Yip, Seaton, & Sellers, 2006). However, there may be differences in the study and outcomes of identity centrality for individuals with concealable identities (Williams & Fredrick, 2015). The one study examining the association between identity centrality and mental health among sexual minorities found greater identity centrality to be associated with increased psychological distress among those with concealable identities, such as sexual orientation (Quinn & Chaudoir, 2009). Feeling rejected or disconnected from one's community may lead to especially negative outcomes for a man whose sexual orientation is a

salient or central aspect of his identity. Conversely, community connectedness may matter less for gay men who believe sexual orientation is less important or central to their identity. Accordingly, we predict that the association between community connectedness and internalizing symptoms will be stronger for individuals with high levels of identity centrality than for individuals with low levels of identity centrality.

Gender expression may also play an important role in how gay men interact with their community. Gay men generally choose to present as more masculine (e.g., muscularity and facial hair) and less feminine (Duggan & McCreary, 2004; Glick, Gangl, Gibb, Klumpner, & Weinberg, 2007; Martins, Tiggemann, & Churchett, 2008; Schippert, 2007) through behavior or appearance to conform to societal and community expectations. Indeed, self-reported conformity to masculine norms and rejection of femininity are associated with outcomes like health risk behaviors (e.g., substance use; Hamilton & Mahalik, 2009) and difficulties with self-image and self-acceptance (Sánchez, Greenberg, Liu, & Vilain, 2009). Empirical work indicates negative attitudes and prejudice toward gay men perceived to be feminine (Bailey, Kim, Hills, & Linsenmeier, 1997; Taywaditep, 2002). With regard to masculinity, increased pressures to conform to masculine ideals (e.g., from other gay men) and preoccupation with displays of masculinity are associated with greater internalization of negative feelings toward one's sexual orientation and internalizing symptoms (Guarnero & Flaskerud, 2008; Sánchez & Vilain, 2012). Together, the evaluation of one's gender conformity and, thereby, acceptance within gay communities are often contingent upon these displays and perceptions of masculinity and femininity (Rieger, Linsenmeier, Gygax, Garcia, & Bailey, 2010). A sense of connectedness with other gay men or the broader gay community may thus confer unique benefits to men who experience marginalization due to actual or perceived low masculinity or high femininity.

Specifically, we expected the negative association between community connectedness and psychological distress to be stronger for those endorsing low masculinity (i.e., compared to high masculinity) and for those endorsing high femininity (i.e., compared to low femininity).

Lastly, racial and ethnic minority men in the LGB community face incrementally greater stress compared to their White LGB peers, including actual and perceived rejection from within the broader LGB community as well as stigma associated with their sexual minority status from within their respective racial or ethnic community (Arnold, Rebchook, & Kegeles, 2014; Boone, Cook, & Wilson, 2016; González-Guarda, McCabe, Leblanc, De Santis, & Provencio-Vasquez, 2016; Gray, Mendelsohn, & Omoto, 2015). The intersectionality of minority identities confers particularly disadvantaged social status and can limit the availability of coping resources, (Meyer, Schwartz, & Frost, 2008) thereby putting them at particularly high risk for poor outcomes. As such, community connectedness may be especially important for racial and ethnic minority gay men compared to their White peers. Accordingly, we hypothesize that the negative association between community connectedness and mental health problems will be stronger among gay men who are also members of racial/ethnic minority groups compared to White gay men.

# CHAPTER 2

# METHOD

## Participants

Participants included 147 gay men in the greater New York City area who were recruited in-person (e.g., bars and gay men's groups) and online (e.g., Facebook groups). Individuals who expressed interest were screened for initial inclusion criteria: (a) self-identified as a gay man, (b) between 18 and 65 years old, (c) lived in the greater New York City area, and (d) had access to the Internet. Individuals who met criteria were given more information about the study. Those who were interested in participating were emailed within 48 hours to complete an online consent form and assessment ($n$ = 147).

Data were collected between November 2013 and May 2014 via PsychData, an Internet-based data collection platform. All procedures were approved by the sponsoring institution's Institutional Review Board (Feinstein, Davila, & Dyar, 2017).[1]

Men averaged 37.3 years old (SD = 11.4) and were diverse in terms of educational attainment: High School/GED (4%), Some College (16%), 2-Year College Degree (5%), 4-Year Degree (48%), Master's Degree (22%), and Doctoral Degree (5%). Sixty-eight percent were Caucasian/White, 11% were Black/African-American, 10% were Asian, and 11% chose "Other" for their race. Nineteen percent identified as Hispanic or Latino. The median income was between $40,000 and $49,999.

[1] The current sample has been described elsewhere (Feinstein et al., 2017), but this is the first study to examine community connectedness, its association with internalizing symptoms, and the characteristics that moderate this association.

## Procedures

Eligible gay men completed a set of online questionnaires assessing demographics, community connectedness, identity centrality, masculinity, femininity, and other measures beyond the scope of the current study. Participants received $10 (Times 1 and 8) or $5 (Times 2-7) for each completed weekly diary.

## Measures

**Demographics.** Participants provided responses to standard questions about age, race, ethnicity, and other demographic variables.

**Community Connectedness (CC).** The Connectedness to the LGBT Community Scale (Frost & Meyer, 2012) is an 8-item measure reflecting the extent to which individuals perceive themselves to belong to a larger LGBT collective ($M$ = 2.93, $SD$ = .63). Participants were asked the degree to which they agreed with each item on a 4-point Likert scale (1 = *disagree strongly*; 4 = *agree strongly*). Example items included: 1) "You feel you're a part of NYC's LGBT community" and 2) "You feel a bond with the LGBT community." Cronbach alpha was .85.

**Identity Centrality (IC).** We assessed identity centrality using the Identity Centrality subscale of the Lesbian, Gay, and Bisexual Identity Scale (Mohr & Kendra, 2011). This subscale consists of five items rated on a 6-point Likert scale (1 = *disagree strongly*; 6 = *agree strongly*), such that higher scores reflect greater centrality of one's sexual orientation to his identity. Example items included: 1) "To understand who I am as a person, you have to know that I'm LGB" and 2) "I believe being LGB is an important part of me." Cronbach alpha was .81.

**Masculinity.** At Time 1, two questions were used to assess the extent to which participants believed they and others saw them as masculine. This measure consisted of two items derived from the Masculine-Feminine Scale (MFS; Lippa, 2008): 1) "I see myself as

someone who is masculine" and 2) "I see myself as someone who acts, appears, and comes across to others as masculine." Items were rated on a 5-point Likert scale (1 = *not at all*; 5 = *extremely*). Cronbach alpha was .86.

**Femininity.** Participants were also asked the extent to which they and others saw them as feminine at Time 1 using two items from the MFS (Lippa, 2008): 1) "I see myself as someone who is feminine" and 2) "I see myself as someone who acts, appears, and comes across to others as feminine." Items were rated on a 5-point Likert scale (1 = *not at all*; 5 = *extremely*). Cronbach alpha was .91. Previous work has supported the measurement of masculinity and femininity as separate constructs on separate dimensions (e.g., demonstrating good discriminant validity; Bem, 1974; Lippa, 2001). In the current sample, they were negatively correlated, $r(142) = -.46$, $p < .001$.

**Cross-Sectional Internalizing Symptoms.** The Mini Mood and Anxiety Symptom Questionnaire (Mini-MASQ; Casillas & Clark, 2000) is a 26-item measure of internalizing symptoms and is designed for use with community samples. Participants were asked to rate the degree to which they experienced each symptom over the past week on a 5-point Likert scale (1 = *not at all*; 5 = *extremely*). Sample items include 1) "Felt hopeless" and 2) "Felt like a failure." Cronbach alpha was .75.

**Longitudinal Internalizing Symptoms.** At Times 2-8, participants were asked to rate their levels of depression ("How depressed did you feel?") and anxiety ("How anxious did you feel?") since their last assessment on a 5-point Likert scale (1 = *very slightly/not at all*; 5 = *extremely*). Concurrent associations between these items (e.g., Time 2 depression by Time 2 anxiety) ranged from .60 to .78, with a mean correlation of .67. Accordingly, scores for depression and anxiety were averaged to create an internalizing symptoms variable (Weekly

INT) at each time point. Across time points, mean weekly INT ranged from 1.74 to 2.10 (SD = .88-.99).

Descriptive statistics for continuous variables are presented in Table 1.

## Data Analysis

**Preliminary Analyses.** Data were inspected for missing values, invalid responses, outliers, and distribution normality. Bivariate correlations were generated to examine relations among demographic and study variables.

**Primary Cross-Sectional Analyses.** Cross-sectional analyses (e.g., predicting Mini-MASQ scores) were conducted using SPSS 24.0 and the PROCESS Macro (Hayes, 2012). Multiple regression analyses were used to examine the association between CC and internalizing symptoms assessed using the Mini-MASQ, and whether the five demographic and individual factors (i.e., age, IC, masculinity, femininity, and race/ethnicity) moderated these associations. After first examining the main effect of CC on internalizing symptoms, we then examined five separate models (one for each moderator) predicting internalizing symptoms cross-sectionally (i.e., Mini-MASQ scores at Time 1). In each model, CC and the moderator (e.g., age) were entered simultaneously as main effects in Step 1, and the product term (e.g., CC x age) was added to these main effects in Step 2. Significant interactions were probed and plotted to examine the direction of effects.

**Primary Longitudinal Analyses.** Longitudinal data were analyzed using a 2-level multilevel model within the HLM 7.0 computer program (Raudenbush, Bryk, & Congdon, 2010). We tested the effect of CC on the overall level (intercept) of weekly INT, controlling for time in order to account for natural or random individual fluctuations or changes over time. In this model, the outcome was modeled at Level 1, and CC was modeled at Level 2 as a predictor

of the Level 1 intercept/level term using the following equations:

Level 1: $Y_{ij}(\text{Weekly INT}) = \pi_{0j}(\text{Intercept}) + \pi_{1j}(\text{Time}) + e_{ij}$

Level 2: $\pi_{0j} = \beta_{00} + \beta_{01}(\text{CC}) + \mu_{0j}$

$\pi_{1j} = \beta_{10} + \mu_{1j}$

To examine whether demographic (i.e., age and race/ethnicity) or individual factors (i.e., IC, masculinity, and femininity) moderated the main effect of CC on weekly INT, we examined five additional models, one for each moderator, and we used the following general equation:

Level 1: $Y_{ij}(\text{Weekly INT}) = \pi_{0j}(\text{Intercept}) + \pi_{1j}(\text{Time}) + e_{ij}$

Level 2: $\pi_{0j} = \beta_{00} + \beta_{01}(\text{CC}) + \beta_{02}(\text{Moderator}) + \beta_{03}(\text{Interaction Term}) + \mu_{0j}$

$\pi_{1j} = \beta_{10} + \mu_{1j}$

Here, CC, the moderator (e.g., age), and their interaction (e.g., CC x age) were entered simultaneously as Level 2 predictors of the Level 1 intercept/level term.

Table 1

*Sample Means, Standard Deviations, and Ranges for Continuous Variables*

| Variable | *M* | *SD* | Range | *N* |
|---|---|---|---|---|
| 1. CC | 2.94 | 0.63 | 1 - 4 | 143 |
| 2. Age | 37.27 | 11.42 | 18 - 65 | 146 |
| 3. IC | 4.16 | 1.10 | 1 - 6 | 145 |
| 4. Masculinity | 12.06 | 6.13 | 1 - 25 | 143 |
| 5. Femininity | 4.80 | 4.23 | 1 - 20 | 143 |
| 6. Mini-MASQ | 50.48 | 13.65 | 27 - 98 | 147 |
| 7. INT (mean level) | 3.69 | 1.42 | 2 - 9.43 | 144 |
| Week 2 | 4.20 | 1.97 | 2 - 10 | 142 |
| Week 3 | 3.86 | 1.99 | 2 - 10 | 139 |
| Week 4 | 3.71 | 1.76 | 2 - 10 | 140 |
| Week 5 | 3.59 | 1.81 | 2 - 10 | 138 |
| Week 6 | 3.48 | 1.85 | 2 - 10 | 138 |
| Week 7 | 3.56 | 1.68 | 2 - 9 | 138 |
| Week 8 | 3.52 | 1.80 | 2 - 10 | 134 |

*Note*. CC = Community Connectedness; IC = Identity Centrality. INT = Weekly Internalizing Symptoms. *N* for mean level INT reflects the number of participants who completed at least one INT measure throughout the study.

# CHAPTER 3

# RESULTS

## Preliminary Analyses

We examined the bivariate correlations among CC, moderator variables, and cross-sectional and longitudinal internalizing symptoms (Table 2). Community connectedness was significantly positively associated with age ($r$ = .25, $p$ < .01) and IC ($r$ = .47, $p$ < .01), but it was not significantly associated with masculinity or femininity. White ($M$ = 2.92, $SD$ = .64) and non-White ($M$ = 2.95, $SD$ = .61) participants did not differ in community connectedness, $t(141)$ = -.28, $p$ = .78. Weekly INT was not associated with CC or other moderators, but scores on the Mini-MASQ were positively associated with IC ($p$ < .05) and negatively associated with CC ($p$ < .01). Significant effects were in the small to medium range.

## Associations between Community Connectedness and Internalizing Symptoms

The first aim of the study was to examine whether community connectedness was associated with internalizing symptoms cross-sectionally and longitudinally. The cross-sectional association in which internalizing symptoms, as measured by the Mini-MASQ, were regressed on community connectedness was significant, $B$ = -4.875, $t(141)$ = -2.72, $p$ = .007. However, in the longitudinal multilevel model, CC was not a significant predictor of average weekly INT, $B$ = -.028, $t(137)$ = -1.34, $p$ = .183.

## Moderation Effects

The second aim of the study was to examine whether the relation between community connectedness and internalizing symptoms was moderated by demographic and other individual

factors. We conducted separate analyses for the cross-sectional associations and the longitudinal associations, as described below.

**Cross-Sectional Internalizing Symptoms.** We conducted multiple linear regression analyses to examine whether the five demographic and individual factors (i.e., age, IC, masculinity, femininity, and race/ethnicity) moderated the relation between CC and scores on the Mini-MASQ (Table 3). The main effects of CC ($t$ = -2.72, $p$ < .01), masculinity ($t$ = -2.21, $p$ < .05), and femininity ($t$ = 4.59, $p$ < .001) were significant. The main effects of age ($t$ = -1.54, $p$ > .05), IC ($t$ = .22, $p$ > .05), and race/ethnicity ($t$ = .57, $p$ > .05) were not significant. The interactions between CC and IC ($t$ = -2.17, $p$ < .05), CC and femininity ($t$ = -2.43, $p$ < .05), and CC and race/ethnicity ($t$ = -2.68, $p$ < .01) were significant, indicating IC, femininity, and race/ethnicity each moderated the relation between CC and Mini-MASQ scores.

Plots of the significant moderation analyses are depicted in Figure 1. To probe the interactions, we calculated simple slopes at low (-1 *SD*), moderate (mean), and high (+1 *SD*) for the continuous variables (Preacher, Curran, & Bauer, 2006). For IC (Panel A), the association between CC and internalizing symptoms was strongest for men high in IC ($t$ = -3.82, $p$ < .001) and weaker (though still significant) at moderate ($t$ = -3.74, $p$ < .001) and low levels ($t$ = -2.30, $p$ < .05) of IC. Similarly, for femininity (Panel B), the association between CC and internalizing symptoms was strongest for men high in femininity ($t$ = -3.83, $p$ < .001) and weaker at moderate levels of femininity ($t$ = -2.89, $p$ < .01); the association between CC and internalizing symptoms was non-significant for men low in femininity ($t$ = -1.05, $p$ > .05). Lastly, for race/ethnicity (Panel C), the association between CC and internalizing symptoms was significant for non-White men ($t$ = -3.81, $p$ < .001) but not for White men ($t$ = -.62, $p$ > .05).

**Longitudinal Internalizing Symptoms.** We repeated these analyses with weekly INT as the outcome using multilevel modeling (Table 4). The main effects of masculinity ($t$ = -2.72, $p$ < .01) and femininity ($t$ = 3.73, $p$ < .001) were significant, while the main effects of CC, age, IC, and race/ethnicity were not significant. There was evidence for only one significant moderating effect: the interaction between CC and femininity ($t$ = -3.78, $p$ < .001) was significant, such that the association between CC and weekly INT was strongest among men high in femininity (Figure 2), consistent with the cross-sectional results described above.

Table 2

*Correlations Among Study Variables*

| Variable | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|---|
| 1. CC | - | | | | | | |
| 2. Age | .252** | - | | | | | |
| 3. IC | .472** | .282** | - | | | | |
| 4. Masculinity | .018 | .049 | -.154 | - | | | |
| 5. Femininity | .005 | -.136 | .113 | -.464** | - | | |
| 6. Mini-MASQ | -.223** | -.127 | .018 | -.183* | .361** | - | |
| 7. INT | -.107 | -.054 | .080 | -.195* | .313** | .722** | - |

*Note.* Weekly INT scores were averaged within participants in order to calculate correlations with other variables. * $p < .05$. ** $p < .01$.

Table 3

*Cross-Sectional Results for Moderation of the Association between Community Connectedness (CC) and Internalizing Symptoms*

| Variable | *B* | *SE* | *t* |
|---|---|---|---|
| Model 1: Age | | | |
| CC | -4.43 | 1.95 | -2.28* |
| Age | -0.10 | 0.11 | -0.91 |
| CC x Age | 0.08 | 0.20 | 0.40 |
| Model 2: IC | | | |
| CC | -7.83 | 2.10 | -3.74*** |
| IC | 1.61 | 1.14 | 1.41 |
| CC x IC | -2.66 | 1.23 | -2.17* |
| Model 3: Masculinity | | | |
| CC | -4.83 | 1.80 | -2.69** |
| Masculinity | -0.40 | 0.18 | -2.20* |
| CC x Masculinity | 0.02 | 0.26 | 0.09 |
| Model 4: Femininity | | | |
| CC | -4.80 | 1.65 | -2.91** |
| Femininity | 1.20 | 0.25 | 4.85*** |
| CC x Femininity | -0.71 | 0.29 | -2.43* |
| Model 5: Race/Ethnicity | | | |
| CC | -1.36 | 2.20 | -0.62 |
| Race/Ethnicity | 1.39 | 2.27 | 0.61 |
| CC x Race/Ethnicity | -9.83 | 3.70 | -2.68** |

*Note*. IC = Identity Centrality. * $p < .05$. ** $p < .01$. *** $p < .001$.

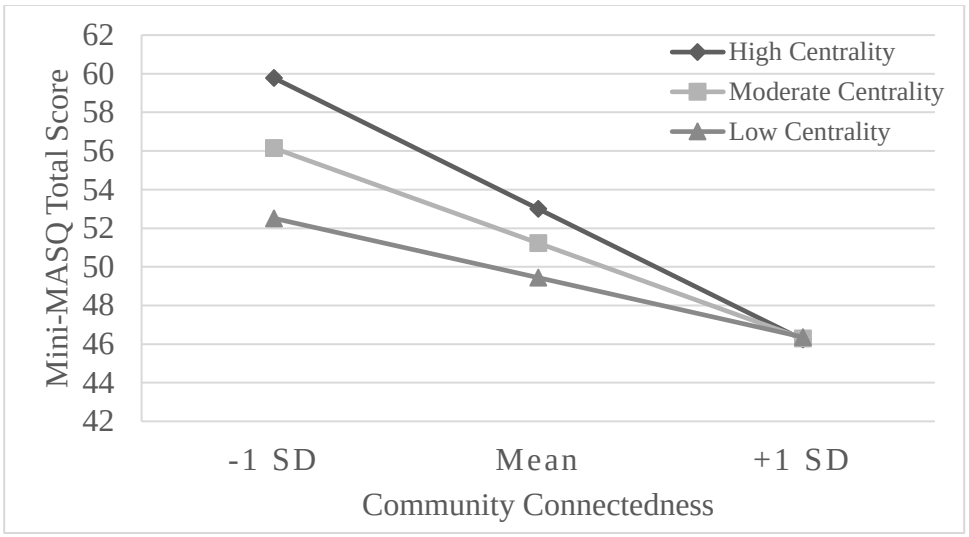
Table 4

*Longitudinal Results for Moderation of the Association between Community Connectedness (CC) and Average Weekly Internalizing Symptoms (INT)*

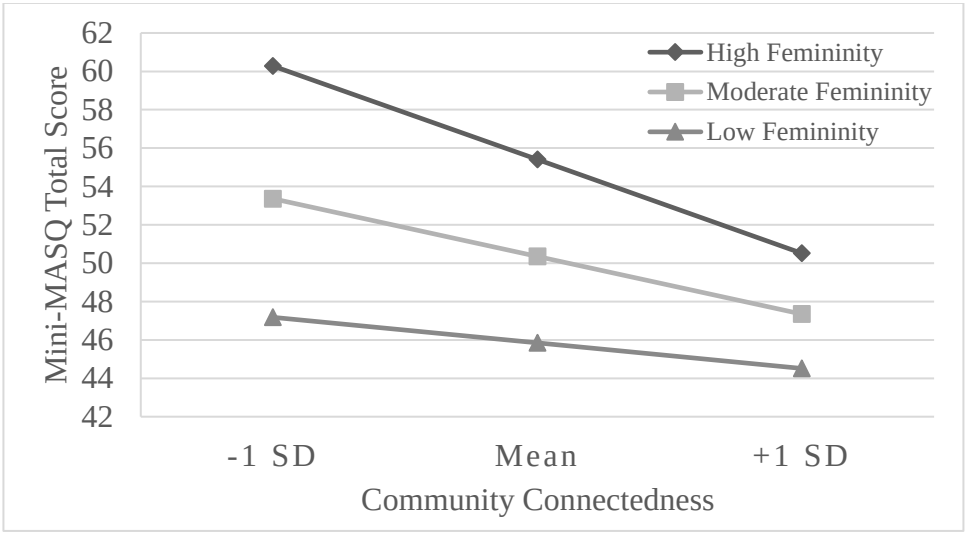
| Variable | *B* | *SE* | *t* |
|---|---|---|---|
| Model 1: Age | | | |
| CC | -0.20 | 0.19 | -1.03 |
| Age | -0.01 | 0.01 | -0.79 |
| CC x Age | 0.03 | 0.02 | 1.47 |
| Model 2: IC | | | |
| CC | -0.50 | 0.24 | -2.04* |
| IC | 0.19 | 0.11 | 1.72 |
| CC x IC | -0.15 | 0.10 | -1.59 |
| Model 3: Masculinity | | | |
| CC | -0.28 | 0.21 | -1.34 |
| Masculinity | -0.05 | 0.02 | -2.72** |
| CC x Masculinity | 0.01 | 0.02 | 0.52 |
| Model 4: Femininity | | | |
| CC | -0.23 | 0.17 | -1.39 |
| Femininity | 0.11 | 0.02 | 5.52*** |
| CC x Femininity | -0.07 | 0.02 | -3.78*** |
| Model 5: Race/Ethnicity | | | |
| CC | -0.18 | 0.18 | -0.98 |
| Race/Ethnicity | 0.17 | 0.26 | 0.65 |
| CC x Race/Ethnicity | -0.26 | 0.47 | -0.56 |

*Note*. Time was statistically significant ($p < .001$) in all models and was controlled for by including it as a Level 1 predictor of weekly INT. IC = Identity Centrality. * $p < .05$. ** $p < .01$. *** $p < .001$.

Panel A.




Panel B.




Panel C.

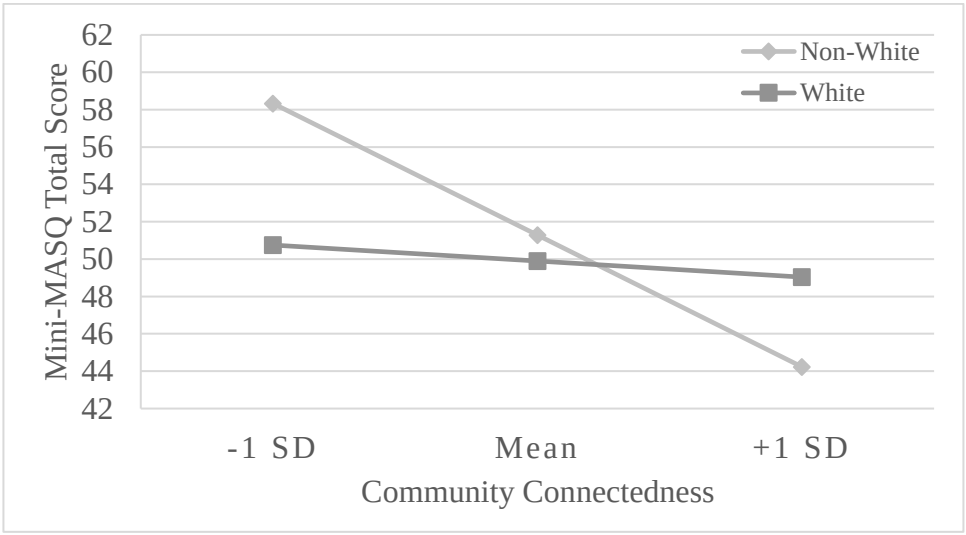



*Figure 1*. Conditional effects of community connectedness on Mini-MASQ scores examined at low (-1 SD), moderate (at the mean), and high (+1SD) levels of identity centrality (Panel A) and femininity (Panel B) and for Non-White and White participants (Panel C).

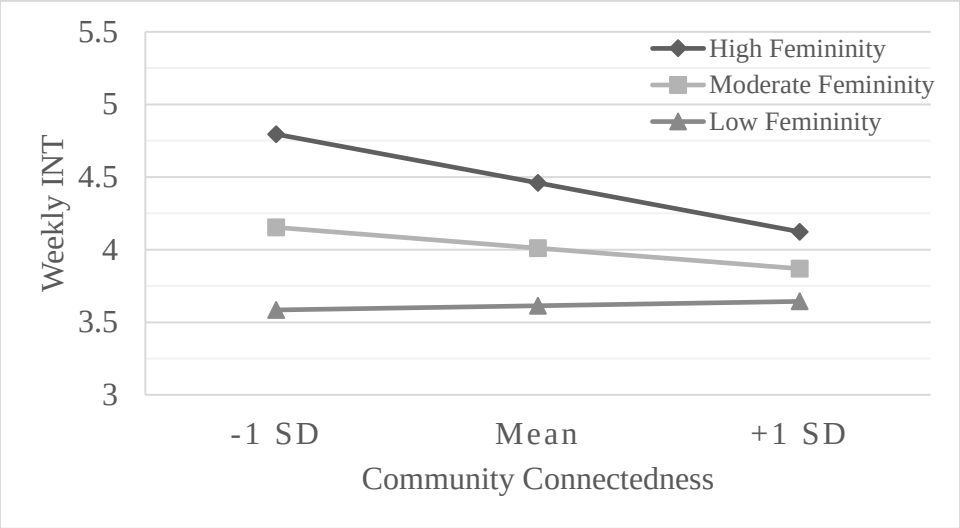



*Figure 2*. Conditional effects of community connectedness on weekly INT examined at low (-1 SD), moderate (at the mean), and high (+1SD) levels of femininity.

# CHAPTER 4

# DISCUSSION

Gay men are at greater risk for mental health problems than their heterosexual counterparts (Meyer, 2003). A significant body of research on minority stress has examined gay-related stressors (e.g., experiences of discrimination based on sexual orientation) that contribute to mental health difficulties (Puckett, Newcomb, Garofalo, & Mustanski, 2016; Sattler & Christiansen, 2017) but has largely overlooked promotive factors associated with more positive functioning among gay men. The current study addressed this gap using weekly diary data collected from 147 gay men to examine the cross-sectional and longitudinal associations between community connectedness and internalizing symptoms and the conditions under which the strengths of these associations change.

Results provide partial support for our hypotheses that 1) community connectedness would be associated with internalizing symptoms and 2) that various demographic and individual factors would moderate this association. Specifically, the current findings indicate significant negative associations between community connectedness and cross-sectional internalizing symptoms, such that greater community connectedness was associated with lower levels of internalizing symptoms. Findings are consistent with minority stress theory (Meyer, 2003, 2015) and other work examining the benefits of community coping resources (Hotton, Keene, Corbin, Schneider, & Voisin, 2018; Shilo, Antebi, & Mor, 2015) in suggesting that gay community connectedness may be associated with more positive outcomes among gay men. Longitudinal

associations, although not statistically significant, generally followed a similar direction as the cross-sectional results and warrant further study.

The current study also provides novel support for several factors that moderate the cross-sectional association between community connectedness and internalizing symptoms (i.e., identity centrality, femininity, and race/ethnicity in the cross-sectional analyses; femininity in the longitudinal analyses), such that these associations were stronger for some individuals than others. First, identity centrality moderated the association between community connectedness and internalizing symptoms, such that the association between community connectedness and identity centrality was strongest among individuals whose sexual orientation was more central to their overall identity (though still significant among individuals with lower levels of identity centrality). Perceptions that one is not connected to his community may be particularly problematic for gay men whose sexual orientation is central to their identity, whereas community connectedness may be less important for individuals whose sexual orientation is less central. Second, the association between community connectedness and internalizing symptoms was moderated by levels of femininity. As hypothesized, community connectedness had the strongest association with internalizing symptoms among men high in femininity and weaker associations with internalizing symptoms among men with lower levels of femininity. Third, our findings regarding race/ethnicity were consistent with our hypothesis, such that the association between community connectedness and internalizing symptoms was significant only for non-White participants. This pattern suggests that community connectedness may be particularly important for racial and ethnic minority gay men. In contrast, community connectedness and internalizing symptoms were not associated among White men, indicating that even when White men reported low levels of connectedness, they did not display higher levels of internalizing symptoms. For

both the cross-sectional and longitudinal analyses, the association between community connectedness and internalizing symptoms was not moderated by age or masculinity, indicating similar associations were found across levels of masculinity and age.

Before discussing the implications of these results, it is important to acknowledge several limitations. First, results were more robust for the cross-sectional associations than for the longitudinal associations. This may be due to the longitudinal measure of weekly internalizing symptoms consisting of only two items, and thus may have lacked sufficient variability to allow for significant differences on the basis of the variables studied here. Future research is needed to examine whether the cross-sectional results replicate using more robust and valid longitudinal assessments of internalizing symptoms. Second, our measure of community connectedness was administered only once, at the beginning of the study. It is possible that one's sense of community connectedness could fluctuate or change in response to environmental factors. Future research should examine the stability of community connectedness, as well as the direction and strength of within-person effects (e.g., changes in community connectedness could explain changes in internalizing symptoms). Third, we did not measure connectedness with the broader gay community as separate from connectedness to specific gay subgroups. It is possible that individuals felt more connected to a particular subgroup (e.g., bear community, party/club scene, other racial/ethnic minorities) than to the broader community. It may be useful to measure connectedness at multiple levels to identify and understand possible differences. Fourth, the current sample was comprised entirely of individuals living in New York City. It is likely that the experiences of and challenges faced by gay men in rural or suburban areas differ from those of urban gay men (e.g., political attitudes, availability of other resources, and different rates of victimization based on sexual orientation). It will be important for future research to replicate

findings in samples from more non-urban areas and to examine other factors unique to these samples (e.g., physical proximity to gay venues or other gay men). Finally, the study consisted of gay-identified cisgender men, and the current findings may not replicate to other sexual minority individuals.

Notwithstanding these limitations, the present findings add to the limited body of work examining gay-specific factors associated with more positive outcomes among gay men (Meyer, 2015; Meyer et al., 2008) by indicating that community connectedness is associated with lower levels of internalizing symptoms. Future research should examine the cognitive, affective, and behavioral processes explaining these linkages. For example, individuals who are more connected to their community may have more opportunities to challenge their own stigmatized beliefs about their identity (i.e., internalized stigma) as well as counter negative perceptions of the gay community. A stronger sense of connectedness may also lead to greater community participation and, consequently, increased social support and connectedness. Our findings also indicate that these associations may be particularly strong among certain gay men – in our study, those gay men whose sexuality is more central to their identity, are more feminine, and are non-White – calling attention to the importance of considering how multiple aspects of gay men's identity interact to influence their functioning. To the extent that two of these characteristics (i.e., femininity and racial minority status) are often marginalized within the gay community (Callander, Holt, & Newman, 2016; Han, 2008; Taywaditep, 2002) and/or associated with higher levels of psychological distress (Diaz, Ayala, Bein, Henne, & Marin, 2001; Remafedi, French, Story, Resnick, & Blum, 1998), these findings also suggest that community connectedness may be particularly important among groups that are otherwise at risk for poor outcomes.

These findings also raise practical implications for intervention. Recent work (Burton, Wang, & Pachankis, 2017; Pachankis, Hatzenbuehler, Rendina, Safren, & Parsons, 2015) has examined the efficacy and effectiveness of tailored psychotherapeutic interventions specifically aimed at addressing minority stress and mental health problems among sexual minorities. Our findings indicating that low levels of community connectedness are associated with more internalizing symptoms suggest that gay men's level of community connectedness should be assessed and examined as one possible contributor to their difficulties. If appropriate, increasing community connectedness may be one valuable target in these interventions, particularly for gay men who report low levels of connectedness and who indicate that this is distressing to them. Traditional interventions tend to overlook the importance of community connectedness (Herrick, Egan, Coulter, Friedman, & Stall, 2014), but greater focus on this domain among sexual minority communities may be especially important given that they may be less likely to receive support from their family-of-origin (Ryan, Huebner, Diaz, & Sanchez, 2009) or from their colleagues (Ragins & Cornwell, 2001). At the same time, the benefits of increased community connectedness may not be shared equally among all gay men, calling for a nuanced consideration of each client's specific circumstances when recommending greater integration into the gay community.

In conclusion, the current findings highlight associations between higher levels of community connectedness and lower levels of internalizing symptoms among gay men, underscoring the need to consider contextual factors underlying positive outcomes when examining components of minority stress. Future research should extend this work to more diverse samples of LGBT individuals and examine the processes linking community connectedness and mental health outcomes among this population.

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