An analysis of the relationship between double stigmatized identities and mental health, and the influence of employment

Mara Hofland (6289487)

Utrecht University, Faculty of Social and Behavioural Sciences, Department of Sociology

Supervisor: Dr. T. Spiegel

Second corrector: Kasper Otten

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Universiteit Utrecht

Abstract

Research has emphasized the relationship between having a stigmatized identity and mental health. In this study minority stress theory is used to explain why men with two stigmatized identities will have a worse mental health than men with one or no stigmatized identities. It was also examined if employment has a buffering effect on the relationship between having multiple stigmatized identities and mental health. Analysis was conducted in the USA on 63849 men who were either gay/bisexual or straight, and either white, black, Asian or Hispanic. Regression showed that 1) gay or bisexual men have a worse mental health than straight men, 2) white men have a worse mental health than the other ethnicities, 3) gay or bisexual white men have a worse mental health than all other identities combinations, and 4) employment works as a negative buffer for all groups except for gay or bisexual Asian men, for whom it is a positive buffer. Implications of these results are discussed.

Keywords: stigma; mental health; multiple stigmatized identities; minority stress; employment

Introduction

For some people it is hard to believe that in the modern world we live in today there is still discrimination, for other people it is their reality. Research from the Center for American Progress conducted in 2017 shows that people who are part of the LGB-community still face discrimination in their daily life (Singh & Laura, 2017). This discrimination can take all kinds of forms, from name-calling and exclusion to serious harassment. One participant told; "When partners at the firm invite straight men to squash or drinks, they don't invite the women or gay men. I'm being passed over for opportunities that could lead to being promoted.". Another stated; "I wonder whether I would be let go if the higher-ups knew about my sexuality". These people are seen and treated differently, essentially discriminated against, because of the stigma surrounding their identity.

According to Link and Phelan (2001) stigma is the co-occurrence of the following components: labelling, stereotyping, separation, status loss, and discrimination. Labelling is noticing that there is a difference between different kinds of people, like straight and gay people. Stereotyping is ascribing a set of undesirable characteristics to a person with a certain

label. Separation is considering the people with a different label as being fundamentally different from you and part of a different group. Because of the negative stereotypes people have to live with they will experience status loss and discrimination. Having a stigmatized identity is a psychological burden, which reduces the dignity and self-confidence of the people that have that identity (Remedios & Snyder, 2018).

Living with a stigmatized identity is not easy. Research has found that there is a relationship between stigma and symptoms of depression and anxiety (Markowitz, 1998). One identity that carries a stigma is the sexual orientation of people. In the past homosexuality was seen as a disease, and some people still view it that way. There is agreement in the academic literature that people who are part of the LGB-community are more likely to suffer from mental health problems like anxiety, suicidal ideation and depression than their heterosexual counterparts (Almeida, Johnson, Corliss, Molnar & Azreal, 2009; Furgesson, Horwood & Beautrais, 1999; Spittlehouse, Boden & Horwood, 2019). LGB people also have a higher chance of partaking in an act of self-harm (Almeida, Johnson, Corliss, Molnar & Azreal, 2009). Overall, they have poorer mental health and have more unmet mental health needs than non-LGB people (Burgess, Lee, Tran & Ryn, 2007). Some research has found that this discerption in mental health between LGB and non-LGB people is due to discrimination (Burgess, Lee, Tran & Ryn, 2007; Almeida, Johnson, Corliss, Molnar & Azreal, 2009). LGB people experience discrimination, like verbal abuse and physical assaults, because of their sexual orientation which non-LGB people do not endure (D'augelli & Grossman, 2001; D'augelli, Pilkington & Hershberger, 2002). Another identity with a stigma is the ethnicity of people. Research has shown that people with a non-native ethnicity or ethnic minorities endure higher levels of psychological distress than people with a native ethnicity (Erdem, Burdorf & Van Lenthe, 2017; Erdem, Riva, Prins, Burdorf & Van der Doef, 2019; Moore, Jayaweera, Redshaw & Quigley, 2019). This psychological distress is caused by anxiety and depression resulting in poorer mental health. According to literature, depression and poorer mental health is linked to (perceived) discrimination (Mereish, N'cho, Green, Jernigan & Helms, 2016; Ikram, Snijder, Wit, Schene, Stronks & Kunst, 2016). Some forms of discrimination that ethnic minorities endure are rental discrimination, refusing to rent a house to someone of a certain race/ethnicity, and other forms of everyday discrimination (Carpusor & Loges, 2006; Gong, Xu & Takeuchi, 2017).

A person's identity consists of different identities put together. For example, you can be both part of the LGB-community and at the same time be an ethnic minority. When this is the case, you have multiple stigmatized identities. Literature regarding multiple stigmatized

identities mostly shows that having multiple stigmatized identities leads to an increase in negative mental health outcomes in comparison to having one stigmatized identity (Remedios & Snyder, 2018; Hayes, Chun-Kennedy, Edens & Locke, 2011). They experience an increase in psychological distress and perceived discrimination in comparison to people with one stigmatized identity (Remiodos & Snyder, 2018; Hayes, Chun-Kennedy, Edens, & Locke, 2011). This specific combination of identities, sexual orientation and ethnicity, has already been researched before (McConnell, Janulis, Phillips, Truong & Birkett, 2018; Ramirez & Galupo, 2019) . Findings are consistent in that LGB people of color experience more distress than straight people of color. However, some research states that there is not much difference in distress between white LGB people and LGB people of color (Hayes, Chun-Kennedy, Edens & Locke, 2011). This would be in line with some studies that state that a certain combination of stigmatized identities will increase one's ability to cope with stigma (Crawford, Allison, Zamboni & Soto, 2002; Greene, 1996). This ability to cope with stigma, and discrimination, is experienced by people who are part of an ethnic minority group. People who are of a certain ethnicity are very likely to have the same ethnicity as their parents. Due to this, the discrimination that they experience, their parents have already experienced before. As a result, parents can teach their children how to deal with the stigma, something they learned from their own experience. Therefore, ethnic minorities will be more resilient to the discrimination they experience. For sexual minorities however, the chance of this happening is not the same. The chance that one’s parent has the same sexual orientation, so in this case that the father is gay or bisexual, is much smaller. Because of this the father doesn’t experience the stigma and discrimination that his child does. He won’t be able to teach you on how to deal. As a result sexual minorities will not be resilient to the experience they experience. However, when someone is part of both an ethnic minority group and a sexual minority group, that person can transfer their skills in dealing with ethnic stigma, to the extent that it is possible, to dealing with sexual stigma. When this is the case it does not mean that for this combination of stigmatized identities the person will experience more mental health issues due to discrimination than they would with only one stigmatized identities. It could also be that when someone has this combination of identities they will have a better mental health than when they are only part of a sexual minority group since they won’t be resilient. In order to examine if having multiple stigmatized identities will lead to a somewhat the same or worse mental health than having one stigmatized identity the following question will be answered:

What is the relationship between having multiple stigmatized identities, sexual orientation and ethnicity, and mental health?

After establishing this relationship, a possible buffer will be analysed. There are buffers like resilience and social support which have been looked at before in context of the relationship between having a stigmatized identity and mental health and these buffers have been proven to work (Bowleg, Huang, Brooks, Black & Bruckholder, 2003; Breslow, Brewster, Velez. Wong, Geiger & Soderstorm, 2015; Russel, 2005; Steers, Chen, Neisler, Obasi, Mcneill and Reitzel, 2019). However, this study will be focussing on a different buffer, namely employment. Employment has been researched as a buffer before in other contexts (Harada, Masumoto, Katagiri, Fukuzawa, Chogahara, Kondo & Okada, 2017; Delle & Amadu 2016; Neneh, 2019)). While most studies found that employment did indeed function as a buffer, some did not (Ozden-Yildirim & Ermis, 2017). For this study employment is an interesting buffer because not everyone in this study has the same changes of getting a job. Ethnic minorities often face discrimination when applying for a job (Sego, 1999; Rinne, 2018; Griffin, Attaway & Griffin, 2019). For example, white people are generally evaluated more positively than ethnic minorities (Derous, Peperman & Ryan, 2016). Overall, ethnic minorities are less likely to get a job than white people. So, when these ethnic minorities do get hired for a job, it is often experienced as something special. Because having work is so special to them, it would not be strange for employment to have an effect on the relationship between having multiple stigmatized identities and mental health. People within the LGB community also report experiencing discrimination during the hiring process (Luiggi-Hernández, Torres, Domínguez, Sánchez, Meléndez, Medina, & Rentas, 2015). So, the same feeling about getting a job being special applies to them. Because for both groups it is something special to get employment, it might even have a bigger effect for people who have two stigmatized identities. To examine if employment works as a buffer in the context of this study the following question will be answered:

What is the effect of employment on the relationship between having multiple stigmatized identities and mental health?

This research will try to answer the stated research question by looking at gay, bisexual, or straight men who identity as being white, black, Asian, or Hispanic in the United States of America (USA). The choice to look at men only was made for several reasons. The first reason being that in some households in the USA traditional gender roles are still prominently at play (Pew research center, 2017). According to traditional gender roles the man of the house should be the breadwinner while the woman of the house does all the

housework. Because of this there is more emphasis on the man to have a job instead of on the woman. It is likely that as a result employment has more of a buffering effect for men than for women. The choice to look at the US was made for two reasons. The first reason being that the US has a very diverse population that has only risen in diversity the last few years (Frey, 2019). The second reason has to do with the cultural and institutional changes that the USA has gone through the last years. Two of the most important changes for this study are the legalization of same-sex marriages and the black lives matter movement that originated from the USA (BBC, 2015; BlackLivesMatter, 2020).

Theory

In this theory section two different theories will be discussed and applied to the context of this study. First, the minority stress theory will be used to explain, why people of a sexual minority group experience negative health outcomes, why people of an ethnic minority group experience negative health outcomes and what outcome having double stigmatized identities will have. Second, theories of intergroup relation will be used to explain how employment will act as a buffer in the relationship between stigmatized identities and mental health.

Minority stress theory

In 2003 Meyer came with a framework for minority stress theory. This theory considers the degree of stress involved with being part of a sexual minority group. In society there are sexual majority groups, heterosexual people, and sexual minority groups, for example gay people. Both groups experience stressors in their day to day life. However, people who are part of a sexual minority group experience unique stressors, mostly discrimination, oppression, and prejudice, related to their minority status on top of the general stressors people experience. According to Meyer there are three different stress processes relevant to minority stress; 1) events and conditions which are objective to the perception of the one experiencing them, 2) the expectations one has of these events and the vigilance towards this, and 3) internalization of negative societal attitudes. These extra stressors sexual minorities experience can be related to the stigma that rests on their sexual identity, but that is not always the case.

An example of a stressor that was more of an added stressor for the LGB-community than non-LGB people was the HIV epidemic (Herek & Garnets, 2007). Gay and bisexual men were the ones most impacted by this disease. This caused stressors, like being scared to get infected or losing a loved one to HIV, which is unique for the LGB-community. As stated before, stressors can also be a result of stigma. There are different kinds of stigma that entail these stressors. There is structural stigma, enacted stigma, and felt stigma.

Structural stigma is about cultural norms and institutional policies that have a negative influence on the opportunities, resources, and wellbeing of the stigmatized (Hatzenbuehler, Bellatorre, Lee, Finch, Muennig, & Fiscella, 2014). A popular example is gay marriage. Not that long ago it was still not legal in all states of the USA to have a same-sex marriage (Georgetown Law Libray, n.d.). Even though it is legal at the moment, it is still frowned down upon by some people (Pew Research Center, 2019). These people who don't support same-sex marriages might refuse to rent them a wedding location, or they might refuse to make a wedding cake for a same-sex couple. This puts a strain on same-sex couples who want to get married. Some religious groupings condemn same-sex marriages. This is also a form of structural stigma. The cultural norms which are in place in that religion prevent LGB people from getting support from these religious followers. Enacted stigma or interpersonal stigma is about how you are treated by other people and how you experience that. This type of stigma has different dimensions. The first dimension is major life events (Meyer, 2011). These are big events that will have a big impact, being fired from your job for being gay for instance. The second dimension is chronic strains. These are things that are constantly happening. It could be that when a person reveals to his family and friends that he is gay or bisexual, that his family and friends might reject them. From that point on that person has a non-existing or damaged relationship with these friends and families. Not being able to interact with these people like you did before will be a constant strain in your life. The third dimension is minor events. Minor events are about the day to day hassle people of the LGB-community have to go through. Some examples are getting dirty looks on the street when you are holding your same-sex partner's hand or getting verbally abused for it. Or as the respondent in the intro told, not being included by heterosexuals. The fourth and last dimension are non-events. Because of the discrimination that sexual minorities experience they might go to a less successful but more tolerant school instead of the top school they wanted to go to because of homophobia in that school. These non-event shape in which direction their lives will go. Non-events also entail not presenting yourself as your real self is to draw less attention to yourself

for your safety. These non-events result in lost opportunities, not being able to go to the school you want, and concerns about safety and not expressing yourself. The last form of stigma is felt stigma. You yourself do not need to experience the direct consequence of enacted stigma to feel like you are discriminated against. When you see that the group that you belong to, the LGB community, is being wronged, you feel like you are also being discriminated against. An example of this was the nightclub shooting in Orlando in 2016 (Zambelich & Hurt, 2016). This nightclub was a gay club and the shooting was directed towards the gay people that were inside. Even though a part of LGB people was directly affected, people of the LGB community all over the world felt targeted.

Because of all the stressful events and conditions, LGB people go through because of their sexual minority status, they experience unique stressors that people who are not sexual minority do not experience. These stressors can be related to the above-mentioned stigma and the discrimination this stigma brings. These unique stressors add up with the stressors that everybody, LGB and non-LGB, experience. With the added stressors, LGB people experience more stress. When a person experiences more stress, their chances of developing a bad mental health increases. Since stigma causes people living with a stigmatized identity to experience more stress than people who are not living with that stigmatized identity, they will experience a worse mental health than the other group. In this case LGB people, as mentioned before, experience more added stressors and more stress than non-LGB people, because of this it is very likely that LGB people experience worse mental health than non-LGB people. This results in the following hypothesis:

H1. Gay or bisexual men experience worse mental health than heterosexual men

Even though minority stress theory is focussed on sexual minorities, it can also be applied to other types of minority groups. For this study ethnic minorities will be used. As stated before, the essence of minority stress theory is that the minority groups experience unique stressors related to their minority status on top of the common stressors everybody endures. These stressors are related to prejudice, stigma, oppression, and discrimination. Just like sexual minorities, ethnic minorities experience stigma and unique stressors. While the days of color segregation are long gone, the effects are still visible. Ethnic minorities commonly deal with a lot of discrimination.

An example of structural stigma ethnic minorities experience is ethnic profiling (ENAR & open society justice initiative, 2019). With this type of profiling police determine whom they see as suspicious according to what they look like and who they are instead of what they are doing. A result of ethnic profiling is that ethnic minorities are more often questioned than white people. Next to structural stigma, ethnic minorities also experience enacted stigma. For example, ethnic minorities are often turned down for jobs they would have gotten if they were white (Carpusor and Loges, 2006). In their day-to-day life they have to put up with being verbally abused and being treated like they are dangerous. Lastly, ethnic minorities experience a lot of felt stigma. The #BlackLivesMatter movement came to life because of the murder of Trayvon Benjamin Martin (BlackLivesMatter, 2020). Many black people felt personally targeted by this murder since the only reason Martin was shot was because the shooter thought he looked suspicious.

Ethnic minorities are often targeted for being an ethnic minority. Because of this they experience unique stressors related to their minority status, stressors that people who aren't ethnic minorities don't experience. These unique stressors add on top of the general stressors that everybody can experience. Because of the added stressors ethnic minorities, just like sexual minorities, have an added mental health risk.

It is important to notice that even though all ethnic minorities experience added stressors, these unique stressors can be different from one ethnicity to another. Black people get discriminated against the most (Carpusor & Loges, 2006; Lewis, Yang, Jacobs & Fitchett, 2012). A reason for this could be found in the history of black people. They were used as slaves without any human rights. To break free of this they had to stand up to the people that oppressed them, which resulted in an aggressive view of black people. All these historic events seem to influence the view of some people have of black people today. Even though it is not the case they are still seen by some as more dangerous and less smart than other people. Because of this black people experience more unique added stressors than Asians and Hispanics, making their health risks even higher. After black people, it is not clear which ethnicity, Asian or Hispanic, endures the most discrimination. Some sources state it is Hispanics because they are more often looked at as doing something wrong than Asians (Hwang & Goto, 2008). Other sources state it is Asians because they experience more peer discrimination than Hispanics (Rosenbloom & Way, 2004; Greene, Way & Pahl, 2006). There are also studies which put Asians and Hispanic on the same level of discrimination (Forrest-Bank & Jenson. 2015). For this study Asians and Hispanics are considered to experience the same level of discrimination. Lastly, white people are not part of a minority group, therefore

they will not experience unique stressors related to their ethnicity. They will only experience the general stressors that everybody experiences. Therefore white people will have a better mental health compared to black, Asian and Hispanic people. This results in the following hypothesis;

H2. Black men experience worse mental health than Asian, Hispanic and white men and Asian and Hispanic men experience worse mental health than white men.

As explained in the introduction, one's personality consists of multiple identities. As a result, you can experience unique stressors from two stigmatized identities. With having multiple stigmatized identities, a unique stressor is added on top of the stressors you experience in general and those unique for the stigmatized identities apart (Ferraro & Farmer, 1996). If you are gay and black, there is a high chance that you are experiencing enacted stigma from within the black community for being gay. The other way around could also be the case, you can experience enacted stigma from within the LGB-community for being black. A result is that you don't get the social support from that community, which you would have gotten in the case of one stigmatized identity. This will give unique added stressors for people with multiple stigmatized identities that people with one or none stigmatized identity don't experience. Because of this people with multiple stigmatized identities have more added health risks. As stated before, when looking at ethnic minorities black people experience the most stressors, followed by Asian and Hispanic people, and lastly white people and when looking at sexual minorities people who are gay or bisexual experience more stressors than straight people. When you add these two ranks together, with keeping in mind that having two stigmatized identities is worse than having one, the following hypothesis follows:

H3. Gay or bisexual and black men experience the worst mental health, this is followed by gay or bisexual and Asian or Hispanic men, after this straight and black men experience the worst mental health, followed by straight and Hispanic or Asian men and gay or bisexual and white men, lastly straight and white men experience the least bad mental health.

Theories of intergroup relations

In 1979 Tajfel and Turner came up with the social identity theory. The core of the theory is that people want a positive self-identity. This desire makes them compare the group they belong to with other groups.

There are four concepts that are central to social identity theory; social categorization, social identity, social comparison, and psychological group distinctiveness. Social categorization means that people order the world in different segments. From these segments people get their locus of identification for the self. Structure of the social environment and define their place in it. Social identity is about knowledge about your identity, derived from which group you belong to combined with the attachment to the membership. Social comparison means that the characteristics of the group one belongs to (the in-group) are compared to the characteristics of other groups (the out-group). This is a way to know if your group holds a positive or negative position. And lastly, Psychological group distinctiveness means that a desired status where the in-group is seen as distinct and positive in comparison with out-groups

Individuals strive to have a positive social identity to feel good about themselves. Since individuals derive their social identity from the group they belong to, members of a more favorable group will view themselves more positively than people from a less favorable group. Through intergroup comparison members will try to make their in-group more favorable. The attempt to achieve a comparatively superior group is a key factor in discriminatory intergroup behavior. When people are part of an in-group which has a negative identity, they will strive for change when this is possible. There are some different ways in which the groups or individuals will try to accomplish this change. One of these ways is social mobility. With social mobility people try to exit the disadvantaged group and join a more positively evaluated group. This is only possible when the group is open and exit is possible. An example of a situation where exit is not possible, is when the disadvantage is related to skin color or sex. When social mobility is not an option, individuals will adopt the strategy intragroup comparison. In this strategy an individual will compare him/herself to others in the same in-group. When you have a better status than other people in your group, maybe you are employed and they are not, you will feel like you are better than they are. This type of comparison is less likely to lead to an unfavorable evaluation of the individual.

From this theory it can be concluded that people who can either join a more positive group or excel in their group are more positive about themselves. The job that someone has, gives that person a certain status (Lievens, 2015). People who are unemployed lack that

status, therefore people who have a job are automatically higher in status in the in-group than people without a job. As a result these people with a job will feel better about themselves when they compare themselves to others. Even though people who have a job still experience stressors related to their minority status, they do feel better about themselves than people who don't have a job. This will result in them having higher self-esteem. Having higher self-esteem works as a mediator between stressors and negative mental health outcomes because people with a higher self-esteem are less influenced by the opinion of others than people with a low self-esteem (Mäkikangas & Kinnunen, 2003). It is to be assumed that people with a job have a higher self-esteem because they have a more positive image of themselves then people without a job. This buffer will not work for those who are not part of a minority group. These people are already in a more favorable group that gives them a positive social identity. They do not have to compare themselves to others in the in-group to feel better about themselves. This results in the following hypothesis:

H4: Having employment works as a positive buffer between having (multiple) stigmatized identities and mental health.

Method

In this study data from the Behavioural risk factor surveillance system 2018 was used (CDC). Behavioural risk factor surveillance system is a standardized telephone survey conducted in the US and its territories annually. The BFRSS is aimed at behavioural risk factors and chronic conditions in adults aged 18 or older. It is conducted in all 50 states of the USA, the district of Columbia, Puerto Rico and Guam. In order to conduct the survey calls were placed to both landlines and cell phones using random digit dialling methods of sampling. In 2018, the response rates of the landline were 53,3% and for the cell phone were 43,4%. The total number of respondents who participated in the study was 437436. People who were not male were excluded (N= 240024). After excluding people who did not have a valid answer to the question used to make the later mentioned variables (ethnicity, sexual orientation, mental health) there were 63849 respondents left. Of these 63849 respondents, 95,8% were straight (N=61148) and 4,2% were gay or bisexual (N=2701). When it comes to ethnicity, 78.7% of the respondents were white (N=50253), 9,1% were black (N=5792), 3,8% were Asian (N=2445) and 8,4% were Hispanic (N=5359). After combining the two identities together 75,5% were straight and white (N=48192), 8,7% were straight and black (N=5550), 3,7%

were straight and Asian (N=2343), 7,9% were straight and Hispanic (N=5063), 3,2% were gay or bisexual and white (N=2061), 0,4% were gay or bisexual and black (N=242), 0,2% were gay or bisexual and Asian (N=102), and 0,5% were gay or bisexual and Hispanic (N=296).

Sexual orientation

The male respondents were asked 'which of the following best represents how you think of yourself?'. The answer options were; 1 'gay' 2 'straight, that is, not gay' 3 'Bisexual' 4 'Something else' 7 'I don't know the answer' 9 'Refused'. For this study only the respondents who chose option 1, 2 or 3 were included. Respondents who chose one of the other two categories were recoded into missing. This variable was recoded into a new variable were 1 'gay/bisexual' and 0 'straight'.

Ethnicity

For the ethnicity, the variable computed race/ethnicity was used. This is because in this variable people who were multiracial were separated from the other answer options. Since it is not possible to know which ethnicities the multiracial respondents are, there could be a chance that both the ethnicities of these respondents are of a minority status. This could influence the results, since these people already experience multiple minority stress without taking their sexual orientation into consideration. The categories were 1 'white only, non-Hispanic' 2 'Black only, non-Hispanic' 3 'American Indian or Alaskan Native only, non-Hispanic' 4 'Asian only, non-Hispanic' 5 'Native Hawaiian or other Pacific Islander only, Non-Hispanic' 6 'Other race only, non-Hispanic' 7 'Multiracial, non-Hispanic' 8 'Hispanic' 9 'Don't know/Not sure/Refused'. For this study only the categories 1, 2, 4 and 8 were used. The variable computed race/ethnicity was recoded into variable Ethnicity with values 1 'white' 2 'black' 3 'Asian' 4 'Hispanic'. Respondents who had chosen other categories are recoded as missing.

Multiple stigmatized identities

Groups were made in order to analyse which combination of stigmatized and non-stigmatized identities had the worst mental health. For these groups the variables sexual orientation and ethnicity were combined. This resulted in a variable multiple identities groups with the values 1 ‘gay/bisexual and white’ 2 ‘gay/bisexual and black’ 3 ‘gay/bisexual Asian’ 4 ‘gay/bisexual and Hispanic’ 5 ‘straight and white’ 6 ‘straight and black’ 7 ‘straight and Asian’ 8 ‘straight and Hispanic’.

Mental health

Mental health was measured using the question; “Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?” Respondents answered in numbers from 1 to 30 corresponding to how many days they had experienced their mental health to not have been good. People who had not experienced bad mental health days were given the values 88 ‘None’, people who didn’t know were giving the value 77 ‘Don’t know/not sure’, and people who did not want to answer were given value 99 ‘Refused’. For this study this variable was recoded into the variable bad mental health. The value 88 was recoded into 0 so that the answer in days would be on a scale. There were no odd values for this variable in the data. Furthermore, people who were ascribed value 77 or 99 were put as missing as their answer could not be used in the analysis.

Employment

For employment people were asked ; ‘are you currently…?’ 1 ‘employed for wages’ 2 ‘Self-employed’ 3 ‘out of work for 1 year or more’ 4 ‘out of work for less than 1 year’ 5 ‘a homemaker’ 6 ‘a student’ 7 ‘retired’ 8 ‘unable to work’ 9 ‘refused’. For this study a new variable was recoded were people who originally answered 1 ‘employed for wages’ or 2 ‘Self-employed’ were given the value 1 ‘employed’ and people who originally answered 3 ‘out of work for 1 year or more’ 4 ‘out of work for less than 1 year’ 5 ‘a homemaker’ 6 ‘a student’ 8 ‘unable to work’ were given the value 0 ‘unemployed’. The people who originally answered 7 ‘retired’ or 9 ‘refused’ were put as missing. For value 7 ‘retired’ this is because some people who are retired still can hold some form of status from their previous job, take a

lawyer or judge for instance. The end values or employment were; 0 ‘unemployed’ 1 ‘employed’.

Control variable

In this study two control variables were, the first one being age and the other income. For age the respondents were put into categories with an interval from 5 years. The values are 1 'age 18 to 24' 2 'age 25 to 29' 3 'age 30 to 34' 4 'age 35 to 39' 5 'age 40 to 44' 6 'age 45 to 49' 7 'age 50 to 54' 8 'age 55 to 59' 9 'age 60 to 64' 10 'age 65 to 69' 11 'age 70 to 74' 12 'age 75 to 79' 13 'age 80 or older' 14 'Don’t know/refused/missing'. People who answered 14 ‘don’t know/refused/missing’ were put as missing. For income the respondents were put into six different categories of income with the values 1 'Less than $15000' 2 '$15000 to less than $25000' 3 '$25000 to less than $35000' 4 '$35000 to less than $50000' 5 '$50000 or more' 9 ‘don’t know/not sure/refused’. People who were attributed value 9 were put down as missing. For age 818 respondents out of the 63849 were put down as missing and for income that number was 7356. Since these variables function as control variables it would be a waste to not include the men who only had missing on these variables and not the rest. To solve this problem, the men who had a missing on either age or income, or both were given the mean of the variable as their answer in order to still be able to put them in the analysis.

Data analysis

In order to answer the research question the data was analysed using a regression. The first regression, table 2, was to analyse the relationship between mental health and sexual orientation. To analyse the relationship between ethnicity and mental health a second regression was conducted shown in table 3.The regression to analyse the relationship between the multiple identities and mental health is shown in table 4, and the moderating effect of employment is shown in table 6. All regression, except for the one for the moderation, were run with and without the control variables age and income. The outcomes without the control variables will be shown in the tables but not discussed in the text. The effect of the control variables will be discussed at the end of the result section.

Table 1. Descriptives

	N	Minimum	Maximum	Mean	SD
Mental health	63849	,00	30,00	3.418	7.744
Sexual orientation	63849	,00	1,00	.042	.201
Ethnicity	63849	1,00	4,00	1.419	.908
Straight white (reference)	48192	,00	1,00	.755	-
Straight black	5550	,00	1,00	.087	-
Straight Asian	2445	,00	1,00	.037	-
Straight Hispanic	5063	,00	1,00	.079	-
Gay/bisexual white	2061	,00	1,00	.032	-
Gay/bisexual black	242	,00	1,00	.004	-
Gay/bisexual Asian	102	,00	1,00	.002	-
Gay/bisexual Hispanic	296	,00	1,00	.005	-
Employment	63849	,00	1,00	.815	-
Age	63849	1,00	13,00	6.145	3.003
Income	63849	1,00	5,00	4.035	1.268

From table 1 it becomes clear that overall the mental health of the men in this study is relatively good and that more men are straight than gay. Furthermore, the men in this study are mostly white. When looking at the combination of the identities it becomes visible that most men are white and straight. The smallest group is those of gay/bisexual Asian men. Lastly, the men in this study fall mostly in the higher income categories and are generally middle aged.

Results

Prior to doing the regression several assumptions were evaluated. The first assumption was normal distribution. Steam and leaf plots showed that the data was not normally distributed. As a result is the test is sensitive to non-normality the results will be influenced. Because the sample population is large the non-normality is not expected to be a problem. Furthermore, boxplots showed that there were univariate outliers, however these outliers seem to be plausible answers so they were left in. Second, the normality probability plot of standardised residuals as well as the scatterplot of standardised residuals against standardised predicted values were inspected and showed that the assumptions of homoscedasticity of residuals and linearity were met. Third, Mahalanobis distance exceeded the critical X^2 for all regressions. Lastly the tolerance and VIF were investigated. Both the tolerance as the VIF showed that there was no multicollinearity for most of the regressions. In the regression to test the effect of the combined identities on mental health some combinations of identities showed signs of multicollinearity. It was not clear what caused this.

Table 2. Regression analysis results between Sexual orientation, age, income and bad mental health

	Model 1		Model 2	
	B	s.e.	B	s.e.
Constant	3.302***	,031	9.818***	.115
Sexual orientation	2.742***	,152	2.212***	,148
Age			-.190***	,010
Income			-1.319***	,023
F	325.908***		1314.290***	
R^2	,005		,058	

*** p < .001, ** p < .01, * p < .05

In table 2 it is shown that in model 2 the combination of the effects of sexual orientation, age, and income accounted for a significant 5.8% of mental health (R^2=.058 F(3,63845)= 1314.290, p<.001).

Model 2 shows that when age and income are held constant, there is still a significant difference in mental health between straight and gay or bisexual men (B=2.212, t=14.927, p<.001). Meaning that gay or bisexual men have a worse mental health than straight men. This difference is medium to large size considering it is slightly less than the mean of mental health.

In conclusion, gay or bisexual men experience a worse mental health than straight men.

Table 3. Regression between different ethnicities mental health and the control variables with white as reference group

	Model 1		Model 2	
	B	s.e.	B	s.e.
Constant	3.410***	.035	10.650***	,123
Black	.550***	.107	-.515***	,106
Asian	-1.314***	.160	-1.867***	,156
Hispanic	.101	.111	-1.299***	,111
Age			-.228***	,010
Income			-1.388***	,024
F	33.707		797.674	
R2	.002		,059	

*** p < .001, ** p < .01, * p < .05

Table 3, model 2, shows the results of one of the multiple regression analysis between different ethnicities (white (reference), black, Asian, and Hispanic), the control variables age and income, and mental health. Multiple different regressions were run with each a different

reference group to have a better picture of the effect. The combination of the multiple linear regression effect of the different ethnicities, age, and income accounted for 5.9% of the variance of mental health (R^2=.059, $F(5,63848)$=797.674, $p<.001$).

Table 3, model 2, shows that when age and income are held the difference in mental health between the reference group (white) and the other groups. In line with the hypothesis it is found that there is a significantly negative difference in mental health between black men and Asian (B=-1.352, t=-7.431, $p<.001$) and Hispanic men (B=-.783, t=-5.478, $p<.001$). Showing that black men have a significantly worse mental health than both Asian and Hispanic men. One unexpected finding is that of white men having a negative significant difference in mental health than all three other groups. Against expectations white men have a worse mental health than black, Asian and Hispanic men. There was also a positive significant difference in mental health between Asian and Hispanic men (B=.569, t=3.092, $p=.002$), meaning that Hispanic men have a worse mental health than Asian men.

In conclusion, while it is found that black men do have a worse mental health than Asian and Hispanic men, white men have the worst mental health.

Table 4. Regression between the different combinations of identities, mental health and the control variables with straight white as reference group

	Model 1		Model 2	
	B	s.e.	B	s.e.
Constant	3.291***	.035	10.436***	.124
Straight Black	.616***	.109	-.444***	.108
Straight Asian	-1.277***	.163	-1.807***	.159
Straight Hispanic	.050	.114	-1.329***	.114
Gay/bisexual white	2.891***	.174	2.323***	.169
Gay/bisexual black	1.998***	.497	.475	.484
Gay/bisexual Asian	.679	.765	-.580	.744
Gay/bisexual Hispanic	3.121***	.450	1.429**	.438
Age			-.219***	.010
Income			-1.374***	.024
F	62.430***		470.548***	
R2	.007		.062	

*** p < .001, ** p < .01, * p < .05

Table 4, model 2, shows the difference in mental health between men who are straight and white (reference group) and the other groups when age and income are held constant. Next to this regression, other regressions were run with other reference groups to have a full picture of how the groups compare to each other. The combination of variables of the second regression, with the control variables, accounted for 6.9% of the variance of mental health (R2=.062, F(9,63839)=470.484, p<.001).

Analysis showed that men who are gay or bisexual and black were not the ones who have the worst mental health, men who are gay or bisexual and white are. A large to medium-sized positive significant difference was found between these two groups (B=1.848, t=3.625,

p=.001). Next to this, men who are gay or bisexual and black had a non-significant positive difference in mental health with men who are gay or bisexual and Hispanic (B=.954, t=1.468, p=.142). There was also a small non-significant negative difference in mental health between men who are gay or bisexual and black and men who are gay or bisexual and Asian (B=-1.055, t=-1.191, p=.234). Since both gay or bisexual white and Hispanic men seem to have a positive difference in mental health compared to gay or bisexual black men, it is interesting to look at how they compare to each other. Analysis showed that there was a fairly small to medium non-significant negative difference in mental health between men who are gay or bisexual and white and men who are gay or bisexual and Hispanic (B=-.894, t=-1.916, p=.055). Surprisingly, there was a positive difference in mental health between men who are gay or bisexual and Asian and men who are straight and white (B=.580, t=.780, p=.436) and men who are gay or bisexual and Asian and men who are straight and black (B=.136, t=.181, p=.857), but again these differences are non-significant. A positive difference in mental health is also found between men who are straight and black and men who are straight and white, but this time the difference is significant (B=.444, t=4.126, p<.001). This means that men who are straight and white have a worse mental health than men who are straight and black. Analysis shows a negative significant difference in mental health between men who are straight and black and men who are straight and Asian (B=-1.363, t=-7.348, p<.001) or straight and Hispanic (B=-.884, t=-6.044, t<.001), meaning that men who are straight and black have a worse mental health than men who are straight and Asian or Hispanic. Between men who are straight and Asian and men who are straight and Hispanic there is a small significant positive difference (B=.478, t=2.545, p=.011).

In conclusion, men who are gay or bisexual and black do not experience a worse mental health than the other identity combination, men who are gay or bisexual and white do. After men who are gay or bisexual and white, men who are gay or bisexual and Hispanic experience worse mental health and only after them men who are gay or bisexual and black experience worse mental health than the remaining identity combinations. This is followed by, surprisingly, men who are straight and white and after them men who are straight and black have a worse mental health. Next in line are gay or bisexual and Asian man, who have a worse mental health then straight and Asian or Hispanic men. Lastly men who are straight and Hispanic have a worse mental health than men who are straight and Asian.

Table 5. Regression between employment, mental health and the control variables

	Model 1		Model 2	
	B	s.e.	B	s.e.
Constant	9.451***	.146	13.800***	.183
Employment	-5.216***	.076	-3.943***	.084
Multiple identities groups	-.340***	.025	-.477***	.025
Age			-.210***	.010
Income			-.834***	.026
F	2441.746***		1629.114***	
R^2	.071		.093	

*** p < .001, ** p < .01, * p < .05

Table 5 shows the results of the regression between employment, mental health and the control variables age and income. The combination of these variables accounted for 8.3% of the variance of mental health (R2=.093, F(4,63844)=1629.114, p<.001)

When controlled for age and income, employment has a significant negative main effect. Men who are unemployed have a worse mental health than men who are employed (B=-3.943, t=-46.762, p<.001).

Table 6. Regression between the combination of identities, mental health, the control variables and the moderator.

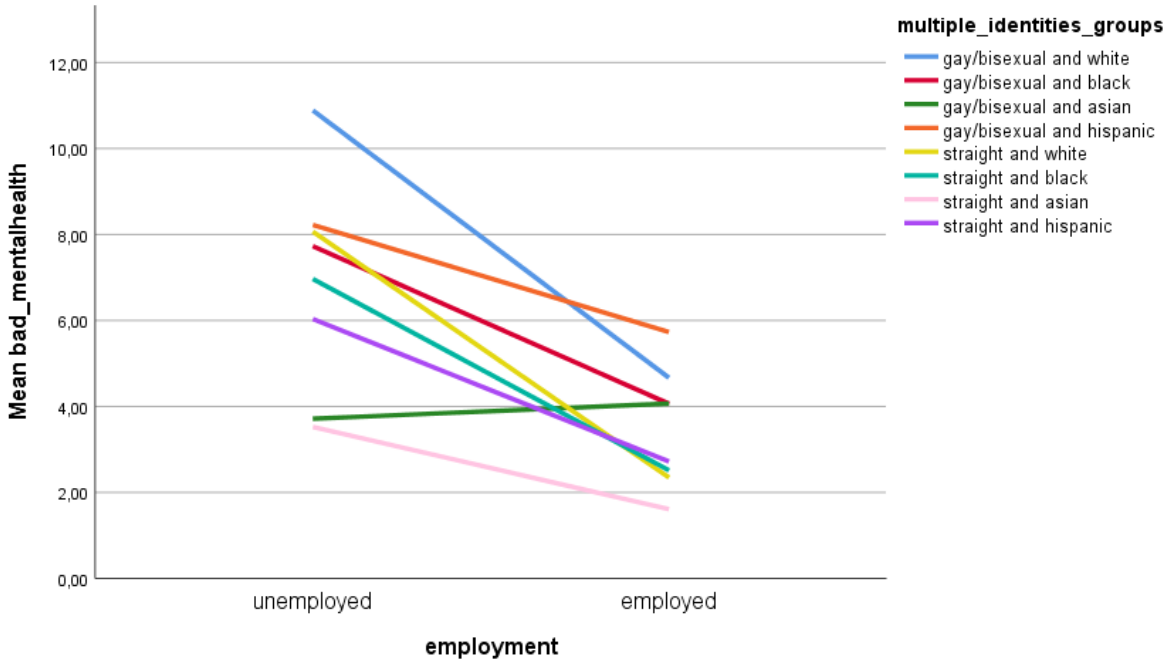
	Model 1		Model 2	
	B	s.e.	B	s.e.
Constant	10.436***	.124	11.712***	.129
Straight Black	-.444***	.108	-1.325***	.195
Straight Asian	-1.807***	.159	-4.854***	.343
Straight Hispanic	-1.329***	.114	-2.562***	.254
Gay/bisexual white	2.323***	.169	2.517***	.339
Gay/bisexual black	.475	.484	-1.004	.823
Gay/bisexual Asian	-.580	.744	-4.903***	1.394
Gay/bisexual Hispanic	1.429**	.438	-.308	.823
Age	-.219***	.010	-.213***	.010
Income	-1.374***	.024	-.799***	.026
Employment			-4.450***	.099
Straight black * Employment			.911***	.232
Straight Asian * employment			3.732***	.384
Straight Hispanic * Employment			1.921***	.281
Gay/bisexual white * Employment			-.521	.389

Gay/bisexual black * Employment		1.827	1.007
Gay/bisexual Asian * Employment		5.687**	1.636
Gay/bisexual Hispanic * Employment		2.394*	.965
F	470.584***	398.556***	
R^2	.062	.096	

*** p < .001, ** p < .01, * p < .05

Table 6 shows the results of one of the multiple linear regression analyses between the groups of the combination of identities, the control variables age and income, mental health and the interaction of employment. Multiple regressions were run with each having a different reference group to have a bigger picture of the effects. This combination of variables accounted for 9.6% of the variance of mental health (R2=.096, F(17,63831)=398,556, p<.001). There is sufficient evidence that the effect of employment differs between groups (R2 chance =.034, F chance=297.872, p<.001).

Figure 1. Interaction between employment and the identities.



As shown in figure 1 for most groups employment works as a negative effect on the relationship between multiple stigmatised identities and mental health. The only identity combination to have a non-significant negative effect is men who are straight and Asian, the other groups had a significant negative effect. The only exceptions to not having a negative effect are men who are gay or bisexual and Asian. For most groups, being employed causes the relationship between their identities and mental health to be less strong. This impact on the relationship was the strongest for men who are gay or bisexual and white (B=-4.962, t=-13.066, p<.001) and the least strong for men who are straight and Asian (B=-.718, t=-1.920, p=.055). For men who are gay or bisexual and Asian employment has a non-significant positive effect on the relationship between multiple stigmatized identities and mental health (B=1.236, t=.757, p=.449).

In conclusion, employment functions as a negative buffer for all groups except gay or bisexual Asian men, for whom it functions as a positive buffer.

Both control variables, age and income, had a consistent negative significant effect on mental health. For age this means that men who are younger have a worse mental health than men who are older, and for income this means that men who have a lower income have a worse mental health than men who have a higher income. The effect of income was overall stronger

than that of age. When controlling for both variables the constant of the regression generally more than doubled. Sometimes differences that were positive before switched to being negative, or the other way around, once controlled for age and income or it changed from significant to non-significant.

Discussion

This study was conducted in order to examine the relationship between stigmatized identities and mental health and whether having multiple stigmatized identities is worse for your mental health than having one stigmatized identity. It was also analysed if employment had a buffering effect on this relationship and for which identity combinations this was the case. The first finding was one that aligned with what many researchers have found before (Almeida, Johnson, Corliss, Molnar & Azreal, 2009; Furgesson, Horwood & Beautrais, 1999; Spittlehouse, Boden & Horwood, 2019). Men who are either gay or bisexual have a worse mental health than men who are straight. The second finding was quite surprising. Analysis showed that white men have a worse mental health than black, Asian or Hispanic men. Another reason could have to do with masculinity. Nowadays there is a shift in society about masculine styles. With the traditional masculinity style men had to be assertive, skilled and completely straight among some other things (Gordon, 2019). Because of the negative influence this type of masculinity had on other men in the society, it has been receiving a lot of critique (McDermott, Kilmartin, Mckelvey & Kridel, 2015). As a result, a modern form of masculinity has risen. This shift causes frustration, confusion and distress for men who have more traditional sexual orientation and gender and have internalized the new modern ideals. Men who fit this profile will experience sexual shame which is found to be a cause for depression (Gordon, 2019). It could be that white men overall have a more traditional gender and sexual orientation than the men from the other ethnicities. This would explain why they score so high for mental health meaning they have a bad mental health but is something that has still to be researched.

When looked that the combination of sexual orientation and ethnicity it was again found that men who are white and either straight or gay or bisexual experience a worse mental health, followed by gay or bisexual Hispanic men, only after those two gay or bisexual black men experience a worse mental health. Another surprise was that straight white men followed after gay or bisexual black men, they had a much higher score for mental health than expected. A reason for this could be one already mentioned earlier. It could be that ethnic

minorities learned from their parents how to deal with discrimination regarding their ethnicity and they are also in some form able to apply these tactics to dealing with discrimination regarding their sexual orientation (Crawford, Allison, Zamboni & Soto, 2002; Greene, 1996). White men don't experience discrimination because of their ethnicity so their parents won't have to teach them how to deal with it. The chance they have a parent with the same sexual orientation, if that is another orientation than straight, is fairly small. As a result, gay or bisexual white men won't learn how to deal with discrimination regarding their sexual orientation from their parents. Even though it could be that these parents will be supportive about their child being gay or bisexual, the parents will not completely understand what the child is going through and cannot teach them how to deal with the discrimination since they don't experience it directly themselves. This leaves them with a worse mental health since they don't know how to deal with the discrimination. Next to this the already mentioned having of a traditional gender or sexual orientation comes into play again explaining why straight and white men score this high on mental health. Another reason why these results were found is that there may be another stigmatized identity at play. In this study only two identities are looked at but there are other types of identities that also are stigmatized, examples are having a disability or having a mental illness. It could be the case that another kind of stigmatized identity that is not taken into account in this current study is causing these results.

The last finding was that of employment functioning as a negative buffer except for men who are gay or bisexual and Asian. Employment caused the relationship between the identities and mental health to be less strong for the other groups, and stronger for gay or bisexual Asian men had the effect been significant. Interestingly enough, the negative buffering effect was the smallest for straight Asian men. This could have something to do with the work culture in some Asian countries. In Asia there is a Confucian culture, this means that a person has to be a good and moral person within society and one condition of doing this is recognize the importance of your role in the workplace (Kang, Matusik, Barclay, 2015). Because of this it can be expected that when an Asian man has work, he may feel more pressure to perform good at this job than men of other ethnicities. This pressure might be the reason that employment doesn't perform that well as a buffer for Asian men. What is also interesting to notice is that employment had the strongest effect on the relationship with mental health for white man, either gay or bisexual or straight. It might be that white men have more internalized traditional gender roles than men from other ethnicities. For them, having a job is seen as a man's duty and as something important. As a result, when they have

a job, they feel better about themselves since they are doing their duty. Because other ethnicities might not experience these internalized traditional gender roles to the same degree as white man, the effect of employment is not as big for them as it is for white man. However, research regarding internalized traditional gender roles is necessary to confirm this.

This study has a few limitations. Firstly, this study used data from an already existing questionnaire. A problem that arises when using data from an existing question is that of validity. Since the questionnaire used in this study is not designed to answer the questions stated in this study, it could be that what is really needed to answer these questions is not asked. When this is the case, something else is measured instead of the concept wanted or not every aspect of that concept is measured. In this study it is possible that not all of mental health was measured since it was only asked with one question and mental health is seen as a complicated concept. This has an influence on the findings. In this study employment is used as employed vs not employed. However, what kind of job you have will also have an influence on how much status you get from it. For example, being a garbage man is looked at as being less of a good job than being CEO of a company. The difference in status you get from the job will also result in how effective the buffer is for somebody, as a job with more status will give you a better position within your in-group, which will result in a more positive self-identity than a job with less status. Lastly, some groups in this study had a fairly small number of respondents. The smallest groups were gay or bisexual Asians and gay or bisexual Hispanics. Because these groups were so small it could be that the found results are not representative of these groups.

Some suggestions for future research have already been discussed. Another suggestion would be to take the different kinds of jobs into consideration instead of only looking at employed vs unemployed. As stated before, the kind of job you have could have an influence on the buffering effect of employment. Looking at different effects of different kinds of jobs would paint a better picture of the buffering effect of employment. In this study some groups, like gay or bisexual Asian men, only had a small number of respondents. As stated before this could have formed a problem. Because of this it would be a good idea to recreate this study with a larger number of respondents for the groups that where relatively small. This could result in a more representative outcome. Lastly, research regarding different buffers would be a good addition to the existing literature to understand more what influences the relationship between identities and mental health.

This study showed that there is often more at play than expected. When not everything is taken into consideration, like maybe a not named stigmatized identity, you might not get what is expected. It is important to get the bigger picture in every situation.

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