Coping and self-compassion in gay men

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Introductory Chapter: Thesis Overview

Compassion-based approaches (CBA) are a relatively new, transdiagnostic and evidence-based development in the field of clinical psychology (Gilbert & Proctor, 2006; Neff & Germer, 2013). Compassion-focused therapy (Gilbert, 2009), a multimodal and integrated CBA, developed from a clinical need for more effective interventions for the transdiagnostic problems of shame and self-criticism. These approaches may hold promise for working with clients whose difficulties are formulated to relate to sexual shame and stigma. However, to date there is no published literature in this area.

Self-compassion, defined here as a healthy form of self-relating and self-acceptance, is a psychosocial construct that is targeted in CBA. This construct, rooted in Buddhist psychology, has growing empirical support for its adaptive psychological benefits that support resilience (Neff, 2004; Neff, 2009; Neff, Rude & Kirkpatrick, 2007; Neff & McGeehee, 2010). The development of a self-report questionnaire measure, the Self-Compassion Scale (Neff, 2003), has led to a proliferation of research from a positive psychology perspective investigating the many benefits of self-compassion for well-being and positive mental health. To date there is no published literature investigating self-compassion from a positive psychology perspective, within sexual minority populations.

This dissertation was undertaken to fulfil the research component of a professional Doctorate qualification in Clinical Psychology. A positive clinical psychology perspective (see Wood & Tarrier, 2010) was utilised to explore self-compassion in a sexual minority population. This perspective minimised the risk of the research contributing to a pathologising discourse of same-sex attraction and supports a gay-affirmative stance to working with sexual minority populations.

The development of gay identities, communities and subcultures is a relatively recent phenomenon in western society. Gay identity is a set of cultural beliefs, values and support networks, institutions, artefacts, and languages which contribute towards subcultures of which modern lesbians or gay men can identify themselves (Davies & Neal, 1996, p. 13). The literature consistently reports the importance of distinguishing between bisexuals and exclusive gays, as well as men and women, in research on the experiences of sexual minority individuals (e.g. Balsam & Mohr, 2007). Therefore, self-identifying gay men are the focus of this dissertation.

Past research concerning the mental health of gay men has suffered from a deficit bias and research from a resiliency and well-being perspective is in its infancy. A positive clinical psychology perspective provides an opportunity to explore this area from a more balanced perspective. Sexual stigma is a problem in society that results in sexual prejudice in the heterosexual majority and shaming, self-stigma and minority stress, in and of those who identify as lesbian, gay or bisexual (LGB; Herek & Gills, 2009). Those people that choose to embrace a minority sexual identity, resolve much of their self-stigma through a process of 'coming out' that is characterised by deepening self-acceptance of their same-sex desires and resolution of internalised sexual stigma (Herrick et al., 2013). Self-compassion, as a healthy form of self-acceptance, may be a natural strength and resilience factor in those people that manage to successfully navigate the 'coming out' process. Indeed, the finding from one unpublished social work PhD thesis provides support for this hypothesis (Crews, 2012). Although there has been a flourishing of psychological research focused upon compassion and self-compassion (for a recent review of the compassion literature please see MacBeth & Gumley, 2012, and specifically self-compassion please see Barnard & Curry, 2011), there is a paucity of literature specifically focusing upon this construct within sexual minority populations. The lack of empirical research in this area led to a broadening of the scope of the

literature from self-compassion to coping, to form the basis of the original literature review included in chapter one of this dissertation.

Conceptualising sexual stigma as a social stressor in the lives of LGB people invites consideration of how the individual perceives, interacts and attempts to cope with these forces (Meyer, 2003). Chapter one is a narrative review of the psychological literature concerning how gay men cope with the sexual minority stress they experience and the effects of this coping upon them. This literature area was reviewed because of an identified gap in the literature. The minority stress model (MSM; Meyer, 2003) is the dominant model that is utilised to explain an increased life-time risk of mental disorder, in terms of unique social stress experienced by the LGB person in relation to their stigmatised sexual identity. Previous reviews in this area focused on the unique stressors LGB people experience in relation to their sexual minority status but do not consider the individual differences of coping efforts in mitigating these often deleterious effects (Meyer, 2003; Herek & Garnets, 2007; Hatzenbuehler, 2009). In the original narrative review reported in chapter one attention is drawn to the complexity of coping, and the variety of internal and external resources that gay men draw on in their coping efforts. There is evidence that coping can have both positive and negative consequences but that many people learn to proactively cope with the additional stress in their lives and maintain a sense of wellness, often in spite of adversity. Although much is known about individual level and group level gay-specific resources, less is known about the individual and group level general factors that contribute to well-being and resilience in gay men.

Self-compassion is one individual level factor identified from the positive psychology literature that may contribute to well-being and resilience in gay men. However, to the authors knowledge there is no published research exploring self-compassion from a positive clinical psychology perspective with a gay male population. Chapter two reports an original

online questionnaire-based study exploring the role of self-compassion in the well-being of a cross-sectional sample of self-identifying gay men.

The clinical implications of these research findings are expanded and discussed in Chapter 3, utilising a social justice framework (Goodman et al., 2004). The discussion is followed by an article disseminating the findings to the wider gay community. To conclude the dissertation, a research proposal outlines a proposed study as the next logical step to continue this important area of research.

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Chapter 1.

Sexual minority stigma and coping in gay men: A narrative review of the literature[1]

[1] Article prepared for submission to Psychology of Sexualities Review journal for peer review. Please see appendix 1 copy of journal guidelines for authors.

Abstract

This article sets out to review the current evidence for the role of coping in explaining how gay men in the Western world adapt to their sexual minority status. There is current consensus that gay men have a higher life-time risk of experiencing mental health difficulties, the minority stress model (MSM) explains this increased risk in terms of excess stress related to their sexual minority status in society. However, the role of coping is often ignored in examining this relationship and sexual minorities are portrayed as passive victims of oppression. Quantitative data, in terms of coping style research and qualitative data, are summarised and synthesised to highlight the importance of coping and resilience in the lives of gay men. Findings are presented in terms of six inter-related themes that were consistently found throughout the literature. Gaps in the literature are identified and directions for future research are suggested.

Keywords: sexual minority stress, stigma, coping, resilience, gay men

Introduction

There is current consensus that sexual minorities have an increased life-time risk of experiencing mental health difficulties compared to the heterosexual majority. Initial research into the mental health needs of sexual minorities needed to be interpreted with caution because of flaws in their methodology e.g. the sampling methods employed, operational definitions of sexual orientation and psychological distress and data analysis strategies (Herek & Garnets, 2007). More recently, epidemiological studies that have improved on these limitations reveal consistent findings of mental health disparities between sexual minorities relative to heterosexuals. Meyer (2003) conducted a meta-analysis and concluded that sexual minorities are two and a half times more likely to have a lifetime history of mental disorder and twice as likely to have a current mental disorder, in comparison to the heterosexual majority. These findings indicate that recent widespread positive changes in social attitudes have had little positive impact on rates of mental disorder in sexual minorities. However, the meta-analysis only reported life-time incidence rates and not current prevalence rates, therefore the occurrence of mental distress or disorder may have occurred earlier in life, before recent changes in the socio-political context towards greater social acceptance of sexual minorities. In the UK, King et al., (2008) reported a systematic review of mental disorder, suicide and deliberate self-harm in lesbian, gay and bisexual (LGB) people. Meta-analysis revealed a two-fold excess in suicide attempts in LGB people and at least 1.5 times higher for depression and anxiety disorders. Alcohol and other substance dependence over 12 months were also 1.5 times higher among LGB people as compared to heterosexual individuals. Results were similar for both sexes but meta-analyses revealed that lifetime prevalence of suicide attempt was especially high in gay and bisexual men.

The dominant conceptual framework utilised to explain this increased risk is the MSM (see meta-analysis by Meyer, 2003).

The MSM contextualises the findings of increased risk in sexual minorities within a framework that compliments the gay-affirmative stance of current professional guidelines (British Psychological Society, 2012; American Psychological Association, 2012). The MSM conceptualises the stigma and prejudice that sexual minorities experience as unique stressors in their lives and therefore risk factors for experiencing mental health difficulties. Conceptualising stigma, discrimination and prejudice as stressors in the lives of sexual minorities invites consideration of the importance of cognitive appraisals and the coping responses made to that stress (Lazarus & Folkman, 1984).

The MSM (Meyer, 1995; 2003), using a distal-proximal distinction, proposes that the higher prevalence of mental disorder observed in sexual minority populations is caused by excess social stress related to stigma and prejudice. Distal prejudiced-social attitudes can be cognitively reappraised resulting in proximal concepts with psychological importance to the individual. The excesses of social stress are hypothesised to be created by multiple forms of stigma-related stressors, including experiences of violence and discrimination, expectations of rejection, concealment/disclosure and internalised heterosexism. For example, experiencing or witnessing violence and discrimination directed towards sexual minorities may result in increased vigilance around others (expectations of rejection), attempts to pass as a member of the heterosexual majority (concealment) or the internalisation of negative societal attitudes (internalised stigma/heterosexism).

The MSM is informed from a variety of insights from a social psychological perspective. Herek, Cogan & Gillis (2009) describe a social psychological framework for understanding sexual stigma that complements the MSM. The term sexual stigma is used

here to refer broadly to the inferior status, relative powerlessness and negative regard that society collectively accords to anyone associated with non-heterosexual behaviours, identities, relationships or communities. This framework differentiates structural sexual stigma, or heterosexism from three different, individual manifestations of sexual stigma. Enacted sexual stigma refers to the individual other-focused stigma and underlies overt discrimination or anti-gay violence. Felt sexual stigma refers to the likelihood of stigma being enacted in a given situation and can motivate both heterosexual's and nonheterosexuals to use various self-presentation strategies to avoid being labelled as gay or bisexual. Finally, the third manifestation is internalised or self-sexual stigma, this occurs when an individual personally accepts sexual stigma as part of their value system.

The internalisation of sexual stigma is thought to be one of the most insidious stigma-related stressors (Meyer, 2003). This construct continues to develop and has a rich history in the psychology literature. The term internalised homophobia was coined by Weinberg (1972) to describe the self-loathing observed in sexual minority populations. This was based on the concept of homophobia observed in the heterosexual majority. However, this concept has been criticised for its narrow focus on fear, as research suggests that heterosexual's negative emotional responses to LGB people are more characterised by anger and disgust than fear (Herek, 2004).

Two alternative terms that have been proposed are internalised homonegativity (Mayfield, 2001) and internalised heterosexism (Szymanski, 2004). Homonegativity refers to negative affect and beliefs regarding sexual minority orientations (Morrow, 2000). Heterosexism refers to an ideological system that operates on many levels to stigmatise any non-heterosexual way of being (Szymanski, Kashubeck-West & Meyer, 2008).

Internalised shame correlates highly with measures of internalised homophobia (Allen, 1999). The emotion of shame draws attention to real or imagined stigmatising features of the self and is experienced as a stinging, hot feeling that leads the individual to feel flushed, small and a wish to hide (Tangney, 1998). Shame can be induced externally, through public knowledge of the stigmatising feature or internally through private knowledge of the stigmatising feature. The combination of the strength of early heterosexist socialisation experiences and continued exposure to antigay attitudes ensures that internalised heterosexism remains important to the psychological adjustment of LGB people (Meyer, 2003). Comparisons have been drawn between this form of cultural victimisation and physical or sexual abuse. Nelsen (1993) labels it a form of covert, cultural sexual abuse.

Hatzenbuehler (2009) extends the MSM to include both general psychological processes that are common to all people (e.g. emotion dysregulation) and minority-specific stressors that interact to confer risk for mental disorder. Although the focus of this psychological mediation framework of mental disorder is on explaining how sexual minority stigma "gets under the skin", it points to several psychosocial factors that may explain how the majority of LGB people maintain wellness despite experiencing stigma-related stress. This framework suggests that effective emotion-regulation in response to specific stressors should support well-being.

Both Meyer (2003) and Hatzenbuehler (2009) provide detailed reviews of the psychological literature in this area. However, neither provide much coverage for the extensive role of appraisal and coping in the stress-distress relationship. Whilst acknowledging that denying individual agency and resilience would ignore an impressive body of social psychological research that demonstrates the importance and utility of coping with stigma (Branscombe & Ellemers, 1998; Crocker & Major, 1989; Miller & Major, 2000; Miller & Myers, 1998), Meyer (2003) warns that focusing on effective coping risks shifting

the weight of responsibility for change from social to personal and his focus on coping remained at the group level. The term minority coping is used to collectively refer to these group level resources (Meyer, 2003). However, the MSM risks viewing sexual minorities as passive victims that fail to interact resiliently with the stress in their lives, especially those who have chosen not to, or are not able to, access these group level resources.

Overview of general coping literature

The extensive literature on stigma and coping indicates that people have many responses to stigma, including emotional, cognitive, behavioural and physiological (Miller & Kaiser, 2001). Some of the divisions that have been suggested as important include distinguishing between emotion-focused and problem-focused coping responses, active versus passive coping and voluntary and involuntary responses. Agreement about the relative importance of these dimensions has not yet been established (Zeidner & Endler, 1996).

In reviewing the diversity in coping research, Compas, Connor-Smith, Saltzman, Thomsen and Wadsworth (2001) suggest a theory of coping and stress responses that organises most of the divisions into a coherent and empirically supported model. Accordingly, the most important distinction between different responses to stress is between voluntary and involuntary coping responses, emphasising that not everything a person does in response to stress reflects coping. The term coping in this model is reserved for "conscious volitional efforts to regulate emotion, thought, behaviour, physiology and the environment in response to stressful events or circumstances" (Compas et al., 2001, p. 89).

Miller and Kaiser (2001) utilise the theory developed by Compas et al. (2001) to provide a theoretical perspective on coping with stigma. Voluntary responses to stigma are further subdivided into engagement and disengagement coping. Voluntary disengagement coping includes voluntary avoidance, denial and wishful thinking. Voluntary engagement

coping is further split into primary and secondary control coping. Primary control coping includes problem-solving, emotion regulation and emotional expression. Secondary control coping includes distraction, cognitive restructuring and acceptance. Involuntary stress responses are further subdivided into engagement and disengagement coping. Involuntary engagement coping includes physiological and emotional arousal, intrusive thoughts, impulsive actions and rumination. Involuntary disengagement includes involuntary avoidance through, for example, successfully screening the stressor out at the pre-attentional level (Mogg, Bradley & Hallowell, 1994).

The above model is useful for considering reactions and responses to stress. However, proactive attempts to cope with stress are not considered. Proactive coping, variously termed preventative and anticipatory coping, involves making an effort to prepare for stressful events that can occur in the future (Aspinwall, 2005; Aspinwall & Taylor, 1997). Another important distinction to be made is that between coping, competence and resilience (Compass et al., 2001). Coping refers to processes of adaptation; competence refers to the characteristics and resources that are required for successful adaptation, and resilience is observed in those processes for which competence and coping have been effective in response to stress and adversity.

Aims and scope of literature review

In the context of the above literature, what follows is a narrative review of the psychological literature that focuses on the role of coping in the relationship between minority stress and psychological well-being in gay men. Previous research recommends that sexual minority groups are studied separately (Herek, Gillis & Cogan, 2009). The review included both quantitative and qualitative studies and therefore a narrative review approach

was taken rather than a systematic review because of a lack of agreed protocol for undertaking a systematic review of literature which includes both quantitative and qualitative data. The review is organised around common themes from the qualitative studies. The qualitative papers identified for inclusion in the review were critically appraised against a checklist for qualitative research (Critical Appraisal Skills Programme; CASP, 2010). Common themes were noted and the final themes developed through a process of thematic analysis. Initially quantitative studies were reviewed that utilised coping style measures. These are summarised and critiqued in the first theme, titled the complexity of coping. Qualitative studies are the focus of the review, but where quantitative data is available in connection to these themes then these are also included to provide empirical support for the identified themes. Social attitudes towards sexual diversity have changed considerably in recent years, therefore the review is limited to articles published since the year 2000 to reflect coping within recent past and current socio-political context. HIV/AIDS literature was excluded to enable a focus on coping with minority stress and stigma related to sexual identity, not HIV/AIDS related stigma. Adolescence research that solely focused on those aged 18 and under was also excluded to focus upon coping in adults. The literature was searched using PsycINFO, Web of Knowledge and Scopus online search engines. Some of the questions that this review hopes to draw attention to includes: how do gay men cope with their minority status; what effect does coping with minority status have on the well-being of gay men; what are the internal and external strengths and resources that contribute to positive coping in gay men; and, is there any evidence of resilient processes for how gay men learn to cope with and overcome adversity related to their gay identity?

Themes

The complexity of coping

How gay men cope with their minority status is a complex process that unfolds in the context of a given situation or circumstance that is appraised as personally significant and demanding or surpassing the individual's resources for coping (Miller & Kaiser, 2001). Therefore, the discovery task is not simple, as coping does not happen in isolation but is embedded in a dynamic process involving the environment, the person and the relationship between them. Three quantitative studies have reported the use of coping styles, as measured by coping inventories, and its relationship to mental health outcomes in gay men (Sandfort, Bakker, Schellvis & Vanwesenbeeck, 2009; David & Knight, 2008; Talley & Bettencourt, 2011).

Using data collected via a general population-based study in Belgium (N = 9684, gay men = 64), Sandfort et al. (2009) found that gay men reported a higher prevalence of both mental and physical health problems in comparison to heterosexual men. An emotion-orientated coping style, as assessed by an abbreviated version of the Coping Inventory for Stressful Situations (Endler, 1990), was found to mediate these sexual orientation-related health differences, with gay men more strongly applying emotion-orientated and avoidance coping strategies.

The 64 gay men identified in this study represent 0.66% of the total sample and is not representative of even conservative estimates of the gay population. In Belgium the law regarding personal data is more relaxed and researchers are able to legally access government data for research purposes without the permission of the person the data pertains too. This may have an effect on the number of people who are willing to disclose personal information such as sexual identity. Therefore these results must be interpreted with caution as they are not considered representative of the gay population.

David and Knight (2008) investigated the relationship between perceived stigmatisation (related to sexual minority status, age and ethnicity), coping styles (measured by the Brief Cope Scale; Carver, 1997) and negative mental health outcomes in a sample of 383 gay men. Older black men reported significantly higher levels of perceived ageism than the older white group and significantly higher levels of homonegativity than the younger black and white groups, and also utilised disengagement coping (considered a less effective coping style) more than white gay men. However, contrary to the MSM, older black gay men did not experience significantly higher levels of negative mental health outcomes. This finding brings into question the current consensus from the empirical literature regarding disengagement coping. The minority resilience hypothesis (Crocker et al., 1998), which is contrary to the minority stress hypothesis, may explain why this study seems to find the opposite in terms of outcome, to that which is predicted by the MSM. The minority resilience hypothesis originates from the study of ethnic minorities and claims that stigma does not necessarily negatively affect self-esteem. A key difference between these groups that deserves future study concerns the socialisation of minority group members. Ethnic minority groups grow up and are socialised in a validating environment where they can learn the skills required to effectively cope with minority stress that may be transferrable to dealing effectively with sexual minority stress. Sexual minorities are usually lacking this early validating environment that may contribute to resiliency in other minority groups.

Whilst the use of coping style inventories are useful, in so far as they assist people to self-report multidimensional descriptions of situation-specific coping thoughts and behaviours (Stone, Kennedy-Mare, Neman, Greenberg & Neale, 1992), they do have many limitations that may be masking important findings. The abbreviated Coping Inventory for Stressful Situations (Endler, 1990), used in the Sandfort et al. (2009) study measures three distinct coping styles: task-orientated; emotion-orientated; and avoidance. Past coping theory

assumed that task-orientated coping is superior to both emotion-orientated and avoidance coping, as the stressor is approached and dealt with, as opposed to dealing with the resulting negative emotions or avoiding the stressor completely The Brief Cope Scale (Carver, 1997), utilised in the David and Knight (2008) study, is designed to measure both active (including use of emotional support, instrumental support, active coping, positive reframing, planning, humour, acceptance and religion) and disengagement coping styles (including denial, substance use, behavioural disengagement, venting and self-blame). Here, active coping is assumed to be superior to disengagement coping. However, these distinctions are based on now out-dated theoretical understanding of the role of coping in the stress process (Miller & Kaiser, 2001). For instance, in situations that cannot be changed, a coping style that deals with the negative emotions that have been aroused, or disengaging from/avoiding the situation altogether may be more effective for the individual concerned.

In a more recent study, Talley and Bettencourt (2011) adapted the Brief Cope Scale (Carver, 1997) to create a theoretically derived problem-solving coping dimension and an avoidant coping dimension (Szymanski & Owens, 2008). In a younger sample of 79 gay men and lesbians (age range from18-27 years), the moderating role of coping style and identity disclosure as a coping strategy was investigated in the relationship between perceived sexual stigma and psychological distress. Consistent with the MSM (Miller & Kaiser, 2001), individuals who were more likely to disclose their sexual identity were also more likely to utilise adaptive, problem-solving coping when dealing with sexual prejudice. Those who utilised avoidant coping strategies were more likely to be depressed. This supports the hypothesis that voluntary disengagement coping strategies, involving avoidant responses to stigmatising situations (Compas et al, 2001), are more likely to have a negative effect on a person's psychological adjustment.

The most significant patterns in Talley & Bettencourt's (2011) study were found amongst those with higher perceptions of sexual prejudice. The strength of the deleterious relationship between avoidant coping and depression was strongest for those who were more disclosing of their sexual identity. This suggests that avoidant strategies are especially harmful for sexual minorities who are more open about their sexual orientation. However, it is important to note that although the above study had a higher male to female ratio recruited; separate analyses for gay men and lesbians were not reported, therefore limiting the ability to generalise about these findings regarding gay men.

Although the ability to generalise about the above research is limited, it does highlight the complexity of attempting to research the role of coping in how gay men deal with their minority status. A coping style that is effective for one person in one given situation may be ineffective for another person or the same person in a different situation. Important individual differences in levels of outness, ethnicity and age may have implications for how someone copes and the effectiveness of any given strategy. Qualitative approaches provide an interesting alternative, as they are helpful in contextualising the person's coping efforts and for uncovering ways of coping that are not included in traditional quantitative coping style questionnaires (Folkman & Moskowitz, 2004).

In this literature review 10 qualitative studies were included that addressed the role of coping in gay men's lives (Hequembourg & Brallier, 2009; Riggle, Whitman, Olson, Rostosky & Strong, 2008; Kidd, Veltman, Gately, Chan & Cohen, 2011; Ridge, Plummer & Peasley, 2006; Wilson et al., 2010; McDermott, Roen, Scourfield, 2008; McDavitt et al., 2008; DiFulvio, 2011; Harper, Brodsky & Bruce, 2012; Vaccaro & Mena, 2011). These studies provide evidence for the whole spectrum of coping responses outlined by Miller and Kaiser (2001), and additional coping responses not covered by this model. There is evidence of positive and negative outcomes associated with coping and stories of resilience and

strengths in gay men learning from their adversity and thriving often in the face of minority stress and stigma. These studies will be organised around common themes and discussed throughout. Where available, quantitative research evidence that supports the qualitative themes will also be included.

Coming out and developing a gay identity

The heterosexist nature of society assumes a person to be heterosexual unless proven otherwise. The theme of coming out and the development and integration of a gay identity into a personal sense of self was a common theme throughout the qualitative data (McDermott et al., 2008; Harper et al., 2012; Riggle et al., 2008; DiFulvio, 2011; Vaccaro & Mena, 2011). Coming out to self and others is considered an important step in the achievement of a positive identity (Cass, 1979; McCarn & Fassinger, 1996).

Coming out is an experience unique to people with concealable stigmas and raises important questions for understanding how gay men cope with their minority status. If it is considered an important step in the achievement of a positive identity, without some resilience processes at work, how is this so? The initial point of coming out is also the point at which a gay man beings to embody his minority status and is therefore susceptible to the adversity this creates.

The coming out literature generally defines coming out as the point at which someone began to embrace their sexual minority identity (Davies, 1996; Hanley-Hackenbruck, 1989). However, operationalizing an agreed upon definition within the literature has been, and continues to be, a challenging process (Herek & Garnets, 2007; Moradi, Mohr, Worthington & Fassinger, 2009). In reality, coming out represents a life-long process of choosing whether

to hide or conceal one's gay identity based on continually assessing changing contexts and practical considerations (Mohr & Fassinger, 2000).

Common in the qualitative data was the theme of hiding and denying sexuality, decreasing as self-acceptance and connection to the gay community increase (DiFalvio, 2011, Kidd et al., 2011). Hiding and concealing can take a toll on psychological resources required to be vigilant and monitor the environment for signs of safety. However, it would be premature to conclude that this strategy is not adaptive because in certain vulnerable situations this may be the most effective strategy to maintain safety.

Many gay men in the qualitative studies reviewed here spoke of finding strength from the initial coming out period they were then able to draw on to face other challenges related to their minority status (Wilson et al., 2010; DiFulvio, 2011; Riggle et al., 2008; Harper et al., 2012; McDermott et al., 2008)). Attempts have been made to investigate the concept of 'coming out growth' empirically (Moradi, Mohr, Worthington & Fassinger, 2009; Cox, Dewaele, van Houtte & Vincke, 2010), however, these have relied on measures of the broader construct of stress-related growth and results have been mixed and inconclusive. Vaughan and Wachler (2010) have developed and initially validated a specific measure of coming out growth (the Coming Out Growth Scale, COGS). They found that coming out growth appears to be influenced by the extent to which a lesbian, gay or bisexual (LGB) identity is accepted and by the strength of in-group ties with the LGB community. In turn, coming out growth has a significant impact on the degree of internalised homonegativity without functioning as a buffer between coming out and internalised homonegativity.

Another common theme identified was related to the challenges of maintaining a positive identity and sense of self. Involvement in the gay community provided gay men with some unique challenges related to their sense of identity (these are discussed further

later). The participants discussed drawing on their unique strengths and positive attributes related to their sexuality in developing a positive gay identity. Riggle et al. (2009) collected data on the positive aspects of being a lesbian or gay man (N = 553, gay men = 203) and utilised a grounded theory approach to analyse the responses to the question of "What do you think are the positive aspects of being a lesbian or gay man?" Qualitative analysis revealed three domains: disclosure and social support; insight into and empathy for self and others; and freedom from societal definitions of roles; with eleven themes, but only ten applicable to men. These ten are: belonging to a community; creating families of choice; having strong connections with others; serving as positive role models; authentic self and honesty; personal insight and sense of self; increased empathy and compassion for others; social justice and activism; freedom from gender-specific roles; and exploring sexuality and relationships. Harper, Brodsky and Bruce (2012) identified two themes of positive personal conceptualisations of being gay: flexibility; and connectedness. Flexibility incorporated sexual flexibility, environmental flexibility and gender flexibility. Connectedness related to either being connected with females or to the gay community.

Coming out and developing a positive identity is a key theme in how gay people learn to cope with and adapt to their minority status. It represents a variety of coping strategies that can be more or less adaptive depending on the context of any given situation. It should not be considered in isolation. Developing a gay identity opens up important avenues to connect with group level resources.

Establishing alternative structures and values

Non-heterosexuals who actively participate in a sexual minority community report less psychological distress than those who do not (Lewis, Derlega, Berndt, Morris & Rose,

2001; Luhtanen, 2003, Mills et al, 2004). This pattern may occur because a collective identity affords individuals resources beyond those available through a purely personal identity. Thus in comparison to other non-heterosexuals, individuals who adopt a collective identity may be better equipped to cope with minority stress. In such environments people can develop a world view that invalidates negative stereotypes and biases while affirming positive evaluations of the group and its members. This world view can reduce an individual's level of internalised stigma while fostering a positive collective identity (Frable et al, 1997). Minority communities can also provide emotional and instrumental support for dealing with stigma and teach survival skills for meeting the challenges created by sexual stigma (Bowleg, Huang, Brooks, Black & Burkholder, 2003; Ueno, 2005).

The qualitative data reviewed demonstrated support for early findings that establishing alternative, group enhancing structures and values can counteract minority stress in gay men (Crocker & Major, 1989; D'Emiglio, 1983), but also that involvement in the gay community provided some unique challenges of its own. The narratives of the gay male participants in Hequembourg & Brallier's study (2009) spoke of alternative structures and values serving as an avoidance coping response to dangerous situations that could alternatively be a part of daily life, but that harsh judgements about non-conforming behaviour were also sustained within the gay community.

Wilson et al., (2010) utilised an ethnically diverse sample (N = 39) of predominantly gay (N = 30) male adolescents to explore challenges to developing various identities, exploration with sexual behaviours and drug use, and community involvement. They found that a variety of coping responses serve the purpose of negotiating dominant masculine ideologies, most centring on balancing presentations of masculine and feminine characteristics. These negotiation strategies served a variety of functions including avoiding

anti-gay violence, living up to expected images of masculinity and creating unique images of personhood free of gender role expectations.

Ridge, Plummer and Peasley (2006) investigated social transitions, constructions of masculinity and coping amongst gay men on the commercialised gay scene (e.g. nightclubs and bars) amongst a sample of 36 younger gay men (age range 19-36 years). Their grounded theory analysis recasts coming out into the gay scene as a process of liminality, a transitional phase where the masculine self can be explored through ritualised behaviours and performances of masculinity. This presents unique challenges that, if successful, can lead to greater social acceptance but also that those who express less valued forms of masculinity can struggle harder. Some of these ritualised behaviours can serve as modalities of shame-avoidance, such as getting lost in the commercial alcohol and drug scene, and high risk sexual behaviour (McDermott et al., 2008). They can also serve as covert forms of internalised heterosexism, where residual self-loathing results in an ambivalent relationship between self-acceptance and attempts to self-sabotage (Gonsiorek, 1988).

The alternative structures bring with them a new pecking order and competition for social status. Fears of becoming over-exposed and risks of exclusion and addiction featured prominently in these narratives. The narratives resembled movement through the stages of sexual identity development suggested by Cass (1979) and others (McCarn & Fassinger, 1996), moving towards resolution and demotion of the importance of the scene as gay identity is incorporated equally with other personal identities. Talk of limiting involvement to cope and signs of 'burn out' also featured (Vaccaro & Mena, 2011).

Resilience: Drawing on internal and external resources

Resilience has been defined as the ordinary process of adaptation and growth through adversity, rather than as special individual characteristics a person possesses (Masten, 2001). Resilience and narratives of growing through adversity were the most common theme in the qualitative studies. Resilience is reflected in the organised and collective action that has resulted in the largely successful bid for civil rights, often in the face of community wide devastation from the HIV/AIDS epidemic. Activism is covered in a separate theme.

McDavitt et al., (2008) investigated the strategies used by 40 ethnically diverse 18-22 year old gay or bisexual men within a grounded theory approach. They found that whilst multiple strategies to cope with heterosexism was utilised, often in a single situation, and that the experiences of heterosexism varied widely from casual anti-gay remarks to severe physical violence, most experiences had a high degree of emotional intensity in common. Most of the coping strategies used by the young men fitted well within one of the five classes of emotion regulation behaviour put forward by Gross (1998): situation selection; situation modification; attentional deployment; cognitive change and response modulation.

McDermott et al., (2008) found that gay men attempt to regulate their emotions through the development of a self-reliant, responsible and rational attitude. Individual responsibility to cope with homophobia and feelings of worry and shame related to not coping were key factors in understanding young gay men's experiences with suicide. Ridge et al., (2006) also emphasised autonomous and self-reliant ways of dealing with problems, for example utilising self-talk to reframe feeling isolated and construct internal dialogues that contribute to resilience rather than being self-defeating e.g. through self-blame or self-pity.

Resilience in the face of gay related oppression was a dominant narrative in Harper, Brodsky and Bruce (2012)'s qualitative study of the positive aspects of being gay from a youth perspective. Participants expressed their resilience in four ways: acceptance; self-care;

rejection of stereotypes, and activism. Kidd et al.'s (2011) sample of LGB people with severe mental illnesses conceptualised resilience as finding relationships in which they could find connection, belonging, acceptance and understanding and also as finding strength and increased self-esteem through defying oppression. Social connectedness emerged from the narratives in a study by DiFulvio (2011) as a process by which participants demonstrated their resilience.

Resilience can be conceptualised at an individual and community level, as both a proactive and reactive means of coping with adversity related to sexual minority status. Adversity is a precursor to resilience (Masten, 2001), and depends on the self-regulation abilities of the person to effectively coordinate the internal and external resources they possess to overcome difficulties related to their sexual minority status. There is quantitative support for personal mastery (Greene & Britton, 2012) and emotion regulation (Hatzenbuehler, Dovidio, Nolen-Hoeksema & Phills, 2009) as individual level resources; social support (Burns, Kamen, Lehman & Beach, 2012) and community connectedness (Frost & Meyer, 2012) are two group level resources that have been investigated empirically. This studies will now be summarised.

In a sample of 32 gay men, 61 heterosexual men, 34 lesbians and 179 heterosexual women in emerging adulthood (age range 18-30 years), Spencer and Patrick (2009) examined differences by sexual orientation in depressive symptomatology and self-esteem (as indicators of psychological well-being) and explored the role of personal resources in explaining these aspects of psychological well-being, Lesbian and gay individuals' experienced higher depressive symptomatology and lower self-esteem than the heterosexual participants. Variations in well-being were explained by personal mastery and social support. Therefore, the formation of social relationships, coupled with personal mastery, appear to serve as protective resources during emerging adulthood. These findings are consistent with

Meyer's (1995) minority stress hypothesis. Results indicate that personal resources were associated with more positive psychological outcomes for the entire sample but findings on sexual orientation warrant further discussion.

Previous research has shown that emotional well-being across sexual orientations is maintained through the use of both internal and external resources (Bovier, Chamot & Perneger, 2004; Otis and Skinner, 1996). Anderson (1998) suggested that such personal resources were protective, assisted in identity maintenance, and indicated the presence of resilience. In the Spencer and Patrick's study, these resources appeared to mediate the relationship between sexual orientation and well-being (i.e. group differences were significantly reduced after personal mastery and social support included in the models). However, for sexual minorities, availability of social support in times of crisis is not guaranteed; furthermore, feelings of victimisation may lead to reduced sense of personal mastery. This emphasises the need for lesbian and gay individuals in emerging adulthood to structure their environments in a way that maximises the protective benefit of both internal and external resources.

Hatzenbuehler et al., (2009) examined whether specific emotion regulation strategies account for the stigma-distress association. In an experience sampling study, rumination and suppression occurred more on days when stigma-related stressors were reported than on days when stigma-related stressors were not reported, and rumination mediated the relationship between stigma-related stress and psychological distress. The effect of social support on distress was moderated by the concealibility of the stigma. LGB respondents reported more isolation and less social support than African-American respondents subsequent to experiencing stigma-related stressors. In a second experimental study, participants who ruminated following the recall of an autobiographical discrimination event evidenced

prolonged distress on both implicit and explicit measures relative to participants who distracted themselves.

Beals, Peplau and Gable (2009) attempted to answer why disclosing one's sexual orientation is often beneficial, testing a model in which perceived social support, emotional processing and suppression mediate the association between disclosure and well-being. One hundred and two participants completed a two week daily diary and were followed-up at two months. As expected, participants generally reported greater well-being on days when they disclosed (vs. concealed) their sexual orientation. Perceived social support was a consistent predictor of well-being and mediator of the association between disclosure and well-being. Although less consistent across time and measures, emotional processing, and to a lesser extent suppression, were also significantly associated with disclosure and well-being. Well-being was measured by self-esteem, satisfaction with life and absence of depression.

Activism: Confronting Stigma

The gay community has a long history of activism, epitomised by the Stonewall riots of 1969. This was a theme that also featured highly within the qualitative data. DiFulvio (2011) found that groups that provided their participants with ways in which to resist a heterosexist or gender conforming culture also served to reinforce the positive aspects of one's sexual identity. It also served as a way to direct anger and other emotions. Harper et al., (2012) report several participants' narratives featuring activism as a form of resilience. Kidd et al.'s, (2011) sample of LGB people with severe mental illness spoke of activism on an individual level through defiance of negative stereotypes and confronting stigma head-on. It is important to note that this is the only study in the literature to have explored the experiences of LGB people with severe mental illnesses. Riggle et al. (2008), who explored

positive aspects, report the most common theme amongst gay men was a sense of increased empathy and compassion for others who are oppressed. Relative to this, some participants expressed their desires to promote social justice and be active in the fight for gay rights as well as a broader set of social issues.

Confronting stigma appears to be an adaptive coping strategy that is used both reactively and proactively. However, reports of burn out and compassion fatigue have been reported (Vaccaro & Mena, 2011). In a quantitative study of the stressors and resiliencies involved in confronting anti-gay politics, Russell and Richards (2003) found evidence for five resilience factors: maintaining a movement perspective; confronting internalised homophobia; expression of affect; successful witnessing; and involvement in the LGB community.

Struggling to cope

Many of the themes discussed so far have emphasised how gay men successfully cope with their minority status. However, the struggle to cope also featured prominently in the narratives of the qualitative data. These can be broadly split into two difficulties: the use of ineffective coping mechanisms and the difficulties experienced when coping becomes too much.

Many of the gay men in Hequenbourg and Brallier's (2009) study described substance use (both alcohol and drugs) as an "escape mechanism" to cope with stress and hide the shame related to their sexual identities. However, a smaller number of gay men warned against making broad generalisations about substance use in the gay community. Ridge et al., (2006) reported drug use and casual sex as less helpful and more reactionary responses to

the stress they experience in relation to their minority status and navigating the gay scene. McDermott et al., (2008) describe a variety of self-destructive behaviours that develop as a way of coping with the minority stress they experience, including cutting, use of alcohol and drugs, high risk casual sex and suicide. These strategies can be seen as both escape/avoidance and also attempts at emotion regulation that lack effectiveness.

Another theme to develop in the literature was the experience of when coping becomes too much, particularly in those gay men involved in social activism. Vaccaro and Mena (2011) conducted a phenomenological study of the experiences of ethnic minority, self-identified gay activists. Although they demonstrated numerous strengths, they often contended with a variety of internal and external pressures and a lack of self-care. This coupled with a heightened sense of responsibility that has already been outlined, left the participants experiencing burnout, compassion fatigue and in some cases, suicidal ideation.

Discussion

Common themes have been identified that address the role of coping with minority stress in the lives of gay men. Coping styles research provides for bleak reading at first glance, however, given that researchers in the area have failed to take advantage of developments in the general coping literature (Compass et al., 2001) suggests that these findings hold little value due to measurement issues. For example, the emotion-focused coping style of the Brief COPE inventory (Carver, 1997) measures emotional strategies as avoidance. Recent conceptual advances provide consistent evidence to suggest that emotion regulation and emotional expression load highly with problem-solving and voluntary engagement rather than with avoidance and disengagement (Miller & Kaiser, 2001). In line

with all coping research, how gay men cope with their minority status is a complex process that depends on the type of stressor, and many individual and contextual factors.

The qualitative data illuminate some of the complexity of coping. The themes that emerged are not separate but likely to be highly inter-related. Organising them in this way helps to answer the question of what effect coping with their minority status has on the well-being of gay men, with all areas having the potential to have a positive or negative effect on well-being. A clear message is that coping can take an emotional toll on even the most resilient of men. Evidence was found for all the responses to coping outlined by Compass et al., (2001) and also for proactive coping outlined by Aspinwall (2005). There is, however, a lack of evidence to suggest which strategies may be more or less effective, without differentiating voluntary from involuntary engagement and disengagement.

Resilience and wellness was a key theme to emerge from the qualitative data. It appears that gay men develop and rely on some gay-specific internal and external resources, as well as the general internal and external resources at everyone's disposal. It is important to note that the majority of these studies employed a young adult/youth sample (ranging from 14-25 years) and is therefore limited in generalizability beyond this age range.

This review suggests several possible strengths that could now be quantitatively defined and measured in samples of gay men. Specific strengths such as coming out growth and involvement in activism, and general strengths such as mastery and emotion regulation deserve empirical investigation, possibly to inform future mental health prevention and promotion work. The focus on gay men allowed for the complexities related to masculinity to be captured. The review provides an up-to-date summary of the psychological literature concerning how gay men cope with their minority status. The focus on strengths found in

gay-identified men may point to interventions that support men struggling with their sexual identity.

Future research could capitalise on the strengths that have been found within the qualitative data. These include measuring the role of personal and community resilience, emotion regulation, coming out growth and positive attributes, such as authenticity and compassion for self and others, in the relationship between minority status and distress. The preliminary evidence for proactive coping in how gay men learn to adapt to their minority stress suggests that researchers will need a rethink in how to conceptualise and measure the proposed variables involved. Traditionally, markers for depression or anxiety have been used to represent negative outcomes. These may be better conceptualised as predictor, mediator or moderator variables, as minority stress is often accompanied by high emotion, and it is this emotion that needs to be coped with via, for example, emotion regulation strategies. Future research would benefit from focusing on a broader adult age range rather than being skewed towards youth.

Recommendations for practice

Many of the factors that influence coping and resilience are amenable to cognitive behavioural interventions. However, the complexity of coping and the lack of data to suggest the effectiveness of particular coping responses is an important reminder that clinicians need to contextualise coping efforts and ensure a thorough assessment of stressors, coping responses and the function of the coping when working with sexual minority clients. Evidence for burn-out and compassion fatigue in otherwise resilient gay men supports the use of new approaches, which promote resilience and well-being in this population. Meyer (2003) warned of the potential negative consequences of the weight of responsibility for

distress related to minority status being shifted to the individual. Evidence for individual and community resilience presents a more optimistic picture of the ability of gay men to adapt to and grow through adversity whilst acknowledging their success and the continued need to work for societal and structural change.

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Chapter Two

Self-compassion: A potential resource for gay men[1]

[1] Manuscript prepared for submission to the Journal of Gay and Lesbian Mental Health. Please see Appendix 2 for copy of journal guidelines for authors.

Abstract

This study explores the relationships between self-compassion, well-being, self-esteem, pride (authentic and hubristic), attachment and two minority specific processes, outness and internalised heterosexism in an effort to examine self-compassion as a potential resource for gay men.. A sample of predominantly White, self-identifying gay men (N = 139) completed an online survey consisting of demographic variables and questionnaires related to the above constructs. Authentic pride, self-esteem, self-compassion and outness were significantly positively related to well-being. Avoidant and anxious attachment styles and internalised heterosexism were significantly negatively related to well-being. No relationship was found between hubristic pride and self-compassion, or well-being. Multiple linear regression analysis revealed that the self-compassion components of self-kindness and isolation, gay affirmation component of internalised heterosexism, outness and avoidance component of attachment were significant predictors of general well-being. Results suggest that, in addition to developing an authentic sense of pride, self-compassion may be beneficial in cultivating well-being in gay men.

Herek, Gillis and Cogan (2007) have proposed a social-psychological framework to understand prejudice and self-stigma related to heterosexism. The framework proposes sexual stigma, defined as the shared knowledge of society's negative regard for any non-heterosexual behaviour, identity, relationship or community, is a cultural phenomenon with structural (heterosexism) and individual manifestations. The latter includes enacted stigma, felt stigma, and self-stigma amongst sexual minorities and sexual prejudice amongst heterosexuals.

Self-stigma has also been labelled internalised homophobia (Weinberg, 1972), internalised heterosexism (Szymanski, 2004) and internalised homonegativity (Mayfield, 2001). Not surprisingly, self-stigma often has important negative consequences for the physical and psychological well-being of sexual minority individuals (Herek & Garnet, 2007; Meyer, 2003). However, Herek et al. (2009) suggest important differences amongst sexual orientation and gender groups on self-stigma, its effects on well-being and its affective, belief, and behavioural correlates. Although differences are beyond the scope of this paper, the literature consistently reports the importance of distinguishing between bisexuals and exclusive gays, as well as men and women, in research on the experiences of sexual minority individuals (e.g. Balsam & Mohr, 2007).

Some investigators report more symptoms of poor mental health among gay individuals compared to their heterosexual counterparts (Bagley & Tremblay, 2000; Faulkner & Cranston, 1998; Fergusson, Horwood & Beautrais, 1999; French et al, 1998; Lock & Steiner 1999; Morris, Weldo & Rothblum, 2001; Safren and Heimberg, 1999). Further a meta-analysis of more than a dozen studies seems to confirm that gay individuals are at greater risk of developing a mental disorder (Meyer, 2003). However, the vast majority of studies investigated adolescent samples, relied on reports of life-time incidence of mental disorders or combine adolescent and /or college students with older adults.

The minority stress concept (Meyer, 2003) is the most commonly employed framework for understanding mental health in sexual minorities. This framework, although based on social stress theory, draws on a variety of insights from social psychological research (Meyer, 2003). A number of stress processes are outlined based on a distal-proximal distinction. Distal social attitudes gain psychological importance through cognitive reappraisal and become proximal concepts with psychological importance to the individual. Distal processes are objective events such as experiences of violence, prejudice and discrimination that do not depend on the individual's perceptions or appraisals and are independent of personal identification with the assigned minority status. Proximal processes are more subjective and therefore related to self-identity of sexual minorities and include internalised heterosexism, expectations of rejection and hiding/concealing (Diamond, 2000).

Hatzenbeuhler (2009) has extended the minority stress model, utilising a psychological mediation theoretical framework to explain how sexual minority stigma "gets under the skin". This framework integrates findings from the minority stress literature with important insights from research focused on general psychological processes that are common across sexual orientations, to explain the increased risk of psychopathology in sexual minorities compared to the heterosexual majority. The focus of this framework is not well-being or resilience but to understand the processes leading to mental health disparities between heterosexuals and sexual minorities. It does however point to a variety of psychosocial variables, such as emotion regulation that may explain why many sexual minorities maintain a state of well-being in spite of the minority stress they experience.

The deficit focus that pervades psychological research predisposes prevention and intervention efforts to ignore the strong body of evidence for resilience that also exists in this population (Herrick, Stall, Goldhammer, Egan & Mayer, 2013). Deficit based analogues cannot explain why so many gay men experience a sense of wellness despite the fact they are

subject to adversity and marginalisation. This suggests that we need to refine our theoretical understanding of patterns of health and illness among gay men that take into account the many strengths found in this population (Herrick, Stall, Goldhammer, Egan & Mayer, 2013). By framing heterosexuals' sexual prejudice and sexual minorities' self-stigma as manifestations of internalised stigma, it suggests that similar psychological constructs might play important roles in eliminating both of them. Thus, exploring how sexual minorities overcome their self-stigma may yield valuable insights into the process of prejudice reduction among heterosexuals.

Current focus: Coming out and developing proud identities

The development of gay identities, communities and subcultures is a relatively recent phenomenon in Western Society. Gay identity is a set of cultural beliefs, values and support networks, institutions and artefacts, and languages which contribute toward subcultures of which modern lesbians or gay men can identify themselves as members (Davies and Neal, 1996, p. 13). The emphasis here is on the individuals' interaction with a community, whereas sexual identity focuses on the individual.

Relevant to the development of gay identities is Social Identity Theory (Tajfel & Turner, 1979), which was originally developed to understand the psychological basis of intergroup discrimination. A core assumption of this theory is that individuals have not one personal self, but rather several selves that correspond to a variety of social groups. The theory states that group membership creates self-categorization and in-group enhancement in ways that favour the in-group at the expense of the out-group.

Self-identifying as a sexual minority requires lesbian, gay and bisexual (LGB) people to manage being positioned, because of their sexual desire or gendered ways of being, as inferior to the heterosexual majority. At the centre of how LGB people negotiate heterosexism and manage the stigma associated with their sexual identity are modalities of shame avoidance including constructing proud identities (McDermott, Roen & Scourfield, 2008). One strategy to combat these feelings of shame and inferiority is to declare pride for that quality for which the dominant group is trying to impose shame. It is a statement to the majority group that they cannot shame the minority and that all their efforts to do so have failed and will fail.

The formation of a cohesive sense of identity is a cornerstone of human development throughout the entire life span (Sharma & Sharma, 2010). Since the 1970's there has been increasing interest in studying the process in which gay men develop a sense of identity (Crocker & Major, 1989). Often referred to as coming out, this process is well noted clinically but surprisingly little research has been conducted to investigate the pathways leading to the acquisition of an integrated gay identity. Cass (1979) offers a model of gay identity development consisting of six stages; identity confusion, identity comparison, identity tolerance, identity acceptance, identity pride and identity synthesis. Halpin and Allen (2004) investigated changes in psychosocial well-being during stages of gay identity development and found that the relationship was U-shaped, with initially higher well-being that decreased as the person moves through the middle stages and then returned to similar levels in the latter two stages.

Bybee, Sullivan, Zielonka & Moes (2009) reconceptualise Brady and Busse's measure of gay identity development, based on Cass's (1979) stage model, as coping responses throughout the 'coming out' journey (*not out and confused, not out and upset, not self-accepting, partially out, out, proud but angry and out and integrated*) with participants

assigned a score for each stage rather than being assigned a single score. Earlier stages were associated with higher chronic guilt and shame, participants who scored higher *on the out, proud but angry* subscale has more depressive symptoms, negative self-esteem, greater neuroticism and they were more constrained in their ability to express feelings spontaneously. In contrast, individuals with higher scores on the *out but integrated* subscale reported fewer depressive symptoms, indicating more affirming life experiences or more adaptive coping skills results in fewer feelings of depression.

The concept of gay pride has received little attention in the psychological literature. There are numerous instruments to measure what has been variously termed internalised homophobia, internalised heteronormativity or internalised heterosexism. It appears the main way gay pride is measured by Psychologists is the absence of internalised homophobia. Discussion of gay pride within the psychological literature is also evident in the creation of models of identity formation, as discussed previously. In the wider psychological literature concerning pride, several researchers have argued that pride is too broad a concept to be considered a single, unified construct and is better viewed as two distinct emotions (Elkman, 2003; Lewis, 2000). Consistent with this perspective pride has been empirically and theoretically linked to highly divergent outcomes. Building on previous theoretical work, Tracey and Robins (2007) have argued that two facets of pride can be distinguished by subsequent attributes. Authentic (beta) pride might result from attribute's to internal unstable and controllable causes, whereas pride in the global self, referred to as hubristic, or alpha pride might result from attributions to internal, stable, uncontrollable causes.

Authentic pride is the more socially desirable and linked with positive outcomes that might motivate behaviours geared towards the long-term attainment and maintenance of status, whereas hubristic pride might be a "short-cut" solution, proving status that is more immediate but fleeting. The likely outcomes of hubristic pride might be adaptive in

situations in which it is advantageous to display one's relative superiority in order to intimidate an opponent. Hubristic pride, however, has been linked to several distinct forms of dysfunction including narcissistic self-aggrandisement and is for the most part unrelated to mental health; and genuine self-esteem and authentic pride may promote a clean bill of mental health. Gay pride considered from this perspective raises important questions regarding the relationship of gay pride to well-being. If being gay is considered to result from attribution to internal, stable and uncontrollable causes (e.g. I am gay and I didn't chose it) then it may not support well-being.

Without sufficient information about what strengths exist among gay men, and how these strengths contribute to resilience, it is difficult to envisage an empirically supported 'Theory of Resilience' as a sub-cultural phenomenon. Investigating and harnessing these natural strengths and resiliencies may enhance gay affirmative mental health prevention and intervention programmes. If gay men are exposed to healthy coping strategies and community supports as adults, they may also develop a sense of shamelessness that could be protective against the effects of overt homophobia and marginalisation. This sense of shamelessness, or pride may be one of the greatest strengths that sexual minority communities have developed (Herrick et al., 2011).

Potential Strength & Resource: Self-compassion

Self-compassion is healthy form of self-acceptance that entails the ability to be kind and caring to oneself in instances of perceived inadequacy, and experiences of failure and suffering (Neely, Schallert, Mohammed, Roberts & Chen, 2009). There is growing evidence that self-compassion is an important variable in the study of positive psychological attributes and well-being (Neff, 2003; Neff, 2004; Neff, Rude & Kirkpatrick, 2007; Neff, 2009; Neely

et al., 2009; Neff & McGehee, 2010; Raes, 2011; Van Dam, Sheppard, Forsyth & Earleywine, 2011). This suggests the potential for self-compassion to be particularly meaningful for populations facing the constant paradox of simultaneous personal fulfilment and societal oppression, such as sexual minorities. Self-compassion research within LGB populations may help to clarify the significance of self-compassion in many dimensions of LGB identified existence.

Neff (2003) conceptualized self-compassion as entailing three components; extending kindness and understanding to oneself rather than harsh self-criticism and judgment, seeing one's experience as part of the larger human experience rather than separating and isolating, and holding one's painful thoughts and feelings in balanced awareness rather than over identifying with them. Self-compassion has been found to be associated with a wide variety of positive outcomes in the general literature, including life satisfaction, social connectedness, autonomy, resilient coping, personal growth, happiness and optimism (Neff, Rude & Kirkpatrick, 2007).

A review of the literature identified one unpublished Ph.D. thesis that has examined self-compassion within a sexual minority population (Crews, 2012). The study reports in-depth interviews with 16 LGB individuals, exploring how the participants processes their personal coming-out narratives through the lens of self-compassion, and a further quantitative investigation into the role of self-compassion in the development of a sexual minority identity in 215 LGB adults, aged between 18-70. The narratives from the interviews purport that self-compassion helped to provide the emotional safety required during the coming-out process to enable the person to move to a more self-accepting position without fear of self-condemnation. Multi-variate analyses of the larger sample demonstrated that self-compassion has a positive impact on LGB identity development, explaining 17% of the total variance in LGB identity scale scores.

This study aims to build on previous research in this area by exploring the relationships between well-being, self-compassion, authentic and hubristic pride, attachment, self-esteem, age, level of outness and self-stigma in gay men. The hypotheses are fourfold.

- Hypothesis 1 - Authentic pride, self-esteem, self-compassion, outness and age will have a significant positive correlation with well-being.
- Hypothesis 2 - There will be no correlation between hubristic pride and well-being.
- Hypothesis 3 - Self-stigma will be negatively correlated with well-being.
- Hypothesis 4 - Self-compassion will predict well-being within the model of variables being explored.

As this study is exploratory in nature, a cross-sectional within-subject design will be utilised. The variables included in hypothesis one are all hypothesised to be positively related to well-being. The variables included in hypothesis two are hypothesised to have no relationship with well-being. The variables included in hypothesis three are hypothesised to be negatively related to well-being. Hypothesis four predicts that self-compassion will be a predictor of well-being within a regression model.

Method

Participants

One hundred and thirty-nine self-identifying gay men aged 18 and over completed an online survey; seven of these identified as female to male transgender gay men, with a mean age of 38.3 years (range from 19 to 82 years). In total, the online study was accessed 439 times, 201 potential participants provided their consent and 140 of these fully completed the

survey. One participant's data was removed due to them not meeting the criteria of being a self-identifying gay man. Due to the self-selecting sampling procedure utilised in this study it is not possible to give an estimate of the sample approached. Of the 139 study participants in this sample, a majority of 117 (84.2%) described themselves as 'White British', with five describing themselves as 'White Irish', one as 'Black or Black British African', nine as 'White European' and seven as 'Other'. Forty-five (32.4%) reported their religious or spiritual belief as 'Atheist', 30 (21.6%) as 'Agnostic', 43 (30.9%) as 'Christian', six as 'Buddhist', two as 'Jewish', two as 'Muslim', five as 'Other' and six did not state their religious or spiritual beliefs.

Participants reported their total annual household income as less than £10,000 in 16 (11.5%) cases, 20 (14.4%) as £10,001-£20,000 per annum, 24 (17.3%) as £20,001-£30,000 per annum, 20 (14.4%) as £30,001-£40,000 per annum, 19 (13.7%) as £40,001-£50,000, 29 (20.9%) as £50,001 or more per annum, while 11 (7.9%) did not state their income.

In this sample, seventy-six participants (54.7%) reported that they had previously engaged in counselling or therapy, 62 stated that they had never experienced therapy or counselling and one chose to not reveal this. Eighty-one (58.3%) stated that they were in a committed relationship at the time of completing the survey and 13 (9.4%) stated that they were registered disabled.

Sample size, power and precision

A sample size of 139 participants were recruited, based on the calculation of apriori GPower 3.1 analysis using G*Power 3.1 of 137 participants required, with 9 predictor variables, a medium effect size (0.15), error probability of 0.02, and power of 0.8 (Faul, Erdfelder, Buchner & Lang, 2009). The relationship between self-compassion and psychological well-being has not been measured before, therefore a medium effect size was

selected based on research measuring similar relationships between self-compassion and happiness, optimism and life satisfaction (Neff, Rude & Kirkpatrick, 2007).

Measures

Outness – The Outness Inventory (OI; Mohr and Fassinger, 2000) was used to assess the degree to which participants were open about their gay identity. This is an 11-item scale, on which respondents indicate how open they are on a Likert scale of one-seven, to various people and groups of people in their life. Participants indicate if an item is not applicable to them and a total score is calculated from the average of those completed. The OI can be used to either provide information about levels of outness in three different life domains: family, everyday life and religion, or to provide an index of overall outness. The higher score indicates a higher level of outness about one's sexual identity. Analyses from the instrument development study provided an estimated internal consistency of .79. Evidence for convergent validity was provided through predicted correlations with measures of need for privacy and degree of interaction with heterosexual individuals. Evidence for discriminate validity was provided by analyses indicating that individuals whose parents practiced antigay religions did not differ from others in level of public outness, but did differ from others in level of outness to family members (Mohr and Fassinger, 2000). In the current study the Cronbach alpha co-efficient was .91, indicating high internal reliability.

General well-being – The 24-item BBC Wellbeing Scale (Kinderman, Schwannauer, Pontin & Tai, 2011) was used to assess general levels of subjective well-being. This measure provides an overall measure of well-being based on a three factor model of psychological well-being, physical health and well-being and relationships. Participants are required to answer each question on a four-point Likert scale. This measure has demonstrated good internal consistency (Cronbach alpha = .94) and has correlated significantly with measures of

concurrent validity in past validation research (Kinderman, Schwannauer, Pontin & Tai, 2011). In the current study the Cronbach alpha co-efficient for the total scale was .95, r = .94 for the psychological well-being sub-scale, r = .80 for the physical health and well-being subscale, and r = .85 for the relationships subscale, indicating high internal reliability.

Self-compassion scale – The 26-item Self-Compassion Scale developed by Neff (2003) was used to assess six different aspects of self-compassion (negative aspects are reverse coded): Self-Kindness (e.g. "I try to be understanding and patient toward aspects of my personality I don't like"), Self-Judgement (e.g. "I'm disapproving and judgemental about my own flaws and inadequacies"), Common Humanity (e.g. "I try to see my failings as part of the human condition"), Isolation (e.g. "When I think about my inadequacies it tends to make me feel more separate and cut-off from the rest of the world"), Mindfulness (e.g. "When something painful happens I try to take a balanced view of the situation"), and Over-identification (e.g. "When I'm feeling down I tend to obsess and fixate on everything that's wrong"). Responses are given on a five-point Likert scale. The measure has demonstrated good test-retest reliability and validity in past research. Neff (2003) compared the same participant's scores on two testing occasions. Test-retest correlations were as follows: Self-Compassion Scale (overall score) = .93; Kindness subscale = .88; Self-Judgment subscale = .88; Common Humanity subscale = .80; Isolation subscale = .85; Mindfulness subscale = .85; and Over-Identification subscale = .88. A six-factor model was found to fit the data well (NNFI = .92; CFA = .93). A higher-order CFA confirmed that a single higher-order factor of self-compassion explained the inter-correlations between the six factors (NNFI = .90; CFI = .92). In the current study the Cronbach alpha co-efficient for the total scale was r= .95, for the subscales of Self- Kindness r = .87; Self-Judgment r = .87; Common Humanity r = .82; Isolation r = .85; Mindfulness r = .78; and Over-Identification subscale r = .80, indicating high internal reliability.

Internalised sexual stigma – The 23-item Internalised Homonegativity Inventory (Mayfield, 2001) was used to assess what has variously been termed internalised homophobia, internalised homonegativity and internalised heterosexism. This measure is specific to the measurement of internalised homonegativity in gay men and assesses three different aspects (positive aspects are reverse coded): Personal Homonegativity (e.g. "I feel ashamed of my homosexuality"), Gay Affirmation (e.g. "I am proud to be gay") and Morality of Homosexuality (e.g. "In general, I believe that gay men are more immoral than straight men). Responses are given on a six-point Likert scale. The measure provides an overall measure of internalized homonegativity in gay men based on the above three factor model. In the current study Cronbach alpha co-efficient for the total scale was r = .91, for the Personal Homonegativity subscale r = .92, for the Gay affirmation subscale r = .77 and for the Morality of Homosexuality subscale r = .46. This indicates high internal reliability for all subscales, except the latter.

Self-esteem scale – The 10-tem Rosenberg self-esteem scale (Rosenberg, 1965) is the most commonly used measure of global self-esteem and has demonstrated high reliability and construct validity in past research. Reponses are given on a five-point Likert Scale with half the items negatively worded and reverse scored. Test-retest correlations are typically in the range of .82 to .88, and Cronbach's alpha for various samples are in the range of .77 to .88 (see Blascovich and Tomaka, 1993; and Rosenberg, 1986). In the current study, the Cronbach alpha co-efficient for the total scale was r = .91, which indicates high internal reliability.

Pride - The Authentic and Hubristic Pride Scales (Trait version; Tracy & Robins, 2007) were used to assess dispositional tendencies to experience pride. Participants are asked to rate seven-items for authentic pride (e.g. "Accomplished") followed by seven-items for hubristic pride (e.g. "Arrogant") on a five-point Likert scale, indicating the extent to which

they generally feel like the word being described. These have demonstrated to be a brief, relatively independent and reliable measure in past research. In a sample of 362 undergraduate students the reliability co-efficient for each scale ranged between .88-.90. In the current study, the Cronbach alpha coefficient for both scales was r = .91, indicating high internal reliability.

Attachment –The Experience in Close Relationships Scale-Short Form (Wei, Russell, Mallinckrodt & Vogel, 2007) was used to assess two facets of attachment in adult relationships; anxiety and avoidance. Positively phrased questions are reverse scored; high scores on either or both scales represent insecure attachment. A low score on both scales represents a secure attachment. This has been shown to possess stable factor structure, acceptable internal consistency, test-retest reliability and construct validity. In a sample of 851 undergraduate students, the reliability co-efficient for the Anxiety subscale was .78 and for the avoidance subscale was .81. In the current study, the Cronbach alpha coefficient for the anxiety subscale was r = .81 and r = .84, for the avoidance subscale, indicating high internal reliability.

Design

As this study is exploratory in nature it utilised a within-subjects, cross-sectional design, exploring the concept of self-compassion and the relationships with psychological well-being, authentic and hubristic pride, self-esteem, internalised homonegativity, expectations of rejection and outness. The data was analysed utilising exploratory correlation analysis and hierarchical multiple regression.

Procedures

The University of Liverpool Institute of Psychology, Health and Society Research Ethics Committee provided favourable ethical review of the study. The study was advertised widely both online and through posters in gay community venues to support the recruitment of a diverse population of self-identifying gay men. Due to recognised difficulties in accessing and recruiting sexual minority populations, a self-selecting sampling procedure was utilised. The sample was self-selecting by following a link from the study advert to the online survey.

The study was initially piloted for one month with a sample of self-identifying gay men who volunteered for a large LGBT charity to test the procedures for sensitivity to the participants' needs and perspectives. The online survey was accessed on 73 occasions throughout the pilot stage of the study, 54 people consented, of these 37 completed the survey in full. The pilot stage did not result in any changes being made to the study procedures, therefore the pilot data was combined with the data collected from the live study to provide the final sample.

The study was available online for a period of five months between December 2012 and May 2013. Participants who followed the link to the study were presented with a participant information sheet outlining the nature of the study, information regarding the ethical considerations and an estimate of 20 minutes to complete the survey. The information sheet included a space for participants to confirm their informed consent to participate in the study; those who provided their informed consent were then directed to the demographics page to commence data entry. The demographics page was followed by eight pages each one containing a different measure. The measures were followed by written debriefing information regarding the nature of the study.

Those participants who completed the survey in full were provided with the option to enter a prize draw to win up to £75 in high-street shopping vouchers by providing an email address through which they could be contacted at the end of the study. Providing incentives to participants in sexual minority populations is recommended (Moradi, Mohr, Worthinton & Fassinger, 2009).

Results

Table 1 provides means, standard deviations and correlation co-efficients between all measures. At the initial stage of analysis, correlations were conducted to explore the relationships between each of the variables. In the second stage, a multiple linear regression model was run on the data, with general well-being held as the predictor and all other variables as predictors. The results of the correlation analysis are presented, followed by the regression model.

Table 1 Means, standard deviations and correlations for all measures

	Variable	M	SD	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
1	Total Well-being	63.58	13.22	1																					
2	Psychological well-being	32.47	7.59	.960**	1																				
3	Physical Health & Well-being	18.22	3.79	.822**	.676**	1																			
4	Relationships	15.66	3.79	.908**	.838**	.642**	1																		
5	Total Self-compassion Mean	3.04	0.75	.628**	.653**	.401**	.593**	1																	
6	Self-kindness	2.74	0.87	.550**	.558**	.396**	.496**	.827**	1																
7	Self-judgement	3.09	0.91	.564**	.594**	.332**	.533**	.820**	.589**	1															
8	Common Humanity	2.99	0.9	.365**	.411**	.182*	.347**	.741**	.609**	.386**	1														
9	Isolation	3.13	1.09	.632**	.653**	.406**	.598**	.844**	.568**	.736**	.495**	1													
10	Mindfulness	3.16	0.78	.473**	.476**	.313**	.473**	.823**	.791**	.493**	.689**	.539**	1												
11	Over-identification	3.14	0.91	.476**	.488**	.327**	.444**	.855**	.561**	.782**	.499**	.725**	.609**	1											
12	*Outness*	*5.36*	*1.32*	*.301***	*.301***	*.188**	*.430***	*.172**	*.104*	*.221***	*.143*	*.199**	*.136*	*.081*	*1*										
13	Self-esteem	36.82	8.37	.774**	.811**	.551**	.667**	.758**	.605**	.729**	.452**	.714**	.538**	.657**	*.189**	1									
14	Authentic Pride	21.19	5.92	.786**	.796**	.586**	.697**	.601**	.492**	.498**	.414**	.631**	.445**	.437**	*.214**	.749**	1								
15	*Hubristic Pride*	*11.37*	*5.35*	*.044*	*-.003*	*-.112*	*-.085*	*-.186**	*-.143*	*-.143*	*-.089*	*-.112*	*-.153*	*.202***	*.044*	*-.099*	*.078*	*1*							
16	ECR Avoidance	17.6	7.32	-.466**	-.460**	-.279**	-.499**	-.441**	-.363**	-.424**	-.279**	-.452**	-.331**	-.297**	*-.226**	-.470**	-.470**	*-.371***	1						
17	ECR Anxiety	23.69	8	-.435**	-.418**	-.300**	-.451**	-.468**	-.243**	-.417**	-.298**	-.524**	-.279**	-.490**	*-.054*	-.494**	-.494**	*-.237***	.339**	1					
18	*Total Internalised Homonegativity*	*41.72*	*16.41*	-.386**	-.549**	*-.301***	*-.562***	*-.456***	*-.302***	*-.302***	*-.267***	*-.474***	*-.254***	*-.403***	*-.386***	*-.578***	*-.466***	*-.110*	*-.451***	*-.242***	*1*				
19	*Personal Homonegativity*	*19.68*	*10.79*	-.386**	*-.501***	*-.348***	*-.550***	*-.482***	*-.296***	*-.296***	*-.256***	*-.517***	*-.243***	*-.430***	*-.386***	*-.578***	*-.467***	*-.081*	*-.443***	*-.286***	*-.858***	*1*			
20	*Gay affirmation*	*15.53*	*6.34*	-.360**	*-.436***	*-.168**	*-.420***	*-.286***	*-.221***	*-.221***	*-.189*	*-.276***	*-.215**	*-.248***	*-.360***	*-.386***	*-.297***	*-.086*	*-.288***	*-.077*	*-.811***	*-.481***	*1*		
21	*Morality of Homosexuality*	*6.51*	*2.32*	*-.138*	*-.109*	*.032*	*-.120*	*-.153*	*-.91*	*-.091*	*-.149*	*-.095*	*-.157*	*-.133*	*-.138*	*-.152*	*-.096*	*.053*	*.199**	*.103*	*.416***	*.332***	*.219***	*1*	
22	Age	38.27	11.61	.045	.048	.115	-.046	.155	.068	.221**	-.044	.176*	.055	.261**	*-.126*	.202*	.056	*.015*	-.095	-.049	*-.151*	*-.186**	*-.163*	*.038*	*1*

Note. N = 139. *p < .05, **p < .01 None italics = Pearson's r, Italics = Spearman rho

Preliminary analyses were performed to ensure the parametric assumptions of normality, linearity and homoscedasticity were upheld. All scales met these assumptions except for Outness, Internalised Homonegativity and each of its three subscales. Initially the data was inspected for the hypothesised relationships.

In line with Hypothesis 1, authentic pride, self-esteem, self-compassion and outness displayed a significant positive correlation with general well-being; however the relationship between age and well-being was not significant. Authentic pride, self-esteem and self-compassion all displayed a large effect size, each, respectively accounting for 62%, 60%, and 40%, of the variance in their relationships with general well-being. The relationship between outness and well-being displayed a medium effect size, accounting for 9% of the variance with well-being. Therefore, the first hypothesis was partially supported, except for the hypothesized relationship between well-being and age.

Hypotheses 2 and 3 were fully supported by the data. The relationship between hubristic pride and general well-being was not significant. Sexual self-stigma, as measured by the internalised homonegativity inventory, attachment avoidance and attachment anxiety all displayed a significant, medium size, negative relationship with general well-being. However, the subscale of Morality of Homosexuality was not significantly correlated with any other variable.

To examine the fourth hypothesis, a multiple linear regression was conducted on the data. Graphical analysis indicated that the assumptions of the linear regression model were upheld. Authentic pride and self-esteem were removed from the regression model because of evidence of multicollinearity. The high strength of their correlation with general well-being indicated that the constructs used to measure these variables were not sufficiently differentiated and therefore measuring similar underlying constructs. Rather than entering

the total self-compassion or internalised homonegativity scores data into the model, they were broken down into their subscale scores to differentiate which aspects of self-compassion and internalised homonegativity uniquely predict general well-being. Separating the total self-compassion score into its six subscales allowed the researchers to determine which elements of self-compassion contributed to well-being whilst controlling for the combined impact of the other variables. The subscale of morality of homosexuality and data for age and hubristic pride were withheld from the model because they did not evidence significant relationships with general well-being in the correlation stage of analysis.

Using the enter method, a significant model emerged: $F(11,127) = 15.256, p<.001$. The model explains 53.2% of the variance ($R^2 = .532$). Table 2 gives information for the predictor variables entered into the model. Self-judgement, common humanity, mindfulness, over-identification personal homonegativity and ECR-Avoidance were not significant predictors, but outness, self-kindness, isolation, gay affirmation and ECR-Anxiety were.

Table 2. The unstandardized and standardised regression coefficients for the variables entered into the model for general well-being.

Variable	B	SE B	β	Sig
Outness	1.522	.710	.152*	.034
Self-kindness	4.544	1.626	.298**	.006
Self-judgement	.942	1.660	.065	.571
Common humanity	-1.590	1.236	-.108	.201
Isolation	3.406	1.253	.280*	.007
Mindfulness	.702	1.881	.042	.709
Over-identification	-1.617	1.673	-.112	.336
Personal homonegativity	-.052	.105	-.043	.619
Gay affirmation	-.311	.153	-.149*	.044
ECR – Avoidance	-.133	.129	-.073	.306
ECR – Anxiety	-.352	.121	-.213**	.004

*p = < .05. **p = < .01

The regression was run again for each component of general well-being; psychological well-being, physical health and well-being and relationships. The model remained significant for each. Significant predictors for psychological well-being were self-kindness (β = .258, p < .05, R^2 = .594), isolation (β = .297, p < .01, R^2 = .594), gay affirmation (β = -.196, p < .01, R^2 = .594) and ECR-Anxiety (β = -.173, p < .05, R^2 = .594) . Only one predictor, self-kindness, remained significant for physical health and well-being, (β = .379, p < .01, R^2 = .258). The significant predictors for relationships were outness (β = .231, p < .05, R^2 = .590), isolation (β = .203, p < .05, R^2 = .590) and ECR-Anxiety (β = -.256, p < .001, R^2 = .590). Therefore the data suggests that different components of self-compassion predict well-being, depending on which aspect of well-being is being measured.

Self-kindness appears to be a predictor of psychological well-being and physical health and well-being. Isolation appears to be a predictor of psychological well-being and relationships.

Discussion

This study revealed a pronounced relationship between self-compassion and general well-being in gay men, with some aspects of self-compassion appearing more important than others depending on which aspect of well-being is being explored. Self-kindness and isolation were both significant predictors of psychological well-being, whereas only self-kindness was a significant predictor of physical health and well-being, and isolation the only significant aspect of self-compassion that predicted relationships. This finding points to the potential for self-compassion to be a naturally occurring strength that contributes to resiliency in this population.

It is interesting that only two of the self-compassion subscales were significant predictors of well-being and that the relative importance of these differed depending on which component of well-being is being explored. This highlights the importance of measuring all components of self-compassion rather than the total construct. Most research that has explored self-compassion has utilised the short-form version and only reported total self-compassion scores. The reporting of the subscale scores is a strength of this research and suggests the need to explore the relative contribution of the various components of self-compassion in other research.

These results indicate that the self-kindness and isolation are the two components of self-compassion that predict well-being in this sample of gay men. In relation to minority stress, it may be that treating yourself kindly predicts psychological well-being through a

buffering effect on stress or that someone who treats themselves kindly may appraise stress differently than someone who is prone to self-criticism. Similarly, people who view their experiences as isolating will appraise any stressful events more negatively than someone who reminds themselves that what they are experiencing is not unique to them. In terms of physical health and well-being, treating yourself kindly may ensure greater resources are available for self-care. Finally, in terms of the relationships component of well-being, an isolating view in regards to personal difficulties may be a barrier to seeking out and utilising social support networks, as social support buffers the relationship between social stress and well-being. However, this needs to be explored in future research to test specific hypotheses.

The findings regarding pride and well-being raise important questions. Authentic pride had the most pronounced relationship with well-being, however its ability to predict well-being could not be distinguished because the strength of relationship between the two constructs indicated that they were perhaps not distinct and therefore potentially measuring a similar underlying construct. Hubristic pride exhibited no relationship with well-being. Although these measured a general tendency to experience authentic or hubristic pride, they point to important potential differences in the relationship between gay pride and well-being, based on the types of attributions the person is making regarding their sense of gay pride. To explore the potential of gay specific pride, the finding that the gay affirmation subscale of the internalised homonegativity inventory was a significant predictor of psychological well-being (negatively related due to it being reverse scored), indicates that a lack of gay affirmation has negative consequences for well-being. The necessity to extrapolate findings regarding gay pride from a measure of internalised homonegativity is further evidence for the deficit focus of sexual minority mental health research. The development of a measure of gay pride that differentiates authentic and hubristic pride has the potential to improve upon and extend these

initial findings, and to explore questions such as, what form does gay pride take that has positive consequences for the well-being of gay men?

Attachment anxiety was also a negative predictor of well-being, specifically psychological well-being and the relationships component of well-being. This finding supports the notion of self-compassion being a positive predictor of well-being because self-compassion is linked to attachment styles. Past research has found that people with secure attachment styles report significantly higher levels of self-compassion (Neff & McGehee, 2010).

Regarding the gay specific factors of outness and internalised homonegativity, previous research was supported. Level of outness, whilst increasing some risk factors such as experience of violence of discrimination, is a significant predictor of general well-being and specifically of the *relationships* component of well-being. Internalised homonegativity, whilst having a significant negative relationship with well-being did not predict well-being. Rather, a lack of gay affirmation was a significant negative predictor of psychological well-being. However, there are important limitations regarding the measurement of sexual stigma that will be addressed later.

The finding that there was no relationship between age and internalised homonegativity was unexpected and inconsistent with previous research. However, not measuring the length of time someone has self-identified as gay may have important implications here. This will be discussed further in the limitations section.

Limitations

The authors recognise several limitations to the internal and external validity of the study. These influence the extent of the conclusions that can be drawn and generalizability of

the findings to the larger gay male community. They relate to the study design, representativeness of the sample, measurement issues and influence of confounding variables.

This study utilised a cross-sectional correlational design. Whilst the effects of self-compassion and well-being make theoretical sense, it is possible that a sense of well-being enables people to be more self-compassionate. Correlation can only suggest explanatory mechanisms, and cross-sectional surveys make it difficult to ascertain the timing of events, to ensure that theorised causes actually occur before the effects attributed to them. However, correlational studies such as this can offer evidence around theories that can be tested further within longitudinal research design. The lack of a comparison group makes it impossible to assess whether self-compassion is a relative strength of gay men, compared to other sexual minority groups and the male heterosexual majority. The difficulties of recruiting a matched comparison group for sexual minority research are well noted however, and were beyond the scope of this research. This is an important area for further research.

The sampling procedure utilised a self-selecting and snowball sampling method therefore the results cannot be generalised beyond the characteristics of this particular sample. Self-selecting and internet-based research designs are known to recruit a restricted range of the population of interest, which is biased towards higher well-being and more affluent participants. Although the use of these methods are justified in research with minority groups, and particularly in the present research because the aim was to explore the natural occurrence of self-compassion within a healthy self-identifying gay male sample, the findings cannot be generalised to the wider gay community.

No measure of gay pride currently exists; whilst the inclusion of general measures of pride point to potentially important areas for future research, they do not measure gay pride specifically. Therefore, any conclusions regarding the role of gay pride need to be interpreted

cautiously. The internalised homonegativity measure was chosen as the most appropriate measure based on construct validity of past research. However, this only measured internalised sexual stigma regarding sexual attraction and not sexual stigma related to the wider aspects of sexual identity, for example gender non-conformity and stereotypes regarding the gay community. The lack of significance regarding any of the relationships between the morality of homosexuality subscale indicate that this conceptualisation of sexual self-stigma may no longer be valid in the current social and political context of greater acceptance of sexual minorities in society.

The lack of significance regarding the relationship between age and internalised homonegativity may be due to the influence of a confounding variable that was not measured. Time since coming out was not measured because of the complex and on-going dynamic nature of this process. However, in hindsight, this would have been a valuable variable to include, due to the importance of time required to develop a sexual identity and learning to cope with the minority stress, as well as sexual stigma that sexual minorities experience. Whilst this study has drawn preliminary conclusions regarding the potential importance of self-compassion as general psychological process in the well-being of gay men, it does not represent the complete picture because there are many other variables, both general (e.g. mastery and social support) and gay-specific (e.g. sense of connection to community, coming out growth) that are considered to influence well-being.

Clinical implications

This is the first investigation, to the author's knowledge, of the role of self-compassion in well-being amongst men who self-identify as gay. Whilst it seems self-compassion is a predictor of well-being, over and above the gay specific factors of outness, gay affirmation and personal homonegativity variables, there is scope to examine

dispositional self-compassion. For example, investigating the extent to which those who have greater self-compassion are less likely to exhibit greater stress, anxiety, depression or more likely to exhibit resilient outcomes in terms of adversity related to MSM. Given the multiple stressors, and increased prevalence of mental health issues, there could be a role of fostering self-compassion, or exploring compassion-based interventions to aid the development of a compassionate stance to the self in sexual minority clinical populations. For example, individuals who are struggling to come to terms with their sexual identity may struggle to develop a self-compassionate stance.

Compassion-based approaches were initially developed to support people to overcome the barriers to self-compassion in relation to their high levels of shame (Gilbert & Proctor, 2006), and therefore may have particular clinical utility when working with LGB people. Cooper (2013) provides a formula for a compassion-based approach for working with stress that may have relevance here. For example, where self-acceptance and resolution of internalised heterosexism has been identified as a goal for psychological therapy, the client could be supported to use mindfulness meditation and compassionate imagery to make space for and approach the pain and distress stemming from the shame of internalised heterosexism, over time learning to respond with care and kindness rather than habitual patterns of avoidance. Themes of shame and compassion could be explored as part of the assessment process, for example, utilising the Fear of Compassion Scales (Gilbert, ???) and if identified as potentially useful to the client's reported problems and goals, there are many resources available to support interventions that focus on training in self-compassion (Gilbert, 2009; Neff, 2012; Gerner, 2009).

Past research in this area has been deficit focused and resiliency research is in its infancy. This initial study utilised a non-clinical sample to identify self-compassion as a naturally occurring strength in this population. It is possible that mental health prevention in

this population could be improved by capitalising on this naturally occurring resource. Herrick et al. (2011) suggests a number of positive constructs that are deserving of future investigation as possible strengths that exist within the gay community. One of these constructs, shamelessness, which is attributed to the proud identities that gay men develop, requires further investigation. The current findings suggest that this sense of shamelessness may be more related to the ability to be self-compassionate when experiencing shame rather than developing a proud identity. The identification of self-compassion as a strength that exists in gay men supports its inclusion in future research towards developing an empirically supported 'Theory of Resilience' in gay men.

Further research is needed to explore how self-compassion interacts with minority stress in a longitudinal design to explore if there are differences in self-compassion compared to other populations, both within and between groups who may or may not experience stress in line with the MSM. Although the impact of stigma related to HIV/AIDS was not examined in this study, there is evidence that those people who are affected by HIV/AIDS also suffer stigma specifically related to this (Smit et al., 2012). There may be a role for fostering self-compassion for those with a diagnosis in terms of well-being and self-care.

Future Directions

This exploratory cross-sectional study has provided evidence for the potential role of self-compassion as a naturally occurring strength and resource that exists within gay men and also points to important areas regarding the role of pride in gay men's well-being that justifies further research efforts. Given the finding that self-compassion is a significant predictor of well-being; it is worth exploring whether self-compassion buffers the effects of stigma on well-being or mediates the relationship between stigma and well-being in gay men.

This research focused on one specific sexual minority population and could also be replicated on other sexual minority populations, such as those with intersecting identities, and other minority populations such as lesbian, bisexual, transgender and adolescent populations Understanding the role of self-compassion could be particularly fruitful with an adolescent population, when established risk factors for poor well-being are higher and sexual minority adolescents are particularly at risk due to the additional complexity of developing a sexual minority identity. Future research should take a longitudinal design to allow for identification of the timing of events and causal pathways.

Self-compassion is a construct that is being increasingly recognised as an important clinical tool for a variety of difficulties because of its protective benefits to adaptive psychological functioning and because it is amenable to change. However, there has been no empirical research exploring this construct as a tool within gay-affirmative therapeutic frameworks. Not only is self-compassion a resource that can be promoted within the wider gay community, but also deserves investigation as a clinical tool for use with gay men when experiencing psychological distress, whether or not related to their sexual identity. Future research could explore experimental manipulations of self-compassions in this population and compare gay affirmative approaches that include self-compassion to more traditional affirmative approaches that tend to emphasis increasing self-esteem. Self-compassion could also inform work with other stigmatised minority groups and the wider social problem of sexual stigma and sexual prejudice within the wider heterosexual majority of society.

In conclusion, this study offers preliminary support for the role of self-compassion as a naturally occurring resource and strength within the gay male community that contributes to well-being and deserves further attention. The potential implications go beyond promoting and supporting resilience in gay men and developing traditional gay-affirmative approaches.

If self-compassion supports the resolution of sexual stigma in gay men then it may have potential to reduce sexual prejudice in wider society.

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Chapter 3

Concluding Discussion

Expanded Discussion

General overview

This study has considered the mental health of gay men from a positive clinical psychology perspective (see Wood & Tarrier, 2010). The many and complex ways that gay men cope with sexual stigma have been highlighted, the role of pride in gay men's well-being has been examined and self-compassion has been found to be a naturally occurring resource that is positively associated with well-being and negatively associated with internalised heterosexism. Although this study was exploratory and correlational in nature, it provides evidence supporting the case for further study of the role of self-compassion, pride and internalised heterosexism in gay men.

A strengths based perspective was utilised to study a naturally occurring resource in a sample of self-identifying gay men. This perspective allowed gay men to be approached, not as clients with problems but people with life experiences that seem valuable. Self-compassion is a resource with an increasing evidence base that is utilised by many clinical Psychologists (Gilbert & Proctor, 2006; Neff & Germer, 2013). Sharing this knowledge with the gay community has the potential to significantly contribute to the lives of gay men and other sexual minority groups. In turn, the discipline of clinical psychology has the potential to be enriched through a more thorough understanding of the diversity of its clients or participants. Understanding how gay men maintain their well-being, despite the stigma and prejudice they experience, has the potential to provide insights into how the wider effects of sexual stigma can be overcome. The research is gay-affirmative and has the potential to serve a protective function, to the extent that it challenges heterosexism and affirms gay lives (Clarke, Ellis, Peel & Riggs, 2010).

Clinical psychology has traditionally focused on a deficit model and has a complex history with sexual minorities, contributing to the pathologising of these ways of life for many years (Herek, 2010). The profession of counselling psychology has taken a lead in contributing to the literature on working therapeutically with sexual minorities, possibly preferred by these clients because of the basis in humanistic psychology (Brown, 2008; Moradi, Mohr, Worthington & Fassinger, 2009). Conceptually, self-compassion has many similarities with the unconditional positive regard and self-acceptance associated with more humanistic/person-centred approaches (Barnard & Curry, 2011). However, Clinical Psychologists also have a role in promoting well-being and mental health prevention. A positive clinical psychology perspective has much to offer in this respect. Conceptualising self-compassion within a positive clinical psychology framework has enabled a strengths based and affirmative approach to the study of gay men's mental health. Although this study was exploratory and requires further scientific investigation, it raises some important questions for theory and research and potential implications for the practice of clinical psychology, not only with those clients who identify as gay or other sexual minorities, but for any client affected by the stigma of being diagnosed with a mental disorder or occupying a minority position within society. The theoretical, research and practical implications are discussed below.

Theoretical implications

Whilst acknowledging that the study of coping and resilience is central to theoretical understandings of the minority stress model (MSM) of mental health, Meyer (2003) warns against conceptualising minority stress in terms of resilience because of the potential to shift the weight of focus for change on to the individual rather than society. However, to portray

gay men as passive victims to the adverse effects of oppression presents an incomplete picture and does not honour the human rights and social changes that those involved in the gay rights movement have heroically fought for and largely won. This study recognises self-compassion as a naturally occurring resource that may contribute to resiliency in this population. A balanced understanding of the role of both risk and resilience factors are required for a more complete understanding of mental health; a positive clinical psychology perspective incorporates both of these (Tarrier & Wood, 2010).

Resiliency research concerning gay men's health is in the very early stages. Herrick et al., (2011, 2013a, 2013b) has drawn attention to resilience as a research framework, a cornerstone of prevention research and untapped resource for behavioural intervention design for gay men, from a HIV/AIDS prevention and intervention perspective. This body of research suggests several constructs that deserve future investigation as possible strengths that exist within the gay community. The current findings have implications for one of these constructs. Shamelessness, attributed to the proud identities that gay men develop, requires further investigation. These findings suggest this may be more related to the ability to be self-compassionate when experiencing shame rather than developing a proud identity. The identification of self-compassion as a strength that exists in gay men supports its inclusion in future research towards developing an empirically supported 'Theory of Resilience' in gay men.

Gay-affirmative practice is a framework recommended for all practice with sexual minorities, regardless of the Psychologists' therapeutic orientation (BPS, 2012). Self-compassion has the potential to contribute to this theoretical framework through its theoretical and research links to social status and the self-conscious emotions (e.g. shame, guilt and pride; Gilbert, 2009) and potential benefits recognised in the general literature as a healthier form of self-relating than self-esteem (Neff, 2003; Neff & Vonk, 2009).

Research implications

Although this research was a preliminary exploratory investigation, the findings produce several avenues for future research. This study has drawn attention to the lack of quantitative research concerning coping with stigma in gay men. Future research is required that builds on the recent advances in the general coping literature. Proactive coping is also an area worthy of future investigation concerning how gay men adapt to their minority position and learn to effectively manage the stigma associated with this.

The finding that self-compassion is a naturally occurring individual level resource that contributes to well-being in gay men contributes to the research literature concerning the minority stress model (Meyer, 2003). Group level resources have been the subject of past research, however very little research exists concerning individual level resources. Group level resources are important because without them collective action cannot be taken to challenge stigma and heterosexism at an institutional level (Meyer, 2003). However, many people are not able to access these resources for a variety of reasons and therefore individual level resources are also required. Future research could investigate whether self-compassion, with its focus on common humanity, supports people to seek out and access these group level resources.

Adolescence is known to be a challenging time for most people; this is compounded for those who are developing a sexual minority identity (Wilson et al., 2010). Resilience research is more advanced in this population (DiFulvio, 2011); however self-compassion has not been studied with sexual minority adolescents. This is worthy of future study and possible interventions to support the development of a positive identity at this challenging life-stage. The literature would also benefit from investigation in other sexual minority groups and populations (e.g. bisexual, lesbian and men who have sex with men).

This study has made a contribution to the affirmative research concerning sexuality. Current affirmative approaches lack empirical investigation. Future studies could examine the effectiveness of these interventions with and without adaptations to include the concept of self-compassion. A strengths based perspective has the potential to contribute to challenging heterosexism in society and contribute to resiliency research, influencing mental health promotion efforts in this population. The findings regarding pride have highlighted the need for the development of an effective measure of the construct of gay pride and future research concerning how this impacts on the well-being and resiliency of gay men.

Clinical implications and training considerations

Clinical Psychologists have an ethical duty to have a level of cultural competency to work with sexual minorities (BPS, 2012). The study of self-compassion from within a positive clinical psychology framework contributes to challenging heterosexism and affirms the lives of gay men. It highlights skills and knowledge that many Clinical Psychologists already possess, that may be transferable to working with this client group and more generally when working with clients who face stigma such as those diagnosed with a mental disorder or who occupy other minority positions within society.

Albee (1983, 1995) recommends a social justice model for the primary prevention of mental health consequences of social injustice. Many Clinical Psychologists have engaged in social justice advocacy at the micro or individual level (e.g. challenging heterosexism within 1:1 therapy). Goodman et al., (2004) has called for counselling Psychologists to engage in social justice work at also the meso (communities and organisations) and macro levels (social structures, policies and ideologies). This framework of micro, meso and macro levels will be utilised here to explore the clinical and training implications of this dissertation for Clinical

Psychologists working specifically with gay men but also applicable to other sexual minority groups.

Micro level

Many Clinical Psychologists will have experience of working at the micro or individual level with clients who identify as gay. Gay affirmative therapy is recommended as a therapeutic framework for use with all sexual minority clients, although this lacks empirical evidence (BPS, 2012). Gay affirmative therapy can be operationalized as a soft or strong version. In the strong version gay affirmative therapy is the main therapeutic orientation used whereas the weak version involves utilising existing therapeutic orientations within an affirmative framework. Most Psychologist utilise the latter because of core training and stronger evidence base for other orientations such as CBT.

The strong version of gay affirmative therapy would benefit from empirical investigation to create an evidence-base for this approach. Compassion-based approaches may compliment gay affirmative approaches; though the author is not aware of any published literature regarding this. Psychologists competent in gay affirmative approaches could play a role in meeting this need. As most Psychologists practice the soft version and are competent in at least CBT, they already possess many skills in relation to the psychological understanding and therapeutic use of compassion in therapy. Therefore they already possess many transferrable skills to support individuals to develop this resource for themselves.

The literature review points to the need to assess coping strategies on an individual basis and explore the positive and negative consequences of these strategies for the individual concerned. Involvement in the gay community should also be assessed for positive and

negative consequences. Anxieties concerning a wish not to offend may prevent Psychologists from exploring this with clients. This study provides evidence that this is a potentially important area to include in assessment and not assume that gay community has only a positive influence on mental health. There is particular importance of exploring coping strategies in relation to shame avoidance (McDermott, Roen & Scourfield, 2008).

Working at the individual level does not prevent distress but does help to reduce suffering. However, exclusive reliance on such individual level work may hamper the empowerment process and deprive people from learning from one another about how people deal with oppressive traumas (Kashubeck-West, Szymanski & Meyer, 2008). Therefore there is also a need to work at the meso and macro level to challenge stigma related to sexual identity.

Regarding the training of Clinical Psychologists, experiential exercises related to self-compassion could be included in sexuality modules and trainees guided to recognise the particular challenges that face this population and to what transferrable competencies they possess that may be of relevance. Trainees could also be instructed to prepare research proposals that extend the current project and focus on sexual minority issues from a positive clinical psychology perspective.

Meso level

In addition to supporting clients to access community and organisational level activities, Clinical Psychologists themselves can participate in such activities. Volunteering time to run workshops, support or therapy groups and sharing our skills regarding self-compassion and other therapeutic techniques that may assist in primary prevention and

mental health promotion to support effective coping is one possibility. There is a need for closer relationships between Clinical Psychologists and gay community organisations. Community organisations have long recognised the benefits of a strengths based approach but lack the resources to evaluate these efforts. Clinical Psychologists are well placed to share their research skills and knowledge to support these organisations to evaluate their strengths based work. The literature regarding compassion and self-compassion could be utilised to highlight suffering related to sexual stigma and challenge sexual prejudice in wider society.

Clinical Psychologists often lack the skills and confidence to work at such a level, there is an opportunity to learn from our colleagues in community psychology here (Russell & Richards, 2003). Core training could also include discussion of the historical relationship between the profession and sexual minorities, to ensure an appreciation of the role psychology has played in contributing to the pathologisation of sexual minorities and the need to work to undo this. Training needs include the provision of information regarding particular challenges facing those with distress related to their sexual orientation or identity, including coping and resilience.

Macro level

This requires working at a social structure and policy level. Consideration should be given to extending the current scientist-practitioner model to a scientist-practitioner-advocate model (Fassinger & Gallor, 2006) to give central importance to the role of inequality and social influences in the development of mental distress. Conducting affirmative research such as this, that challenges heterosexism and affirms the lives of sexual minorities, can contribute to challenging heterosexism at a social and institutional level.

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Dissemination of findings

Title: Gay men's mental health: A psychological perspective[2]

Mental health issues are often considered a taboo subject within the gay community. Research shows that gay men are more likely to suffer a variety of difficulties related to their mental health, including depression, anxiety, self-harm, drug abuse and suicide. However, the past demonising of the male 'homosexual' by mental health professionals, equating same sex attraction with mental illness has contributed to the silence and taboo surrounding this important subject.

In September 2010, the editor of a popular gay magazine attempted to raise awareness and discussion of the mental health 'crisis' facing the gay male community (ref). A central argument to that article regarded the damaging effects of shame, created by growing up gay in a straight man's world, and the understandable but often self-defeating way that we deal with these difficult feelings. At this time, I was just about to embark on my clinical psychology doctorate, the final three years of my training to qualify as a Clinical Psychologist.

The aim of a Clinical Psychologist is to reduce psychological distress and to enhance and promote psychological well-being. A key difference between Clinical Psychologists and other mental health professions is that Clinical Psychologists' develop an individualised understanding of the unique combination of factors contributing to a person's distress and therefore identifying what actions may bring about a reduction in distress or improvement in

[2] Prepared for submission to Out North West magazine, published by the Lesbian and Gay Foundation, to feedback to the study participants and disseminate findings to the wider gay community.

well-being. Experiences traditionally considered signs of mental illness are framed as an understandable response to often challenging circumstances. We do not prescribe medication but work with people, often through the provision of a talking therapy, to support them to consider what changes may be helpful and how to go about making these positive changes. The profession has recently released a statement challenging traditional medical views of mental health, in an attempt to draw the public's attention to the limited science behind the current system of diagnosing and labelling forms of human distress as mental disorder; labels that often lead to stigma and further distress for the person concerned. It seems the profession may have much to learn from the gay community, who successfully campaigned to have homosexuality removed from the list of mental disorders between 1960 and 1993.

As part of this training I was required to undertake a substantial research component. As a gay man and someone undertaking doctoral level training in a mental health profession, I decided that this would be a perfect opportunity to explore these issues further and so focused my research on the area of gay men's mental health. Three years on and this research project has now come to an end with some interesting findings. This article is an opportunity to share a psychological perspective on gay men's mental health and what these findings may mean for gay men.

Do gay men have worse mental health than straight men?

Historically this has been a very difficult question to answer, due to the relative invisibility of gay men and challenges to undertaking a scientific approach to answer this question with any level of confidence. However, recent inclusion of sexual orientation monitoring in large studies have improved the accuracy with which this question can be

answered. It appears that gay men do have a higher life-time risk of experiencing a diagnosable mental disorder. This finding is often used by those who are against gay rights to support their argument that being gay is a mental disorder in and of it-self. However, the main psychological model that is utilised to explain this increase is the damaging effects of minority stress, experiencing stigma and prejudice throughout life due to our sexual minority status and widespread heterosexism throughout society.

Closer inspection of these findings has led me to question whether we do have worse mental health than heterosexuals. The majority of studies measured sexual orientation rather than identity and therefore included a much broader range of men than those who identify as gay, for example bisexual men and men who have sex with men. The majority of studies also used a sample including adolescent sexual minorities, a time that is known to be disruptive to mental well-being in the general population, let alone for individuals also dealing with the feelings aroused by the recognition and development of a minority sexuality and sexual identity.

'Coming out' and developing a gay identity that one accepts and is at ease with is associated with increased well-being in sexual minorities. Therefore the self-acceptance and connection with the gay community must provide resources that outweigh the challenges of facing increased discrimination and anti-gay violence. Internalised sexual stigma, what some call internalised homophobia or internalised heterosexism is an insidious problem for gay men, but again there is evidence that through adopting a sexual minority identity, gay men learn the skills to question and cope with these difficulties, with a reduction of internalised sexual stigma over time.

Regardless of whether we do have worse mental health, one thing I do recognise through my lived experience as a member of the gay community, is that gay men do have to

confront unique challenges related to their gender and sexual identity that can have damaging effects. However, we are not passive victims to the oppression and stigma that we face, but interact with the stress caused by living in a heterosexist society, maintaining our well-being often in the face of adversity.

Resilience, the ability to maintain well-being or 'bounce back' to previous levels of well-being following stress, is a concept that is only just beginning to gain the recognition it deserves regarding how gay men interact successfully with a heterosexist society. The fact that gay men, with other sexual minority groups, have fought and largely won a battle for increased human and civil rights, whilst often facing community wide devastation from the HIV/AIDS epidemic, supports the notion of gay resilience on a community wide scale.

Gay coping

Prior to conducting my research I explored the psychological literature concerning gay men's mental health. Although this provided a wealth of evidence concerning the risks that we face and the resultant negative consequences of these risks, there was much less research concerning how we interact and cope with the stress and stigma related to heterosexism and sexual prejudice in society. Coping research is still in its early stages but one thing that the literature clearly showed was that gay men cope in a wide of variety of ways, some of which are largely successful, others not so. Taking a problem-solving approach and tackling the stress and stigma often leads to more positive outcomes. However, many gay men reported the use of drugs, alcohol or sex as a form of coping, to avoid and/or block out deep feelings of shame and inadequacy. Connection to the gay community also raised important differences, for some this led to an increase in well-being through involvement in community activism and connecting with other sexual minorities to

reappraise the messages they received during childhood that gay is bad, into more positive conceptualisations of what being a gay man means. However, there were also many reports that gay men were dissatisfied with the commercialised nature of the gay scene and the challenges related to meeting the expectations and cultural norms that exist within it.

I was also interested in the concept of gay pride. The gay community emphasises developing an attitude of gay pride to overcome the feelings of shame related to occupying a minority sexual identity. Unfortunately, and another example of the deficit focus of traditional psychological research, the concept of gay pride has not been studied from a psychological perspective, preferring to study gay shame in its various guises (internalised homophobia/homonegativity/heterosexism). However, an important distinction has been made in the general literature concerning pride: that there is not one type of pride but two distinct types called authentic and hubristic pride. Authentic pride is experienced in relation to actual achievements and is generally considered to have a positive impact on well-being. Hubristic pride is more of a short-cut to feeling pride and lacks substance. Whilst not necessarily being detrimental to well-being, it does not provide support for well-being.

Self-compassion: A potential resource

Another relatively new idea in psychology that may be of relevance to gay men is that of self-compassion. This concept originates from Buddhist thought and is defined as a healthy form of self-acceptance and the tendency to treat oneself kindly in instances of pain and perceived inferiority/inadequacy. It entails being kind to oneself in instances of pain or perceived failure rather than being harshly self-critical; seeing one's experiences as part of common humanity rather than seeing them as isolating; and holding painful thoughts and feelings in mindful awareness rather than over-identifying with them. One study has

investigated the connection between this and gay identity development, and found that self-compassion contributed to the development of a positive gay identity. Self-compassion is being increasingly used within talking therapies and programmes to increase well-being or reduce distress. It is a healthy form of self-relating that can be learnt, has many of the same benefits of self-esteem but because it is not contingent on comparing yourself to others, is more stable than self-esteem and not related to some of the egotistical aspects related to high self-esteem. Self-compassion has been linked to increased well-being and as contributing to resiliency in the wider literature.

My study

I wanted to take an positive approach to my research, partly to off-set the negative focus of previous research in this area but also to provide research that lead to optimism in any reader currently struggling with issues related to their sexual identity, or more correctly, related to widespread heterosexism and sexual prejudice in society. I considered that self-compassion may be a naturally occurring strength and resiliency factor that many gay men possess that already contributes to their ability to maintain well-being, often in the face of adversity. This would not only have potential implications for gay men and those working with gay men in distress but also for wider society. Sexual stigma is not just a gay problem; it underlies sexual prejudice in the heterosexual majority. Therefore I wanted to explore the possibility of a resource or strength that gay men possess, being utilised for the good of wider society.

One hundred and thirty nine self-identifying gay men participated in an online survey and completed measures related to self-compassion, pride, internalised homonegativity, level of outness, self-esteem and well-being. I was interested in how these constructs related to

each other within my sample. Authentic pride, self-esteem, self-compassion and outness were positively related to well-being. Personal homonegativity and lack of gay affirmation were negatively related to well-being. Hubristic pride was not related to well-being.

The most important aspects of self-compassion appeared to be self-kindness and not taking an isolating perspective of one's experience, these were predictors of well-being in this study. Self-kindness is defined here as extending forgiveness, empathy, sensitivity, warmth and patience to all aspects of oneself, including all of one's actions, feelings, thoughts and impulses. A person who is self-kind views their worth as unconditional and is affirming, even after failure or perceived inadequacy, that they deserve love, happiness and affection. This was a predictor of both psychological well-being and physical health . Isolation as defined here, refers to the feeling of being cut-off from others during times of pain or frustration. It is particularly relevant to those who believe that they are shameful, as these people often withdraw, hide by themselves and feel that they are alone in their struggle with particular inadequacies or failures.

Implications and future directions

Although a preliminary study, I feel that this piece of research sheds some light on the topic of gay men's mental health, from a positive well-being perspective. This research explored the relationships between several factors implicated in gay men's well-being at one-point in time; therefore conclusions cannot be drawn regarding causation. For example, although it seems likely that adopting a self-compassionate mentality leads to increased well-being; it is possible that high well-being enables people to be more self-compassionate. However, it has provided evidence that self-compassion is implicated in how self-identifying gay men maintain a sense of well-being, often in the face of adversity. The findings

regarding pride need to be treated with caution because they did not directly measure gay pride but rather a propensity to generally experience hubristic and authentic pride.

In future research, more experimental studies that allow for levels of self-compassion to be isolated by the researcher and measured over time is needed. Also this study only focused on self-compassion within a sample of gay men, it may have further relevance for other groups such as adolescents or those struggling with their own sexual identity. Self-compassion has the potential as a resource for mental health prevention and promotion as well as treatment. It is something that gay men could explore further themselves in terms of promoting their own mental health. It also alerts Psychologists that may be working with sexual minority clients that self-compassion may be a useful clinical tool. Community-based organisations for gay and bisexual men have long recognised that focusing on the strengths, resilience, and other protective factors can bring about positive individual and community level results. However, few community programmes have had the resources to test or evaluate their work. Utilising self-compassion may be one possible avenue worthy of their time and attention.

Future Research Proposal

Proposed Title: Self-compassion and reactions to daily experiences with heterosexism in gay men: The implications of treating oneself kindly

1. Summary of main study

The study reported in Chapter two utilised a cross-sectional design to explore the relationships between self-compassion and well-being in a non-clinical sample of self-identifying gay men. One hundred and thirty-nine gay men were recruited through advertisements placed in various gay community and social networking forums. Those who consented followed an online link to the study and completed a series of demographic and questionnaire measures. Self-compassion exhibited a medium-sized significant positive correlation with well-being, and specifically the components of self-kindness and isolation were significant predictors of well-being in a linear regression analysis. These initial findings suggest that self-compassion may be a naturally occurring strength and resource that supports well-being in gay men and could be utilised in mental health prevention and promotion work.

2. Introduction

This line of research could be extended in a number of directions. Longitudinal research is required that explores the development of self-compassion and its interaction with sexual minority stigma-related stressors, gay identity, and well-being, over-time. However, this would be difficult to achieve due to challenges defining the gay population in adolescence, prior to the development of a sexual identity. The question from a clinical psychology perspective is whether self-compassion is a safe and effective therapeutic tool to use in relation to a variety of unique issues that sexual minority clients may bring to therapy. This

study utilised a non-clinical sample, but research from the general compassion literature has found that some people, particularly those with high levels of internalised shame, can find it difficult to experience self-compassion (Gilbert, 2009). Therefore, Psychologists must utilise clinical judgement when considering the use of self-compassion as therapeutic tool, particularly with those exhibiting signs of high internalised shame and self-criticism. The logical progression in clinical intervention terms is to now undertake a systematic case-study approach, integrating compassion-based approaches within gay-affirmative therapy.

However, continuing with the strengths based perspective of this research; self-compassion may also have much potential as a mental health prevention and promotion tool in non-clinical samples. Therefore, it is important to investigate the role of self-compassion and the implications of treating oneself kindly, in gay men's reactions to daily experiences with heterosexism.

The majority of gay men manage to achieve and maintain a sense of well-being, often despite the adversity they face in relation to their sexual minority status (Balsam & Mohr, 2007). The proposal for this study is to again utilise a non-clinical sample in the next stage of research, and investigate the moderator and mediator effects of self-compassion on the relationship between daily experiences with heterosexism and psychological well-being in gay men. The research will use daily diary methods to capture data in real-time and assess the effects of heterosexist daily hassles on the well-being of a sample of self-identifying gay men, and the moderator/mediator effects of self-compassion on the relationship between daily experiences with heterosexism and well-being.

The rationale for the empirical study reported in Chapter two was to identify if there was a relationship between self-compassion and well-being in a non-clinical sample of gay men. That study has provided evidence for relationships between elements of the two constructs

and elements of self-compassion seem to be predictors of well-being in this population. However, due to the cross-sectional nature of that study the impact of those relationships are not known. This study will extend the research by first establishing whether there is a relationship between self-compassion and well-being, thereby providing support to the current findings and their generalizability/external validity; and second, by examining the impact of those relationships over time with a variety of minority stress factors and coping responses. Should the study indicate significant positive differences in relation to self-compassion and minority stress over time, this would then provide a preliminary rationale to developing specific self-compassion based interventions to support well-being, and to explore its associated impact in promoting mental health and well-being in this population.

3. Research aims/questions/hypotheses

Research question: Does self-compassion buffer the impact of minority stressors on the well-being of gay men?

Research aims: To explore the role of self-compassion in terms of minority stress in the daily life of a sample of self-identifying gay men.

Hypotheses:

1) Is self-compassion related to well-being?

2) Do those who report more self-compassion perceive minority stress in a different way to those who report less self-compassion?

3) Do those who report more self-compassion cope differently with minority stress than those who report less self-compassion?

4. Design

This study proposes to utilise a longitudinal repeated measures design to measure within-subject changes over time and examine group differences between high and low self-compassion scorers.

Outcome variable:	Well-being
Predictor variables:	Self-compassion
	Coping
	Stressor type
	Stressor frequency
	Internalised heterosexism

5. Participants/Sampling/Access/Power

A non-clinical sample will be recruited from a wide variety of the gay community. Advertisements will be placed in gay media, online social media and community venues, directing potential participants to the study via a web-link. The online nature of the study should ensure that sufficient numbers are available to participate. The positive nature and relevance of the study to potential participants provides a reason for their co-operation in the research, as does the offer to be entered into a prize draw.

The study aims to recruit a minimum of 78 participants, based on the calculation of apriori GPower 3.1 analysis using G*Power 3.1, with 5 predictor variables, a medium effect size (0.25), alpha of .05, and power of 0.8 (Faul, Erdfelder, Buchner & Lang, 2009). A medium effect size was selected based on the research reported in Chapter two. However,

approximately twice this number of participants would be required to explore the six individual facets of self-compassion. A likely response rate is difficult to calculate given the nature of the recruitment and sampling methods employed. Given UK population estimates ranging from 1.5-2 million gay men and the online nature of the study, it is likely that sufficient numbers will be recruited.

Ethical approval will be sought from the host or link organisation relevant research Ethics Committee. It is not envisaged that participating in the study will have a negative impact on well-being. However, to safeguard this participants will be signposted to relevant organisations and reminded that they can withdraw from the research at any time. Informed consent will be sought from all potential participants. All data will be stored anonymously and securely. Participants will be appropriately debriefed.

Participants will be asked to complete X, Y, Z measures at baseline (T1, at time of consenting to the study). Daily diaries will then be recorded in terms of X Y, Z, over a period of X weeks (tracking, daily stressors data). After XX weeks, all participants will be asked to complete X, Y, Z measures again (T2).

6. Proposed data analysis

The data will be analysed utilising a repeated measures ANOVA to indicate within-subject changes over time. Post-hoc tests will be used to explore group and time effects.

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Appendices

Appendix 1

Author guidelines for submission of literature review paper to

Psychology of Sexualities Review

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The British Psychological Society
Promoting excellence in psychology

Psychology of Sexualities Review (PoSR) - ISSN 2047-1467

Notes for Contributors

Articles

1. All articles will be peer-reviewed through a double-blind process. Article manuscripts (maximum 8000 words excluding references) should be typewritten in 12 point Arial font, double spaced with 1" margins on one side of A4 paper. Each manuscript should include a word count (both for the entire article and for the abstract).

2. On a **separate** sheet, include the author's name, professional address, telephone number, email address and current professional activity. As all academic articles are subjected to blind peer-review, the rest of the manuscript should be free of information identifying the author(s).

3. Empirical, theoretical and review articles should include an abstract (maximum 120 words) and up to six key words that describe the paper (for indexing purposes). Words in the abstract may be conserved by: using digits for numbers (except at the beginning of sentences); using well-known abbreviations; using the active voice. Graphs, diagrams, etc. should be supplied in camera ready form. Written permission should be obtained by the author for the reproduction of tables, diagrams, etc., from other sources.

4. Full bibliographic references should be contained in the list of references at the end of each article. They should be listed alphabetically by author, be complete, accurate and in APA format (see http://www.apastyle.org). For example:

Journal Articles:

Peel, E. (2001). Mundane heterosexism: Understanding incidents of the everyday. *Women's Studies International Forum*, 24(5), 541-554.

Books:

Kitzinger, C. (1987). *The Social Construction of Lesbianism*. London: Sage.

Edited Books:

Rothblum, E.D. & Bond, L.A. (Eds.) (1996). *Preventing Heterosexism and Homophobia.* Thousand Oaks, CA: Sage.

Book Chapters:

Ellis, S.J. (2002). Student support for lesbian and gay human rights: Findings from a large-scale questionnaire study. In A. Coyle & C. Kitzinger (Eds.), *Lesbian and Gay Psychology: New perspectives* (pp.239-254). Oxford: BPS Blackwell.

References within the text should be listed in alphabetical order separated by a semi-colon. Footnotes should be kept to a minimum.

5. In preparing your manuscript please avoid the following common errors:

- Omitting the page numbers of book chapters, or the issue number of journal articles.
- Using capital letters in titles or headings (except the initial character or character following a colon).
- Not using an ampersand where necessary (e.g. *Lesbian & Gay Psychology Review*).

If in doubt about any formatting issue, authors should consult the Editors or should adhere to the format used in past articles published in *Psychology of Sexualities Review*.

6. Respect for the Privacy and Dignity of Human Participants

Authors must respect the privacy and dignity of individuals, and will ensure that individuals are not personally identifiable, except in exceptional circumstances and then only with clear, unambiguous informed consent. Authors will respect confidentiality, and will ensure that information or data collected about individuals are appropriately anonymised and cannot be traced back to them by other parties, even if the participants themselves are not troubled by a potential loss of confidentiality. Authors must not use sexist, racist or heterosexist language. Furthermore, authors are directed to the British Psychological Society's *Code of Human Research Ethics* guidelines for further information.

Steps 1 - 6 should be followed carefully before submission.

Submitting your work

Articles and General Submissions should be sent electronically to the Editor, Dr Kristoff Bonello at: kristoffbonello@hotmail.com with the text **'Manuscript Submission POSR'** in the email header. Submissions should be sent as a Word Document attachment, together with a covering letter. PDF attachments are also acceptable in the first instance. A copy should be retained by the author(s).

Book reviews, bibliographic articles, conference reports, contributions to 'Research in Brief' and 'Focus on Activism', letters and notices about courses, conferences, research and other forthcoming events are not refereed but are evaluated by The Editor. However, book reviews and all other reports should conform to the general guidelines for academic articles.

Other submissions

Book Review submissions should be sent to Dr Roshan das Nair, Trent Doctorate in Clinical Psychology, IWHO, B13, International House, The University of Nottingham, Jubilee Campus, Nottingham NG8 1BB. E-mail: roshan.nair@nottingham.ac.uk

All other submissions (Focus on Activism & Research in Brief submissions) should be sent to The Editor, as detailed above.

Dr Kristoff Bonello DPsych CPsychol
The Editor – Psychology of Sexualities Review
Email: kristoffbonello@hotmail.com

Appendix 2

Author guidelines for submission of empirical paper to

Journal of Gay and Lesbian Mental Health

Instructions for authors

SCHOLARONE MANUSCRIPTS™

This journal uses ScholarOne Manuscripts (previously Manuscript Central) to peer review manuscript submissions. Please read the guide for ScholarOne authors before making a submission. Complete guidelines for preparing and submitting your manuscript to this journal are provided below.

Aims and Scope: *Journal of Gay & Lesbian Mental Health* seeks out and publishes the most current clinical and research scholarship on LGBT mental health with a focus on clinical issues.

The Journal strives to represent the full breadth of LGBT mental health treatment, including issues relevant to patients and mental health care providers in all types of settings. *Journal of Gay & Lesbian Mental Health* also strives to cover the full spectrum of sexual and gender minority populations – lesbian, gay, bisexual, transgender, intersex, queer, and gender-queer.

This peer-reviewed journal emphasizes original research articles, critical reviews of the literature, reports of innovative programs for LGBT mental health care training and delivery, and case reports that advance our understanding of LGBT mental health.

Address manuscripts to the Editor: The *Journal of Gay & Lesbian Mental Health* receives all manuscript submissions electronically via their ScholarOne Manuscripts website located at: http://mc.manuscriptcentral.com/wglm . ScholarOne Manuscripts allows for rapid submission of original and revised manuscripts, as well as facilitating the review process and internal communication between authors, editors and reviewers via a web-based platform. ScholarOne Manuscripts technical support can be accessed via http://scholarone.com/services/support/ . If you have any other requests please contact Mary Barber and Alan Schwartz, the journal's coeditors, at Editors@aglp.org . Authors must complete a Manuscript Submission & Limited Copyright Transfer Form.

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Authors should follow style and ethical guidelines of the American Psychological Association (APA). Grant numbers or other credits should be included as a separate, asterisked footnote and any conflict(s) of interest, whether financial or otherwise, should be fully disclosed. Statements on human/animal rights, and informed consent are also required where appropriate.

All parts of the manuscript should be typewritten, double-spaced, with margins of at least one inch on all sides. Number manuscript pages consecutively throughout the paper. Authors should also supply a shortened version of the title suitable for the running head, not

exceeding 50 character spaces. Each article should be summarized in an abstract of not more than 100 words. Avoid abbreviations, diagrams, and reference to the text in the abstract. Please consult our guidance on keywords here .

Study approval and informed consent: Manuscripts that report the results of experimental investigation and interviews with human subjects must include a statement that written informed consent was obtained after the procedure(s) had been fully explained. In the case of children, authors are asked to include information about whether the child's assent was obtained. If your submission dealing with human experimental investigation or interview does not contain information about written informed consent and Institutional Review Board approval, it will not be reviewed.

Disclosure of competing interests: All forms of financial support must be stated in an Acknowledgment. Any commercial or financial involvements among the authors that might present the appearance of a conflict of interest in connection with the submitted article should be disclosed in the cover letter. Such involvements may include (but are not limited to) institutional or corporate affiliations not already specified, support from pharmaceutical companies, paid consultations, stock ownership or other equity involvement, patent ownership, travel funds, and royalties received from rating scales, inventions, or therapeutic methods. The Editor may share this information with the reviewers, but such involvements will not represent automatic grounds for rejection of the submission. A statement of such involvements will accompany the article, if published. Authors will be asked to attest in writing concerning any competing interests at the time of submission.

References: References, citations, and general style of manuscripts should be prepared in accordance with the APA Publication Manual, 6th ed. Cite in the text by author and date (Smith, 1983) and include an alphabetical list at the end of the article. Examples:
Journal: Tsai, M., & Wagner, N. N. (1978). Therapy groups for women sexually molested as children. Archives of Sexual Behaviour, 7(6), 417–427.
Book: Millman, M. (1980). Such a pretty face. New York, NY: W. W. Norton.
Contribution to a Book: Hartley, J. T., & Walsh, D. A. (1980). Contemporary issues in adult development of learning. In L. W. Poon (ed.), Ageing in the 1980s (pp. 239–252). Washington, DC: American Psychological Association.

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Tables and Figures: Tables and figures (illustrations) should not be embedded in the text, but should be included as separate sheets or files. A short descriptive title should appear above each table with a clear legend and any footnotes suitably identified below. All units must be included. Figures should be completely labeled, taking into account necessary size reduction. Captions should be typed, double-spaced, on a separate sheet.

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