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Gender nonconformity, same-sex attraction, and mental health

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CHAPTER 1

Gender nonconformity, same-sex attraction,
and mental health: General introduction

Gender nonconformity refers to the expression of characteristics that are culturally more strongly associated with the opposite sex (Bailey & Zucker, 1995; Lippa, 2000, 2002). For instance, boys who are more feminine or less masculine relative to other boys in their interests, activity choices, and appearance are gender non-conforming. Prior research indicates that gender nonconformity is associated with poor mental health outcomes (e.g., Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003; Rieger & Savin-Williams, 2012; Toomey, Ryan, Diaz, Card, & Russell, 2010). Findings of such studies indicate, for instance, higher levels of anxiety, depression, and social withdrawal among clinically referred gender dysphoric children and youth when compared to children and youth from the general population (Cohen-Kettenis et al., 2003; Singh, Bradley, & Zucker, 2011; Steensma et al., 2014). High prevalence of such mental health problems was also found among community samples of transgender populations (e.g., Bockting, Miner, Swimburne Romine, Hamilton, & Coleman, 2013).

Same-sex sexual orientation and mental health

The term sexual minority refers to individuals who self-identify as lesbian, gay, and bisexual (LGB), but also those who do not identify as such, but who do report feelings of same-sex sexual attraction (SSA) or same-sex sexual behavior. There is strong empirical evidence indicating that sexual minority status is associated with poor mental health outcomes, including depression, anxiety, lower self-esteem, and suicidal thoughts (e.g., Fergusson, Horwood, & Beautrais, 1999; Russell & Joyner, 2001; Russell, Seif, & Truong, 2001; Sandfort, Bos, Collier, & Metselaar, 2010). These findings have been found in population-based studies carried out in various countries (e.g., McLaughlin, Hatzenbuehler, Xuan, & Conron, 2012; Sandfort, De Graaf, Ten Have, Ransome, & Schnabel, 2014), and with cross-sectional as well as longitudinal studies (e.g., La Roi, Kretschmer, Dijkstra, Veenstra, & Oldehinkel, 2016; Marshal et al., 2013; Needham, 2012).

Sexual minority stress theory

To explain why gender nonconformity and a same-sex sexual orientation are negatively related to mental health outcomes, research often draws on sexual minority stress theory (Meyer, 1995; 2003). Sexual minority stress theory has been developed to explain mental health disparities between sexual minority and heterosexual individuals. More recently, studies are expanding sexual minority stress theory by assessing the role of gender nonconformity. In the following sections, I first discuss how sexual minority stress theory is used as a framework to understand elevated

levels of mental health problems among sexual minorities. Next, I will discuss, sexual minority stress theory as a potential framework for understanding mental health problems associated with gender nonconformity.

Sexual minority stress theory and sexual minorities

Sexual minority stress theory posits that sexual minority individuals are at increased risk for poor mental health because they are exposed to *specific* stressors related to their minority position, such as prejudice and discrimination (Dohrenwend, 2000; Frost, 2011; Schwartz & Meyer, 2010). These stressors, which are additional to general life stressors that everyone may experience, can lead to stress, which can accumulate over time and can result in the development of mental health problems (Meyer, 1995; 2003).

For sexual minorities, four specific stressors have been distinguished: (1) negative social experiences related to one's sexual orientation, such as victimization /discrimination; (2) the expectation of such negative social experiences and the vigilance that this expectation requires; (3) the concealment of one's sexual orientation to others; and (4) internalized homophobia (i.e., the internalization of negative societal attitudes towards same-sex sexuality and sexual minority individuals). The first minority stressor (negative social experiences related to one's sexual orientation) is labeled as a distal minority stressor, whereas the other minority stressors (the expectation of negative social experiences because of one's sexual orientation; the concealment of one's sexual orientation; and internalized homophobia) are referred to as proximal minority stressors (Meyer, 1995; 2003). The theory further posits that the degree to which minority stressors affect mental health is influenced by coping resources and available social support (Meyer, 2003; 2015).

Numerous studies have offered support for sexual minority stress theory. For instance, research among adolescents has shown that sexual minority youth are more likely to report poor mental health when compared to heterosexual youth, due to increased exposure to sexual orientation related victimization and discrimination (for an overview see: Collier, Van Beusekom, Bos, & Sandfort, 2013; Fedewa & Ahn, 2011). Furthermore, studies among LGB people show that perceived experiences with victimization (e.g., Friedman, Marshall, Stall, Cheong, & Wright, 2008), the expectancy of victimization or rejection (e.g., Cox et al., 2008; Lewis, Derlega, Griffin, & Krowinski, 2003; Vanden Berghe, Deweale, Cox & Vincke, 2010), openness about an LGB identity (e.g., Beals, Peplau, Cable, 2009; Koh & Ross, 2006), and internalized homophobia (e.g., Newcomb & Mustanski, 2010) are important correlates for poor mental health outcomes. Although most studies used cross-sectional designs, a

growing body of research demonstrates that experiences with victimization among sexual minorities is also longitudinally related to poor mental health (e.g., Burton, Marshal, Chisolm, Sucato, & Friedman, 2013; La Roi et al., 2016).

Sexual minority stress theory in relation to gender nonconformity

Aside from gender nonconformity and a same-sex sexual orientation both being related to poor mental health outcomes, gender nonconformity is also related to a same-sex sexual orientation (Bailey, Dunne, & Martin, 2000; Bailey & Zucker, 1995; Lippa, 2005; Rieger, Linsenmeier, Gygax, & Bailey, 2008). Specifically, sexual minority individuals tend to report higher levels of gender nonconformity when compared to heterosexuals. Observant and self-reports of gender nonconformity show that this difference is apparent in childhood and persists through adulthood (Rieger et al., 2008).

Unlike other minorities, such as ethnic minorities, sexual minorities might avoid being victimized or discriminated against by not disclosing their same-sex sexual orientation to others. This may, however, be more difficult for sexual minorities that are gender-nonconforming, because they are more likely seen by others as gay or lesbian because of their gender expression (Johnson & Ghavami, 2011; Rieger, Linsenmeier, Gygax, Garcia, & Bailey, 2010; Valentova, Rieger, Havlicek, Linsenmeier, & Bailey, 2011). That is, people in general tend to equate expressions of gender nonconformity as a sign of a same-sex sexual orientation. It has therefore been suggested that gender nonconformity increases sexual minority individuals' exposure to experiences with victimization or discrimination (Sandfort, Melendez, & Diaz, 2007; Skidmore, Linsenmeier, & Bailey, 2006). Research has indeed shown that perpetrators of homophobic violence rely on gender-nonconforming cues to identify sexual minorities (Namaste, 1996). In line with minority stress theory, research among LGB youth and adults indeed indicate that those with higher levels of gender nonconformity experience more sexual-orientation related victimization and rejection, and accordingly experience more mental health problems (e.g., Baams, Beek, Hille, Zevenbergen, & Bos, 2013; Sandfort et al., 2007).

Sexual orientation differences in gender nonconformity-related outcomes

Although gender nonconformity and a same-sex sexual orientation are associated (e.g., Rieger et al., 2008), this does not imply that all sexual minority individuals are

gender nonconforming, nor that all heterosexual individuals are gender conforming. Furthermore, a small but growing body of research indicates that gender nonconformity is also associated with poor mental health outcomes among heterosexual individuals, including greater levels of post-traumatic stress and depressive symptoms (Roberts, Rosario, Corliss, Koenen, & Austin, 2012; Roberts, Rosario, Slopen, Calzo, & Austin, 2013). One possible explanation for the mental health problems associated with gender nonconformity among heterosexuals is that they are exposed to the same distal minority stressors as sexual minorities (i.e., victimization/rejection related to one's presumed same-sex sexual orientation) when they are perceived to be gay or lesbian due to their gender nonconformity. Accordingly, gender nonconformity - as an indicator of perceived same-sex sexuality - might elicit negative responses related to one's (assumed) sexual orientation in similar vein for heterosexual and sexual minority individuals. In contrast, it might also be that gender nonconformity, in and of itself, elicits negative responses from others, regardless of whether it is perceived as an indicator of same-sex sexuality. If so, sexual minority individuals with high levels of gender nonconformity might have two aspects that would make them vulnerable for victimization and subsequent distress; their gender expression and their sexual orientation.

Empirical support for these assumptions is limited, because there are relatively few studies that assessed the relations between gender nonconformity, victimization or rejection and mental health across both heterosexual and sexual minority individuals. Findings from such exceptional studies indicate no sexual orientation differences for adults in the relations of gender nonconformity with abuse and mental health (Roberts et al., 2012, 2013). Furthermore, Rieger and Savin-Williams (2012) found gender nonconformity and not a same-sex sexual orientation to be related to mental health among adolescents, suggesting that gender nonconformity might be more relevant to the mental health of adolescents than their sexual orientation. More research is needed to understand whether gender nonconformity elicits victimization and affects mental health in a similar manner for sexual minority or heterosexual individuals, or whether negative outcomes associated with gender nonconformity are heightened for sexual minorities. Therefore, the current dissertation addresses potential differences between sexual minority and heterosexual youth in the relation between gender nonconformity and mental health, via experiences with peer victimization.

Sex differences in gender nonconformity-related outcomes
Male gender nonconformity might be less socially accepted when compared to

female gender nonconformity. Several gender role theorists suggest that the more negative attitudes toward male gender nonconformity derive from how masculinity is perceived in our contemporary society (e.g., Herek, 1986; Vandello & Bosson, 2013). In contrast to femininity, masculinity has been described as a status that has to be achieved and that can be easily lost unless reaffirmed (Gilmore, 1990; Vandello & Bosson, 2013). As a result of stricter gender roles for men as opposed to women, men more often feel the need, to prove their masculinity when publicly challenged (Glick, Gangl, Gibb, Klumpner, & Weinberg, 2007; Herek, 1986; Kimmel, 1997; Theodore, & Basow, 2000).

Due to the confusion of gender nonconformity with a same-sex sexual orientation, men often strengthen their masculine identities through the expression of sexual prejudice (Herek & McLemore, 2013). For instance, research among adolescents' indicates that boys label other boys who fail to adhere to stereotypical notions of their gender as 'gay' or 'fag' (Pascoe, 2007; Plummer, 2001). By calling another boy 'gay', boys distance themselves from the behavior they associate with the label of being gay. By doing so boys not only reject the gender-nonconforming behaviors of their male peers, but also reinforce their own masculinity.

Indeed, studies that assessed sex differences in the associations of gender nonconformity with victimization/rejection, and mental health generally found stronger associations for men than for women (D'Augelli, Grossman, & Starks, 2006; Roberts et al., 2013; Young & Sweeting, 2004). For instance, findings based on LGB youth show that gay and bisexual (GB) boys experience more negative rejections due to their gender nonconformity than lesbian and bisexual (LB) girls (D'Augelli et al., 2006). However, one study among LGB and transgender (LGBT) youth found no differences between boys and girls in the relation of gender nonconformity with sexual orientation-based peer victimization (Toomey et al., 2010). Differences between men and women were also not found in the mediated relation of gender nonconformity with mental health via sexual orientation-based peer victimization (Baams et al., 2013). Due to these contrasting findings in the literature, the current dissertation therefore assesses potential sex differences in the associations between gender nonconformity and mental health via perceived experiences with (peer) victimization and homophobic rejection.

Furthermore, in contrast to knowledge about the associations between gender nonconformity, experienced rejection and mental health, little is known about how gender nonconformity relates to internalized homophobia and subsequent mental health. In one exceptional study, among South African Black men who have sex with men, gender nonconformity was associated with lower levels of depression through reduced scores on internalized homophobia (Sandfort, Bos, Knox, & Reddy, 2015).

These findings suggest that gender nonconformity is not only a risk factor for poor mental health, but may also protect against poor mental health via reduced levels of internalized homophobia. The current dissertation, attempts to clarify whether the role of internalized homophobia in the association between gender nonconformity and mental health also extends to Dutch self-identified LGB people, and whether there are differences between GB men and LB women in these associations.

The protective role of parental acceptance

Much of the current literature on gender-nonconforming and sexual minority youth has focused on risk factors instead of on factors that can support their mental health. Protective factors might ameliorate/buffer the impact of stress processes on mental health problems among gender-nonconforming and sexual minority youth (Meyer, 2003; 2015). The identification of protective factors at the individual or environmental level is important as they pinpoint factors that may be particularly salient for gender-nonconforming and sexual minority youth to improve their mental health.

A strong parent–child relationship could be a potential protective factor for sexual minority and gender-nonconforming youth. Studies on youth in general have indicated, for instance, that despite the increased significance of peers and school, parents remain important during their children’s adolescence (Turrisi, Mastroleo, Mallett, Larimer, & Kilmer, 2007; Wood, Read, Mitchell, & Brand, 2004). However, there is little research on parenting-related protective factors for gender-nonconforming and same-sex attracted youth. A few studies suggest that not all sexual minority youth experience conflict in their relationships with their parents. For instance, it has been found that although parents’ initial reactions following their offspring’s coming out may be negative, many parents are able to overcome these negative reactions and show more acceptance over time (Ben-Ari, 1995; Savin-Williams & Dubé, 1998). Therefore, the current dissertation addressed the protective role of having a positive relationship with one’s parent for sexual minority and gender-nonconforming youth, while taking into account potential differences between boys and girls, and potential differences in their relationships with their mothers and fathers.

The current dissertation

Aims and rationale

Based on the sexual minority stress theory, the current dissertation further examines the role of gender nonconformity in predicting minority stress processes and subsequent mental health outcomes among Dutch adolescents and adults. This dissertation addresses three main aims.

The first aim of this dissertation was to assess potential differences between sexual minority youth and heterosexual youth in how gender nonconformity is related to experiences with peer victimization and mental health outcomes. By addressing this aim, the current dissertation builds on previous work that has shown relations between gender nonconformity and sexual prejudice. By assessing differences between sexual minority and heterosexual youth in gender nonconformity-related outcomes, the current dissertation offers a better understanding as to whether gender nonconformity increases sexual minority youths' exposure to peer victimization, or whether gender nonconformity elicits peer victimization regardless of youths' sexual attractions. That is, the current dissertation expands minority stress theory by assessing whether *some* aspects of minority stress experienced by sexual minority youth (i.e., exposure to victimization or rejection) might also affect heterosexual youth when they show signs of gender nonconformity.

The second aim of this dissertation focuses on potential differences between men and women in how gender nonconformity affects mental health through experiences with peer victimization, homophobic rejection, and internalized homophobia. Identifying sexual attraction and (biological) sex as potential determinants may offer important directions for interventions aimed at reducing mental health problems among gender-nonconforming and sexual minority youth and adults.

The third aim of this dissertation addresses the role of protective factors that can reinforce mental health among gender-nonconforming and sexual minority youth. This aim addresses an existing gap in the research literature because in contrast to what is known about risk factors, there is relatively little known about factors that can improve mental health among gender-nonconforming and sexual minority youth.

It should be noted that the studies presented in this dissertation, however, questioned participants about their gender expression, their assigned sex at birth, but not about their current gender identification. Therefore, in the current dissertation we are unaware of whether individuals with high levels of gender nonconformity identified as trans- or cisgender. Furthermore, the majority of studies presented in this dissertation were carried out among adolescents. Because adolescents may not yet engage in same-sex sexual activity and may not yet self-identify as LGB, we

often assessed sexual minority status by surveying adolescents about their same-sex attracted feelings.

Outline of this dissertation

To address the three abovementioned research aims, five independent studies were carried out that are presented in Chapters 2 to 6. The first two research aims are addressed in Chapters 2 to 5. **Chapter 2** involves a cross-sectional study among a school sample of Dutch adolescents, aged 11 to 16 years. This study assessed whether perceived experiences with homophobic name-calling accounted for (i.e., mediated) the relationship between gender nonconformity and mental health (operationalized as psychological distress and social anxiety). In addition, this study assessed potential differences in levels of same-sex attraction (SSA) and differences between boys and girls in the mediated relation between gender nonconformity and mental health via homophobic name-calling. This was assessed by testing differences in levels of SSA and differences between boys and girls in the relation between gender nonconformity and homophobic peer victimization. **Chapter 3** is a cross-sectional study among a school sample of Dutch adolescents (aged 11 to 18 years). This study further examined the role of SSA and biological sex in the relation between gender nonconformity and peer victimization (operationalized as perceived experiences with homophobic name-calling and peer victimization in general). We assessed whether potential differences in levels of SSA and differences between boys and girls in the relation of gender nonconformity with peer victimization varied along with adolescents' age. **Chapter 4** involves a cross-sectional study among a sample of self-identified LGB adults. This study is different from all other studies in this dissertation because it includes an adult sample (aged 18–73 years) and only focusses on self-identified LGB individuals. This study investigated whether self-perceived experiences with homophobic stigmatization and internalized homophobia explained (i.e., mediated) the relation between gender nonconformity and mental health (operationalized as psychological distress). In addition, it was assessed whether there were differences between GB men and LB women in these relations. Because this study only focused on LGB individuals we were unable to assess differences between LGB and heterosexual individuals in these mediated relations. However, in subsequent analyses we did control for sexual identity (LG versus B) and life time same-sex attracted feelings and experiences. Furthermore, given the wide age range of participants in this study, we also explored whether the relations of gender nonconformity with mental health via homophobic stigmatization and internalized homophobia, would vary along participants' age. Sex and age differences in these mediated relations were explored by assessing sex

and age differences in the relations of gender nonconformity with homophobic stigmatization and internalized homophobia, as well as in the relations of homophobic stigmatization and internalized homophobia with mental health. **Chapter 5** is unique from the other chapters in that it presents findings from a longitudinal study with 3 waves of measurement occasions (6-month interval; aged 10-17 at first measurement occasion) among a school sample of Dutch adolescents. We operationalized mental health in this study by focusing on internalizing and externalizing problems. This study assessed multi-group differences (youth with SSA versus youth without SSA and boys versus girls) in the potential bidirectional longitudinal relations between gender nonconformity, peer victimization, and mental health. By using a longitudinal design, we could confirm whether hypotheses from the previous studies described in this dissertation would hold longitudinally. In addition, by assessing bidirectionality in the longitudinal relations this study also took into account the potentially more complex relations of gender nonconformity, peer victimization, and mental health over time.

The third and last aim of this dissertation is addressed in **Chapter 6**. This Chapter presents a cross-sectional study among a school-based sample of Dutch adolescents (aged 15 to 18). This study assessed whether a positive relationship with one's parents (operationalized as parental acceptance) buffers the negative influence of gender nonconformity and SSA on adolescents' mental health outcomes (operationalized as psychological distress and social anxiety). A strength of this study is that, instead of using a general measure of parental acceptance, we assessed the influence of father and mother acceptance separately. Analyses were carried out separately for boys and girls, to take into account that sexual minority and gender-nonconforming boys and girls might differ in the degree to which they profit from the relationship with their mothers and fathers. In the final Chapter of this dissertation, **Chapter 7**, the results of the independent studies will be summarized and discussed along with suggestions for future research.