

The Determinants and Experience of Social Anxiety Among Sexual Minority Individuals

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Thesis submitted in partial fulfilment for the award of
Doctor of Philosophy (PhD)

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September 2021



Declaration

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Doctor of Philosophy (PhD) is entirely my own work, and that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

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Acknowledgements

As I complete this PhD journey, I would like to acknowledge the wonderful support of my colleagues, family, and friends. Without you all, crossing the finish line would have been an impossibility.

First and foremost, I wish to express my gratitude to my supervisors, Prof Pamela Gallagher and Dr. Gemma Kiernan. Pamela, I am eternally grateful for all the opportunities that you have given me over the years. It seems like yesterday that I was excitedly reading your email offering my first real endeavour into the world of psychological research via a studentship. From that day forward, I have been inspired by your hard work and appreciative of your insightful guidance. Thank you for teaching me so many things along this journey, allowing me the freedom to explore ideas, and keeping me grounded. Your thoughtful supervision is something that I will always appreciate. Gemma, I am extremely thankful for your enduring support over the years. My passion for this topic began as a final year undergraduate student in your class and I am privileged to have worked with you since then. Thank you for sharing your knowledge with me and for the continuous encouragement. I am so grateful for your mindful guidance which has been a great help in allowing me to progress through this PhD.

To Dr. Aisling McMahon, my independent panel member. Thank you for the inspirational conversations during our review meetings and for showing such an interest in my research. I always finished our meetings feeling encouraged and raring to continue. I would also like to thank Prof Anne Matthews for the guidance and feedback provided during my transfer examination. To Patrick Boylan, thank you for all the technical help (and for the chats on the corridor). You have always been so generous with your time and I greatly appreciate it. I would also like to extend a thank you to Gerry Conyngham and Dr. Lorraine Boran for all of the extremely helpful graduate training classes. Thank you to Dr. Richard Lombard Vance for the great work as a second reviewer on the systematic review.

To Dr. Liz McLoughlin, my unofficial mentor. Thank you for being there in the moments when I doubted myself the most. Our phone calls, chats, and laughs over the past few years have been so helpful in keeping me on track. Above all, thank you for encouraging me to believe in myself.

I wish to express my utmost thanks to Dr. John Pachankis. Thank you for paving the way with your incredible contributions to our field. It has been my honour to collaborate with you and visit your lab in NYC. Your work will continue to inspire me.

This experience would not have been the same without my fellow PhD students in the School of Psychology at DCU with whom I shared so much of the journey. The mutual celebrations of each other's victories and the sense of togetherness through the bumps in the road were so important to me throughout this process. Thank you for the astute support that only PhD students can provide for one another, and I have no doubt that the future is bright for you all! To Arjan, my favourite unofficial co-worker and conference buddy. We have had so many memorable conversations these past few years (many ending in tears of laughter!). Thank you for listening, for your expertise, but most of all, for your friendship.

To my Mum and Dad, Linda and Paddy, I will never be able to thank you enough for all you have done for me. You have always taken such a keen interest in my career and I truly feel empowered by your support. Thank you for providing me with the foundation that I needed to achieve my goals. It is a special feeling to know that you both always have my back, and your advice and love is invaluable to me. Thank you to my sisters, Aislinn and Ciara, and their partners Matt and Tom. I have never had to look too far for role models as my two older siblings are such incredible people. Thank you all for the encouragement and for constantly uplifting me throughout this process. Special thanks also go to Marie, John, and Shauna, for always being so supportive and reassuring. I am so lucky to have such a wonderful family who understand the importance of being there for one another and having a laugh along the way! I love you all.

Thanks are also due to my closest friends (you know who you are!). To old friends, the college crew, and those I have become close with in recent years. Thank you for all the support and the fun times that allowed me to put the PhD aside for a few hours when necessary.

Finally, I would like I would like to acknowledge those who participated in this study. Thank you for your time, openness, and bravery in sharing your stories with me. I dedicate this study to you.

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List of Abbreviations

ANOVA	Analysis of variance
AVE	Average variance explained
BFNE	Brief Fear of Negative Evaluation Scale
BFNE-S	Brief Fear of Negative Evaluation Scale straightforwardly worded items
BMI	Body mass index
CB	Concealment behaviour
CBT	Cognitive behavioural therapy
CCAT	Crow Critical Appraisal Tool
CES-D	Center for Epidemiologic Studies–Depression Scale
CFI	Comparative fit index
CR	Composite reliability
DSM	The Diagnostic and Statistical Manual of Mental Disorders
ED	Experiences of discrimination
EDS	Everyday Discrimination Scale
EFA	Exploratory factor analysis
FNE	Fear of Negative Evaluation Scale
GCN	Gay Community News
GCSS	Intraminority Gay Community Stress Scale
G-RRSS	Gay-Related Rejection Sensitivity Scale
HAM-D	HAM-D = Hamilton Depression Rating Scale
HIV	Human immunodeficiency virus
IA	Inventory of Anxiousness
IAM	Integrated aetiological and maintenance
IH	Internalised homonegativity
IHP-R	Revised Internalized Homophobia Scale
IMS	Intraminority stress
LBQ	Lesbian, bisexual, queer
LGB	Lesbian, gay, bisexual
LGBT	Lesbian, gay, bisexual, transgender
LGBTI+	Lesbian, gay, bisexual, transgender, intersex +

LGBTQ	Lesbian, gay, bisexual, transgender, queer
LGBTQCC	Connectedness to the LGBT Community Scale
LSAS	Liebowitz Social Anxiety Scale
LSAS-A	Liebowitz Social Anxiety Scale avoidance subscale
LSAS-F	Liebowitz Social Anxiety Scale fear subscale
MSM	Men who have sex with men
MSMW	Men who have sex with men and women
MSV	Maximum shared variance
MSW	Men who have sex with women
NOS-C	Nebraska Outness Scale Concealment subscale
OI	Outness Inventory
PTSD	Post-traumatic stress disorder
RMSEA	Root mean square error of approximation
RS	Rejection sensitivity
SA	Social anxiety
SAD	Social anxiety disorder
SEM	Structural equation modelling
SET	Social-evaluative threat
SIAS	Social Interaction Anxiety Scale
SMW-RSS	Sexual Minority Women's Rejection Sensitivity Scale
SOC	Sense of coherence
SOCS	Sense of Coherence Scale
SOMO	Sense of missing out
SPS	Social Phobia Scale
SRMR	Standardized root-mean-square residual
STI	Sexually transmitted infection
TGNB	Transgender, gender nonconforming, non-binary
WSM	Women who have sex with men
WSMW	Women who have sex with men and women
WSW	Women who have sex with women

Abstract

Thesis Title: The Determinants and Experience of Social Anxiety Among Sexual Minority Individuals

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Sexual minority individuals report disproportionately high social anxiety compared to heterosexuals. Existing research highlights minority stress processes as important determinants of social anxiety within this sub-population; yet, the interrelationships between minority stress processes, stressors emerging from within the sexual minority community (i.e., intraminority stress), and sources of resilience to social anxiety remain notably underexplored. Qualitative explorations of this phenomenon that may uncover important aspects of living with social anxiety are also lacking. A systematic review of published literature pertaining to social anxiety within sexual minority populations was conducted. Following this, a sequential explanatory mixed methods study was carried out consisting of two phases; a cross-sectional online survey completed by 501 sexual minority individuals, aiming to test a comprehensive model of the determinants of social anxiety, and qualitative interviews with 21 sexual minority individuals, aiming to explore their experience of social anxiety. Findings demonstrate that experiences of discrimination and intraminority stress were associated with social anxiety through increased deleterious internal processes (i.e., primarily rejection sensitivity) and diminished individual-level resilience (i.e., sense of coherence). Sexual minority individuals encounter distinct social stressors through their navigation of social interactions with heterosexuals (i.e., heteronormative processes) and fellow sexual minority individuals (e.g., social hierarchies and ideals). Further, results indicate that resources within the sexual minority community, broader social support networks, and formal supports (e.g., psychotherapeutic interventions) may help sexual minority individuals to cope with social anxiety. Overall, the findings suggest that social anxiety is determined by both sexual minority-specific and general psychological processes, and social anxiety is experienced distinctly at the within- and wider-community levels. Future social anxiety interventions should account for the distinctive and complex social stressors encountered by sexual minority individuals, and aim to promote both individual- and community-level resilience.

Chapter 1 Introduction

1.1 Introduction to the Current Study

At the turn of the century, mental health scholarship began to signify the presence of social anxiety disparities based on sexual orientation (e.g., Gilman et al., 2001; Sandfort et al., 2001; Bostwick et al., 2010). Specifically, elevated levels of social anxiety symptoms are reported by sexual minority individuals (e.g., individuals who identify as lesbian, gay, or bisexual) when compared to their heterosexual counterparts. As this area of research has garnered more empirical attention, studies have begun to uncover the underpinnings of this phenomenon. Nonetheless, the knowledge base remains somewhat in its infancy. Due to the pernicious and debilitating nature of social anxiety (American Psychiatric Association, 2013), increased knowledge relating to the determinants and experiences of social anxiety among sexual minority individuals is warranted.

This first chapter introduces social anxiety and social anxiety disorder (SAD), the aetiological and maintenance factors of social anxiety, theoretical frameworks explaining elevated mental health difficulties in sexual minority populations, and provides an overview for the current study. The thesis conspectus is also provided at the end of the chapter.

1.2 Social Anxiety and Social Anxiety Disorder

Social anxiety is commonly experienced by many individuals and is characterised by a profound fear of interpersonal and social situations in which one perceives themselves to be scrutinised by others (American Psychiatric Association, 2013; Morrison & Heimberg, 2013). Commonly feared situations include social interactions (e.g., meeting acquaintances and engaging in small talk), being observed (e.g., while working or eating), and performing in front of others (e.g., delivering a presentation at work). Social anxiety is experienced on a severity continuum (Rapee & Spence, 2004; Spence & Rapee, 2016), from lower levels, through moderate social anxiety, to higher sub-clinical social anxiety symptoms, and lastly, to SAD. In the general population, yearly and lifetime prevalence rates of SAD are 7.1% and 12.1% respectively (Kessler et al., 2005; Ruscio et al., 2008). The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) specifies that a diagnosis of SAD, formerly known as social phobia, is warranted when the following criteria are met: the fear of social and performance situations is pronounced and persistent (criterion A); the individual fears being negatively evaluated by others due to their behaviours and/or their demonstration of anxiety

symptoms (e.g., sweating, cracking voice, or blushing; [criterion B]); social situations invariably induce fear or anxiety within the individual (criterion C); feared social situations are actively avoided and, when faced, are experienced with extreme levels of distress (criterion D); the individual's fear or anxiety is disproportionate to the magnitude of the threat presented by the social or performance situation (criterion E); the fear, anxiety, or avoidance is enduring, lasting for a minimum period of six months (criterion F); the fear, anxiety, or avoidance results in clinical levels of distress or considerable deficits in social, occupational, or other salient dimensions of everyday functioning (criterion G; American Psychiatric Association, 2013).

The onset of SAD primarily occurs during late childhood and adolescence (Beesdo et al., 2007, 2009; Wittchen & Fehm, 2003), onsets later in life are relatively infrequent and usually involve SAD occurring due to another primary diagnosis (e.g., depression or eating disorders; Wittchen & Fehm, 2003). Unique challenges faced at biological, cognitive, behavioural, and interpersonal levels make adolescence a particularly sensitive period for the development of SAD (Guerry et al., 2015). However, due to its chronic and unremitting course if treatment is not sought (Keller, 2003; Wittchen & Fehm, 2003), SAD represents a significant psychological burden for adults also. A diagnosis of SAD is also associated with specific sociodemographic features such as younger age, female sex at birth, and unmarried status (Stein et al., 2017).

The social avoidance and the difficulties in social interactions that are characteristic to SAD lead to significant impairment in many domains of daily functioning across occupational, educational, and interpersonal relationship contexts (Aderka et al., 2012; Alden & Taylor, 2004). Precisely, when compared to their counterparts without SAD, those with SAD are more likely to drop out of education early (Stein & Kean, 2000), to have reduced educational attainment and work in occupational positions they are overqualified for (Katzelnick & Greist, 2001), to be unemployed (Lecrubier et al., 2000), and in instances of employment, tend to report increased absenteeism (Wittchen et al., 2000). Further, a SAD diagnosis is associated with reduced quality of life (Alonso et al., 2004; Olatunji et al., 2007), increased suicide attempts (Nepon et al., 2010; Wunderlich et al., 1998), and increased substance dependence (Buckner et al., 2012). While the functional impairments associated with SAD are well established, research also demonstrates similar impairments, as well as high comorbidity with other mood and anxiety disorders, in those experiencing high sub-clinical threshold social anxiety symptoms (Dell'Osso et al., 2003; Fehm et al., 2008).

1.3 The Aetiology and Maintenance of Social Anxiety and Social Anxiety Disorder

The risk factors for social anxiety have been reviewed through several publications over the past two decades (e.g., Higa-McMillan & Ebestuani, 2011; Kimbrel, 2008; Morrison & Heimberg, 2013; Ollendick & Hirshfeld-Becker, 2002; Spence & Rapee, 2016; Wong & Rapee, 2015). The knowledge base portrays genetic predispositions, temperament, early cognitive biases, the experiences of deleterious social or life events, and negative parent and peer relationships as early risk factors for social anxiety. In terms of the maintenance models of social anxiety, several remain particularly dominant in the literature (e.g., Clark & Wells, 1995; Heimberg et al., 2010; Hofmann, 2007), all of which posit that individuals experiencing high social anxiety engage in maladaptive cognitive and behavioural processes that sustain anxiety during social-evaluative situations (i.e., any social situation in which the individual perceives the possibility of experiencing negative evaluation). All components of the domineering theoretical frameworks were recently synthesised in order to create a comprehensive integrated aetiological and maintenance (IAM) model of SAD (Wong & Rapee, 2016). The IAM model is the chosen social anxiety-specific theoretical framework for the current study as it was systematically developed through the amalgamation of, and includes all the major components of, all cognitive and behavioural frameworks that previously persevered in social anxiety scholarship.

1.3.1 The IAM Model

The primary components of the IAM Model are summarised below (see Figure 1.1).

1.3.1.1 The SET Principle

The integral component of Wong and Rapee's (2016) IAM model is the social-evaluative threat (SET) principle. The SET principle is posited to decipher the degree of threat represented by social-evaluative stimuli (e.g., the expressions, mannerisms, and behaviours of others that communicate evaluation, or higher order concepts such as authority or social status) and govern an individual's social functioning. Through designating a threat value to social-evaluative stimuli (i.e., on a continuum from non-threatening to extremely threatening), the SET principle designates the degree of threat (hereby referred to as 'SET value') represented by stimuli encountered in social situations. Wong and Rapee (2016) posit that the SET value is realised by variations in an individual's neurobiological (e.g., aberrant activity in the amygdala; Brühl et al., 2014; Cisler & Koster, 2010; Fouche et al., 2013) and cognitive processes (e.g., negative social-evaluative cognitions related to the self; Hackmann et al., 2000; Wong et al., 2014). In summary, the SET principle represents an individual

difference variable and it is posited that those with more extreme SET values will respond to social-evaluative stimuli with greater atypical neurobiological activity and more severe negative social-evaluative cognitions, which in turn leads to elevated social anxiety symptoms.

1.3.1.2 Aetiological Factors

To align with the early onset of SAD (Beesdo et al., 2007), the IAM model places a particular emphasis on aetiological factors (i.e., factors that increase or decrease the SET value) that play a pertinent role in childhood and adolescence. Yet, it is also acknowledged that these factors may play a pertinent role beyond adolescence (Wong & Rapee, 2016). Inherited tendencies (e.g., avoidant temperament style such as behavioural inhibition) and parent behaviours (e.g., communication of danger represented by social-evaluative stimuli) are proposed to play an important role in influencing the SET value from birth to childhood. These assertions are supported by longitudinal research linking both childhood behavioural inhibition (Muris et al., 2011; Rapee, 2014), overcontrolling parenting styles (Lewis-Morrarty et al., 2012), and insecure parent-child attachment (Bar-Haim et al., 2007; Brumariu & Kerns, 2008) to symptoms of social anxiety or a SAD diagnosis later in life. Beginning in childhood and extending into adolescence and adulthood, negative peer interactions and experiences are posited to impact the SET value. Longitudinal studies affirm that negative peer experiences (e.g., overt victimisation, rejection, and low acceptance) predict increased social anxiety symptoms (Ranta et al., 2013; Siegel et al., 2009; Tillfors et al., 2012). Severely traumatic life events related to social functioning (e.g., particularly humiliating events, extreme interpersonal conflict, or suffering abuse) are also portrayed as salient aetiological factors within the IAM model. The longitudinal association between stressful life events and social anxiety symptoms has been established by previous research (Aune & Stiles, 2009; Hamilton et al., 2013). Lastly, cultural factors are also proposed to impact the SET principle. For example, research demonstrates elevated social anxiety symptoms in individuals of Asian descent compared to those of Caucasian descent (Krieg & Xu, 2015; Woody et al., 2015).

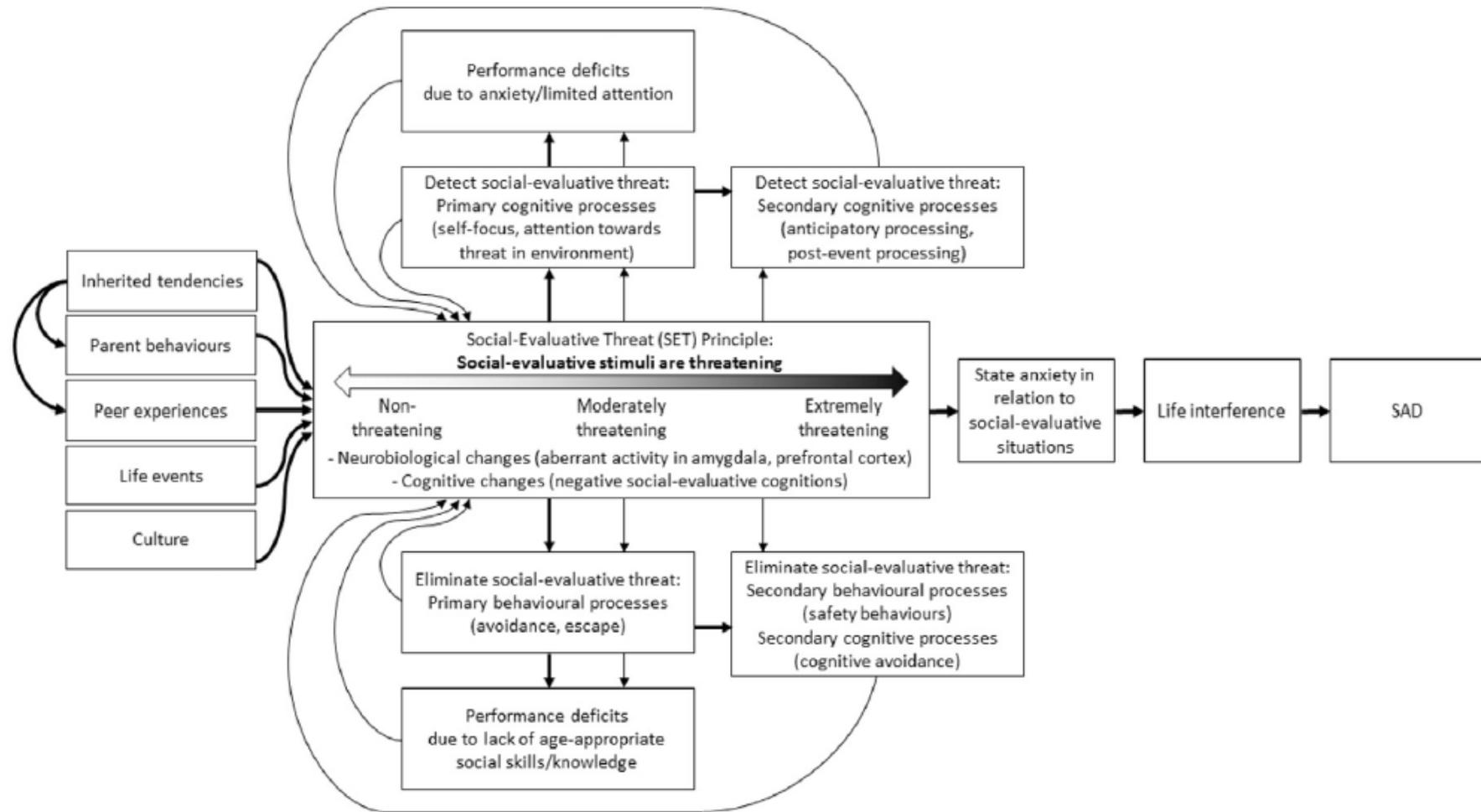


Figure 1.1: Wong and Rapee's Integrated Aetiological and Maintenance Model for SAD. Reprinted from Wong and Rapee (2016). Copyright 2016 The authors. <http://creativecommons.org/licenses/by-nc-nd/4.0/>

Note. Bold lines represent aetiological pathways; other arrows represent maintaining pathways.

1.3.1.3 Maintenance Processes

Wong and Rapee (2016) posit that changes in the SET principle stimulate primary cognitive and behavioural processes (i.e., the first set of processes that emerge when threatening social-evaluative stimuli are encountered by an individual). Primary cognitive processes, designed to detect social-evaluative threat, are represented by self-focus (e.g., attending to bodily anxiety symptoms and deleterious cognitions) and attention toward external threats in the surrounding social environment. The association between social anxiety symptoms and these primary cognitive processes is evidenced by experimental and cross-sectional studies (Bögels et al., 2014; Eastwood et al., 2005; Gaydukevych & Kocovski, 2012; Moriya & Tanno, 2011; Sposari & Rapee, 2007). Primary behavioural processes, designed to eliminate social-evaluative threat, are represented by behaviours that facilitate the avoidance or escape from social-evaluative situations. Cross-sectional research portrays a consistent association between both avoidance and escape behaviours, and social anxiety symptoms (Carleton et al., 2010; Ottenbreit et al., 2014; Whiteside et al., 2013).

Wong and Rapee (2016) propose three outcomes associated with the above mentioned primary cognitive and behavioural processes, all of which serve to maintain the SET value. First, the primary cognitive and behavioural processes are posited to directly maintain the SET value. In support of this position, experimental research demonstrates that induced self-focus stimulates high social anxiety symptoms (Bögels & Lamers, 2002; Gaydukevych & Kocovski, 2012). Further, social anxiety symptoms can reduce when social-evaluative situations are encountered and the engagement in avoidance or escape behaviours are resisted (Taylor & Amir, 2012). Second, the primary cognitive and behavioural processes may generate social performance deficits (Wong & Rapee, 2016). The allocation of attentional resources to detecting social-evaluative threat may impede the individual's ability to successfully partake in the social task at hand (e.g., responding in conversation). Further, opportunities to acquire social skills and knowledge are limited should an individual continually avoid and/or escape from social situations. Indeed, previous social anxiety maintenance models assert that the occurrence of social performance deficits increases the likelihood that the individual's fears of negative evaluation from others will be realised (Clark & Well, 1995; Heimberg et al., 2010). Third, it is postulated that the primary cognitive and behavioural processes will stimulate the emergence of secondary cognitive and behavioural processes. Wong and Rapee (2016) propose that the primary cognitive processes stimulate the secondary cognitive processes of anticipatory and post-event processing. The former occurs before a social-evaluative situation, whereas the latter occurs after these

events. Both processes aim to detect social-evaluative threat, and are characterised by repetitive thinking, negatively biased evaluations, and negative self-beliefs (Wong et al., 2019). Further, experimental research demonstrates that both secondary cognitive processes maintain high levels of social anxiety (Brozovich & Heimberg, 2011; Mills, Grant, Judah, & Lechner, 2014; Mills, Grant, Judah, & White, 2014). The primary behavioural processes are proposed to stimulate secondary behavioural (i.e., safety behaviours) and cognitive (i.e., cognitive avoidance) processes designed to eliminate social-evaluative threat. Safety behaviours refer to actions taken by an individual to minimise the perceived likelihood of negative evaluation occurring, or to decrease feelings of anxiety, without physically removing oneself from the social-evaluative situation (Piccirillo et al., 2016). Cognitive avoidance is exemplified by utilising strategies such as thought suppression, distraction, and thought substitution (Hearn et al., 2017). Engaging in safety behaviours and cognitive avoidance is likely to hinder optimal social functioning and prevent the individual from acquiring experiences that disconfirm the SET value. Furthermore, both safety behaviours (Plasencia et al., 2011; Thomas et al., 2012) and cognitive avoidance (Kashdan et al., 2013; Panayiotou et al., 2014) demonstrate consistent associations with social anxiety symptoms.

To summarise, the primary cognitive and behavioural processes, performance deficits, and secondary cognitive and behavioural processes emerge as a result of increases in the individual's SET value. All of these components also function as maintenance factors of the SET value, thus a self-perpetuating cycle is established (Wong & Rapee, 2016). Those with high SET values are proposed to experience increased social anxiety symptoms in social-evaluative situations. In cases where life interference is severe, this may lead to a diagnosis of SAD.

1.4 Sexual Minority Populations

Sexual orientation encompasses an individual's capacity for emotional, affectional, and sexual attraction toward (and sexual or intimate behaviours with) persons of any gender. Sexual minority individuals embody those who are not solely sexually orientated toward persons of the opposite gender (Blondeel et al., 2018). Sexual orientation is portrayed as operating across three dimensions: identity, behaviour, and attraction (Laumann et al., 1994). Therefore, sexual minority populations consist of individuals who utilise a non-heterosexual label to describe their sexual orientation (e.g., lesbian, gay, bisexual, pansexual, asexual, or queer), who experience same-gender or multiple-gender (i.e., same- and opposite-gender, or all genders) sexual attraction, or who have had same-gender sexual partners (Blondeel et al., 2018; Brennan et al., 2017).

Sexual minority identity labels include lesbian or gay (women and men who experience same-gender attraction and have same-gender sexual partners respectively), bisexual (refers to a person who experiences sexual attraction to, and has sex with, women and men), and queer (a person who challenges both the use of the aforementioned labels and heterosexual norms; Blondeel et al., 2018). Additional sexual minority identities are represented by the labels pansexual (an individual who experiences attraction to, and has sex with, people regardless of their gender; Greaves et al., 2019), questioning (people who are unsure of their sexual orientation), and asexual (individuals who do not experience sexual attraction; Mollet & Lackman, 2018). Collectively, the sexual minority identity labels that have only recently been widely acknowledged in research (i.e., queer, pansexual, questioning, and asexual) are known as emerging identity labels (Borgogna et al., 2019). Furthermore, terminology is utilised to specifically decipher between sexual behaviour subgroups in terms of sexual orientation: women who have sex with women (WSW), women who have sex with men (WSM), women who have sex with men and women (WSMW), men who have sex with men (MSM), men who have sex with women (MSW), and men who have sex with men and women (MSMW) (Blondeel et al., 2018). These specific terminologies based on sexual behaviour are used as the label individuals select to identify themselves are not always congruent to their sexual behaviour. For instance, a woman who has sex with men and women may be considered “behaviourally bisexual”, but may not identify with the label bisexual. In terms of sexual attraction, the following terminologies are often used to decipher between subgroups “only attracted to same-gender”, “mostly attracted to same-gender”, “equally attracted to all genders”, “mostly attracted to opposite-gender”, and “only attracted to opposite-gender”. For the current PhD thesis, a wide-ranging definition of sexual minority populations, incorporating all sexual minority identity labels and all three dimensions of sexual orientation (i.e., identity, behaviour, and attraction) is utilised.

In terms of gender identity, cisgender describes an individual whose sex assigned at birth (i.e., related to appearance of reproductive organs) aligns with their current gender identity (i.e., their profound inherent sense of being a woman or man) (American Psychological Association, 2015). When the term gender minority individuals is used, the researcher is referring to non-cisgender individuals. Such persons are exemplified by transgender (those whose sex assigned at birth does not align with their current gender identity) and gender non-conforming, genderqueer, or non-binary individuals (those whose gender identity does not align with a binary portrayal of gender) (American Psychological Association, 2015).

1.5 Mental Health Difficulties in Sexual Minority Populations

An ever expanding body of research has consistently portrayed sexual minority individuals as more at risk of experiencing mental health difficulties than heterosexuals. Indeed, across all three dimensions of sexual orientation, systematic reviews demonstrate elevated rates of depressive disorders, anxiety disorders, substance use problems, and suicide among sexual minority populations (e.g., King et al., 2008; Lucassen et al., 2017; Plöderl & Tremblay, 2015). In terms of mental health disparities across sexual minority subgroups, there is also emerging evidence that bisexual individuals exhibit higher rates of depression and anxiety than their gay/lesbian counterparts (Plöderl & Tremblay, 2015; Ross et al., 2018). Population based studies echo these findings in a social anxiety context, mostly recently lesbian/gay (6.6%), bisexual (11.1%), and questioning/not sure individuals (8.6%) were at an increased risk for 12-month SAD compared to heterosexuals (2.7%) (Kerridge et al., 2017).

In an Irish context, the Supporting LGBT Lives study demonstrated markedly high levels of depression (e.g., 66% and 44% reported feeling sad or down in the last 12 months and 30 days respectively) in a large sample ($N = 1,110$) of sexual and gender minority individuals (Mayock et al., 2009). Despite recent socio-political progress for the sexual minority community in Ireland (e.g., the passing of same-sex marriage by popular vote in 2015), a recent study sustained the concerning findings of its predecessor in this area. The LGBTIreland study (A. Higgins et al., 2016) which represents the largest study of sexual and gender minority mental health in the history of the state ($N = 2,264$), showed that 20%-23% of sexual and gender minority individuals were experiencing depression and generalised anxiety at severe or extremely severe levels.

1.5.1 Theories of Mental Health Difficulties in Sexual Minority Populations

This section summarises domineering and emerging theoretical frameworks developed and tested to account for sexual orientation-based mental health (including social anxiety) disparities.

1.5.1.1 Minority Stress Theory

Originally conceptualised by V. R. Brooks (1981; Rich et al., 2020) and advanced by Meyer (1995, 2003, 2013) the preponderance of mental health researchers utilise minority stress theory in order to explain sexual minority individuals increased risk for mental health difficulties when compared to heterosexuals (see Figure 1.2). This theoretical framework postulates that (a) prejudice and stigma aimed at sexual minority individuals based on their

sexual minority status generates unique stressors and (b) these unique minority stressors lead to adverse mental health outcomes (Meyer, 2003). Minority stress theory emphasises that environmental circumstances, particularly those pertaining to stigma and prejudice, may generate unique minority stressors that sexual minority individuals encounter in their everyday lives.

Meyer (2003) utilises a distal to proximal continuum to encompass the variety of minority stress processes experienced by sexual minority individuals in relation to their stigmatised identities. Distal stressors are interpersonal prejudice events (i.e., interpersonal-level stigma) that occur external to the individual such as victimisation, harassment, or everyday discrimination (Meyer, 2003, 2015). Proximal stressors are stigma-related reactions that occur as internal processes (i.e., individual-level stigma) such as sexual orientation-based rejection sensitivity, internalised homonegativity, and concealment of sexual orientation. Rejection sensitivity refers to the anxious expectation of rejection or discrimination based on one's stigmatised sexual minority status (Dyar et al., 2016; Pachankis et al., 2008); internalised homonegativity describes the incorporation of negative societal views toward sexual minority individuals into one's self-concept (Herek et al., 2009); and concealment of sexual orientation relates to refraining from disclosing one's minority sexual orientation or actively covering it (Meidlinger & Hope, 2014). Experiences of discrimination (Birkett et al., 2015; Mays & Cochran, 2001), rejection sensitivity (Feinstein et al., 2012), internalised homonegativity (Newcomb & Mustanski, 2010), and concealment of sexual orientation (Pachankis, Mahon et al., 2020) demonstrate associations with mental health difficulties among sexual minority populations. Recent research also signifies that many sexual minority individuals encounter minority stressors on a regular basis, and this impacts their daily levels of psychological distress (Eldahan et al., 2016; Livingston, 2017).

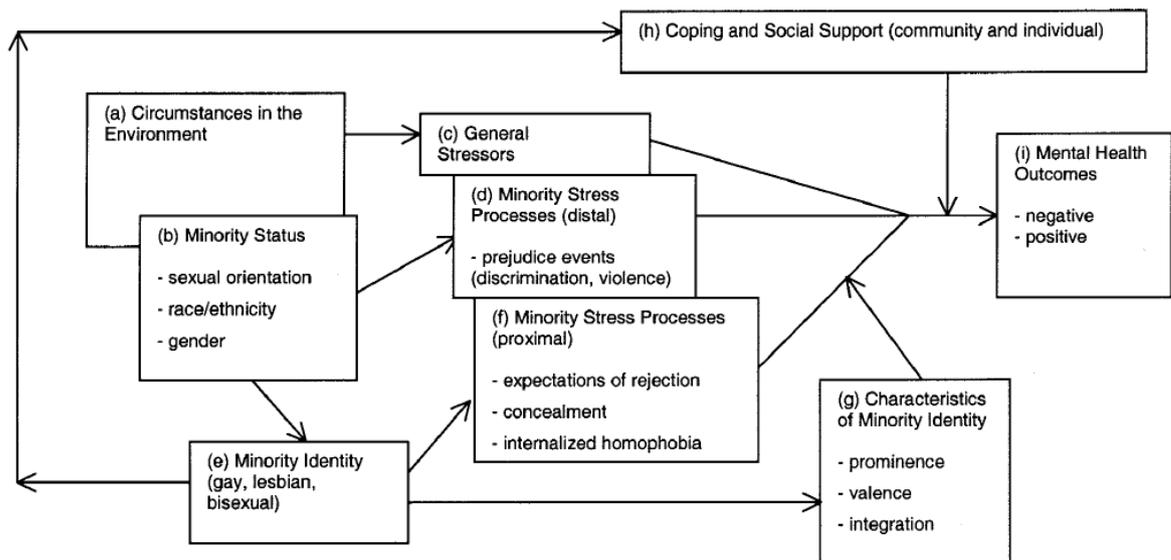


Figure 1.2: Meyer’s Minority Stress Model. Reprinted from Meyer (2003). Copyright 2003 by the American Psychological Association.

Alongside the postulation of unique minority stress processes that exacerbate mental health difficulties, minority stress theory (Meyer, 2003; 2015) also proposes stress-ameliorating factors such as social support, as well as individual- and community-based resilience. A recent systematic review highlighted social support (i.e., from friends and family) as a salient protective factor for mental health difficulties among sexual minority individuals (Hall, 2018). Individual resilience constructs include mastery (Pearlin & Schooler, 1978), locus of control (Rotter, 1966), personality traits (e.g., extroversion), and “world view” constructs such as a sense of coherence (Antonovsky, 1979), the latter of which has shown to protect against minority stress processes within this population (Lyons et al., 2014). Sexual minority-specific community-level resilience (e.g., feeling connected to the sexual minority community) refers to both tangible (e.g., support groups, community centre, or role models) and intangible resources (e.g., reframing of social values and norms) that aid the sexual minority individual in sustaining their wellbeing (Meyer, 2015).

Sexual minority stress focused research has been relatively scarce in the Republic of Ireland. Nonetheless, a limited amount of studies advanced the knowledge base pertaining to mental health difficulties within this population (see section 1.5) and minority stress processes. Sexual and gender minority secondary school students reported frequent experiences of heterosexist bullying (Minton et al., 2008), whereas heterosexist discrimination, rejection sensitivity, and internalised homonegativity were significantly associated with psychological distress in a sample of young (i.e., aged 16-24) sexual and gender minority individuals (Kelleher, 2009). The Supporting LGBT Lives study also demonstrated

markedly high levels of heterosexist discrimination (e.g., 80% verbally abused and 25% physically abused) within this population (Mayock et al., 2009). The high levels of everyday discrimination illustrated in the Supporting LGBT Lives study were replicated in the LGBTIreland study (A. Higgins et al., 2016), with 75% reporting experiences of verbal abuse and one in five reporting physical abuse based on sexual or gender minority status. Similarly, in a study that recruited a nationally representative sample of sexual and gender minority youth (i.e., aged 13-20), 77% of students reported experiencing verbal harassment, whilst 25% were physically harassed on the basis of their sexual orientation (Pizmony-Levy & BeLonG To Youth Services, 2019).

1.5.1.2 The Psychological Mediation Framework

Extending minority stress theory, Hatzenbuehler (2009) established the psychological mediation framework in order to explicate the mechanisms underpinning the association between minority stress processes and adverse mental health outcomes among sexual minority populations (see Figure 1.3). In terms of sexual minority-specific processes (i.e., minority stress variables that apply specifically to sexual minority individuals), the psychological mediation framework postulates that proximal stressors serve as mediators of the association between distal stressors and mental health difficulties. Thus, it is posited that experiences of victimisation and discrimination stimulate increased proximal stress, conferring risk for mental health difficulties. Additionally, Hatzenbuehler (2009) emphasises the pertinent role of general psychological processes (i.e., factors that apply to all individuals regardless of their sexual orientation) as determinants of mental health among sexual minority populations. These general processes represent universal risk factors and are embodied by cognitive, affective, and social processes. The psychological mediation framework also proposes that sexual minority individuals' experiences of distal stress leads to diminishing functioning across general psychological processes, and in turn, these general psychological risk factors mediate the relationship between distal minority stress processes and mental health difficulties.

Research evidence supports the assertions of the psychological mediation framework across all three domains of general psychological processes. In terms of cognitive processes, sexual minority individuals report heightened hopelessness compared to heterosexual individuals (Plöderl & Fartacek, 2005; Safren & Heimberg, 1999), and diminished self-esteem is a mediator of the association between minority stress and psychological distress (Herek et al., 2009). Focusing on affective processes, sexual minority adolescents indicated increased

rumination and diminished emotional awareness compared to their heterosexual counterparts (Hatzenbuehler et al., 2008). Further, in a sample of sexual minority undergraduate students, heightened rumination mediated the association between minority stress and psychological distress (Hatzenbuehler, Nolen-Hoeksema, et al., 2009). Lastly, for social processes, sexual minority individuals report lower social support than their heterosexual counterparts (Eisenberg & Resnick, 2006; Plöderl & Fartacek, 2005; Safren & Heimberg, 1999). Studies also demonstrated that minority stress is associated with diminished social support and increased social isolation, which in turn leads to psychological distress (Hatzenbuehler, Nolen-Hoeksema, et al., 2009; Lehavot & Simoni, 2011).

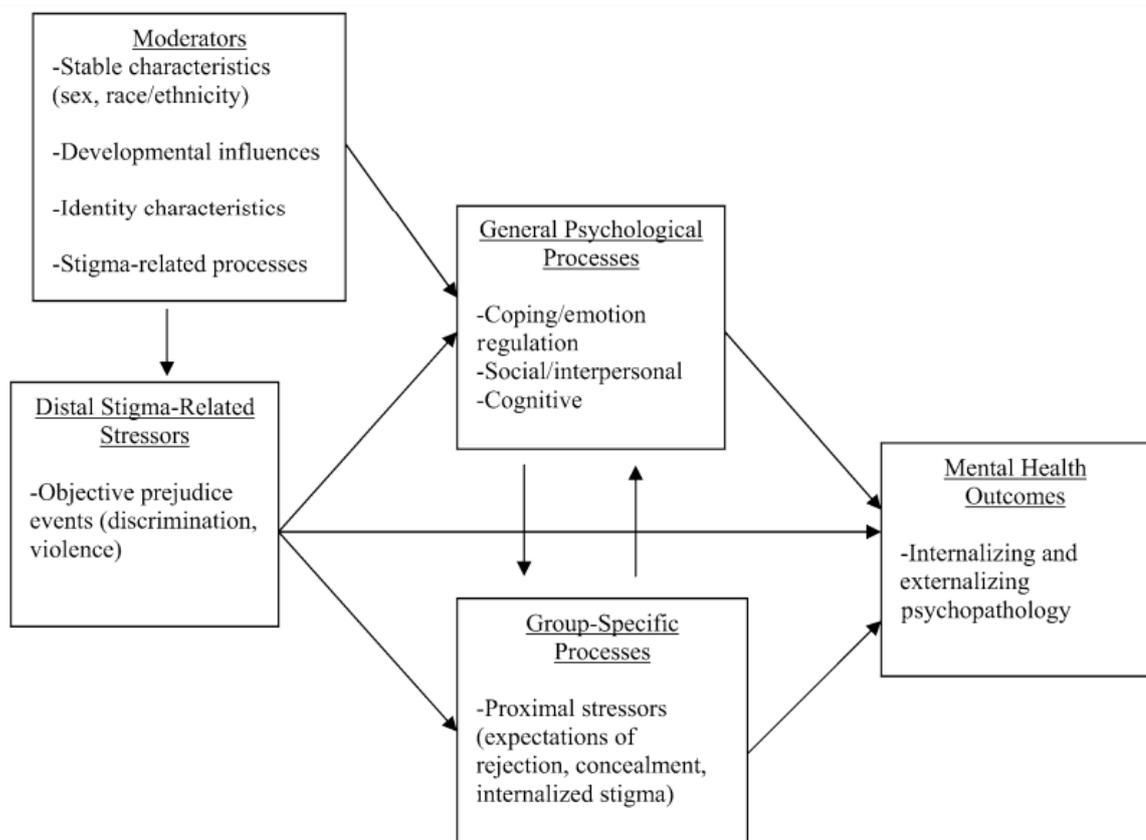


Figure 1.3: Hatzenbuehler’s Integrative Psychological Mediation Framework. Reprinted from Hatzenbuehler (2009). Copyright 2009 by the American Psychological Association.

1.5.1.3 *Intraminority Gay Community Stress Theory*

As discussed in section 1.5.1.1, sexual minority individuals may access a unique form of community resilience within the sexual minority community that could potentially serve as a protective factor for adverse mental health outcomes, including social anxiety. Nonetheless, the very same community may serve as a source of unique stressors that exacerbate social anxiety. For almost two decades, researchers have suggested that minority

stress processes may not fully account for sexual orientation disparities in mental health difficulties (Mays & Cochran, 2001; Meyer, Schwartz, et al., 2008). Seeking additional explanations for elevated psychological distress among sexual minority men, Pachankis, Clark, et al., (2020) developed a novel theoretical position exploring potential stressors at the within-community level (i.e., those stemming from sexual minority men's social and sexual competition with one another). Termed *intraminority gay community stress* (henceforth referred to as intraminority stress), this theoretical stance integrates three existing theories: 1) intrasex competition theory (Anderson et al., 2001; Singh-Manoux et al., 2003); 2) sexual field theory (Green, 2013); and 3) the theory of precarious manhood (Vandello et al., 2008). The researchers posit that sexual minority men encounter status hierarchies (e.g., pertaining to wealth, masculinity, and attractiveness) upheld by all male communities. However, they experience unique gender homogeneous stressors as these hierarchies may intensify at the within-community level for this particular population, in which all members feel particularly obliged to preserve their individual status. Drawing on the empirical evidence from this emerging body of research, Pachankis, Clark, et al. (2020) measured intraminority stress (i.e., within-community stress due to factors related to status, sex, competition, and exclusion) in sexual minority men. Findings indicated that intraminority stress predicted depression and generalised anxiety over-and-above traditional sexual minority stress. Due to its high levels of comorbidity with depression and generalised anxiety in sexual minority individuals (e.g., Cohen, Blasey, et al., 2016), intraminority stress might be an important determinant of social anxiety also. By their nature, factors underpinning intraminority stress may likely encourage a fear of negative evaluation from peers amongst sexual minority men.

Whilst intraminority stress theory was originally developed and tested using samples of sexual minority men, experiences of within-community stress and discrimination are not restricted to this subgroup (e.g., Boyle & Omoto, 2014; Parmenter et al., 2020a). Past research indicated that strict social norms with potentially deleterious consequences for sexual minority women's mental health are upheld within sexual minority women's communities (Aragon, 2006; Boyle & Omoto, 2014; Heath & Mulligan, 2008). Examples of these social norms include solely having women as sexual partners and identifying as lesbian (Hartman, 2006; McLean, 2008; Rust, 1992, 1993), acquiring financial independence and high levels of education, and associating with a group of sexual minority friends who are racially and ethnically similar to oneself (Bennett & Gibbs, 1980; Lehavot et al., 2009). A recent study found that lesbian women with greater discordance between their self-identity

and lesbian community ideal standards report higher levels of psychological distress (Boyle & Omoto, 2014). Further, within the context of partner selection in sexual minority women, it was found that physical attractiveness and wealth are revered in potential partners, which elicits jealousy and competition as sexual minority women compete for sexual/romantic partners (Bassett et al., 2001; Buunk & Dijkstra, 2001).

As highlighted above, sexual minority women might encounter social ideals embedded in status hierarchies at the within-community level as they compete for sexual and social capital in a similar manner to their sexual minority men counterparts. Sexual minority women who find it difficult to adhere to these social norms and those who are members of minority subgroups (e.g., bisexually identified, racial and ethnic minority sexual minority women; Lehavot et al., 2009; McLean, 2008) may be particularly vulnerable to experiencing within-community stress and subsequent psychological distress. Thus, the potential role of intraminority stress as a determinant of social anxiety in sexual minority women also warrants empirical exploration.

1.6 Theoretical Rationale and Overview for the Present Study

As outlined above, social anxiety is a pernicious mental health difficulty suffered disproportionately by sexual minority individuals (Kerridge et al., 2017) that negatively impacts multiple domains of everyday functioning (Aderka et al., 2012). This PhD thesis proposes to utilise the most beneficial theoretical frameworks from social anxiety and sexual minority mental health scholarship, with the aim of uncovering facets of the current phenomenon. The rationale for the theoretical perspectives adopted in this PhD thesis is provided below.

As discussed in section 1.3, several theoretical frameworks have been influential in social anxiety research, with most undertaking a cognitive behavioural approach in highlighting the aetiological and maintenance factors of social anxiety. With regards to aetiological factors, Spence and Rapee (2016) posit that the interaction between genes/temperament (e.g., behavioural inhibition), environmental factors (e.g., parent and peer influences), and proximal factors (e.g., poor social skills and negative social beliefs) result in elevated levels of social anxiety. Exemplifying an influential maintenance model, Clark and Wells (1995) propose that upon encountering a social-evaluative situation, perceptions of social danger (i.e., negative automatic thoughts) arise in the individual, which in turn facilitate self-focus (i.e., processing of the self as a social object). This self-focus is posited to feedback into the negative automatic thoughts (e.g., creating negative self-imagery). Further, perceptions of

social danger are proposed to stimulate behavioural, cognitive, and bodily symptoms of social anxiety, and these symptoms maintain self-focus and encourage the avoidance of social situations. The IAM model (Wong & Rapee, 2016) systematically combined all the theoretical assertions of prominent aetiological and maintenance models, such as those outlined above. This resulted in a more sophisticated understanding of processes associated with social anxiety; for instance, the distinguishing between primary and secondary maintenance processes. Utilising the IAM model is advantageous in both elucidating the general psychological processes involved in sexual minority individuals' experiences of social anxiety and highlighting the potential overlap between these general cognitive and behavioural processes and sexual minority-specific processes (i.e., utilising alongside theories of sexual minority mental health). Moreover, since its inception, the IAM model has been positively critiqued by world leading social anxiety researchers; "Wong and Rapee (2016) conducted a much-needed comprehensive review of etiological and maintenance models of social anxiety disorder (SAD) to formulate a cutting-edge integrative model" (Heeren & McNally, 2016, p. 1).

As section 1.5.1 highlights, multiple theoretical frameworks stemming from the field of sexual minority mental health research are being utilised in the current study. It is important to note that alternative approaches were also considered. For example, 'syndemics' theory describes the co-occurring and mutual enhancing multiple health conditions, which manifest and are maintained due to deleterious social contexts (Singer & Clair, 2003). This theoretical position has been used to understand negative health outcomes in marginalised populations (e.g., sexual minority men) as being driven by structural contexts. Therefore, in contrast to minority stress theory, which places a particular emphasis on the individuals' encountering of sexual minority stress processes, syndemics theory focuses more on the marginalised populations' shared and intertwining risk factors for numerous pathologies. While future research primarily concentrating on social anxiety and comorbid health and psychological difficulties among sexual minority populations may benefit from utilising syndemics theory, the frameworks outlined in section 1.5.1 were deemed more advantageous to employ in the current PhD thesis. For instance, comprehensively using both Meyer's (2003) and Hatzenbuehler's (2009) frameworks will enable the potential uncovering of pathways to social anxiety from distal stress through both increased sexual minority-specific proximal processes and diminished general psychological processes. Specifically, facets of these frameworks have been illustrated as predictors of social anxiety among sexual minority women and men (e.g., Feinstein et al., 2012; Mason & Lewis, 2016). Yet, reliance on these

traditional minority stress theories from sexual minority mental health scholarship is limited in solely viewing a sexual minority person as a minority, socially operating in a heterosexual majority world. Of course, interactions with fellow sexual minority peers at the within-community, and perceptions of the social climate of the sexual minority community might also be pertinent to social anxiety. The emerging theoretical standpoint of intraminority gay community stress (Pachankis, Clark, et al., 2020), advocates for the acknowledgment of within-community stressors (e.g., stress emerging from interactions with fellow sexual minority individuals) as determinants of social anxiety within this population. Overall, the multidimensional theoretical approach used in this PhD thesis will allow a thorough and multifaceted investigation of the current phenomenon.

In order to advance the knowledge pertaining to social anxiety among sexual minority individuals, this PhD thesis aims to explicate the determinants of social anxiety within this population. A more comprehensive understanding of this topic area may be achieved by exploring the psychological processes and social experiences of sexual minority individuals at the within- and wider-community levels whilst utilising sexual minority-specific (Hatzenbuehler, 2009; Meyer, 2003; Pachankis, Clark, et al., 2020) and social anxiety-specific (Wong & Rapee, 2016) theoretical frameworks. This thesis aims to both examine whether specific sexual minority subgroups (i.e., across the three dimensions of sexual orientation) are most at risk for social anxiety and test an extensive model of risk and protective factors of social anxiety within this population. Further this PhD thesis aims to elucidate the experience of social anxiety within this population. This will be the first study to assess social anxiety in sexual minority individuals in the Republic of Ireland and the first to account for the diverse stress processes (i.e., general and sexual-minority specific) experienced by this population at multiple community levels (i.e., within- and wider-) when attempting to understand the current phenomenon. This will also be the first study to explore the experience of living with social anxiety in sexual minority individuals.

1.7 Thesis Conspectus

In total, this thesis comprises eleven chapters.

Chapter two details a systematic review of published research pertaining to social anxiety among sexual minority populations, the findings of which inform the specific aim and objectives this PhD thesis purposes to fulfil.

Chapter three provides an overview of the current study, including the philosophical foundations and methodological design

Chapters four, five, and six focus on the phase one quantitative study. Chapter four provides the background and details the methods implemented for the first phase. Chapter five outlines the quantitative findings generated through the analyses of the cross-sectional online survey data from 501 sexual minority individuals. Chapter six provides a critical discussion of the quantitative findings, as well as a clear indication of how the phase one findings influenced the development of the phase two qualitative study.

Chapters seven, eight, and nine focus on the phase two qualitative study. In Chapter seven, methodological details related to the qualitative study are presented. Next, Chapter eight outlines the qualitative findings generated through the thematic analysis of 21 interviews with sexual minority individuals. Chapter nine provides a critical discussion of the qualitative findings.

An integration of both the phase one quantitative study and phase two qualitative study findings, and a subsequent discussion of the key findings of the overriding mixed methods study is presented in Chapter ten.

Finally, to conclude this PhD thesis, Chapter eleven outlines the unique contribution of the current mixed methods study to the knowledge base. Additionally, this final chapter highlights the implications for practice, research, and policy associated with the current mixed methods inquiry.

Chapter 2 Systematic Review of the Literature

2.1 Introduction

This chapter presents a systematic review of studies pertaining to social anxiety among sexual minority individuals. This review aims to systematically collate existing evidence pertaining to this phenomenon. This approach will consist of identifying the characteristics of existing studies in the area, comparing social anxiety across sexual orientation subgroups, synthesising existing qualitative and quantitative research evidence, and identifying related psychological interventions that have been tested in the area.

2.2 Systematic Review Background

As discussed in section 1.5, population-based epidemiological investigations of psychological disorder prevalence (including SAD) that assess sexual orientation (e.g., Bostwick et al., 2010; Kerridge et al., 2017) suggest that sexual minority individuals are at significantly greater risk of SAD compared to heterosexuals. Indeed, the first effort to systematically review the association between sexual orientation and SAD confirmed that sexual minority individuals are at an increased risk for SAD when compared to heterosexuals, particularly those who identify as bisexual (Campo-Arias et al., 2017). However, Campo-Arias et al. (2017) omitted relevant data in studies that assessed more than one dimension of sexual orientation. For example, only Bostwick et al.'s (2010) social anxiety data across sexual identity subgroups was included, despite the fact that social anxiety was also assessed across sexual attraction and sexual behaviour subgroups. Nevertheless, this sexual orientation disparity calls for a greater understanding of social anxiety among sexual minority individuals, a disproportionately at risk sub-population. In order to achieve this understanding, it is necessary to conduct a systematic review with broader objectives. Specifically, in aiming to compare social anxiety levels across sexual orientation subgroups, all data (i.e., pertaining to identity, behaviour, and attraction) should be included. Such an approach coincides with the definition of sexual minority populations (Blondeel et al., 2018) outlined in section 1.4 and may be more efficacious in representing the diverse experiences of individuals across the spectrum of sexual orientation in its entirety (Akibar et al., 2019). This may also highlight specific sexual minority subgroups that are most at risk for experiencing heightened social anxiety symptoms.

The proportion of sexual minority participants in population-based prevalence studies is often very small. For instance, just 1.4% of participants in Bostwick et al.'s (2010) study

indicated lesbian, gay, or bisexual identities. As a result, our knowledge of potential SAD disparities across sexual orientation subgroups (i.e., sexual identity, behaviour, and attraction subgroups) are based on small sub-samples of sexual minority individuals, which also makes explicating potential variability within sexual minority subgroups difficult (Meyer & Wilson, 2009). Therefore, it may prove advantageous to consult findings from studies using non-probability samples that have a larger proportion of sexual minority participants, given that they specifically recruit sexual minority individuals. In fact, non-probability studies seem to indicate a similar trend to population-based studies, in that sexual minority individuals report higher social anxiety symptoms than heterosexuals (Cohen, Blasey, et al., 2016), and bisexual individuals report higher social anxiety symptoms than their gay/lesbian counterparts (Wadsworth & Hayes-Skelton, 2015).

There has been no previous effort to collate data pertaining to both SAD prevalence *and* social anxiety symptoms (e.g., fear of negative evaluation) while stratifying sexual orientation subgroups by identity, behaviour and attraction. This is especially pertinent given the evidence that high sub-clinical threshold social anxiety symptoms can also impair everyday functioning (Dell’Osso et al., 2003; Fehm et al., 2008). Undertaking this multidimensional approach acknowledges the potentially distinct experiences of sexual orientation subgroups across the sexual orientation spectrum (Akibar et al., 2019), and might guide a more focal search for determinants of any disparities in social anxiety across sexual orientation subgroups.

The social anxiety- (Wong & Rapee, 2016) and sexual minority-specific (Hatzenbuehler, 2009; Meyer, 2003) theoretical frameworks discussed in sections 1.3 and 1.5.1 respectively, offer explanations as to why social anxiety symptoms and SAD are elevated among sexual minority individuals. Recent research has highlighted that minority stress processes are salient determinants of social anxiety within this population (e.g., Feinstein et al., 2012; Mason & Lewis, 2016). Wong and Rapee (2016) highlight the important role of social processes (e.g., parent and peer relationships) as aetiological factors for high social anxiety symptoms. In fact, sexual minority individuals report more parental rejection (Balsam et al., 2005) and negative peer experiences (Friedman et al., 2011) than heterosexuals. These stigma-related social stressors may set the stage for sexual minority individual’s anxious interpretation of the social world. Thus far, there has been no effort to collate quantitative evidence concerning the determinants and outcomes of social anxiety among sexual minority individuals, or to synthesise findings of qualitative studies in the area. As qualitative research has uncovered the lived experience of minority stress among sexual minority individuals

(e.g., Bjorkman & Malterud, 2012; Holloway et al., 2015), synthesising qualitative evidence pertaining to social anxiety could also prove beneficial in elucidating richer aspects of this phenomenon.

Research evidence highlights effective psychological interventions for SAD in the general population, such as cognitive behavioural therapy (CBT; for meta-analysis see Mayo-Wilson et al., 2014). In addition, there has been recent progress in developing efficacious psychological interventions to reduce mental health difficulties among sexual minority populations (e.g., Pachankis, Hatzenbuehler, et al., 2015; Pachankis, McConocha, et al., 2020). Despite high prevalence of social anxiety in sexual minority individuals (e.g., Kerridge et al., 2017), there have been no prior attempts to combine research evidence related to the efficacy of existing psychological interventions designed to address SAD in this population. Combining such findings would prove valuable in suggesting appropriate psychological interventions to test in potential future large-scale randomised controlled trials focused on sexual minority populations.

With an increasing body of research relevant to social anxiety among sexual minority individuals, synthesising this research evidence is important to gain a greater understanding of their lived experience of social anxiety, and help guide the search for determinants of social anxiety symptoms, and more effective population tailored interventions to address them.

2.3 Systematic Review Aims and Objectives

In order to build a thorough profile of the current research evidence, this chapter aims to systematically review empirical research pertaining to social anxiety among sexual minority individuals.

The objectives were fourfold:

1. Describe the characteristics of existing studies in the area, including sample characteristics and social anxiety measures used.
2. Compare social anxiety levels across sexual orientation subgroups (i.e., stratified by dimension of sexual orientation assessed – identity, behaviour, and attraction, and nature of social anxiety assessment – SAD prevalence and social anxiety symptoms).
3. Synthesise the range of quantitative associations involving social anxiety in the published literature, and collate qualitative evidence pertaining to social anxiety among sexual minority individuals.

4. Identify psychological interventions that have been empirically tested to target social anxiety in sexual minority individuals.

2.4 Systematic Review Method

The Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) guided the development of this systematic review (Moher et al., 2010).

2.4.1 Search Strategy

A search was carried out across six electronic databases (i.e., PsycINFO, Pubmed, Web of Science [Social Science Citation Index], CINAHL, Scopus, and Embase) to identify studies related to social anxiety in sexual minority individuals. As no publishing date limiters were used, the search included the earliest relevant papers up to the date the searches were run (i.e., 16th August 2019). The search strategy contained sexual minority search terms informed by a recent systematic review on sexual minority search terminology used in health research (J. G. L. Lee et al., 2016). Social anxiety search terms were developed through consulting a number of existing systematic reviews focusing on social anxiety (e.g., Heeren et al., 2015; Kashdan, 2007). The search strategy for PsycINFO is illustrated in Appendix A. A manual search of reference lists was conducted for all studies deemed eligible for inclusion to identify other studies that may not have been retrieved by the electronic database search.

2.4.2 Study Selection Criteria

Studies included in this systematic review: (1) were published in peer-reviewed journals; (2) were published in the English language; (3) were empirically based, containing original data and analysis (review papers were excluded); (4) included samples containing sexual minority participants; (5) reported social anxiety data pertaining to sexual minority populations separately (i.e., sexual minority data is not combined with non-sexual minority data or social anxiety data is not combined with other mental health data); (6a) provided statistical information pertaining to: (i) the prevalence of SAD in sexual minority subgroups, or (ii) social anxiety symptoms (e.g., fear of negative evaluation and social interaction anxiety) among sexual orientation subgroups, or (iii) bivariate or multivariate associations between social anxiety and other variables among sexual minority individuals, or (iv) the efficacy of psychological interventions targeting social anxiety among sexual minority individuals; or (6b) included a qualitative analysis focused on social anxiety among sexual minority individuals. All types of research designs were considered across quantitative, qualitative,

and mixed method paradigms, and no exclusion criteria were applied with regard to geography or time of publication.

2.4.3 Data Extraction

The researcher and a research colleague independently screened titles and abstracts of papers. Next, the researcher and his colleague independently read and assessed the full-text of remaining papers according to the predetermined inclusion criteria. The researcher and his research colleague then compared evaluations and resolved any discrepancies by consensus, and, if unresolved, the researcher's supervisors were consulted and an agreement was reached through further discussion. The relevant data from each included study were extracted in line with the review objectives. This included study characteristics such as author(s), year of publication, location, study aim(s), sample size, sample composition (i.e., gender, sexual orientation, and ethnicity), and age (i.e., range, mean, and standard deviation when reported). Data pertaining to social anxiety (i.e., SAD prevalence or social anxiety symptoms) were also extracted. The bivariate and multivariate associations between social anxiety and other variables detailed in included studies were also extracted. Lastly, the researcher extracted data pertaining to the efficacy of psychological interventions addressing social anxiety (e.g., pre-test and post-test scores). All extracted data was compiled in Microsoft Word and Excel files.

2.4.4 Quality Appraisal

All included papers were appraised for their quality using the Crowe Critical Appraisal Tool (CCAT), version 1.4 (Crowe, 2013). The CCAT was chosen as the tool is designed to appraise the quality of diverse research designs (i.e., quantitative, qualitative, and mixed methods). The CCAT is comprised of eight different categories (e.g., data collection, results, and ethical matters) containing 22 items. Each item is signified to be either 'Present', 'Absent', or 'Not Applicable'. Each category is then scored on a 6-point Likert-type scale (i.e., 0-5) and category scores are summed to produce a total score (range from minimum score of 0 to maximum score of 40). These scores are then converted to percentages. Assisted by the user guide, designed to sustain reliability, the researcher and his research colleague independently critically appraised each article. The authors discussed any discrepancies in scores to reach an agreement.

2.4.5 Data Synthesis

In order to fulfil the second objective to compare social anxiety levels across sexual orientation subgroups, data were stratified according to the dimension of sexual orientation assessed (i.e., identity, behaviour, and attraction) and nature of social anxiety assessment (i.e., SAD prevalence [12-month/current and lifetime] and social anxiety symptoms). Meta-analyses were not performed on these data due to the heterogeneity in the categorisation of participants by sexual orientation across studies and the small number of studies that provided data related to objective two. To achieve the third objective of synthesising the range of quantitative associations with social anxiety, all quantitative associations tested across included studies with social anxiety were thematically grouped (e.g., all associations related to rejection sensitivity, sexual identity concealment, and internalised homonegativity were grouped under a sexual minority stress processes theme). Relevant findings emerging from qualitative studies would have also been grouped in the same manner; however, all included studies used quantitative methods.

2.5 Systematic Review Findings

Figure 2.1 illustrates the selection process. The initial searches of electronic databases yielded 1,317 papers, 668 of which were duplicates. The abstracts of the 649 unique papers were reviewed, and 505 papers were excluded at this stage. The full-texts of the remaining 144 papers were reviewed, and 54 papers were deemed eligible for inclusion. Twenty-seven papers not retrieved by the electronic database search were identified for potential inclusion through manually searching the reference lists of the 54 papers, and seven of these were deemed eligible for inclusion. Overall, the full texts of the 171 papers were reviewed, and 110 papers were excluded as they did not fulfil the inclusion criteria (reasons for exclusion are outlined in Figure 2.1). In total, 61 papers detailing 46 unique studies were deemed eligible for inclusion in the systematic review (see Appendix B.1).

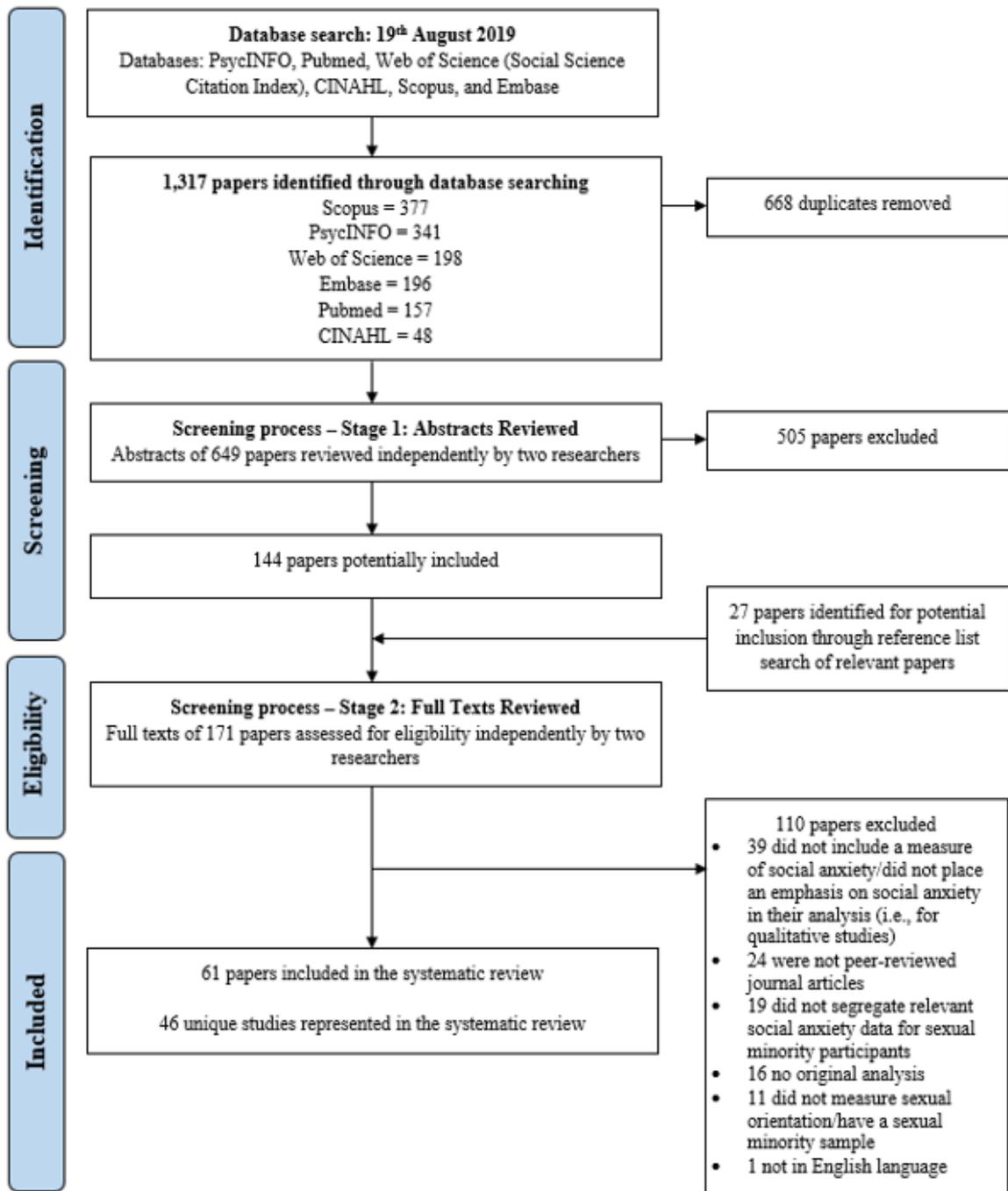


Figure 2.1: PRISMA Flow Diagram of Article Selection.

2.5.1 Characteristics of Included Studies

The main characteristics of the 46 included studies and their respective quality appraisal scores are described in Appendix B.1. In total, 12,407 sexual minority participants are represented in the included studies. Half ($k = 23$) of the included studies focused solely on men, 20 (43.5%) had samples consisting of both men and women, while just three (6.5%) focused solely on women. Seventeen studies (37%) included samples partially comprised of non-sexual minority individuals (i.e., heterosexual comparison groups), while the remaining

29 studies (63%) used samples consisting of solely sexual minority individuals. Forty-one studies reported a sample mean age; seventeen of these (41.5%) had a mean age less than 30, 15 (36.6%) between the ages 30 and 39, and nine (21.9%) had a mean age above 40. Thirty out of 37 studies (81.1%) that reported ethnicity/race had a majority of White participants, and in 26 (70.3%) of these studies the proportion of White participants was $\geq 70\%$. The studies were published over a 35-year period from 1984 to 2019. Twenty-seven (58.7%) of the included studies were published from 2010 onwards, 17 (37%) in the years 2000-2009, and just two (4.3%) prior to the 21st century. Thirty-six studies were based in the USA (78.3%), three in Canada, two in Italy and the Netherlands respectively, and one each in Switzerland, Israel, and the Philippines.

In terms of the methodology of the included studies, one used an experimental research design (Jacobson et al., 2016), another used a retrospective evaluation design (Reisner et al., 2011), two studies used a longitudinal design (Kurdek, 1996; Pachankis, Sullivan, Feinstein, & Newcomb, 2018; Pachankis, Sullivan, & Moore, 2018), two utilised a case study/case series design (Hart et al., 2014; Walsh & Hope, 2010), while all the remaining studies reported a cross-sectional design. There were no eligible studies using qualitative analyses. In total, 18 different measures were used to assess social anxiety, all of which are detailed in Appendix B.1. The most frequently used measures include the Social Interaction Anxiety Scale ($k = 10$), the Brief Fear of Negative Evaluation scale ($k = 10$), the Liebowitz Social Anxiety Scale ($k = 7$), various versions of the Composite International Diagnostic Interview ($k = 5$), and the Social Phobia Scale ($k = 4$).

2.5.2 Compare Social Anxiety Levels Across Sexual Orientation Subgroups

The findings of all studies comparing social anxiety levels across sexual orientation subgroups are outlined below. These findings are firstly stratified by sexual orientation dimension assessed (i.e., identity, behaviour, and attraction), and secondly by nature of social anxiety assessment (i.e., SAD prevalence [12-month/current and lifetime] and social anxiety symptoms). In accordance with how the analyses of included studies were conducted, the results were presented by gender for SAD prevalence (Tables 2.1, 2.2, 2.4, 2.5, and 2.6). The results are not presented by gender for studies assessing social anxiety symptoms across sexual orientation subgroups (Table 2.3) as many of these studies did not include distinct analyses by gender.

2.5.2.1 Sexual Identity

Six studies reported 12-month or current SAD prevalence in sexual identity subgroups (see Table 2.1). One of these studies provided analyses comparing current SAD prevalence between heterosexuals and sexual minority individuals (Cohen, Blasey, et al., 2016), and demonstrated significantly higher rates in the latter (i.e., all genders combined). When stratified by gender, only sexual minority women reported significantly higher SAD than their heterosexual counterparts (Cohen, Blasey, et al., 2016). Two studies provided analyses comparing 12-month SAD prevalence between heterosexuals and sexual minority individuals (i.e., all genders combined; Hatzenbuehler, Keyes, et al., 2009; Kerridge et al., 2017) and demonstrated significantly higher rates in the latter group. Also, Kerridge et al. (2017) reported higher 12-month SAD prevalence in bisexual and questioning/not sure women compared to heterosexual women, and in gay and bisexual men compared to heterosexual men. However, analyses focused solely on sexual minority identity subgroups (i.e., excluding the heterosexual group) revealed no significant differences between gay/lesbian, bisexual and questioning/not sure participants (Kerridge et al., 2017).

Three studies reported lifetime SAD prevalence in sexual identity subgroups (see Table 2.2). In one study, sexual identity was significantly associated with lifetime SAD prevalence for both men and women; whilst all sexual minority groups reported higher rates than heterosexuals, specific analyses comparing SAD prevalence across sexual identity subgroups were not included (Bostwick et al., 2010). Further, in samples of individuals with alcohol use disorders, sexual minority women reported significantly higher SAD lifetime prevalence than their heterosexual counterparts (Mereish et al., 2015), whereas sexual minority men did not report significantly higher SAD lifetime prevalence than heterosexual men (J. H. Lee et al., 2015). Kerridge et al. (2017) found that sexual minority individuals (i.e., all genders combined) reported higher lifetime SAD prevalence than heterosexuals, bisexual and questioning/not sure women reported higher rates than heterosexual women, and gay and bisexual men reported higher rates than heterosexual men. While bisexual individuals reported higher lifetime SAD prevalence than gay/lesbian individuals in all three studies (Bostwick et al., 2010; Kerridge et al., 2017; Meyer, Dietrich, et al., 2008), only Kerridge et al. (2017) tested the statistical significance between these two groups, and the difference was not significant.

Table 2.1*12-month and Current SAD Prevalence Across Sexual Identity Subgroups*

Study	Overall					Women					Men				
	Hetero- sexual	Sexual minority	Gay/ Lesbian	Bi- sexual	Not sure	Hetero- sexual	Sexual minority	Lesbian	Bi- sexual	Not sure	Hetero- sexual	Sexual minority	Gay	Bi- sexual	Not sure
Burns et al. (2012b) ^a													12.4%		
													307		
Cohen, Blasey et al. (2016) ^a	8.9%	22.3%**				11.5%	26.8%*				3.8%	15.0%			
	156	157				103	97				53	60			
Hatzenbuehler, Keyes, et al. (2009) ^{b, c, d}	2.5%	6.6%*													
	34,076	577													
Kerridge et al. (2017) ^{b, c}	2.7%		6.6%*	11.1%*	8.6%*	3.2%		5.9%	12.2%*	9.7%*	2.1%		7.1%*	8.1%*	7.0%
	34,644		586	566	199	19,454		265	422	130	15,190		321	144	69
O’Cleirigh et al. (2013); O’Cleirigh et al. (2015) ^a												22.3%			
												503			
J. Wang et al. (2007) ^b												13.5%			
												571			

Note. The total number (*n*) of participants in each sexual identity subgroup is presented below their respective SAD prevalence rate (%).

^a Represents current SAD prevalence. ^b Represents 12-month SAD prevalence. ^c Analyses adjusted for sociodemographic characteristics. ^d When stratified by presence of state-level sexual minority protective policies, both sexual minority individuals living in states with and without protective policies were at higher odds of 12-month SAD than their heterosexual counterparts.

*significantly higher than heterosexuals ($p < .05$), **significantly higher than heterosexuals ($p < .01$).

Table 2.2*Lifetime SAD Prevalence Across Sexual Identity Subgroups*

Study	Overall					Women					Men				
	Hetero- sexual	Sexual minority	Gay/ Lesbian	Bi- sexual	Not sure	Hetero- sexual	Sexual minority	Lesbian	Bi- sexual	Not sure	Hetero- sexual	Sexual minority	Gay	Bi- sexual	Not sure
Bostwick et al. (2010) ^a						7.9%		9.6%	18.2%	13.6%	5.8%		12.4%	14.2%	15.6%
						19,489		145	161	101	14,109		190	81	69
J. H. Lee et al. (2015) ^{b, c}											8.1%	15.8%			
											6,723	176			
Mereish et al. (2015) ^{b, c}						14.2%	19.7%*								
						4,151	191								
Kerridge et al. (2017) ^c	3.5%		8.1%*	12.7%*	9.8%*	4.1%		6.6%	13.7%*	10.9%*	2.8%		9.3%*	10.2%*	7.9%
	34,644		586	566	199	19,454		265	422	130	15,190		321	144	69
Meyer, Dietrich, et al. (2008) ^d			21.1%	27.1%			20.5%					23.8%			
			318	70			195					193			

Note. The total number (*n*) of participants in each sexual identity subgroup is presented below their respective SAD prevalence rate (%).

^a Sexual identity was significantly associated with lifetime SAD for women ($p \leq .05$) and men ($p \leq .05$), however, subgroup analyses were omitted. ^b Sub-samples of Bostwick et al. (2010).

^c Analyses adjusted for sociodemographic characteristics. ^d Did not conduct subgroup analyses specific to SAD.

*significantly higher than heterosexuals ($p < .05$).

Nine studies provided comparative data on social anxiety symptoms across sexual identity subgroups (see Table 2.3). Eight studies provided comparative data between heterosexuals and sexual minority individuals. In three of these studies, sexual minority individuals reported significantly higher social anxiety than heterosexuals (Akibar et al., 2019; Pachankis & Goldfried, 2006; Shulman & Hope, 2016). Further, in one study, bisexual and emerging identity individuals, but not gay/lesbian individuals, reported higher social anxiety than heterosexuals (Wadsworth & Hayes-Skelton, 2015). Two studies reported no significant difference in social anxiety between gay and heterosexual men (Jacobson et al., 2016; Reilly & Rudd, 2007), whereas one study reported significantly higher social anxiety in heterosexuals compared to gay/lesbian individuals (Schmitt & Kurdek, 1984). One study reported higher social anxiety in young sexual minority men and women compared to heterosexuals, but specific sexual identity subgroup analyses were not included (Baiocco et al., 2014). Bisexual individuals reported higher social anxiety than gay/lesbian individuals in all three studies that provided comparative data across multiple sexual minority subgroups (Akibar et al., 2019; Meidlinger & Hope, 2014; Wadsworth & Hayes-Skelton, 2015). However, the difference between groups was only significant in Wadsworth and Hayes-Skelton (2015), in which bisexual and emerging identity individuals reported higher social anxiety than gay/lesbian individuals.

Table 2.3*Means and Standard Deviations on Social Anxiety Screening Measures Across Sexual Identity Subgroups*

Study	Measure	Sexual identity subgroup								
		Hetero- sexual	Sexual minority	Gay/ Lesbian	Mostly gay/lesbian	Bisexual	Emerging identity	Not sure	Asexual	Pansexual
Akibar et al. (2019) ^a	SIAS, SPS	46.19±29.20 947	57.67±33.56*** 187	51.50±30.99 50		60.04±35.44* 83		59.81±36.00 22	71.44±27.60 9	55.08±31.42 23
Baiocco et al. (2014) ^b – women	SCARED	3.69±2.77 504		4.14±2.62 169						
Baiocco et al. (2014) ^b - men	SCARED	3.04±2.15 210		3.74±3.14 217						
Jacobson et al. (2016)	LSAS	36.68±19.0 18		26.72±17.0 18						
Meidlinger & Hope (2014)	BFNE			36.46±10.06 102	37.00±9.77 23	40.13±12.83 24				
Pachankis & Goldfried (2006) ^a	SIAS	18.71±10.86 87		25.18±12.58*** 87						
	SPS	15.56±9.35 87		18.53±11.82 87						
	FNE	11.75±6.92 87		16.74±8.20*** 87						
	IA	1.86 87		2.80*** 87						
Reilly & Rudd (2007)	LSAS	39.12 33		34.32 34						
Schmitt & Kurdek (1984) ^c	SCS	12.95* 92	11.19 62							

Table 2.3*Means and Standard Deviations on Social Anxiety Screening Measures Across Sexual Identity Subgroups*

Study	Measure	Sexual identity subgroup								
		Hetero- sexual	Sexual minority	Gay/ Lesbian	Mostly gay/lesbian	Bisexual	Emerging identity	Not sure	Asexual	Pansexual
Shulman & Hope (2016) ^{a, d}	SPAI	83.26±44.57		101.76±42.96**						
Wadsworth & Hayes- Skelton (2015) ^e	LSAS- Fear	18.21±12.00 54		18.49±10.98 43		26.27±11.85** 55	26.29±11.46* 28			
	LSAS- Avoidance	17.84±10.73 54		18.11±9.94 43		25.93±12.42** 55	23.92±11.94 28			
	LSAS- Social	18.14±12.31 54		17.96±10.18 43		27.52±13.16** 55	26.53±13.24* 28			
	LSAS- Performance	17.87±10.22 54		18.66±11.10 43		24.49±11.92* 55	23.33±11.29 28			

Note. The total number (*n*) of participants in each sexual identity subgroup is presented below the *M*±*SD*. SIAS = Social Interaction Anxiety Scale; SPS = Social Phobia Scale; SCARED = Screen for Child Anxiety-Related Emotional Disorders; LSAS = Liebowitz Social Anxiety Scale; BFNE = Brief Fear of Negative Evaluation Scale; FNE = Fear of Negative Evaluation Scale; IA = Inventory of Anxiousness; SCS = Self Consciousness Scale; SPAI = Social Phobia and Anxiety Inventory.

^a significantly greater social anxiety than heterosexual group. ^b statistical analyses across groups not provided. ^c significantly greater social anxiety than sexual minority group.

^d total number of participants included in the analysis is 247, specific number in each sexual identity subgroup not provided.

^e significantly greater social anxiety than heterosexual and gay/lesbian groups.

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

2.5.2.2 Sexual Behaviour

Six studies reported 12-month or current SAD prevalence across sexual behaviour subgroups (see Table 2.4). Three of these studies provided analyses comparing 12-month SAD prevalence between both women who have sex with women (WSW) and women who have sex with men (WSM) only, and men who have sex with men (MSM) and men who have sex with women (MSW) only (Gilman et al., 2001; Sandfort et al., 2001, 2014). WSW reported higher 12-month SAD prevalence than WSM only in all three studies, however, the differences between groups were not significant. Among men, MSM reported higher 12-month SAD than MSW only in all three studies, and the difference was significant in one study (Sandfort et al., 2014).

Three studies reported lifetime SAD prevalence across sexual behaviour subgroups (see Table 2.5). In two studies (Sandfort et al., 2001, 2014), WSW and MSM reported higher lifetime SAD prevalence than WSM only and MSW only respectively. However, the differences between WSW and WSM only were not significant in either of these studies, and MSM's lifetime prevalence was significantly higher than MSW only in just one of these studies (Sandfort et al., 2001). In another study (Bostwick et al., 2010), sexual behaviour was significantly associated with lifetime SAD among women and men. Here, women who have sex with men and women (WSMW) reported the highest SAD prevalence, followed by women who never had sex, WSM only, and WSW only. Among men, men who have sex with men and women (MSMW) reported the highest lifetime SAD, followed by men who never had sex, MSM only, and MSW only.

Table 2.4*12-month and Current SAD Prevalence Across Sexual Behaviour Subgroups*

Study	Women		Men	
	WSM only	WSW	MSW only	MSM
Batchelder et al. (2019) ^a				18.5%
				290
Fletcher et al. (2018) ^a				20.4%
				285
Gilman et al. (2001) ^{b, c}	9.1%	10.4%	6.3%	8.8%
	2,475	51	2,310	74
Mimiaga et al. (2009); Reisner et al. (2009) ^a				57.0%
				189
Sandfort et al. (2001) ^{b, c}	5.8%	7.0%	3.0%	7.3%
	3,077	43	2,796	82
Sandfort et al. (2014) ^{b, c}	3.9%	12.2%	2.7%	12.3%*
	2,832	57	2,379	60

Note. The total number (*n*) of participants in each sexual behaviour subgroup is presented below their respective SAD prevalence rate (%). WSM = women who have sex with men; WSW = women who have sex with women; MSW = men who have sex with women; MSM = men who have sex with men.

^a represents current SAD prevalence. ^b represents 12-month SAD prevalence. ^c Analyses adjusted for sociodemographic characteristics.

*significantly higher than MSW only ($p < .05$).

Table 2.5*Lifetime SAD Prevalence Across Sexual Behaviour Subgroups*

Study	Women					Men				
	WSM only	WSMW	WSW only	WSW	Never had sex	MSW only	MSMW	MSM only	MSM	Never had sex
Bostwick et al. (2010) ^a	7.8%	15.5%	4.0%		11.1%	5.7%	13.8%	6.1%		11.8%
	18,904	445	177		334	13,534	302	342		249
Sandfort et al. (2001) ^b	9.5%			18.6%		5.5%			14.6%*	
	3,077			43		2,796			82	
Sandfort et al. (2014) ^b	10.3%			20.2%		6.6%			17.8%	
	2,832			57		2,379			60	

Note. The total number (*n*) of participants in each sexual behaviour subgroup is presented below their respective SAD prevalence rate (%).

WSM = women who have sex with men; WSMW = women who have sex with men and women; WSW = women who have sex with women;

MSW = men who have sex with women; MSMW = men who have sex with men and women; MSM = men who have sex with men.

^a Sexual behaviour was significantly associated with lifetime SAD for women ($p \leq .01$) and men ($p \leq .01$), however, subgroup analyses were omitted. ^b Analyses adjusted for sociodemographic characteristics.

*significantly higher than MSW only ($p < .05$).

Two studies provided comparative data on social anxiety symptoms across sexual behaviour subgroups. In one study focusing on HIV-positive men (Hart, James, et al., 2008), MSW ($M = 12.68$, $SD = 5.90$) reported significantly higher social anxiety than MSM ($M = 9.17$, $SD = 7.41$, $p < .05$). In an emerging adult sample, Akibar et al. (2019) found that sexual behaviour was significantly associated with social anxiety. Emerging adults who had same-gender sexual partners reported higher social anxiety than those who had exclusively opposite-gender partners ($p < .05$, M s and SD s not reported). Further, those who never had sex ($M = 55.08$, $SD = 29.95$) and those who had sex with mostly opposite-gender partners ($M = 57.21$, $SD = 36.34$) reported higher social anxiety in comparison to individuals who had sex with exclusively opposite-gender ($M = 43.85$, $SD = 28.55$) partners (Akibar et al., 2019). There were no more significant differences between the following sexual behaviour subgroups: exclusively same-gender partners ($M = 50.22$, $SD = 33.02$), mostly same-gender partners ($M = 29.90$, $SD = 19.34$), equal both-gender partners ($M = 55.00$, $SD = 30.74$), and other (i.e., open-ended response that did not fit another category; $M = 59.66$, $SD = 32.65$).

2.5.2.3 Sexual Attraction

Two studies reported 12-month and/or lifetime SAD prevalence across sexual attraction subgroups (see Table 2.6). Sandfort et al. (2014) found that both 12-month and lifetime SAD rates were significantly higher in same-gender attracted men and women in comparison to their opposite-gender attracted counterparts (Sandfort et al., 2014). Further, Bostwick et al. (2010) demonstrated that sexual attraction was significantly associated with lifetime SAD for women, but not for men. Herein, women who are equally attracted to men and women reported the highest lifetime SAD prevalence, followed by mostly same gender-attracted women, mostly opposite-gender attracted women, exclusively opposite-gender attracted women, and exclusively same-gendered attracted women (Bostwick et al., 2010).

One study provided data on social anxiety symptoms across sexual attraction subgroups (Akibar et al., 2019). Here, individuals equally attracted to men and women ($M = 60.41$, $SD = 34.09$), and mostly opposite-gender attracted individuals ($M = 56.25$, $SD = 31.49$), reported significantly higher social anxiety than exclusively opposite-gender attracted individuals ($M = 44.10$, $SD = 28.51$). There were no more significant differences in social anxiety between sexual attraction subgroups: exclusively same-gender attracted ($M = 49.12$, $SD = 34.08$), and mostly same-gender attracted ($M = 56.80$, $SD = 31.12$).

Table 2.6*12-month and Lifetime SAD Prevalence Across Sexual Attraction Subgroups*

Study	Women						Men					
	Only men	Women/ women and men	Mostly men	Equally men and women	Mostly women	Only women	Only women	Men/ men and women	Mostly women	Equally men and women	Mostly men	Only men
Bostwick et al. (2010) ^{a, b}	7.8%		11.0%	13.4%	12.4%	6.5%	5.8%		9.8%	7.9%	7.0%	9.2%
	18,358		880	260	87	275	13,704		277	130	96	229
Sandfort et al. (2014) ^{c, d}	4.2%	15.3%*					2.9%	12.1%*				
	3,435	88					2,799	71				
Sandfort et al. (2014) ^{a, d}	10.4%	25.3%*					7.5%	20.1%*				
	3,435	88					2,799	71				

Note. The total number (*n*) of participants in each sexual attraction subgroup is presented below their respective SAD prevalence rate (%).

^a Lifetime prevalence. ^b Sexual attraction was significantly associated with lifetime SAD for women only ($p \leq .01$), however, subgroup analyses were omitted. ^c 12-month prevalence. ^d Analyses adjusted for sociodemographic characteristics.

*significantly higher than opposite-gender attracted only ($p < .05$).

2.5.3 Bivariate Associations Involving Social Anxiety Among Sexual Minority Individuals

The bivariate associations involving social anxiety, reported across 35 different studies, are detailed below. The correlates of social anxiety were thematically grouped into the following categories: sexual minority stress processes, general psychological processes (i.e., social and cognitive), internalising mental health symptoms, externalising mental health symptoms, body image and related variables, gender roles, sexual practices, sociodemographics, other discrimination (i.e., not based solely on sexual orientation), and other variables. The related bivariate correlation coefficients are detailed in Appendix B.2. The data pertaining to bivariate associations (i.e., other than correlation coefficients) that are not reported in Appendix B.2 are included in the text below.

2.5.3.1 *Sexual Minority Stress Processes*

Heterosexist Discrimination. Seven studies provided bivariate correlations between social anxiety and heterosexist discrimination among sexual minority women and men, demonstrating mixed findings. Three studies found significant positive correlations such that increased heterosexist discrimination was associated with increased social anxiety (Burns et al., 2012a, 2012b; Feinstein et al., 2012; Mason et al., 2017), three reported no significant correlations (Dyar et al., 2016; Pachankis, Sullivan, Feinstein, & Newcomb, 2018; Puckett et al., 2016), while Hart et al. (2019) reported both a non-significant relationship (i.e., with the LSAS) and significant positive relationship (i.e., with the SIAS) between antigay bullying during youth and social anxiety symptoms. Further, an additional study demonstrated both significant positive correlations (i.e., self-blame, importance, and global) and non-significant correlations (other blame and controllability) between attributions for heterosexist discrimination and social anxiety in gay men (Burns et al., 2012a, 2012b).

Internalised Homonegativity. Ten studies provided bivariate correlations between social anxiety and internalised homonegativity among sexual minority individuals. Nine of these studies reported significant positive associations, such that greater levels of internalised homonegativity were associated with increased social anxiety (Burns et al., 2012a, 2012b; Dyar et al., 2016; Feinstein et al., 2012; Hart et al., 2015, 2019; Lingardi et al., 2012; Mason & Lewis, 2016; Meidlinger & Hope, 2014; Puckett et al., 2015). The remaining longitudinal study found no cross-wave association between social anxiety and internalised

homonegativity among sexual minority men (Pachankis, Sullivan, Feinstein, & Newcomb, 2018).

Sexual Identity Concealment. Seven studies provided bivariate correlations between social anxiety and sexual identity concealment among sexual minority men and women. Six of these studies found that higher levels of sexual identity concealment were significantly related to increased social anxiety (Dyar et al., 2016; Mason et al., 2017; Mason & Lewis, 2016; Meidlinger & Hope, 2014; Pachankis, Sullivan, Feinstein, & Newcomb, 2018; Pachankis & Goldfried, 2006; Puckett et al., 2016), while the remaining study demonstrated a non-significant correlation (Schmitt & Kurdek, 1987). Further, Schope (2004) found that gay men who concealed their sexual identity from parents, siblings, colleagues, past colleagues, past classmates, and neighbours reported higher social anxiety than their counterparts who were not concealed to these groups. However, no significant social anxiety differences were reported between gay men who concealed their sexual identity from friends and those who were not concealed to friends (Schope, 2004).

Sexual Orientation Related Rejection Sensitivity. Seven studies provided bivariate correlations between social anxiety and rejection sensitivity among sexual minority women and men, all of which demonstrated significant positive correlations such that heightened sexual orientation related rejection sensitivity was related to increased social anxiety (Cohen, Feinstein, et al., 2016; Dyar et al., 2016; Feinstein et al., 2012; Meidlinger & Hope, 2014; Pachankis et al., 2008; Pachankis, Sullivan, Feinstein, & Newcomb, 2018; Puckett et al., 2016).

Sexual Identity Development. Dyar et al. (2016) and Mason and Lewis (2016) reported significant positive correlations between both acceptance concerns and difficulties processing sexual identity, and social anxiety among sexual minority women. Additionally, Dyar et al. (2016) also found that salience and centrality of sexual orientation were significantly positively associated with social anxiety among sexual minority women. For gay men, identity acceptance (i.e., stage four of sexual identity formation theory: increased contact with other gay individuals, but averseness to disclose one's sexual orientation to heterosexuals; Cass, 1979) demonstrated a significant positive association with social anxiety, whereas identity synthesis (i.e., stage six of sexual identity formation theory: individual fully integrates into gay and straight cultures and perceives their sexual orientation to be just one facet of their identity; Cass, 1979) was significantly negatively correlated with social anxiety (Burns et al., 2012b). Two studies found significant inverse

relationships between comfort being gay and social anxiety in gay men such that increased comfort was related to less social anxiety (Pachankis & Goldfried, 2006; Schmitt & Kurdek, 1987). Lastly, Akibar et al. (2019) found no significant correlation between years since coming out and social anxiety.

2.5.3.2 General Psychological Processes (Social)

Social Support. Six studies provided bivariate correlations between social anxiety and social support among sexual minority women and men. Five of these studies showed significant negative relationships such that increased social support was linked to less social anxiety (Burns et al., 2012a; Hart et al., 2015; Mason et al., 2017; Meidlinger & Hope, 2014; Potoczniak et al., 2007). The remaining study demonstrated both a significant positive association (i.e., with the SPS) and a significant negative association (i.e., with the SIAS) between social anxiety and social support among sexual minority men (Hart & Heimberg, 2005). Hart et al. (2019) reported a significant positive correlation between social anxiety and loneliness in sexual minority men. Lastly, sexual minority individuals at higher risk of social isolation had a higher 12-month prevalence of SAD than those at lower risk (14.5% vs 3.9%; $OR = 4.2 [1.9, 9.15]$; Hatzenbuehler et al., 2011).

Romantic Relationships. Kurdek (1996) demonstrated non-significant correlations between social anxiety and romantic relationship processes (i.e., dissolution, involvement, and changes in positivity and autonomy) among gay and lesbian couples. Further, Schmitt and Kurdek (1987) reported non-significant correlations between social anxiety and relationship involvement (i.e., months in relationships and living with a partner) among gay men.

Parental Relationships. Pachankis, Sullivan, and Moore (2018) reported non-significant correlations between social anxiety and parental rejection, and also found that higher parental unfinished business was significantly related to higher social anxiety among sexual minority men.

Friendship Networks. Baiocco et al. (2014) demonstrated that sexual minority young adults with heterosexual best friends ($M = 3.82, SD = 2.89$) reported significantly lower social anxiety than those with sexual minority best friends ($M = 4.48, SD = 2.66$), $F(1, 296) = 5.58, p < .05$. Further, those with opposite-gender best friends ($M = 3.31, SD = 2.36$) reported significantly lower social anxiety than those with same-gender best friends ($M = 4.71, SD = 2.92$), $F(1, 296) = 19.61, p < .001$ (Baiocco et al., 2014).

2.5.3.3 General Psychological Processes (Cognitive)

General Cognitive Processes. Three studies provided bivariate correlations between social anxiety and general cognitive processes. Among sexual minority individuals, studies found significant relationships between increased self-criticism (Puckett et al., 2015) and dealing with threat through intellectualisation, obsession, and rumination (Schmitt & Kurdek, 1984) and heightened social anxiety. Dyar et al. (2016) reported a significant positive correlation between social anxiety and personal rejection sensitivity (i.e., not attributable to sexual identity) among sexual minority women. Additionally, Schmitt and Kurdek (1984) demonstrated significant inverse relationships between positive self-concept and an internal locus of control, and social anxiety.

2.5.3.4 Internalising Mental Health Symptoms

Generalised Anxiety. Six studies provided bivariate correlations between generalised anxiety symptoms and social anxiety among sexual minority women and men, all of which found that higher generalised anxiety symptoms was significantly linked to heightened social anxiety (Burns et al., 2012a; Cohen, Feinstein, et al., 2016; Dyar et al., 2016; Hart et al., 2015, 2019; Schmitt & Kurdek, 1984).

Depression. Eleven studies provided bivariate correlations between depression and social anxiety, ten of which illustrated that increased depression was significantly related to heightened social anxiety among sexual minority individuals (Blashill, 2010; Blashill & Vander Wal, 2009; Burns et al., 2012a; Cohen, Feinstein, et al., 2016; Dyar et al., 2016; Feinstein et al., 2012; Fletcher et al., 2018; Hart et al., 2015, 2019; Pachankis, Sullivan, Feinstein, & Newcomb, 2018; Puckett et al., 2015). By contrast, the remaining study reported a non-significant correlation between the two constructs (Schmitt & Kurdek, 1984).

Eating Disorder Symptomatology. Three studies provided bivariate correlations between eating disorder symptomatology and social anxiety among sexual minority women and men, all of which indicated that increased eating disorder symptoms were significantly associated with heightened social anxiety (Blashill, 2010; Blashill & Vander Wal, 2009; Hart et al., 2015; Mason et al., 2017; Mason & Lewis, 2016).

Other Internalising Mental Health Symptoms. Studies found that social anxiety was significantly positively related to negative affect (Mason et al., 2017; Meidlinger & Hope, 2014), psychological distress (Puckett et al., 2015), panic, posttraumatic stress (Cohen, Feinstein, et al., 2016), suicide risk and obsessive-compulsive disorder symptomatology

(Fletcher et al., 2018). Two studies demonstrated significant negative correlations between positive affect and social anxiety, such that increased positive affect was associated with less social anxiety (Burns et al., 2012a; Meidlinger & Hope, 2014). Pachankis and Goldfried (2006) found a significant inverse relationship between social anxiety and self-esteem in gay men. For sexual minority men, attachment anxiety was associated with greater social anxiety ($b = 5.02, p < .001$; Pachankis, Sullivan, & Moore, 2018), and those screening for PTSD were more likely to have SAD than their non-symptomatic counterparts (67% vs 41%; $OR = 2.98, p < .001$; Reisner et al., 2009)

2.5.3.5 Externalising Mental Health Symptoms

Antisocial Personality Disorder. In sexual minority men, Fletcher et al. (2018) found a significant positive correlation between social anxiety and antisocial personality disorder symptomatology.

Substance Abuse. Pachankis, Sullivan, and Moore (2018) found no significant association between social anxiety and alcohol abuse among sexual minority men. Another study found that there was a higher prevalence of SAD in methamphetamine dependent MSM dependent on two or more substances other than methamphetamine (42.9%), compared to MSM dependent on one other substance (28.6%) and on methamphetamine only (15.9%). Finally, among methamphetamine using MSM, Fletcher et al. (2018) demonstrated a significant association between SAD and severity of methamphetamine use disorder ($\chi^2 = 8.4, p < .05$), marijuana use disorder ($\chi^2 = 20.0, p \leq .001$), and alcohol use disorder ($\chi^2 = 15.6, p < .01$). By contrast, no significant association between SAD diagnosis and severity of cocaine use disorder ($\chi^2 = 3.9, p = .31$) and inhalants use disorder ($\chi^2 = 6.4, p = .09$) was found within this group (Fletcher et al., 2018).

2.5.3.6 Body Image and Related Variables

Body Image. Two studies demonstrated significant positive correlations between variables associated with body dissatisfaction and social anxiety in sexual minority men (Blashill, 2010; Blashill & Vander Wal, 2009; Hart et al., 2015), whereas Mason and Lewis (2016) reported that higher body shame was significantly related to increased social anxiety in lesbian women.

Body Weight Calculations. Among sexual minority women, one study reported no significant correlation between BMI and social anxiety, while there was a significant

relationship between increased ideal weight discrepancy and social anxiety (Mason et al., 2017; Mason & Lewis, 2016).

2.5.3.7 Gender Roles

Gender Nonconformity. Feinstein et al. (2012) demonstrated a significant positive correlation between childhood gender nonconformity and social among gay men and lesbian women, while Pachankis and Goldfried (2006) reported one significant positive correlation (i.e., with the IA) and multiple non-significant (i.e., with the SIAS, SPS, and FNE) correlations between childhood gender nonconformity and social anxiety in gay men (Pachankis & Goldfried, 2006). Heightened current gender nonconformity was significantly positively correlated with social anxiety in two studies (Puckett et al., 2016; Rubio & Green, 2009). Additionally, increased frequency of childhood teasing related to gender nonconformity was significantly positively related to social anxiety among sexual minority men (Hart et al., 2019).

Gender Rejection Sensitivity and Gender Role Conflict. Gender related rejection sensitivity was significantly positively correlated with social anxiety among sexual minority women (Dyar et al., 2016), whereas increased gender role conflict was significantly positively correlated with social anxiety among gay men (Blashill & Vander Wal, 2009, 2010).

2.5.3.8 Sexual Practices

Condomless Anal Sex and Sexually Transmitted Infections. Hart and Heimberg (2005) reported significant positive correlations between social anxiety (i.e., with the SPS) and increased frequency of any condomless anal sex (i.e., insertive or receptive) and condomless insertive anal sex among sexual sexual minority men. However, this study also reported non-significant correlations between social anxiety and increased frequency of any condomless anal sex (i.e., with the SIAS), condomless insertive anal sex (i.e., with the SIAS), condomless receptive anal sex (i.e., with the SPS and SIAS), and any anal sex with or without a condom (i.e., with the SPS and SIAS). Among HIV-positive MSM, Hart, James, et al. (2008) found significant associations between condomless insertive anal sex with HIV-negative partners and social anxiety: SPS ($\chi^2 = 11.71$, $OR = 15.40$ [1.89, 125.77], $p = 0.01$), LSAS performance ($\chi^2 = 8.13$, $OR = 7.41$ [1.51, 36.34], $p = 0.01$), LSAS interaction ($\chi^2 = 5.53$, $OR = 4.71$ [1.17, 18.93], $p < 0.05$). In methamphetamine dependent MSM, Shoptaw et al. (2003) reported that those with SAD were significantly more likely to report lifetime syphilis than their counterparts without SAD (57.1% vs 18.9%, $\chi^2 = 5.96$, $p < .05$), no such

differences were evident for HIV (85.7% vs 62.2%), chlamydia (14.3% vs 17.4%), genital gonorrhoea (42.9% vs 44.8%) and oral gonorrhoea (14.3% vs 10.3%). Further, compared to their counterparts without SAD, MSM with SAD reported a higher frequency of sexual partners in the last six months ($M_{SAD} = 84.7$, $SD = 117.1$; $M_{withoutSAD} = 43.2$, $SD = 77.7$), lower number of sexual partners in the last 30 days ($M_{SAD} = 5.1$, $SD = 4.0$; $M_{withoutSAD} = 10.4$, $SD = 21.9$), fewer instances of condomless insertive anal sex in the last 30 days ($M_{SAD} = 1.1$, $SD = 1.9$; $M_{withoutSAD} = 2.3$, $SD = 4.8$) and fewer instances of condomless receptive anal sex in the last 30 days ($M_{SAD} = 2.0$, $SD = 3.0$; $M_{withoutSAD} = 2.8$, $SD = 6.3$).

Other Sexual Practices. Experiences of sexual objectification, but not pornography consumption, were significantly positively correlated with social anxiety among sexual minority men (Hart et al., 2015). Also, Mimiaga et al. (2009) reported that, in comparison to their counterparts without SAD, MSM screening for symptoms of SAD were more willing to use public health services that notify their previous sexual partners should they contract HIV or a STI ($OR = 2.63$, $p < .01$).

2.5.3.9 Sociodemographics

Age. Nine studies included bivariate associations between social anxiety and age. Five of these studies provided bivariate correlations between age and social anxiety among gay men and lesbian women, all of which reported a significant relationship between younger age and heightened social anxiety (Blashill & Vander Wal, 2009; Burns et al., 2012a; Mason et al., 2017; Schmitt & Kurdek, 1984; Schope, 2005). Meyer, Dietrich, et al. (2008) found that sexual minority individuals aged 45-59 years (17.8%, $SE = 5.8$) reported lower lifetime SAD prevalence when compared to those aged 30-44 years (23.4%, $SE = 3.2$) and those aged 18-29 years (22.1%, $SE = 3.2$); however, related statistical analyses comparing SAD across age groups were omitted. O’Cleirgh et al. (2013) reported no significant difference in SAD prevalence between younger (aged 20-29) and older (aged 30+) MSM (33.3% vs 22.1%, $p = .12$), whereas J. Wang et al. (2007) demonstrated most cases of SAD had an onset in childhood and adolescence in sexual minority men (25th percentile = 10 years, $Mdn = 12$ years, 75th percentile = 17 years). Lastly, in a longitudinal study with sexual minority men, there was a significant linear increase over time in social anxiety; that is, social anxiety levels increased as participants got older ($b = 0.77$, $p < .001$; Pachankis, Sullivan, Feinstein, & Newcomb, 2018).

Ethnicity. Five studies, reporting mixed evidence, provided bivariate associations between ethnicity and social anxiety. Balsam et al. (2015) reported no significant difference in social

anxiety across race/ethnicity groups in sexual minority women: African American ($M = 14.28$, $SD = 17.81$), Latina American ($M = 15.06$, $SD = 17.00$), Asian American ($M = 17.75$, $SD = 15.09$), White American ($M = 18.48$, $SD = 17.12$), $F(3, 920) = 2.52$, $p = .06$. O’Cleirigh et al. (2013) also found the proportion of HIV-positive MSM meeting the screening criteria for SAD did not differ significantly by ethnicity, $\chi^2(3) = 4.13$, $p = .25$. In a nationally representative sample, Rodriguez-Seijas et al., (2019) found that White sexual minority individuals (10.76%, $SE = 1.51$) reported significantly higher SAD compared to their Black (2.49%, $SE = 1.66$; $p < .05$) but not Hispanic (6.16%, $SE = 2.07$) sexual minority counterparts. Contrastingly, in another study, Latinx sexual minority individuals (27.3%, $SE = 4.0$) reported higher lifetime prevalence of SAD than their White (20.5%, $SE = 3.5$) and Black (18.8%, $SE = 3.5$) counterparts (Meyer, Dietrich, et al., 2008); however, related statistical analyses comparing SAD across racial groups were omitted. Finally, Cathey et al. (2014) demonstrated that dual minority (i.e., ethnic and sexual minority) individuals ($M = 26.8$, $SD = 10.6$) reported the highest social anxiety followed by ethnic majority/sexual minority ($M = 24.1$, $SD = 11.7$), dual majority (i.e., ethnic and sexual majority; $M = 21.8$, $SD = 10.7$), and ethnic minority/sexual majority ($M = 17.1$, $SD = 9.4$).

Income. Sexual minority individuals at higher risk of economic adversity had a higher 12-month prevalence of SAD than those at lower risk (10.1% vs 4.6%; $OR = 2.4$ [1.1, 5.0]; Hatzenbuehler et al., 2011), while another study found that MSM with high social anxiety: LSAS interaction ($OR = 3.23$ [1.29, 8.11], $p < 0.05$), LSAS performance ($OR = 4.90$ [1.90–12.64], $p < 0.01$), were more likely to have an income less than \$10,000 per year (Hart, James, et al., 2008). Sexual minority men from higher, compared to lower, socioeconomic backgrounds did not report significantly different social anxiety in a longitudinal study ($b = -5.00$, $p = .07$; Pachankis, Sullivan, Feinstein, et al., 2018).

Education. Two studies found significant inverse relationships between education and social anxiety, such that higher educational attainment was related to lower social anxiety (Burns et al., 2012a; Mason et al., 2017).

Gender. Schope (2005) highlighted significantly higher social anxiety related to interactions with same-gender sexual minority peers in gay men ($M = 34.0$, $SD = 9.6$) compared to lesbian women ($M = 28.9$, $SD = 9.3$), $p < .001$. Three studies reported no significant difference in social anxiety levels between lesbian women and gay men, although the related data was not included (Feinstein et al., 2012; Potoczniak et al., 2007; Wadsworth & Hayes-Skelton, 2015)

2.5.3.10 Discrimination (Not Solely Based on Sexual Orientation)

Other Discrimination. Four studies reported bivariate correlations between social anxiety and experiences of discrimination not based solely on sexual minority status. These studies reported significant positive correlations between heightened social anxiety and everyday discrimination among lesbian women (Mason & Lewis, 2016), weight discrimination among lesbian women (Mason et al., 2017), heterosexist and ethnic (combined measure) discrimination among sexual minority individuals (Cathey et al., 2014), experiences of racism among sexual minority men of colour (Hart et al., 2015), and childhood bullying among sexual minority men (Hart et al., 2019).

2.5.3.11 Other Variables (Not Thematically Grouped)

Among sexual minority individuals, Puckett et al. (2015) demonstrated that increased LGBTQ community connectedness was significantly associated with less social anxiety. Meidlinger and Hope (2014) also found that higher quality of life was significantly associated with reduced social anxiety. Additionally, neuroticism was positively correlated with social anxiety in gay and lesbian couples (Kurdek, 1996). Finally, Potoczniak et al. (2007) demonstrated that social anxiety was significantly positively correlated with general self-concealment, significantly negatively correlated with ego identity commitment, and not significantly correlated with ego identity exploration among sexual minority men and women.

2.5.4 Multivariate Associations Pertaining to Social Anxiety Among Sexual Minority Individuals

The significant multivariate associations between social anxiety and variables assessed in 13 included studies are summarised and thematised in Table 2.7. In samples consisting of sexual minority men, significant multivariate associations with social anxiety were revealed pertaining to sexual minority stress processes (Burns et al., 2012b; Cohen, Feinstein, et al., 2016; Hart et al., 2015; Pachankis, Sullivan, Feinstein, & Newcomb, 2018), other internalising mental health symptoms (Blashill & Vander Wal, 2009, 2010; Cohen, Feinstein, et al., 2016; Hart et al., 2015), body image and related variables (Blashill, 2010; Blashill & Vander Wal, 2009; Hart et al., 2015), gender roles (Blashill & Vander Wal, 2009, 2010), sexual practices (Hart et al., 2015; Hart & Heimberg, 2005), general social psychological processes (Hart et al., 2015; Pachankis, Sullivan, & Moore, 2018), and other discrimination (Hart et al., 2015). One study focusing solely on sexual minority women demonstrated significant multivariate associations with sexual minority stress processes (Mason et al., 2017; Mason & Lewis, 2016), other internalising mental health symptoms

(Mason et al., 2017; Mason & Lewis, 2016, 2019), other discrimination (Mason et al., 2017; Mason & Lewis, 2016), general social psychological processes (Mason et al., 2017), body image and related variables (Mason & Lewis, 2016), externalising mental health symptoms, and physical activity (Mason et al., 2017). In samples of consisting of both sexual minority men and women, significant multivariate associations pertaining to social anxiety were evident with sexual minority stress processes (Cohen, Blasey, et al., 2016; Feinstein et al., 2012; Hatzenbuehler et al., 2011; Puckett et al., 2016), gender roles (Feinstein et al., 2012; Puckett et al., 2016), sociodemographics (Cohen, Blasey, et al., 2016; Puckett et al., 2016), general social psychological process (Hatzenbuehler et al., 2011; Potoczniak et al., 2007), internalising mental health symptoms (Feinstein et al., 2012), and other variables (Potoczniak et al., 2007).

Table 2.7*Multivariate Associations Pertaining to Social Anxiety*

Study	Themes	Findings
Blashill (2010)	Body image and related variables	<ul style="list-style-type: none"> • The final hierarchical regression model explained 25% of the variance in social anxiety among gay men. <ul style="list-style-type: none"> ○ Significant predictors: Step 1 muscle dissatisfaction; Step 2 body fat dissatisfaction ○ Non-significant predictors: Step 3 height dissatisfaction.
Blashill & Vander Wal (2009)	Body image and related variables; Gender roles; Internalising mental health symptoms	<ul style="list-style-type: none"> • In mediation models assessing social anxiety and depression as mediators of the association between gender role conflict and eating disorder symptomatology, social anxiety mediated the association between gender role conflict and eating disorder symptomatology. • In mediation models assessing social anxiety and depression as mediators of the association between gender role conflict and body dissatisfaction, social anxiety mediated the association between gender role conflict and body dissatisfaction.
Blashill & Vander Wal (2010)	Gender roles; Internalising mental health symptoms	<ul style="list-style-type: none"> • Gender role conflict mediated the association between social anxiety and depression among gay men.
Burns et al. (2012b)	Sexual minority stress processes	<ul style="list-style-type: none"> • The final hierarchical regression model explained 24% of the variance in social anxiety among gay men. <ul style="list-style-type: none"> ○ Significant predictors: Step 1 internalised homonegativity; Step 2 globality/importance attributed to discrimination; Step 3 heterosexist discrimination x globality/importance attributed to discrimination. ○ Non-significant predictors: Step 1 heterosexist discrimination, increased contact with other gay men but reluctance to disclose identity to heterosexuals, and full integration into gay and straight culture; Step 2 blame orientation, internal/external-circumstances attributions, and controllable attributions.
Cohen, Blasey, et al. (2016)	Sexual minority stress processes; Sociodemographics	<ul style="list-style-type: none"> • The final hierarchical regression model explained 8.1% of the variance in social anxiety among sexual minority young adults. <ul style="list-style-type: none"> ○ Significant predictors: Step 1 gender (i.e., identifying as a woman); Step 2 sexual identity concealment.
Cohen, Feinstein, et al. (2016)	Sexual minority stress processes; Internalising mental health symptoms	<ul style="list-style-type: none"> • A structural equation modelling analysis revealed a significant direct effect of rejection sensitivity on social anxiety among sexual minority men when a latent transdiagnostic internalising factor was not included in the model; this direct effect became nonsignificant when the transdiagnostic internalising factor was held constant in the model, indicating the transdiagnostic internalising factor mediated the association between rejection sensitivity and social anxiety; 61.2% of the association between rejection sensitivity and social anxiety was explained by the association between rejection sensitivity and the transdiagnostic internalising factor.

Table 2.7*Multivariate Associations Pertaining to Social Anxiety*

Study	Themes	Findings
Feinstein et al. (2012)	Sexual minority stress processes; Gender roles; Internalising mental health symptoms	<ul style="list-style-type: none"> • A path analysis model assessing internalised homonegativity and rejection sensitivity as partial mediators of the association between heterosexist discrimination (preceded by the exogenous variable of childhood gender non-conformity) and internalising mental health symptoms (i.e., social anxiety and depression as separate outcome variables), explained 11% of variance in social anxiety among gay men and lesbian women. <ul style="list-style-type: none"> ○ Significant direct effects: internalised homonegativity → increased social anxiety; rejection sensitivity → increased social anxiety. ○ Significant indirect effects (controlling for depression): heterosexist discrimination → increased internalised homonegativity → increased social anxiety; heterosexist discrimination → increased rejection sensitivity → increased social anxiety.
Hart & Heimberg (2005)	Sexual practices	<ul style="list-style-type: none"> • After controlling for sociodemographic covariates, the final hierarchical logistic regression model assessing predictors of condomless insertive anal sex among young sexual minority men revealed: <ul style="list-style-type: none"> ○ Significant predictors: Step 2 measure social anxiety (i.e., SPS) ○ Non-significant predictors: Step 1 measures discussing condom use, refusing condomless intercourse, number of social supports and social support satisfaction.
Hart et al. (2015)	Body image and related variables; Internalising mental health symptoms; General psychological processes (Social); Other discrimination	<ul style="list-style-type: none"> • The final hierarchical regression model explained 46% of the variance in social appearance anxiety among sexual minority men. <ul style="list-style-type: none"> ○ Significant predictors: Step 2 generalised anxiety, muscle dissatisfaction, body fat dissatisfaction, and height dissatisfaction; Step 3 experiences of racism and less social support ○ Non-significant predictors: Step 1 age, ethnicity, household income; Step 2 social desirability; Step 3 internalised homonegativity, sexual objectification, and eating disorder symptoms.
Hatzenbuehler et al. (2011)	Sexual minority stress processes; Sociodemographics; General psychological processes (Social)	<ul style="list-style-type: none"> • When adjusted for protective state policies toward sexual minority individuals, state-level attitudes toward sexual minority individuals, and sociodemographic variables, economic adversity and social isolation were positively associated with SAD, whereas state-level concentration of same-sex couples was not associated with SAD. • After stratifying on state-level concentration of same-sex couples, economic adversity was not associated with SAD among sexual minority individuals living in states with a low concentration of same-sex couples and those living in states with a high concentration of same-sex couples, whereas social isolation was significantly associated with SAD for sexual minority individuals living in states with low concentration of same-sex couples but not for those living in states with a high concentration of same-sex couples.

Table 2.7*Multivariate Associations Pertaining to Social Anxiety*

Study	Themes	Findings
Mason & Lewis (2016)	Sexual minority stress processes; Body image and related variables; Internalising mental health symptoms; Other discrimination	<ul style="list-style-type: none"> • A structural equation modelling analysis assessing social anxiety and body shame as sequential mediators of the association between discrimination and proximal minority stress (i.e., composite variable consisting of internalised homonegativity, concealment motivation, acceptance concerns, and difficulty processing sexual identity) and binge eating, explained 31% of the variance in social anxiety among young lesbian women. <ul style="list-style-type: none"> ○ Significant direct effects: discrimination → increased social anxiety; proximal minority stress → increased social anxiety; social anxiety → increased body shame; social anxiety → increased binge eating. ○ Significant indirect effects: discrimination → increased proximal minority stress → increased social anxiety → increased body shame → increased binge eating; discrimination → increased proximal minority stress → increased social anxiety → increased binge eating; discrimination → increased social anxiety → increased binge eating.
Mason et al. (2017)	Sexual minority stress processes; Other discrimination; General psychological processes (Social); Internalising mental health symptoms	<ul style="list-style-type: none"> • A structural equation modelling analysis assessing social support, weight discrepancy, social anxiety and negative affect as sequential mediators of the association between discrimination (i.e., due to weight and sexual minority status) and disordered eating, explained 16% of the variance in social anxiety among young lesbian women and revealed: <ul style="list-style-type: none"> ○ Significant direct effects: weight discrimination → increased social anxiety; family social support → decreased social anxiety; friend social support → decreased social anxiety; social anxiety → increased eating disorder symptoms. ○ Significant indirect effects: heterosexist discrimination → decreased family social support → increased social anxiety → increased eating disorder symptoms; weight discrimination → decreased friend social support → increased social anxiety → increased eating disorder symptoms; weight discrimination → increased social anxiety → increased eating disorder symptoms.
Mason & Lewis (2019)	Internalising mental health symptoms; Externalising mental health symptoms; Physical activity	<ul style="list-style-type: none"> • Latent profile analysis revealed that lesbian women in the obese and binge eating, disordered eating and hazardous alcohol use, and disordered eating and high exercise classes reported higher social anxiety than those in the low health risk and moderate exercise, and low health risk and high exercise classes.
O'Cleirigh et al. (2013)		<ul style="list-style-type: none"> • After controlling for viral load, CD4+ count and current or past anti-retroviral therapy, logistic regression models demonstrated no main effect of SAD on condomless anal sex and the interaction of age and SAD did not significantly predict condomless anal sex.

Table 2.7*Multivariate Associations Pertaining to Social Anxiety*

Study	Themes	Findings
Pachankis, Sullivan, Feinstein, & Newcomb, (2018)	Sexual minority stress processes; Sociodemographics	<ul style="list-style-type: none"> • After adjusting for socioeconomic status, a model assessing the contemporaneous associations of social anxiety with minority stress demonstrated that heterosexist discrimination, rejection sensitivity, and internalised homonegativity were significant contemporate correlates of social anxiety, whereas sexual identity concealment was not. • After adjusting for socioeconomic status, a model assessing the 1-year lagged associations of social anxiety with minority stress, demonstrated that heterosexist discrimination, rejection sensitivity, internalised homonegativity, and identity concealment were not significant predictors of social anxiety.
Pachankis, Sullivan, & Moore (2018)	General psychological processes (Social)	<ul style="list-style-type: none"> • In hierarchical linear regression models, maternal rejection explained 1.1% of variance in social anxiety, whereas the addition of maternal unfinished business explained 11.6% of social anxiety variance; further, paternal rejection explained 1.2% of variance in social anxiety, whereas the addition of paternal unfinished business explained 11.0% of social anxiety variance.
Potoczniak et al. (2007); USA	General psychological processes (Social); Other variables	<ul style="list-style-type: none"> • A structural equation modelling analysis assessing social support and self-concealment as partial mediators of the association between social anxiety and ego identity (commitment and exploration) revealed: <ul style="list-style-type: none"> ○ Significant direct effects: social anxiety → decreased social support; social anxiety → increased self-concealment. ○ Significant indirect effects: social anxiety → decreased social support → decreased ego identity commitment; social anxiety → decreased social support → decreased ego identity exploration; social anxiety → decreased social support → increased self-concealment.
Puckett et al. (2016)	Sexual minority stress processes; Gender roles; Sociodemographics	<ul style="list-style-type: none"> • After controlling for age, gender, and sexual orientation, mediation analysis assessing heterosexist discrimination, rejection sensitivity, concealment and internalised homonegativity as partial mediators of the association between gender nonconformity and social anxiety explained 20% of the variance in social anxiety. <ul style="list-style-type: none"> ○ Significant direct effects: gender nonconformity → increased social anxiety; rejection sensitivity → increased social anxiety; sexual identity concealment → increased social anxiety; internalised homonegativity → increased social anxiety; older age → decreased social anxiety. ○ Significant indirect effects: gender nonconformity → increased rejection sensitivity → increased social anxiety.

Note. The Themes column solely details to significant multivariate associations pertaining to social anxiety. SAD = social anxiety disorder; SPS = Social Phobia Scale.

2.5.5 Psychological Interventions Targeting Social Anxiety Among Sexual Minority Individuals

Three studies detailed psychological interventions aimed at reducing social anxiety among sexual minority individuals (Hart et al., 2014; Reisner et al., 2011; Walsh & Hope, 2010). Reisner et al. (2011) detailed a peer facilitator manualised group intervention, consisting of didactic discussions and social meals, that significantly reduced SIAS ($M = 30.83$, $SD = 13.31$ vs $M = 28.20$, $SD = 13.16$), $\chi^2 = 6.78$, $p < .01$ and BFNE scores ($M = 38.43$, $SD = 10.23$ vs $M = 35.65$, $SD = 9.28$), $\chi^2 = 10.01$, $p < .01$, from baseline to post-intervention in a group of gay and bisexual men over the age of 40. The remaining two studies used case study designs, and detailed individual CBT with sexual minority clients. Over the course of 50 LGB affirmative CBT sessions, Walsh and Hope (2010) demonstrated a significant reduction in scores on the BFNE (from 55, z [in comparison to socially anxious samples] = 0.76 to 31, $z = -1.71$) in a 23-year-old man coming to terms with being gay. Through the use of integrated CBT (i.e., tackling both social anxiety and condomless sex), Hart et al., (2014) showed reductions in pre-treatment vs 3-month follow-up LSAS scores in three gay men (i.e., Client 1: 29 vs 0, Client 2: 78 vs 53, Client 3: 52 vs 45).

2.6 Discussion

This chapter systematically reviews the published literature pertaining to social anxiety among sexual minority populations. The preponderance of research has focused on men, is cross-sectional, and located in the United States. The search strategy did not retrieve any studies suitable for inclusion that used qualitative analyses. Sexual minority individuals appear to experience heightened levels of social anxiety compared to their heterosexual counterparts. The scant research available assessing levels of social anxiety across sexual minority sub-populations suggests bisexual individuals report higher social anxiety than their gay/lesbian counterparts. Across the included studies, social anxiety was significantly correlated with an array of variables, namely minority stress processes, general social psychological processes, and other internalising mental health symptoms. Fewer studies incorporate social anxiety into multivariate or longitudinal analyses, meaning that knowledge of its potential determinants and outcomes are constrained. Further, studies assessing the efficacy of psychological interventions targeting social anxiety among sexual minority populations are notably limited.

Across the included studies, there was an observable trend of sexual minority individuals reporting higher social anxiety (SAD and social anxiety symptoms) than their heterosexual

counterparts (e.g., Akibar et al., 2019; Cohen, Blasey, et al., 2016; Hatzenbuehler, Keyes, et al., 2009; Kerridge et al., 2017; Sandfort et al., 2014). Given the associations involving social anxiety and both increased minority stress processes (e.g., Feinstein et al., 2012) and diminished general psychological processes (e.g., Potoczniak et al., 2007) in sexual minority populations (see objective three findings), this sexual orientation disparity may offer support to the theoretical standpoints related to sexual minority stress (Hatzenbuehler, 2009; Meyer, 2003). There were some notable exceptions to this trend specific to sexual minority women. For instance, in nationally representative samples, the social anxiety disparity between lesbian and heterosexual women was narrow (Bostwick et al., 2010), and in some cases did not reach statistical significance (Kerridge et al., 2017). Further, in Bostwick et al.'s (2010) study, women only attracted to women were least at risk for lifetime SAD of any sexual attraction subgroup. This is incongruent to Sandfort et al.'s (2014) findings that sexual minority women attracted to women/women and men are at a greater risk for 12-month and lifetime SAD than women only attracted to men. Indeed, this exemplifies how the divergence in studies' assessment of sexual orientation may yield different findings pertinent to SAD prevalence. This is observed in this case of examining social anxiety in relation to sexual attraction: Bostwick et al.'s (2010) nuanced assessment using five categories vs Sandfort et al.'s (2014) limited assessment grouping all sexual minority together using two categories.

A similar pattern emerged in terms of SAD disparities across sexual behaviour subgroups. Studies that grouped all sexual minority participants together (i.e., on the basis of having had any same-gender sexual partners) reported elevated rates of SAD in this group compared to those with solely opposite-gender sexual partners (Gilman et al., 2001; Sandfort et al., 2001, 2014). Although in some instances, smaller numbers of sexual minority participants appeared to preclude significant findings. Contrastingly, Bostwick et al. (2010) used four categories to decipher between sexual behaviour subgroups and demonstrated similar SAD prevalence in MSM only and MSW only, lower SAD prevalence in WSW only than WSM only, and the highest SAD prevalence in behaviourally bisexual individuals (MSMW and WSMW) within both gender groups. However, these results must be interpreted with caution. As noted by previous research (Bauer & Brennan, 2013), the number of sexual partners required to categorise WSMW and MSMW (i.e., two, a man and a woman) as behaviourally bisexual compared to that for classifying WSW and MSM as behaviourally homosexual (i.e., one, an opposite-gender partner) might confound the association between gender of sexual partners and social anxiety.

The limited amount of research that assessed social anxiety differences within sexual minority populations found that bisexual, and in some cases emerging identity individuals, report higher social anxiety than their gay/lesbian counterparts (Akibar et al., 2019; Meyer, Dietrich, et al., 2008; Wadsworth & Hayes-Skelton, 2015). This finding coincides with a body of research that consistently illustrates that bisexual individuals are more at risk for negative mental health outcomes than their gay/lesbian counterparts (Feinstein & Dyar, 2017). Bisexual-specific minority stressors experienced by bisexual individuals such as experiences of discrimination due to bisexual identity and internalised binegativity might offer explanations for their elevated levels of social anxiety (Brewster et al., 2013; Brewster & Moradi, 2010; MacLeod et al., 2015). Indeed, bisexual individuals might experience specific processes such as negative stereotypes (Feinstein & Dyar, 2017) and bi-erasure at the within-community level through their interactions with gay/lesbian individuals (Heath & Mulligan, 2008), which could serve to increase their social anxiety levels.

As the objective three findings indicated, social anxiety is significantly associated with a vast array of variables among sexual minority individuals. The salience of minority stress processes is highlighted by their significant associations and complex interrelationships with social anxiety, as demonstrated in bivariate and multivariate analyses across included studies (e.g., Cohen, Blasey, et al., 2016; Mason & Lewis, 2016; Pachankis et al., 2018; Puckett et al., 2016). Further, in line with the psychological mediation framework (Hatzenbuehler, 2009), Feinstein et al. (2012) highlighted proximal minority stress processes as mediators of the association between heterosexist discrimination and social anxiety; however, other aspects of this theoretical position (i.e., universal risk factors/general psychological processes as mediators) remain relatively unexplored.

There is some tentative evidence that general psychological processes such as social support (Mason et al., 2017) and lack of self-criticism (Puckett et al., 2015), and community resilience processes such as connectedness to the LGBT community (Puckett et al., 2015) may encourage healthy social functioning in sexual minority individuals. Whether these variables or other coping mechanisms may protect sexual minority individuals from stigma related stress and subsequent social anxiety warrants further investigation. A more thorough examination of the potential role of general psychological processes and resilience variables (i.e., both individual- and community-level) would both add to the nascent body of research on protective factors for social anxiety among sexual minority populations, and answer recent calls to focus on resilience/strength-based variables in sexual minority individuals (de Lira & de Moraes, 2018; Lyons, 2015).

Multiple studies found significant associations between body dissatisfaction and social anxiety among sexual minority individuals (Blashill, 2010; Hart et al., 2015; Mason & Lewis, 2016). Preoccupation with physical appearance may stimulate cognitive processes related to self-focus that function as maintenance processes for social anxiety (Wong & Rapee, 2016). These experiences may be particularly pertinent within sexual minority communities as both sexual minority women's (Clarke & Spence, 2013; Krakauer & Rose, 2002) and men's (Pachankis, Clark, et al., 2020) communities are known to uphold ideals pertaining to appearance. While there is tentative evidence establishing a link between social anxiety and condomless anal sex in sexual minority men (Hart, James, et al., 2008; Hart & Heimberg, 2005), there are a plethora of other variables related to condomless anal sex and STI epidemiology within this population (e.g., Shuper et al., 2014; H. Wang et al., 2018). Therefore, the potential mechanisms behind this relationship (e.g., whether social anxiety may be associated with insertive and/or receptive condomless anal sex) require further extrapolation through the utilisation of more sophisticated analyses.

The findings pertaining to sociodemographics coincide with research conducted with large, presumably mixed sexual orientation samples, in that lower educational attainment and younger age are associated with heightened social anxiety (Stein et al., 2017). While some of the included studies portraying White sexual minority individuals as most at risk for SAD (e.g., Rodriguez-Seijas et al., 2019) coincides with social anxiety research in the general population (Asnaani et al., 2010; Grant et al., 2005), this evidence was mixed. The consistent associations between social anxiety and other internalising mental health symptoms (primarily generalised anxiety and depression) comes somewhat expected. These mental health difficulties are also elevated among sexual minority individuals, especially bisexual individuals, when compared to heterosexuals (Ross et al., 2018). Further, similar minority stress pathways are associated with all three internalising mental health symptoms (Cohen, Feinstein, et al., 2016; Puckett et al., 2015).

A comprehensive future investigation of social anxiety among sexual minority individuals should utilise both sexual minority- (Hatzenbuehler, 2009; Meyer, 2003) and social anxiety-specific theoretical frameworks (Wong & Rapee, 2016) to advance knowledge pertaining to the determinants and experience of social anxiety within this population. Such an approach could highlight the salient role of both sexual minority-specific (e.g., rejection sensitivity and sexual identity concealment) and general cognitive and behavioural processes (e.g., biased attentional processes and avoidance) in sexual minority individuals' experiences of social anxiety.

The knowledge base detailing interventions targeting social anxiety among sexual minority men is extremely limited, and this issue is exacerbated when focusing on sexual minority women. There is a discernible need to fill this empirical void among sexual minority women, and build upon the minimal evidence available for sexual minority men. Indeed, in line with a recent call to move empirical efforts toward evidence-based affirmative treatments among sexual minority individuals (Budge et al., 2017; Pachankis, 2018), conducting studies (i.e., ideally randomised controlled trials) testing the efficacy of LGB-affirmative CBT in reducing social anxiety symptoms may represent a beneficial starting point as this approach showed favourable results in tackling other mental health difficulties in sexual minority men and women (Pachankis, Hatzenbuehler, et al., 2015; Pachankis, McConocha, et al., 2020).

2.6.1 Strengths and Limitations

The current review represents the most extensive effort to collate data pertaining to social anxiety among sexual orientation subgroups. Further, this chapter represents the first effort to synthesise all variables potentially associated with social anxiety among sexual minority individuals. This is not only beneficial in aiding theoretical progression related to this phenomenon, but also may function as a pragmatic resource for practitioners working with sexual minority clients diagnosed with SAD. Lastly, the review underscores clear deficiencies in the current knowledge base, even though this is a burgeoning area of research as evidenced by a majority of included studies published in the recent years.

Despite its contribution to the knowledge base, the current review carries some limitations. Only papers published in English were included; thus, there was a bias toward English speaking participants (i.e., namely those located in the United States), which might have impeded the detection of plausible cultural differences. This is important to acknowledge, as culture is an important aetiological factor of SAD (Wong & Rapee, 2016), and SAD prevalence varies greatly across countries (Stein et al., 2017), as do sexual minority individuals' experiences of minority stress (Pachankis & Bränström, 2018). Given the broad scope of objectives two and three, and the heterogeneity in assessments of sexual orientation and outcome measures, meta-analyses were not conducted. However, the current review's synthesising of available research evidence would benefit future meta-analyses in the area. Further, only studies published in peer-reviewed journals were included, meaning potentially relevant data from the grey literature has been omitted. The methodologies of included studies hinder the strength of the conclusions that can be drawn from this review. With the vast majority of studies employing cross-sectional designs, it is not feasible to ascertain

whether minority stressors and other relevant variables have a casual influence on social anxiety for sexual minority individuals.

2.7 Conclusion and Implications for Thesis

The findings presented above suggest that social anxiety levels are heightened in sexual minority populations compared to heterosexuals, perhaps even more so in those identifying as bisexual. Despite the large number of studies in this review, knowledge of the determinants and outcomes of social anxiety among sexual minority populations remains somewhat limited; this paucity of knowledge is amplified when focusing on sexual minority women. Further, qualitative investigations in this area are lacking. Rigorous studies examining interventions targeting social anxiety for this population are also largely absent. Future empirical explorations should also employ more diverse research methodologies. Subsequently, the enhanced knowledge base generated from these study findings may allow the testing of more nuanced interventions aiming to alleviate social anxiety among sexual minority populations.

It is proposed that the testing of an extensive model of the risks and protective factors of social anxiety, accounting for the above identified empirical voids is required. Such a model would explore the potential role of sexual minority-specific and general psychological processes as determinants of social anxiety among sexual minority individuals. The model should also account for the experiences of stressors at multiple community levels (i.e., within- and wider-) as risk factors, and aim to uncover protective factors (i.e., individual- and community-level) for social anxiety in this population. The first qualitative exploration of social anxiety among sexual minority individuals should utilise both sexual minority-specific and social anxiety-specific (thus far overlooked) theoretical positions in order to expansively explore the experience of this prominent mental health burden. The next chapter will illustrate in detail how the systematic review's findings influenced the development of the aims and objectives associated with this PhD thesis.

Chapter 3 Overview of the Current Study

3.1 Introduction

Firstly, this chapter demonstrates how the theoretical standpoints discussed in chapter one and the chapter two systematic review findings were combined in order to formulate the aim, objectives, and design associated with this study. This chapter also details the methodology used for this two-phased mixed methods study. A brief synopsis of mixed methods research is provided, including its nature, the paradigm of pragmatism which provides the philosophical foundation for mixed methods research study, and the associated advantages and disadvantages. Lastly, the specific design utilised for this study (i.e., sequential explanatory mixed methods design) is elucidated, and the justification of its utilisation in the context of this enquiry is provided.

3.2 Study Aim

According to the chapter two findings, all current studies published in this area are quantitative in nature. For this reason, there is some empirical evidence available pertaining to the quantitative differences in social anxiety across sexual minority subgroups and the determinants of social anxiety within this population. Yet, there are notable gaps in the quantitative evidence, and the testing of an extensive model (e.g., one that accounts for all of the principle components of sexual minority stress theories) is missing. By the contrary, the systematic review findings revealed that there are no qualitative studies published in this area. Therefore, data pertaining to the experience of social anxiety among sexual minority individuals is lacking.

With the above in mind, a sequential explanatory mixed methods design was deemed appropriate to use for the current investigation (see section 3.5 for greater detail pertaining to study design). The phase one quantitative study intends to build on existing quantitative evidence in order to specify sexual minority subgroups that may be most at risk for elevated social anxiety symptoms and elucidate the risk and protective factors associated with social anxiety. Phase two, which represents the first qualitative exploration of this topic, expounds on phase findings and illuminates the experience of social anxiety within this population.

The overarching aim of this mixed methods study is to elucidate the determinants of, and explore the experience of, social anxiety among sexual minority individuals.

3.2.1 Phase One Aim

The phase one quantitative study aims to specify sexual minority subgroups that may be most at risk for elevated social anxiety symptoms and elucidate the risk and protective factors associated with social anxiety among sexual minority individuals.

3.2.2 Phase Two Aim

Through conducting interviews, the overarching aim of phase two was to explore the experience of social anxiety among sexual minority individuals who believe social anxiety is a personal issue in their lives.

3.3 Study Objectives

This section will outline the objectives associated with the phase one study and, where appropriate, the relevant background information (i.e., systematic review findings and theoretical positions). The hypotheses related to the phase one objectives are communicated in chapter four section 4.3.3. The processes from which the phase two objectives will be developed are also outlined.

3.3.1 Phase One Objectives

1. To examine social anxiety across sexual minority subgroups (i.e., firstly by gender, then by sexual identity, sexual attraction, and sexual behaviour).

As exemplified in chapter two section 2.5.2, certain subgroups within the sexual minority community may be particularly at risk for elevated social anxiety symptoms. There is some evidence that bisexual and emerging identity individuals may be at a heightened risk for social anxiety compared to gay/lesbian individuals (e.g., Bostwick et al., 2010; Wadsworth & Hayes-Skelton, 2015). Tentative evidence also portrays sexual minority individuals with same-gender partners only as less at risk for elevated social anxiety symptoms when compared to their sexual minority counterparts with opposite-gender partners and those who didn't have sex (Akibar et al., 2019; Bostwick et al., 2010). Further, tentative evidence signifies that women who are only attracted to women are less at risk than their sexual minority peers who are attracted to men, whereas the association between sexual attraction and social anxiety among sexual minority men is less clear (Bostwick et al., 2010).

While the systematic review findings advanced knowledge pertaining to social anxiety differences across sexual minority subgroups, there are some notable limitations in the current evidence base. The few studies that compared social anxiety across sexual minority

subgroups predominantly included large proportions of heterosexual individuals (e.g., Akibar et al., 2019; Bostwick et al., 2010; Kerridge et al., 2017), which may preclude the detection of differences between sexual minority subgroups. Further, some studies that assessed social anxiety symptoms across a diverse array of sexual orientation subgroups within the sexual minority community did not provide distinct analyses for sexual minority women and men (e.g., Akibar et al., 2019). A contemporary review signified that women report higher social anxiety symptoms than men in the general population (Asher et al., 2017). Additionally, a large epidemiological study spanning 13 global regions indicated elevated rates of SAD in women compared to men (Stein et al., 2017). Indeed, tentative evidence demonstrates this gender disparity in sexual minority samples (Baiocco et al., 2014; Cohen, Blasey, et al., 2016). In accordance with the above evidence, the current study progressed recent efforts in the field by comparing social anxiety levels between sexual minority women and men, *and* assessing social anxiety across sexual orientation subgroups.

2. To test a comprehensive model of the determinants (i.e., both risk and protective factors) of social anxiety among sexual minority individuals.

As demonstrated in the findings of chapter two (sections 2.5.3 and 2.5.4), the majority of researchers have utilised Meyer's (2003) minority stress model when assessing the determinants of social anxiety symptoms. Indeed, increasing cross-sectional evidence signifies that sexual minority stress processes including experiences of discrimination, rejection sensitivity, internalised homonegativity, and sexual identity concealment are associated with social anxiety across samples comprised of sexual minority women (e.g., Mason & Lewis, 2016), sexual minority men (e.g., Burns et al., 2012b), and both genders combined (e.g., Cohen, Blasey, et al., 2016; Puckett et al., 2016). The sole longitudinal study with a primary focus on social anxiety among sexual minority individuals, in this case men, found that experiences of discrimination, rejection sensitivity, and internalised homonegativity acted as contemporaneous predictors of social anxiety, whereas concealment did not (Pachankis, Sullivan, Feinstein, & Newcomb, 2018).

Emerging research points to the possible role of within-community stressors potentially implicated in this population's elevated rates of social anxiety. Specifically, the unique status-based pressures that have been found to characterise sexual minority communities (Green, 2008) might predict social anxiety, although this possibility remains untested. Recent research suggests that intraminority stressors serve as a powerful predictor of sexual minority men's internalised mental health problems, operationalised as psychological

distress (Pachankis, Clark, et al., 2020). Given that factors underpinning intraminority stress (e.g., status-based social pressures) are closely related to the pathognomonic features of social anxiety (e.g., fear of negative evaluation), intraminority stress is hypothetically related to social anxiety, at least among sexual minority men. Of course the potential role of intraminority stress as a determinant of social anxiety among sexual minority women also warrants empirical exploration. In fact, preliminary evidence suggests that several features of sexual minority women's communities might pose stressors conceptually related to social anxiety (see section 1.5.1.3). Yet, whether and how these stressors are related to social anxiety among sexual minority women remains unknown.

Sexual minority individuals might also encounter identity-specific protective factors against social anxiety. Feelings of connectedness to the wider sexual minority community represent one such factor (Frost & Meyer, 2012). Previous research has demonstrated positive associations between LGBTQ community connectedness and social and psychological well-being among sexual minority women and men (Kertzner et al., 2009). LGBTQ community connectedness also helped to foster resilience to minority stress among sexual minority women (Zimmerman et al., 2015). In another study, sexual minority individuals with higher levels of LGBTQ community connectedness experienced lower levels of psychological distress, operationalised as a composite variable consisting of social interaction anxiety, general psychological distress, and depression (Puckett et al., 2015). Further, in that study, higher levels of internalised homonegativity were associated with lower community connectedness, suggesting a potential association between sexual minority-specific stressors and this protective factor.

In addition to identity-specific factors, social anxiety among sexual minority individuals is likely also predicted by universal risk factors for social anxiety experienced by the general population. However, as outlined in chapter two, there is a notable paucity of research focusing on general psychological processes as determinants of social anxiety for sexual minority individuals. At the same time, one unexamined process which is highlighted as a salient form of individual-based resilience might be particularly relevant. A sense of coherence (Antonovsky, 1987) refers to a global orientation that specifies the degree to which an individual perceives that 1) internal and external environmental stimuli are intelligible and predictable, 2) they possess adequate resources for overcoming the demands presented by those stimuli, and 3) it is worthwhile to invest in overcoming these demands in pursuit of a purpose-driven life. However, individuals with SAD report opposing tendencies in that they 1) view social stimuli in their social environment as unpredictable and

threatening (Eastwood et al., 2005; Moriya & Tanno, 2011), 2) struggle to access advantageous resources in social situations (Cuming & Rapee, 2010; Torgrud et al., 2004), and 3) avoid confronting social demands out of fear (Kashdan et al., 2008; Schneier et al., 2011). Because sexual minority individuals are more likely to report hopelessness, low self-worth, and general patterns of diminished self-efficacy and avoidance, including in social situations (Hatzenbuehler, 2009), and because these factors could characterise a low sense of coherence, it is possible that sense of coherence represents a plausible general determinant of sexual minority individual's social anxiety. Indeed, at least one study shows that a sense of coherence protects against psychological distress among gay men (Lyons et al., 2014). Meyer (2015) also cited a sense of coherence as a form of individual-level resilience that warrants examination in the context of sexual minority stress. Further, sense of coherence closely relates to the three classifications of general psychological processes highlighted in Hatzenbuehler's (2009) psychological mediation framework: coping/emotion regulation processes (e.g., feeling that you know what to do in an unfamiliar situation), social/interpersonal processes (e.g., believing that you have people that you can count on in difficult situations), and cognitive processes (e.g., possessing an optimistic outlook in life). In line with this theoretical standpoint, it is therefore plausible that a diminished sense of coherence may be associated with social anxiety for sexual minority individuals.

As reviewed above, several studies have examined bivariate associations between social anxiety and sexual minority-specific determinants and protective factors, while other research suggests plausible associations between general psychological processes and social anxiety among sexual minority populations. Yet, relatively less research has examined interrelationships among these variables in predicting social anxiety. Some notable exceptions, drawn from samples consisting of both sexual minority men and women, demonstrate that internalised homonegativity and rejection sensitivity partially mediate the association between heterosexist discrimination and social anxiety (Feinstein et al., 2012). Further, a sense of coherence mediates the association between minority stress and psychological distress in sexual minority college students (Roberts, 2018). Whether and how there may be indirect pathways from both experiences of discrimination and intraminority stress to social anxiety through sense of coherence and proximal minority stress (i.e., internalised homonegativity, identity concealment, and rejection sensitivity), or, whether and how there may be indirect pathways from both proximal minority stress and intraminority stress to social anxiety through LGBTQ community connectedness remain unknown.

The phase one study seeks to elucidate a comprehensive set of determinants of social anxiety among sexual minority individuals. It specifically seeks to simultaneously examine experiences of discrimination and intraminority stress as predictors of social anxiety among sexual minority individuals via various sexual minority-specific stressors (i.e., internalised homonegativity, identity concealment, and rejection sensitivity) and protective factors (i.e., LGBTQ community connectedness) and a general psychological and social process (i.e., sense of coherence) found to predict social anxiety in the general population. This phase one study represents the first to simultaneously unite traditional sexual minority stress, intraminority stress, general psychological processes, and social anxiety in a sample of sexual minority individuals.

3.3.2 Phase Two Objectives

As demonstrated in chapter two, there is a dearth of qualitative research in this area. Consequently, the phase two study acts as the pioneering qualitative exploration of social anxiety among sexual minority individuals. The phase two objectives (see chapter seven section 7.3.2 for greater detail and rationale) will aim to explore the experience of social anxiety in sexual minority individuals and will be refined by the phase one results. They will involve delving deeper into the statistical relationships (or lack thereof) pertaining to the risk and protective factors of social anxiety among sexual minority individuals revealed by phase one, and will explore the experience of living with social anxiety for this population across multiple contexts.

3.4 Mixed Methods Research

Since the late 1980s, mixed methods research has progressed in response to the complexities of research questions posed within different fields that were unanswerable by solely using quantitative or qualitative methods (Creswell & Plano Clark, 2017). Quantitative research is associated with the paradigm of post-positivism (Creswell & Plano Clark, 2017; Tashakkori & Teddlie, 2010). Herein researchers acquire knowledge based on determinism (i.e., cause-and-effect thinking), reductionism (i.e., placing a narrow focus on interrelationships between select variables), detailed and intricate observations and measures of variables, and assessing models and theories that are recurrently refined (Slife & Williams, 1995). By the contrary, qualitative research aims to uncover an understanding of how individuals interpret their experience and the world around them (Merriam, 2009). The social constructivist paradigm, now largely influential in qualitative research, emphasises that human perception and experience are not an absolute mirror image of environmental conditions, rather they should

be recognised as a subjective interpretation of these conditions (Burr, 2003). Thus, in addressing research problems in the social world, there are multiple “*knowledges*” as opposed to one knowledge. Succeeding the evolution of quantitative and then qualitative research, mixed methods research is widely regarded as the “*third methodological movement*” (Tashakorri & Teddlie, 2003, p.5) and the “*third research paradigm*” (Johnson & Onwuegbuzie, 2004, p.15). It is a research approach that allows “*multiple ways of seeing and hearing*” (Greene, 2007, p.20), thus enabling researchers to tackle research problems in multiple ways.

Many different definitions of mixed methods research have been proposed over the last 30 years, and these definitions continue to be challenged from both advocates and opponents of mixed methods research. Nonetheless, the majority characterise the approach as combining at least one qualitative and quantitative method within the same overarching research project (Hesse-Biber, 2015). Indeed, in combining these research methods to address a research problem in a single study, mixed methods researchers assert that the strengths of each approach can be amplified whilst their distinct weaknesses may be diminished (Doyle et al., 2009). Creswell and Plano Clark (2017) define mixed methods research as 1) collecting and analysing both qualitative and quantitative data robustly to address research questions and hypotheses, 2) integrating the findings associated with both forms of data, 3) organising these procedures into coherent research designs that provide the rationale for conducting the study, and 4) basing these procedures on theoretical and philosophical foundations. Their definition is utilised for the current mixed methods study as it is more comprehensive than other definitions in referring to methods, research design and processes, and philosophy/paradigm orientation. By comparison, Tashakorri & Teddlie (2003) focus on research process and Greene (2007) focuses on ways of interpreting the social world.

3.4.1 Pragmatism

A paradigm is a profound philosophical stance or worldview pertaining to the nature of social phenomena (Creswell & Plano Clark, 2017; Feilzer, 2010). Employing a specific paradigm is salient to a research project as it adopts particular epistemological, ontological, and axiological stances. The worldview or philosophical perspective of pragmatism influences the mixed methods research approach adopted in the current study. Historically, influential figures in psychological research, such as John Dewey, William James, and Charles Sanders Pierce have advocated the view of pragmatism. The support for this particular set of ideas has also been upheld by contemporary researchers such as Murphy

(1990), D. L. Morgan (2007) and Feilzer (2010). Pragmatism is characteristically associated with mixed methods research and endorsed by the preponderance of renowned mixed methods researchers (Tashakkori & Teddlie, 2010). From this perspective, the primary focus is on the consequences of research, on the principal salience of the overriding research question(s) instead of the methods, and on using diversified data collection methods to elucidate the research problem under investigation.

Opponents of mixed methods research advocate the assertions of the incompatibility thesis: that mixing quantitative and qualitative methods is dubious (Howe, 1988), and the undertaking of a mono-method is preferable (Brannen, 2005; Sale et al., 2002). These researchers argue that the vast ontological, epistemological, and axiological disagreements between the postpositivist and social constructivist paradigms make the integration of quantitative and qualitative findings an insurmountable task. Yet, on the other side of this philosophical debate, proponents of mixed methods research claim that the concerns outlined through the incompatibility thesis are unfounded, and combining quantitative and qualitative methods is achievable (Creswell & Plano Clark, 2017; Denzin, 2010)

Creswell and Plano Clark (2017) summarise the elements of pragmatism and its implications for research practice. From an ontological standpoint (i.e., what is the nature of reality?), there are both singular and multiple realities. This allowed the PhD researcher to both test hypotheses (e.g., related to risk and protective factors) and explore participants' different experiences pertaining to social anxiety. In terms of epistemology (i.e., what is the researcher's relationship to that being researched), a practical and pluralistic approach is undertaken. Thus, the PhD researcher undertook a "what works" approach to answering the research questions associated with the PhD thesis. In addressing the axiological question of "what is the role of values", pragmatist researchers include both biased and unbiased perspectives. For instance, the PhD researcher carried forward an unbiased perspective to test the models of social anxiety associated with the phase one study, whereas the role of his potential biases were acknowledged for the phase two qualitative study. Lastly, focusing on methodology, researchers can utilise both quantitative and qualitative forms of data collection (i.e., online survey and interview data in the current study). In line, Tashakkori and Teddlie (2010) emphasise the connection between pragmatism and mixed methods research based on the following considerations: both quantitative and qualitative phases may be employed within a singular overriding study, the importance of the research question(s) supersedes the method or underpinning paradigm, the enforced selection of either

postpositivism or constructivism should be discarded, and all methodological decisions should be governed by a practical and applied research philosophy.

3.4.2 Advantages and Disadvantages of Mixed Methods Research

There are notable advantages to utilising a mixed methods research design. Through conducting mixed methods research, researchers may avail of the strengths of quantitative approaches to offset the weaknesses of qualitative approaches and vice versa (Creswell & Plano Clark, 2017; Doyle et al., 2009; Johnson & Onwuegbuzie, 2004). Common criticisms of quantitative research include its dismissal of participants' subjective voices (Cherryholmes, 1992; Creswell & Plano Clark, 2017), and its shortcomings in placing findings within a certain context (Doyle et al., 2009; Johnson & Onwuegbuzie, 2004). Further, the personal biases of quantitative researchers are rarely acknowledged. Qualitative research directly addresses these weaknesses, and incorporates participants' perspectives and contextual information into its findings (Johnson et al., 2007). By contrast, qualitative research is deemed as flawed by some critics due to its reliance on the personal interpretation of the researcher, thereby introducing researcher bias, and its dependence on small sample sizes, thereby limiting generalisability of findings (Creswell & Plano Clark, 2017; Doyle et al., 2009; Johnson & Onwuegbuzie, 2004). Quantitative research directly counteracts these weaknesses.

Answering research questions using quantitative and qualitative approaches enables the researcher to attain a thorough and multifaceted insight into the research phenomenon under investigation (Doyle et al., 2009; Farquhar et al., 2011). The researcher can achieve this insight as they are not confined to gathering evidence using solely quantitative or qualitative oriented tools/methods. Mixed methods research also empowers researchers to answer questions that would be impossible to address solely using a quantitative or qualitative approach (Creswell & Plano Clark, 2017). For instance, "in what ways can participants' perspectives explain quantitative associations?". Overall, through bridging the combative division between quantitative and qualitative approaches, and effectively integrating findings from both, mixed method researchers can uncover new knowledge pertaining to research phenomena "*in order to reap the rewards of the integration equation of $1 + 1 = 3$, achieving a sum greater than the individual qualitative and quantitative parts*" (Fetters & Freshwater, 2015, p. 208). The complex phenomenon of social anxiety in sexual minority individuals is best understood using mixed methods rather than a purely quantitative or

qualitative approach as participants' experiences and stories might add rich information to expound on relationships revealed by the statistical models.

Whilst mixed methods approaches are now widely advocated, notable challenges in employing this approach remain. Conducting a mixed methods study, especially those with sequential designs, is extremely time-consuming and requires the availability of an abundance of resources (Almalki, 2016; Ivankova et al., 2006). Further, the successful conduct of a mixed methods study demands a complex set of skills. Researchers are required to be familiar with both quantitative and qualitative data collection and analysis processes (Creswell & Plano Clark, 2017). Lastly, conflicting findings yielded from the quantitative and qualitative phases may pose particular challenges for mixed methods researchers, yet these may be met through utilising an appropriate integration protocol (see section 3.5.1.4).

3.5 Current Study Design

The current study utilises a sequential explanatory mixed methods design comprising two phases: a quantitative phase (phase one) followed by a qualitative phase (phase two). For the quantitative phase, a cross-sectional online survey will be administered to sexual minority individuals. This quantitative data will be statistically analysed, whereby structural equation modelling (SEM) will be used to test a comprehensive model of the determinants of social anxiety among sexual minority individuals. Descriptive, univariate, and multivariate analyses will also be performed to elucidate further determinants of social anxiety within this population. Following this, for the qualitative phase, semi-structured interviews will be carried out with sexual minority individuals who believe social anxiety is a personal issue in their life, to explore their experiences of social anxiety. The development of the semi-structured interview topic guide will be influenced by the systematic review and phase one findings. All interviews will be recorded, transcribed verbatim, and analysed using thematic analysis. Firstly, the findings to each respective phase will be analysed and discussed separately. Subsequently, the findings across both phases will be integrated and discussed together to gain richer and intricate knowledge related to the phenomenon under investigation.

3.5.1 Rationale for Using a Sequential Explanatory Design

Undertaking this mixed methods approach rather than a singular quantitative or qualitative approach is preferable as it enables the answering of the different research questions pertaining to the aim of the PhD thesis (i.e., elucidating the determinants of, and exploring

the experience of, social anxiety among sexual minority individuals), provides a more comprehensive account of the phenomenon of focus, and the phase two qualitative findings will add contextual understanding to the phase one quantitative findings (Bryman, 2006). Further phase one is used to locate a target sample (i.e., sexual minority individuals who believe social anxiety is a personal issue in their life) to study in further depth during phase two, and phase two may be used to address inconsistencies in the quantitative results (Hesse-Biber, 2010).

Several key factors contributed to the decision to apply a sequential explanatory design in the present mixed methods study. The variety of study designs available, timing of study phases, weighting of study phases, approach to data integration, and the advantages and disadvantages associated with a sequential explanatory design represent these key factors. The role of each in contributing the aforementioned decision is outlined below.

3.5.1.1 Type of Study Designs

According to Creswell and Plano Clark (2017), the convergent design, the sequential exploratory design, and the sequential explanatory design represent the three core mixed methods designs available to researchers. When utilising a convergent design, the researcher collects and analyses quantitative and qualitative data concurrently. Both databases are typically given equal weighting and are combined to gain a more thorough understanding of the phenomenon under investigation, and to validate the quantitative and qualitative findings with one another. Sequential timing is used with sequential exploratory designs, whereby the mixed methods study begins with and typically places greater weight on the qualitative data collection and analysis. Using the findings from the exploratory qualitative phase, the development phase then occurs in which the researcher designs a quantitative feature (e.g., design of a new instrument or generation of a set of new variables). Lastly, during the final phase, the researcher quantitatively assesses the new feature. Sequential explanatory designs are also sequential in timing; however, in contrast to sequential exploratory designs, the mixed methods study begins with and typically places more weight on the quantitative data collection and analysis. Subsequently, a qualitative phase is designed based on the quantitative findings, and the qualitative data collection and analysis focuses on expounding on the quantitative results to establish a more complete understanding of the research phenomenon under investigation. The current mixed methods study utilises a sequential explanatory design; the findings from the systematic review and relevant theoretical positions will inform the development of the phase one online survey. Afterwards, the

findings from the systematic review, relevant theoretical positions, and the findings from the quantitative online survey will inform the development of the phase two qualitative interviews. This, in turn, will expound on the online survey findings and fill voids in the knowledge base identified by the systematic review.

3.5.1.2 Timing of Study Phases

The current study's timing of study phases refers to defining the temporal relationship between the quantitative and qualitative phases (i.e., the chronological placement of each phase in the overriding mixed methods study). As described in the previous section, mixed methods designs allow researchers to investigate a phenomenon using concurrent (i.e., quantitative and qualitative phases occur at the same time) or sequential phases (i.e., the quantitative and qualitative phases occur at different times, with one preceding the other). Employing a sequential design enables the researcher to use the findings from the first phase to influence the development of components for the subsequent phase (Creswell & Plano Clark, 2017; Teddlie & Tashakkori, 2009).

In the current mixed methods study, the decision was made to initially test the determinants of social anxiety (i.e., including an extensive model of the risk and protective factors of social anxiety among sexual minority individuals), and following this, conduct a qualitative exploration of the experience of social anxiety among sexual minority individuals. The findings of the systematic review affirmed the suitability of this approach. Firstly, the findings confirmed the presence of a quantitative knowledge base that emphasised the link between minority stress processes and social anxiety. Nonetheless, there were certain interrelationships and components of minority stress theories that remained underexplored. For instance, few studies had assessed pathways from distal stress to social anxiety through proximal minority stressors and general psychological processes as proposed by the psychological mediation framework (Hatzenbuehler, 2009), and there was a notable absence of evidence pertaining to individual- and community-level resilience. Further, the systematic review confirmed that the emerging theoretical framework of intraminority stress theory (Pachankis, Clark, et al., 2020) is yet to be explored in a social anxiety context and that published qualitative studies are notably lacking. Therefore, it was decided that phase one would concentrate on both filling the voids in the quantitative knowledge base pertaining to sexual minority stress theories and expanding the quantitative evidence base to include contemporary theories of sexual minority mental health.

The findings of phase one, alongside the systematic review functioned to formulate the focus of the phase two qualitative study (i.e., the first qualitative exploration of social anxiety among sexual minority individuals). Phase one will also provide a database of participants to recruit (i.e., through voluntary endorsement of further participation) for the subsequent qualitative phase.

3.5.1.3 Weighting of Study Phases

The level of importance assigned to the qualitative and quantitative phases within the overriding mixed methods study is referred to as the weighting of study phases (D. L. Morgan, 1998). As outlined previously in section 3.3, each study phase addresses different research problems and holds distinct aims and objectives. The primary aim of phase one is to quantitatively test an extensive model of the determinants of social anxiety among sexual minority individuals, and in doing so, elucidate risk and protective factors for social anxiety among this population. Following this, interviews will be carried out during phase two to uncover the experience of social anxiety among sexual minority individuals who believe social anxiety is a personal issue in their life. Part of phase two's objectives are to expound on phase one findings; however, each phase also aims to fill distinct voids in the knowledge base. For instance, phase two explores facets of the IAM model (Wong & Rapee, 2016), that was outside the scope of phase one. Therefore, in line with their potentially unique contributions to the knowledge base, and in contrast to many sequential explanatory designs, in which greater weight is assigned to the quantitative study phase (Bilinski et al., 2013), each study phase is given an equal weighting in the current mixed methods study.

3.5.1.4 Data Integration Approach

Data integration is an integral component of mixed methods research as it functions to merge quantitative and qualitative methods in order to accomplish research aims and objectives (Creswell & Plano Clark, 2017). O'Cathain et al. (2010) describe three approaches to data integration of quantitative and qualitative findings yielded through mixed methods enquiries: triangulation protocol, following a thread, and utilising a mixed methods matrix. The triangulation protocol allows researchers to integrate the findings from each phase at the interpretation stage of the mixed methods study after the data related to each stage has been analysed individually (O'Cathain et al., 2010). This approach enables the researcher to fulfil the independent objectives of each phase prior to combining the findings in order to achieve the overarching aim of the study. By contrast, data from each phase are combined during the

analysis stage when following a thread or utilising a mixed methods matrix. For this reason, the triangulation protocol approach to data integration was used for the current study.

Initially, the data obtained from the quantitative and qualitative phases of the current study will be analysed and discussed independently. Following this, a more comprehensive understanding of social anxiety among sexual minority individuals will be attained by an integrated discussion of both the quantitative and qualitative findings. Farmer et al.'s (2006) framework for triangulation protocol will guide the integration of quantitative and qualitative findings within the current study. Specifically, this will clarify whether findings across phase one and two are convergent (i.e., evidence consistencies), complementary (i.e., both feature different perspectives on a similar theme), silent (i.e., only one set of findings elucidates a theme, whereas this theme is absent in the other) or dissonant (i.e., evidence discrepancies).

3.5.1.5 Advantages and Disadvantages of a Sequential Explanatory Design

Creswell and Plano Clark (2017) assert that the sequential explanatory design is the most straightforward mixed methods design to implement, and highlight several associated advantages, three of which are relevant to the current study. First, its structure allows the researcher to collect and analyse one type of data at a time. This allowed the researcher to successfully manage the current PhD project. Second, the report can be compiled in distinct quantitative and qualitative sections; this will enable readers of the current PhD thesis to gain astute knowledge pertaining to the independent objectives of each phase. Last, the sequential explanatory design is conducive to emergent approaches in which the design of the subsequent qualitative phase can be influenced from the initial quantitative findings. This was especially pertinent to the current study as the qualitative exploration was the first in this area; thus, it required guidance from the quantitative phase.

Nonetheless, there are also notable disadvantages to consider when implementing a sequential explanatory design (Creswell & Plano Clark, 2017). A lengthy amount of time is required to implement two phases chronologically. The qualitative phase requires a smaller amount of participants; however, it typically takes more time to fully implement. Also, the qualitative phase may not be specified in its entirety in advance. Therefore, there can be boundaries to initially attaining ethical approval from an ethics review committee for the mixed methods study as a whole. Also, the researcher may not be able to signify the specific participants that will be recruited for the qualitative phase, or the particular questions that will be asked within the interview topic guide. In order to overcome these boundaries, the researcher applied for ethical approval for each phase separately for the current PhD project.

Further challenges with this design are personified by important questions the researcher must answer having conducted the quantitative phase, these include: “What quantitative results require further exploration?” and “What sub-sample should be focused on for the qualitative phase?”. With regards to the current mixed methods study, the researcher dedicated ample time to answering these salient questions prior to designing the qualitative phase.

3.5.1.6 Summary

After scrutinising the variety of mixed methods designs available to researchers, the timing and weighting of the quantitative and qualitative phases, the data integration approached to be utilised, and the advantages and disadvantages of employing a sequential explanatory design, it was decided that a sequential explanatory design was the most appropriate study design to achieve the current study’s aims and objectives. The sequential explanatory mixed methods design is visually depicted in Figure 3.1. Collectively, the findings generated from both phases uncover a more in-depth understanding of social anxiety among sexual minority individuals, a topic area that is markedly underexplored.

3.6 Conclusion

It is clear from the above discussion, that the knowledge base related to social anxiety among sexual minority individuals requires further development. The theoretical positions highlighted in chapter one and the chapter two systematic review findings have been integral in forming the aims and objectives associated with this PhD thesis. Further, this chapter overviewed the mixed methods research design used in the current study, and also provided the specific rationale for utilising a sequential explanatory design. The specific methods utilised for both the quantitative and qualitative phases will be described in chapters four and seven respectively.

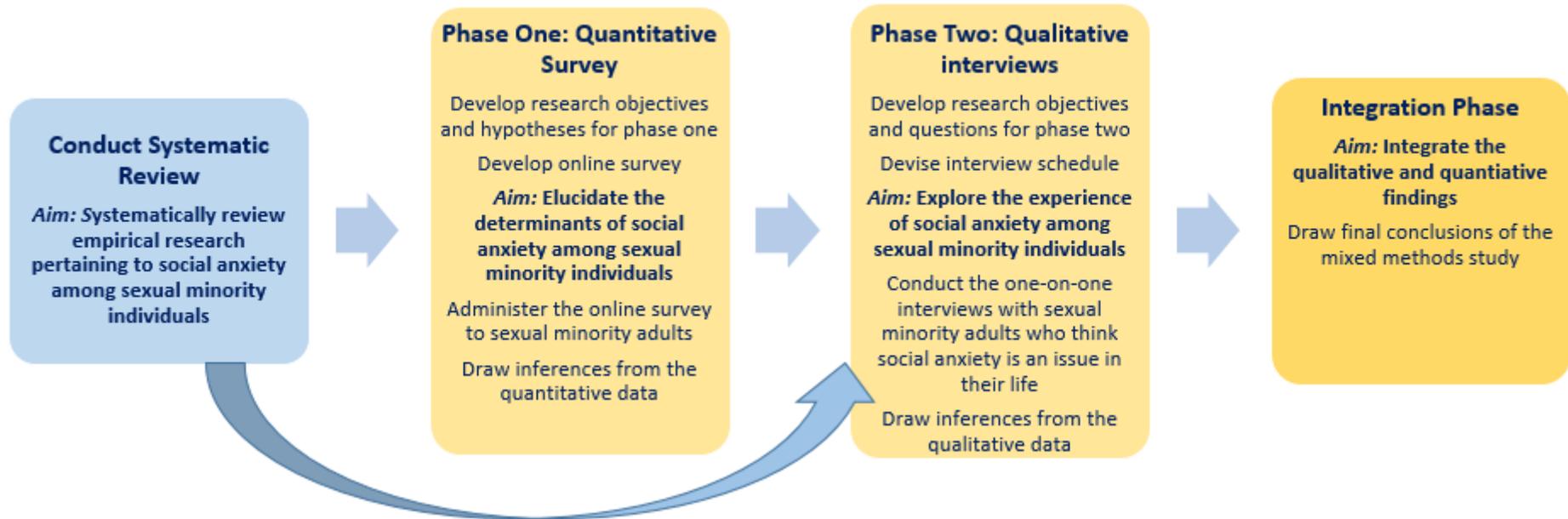


Figure 3.1: Visual Diagram of Sequential Explanatory Design Process.

Chapter 4 Phase One: Quantitative Method

4.1 Introduction

This chapter details the method utilised for the first phase of the current mixed methods study. Specifically, the following methodological details are included: 1) study design; 2) phase one aims, objectives, and hypotheses; 3) sample selection; 4) recruitment processes; 5) data collection procedure; 6) survey materials; 7) ethical considerations; 8) piloting the survey; and 9) data analysis procedure.

4.2 Quantitative Study Design

The first phase of this sequential explanatory mixed methods study involved a cross-sectional quantitative online survey of sexual minority adults residing in the Republic of Ireland.

4.3 Restatement of Aim, Objectives and Hypotheses for Phase One

This section outlines the aim, objectives, and hypotheses associated with phase one.

4.3.1 Phase One Aim

The phase one quantitative study aims to specify sexual minority subgroups that may be most at risk for elevated social anxiety symptoms and elucidate the risk and protective factors associated with social anxiety among sexual minority individuals.

4.3.2 Phase One Objectives

Phase one holds the following objectives:

1. To examine social anxiety across sexual minority subgroups (i.e., firstly by gender, then by sexual identity, sexual attraction, and sexual behaviour).
2. To test a comprehensive model of the determinants (i.e., both risk and protective factors) of social anxiety among sexual minority individuals.

4.3.3 Phase One Hypotheses

The specific hypotheses pertaining to the phase one objectives are outlined below. These hypotheses are posited based on the existing empirical evidence as illustrated in the systematic review findings and theoretical positions outlined in chapter one.

- The following hypotheses are related to objective 1:
 - It is hypothesised that sexual minority women will report significantly higher social anxiety than sexual minority men.

For both sexual minority women and men (i.e., groups will be analysed separately), the following is hypothesised regarding social anxiety differences across sexual orientation subgroups:

- Bisexual individuals and those who adopt an emerging identity label for their sexual orientation will report significantly higher social anxiety than gay/lesbian identified individuals.
 - Individuals who are only attracted to the same-gender will report significantly lower social anxiety than individuals mostly attracted to the same-gender, equally attracted to all genders, and mostly attracted to the opposite-gender.
 - Individuals who had same-gender sexual partner(s) only will report lower social anxiety than those with both same- and opposite-gender partners, those with opposite-gender partners only, and those who did not have sex.
- The following hypothesised pathways are related to objective 2, and are depicted in Figure 4.1; it is hypothesised that there will be:
 - A positive pathway from experiences of discrimination to social anxiety via higher levels of proximal minority stress (Path A X F).
 - A positive pathway from intraminority stress to social anxiety via higher levels of proximal minority stress (Path C X F).
 - A positive pathway from experiences of discrimination to social anxiety via a diminished sense of coherence (Path B X H).
 - A positive pathway from intraminority stress to social anxiety via a diminished sense of coherence (Path E X H).
 - A positive sequential pathway from experiences of discrimination to social anxiety via higher levels of proximal minority stress and reduced LGBTQ community connectedness (Path A X G X I).
 - A positive sequential pathway from intraminority stress to social anxiety via higher levels of proximal minority stress and reduced LGBTQ community connectedness (Path C X G X I).
 - A positive pathway from intraminority stress to social anxiety via reduced LGBTQ community connectedness (Path D X I).

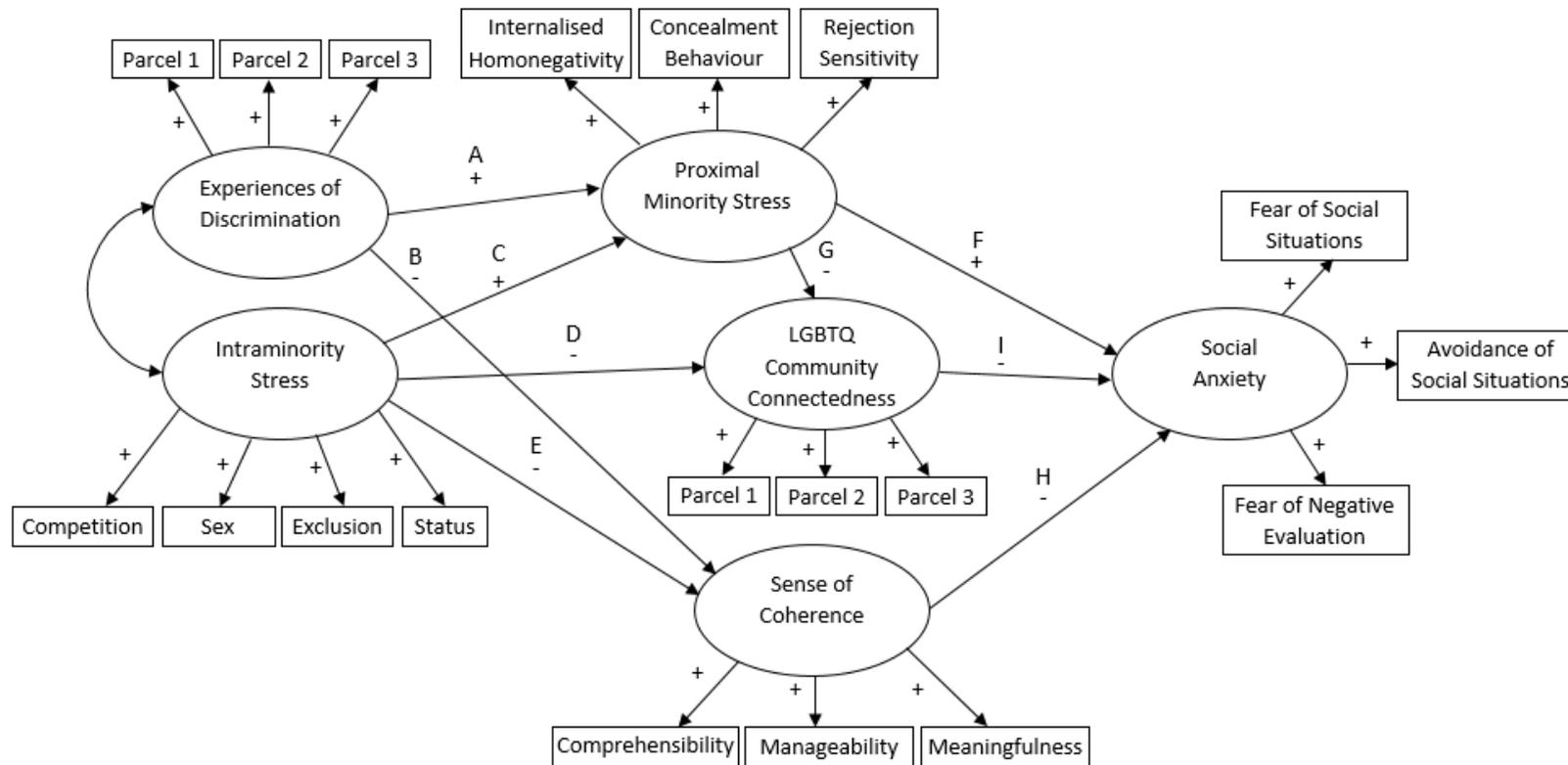


Figure 4.1: Hypothesised Model of Direct and Indirect Relationships Among Relevant Variables.

Note. Minus and plus signs represent hypothesised negative and positive effects respectively.

This conceptual model differs from the models tested in the structural equation analysis for both sexual minority men and women (i.e., individual latent variables were created for each of the proximal minority stress indicators due to their weak factor loadings with the originally conceptualised proximal minority stress latent variable).

4.4 Phase One Participants

Phase one consisted of 501 sexual minority adults who met the selection criteria below. Additional sociodemographic information pertaining to this sample is outlined in the following chapter (see section 5.2.).

4.4.1 Selection Criteria

The inclusion criteria were as follows:

1. The individual must either identify as a sexual minority (i.e., they must identify as gay/lesbian, bisexual, or with an emerging identity label) and/or experience regular same-gender attraction and/or have had same-gender sexual partners.
2. The individual must be aged 18 years or older.

The exclusion criterion was as follows:

1. Individuals not fluent in the English language.

Post-hoc decisions were then made to omit responses from individuals who identified as transgender, gender nonconforming, or non-binary (TGNB) from the analyses herein and individuals residing outside the Republic of Ireland. Regarding the former group, we omitted their responses given the low sample size (i.e., precluding a structural equation modeling analysis) and because measures assessing the unique gender minority stressors that this sub-population face are not included here (Testa et al., 2015). Recent studies have taken a similar approach in omitting smaller TGNB proportions of sexual minority samples (e.g., Puckett et al., 2016). However, the TGNB data will be analysed in papers outside of the current thesis. Regarding the latter group, the vast majority of survey completers resided within the Republic of Ireland. Taking cultural considerations into account (e.g., the fast changing social climate for sexual minority individuals in Ireland), it was decided that responses from individuals residing elsewhere should be omitted ($n = 42$).

4.4.2 Recruitment

A number of different recruitment routes were utilised to recruit potential participants: 1) Facebook Ads, 2) LGBTQ organisations, 3) individuals with large numbers of sexual minority followers on social media, and 4) additional media platforms.

4.4.2.1 Route 1: Paid Facebook Advertising

A project Facebook page entitled “Anxiety in Sexual Minorities Study” was created to facilitate recruitment on the social media platform for phase one of this study (see Appendix C.1). The recruitment was employed in the form of paid Facebook adverts conducted from the project Facebook page. These adverts were used to reach the target sample. Facebook allows a project page to target specific Facebook users with adverts through the creation of targeting criteria. For this study, participants were targeted based on their age (i.e., 18+), location (i.e., Republic of Ireland), and interests. The latter criterion reflects the content that Facebook users engage with on the Facebook platform (e.g., articles read or videos watched). For example, the interests of ‘Same-sex relationship’, ‘Lesbian romance’, and ‘Dublin Pride’ were all included as targeting criteria. In total, two different paid adverts ran from the project page. The first advert was created on April 5th 2018 and consisted of a recruitment poster communicating the study inclusion criteria, methods of accessing the survey and the research team contact details (see Appendix C.2). The second advert was created on April 22nd 2018 and consisted of an image and text celebrating the first 500 completed responses along with a direct link to access the survey (see Appendix C.3). Both of these advertisements provided potential participants with links to the online survey (i.e., clicking on the link brought them to the Plain Language Statement on the Qualtrics platform).

4.4.2.2 Route 2: LGBTQ Organisations

Potential participants were also recruited via LGBTQ organisations (i.e., university student societies, social groups, and sport clubs). The researcher emailed these organisations (see example in Appendix C.4) providing the study details, including the aims and estimated time for participants to complete. Within the email, the researcher asked the organisation if they would share the phase one study details with their members (i.e., via social media, a mailing list, or however they deemed appropriate). Direct links to the survey and the project Facebook page were also included in the email. Gay Community News (GCN), a national monthly free LGBTQ magazine provides an up-to-date directory of Irish LGBTQ organisations in each of their issues; this directory was consulted in to retrieve the contact details of relevant organisations.

4.4.2.3 Route 3: Individuals with Large Numbers of Sexual Minority Followers on Social Media

To recruit potential participants, the researcher also contacted individuals (e.g., journalists, activists, and well known people from the LGBTQ social scene) with large numbers of sexual minority followers on social media via email (see Appendix C.5). This email contained the same information and links as outlined in section 4.4.2.2.

4.4.2.4 Route 4: Additional Media Platforms

Potential participants were also recruited on two additional media platforms. Firstly, the researcher authored an online article for GCN (Mahon, 2018). The article, which was published on the GCN website on April 18th 2018, contained background information to the study, the recruitment poster, and direct links to the online survey and project Facebook page. This article was also shared on the project Facebook page to aid in recruitment (see Appendix C.6). Secondly, the researcher was a guest on an episode of the podcast “Sparking Change with Dil”; this podcast addresses issues surrounding mental health and social justice (Wickremasinghe, 2018). The podcast was released on June 8th 2018 and focused on the topic of social anxiety among sexual minority individuals. Within the discussion, the researcher communicated the study aims and recruitment details. Further, the direct links to the survey and project Facebook page were provided on the podcast website (see Appendix C.7).

4.5 Procedure

An online survey was created using the DCU Qualtrics platform (dcushns.eu.qualtrics.com). Participants could access the direct link to the survey through the various routes outlined in section 4.4.2. Further, the web address and QR code aligned with the survey were shared on the recruitment poster. Therefore, participants could also access the survey through typing the web address into their internet browser or scanning the QR code. Having clicked on the survey link or scanned the QR code, potential participants were directed to the plain language statement (see Appendix D.1). The plain language statement outlined the study background and aims, eligibility criteria, details of participation involvement, associated risks and benefits, data handling, protection and anonymity, right to withdraw, and the study team’s contact details. After reading the plain language statement, potential participants proceeded to the informed consent form if they wished to so do (see Appendix D.2). If potential participants answered ‘No’ to any of the nine questions proposed in the informed consent

form, a message appeared thanking them for their time and communicating their ineligibility to complete the survey (see Appendix D.3). Informed consent was endorsed through answering ‘Yes’ to all nine questions posed in the informed consent form, individuals who endorsed all nine statements were then directed to the survey.

The survey consisted of measures of sociodemographics, social anxiety, minority stress, intraminority stress, LGBTQ community connectedness, and sense of coherence. Sexual minority women and men took unique pathways through the survey. Further details of all measures used and unique pathways through the survey platform are provided in section 4.6. Having completed all the measures in the main survey, participants then encountered a section where they could voluntarily indicate their interest in participating in future studies associated with the project, and provide their email address for future contact. Lastly, before exiting the Qualtrics platform, the contact details of support services were once more provided (see Appendix D.4).

4.6 Survey Materials

The survey was developed from existing valid and reliable multi-item instruments measuring constructs that were deemed salient to social anxiety among sexual minority individuals based on the systematic review findings and theoretical standpoints discussed in chapter one. Sociodemographic characteristics were also measured at the outset of the survey. The materials included in the survey are outlined below.

4.6.1 Participant Sociodemographic Characteristics

Sociodemographic characteristics were collected on age, place of birth and residency, ethnicity and race, relationship status, gender identity, employment status, education, and personal income; this section contained a total of 16 questions (see Appendix E.1).

4.6.2 Sexual Orientation

Three dimensions of sexual orientation were measured using three separate categorical items (see Appendix E.1). Sexual identity was assessed using the item “Which of these categories best describes you?”; there were eight responses options: heterosexual/straight, gay/lesbian, bisexual, queer, pansexual, asexual, questioning/unsure and other [please specify]. Similar to previous studies assessing social anxiety in sexual minority individuals (Wadsworth & Hayes-Skelton, 2015), the latter response option enabled participants to report their sexual identity qualitatively if none of the previous seven response options accurately represented their current sexual identity. Sexual attraction was assessed using the item “People differ in

their sexual attraction to other people. Which category best describes your feelings?"; there were five response options: Only attracted to same-gender, Mostly attracted to same-gender, Equally attracted to all genders, Mostly attracted to opposite-gender, and Only attracted to opposite-gender. Lastly, sexual behaviour was assessed using the item "Please complete the following phrase as relevant to you. During the past year, ..."; there were five response options: I only had sex with same-gender partner(s), I only had sex with opposite-gender partner(s), I had sex with both same-gender and opposite-gender partner(s), I had sex with non-binary partner(s), and I didn't have sex.

4.6.3 Social Anxiety

The two instruments used to assess social anxiety are outlined below; this section contained a total of 36 questions.

4.6.3.1 Fear and Avoidance of Social Situations

The Liebowitz Social Anxiety Scale self-report version (LSAS; Fresco et al., 2001; Liebowitz, 1987) was used to measure fear and avoidance of social (e.g., "Talking with people you don't know very well") and performance (e.g., "Speaking up at a meeting") situations (see Appendix E.2). Using two separate four-point scales, this self-report measure assesses levels of fear from zero (*never*) to three (*severe*) and avoidance from zero (*never [0%]*) to three (*usually [67%-100%]*) across 24 different situations likely to elicit social anxiety. All items across both the fear and avoidance scales are summed for a total social anxiety score (range of 0-144). Summing the responses on the fear and avoidance subscales separately produces total social fear (LSAS-F) and total social avoidance (LSAS-A) scores. The LSAS has shown high internal consistency ($\alpha \geq 0.79$ across the subscales) and good test-retest reliability over a period of 12 weeks in the general population, $r = .83, p < .001$ (Baker et al., 2002). Further, in a sample predominantly comprised of sexual minority individuals (70%), the subscales had excellent internal consistency with Cronbach's α ranging from .88-.92 (Wadsworth & Hayes-Skelton, 2015) The LSAS demonstrated excellent internal consistency for sexual minority women ($\alpha = .96$) and men ($\alpha = .96$) in the current sample.

4.6.3.2 Fear of Negative Evaluation

The Brief Fear of Negative Evaluation Scale (BFNE; Leary, 1983) is a 12-item measure developed to assess one's fear of being scrutinised by others, a core feature of social anxiety (see Appendix E.3). Participants are presented with statements such as "I am usually worried

about what kind of impression I make” and endorse how characteristic each statement is of them using a five-point scale from 1 (*Not at all characteristic of me*) to 5 (*Extremely characteristic of me*). The BFNE allows a minimum score of 12 and a maximum score of 60, and has demonstrated strong convergent and discriminative validity in a clinical sample (Collins et al., 2005). Further, the BFNE showed high internal consistency among samples of sexual minority women ($\alpha = .93$; Dyar et al., 2016) and men ($\alpha = .90-.92$; Blashill & Vander Wal, 2010; Pachankis et al., 2008), and positive associations with minority stress measures in a sample of lesbian women and gay men (Feinstein et al., 2012). Only the 8 straightforwardly worded items were scored (BFNE-S), as this version of the scale has been deemed superior in terms of utility and validity (Carleton et al., 2011; Rodebaugh et al., 2004; Weeks et al., 2005); reverse-worded items 2, 4, 7, and 10 were not included in the current analysis. The BFNE-S allows a minimum score of 8 and a maximum score of 40. The BFNE-S showed similarly excellent inter-item reliability in sexual minority women ($\alpha = .95$) and men ($\alpha = .95$) in the current sample.

4.6.4 Sexual Minority Stress

The five instruments used to assess minority stress processes are detailed below. This section contained a total of 36 questions for sexual minority women and 34 questions for sexual minority men (i.e., sexual minority women and men answered different measures of rejection sensitivity, see section 4.6.4.4).

4.6.4.1 Experiences of Discrimination

The Everyday Discrimination Scale (EDS; D. R. Williams et al., 1997) is a nine-item measure of the frequency of daily experiences of discrimination (e.g., “You are treated with less courtesy than other people are”; see Appendix E.4). Participants indicate how frequently they encounter discriminative experiences in their day-to-day life on a six-point scale from 1 (*never*) to 6 (*almost every day*). Total scores are computed by summing item responses (range of 9-54). The EDS demonstrated strong internal consistency among samples of lesbian women ($\alpha = .91$; Mason & Lewis, 2016) and sexual minority men ($\alpha = .95$; Pachankis, Rendina, et al., 2015). Additionally, the EDS demonstrated positive associations with social anxiety in a sample of lesbian women (Mason & Lewis, 2016) and psychological distress in a sample of sexual minority individuals (S. L. Williams et al., 2017). The EDS showed similarly good inter-item reliability in sexual minority women ($\alpha = .87$) and men ($\alpha = .87$) in the current sample.

4.6.4.2 Internalised Homonegativity

The Revised Internalized Homophobia Scale (IHP-R; Herek et al., 2009) is a five-item measure of sexual minority individuals' negative feelings toward their sexual orientation (e.g., "I feel that being gay/lesbian/bisexual/a sexual minority is a personal shortcoming for me."). Sexual minority women (see Appendix E.5) and men (see Appendix E.6) answered slightly different versions of the IHP-R as some items assess attractions based on gender (e.g., "I have tried to stop being attracted to other women." [version for sexual minority women]; "I have tried to stop being attracted to other men." [version for sexual minority men]). Items are rated on a five-point scale from 1 (*strongly disagree*) to 5 (*strongly agree*) and then responses are averaged to compute a total score (range of 1-5). Similar to previous studies (Lewis et al., 2014), the item (i.e., "I would like to get professional help in order to change my sexual orientation from gay/lesbian/bisexual/a sexual minority to straight.") was removed as it demonstrated extreme skewness (i.e., 6.28 and 5.35 among sexual minority women and men respectively) and kurtosis (i.e., 40.09 and 31.01 among sexual minority women and men respectively). The IHP-R demonstrated good internal consistency ($\alpha = .81$) and a positive association with psychological distress in a sample of sexual minority young adults (Lea et al., 2014). In the current sample, the remaining four items of the IHP-R showed good inter-item reliability in sexual minority women ($\alpha = .84$) and men ($\alpha = .84$).

4.6.4.3 Concealment of Sexual Orientation

The Sexual Orientation Concealment Scale (Jackson & Mohr, 2016) is a six-item measure of concealment behaviour pertaining to sexual orientation (e.g., "In the last two weeks, I have altered my appearance, mannerisms, or activities in an attempt to "pass" as straight"; see Appendix E.7). Participants indicate how often they hid or covered their sexual orientation on a five-point scale from 1 (*not at all*) to 5 (*all the time*); item responses are averaged to compute a total score (range of 1-5). The scale shows good inter-item reliability in sexual minority women ($\alpha = .81$) and men ($\alpha = .84$) in the current sample. This scale was used in line with recent recommendations for measuring concealment of sexual orientation in non-probability sexual minority samples situated in relatively liberal societies (Pachankis, Mahon, et al., 2020), such as the Republic of Ireland.

4.6.4.4 Sexual Orientation Related Rejection Sensitivity

The Sexual Minority Women's Rejection Sensitivity Scale (SMW-RSS; Dyar et al., 2016) is a sixteen-item measure of rejection sensitivity based on sexual minority status specially

developed for sexual minority women (e.g., “Your supervisor begins raising concerns about your performance at work for the first time after you bring your female partner to a company picnic”). Participants report their expectations of rejection from 1 (*Very Unlikely*) to 7 (*Very Likely*) and related levels of concern/anxiety 1 (*Very Unconcerned*) to 7 (*Very Concerned*) across hypothetical scenarios (see Appendix E.8). An average anxiety X expectation total score is computed across the 16 scenarios (ranging from 1-49). The SMW-RSS demonstrated excellent internal consistency and a significant positive association with social anxiety in a sample of sexual minority women ($\alpha = .90$; Dyar et al., 2016). Only sexual minority women answered the SMW-RSS in the current sample ($\alpha = .89$).

The Gay-Related Rejection Sensitivity Scale (G-RRSS; Pachankis et al., 2008) is a fourteen-item measure of anxious expectations of rejection based on sexual minority status across hypothetical scenarios (e.g., “Only you and a group of macho men are on public transport late at night. They look in your direction and laugh”; see Appendix E.9). Using two scales for each vignette, participants indicate the likelihood they would expect to experience rejection from 1 (*Very unlikely*) to 6 (*Very likely*) and the anxiety/concern they would feel due to this rejection from 1 (*Very unconcerned*) to 6 (*Very concerned*). The two responses for each item are multiplied and averaged across the 14 scenarios (totals ranging from 1-36); higher scores represent greater levels of rejection sensitivity. The G-RRSS demonstrated excellent internal consistency and a significant positive association with social anxiety in a sample of young sexual minority men ($\alpha = .90$; Cohen, Feinstein, et al., 2016). Only sexual minority men answered the G-RRSS in the current sample ($\alpha = .89$).

4.6.5 Intraminority Stress

The Intraminority Gay Community Stress Scale (GCSS; Pachankis, Clark, et al., 2020) is a twenty-item measure of sexual minority men’s perceptions of stressors within the gay community (see Appendix E.10). Across four subscales, the measure assesses stress related to perceptions of the gay community’s focus on sex (e.g., “The mainstream gay community is overly focused on sex”), status (e.g., “The mainstream gay community overly values men who are powerful and high status”), competition (e.g., “The mainstream gay community has a culture of competition and jealousy”) and exclusion of diversity (e.g., “The mainstream gay community is racist”). Participants indicate the level to which they agree that the statements are true using a five-point scale from 1 (*Strongly Agree*) to 5 (*Strongly Disagree*) and their levels of stress due to these potential issues using a separate five-point scale from 1 (*Not at all stressed/bothered*) to 5 (*Extremely stressed or bothered*). Only the latter scale

is used in calculating intraminority stress scores. Responses are summed and averaged to produce a total score; a higher total score indicates greater levels of intraminority stress. The GCSS demonstrated strong internal consistency ($\alpha = .95$) and a significant positive association with internalising mental health symptoms in sexual minority men (Pachankis, Clark, et al., 2020). Only sexual minority men answered the original GCSS in the current sample ($\alpha = .93$). The GCSS was unpublished when administered in the current study (i.e., between April and July 2018), however, the same 20-item version was published in early 2020.

Sexual minority women completed an adjusted version of the GCSS in this sample (see Appendix E.11). The sexual minority women responded using the same five-point scales (i.e., only the stress scale was scored) for the 20 questions; however, the terms “men” and “gay community” in the original CGSS were replaced with “women” and “LBQ community” respectively (e.g., “The mainstream LBQ community overly values women who are powerful and high status”). Firstly, to explore the factorial structure of the adjusted GCSS in the sexual minority women proportion of the sample, all 20 questions were subjected to an exploratory factor analysis with oblique rotation. The Kaiser-Meyer-Olkin index of .91 certified the factorability of the matrix, Bartlett’s test of sphericity $\chi^2(190) = 2325.09, p < .001$, indicated an adequate correlational structure, and four factors with eigenvalues exceeding 1.0 were extracted. The cumulative variance explained pertaining to these four factors accounted was 61.86%. One item was removed (i.e., “In the mainstream LBQ community, there is a lot of risky sex”) as it showed both a weak loading with its original sex factor (i.e., .23; the factor it loaded onto in the original GCSS) and stronger loadings with the exclusion and status factors (i.e., .54 and -.31 respectively). A principal components analysis with oblique rotation was then performed, fixing the number of factors to four, with the remaining 19 items. The analysis with 19 items confirmed the structural stability of the adjusted GCSS scale ($\alpha = .91$) for sexual minority women (see Appendix E.12). To further confirm the stability of this four-factor structure, we performed a confirmatory factor analysis (CFA) utilising maximum likelihood estimation to test a first-order model with the four latent subscales (i.e., competition, exclusion, sex, and status) on the remaining 19 items using AMOS 27. The CFA confirmed the structural stability of the adjusted GCSS in sexual minority women $\chi^2(146, N = 245) = 267.37, p < .001, CFI = .94, RMSEA = .06$ (90% CI [.05, .07]), $SRMR = .06$. Similar to men, women’s responses were summed and averaged across all four subscales with higher scores indicating greater levels of intraminority stress.

4.6.6 Resilience

The two instruments used to measure two distinct forms of resilience (i.e., sexual minority-specific community-level resilience and general individual-level resilience) are detailed below; this section contained 21 questions.

4.6.6.1 *LGBTQ community connectedness.*

The Connectedness to the LGBT Community Scale (LGBTQCC; Frost & Meyer, 2012) is an 8-item measure that assesses the degree to which individuals feel connections with the broader LGBTQ community (e.g., “You feel a bond with the LGBTQ community”). Participants indicate their agreement with each item on a 4-point Likert scale from 1 (*agree strongly*) to 4 (*disagree strongly*) and responses are reversed, summed, and averaged to produce a total score (ranging from 1-4) with higher scores indicating greater levels of community connectedness. Sexual minority women (see Appendix E.13) and men (see Appendix E.14) answered slightly different versions of the scale in that one item is designed to assess feelings of bonding with same-gender similar others. Therefore, this item appeared as “You feel a bond with fellow sexual minority women” for sexual minority women, and “You feel a bond with fellow sexual minority men” for sexual minority men. The LGBTQCC demonstrated good internal consistency and a significant negative association with social interaction anxiety among sexual minority individuals ($\alpha = .89$; Puckett et al., 2015). The LGBTQCC showed good inter-item reliability among sexual minority women ($\alpha = .84$) and men ($\alpha = .88$) in the current sample.

4.6.6.2 *Sense of Coherence*

The abbreviated thirteen-item version of Antonovsky's (1987) Sense of Coherence Scale (SOCS) measures the three components of a sense of coherence (see Appendix E.15), that is, comprehensibility (e.g., “Do you have very mixed-up feelings and ideas?”), manageability (e.g., “How often do you have feelings that you’re not sure you can keep under control?”), and meaningfulness (e.g., “How often do you have the feeling that there’s little meaning in the things you do in your daily life?”). Participants respond on seven-point scales, each item requires different responses dependent on the question, such as 1 (*very seldom*) to 7 (*very often*), and 1 (*never happened*) to 7 (*always happened*). Responses are summed to create an overall total score (ranging from 13-91). The SOCS has demonstrated good internal consistency and a negative association with psychological distress in a sample

of gay men ($\alpha = .85$; Lyons et al., 2014). The SOCS showed good inter-item reliability in sexual minority women ($\alpha = .88$) and men ($\alpha = .87$) in the current sample.

4.7 Ethical Considerations

Ethical approval for phase one of this study was obtained from Dublin City University Research Ethics Committee (see Appendix F). The key issues considered for the first phase of this study included the issues of participant vulnerability/potential harm to participants, consent, anonymity and confidentiality, and data storage.

With regard to participant vulnerability, sexual minority individuals are more vulnerable to experiencing mental health difficulties than their heterosexual counterparts (e.g., Kerridge et al., 2017). Additionally, as the findings of the systematic review indicated (see section 2.5.2), sexual minority individuals are also at an increased risk for SAD (e.g., Kerridge et al., 2017) and experiencing heightened social anxiety symptoms (e.g., Akibar et al., 2019). Given the sensitive nature of the survey, and the related concepts it measured (e.g., fear of negative evaluation, social fear and avoidance), including those stressors that are specific to sexual minority individuals (e.g., sexual minority stressors such as internalised homonegativity, concealment of sexual orientation, and rejection sensitivity), it was possible that some participants may experience distress. In order to help reduce this risk, the topics that were addressed in the survey and the possibility that participants may experience distress, were clearly communicated in the plain language statement (see Appendix D.1). This granted potential participants an opportunity to decline to participate should they have felt that encountering these concepts may have caused them to feel distressed. Through the informed consent form, the participants gave their active informed consent for participation. Participants were also able to withdraw from the study without penalisation or having to give a reason for their withdrawal, up until the point of submitting their survey data. They were also informed in the plain language statement that they could contact support services through LGBT Ireland or the Samaritans Ireland should they be concerned about social anxiety or any other issue covered in the survey. The contact details for both LGBT Ireland and the Samaritans were provided in the plain language statement and again upon completion of the survey (see Appendix D.4).

In relation to consent, all participants provided informed consent in an active manner (see section 4.5). In order to protect anonymity, throughout the sociodemographics section of the survey, no names, addresses or information that could identify the participants were collected. Informed consent was recorded through the active endorsement of a number of

statements and no identifying information was required. However, at the end of the survey (see Appendix D.4), one question asked participants if they wished to participate in further studies associated with the project (i.e., Would you be interested in participating in further studies associated with this project? This may consist of further online activities and/or telephone interviews. [Please note that by expressing your interest now you are in no way obliged to participate in future studies when contacted]; response options: Yes/No). The data belonging to the participants who answered “No” to the above question remained anonymous. The participants who answered “Yes” to the above question were presented with another statement, requiring an additional response (i.e., As you have expressed interest in participating in further studies associated with this project, we require an email address in order to contact you in the future. [Please note that if you provide an email address your survey answers are no longer anonymous. They are, however, 100% confidential and can only be viewed by the project research team]; response options: I am happy to provide an email address [please type into the space provided]/ I do not wish to provide an email address). The data belonging to the participants who chose the latter response option remained anonymous. The email addresses of those who volunteered further participation were stored separately to any data collected during both phase one and phase two (i.e., for those who subsequently participated in the qualitative interviews) of the current mixed methods study.

Finally, in terms of data storage, online survey data were collected through Qualtrics, a secure, password-protected, software programme. Therefore, no participant signatures were collected, nor were there any hard copies of consent forms to store. Once data collection was complete, another data file was created in SPSS into which the data from Qualtrics was transferred. The SPSS file is currently kept on the researcher’s password protected Google Drive. The separate SPSS file containing the email addresses of those who volunteered their further participation for phase two was also kept on the researcher’s password protected Google Drive. This file was permanently deleted once recruitment for the phase two qualitative interviews was complete.

4.8 Piloting the Survey

The survey was piloted with five sexual minority individuals known to the researcher. These individuals were informed that their data would not be used in the analysis, nor would it be viewed by any of the research team. The process of piloting continued until no new issues were raised by those participating in the process. The researcher piloted the surveys to assess

the clarity of instructions, the readability and understanding of instruments and questions, and the time duration to completion. Feedback was provided to the researcher via telephone calls.

No major issues were raised by the five sexual minority individuals within the feedback they provided on the survey. On average, the survey was completed in 30 minutes. Whilst the instructions were deemed to be clear, multiple individuals expressed that some instruments (e.g., the LSAS and GCSS) were long, and in scrolling through all the questions, it was challenging to remain focused. Others also stated that the overall visual appeal of the survey could be improved. Taking the feedback into account, minor amendments were made to the survey. Section breaks (i.e., consisting of coloured lines and graphics) were inserted between items within longer instruments, and between different instruments. Further, to improve the visual appeal of the survey, the rainbow coloured study logo was added to the beginning of every new page and the font colour of questions was changed from black to dark blue.

4.9 Data Analysis Plan

All preliminary analyses, and analyses associated with objective one were performed using SPSS 27.0. The data were exported to AMOS 27.0 for the structural equation modelling (SEM) analyses related to objective two.

Responses in which the sociodemographics section (i.e., the first section of the survey; $n = 38$) or the LSAS (i.e., the second section of the survey; $n = 208$) were not completed were removed from the analysis. Another 225 responses were omitted from the analysis as they were missing more than 20% of data overall. The data were also inspected to detect disengaged or disingenuous responses (e.g., evidenced by continually selecting the same responses on measure items), and one response was removed at this stage.

Frequency statistics (n and %s) were calculated for participant sociodemographic characteristics. Means and standard deviations were also calculated for age and the three social anxiety outcome variables (LSAS-F, LSAS-A, and BFNE-S) across geographical region of residence (i.e., Dublin, Other Leinster, Cork, Limerick, Other Munster, Galway, Other Connacht, and Ulster). Three independent samples t -tests (Bonferroni adjustment [$p = .05/3 = .017$]) were carried out to determine if participants' residing outside Dublin social anxiety differed to those residing in Dublin.

Originally, it was planned to test the phase one hypotheses using parametric tests (i.e., independent samples t -test and one-way ANOVAs). However, due to uneven groups

numbers, namely among the sexual orientation subgroups of the sexual minority men portion of the sample, and violations of the assumptions of these parametric tests (e.g., evidence of heterogeneity of variances, outliers, and non-normal distribution across sexual orientation subgroups of both sexual minority women and men), non-parametric tests were deemed more appropriate (Delacre et al., 2019). Despite relying on the median as the measure of central tendency in these analyses, means and standard deviations were still calculated in order to assist in comparing the current study's results with previous related studies that utilised ANOVAs to compare social anxiety levels across sexual orientation subgroups (e.g., Akibar et al., 2019; Wadsworth & Hayes-Skelton, 2015). Mann-Whitney *U* tests were used to test social anxiety between sexual minority women and men, and effect sizes (*r*) were calculated for any significant tests. Separately for sexual minority women and men, Kruskal-Wallis *H* tests were used to test differences across sexual orientation subgroups (i.e., by identity, attraction, and behaviour). To account for the multiple tests assessing the three social anxiety outcome variables, all Mann-Whitney *U* and Kruskal-Wallis *H* tests were performed with the Bonferroni adjustment ($p = .05/3 = .017$). Dunn-Bonferroni post hoc tests (i.e., adjusted for multiple tests) were carried out and effect sizes were calculated (ϵ^2) for any Kruskal-Wallis *H* test that yielded a significant result.

Latent constructs were created for all variables analysed in the models assessing the determinants of social anxiety associated with objective two. To create latent variables, total scores, subscales, and item parcels were used as indicator variables; this process is detailed in section 5.4.2. The data were then screened for univariate normal distribution on all indicator variables used in the structural equation analyses using Kline's (2015) recommendations of skewness less than 3 and kurtosis less than 4. To screen for univariate outliers, *z* scores were computed for all indicator variables (i.e., detecting those ≥ 3.29 ; Tabachnick & Fidell, 2007); to reduce the impact of univariate outliers, values were winsorized at 3 *SDs* above/below the mean. Preliminary analyses were then conducted in order to control for potential confounders. Separately for sexual minority women and men, five Welch's ANOVAs were used to predict the social anxiety latent variable to determine whether it varied as a function of categorical demographic measures: ethnicity, sexual identity, education, employment status, and relationship status (Bonferroni adjustment [$p = .05/5 = .01$]). For the continuous demographic variables (i.e., income and age), correlation analyses were carried out to detect potential confounders. Correlation analyses were also carried out using the latent constructs.

The hypothesised models related to objective two were tested using maximum likelihood estimation, through a two-step process. To guide the evaluation of model fit, the following indices were used: a non-significant chi-square (χ^2) value or a chi-square to degrees of freedom ratio (χ^2/df) of less than five (Kelloway, 1998), comparative fit index (CFI) $\geq .95$, root mean square error of approximation (RMSEA) $\leq .06$, and standardized root-mean-square residual (SRMR) $\leq .08$ (Hu & Bentler, 1999). First, the measurement models were tested in order to establish appropriate fit of the latent variables. As recommended by Russell et al. (1998), each latent variable was represented by a minimum of three indicators, and the factor loading of one of the indicators was fixed to 1. In order to assess the reliability and validity of latent constructs, the following indices were used: Composite Reliability (CR) $> .70$ to test for reliability, Average Variance Explained (AVE) $> .50$ to test for convergent validity, Maximum Shared Variance (MSV) $<$ AVE and square root of AVE $>$ than inter-construct correlations to test for discriminant validity (Hair et al., 2014). Cook's distance was also calculated to test for multivariate outliers using Stevens' (1984) criteria stating values at one or greater represent multivariate outliers. Once the measurement models were fitted, the structural models were then tested. To test the indirect pathways to social anxiety (see Figure 4.1), bootstrapping with 5,000 bootstrap samples was used to generate standard errors for tests of indirect effects (Preacher & Hayes, 2008), and significance testing was carried out using 95% bias-corrected (BC) confidence intervals (CIs) produced from 5,000 bootstrap samples. A significant effect was represented if the CIs did not contain zero. All models were run separately for sexual minority women and men. Lastly, the post-hoc statistical power of the R^2 observations were tested (Sober, 2016); a value greater than 0.8 indicates acceptable power (Gefen et al., 2011).

4.10 Conclusion

This chapter outlined the quantitative method used in the first phase of the current mixed methods study. The quantitative findings related to both of the phase one objectives will be presented in the next chapter.

Chapter 5 Phase One: Quantitative Findings

5.1 Introduction

This chapter details the results from the first phase of this mixed methods study which consisted of a cross-sectional survey of sexual minority individuals aiming to examine potential social anxiety differences across sexual orientation subgroups and the determinants of social anxiety within this group. The phase one aims and hypotheses are outlined in section 4.3 of chapter four.

5.2 Participant Sociodemographics and Characteristics.

In total, 501 participants are included in the analyses in phase one. These 501 sexual minority participants consisted of 245 sexual minority women and 256 sexual minority men. All surveys were completed online using Qualtrics.

Participant sociodemographics and characteristics are displayed for the overall sample and separately for sexual minority women and men in Table 5.1. The mean age for the overall sample was 29.17 with a range of 18-63, whilst the median age was 27.00 (i.e., 25th percentile: 22.00 and 75th percentile: 33.00). Three hundred eighty-four participants indicated that they were born in the Republic of Ireland (76.6%), followed by the United Kingdom excluding Northern Ireland ($n = 40$, 8.0%), the United States of America ($n = 15$, 3.0%), Northern Ireland ($n = 9$, 1.8%), Italy ($n = 7$, 1.4%), Brazil ($n = 6$, 1.2%), Poland ($n = 6$, 1.2%), Germany ($n = 3$, 0.6%), Netherlands ($n = 3$, 0.6%), Spain ($n = 3$, 0.6%), Canada ($n = 2$, 0.4%), and Lebanon ($n = 2$, 0.4%). The remaining 21 participants were born in 21 unique countries not listed above.

Table 5.1

Phase One Participant Sociodemographics and Characteristics

Variable	Overall	Sexual minority women	Sexual minority men
<i>N</i>	501	245	256
Age Range (M ± SD)	18-63 (29.17 ± 9.55)	18-63 (28.00 ± 9.66)	18-62 (30.29 ± 9.34)
Sexual Identity			
Gay/Lesbian	331 (66.1%)	104 (42.4%)	227 (88.7%)
Bisexual	99 (19.8%)	78 (31.8%)	21 (8.2%)
Queer	28 (5.6%)	25 (10.2%)	3 (1.2%)
Pansexual	26 (5.2%)	23 (9.4%)	3 (1.2%)
Asexual	8 (1.6%)	7 (2.9%)	1 (0.4%)
Questioning/Unsure	5 (1.0%)	4 (1.6%)	1 (0.4%)

Table 5.1*Phase One Participant Sociodemographics and Characteristics*

Variable	Overall	Sexual minority women	Sexual minority men
Other ^a	4 (0.8%)	4 (1.6%)	0 (0.0%)
Ethnicity/Race ^b			
White Irish	417 (83.2%)	200 (81.6%)	217 (84.8%)
Irish Traveller	2 (0.4%)	0 (0.0%)	2 (0.8%)
Other White	65 (13.0%)	35 (14.3%)	30 (11.7%)
Black (Irish/African)	2 (0.4%)	2 (0.8%)	0 (0.0%)
Other Black	1 (0.2%)	0 (0.0%)	1 (0.4%)
Chinese	1 (0.2%)	1 (0.4%)	0 (0.0%)
Other Asian	2 (0.4%)	1 (0.4%)	1 (0.4%)
Other/Multiracial	11 (2.2%)	6 (2.4%)	5 (2.0%)
Relationship Status			
Single	273 (54.5%)	118 (48.2%)	155 (60.5%)
Partnered (not married)	192 (38.3%)	110 (44.9%)	82 (32.0%)
Married	36 (7.2%)	17 (6.9%)	19 (7.4%)
Employment Status			
Full-time	242 (48.3%)	101 (41.2%)	141 (55.1%)
Part-time	54 (10.8%)	32 (13.1%)	22 (8.6%)
Student	155 (30.9%)	86 (35.1%)	69 (27.0%)
On disability	24 (4.8%)	17 (6.9%)	7 (2.7%)
Unemployed	24 (4.8%)	8 (3.3%)	16 (6.3%)
Retired	2 (0.4%)	1 (0.4%)	1 (0.4%)
Education			
No secondary school	1 (0.2%)	0 (0.0%)	1 (0.4%)
Some secondary school	18 (3.6%)	8 (3.3%)	10 (3.9%)
Finished secondary school	65 (13.0%)	30 (12.2%)	35 (13.7%)
Some university	170 (33.9%)	89 (36.3%)	81 (31.6%)
University degree	136 (27.1%)	65 (26.5%)	71 (27.7%)
Master's degree/above	111 (22.2%)	53 (21.6%)	58 (22.7%)
Personal Income			
Less than €10,000	176 (35.1%)	108 (44.1%)	68 (26.6%)
€10,000-€24,999	132 (26.3%)	62 (25.3%)	70 (27.3%)
€25,000-€39,999	107 (21.4%)	45 (18.4%)	62 (24.2%)
€40,000-€59,999	54 (10.8%)	23 (9.4%)	31 (12.1%)
€60,000-€79,999	18 (3.6%)	2 (0.8%)	16 (6.3%)
€80,000 and above	14 (2.8%)	5 (2.0%)	9 (3.5%)

^a Demisexual lesbian ($n = 1$), Demi and Queer ($n = 1$), Demisexual pansexual ($n = 1$), greysexual ($n = 1$).

^b Racial and ethnic data were conflated during the data collection phase.

In terms of sexual identity, almost two-thirds of the sample were gay/lesbian (66.1%), one fifth bisexual (19.8%), and the remainder (14.1%) indicated an emerging identity label. Notably, sexual identities were more diverse among sexual minority women (i.e., representative of lesbian, bisexual, and emerging identity women); 88.7% of sexual minority men identified as gay compared to just 42.4% of women identifying as lesbian. The vast

majority of participants were white Irish (83.2%) followed by other white (13.0%). In total just 3.8% of the sample was comprised of racial/ethnic minority individuals. Over half of participants indicated they were single (54.5%), and this portion was higher among sexual minority men when compared to women (60.5% vs 48.2%). Almost half of participants (48.3%) had full time employment, further, a large portion (30.9%) were current students. Overall, the sample was highly educated with almost one half having attained a university degree or above (49.3%). In relation to personal income, 35.1% of the overall sample had an annual income of €10,000 or less, and just 17.2% had an income of €40,000 or higher.

In terms of county of residence, 27 out of the 28 counties of the Republic of Ireland are represented in the current sample (i.e., no participants resided in Longford). Figure 5.1 depicts participants' social anxiety scores by region of residence. More than half ($n = 266$, 53.1%) of the sample resided in Dublin followed by Cork ($n = 51$, 10.2%), Galway ($n = 24$, 4.8%), Kildare ($n = 20$, 4.0%), Limerick ($n = 17$, 3.4%), Meath ($n = 15$, 3.0%), Louth ($n = 14$, 2.8%), Westmeath ($n = 10$, 2.0%), Wexford ($n = 10$, 2.0%), and Wicklow ($n = 10$, 2.0%). The remaining participants ($n = 64$, 12.7%) resided across 17 other counties. Three independent samples t-tests were carried out to determine if participants residing in Dublin differed from participants residing outside Dublin on the three social anxiety outcome measures (Bonferroni adjustment: $p = .05/3 = .017$). The analyses revealed that participants residing outside Dublin ($M = 33.41$, $SD = 15.90$) did not significantly differ from those residing in Dublin ($M = 30.92$, $SD = 13.60$) on social fear, $t(499) = 1.89$, $p = .06$, or fear of negative evaluation (Outside Dublin [$M = 27.36$, $SD = 9.20$], Dublin [$M = 27.39$, $SD = 8.42$], $t[499] = -.04$, $p = .97$). However, participants residing outside Dublin ($M = 30.21$, $SD = 16.14$) reported significantly greater social avoidance than those residing in Dublin ($M = 26.71$, $SD = 13.74$), $t(499) = 2.63$, $p = .01$, Cohen's $d = .24$.

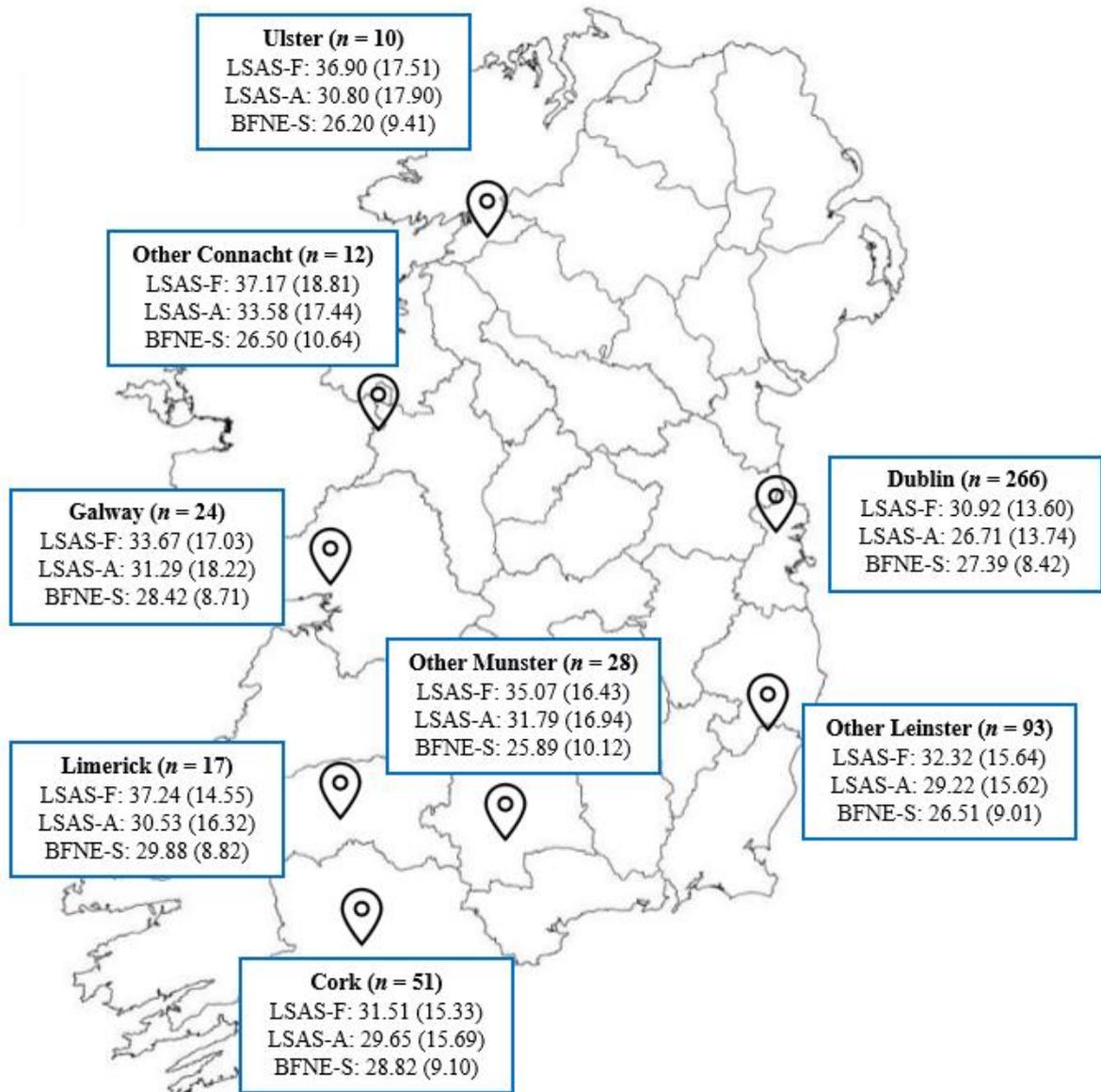


Figure 5.1: Participant Social Anxiety Means and Standard Deviations Across Region of Residence. *Note.* Standard deviations are presented in parentheses. LSAS-F = Liebowitz Social Anxiety fear subscale; LSAS-A = Liebowitz Social Anxiety avoidance subscale; BFNE-S = Brief Fear of Negative Evaluation Scale Straightforward worded items.

5.3 Objective 1 - To Examine Social Anxiety Across Sexual Minority Subgroups

This section presents the results pertaining to the first objective of the phase one study (i.e., to examine social anxiety across sexual minority subgroups). Firstly, results comparing social anxiety between sexual minority women and men are presented. Next, separately for men and women, the results comparing social anxiety across sexual identity, sexual attraction, and sexual behaviour subgroups are outlined.

5.3.1 Social Anxiety by Gender

The results partially supported the hypothesis that sexual minority women will report significantly higher social anxiety than sexual minority men. Sexual minority women reported significantly higher social anxiety than sexual minority men on two of the three social anxiety outcome variables. Specifically, Mann-Whitney U tests revealed that there were significant differences between sexual minority women and men for social fear (women [$Mdn = 36$], men [$Mdn = 27.5$], $U = 24,275$, $Z = -4.38$, $p < .001$, $r = .20$), and social avoidance (women [$Mdn = 30$], men [$Mdn = 24.5$], $U = 24,812.5$, $Z = -4.04$, $p < .001$, $r = .18$). Finally, a Mann-Whitney U test demonstrated that there were no significant differences at the Bonferroni adjusted level between women and men for fear of negative evaluation (women [$Mdn = 30$], men [$Mdn = 28$], $U = 27,684.5$, $Z = -2.27$, $p = .02$).

5.3.2 Social Anxiety Across Sexual Identity Subgroups

Social anxiety means and standard deviations across sexual identity subgroups are displayed separately for sexual minority women and men in Table 5.2. Sexual minority women ($n = 4$) and men ($n = 1$) who indicated that they were currently questioning their sexual identity were omitted from these analyses as they could not be categorised as gay/lesbian, bisexual, or emerging identity. Analyses across sexual identity subgroups were conducted with the remaining sexual minority women ($n = 241$) and men ($n = 255$).

5.3.2.1 Sexual Minority Women

The results partially supported the hypothesis that bisexual and emerging identity women will report significantly higher social anxiety than lesbian women. Specifically, a Kruskal-Wallis H test demonstrated a significant effect of sexual identity on social fear, $H(2) = 8.33$, $p = .016$, $\epsilon^2 = .04$. Dunn-Bonferroni post hoc tests revealed that bisexual women ($Mdn = 37.5$, $p = .04$) reported significantly higher social fear than lesbian women ($Mdn = 32$). There were no significant differences in social fear between bisexual women and emerging identity women ($Mdn = 38$), or emerging identity and lesbian women. A Kruskal Wallis H test also demonstrated a significant effect of sexual identity on social avoidance, $H(2) = 11.26$, $p = .004$, $\epsilon^2 = .05$. Dunn-Bonferroni post hoc tests revealed that emerging identity ($Mdn = 36$, $p < .01$) women reported significantly higher social avoidance than lesbian women ($Mdn = 27.5$); there were no significant differences for social avoidance between bisexual women ($Mdn = 32$) and lesbian women, or bisexual women and emerging identity women. Finally, a Kruskal-Wallis H test demonstrated there was no significant effect of sexual identity on

fear of negative evaluation, $H(2) = 5.49, p = .06$; there were no significant fear of negative evaluation differences between lesbian ($Mdn = 28$), bisexual ($Mdn = 32$), and emerging identity women ($Mdn = 31$).

5.3.2.2 Sexual Minority Men

The results did not support the hypothesis that bisexual men and men who adopt an emerging identity label will report significantly higher social anxiety than gay men. Bisexual and emerging identity men did not report significantly higher social anxiety than gay men on any of the three social anxiety outcome variables. Specifically, a Kruskal-Wallis H test revealed that there was no significant effect of sexual identity on social fear $H(2) = 1.11, p = .58$; there were no significant social fear differences between gay ($Mdn = 29$), bisexual ($Mdn = 25$), and emerging identity men ($Mdn = 24$). A Kruskal-Wallis H test also demonstrated that there was no significant effect of sexual identity on social avoidance, $H(2) = 0.44, p = .80$; significant social avoidance differences were not present between gay ($Mdn = 24$), bisexual ($Mdn = 26$), and emerging identity men ($Mdn = 21$). Finally, a Kruskal-Wallis H test also demonstrated that there was no significant effect of sexual identity on fear of negative evaluation, $H(2) = 1.87, p = .39$; significant fear of negative evaluation differences were not evident between gay ($Mdn = 28$), bisexual ($Mdn = 27$), and emerging identity men ($Mdn = 16$).

Table 5.2*Social Anxiety Means and Standard Deviations by Sexual Identity*

Sexual identity subgroup	Sexual minority women				Sexual minority men			
	<i>n</i>	LSAS-F	LSAS-A	BFNE-S	<i>n</i>	LSAS-F	LSAS-A	BFNE-S
Gay/Lesbian	104	31.88 (14.14)	27.50 (14.16)	26.91 (8.39)	227	29.51 (14.40)	25.68 (14.53)	26.69 (8.53)
Bisexual	78	37.82 (15.38)	33.15 (15.45)	29.10 (8.76)	21	28.19 (18.10)	27.38 (20.10)	25.71 (11.38)
Emerging identity	59	37.22 (12.33)	34.75 (12.62)	29.36 (8.67)	7	23.43 (10.98)	21.43 (10.29)	21.29 (11.21)
Questioning	4	32.75 (11.47)	31.50 (22.93)	32.00 (6.68)	1	-	-	-
Emerging identity subgroups								
Queer	25	37.52 (11.39)	33.52 (12.90)	30.52 (7.74)	3	23.00 (2.65)	17.67 (2.89)	14.33 (2.08)
Pansexual	23	37.26 (13.30)	35.74 (12.55)	29.57 (9.37)	3	23.67 (18.82)	22.33 (15.82)	26.00 (15.62)
Asexual	7	36.00 (12.34)	38.14 (13.21)	26.71 (9.71)	1	-	-	-
Write-in response ^a	4	37.25 (17.21)	30.75 (13.25)	25.50 (9.71)	-	-	-	-

Note. Standard deviations are presented in parentheses. LSAS-F = Liebowitz Social Anxiety fear subscale; LSAS-A = Liebowitz Social Anxiety avoidance subscale;

BFNE-S = Brief Fear of Negative Evaluation Scale Straightforward worded items.

^a Demisexual lesbian ($n = 1$), Demi and Queer ($n = 1$), Demisexual pansexual ($n = 1$), greysexual ($n = 1$).

5.3.3 Social Anxiety Across Sexual Attraction Subgroups

Social anxiety means and standard deviations across sexual attraction subgroups are displayed separately for sexual minority women and men in Table 5.3. As no sexual minority women indicated that they were “only attracted to the opposite-gender”, four sexual attraction subgroups were retained for the analyses ($n = 245$; i.e., “only attracted to same-gender”, “mostly attracted to same-gender”, “equally attracted to all genders”, and “mostly attracted to opposite-gender”). Sexual minority men who indicated that they were “mostly attracted to opposite-gender” ($n = 2$) and “only attracted to opposite-gender” ($n = 1$) were omitted from these analyses due to small group numbers. Therefore, three sexual attraction subgroups were retained for the analyses ($n = 253$; i.e., “only attracted to same-gender”, “mostly attracted to same-gender”, and “equally attracted to all genders”).

5.3.3.1 Sexual Minority Women

The results did not support the hypothesis that sexual minority women who are “only attracted to the same-gender” will report significantly lower social anxiety than “women mostly attracted to same-gender”, “equally attracted to all genders”, and “mostly attracted to opposite-gender”. Specifically, a Kruskal-Wallis H test revealed that there was no significant effect of sexual attraction on social fear $H(3) = 5.07, p = .17$; no significant social fear differences were found between women “only attracted to same-gender” ($Mdn = 32$), “mostly attracted to same-gender” ($Mdn = 37$), “equally attracted to all genders” ($Mdn = 40$), and “mostly attracted to opposite-gender” ($Mdn = 34.5$). A Kruskal-Wallis H test also demonstrated that there was no significant effect of sexual attraction on social avoidance $H(3) = 5.08, p = .17$; there were no significant social avoidance differences between women “only attracted to same-gender” ($Mdn = 28$), “mostly attracted to same-gender” ($Mdn = 29$), “equally attracted to all genders” ($Mdn = 34$), and “mostly attracted to opposite-gender” ($Mdn = 29.5$). Finally, a Kruskal-Wallis H test demonstrated that there was no significant effect of sexual attraction on fear of negative evaluation at the adjusted Bonferroni level, $H(3) = 8.74, p = .03$; there was an absence of significant fear of negative evaluation differences between sexual minority women “only attracted to same-gender” ($Mdn = 27.5$), “mostly attracted to same-gender” ($Mdn = 32$), “equally attracted to all genders” ($Mdn = 31$), and “mostly attracted to opposite-gender” ($Mdn = 31$).

5.3.3.2 *Sexual Minority Men*

The hypothesis that sexual minority men who are “only attracted to the same-gender” will report significantly lower social anxiety than men “mostly attracted to same-gender” and men “equally attracted to all genders” was not supported by the findings. Specifically, a Kruskal-Wallis H test revealed that there was no significant effect of sexual attraction on social fear $H(2) = .62, p = .73$; there was an absence of significant social fear differences between men “only attracted to same-gender” ($Mdn = 29$), “mostly attracted to same-gender” ($Mdn = 27$), and “equally attracted to all genders” ($Mdn = 27$). A Kruskal-Wallis H test also demonstrated that there was no significant effect of sexual attraction on social avoidance $H(2) = .02, p = .99$; no significant social avoidance differences were found between men “only attracted to same-gender” ($Mdn = 24$), “mostly attracted to same-gender” ($Mdn = 23$), and “equally attracted to all genders” ($Mdn = 26$). Finally, a Kruskal-Wallis H test demonstrated that there was no significant effect of sexual attraction on fear of negative evaluation, $H(2) = .84, p = .66$; there were no significant fear of negative evaluation differences between men “only attracted to same-gender” ($Mdn = 27$), “mostly attracted to same-gender” ($Mdn = 29$), and “equally attracted to all genders” ($Mdn = 31$).

Table 5.3*Social Anxiety Means and Standard Deviations by Sexual Attraction*

Sexual attraction subgroup	Sexual minority women				Sexual minority men			
	<i>n</i>	LSAS-F	LSAS-A	BFNE-S	<i>n</i>	LSAS-F	LSAS-A	BFNE-S
Only attracted to same-gender	76	32.83 (15.64)	29.41 (15.30)	25.91 (8.97)	192	29.60 (14.55)	25.54 (14.47)	26.32 (8.65)
Mostly attracted to same-gender	75	36.03 (13.84)	31.00 (14.64)	30.12 (7.07)	50	28.00 (14.38)	25.68 (15.73)	27.54 (8.86)
Equally attracted to all genders	70	37.49 (14.71)	34.40 (15.04)	28.57 (9.28)	11	26.27 (18.53)	26.27 (18.58)	24.73 (13.30)
Mostly attracted to opposite-gender	24	32.17 (7.94)	27.25 (9.17)	29.21 (8.44)	2	35.00 (18.39)	32.50 (27.58)	26.50 (12.02)
Only attracted to opposite-gender	0	-	-	-	1	-	-	-

Note. Standard deviations are presented in parentheses. LSAS-F = Liebowitz Social Anxiety fear subscale; LSAS-A = Liebowitz Social Anxiety avoidance subscale; BFNE-S = Brief Fear of Negative Evaluation Scale Straightforward worded items.

5.3.4 Social Anxiety Across Sexual Behaviour Subgroups

Social anxiety means and standard deviations across sexual behaviour subgroups are displayed separately for sexual minority women and men in Table 5.4. Sexual minority women who indicated that they had “genderqueer or non-binary partner(s)” were omitted from these analyses due to the small number of participants in this group ($n = 3$); four sexual behaviour subgroups were retained in the analyses for sexual minority women ($n = 242$; i.e., “only same-gender partner(s)”, “same- and opposite-gender partner(s)”, “only opposite-gender partner(s)”, and “didn’t have sex”). Sexual minority men who indicated that they had sex with “genderqueer or non-binary partner(s)” ($n = 1$) and “only opposite-gender partner(s)” ($n = 1$) were omitted from these analyses due to the small number of participants in each of these groups. Therefore, three sexual behaviour subgroups were retained for the analyses with sexual minority men ($n = 254$; i.e., “only same-gender partner(s)”, “same- and opposite-gender partner(s)”, and “didn’t have sex”).

5.3.4.1 Sexual Minority Women

The results partially supported the hypothesis that women with “only same-gender sexual partner(s)” will report significantly lower social anxiety than women with both “same- and opposite-gender partner(s)”, women with “only opposite-gender partner(s)”, and women who “didn’t have sex”. A Kruskal-Wallis H test demonstrated a significant effect of sexual behaviour on social fear, $H(3) = 16.49$, $p = .001$, $\varepsilon^2 = .07$. Dunn-Bonferroni post hoc tests revealed that sexual minority women who “didn’t have sex” ($Mdn = 40$, $p = .001$) and those with “only opposite-gender partner(s)” ($Mdn = 38$, $p < .05$) reported significantly higher social fear than women with “only same-gender partner(s)” ($Mdn = 30$). Sexual minority women with “same- and opposite-gender partner(s)” ($Mdn = 34$) did not differ significantly with any other sexual behaviour subgroup on social fear. Further, no significant differences were found on social fear between those with “only opposite-gender partner(s)” and those who “didn’t have sex”. A Kruskal-Wallis H test also revealed a significant effect of sexual behaviour on social avoidance, $H(3) = 13.49$, $p < .01$, $\varepsilon^2 = .06$. Dunn-Bonferroni post hoc tests revealed that sexual minority women who “didn’t have sex” ($Mdn = 35$, $p < .01$) reported significantly higher social avoidance than women with “only same-gender partner(s)” ($Mdn = 27$). There were no significant social avoidance differences between sexual minority women with “only same gender-partner(s)”, “only opposite-gender partner(s)” ($Mdn = 33$), and “same- and opposite-gender partner(s)” ($Mdn = 29$). Further, sexual minority women who “didn’t have sex” did not report significantly different social

avoidance to sexual minority women with “only opposite-gender partner(s)” or those with “same- and opposite-gender partner(s)”. Lastly, A Kruskal-Wallis H test demonstrated a significant effect of sexual behaviour on fear of negative evaluation, $H(3) = 19.03, p < .001, \epsilon^2 = .08$. Dunn-Bonferroni post hoc tests revealed that sexual minority women with “only opposite-gender partner(s)” ($Mdn = 34$) reported significantly higher fear of negative evaluation than both women with “only same-gender partner(s)” ($Mdn = 27, p = .001$) and women with “same and opposite-gender partner(s)” ($Mdn = 27.5, p < .01$). Women who “didn’t have sex” ($Mdn = 31$) did not report significantly different fear of negative evaluation to any other sexual behaviour subgroup, nor were there significant fear of negative evaluation differences between women with “only same-gender partner(s)” and those with “same- and opposite-gender partner(s)”.

5.3.4.2 Sexual Minority Men

The hypothesis that men with “only same-gender partner(s)” and will report lower social anxiety than men with “same- and opposite-gender partner(s)” and men who “didn’t have sex” was not supported by the findings. A Kruskal-Wallis H test demonstrated a significant effect of sexual behaviour on social fear, $H(2) = 9.37, p = .01, \epsilon^2 = .04$. Dunn-Bonferroni post hoc tests revealed that sexual minority men “who didn’t have sex” ($Mdn = 37.5$) reported significantly higher social fear than men with “same- and opposite-gender partner(s)” ($Mdn = 20, p < .01$). No significant social fear differences were found between men with “only same-gender partner(s)” ($Mdn = 27$) and any other sexual behaviour subgroup. A Kruskal-Wallis H test also revealed that there was no significant effect of sexual behaviour on social avoidance, $H(2) = 5.97, p = .051$; no significant social avoidance differences were evident between men who “didn’t have sex” ($Mdn = 30$), those with “only same-gender partner(s)” ($Mdn = 24$), and those with both “same- and opposite-gender partner(s)” ($Mdn = 16$). Lastly, a Kruskal-Wallis H test revealed that there was no significant effect of sexual behaviour on fear of negative evaluation at the adjusted Bonferroni level, $H(2) = 6.55, p = .04$; there were no significant fear of negative evaluation differences between men who “didn’t have sex” ($Mdn = 33$), those with “only same-gender partner(s)” ($Mdn = 28$), and those with both “same- and opposite-gender partner(s)” ($Mdn = 20$).

Table 5.4*Social Anxiety Means and Standard Deviations by Sexual Behaviour*

Sexual behaviour subgroup	Sexual minority women				Sexual minority men			
	<i>n</i>	LSAS-F	LSAS-A	BFNE-S	<i>n</i>	LSAS-F	LSAS-A	BFNE-S
Only same-gender partner(s)	95	30.86 (14.35)	27.06 (13.59)	26.34 (8.79)	215	28.94 (14.33)	25.47 (14.80)	26.66 (8.52)
Same- and opposite-gender partner(s)	38	34.00 (15.15)	30.00 (15.18)	25.87 (8.50)	15	21.27 (14.07)	19.80 (13.72)	20.73 (11.27)
Genderqueer or non-binary partner(s)	3	39.00 (7.55)	38.00 (7.94)	30.33 (7.51)	1	-	-	-
Only opposite-gender partner(s)	48	37.79 (12.50)	33.94 (14.23)	31.71 (7.67)	1	-	-	-
Didn't have sex	61	39.97 (13.59)	35.54 (14.96)	30.02 (8.03)	24	36.75 (15.59)	31.96 (15.57)	28.79 (9.65)

Note. Standard deviations are presented in parentheses. LSAS-F = Liebowitz Social Anxiety fear subscale; LSAS-A = Liebowitz Social Anxiety avoidance subscale; BFNE-S = Brief Fear of Negative Evaluation Scale Straightforward worded items.

5.4 Objective 2 - To Test a Comprehensive Model of the Determinants of Social Anxiety Among Sexual Minority Individuals

This section presents the results pertaining to the second objective of the phase one study (i.e., to test a comprehensive model of the determinants, both protective and risk factors, of social anxiety among sexual minority individuals). All results in this section are presented separately for sexual minority women and men. Firstly, the preliminary analysis to detect potential confounders is detailed. Then, the two-step results for the structural equation modelling analyses are outlined. This begins with the results pertaining to the measurement models, followed by the results related to the structural models (i.e., detailing direct and indirect effects).

5.4.1 Preliminary Analyses

All indicators except one (i.e., item five of the IHP-R; see section 4.6.4.2) satisfied Kline's (2015) recommendations of skewness less than 3 and kurtosis less than 4. For sexual minority women high scoring outliers were winsorised for the following indicator variables: age ($n = 2$), ED 1 ($n = 2$), CB 1 ($n = 4$), CB 2 ($n = 4$), IMS Status ($n = 2$), and income ($n = 5$); a low scoring outlier was winsorised for LGBTQCC 1 ($n = 1$). For sexual minority men high scoring outliers were winsorised for age ($n = 1$), ED 1 ($n = 2$), ED 2 ($n = 1$), ED 3 ($n = 1$), RS 1 ($n = 2$), CB 3 ($n = 7$), and IMS Status ($n = 3$); see Table 5.6 for indicator variable details.

The preliminary analyses demonstrated confounding variables for both sexual minority women and men. For sexual minority women, there were significant differences for sexual identity ($F = 5.52, p < .001$), education ($F = 7.67, p < .001$), employment status ($F = 8.38, p < .001$), and relationship status ($F = 6.96, p = .002$) such that higher social anxiety (i.e., social anxiety latent variable) was reported by single women compared to those who were married/in a relationship, women with lower overall educational attainment compared to those with higher educational attainment, women without full-time employment compared to those with full-time employment, and bisexual/emerging identity women compared to lesbian women. No significant differences were observed for ethnicity ($F = .76, p = .48$). Age ($r = -.40, p < .01$) and income ($r = -.37, p < .01$) were negatively associated with social anxiety for sexual minority women, such that social anxiety was associated with younger age and less income.

There were no significant differences for sexual minority men on categorical variables at the adjusted Bonferroni level (i.e., $p = .01$; ethnicity [$F = 1.02, p = .38$], sexual identity [$F =$

1.02, $p = .51$], education [$F = 3.62, p = .011$], income [$F = 3.46, p = .02$], and relationship status [$F = 4.01, p = .02$]). Age was not associated with social anxiety ($r = -.08, p = .22$), whereas income was negatively associated with social anxiety ($r = -.24, p < .01$), such that social anxiety was associated with less income among sexual minority men. Therefore, in the SEM analysis, income was entered as covariate for sexual minority men; sexual identity, education, employment status, relationship status, age, and income were used as covariates for sexual minority women.

5.4.2 Measurement Models

The subscales of the Intra-minority Gay Community Stress Scale (i.e., sex, status, competition, and exclusion) and the Sense of Coherence Scale (i.e., comprehensibility, manageability, and meaningfulness) served as indicators to define their associated latent construct. Z-scores on the fear and avoidance subscales of the Liebowitz Social Anxiety Scale and the Brief Fear of Negative Evaluation Scale (straightforward worded items) served as three indicators for the social anxiety latent construct. Initially, the researcher planned to use the total scores from the Revised Internalized Homophobia Scale, Sexual Orientation Concealment Scale, Gay-Related Rejection Sensitivity Scale (sexual minority men only) and Sexual Minority Women's- Rejection Sensitivity Scale (sexual minority women only) as observed indicators for the proximal minority stress latent construct; however, for both sexual minority women and men, this data did not demonstrate good fit with this construct (i.e., factor loadings below 0.5). Therefore, separate latent constructs were created for all three proximal minority stress variables.

Due to the lower number of items (i.e., four after removing an item with extreme skewness and kurtosis) in the Revised Internalized Homophobia Scale, its items were used as indicator variables. For the remaining measures without previously established subscales (i.e., Everyday Discrimination Scale, LGBTQ Community Connectedness Scale, Sexual Orientation Concealment Scale, Gay-Related Rejection Sensitivity Scale and Sexual Minority Women's- Rejection Sensitivity Scale) individual items were used to create parcels that functioned as observed indicators for their respective latent constructs (e.g., Weston & Gore, 2006). Specifically, the balancing approach was used to create item parcels (Landis et al., 2000). With this approach, exploratory factor analyses were performed with principal axis factoring using the items of these measures. Individual items were then ranked according to the magnitude of their factor loadings. Next, the remaining items in each scale were designated to three parcels in countervailing order. For example, the item with the

highest factor loading was paired with the item that has the lowest factor loading in the first parcel, the item with the second highest factor loading was paired with the item that has the second lowest factoring loading in the second parcel, and the item with the third highest factor loading was paired with the item that has the third lowest factor loading (Little et al., 2013). This process continued until all items were assigned to a parcel, and parcel scores were formulated by averaging each of their associated items. The balancing approach attempts to recreate the overall factor structure of the associated construct in each parcel (i.e., by including high and lower loading items in each), maximises equal factor loadings across parcels, and develops parallel/tau equivalent parcels (Landis et al., 2000; Sass & Smith, 2006; Yang et al., 2010). Further, this approach is advocated when the items are loading onto a unidimensional construct (Landis et al., 2000; Rogers & Schmitt, 2004), as is the case in the current study. An example of the balancing item parcelling approach (i.e., for concealment behaviour among sexual minority men) is illustrated in Table 5.5.

Table 5.5

Example of Balancing Item Parcelling Approach for the Sexual Orientation Concealment Scale Among Sexual Minority Men

Scale items in rank order according to factor loadings	EFA factor loadings	Parcels created	CB factor loadings
Item 3- avoided the subjects of sex, love, attraction, or relationships to conceal my sexual orientation.	.78	Parcel 1 Items 3 and 5	.78
Item 4- allowed others to assume I am straight without correcting them.	.77	Parcel 2 Items 4 and 2	.85
Item 6- remained silent while witnessing anti-gay remarks, jokes, or activities because I did not want to be labelled as LGB by those involved.	.67	Parcel 3 Items 6 and 1	.82
Item 1- concealed my sexual orientation by telling someone that I was straight or denying that I was LGB.	.66		
Item 2- concealed my sexual orientation by avoiding contact with other LGB individuals.	.64		
Item 5- altered my appearance, mannerisms, or activities in an attempt to “pass” as straight.	.63		

Note. EFA = exploratory factor analysis; CB = concealment behaviour latent construct.

The loadings of all indicator variables on the latent variables are displayed separately for sexual minority women and men in Table 5.6. All observed indicators had factor loadings greater than .50 and were significant at the $p < .001$ level, signifying that the latent variables

were well defined by the indicator variables. The correlations between the latent variables are detailed separately for sexual minority women and men in Table 5.7.

Table 5.6*Factor Loadings for the Measurement Models*

Latent variable and indicators	Sexual minority women			Sexual minority men		
	Unstandardised factor loading	<i>SE</i>	Standardised factor loading	Unstandardised factor loading	<i>SE</i>	Standardised factor loading
Social Anxiety						
Social fear	1.00		.97	1.00		.95
Social avoidance	0.96	.04	.92	1.01	.04	.96
Fear of negative evaluation	0.70	.05	.67	0.70	.05	.67
Experiences of discrimination						
ED 1	1.00		.83	1.00		.80
ED 2	1.06	.07	.84	1.19	.09	.83
ED 3	1.03	.08	.80	1.25	.09	.81
Internalised homonegativity						
IHP-R 1	1.00		.85	1.00		.88
IHP-R 2	0.90	.08	.66	0.68	.07	.59
IHP-R 3	0.92	.07	.83	0.95	.06	.84
IHP-R 4	0.70	.06	.71	0.75	.06	.74
Concealment behaviour						
CB 1	1.00		.80	1.00		.78
CB 2	1.14	.09	.81	0.94	.07	.85
CB 3	1.47	.12	.80	0.83	.06	.82
Rejection sensitivity						
RS 1	1.00		.88	1.00		.88
RS 2	1.02	.06	.83	1.16	.07	.86
RS 3	1.07	.06	.87	1.23	.07	.87
Intraminority stress						
Status	1.00		.72	1.00		.77

Table 5.6*Factor Loadings for the Measurement Models*

Latent variable and indicators	Sexual minority women			Sexual minority men		
	Unstandardised factor loading	<i>SE</i>	Standardised factor loading	Unstandardised factor loading	<i>SE</i>	Standardised factor loading
Exclusion	1.23	.16	.56	0.81	.10	.51
Competition	1.41	.14	.80	1.30	.10	.88
Sex	1.23	.13	.70	1.12	.11	.71
LGBTQ community connectedness						
LGBTQCC 1	1.16	.08	.88	0.99	.05	.89
LGBTQCC 2	1.06	.08	.80	0.97	.05	.86
LGBTQCC 3	1.00		.84	1.00		.89
Sense of coherence						
Meaningfulness	1.00		.67	1.00		.57
Manageability	1.21	.10	.91	1.50	.15	.91
Comprehensibility	1.20	.10	.87	1.40	.15	.85

Note. *SE* = Standard Error. ED 1, ED 2, and ED 3 = three item parcels from the Everyday Discrimination Scale; IHP-R 1, IHP-R 2, IHP-R 3, and IHP-R 4 = four items from the Revised Internalized Homophobia Scale; CB 1, CB 2, and CB 3 = three item parcels from the Sexual Orientation Concealment Scale; RS 1, RS 2, and RS 3 = three item parcels from the Gay-Related Rejection Sensitivity Scale (sexual minority men only) and the Sexual Minority Women Rejection Sensitivity Scale (sexual minority women only); LGBTQCC 1, LGBTQCC 2, and LGBTQCC 3 = three item parcels from the Connectedness to the LGBT Community Scale.

All factor loadings are significant at the $p < .001$ level.

Table 5.7*Summary Correlations, Reliability and Validity Statistics for Latent Variables*

Latent Construct	1	2	3	4	5	6	7	8	CR	AVE	MSV	$\sqrt{\text{AVE}}$
1. Social anxiety	-	.41**	.16*	.28**	.55**	.46**	-.03	-.68**	.90	.74	.46	.86
2. Experiences of discrimination	.42**	-	.10	.35**	.47**	.36**	.09	-.61**	.87	.68	.37	.83
3. Internalised homonegativity	.28**	.24**	-	.53**	.16*	-.04	-.28**	-.15*	.85	.59	.28	.77
4. Concealment behaviour	.37**	.30**	.56**	-	.39**	.11	-.17*	-.31**	.84	.64	.28	.80
5. Rejection sensitivity	.51**	.46**	.27**	.32**	-	.38**	.15*	-.50**	.89	.74	.30	.86
6. Intraminority stress	.46**	.48**	.34**	.28**	.42**	-	.02	-.52**	.79	.49	.27	.70
7. LGBTQ community connectedness	-.17*	-.06	-.42**	-.39**	.01	-.20**	-	-.01	.88	.71	.08	.84
8. Sense of coherence	-.59**	-.66**	-.34**	-.36**	-.52**	-.56**	.16*	-	.86	.68	.46	.83
CR	.90	.85	.85	.86	.90	.81	.91	.83				
AVE	.76	.66	.59	.67	.76	.53	.78	.63				
MSV	.35	.43	.31	.31	.27	.32	.18	.43				
$\sqrt{\text{AVE}}$.87	.81	.77	.82	.87	.73	.88	.79				

Note. CR = Composite Reliability; AVE = Average Variance Explained; MSV = Maximum Shared Variance. Latent construct correlations for sexual minority women ($n = 245$) are presented above the diagonal, and correlations for sexual minority men ($n = 256$) are presented below the diagonal. Reliability and validity statistics for sexual minority women are presented in the vertical columns, and reliability and validity statistics for sexual minority men are presented in the horizontal rows.

* $p < .05$ ** $p < .01$.

5.4.2.1 Sexual Minority Women's Measurement Model

For the sexual minority women's measurement model, the fit indexes were the following: $\chi^2(271, N = 245) = 547.80, p < .001, CFI = .93, RMSEA = .07$ (90% CI [.06, .07]), $SRMR = .06$. Two of these indices indicated excellent fit (i.e., chi-square and $SRMR$), whereas the CFI and $RMSEA$ closely approached the cut-off values for excellent fit and indicated acceptable fit (Weston & Gore, 2006). As displayed in Table 5.7, all latent variables fulfilled Hair et al.'s (2014) criteria for reliability (CRs ranged from .79 [intraminority stress] to .90 [social anxiety]), and discriminant validity (all $MSVs < AVEs$ and all square roots of $AVEs >$ inter-construct correlations). All latent constructs, with the exception of intraminority stress, also fulfilled the criterion for convergent validity ($AVEs$ ranged from .59 [internalised homonegativity] to .74 [both social anxiety and rejection sensitivity]). The AVE of the intraminority stress construct was .49, which is just below the cut-off criterion of .50. However, AVE values ranging from .40-.50 are deemed acceptable in instances in which the CR is higher than 0.7 (Fornell & Larcker, 1981); thus the intraminority stress construct demonstrated adequate convergent validity. Additionally, Cook's distances values (ranged from .00 to .05) indicated an absence of multivariate outliers.

5.4.2.2 Sexual Minority Men's Measurement Model

For the sexual minority men's measurement model, the fit indexes were as follows: $\chi^2(271, N = 256) = 543.14, p < .001, CFI = .94, RMSEA = .06$ (90% CI [.06, .07]), $SRMR = .07$. Three of the four indices indicated excellent fit (i.e., chi-square, $RMSEA$, and $SRMR$) whereas the CFI value closely approached the cut-off value for excellent fit (Weston & Gore, 2006). As Table 5.7 indicates, all latent variables fulfilled Hair et al.'s (2014) criteria for reliability (CRs ranged from .81 [intraminority stress] to .91 [LGBTQ community connectedness]), discriminant validity (all $MSVs < AVEs$ and all square roots of $AVEs >$ inter-construct correlations), and convergent validity ($AVEs$ ranged from .53 [intraminority stress] to .78 [LGBTQ community connectedness]). Lastly, there was an absence of multivariate outliers as indicated by Cook's distance values (ranged from .00 to .09).

5.4.3 Structural Models

For both sexual minority women and men, we tested the hypothesised pathways as illustrated in Figure 4.1 (i.e., with separate latent constructs created for each proximal minority stress variable, see section 5.4.2). As we originally conceptualised an overarching proximal

minority stress latent variable, we correlated the error terms of the internalised homonegativity, concealment behavior, and rejection sensitivity latent variables prior to testing the structural models. Covariates were specified to correlate with one another and with the two exogenous predictors (i.e., experiences of discrimination and intraminority stress), and the social anxiety outcome variable was predicted by the covariates. In order to obtain model fit, for both sexual minority women and men, we consulted the regression weights table (i.e., to detect non-significant paths) and the modifications indices (i.e., to detect correlated constructs) after testing initial structural models.

5.4.3.1 Sexual Minority Women's Structural Model

For the initial structural model, the fit indices were the following: $\chi^2(37, N = 245) = 104.17$, $p < .001$, $CFI = .95$, $RMSEA = .09$ (90% CI [.07, .11]), $SRMR = .05$. Whilst the chi-square, CFI , and $SRMR$ indices fulfilled the criteria for model fit, the $RMSEA$ index did not. Two non-significant paths were removed to obtain model fit: (IMS \rightarrow CB) and (IH \rightarrow SA). Following the removal of these pathways, the original conceptual model is still represented as the paths (IMS \rightarrow Proximal Minority Stress) and (Proximal Minority Stress \rightarrow SA) have been maintained through the inclusion of the paths (IMS \rightarrow RS and IMS \rightarrow IH) and (CB \rightarrow SA and RS \rightarrow SA) respectively. After consulting the modification indices, the sense of coherence and rejection sensitivity endogenous variables were predicted by the covariate age. Further, in addition to the proximal minority stress constructs (i.e., RS \leftrightarrow IH [$\beta = .17$], RS \leftrightarrow CB [$\beta = .32$], and IH \leftrightarrow CB [$\beta = .60$]), three pairs of error terms were also correlated (i.e., SOC \leftrightarrow RS [$\beta = -.17$], SOC \leftrightarrow IH [$\beta = -.19$], and SOC \leftrightarrow CB [$\beta = -.15$]). For the final structural model, the fit indexes were the following: $\chi^2(34, N = 245) = 57.84$, $p < .01$, $CFI = .98$, $RMSEA = .05$ (90% CI [.03, .08]), $SRMR = .04$, indicating excellent model fit. In order to test whether the pathways estimated in the structural model differed for lesbian and bisexual/emerging identity women, a multi-group analysis was carried out constraining all paths to be equal across groups. The chi-square difference test demonstrated that the structural relationships in the model did not significantly differ across the lesbian and bisexual/emerging identity groups $\chi^2(22, N = 245) = 33.52$, $p = .06$.

The results indicated that 11 of the 15 direct paths in the final structural model demonstrated significant effects. All four direct paths from everyday discrimination (i.e., ED \rightarrow RS [$\beta = .37$, $p < .001$], ED \rightarrow IH [$\beta = .15$, $p < .05$], ED \rightarrow CB [$\beta = .39$, $p < .001$], and ED \rightarrow SOC [$\beta = -.46$, $p = .001$]) were significant, whereas two direct paths from intraminority stress

were significant (i.e., $IMS \rightarrow RS$ [$\beta = .25, p < .001$] and $IMS \rightarrow SOC$ [$\beta = -.36, p < .001$]), and two were non-significant (i.e., $IMS \rightarrow IH$ [$\beta = -.09, p = .13$] and $IMS \rightarrow LGBTQCC$ [$\beta = -.12, p = .07$]). Both direct paths from rejection sensitivity were significant (i.e., $RS \rightarrow LGBTQCC$ [$\beta = .33, p < .001$] and $RS \rightarrow SA$ [$\beta = .29, p < .001$]), although the former demonstrated a positive association despite being hypothesised to demonstrate a negative association. The path ($IH \rightarrow LGBTQCC$) was significant [$\beta = -.29, p < .001$], whereas both paths from concealment behavior (i.e., $CB \rightarrow LGBTQCC$ [$\beta = -.15, p = .06$] and $CB \rightarrow SA$ [$\beta = -.04, p = .39$]) were non-significant. Lastly, the significant direct paths ($LGBTQCC \rightarrow SA$; $\beta = -.10, p < .05$) and ($SOC \rightarrow SA$; $\beta = -.51, p < .001$) were also evident.

The model accounted for 61% of social anxiety variance among sexual minority women (see Figure 5.2), and results demonstrated eight significant indirect pathways to social anxiety (see Table 5.8). Specifically, for hypothesised Path A X F, the indirect path ($ED \rightarrow RS \rightarrow SA$) was significant ($\beta = .109, p < .001$), whereas the indirect path ($ED \rightarrow CB \rightarrow SA$) was not ($\beta = -.016, p = .399$). The indirect path ($ED \rightarrow IH \rightarrow SA$) was not estimated due to the removal of the non-significant path ($IH \rightarrow SA$) in the final model. Regarding hypothesised Path C X F, the indirect path ($IMS \rightarrow RS \rightarrow SA$) was significant ($\beta = .073, p < .001$); the indirect paths ($IMS \rightarrow CB \rightarrow SA$) and ($IMS \rightarrow IH \rightarrow SA$) were not estimated due to the removal of the non-significant paths ($IMS \rightarrow CB$) and ($IH \rightarrow SA$) from the final model. The indirect paths related to hypothesised Paths B X H, ($ED \rightarrow SOC \rightarrow SA$; $\beta = .235, p < .001$) and E X H ($IMS \rightarrow SOC \rightarrow SA$; $\beta = .184, p < .001$) were significant. Two indirect paths related to hypothesised Path A X G X I were significant ($ED \rightarrow CB \rightarrow LGBTQCC \rightarrow SA$; $\beta = .006, p = .033$; $ED \rightarrow IH \rightarrow LGBTQCC \rightarrow SA$; $\beta = .004, p = .019$). One other indirect path related to Path A X G X I ($ED \rightarrow RS \rightarrow LGBTQCC \rightarrow SA$; $\beta = -.012, p = .022$), and one indirect path related to hypothesised Path C X G X I were significant ($IMS \rightarrow RS \rightarrow LGBTQCC \rightarrow SA$; $\beta = -.008, p = .016$), however the hypothesised negative effect ($RS \rightarrow LGBTQCC$) was positive. The two other paths associated with Path C X G X I were non-significant ($IMS \rightarrow IH \rightarrow LGBTQCC \rightarrow SA$; $\beta = -.002, p = .052$), and not estimated ($IMS \rightarrow CB \rightarrow LGBTQCC \rightarrow SA$) due to the removal of the non-significant path ($IMS \rightarrow CB$) from the final model. Lastly, for hypothesised path D X I, the indirect path ($IMS \rightarrow LGBTQCC \rightarrow SA$) was non-significant ($\beta = .011, p = .067$).

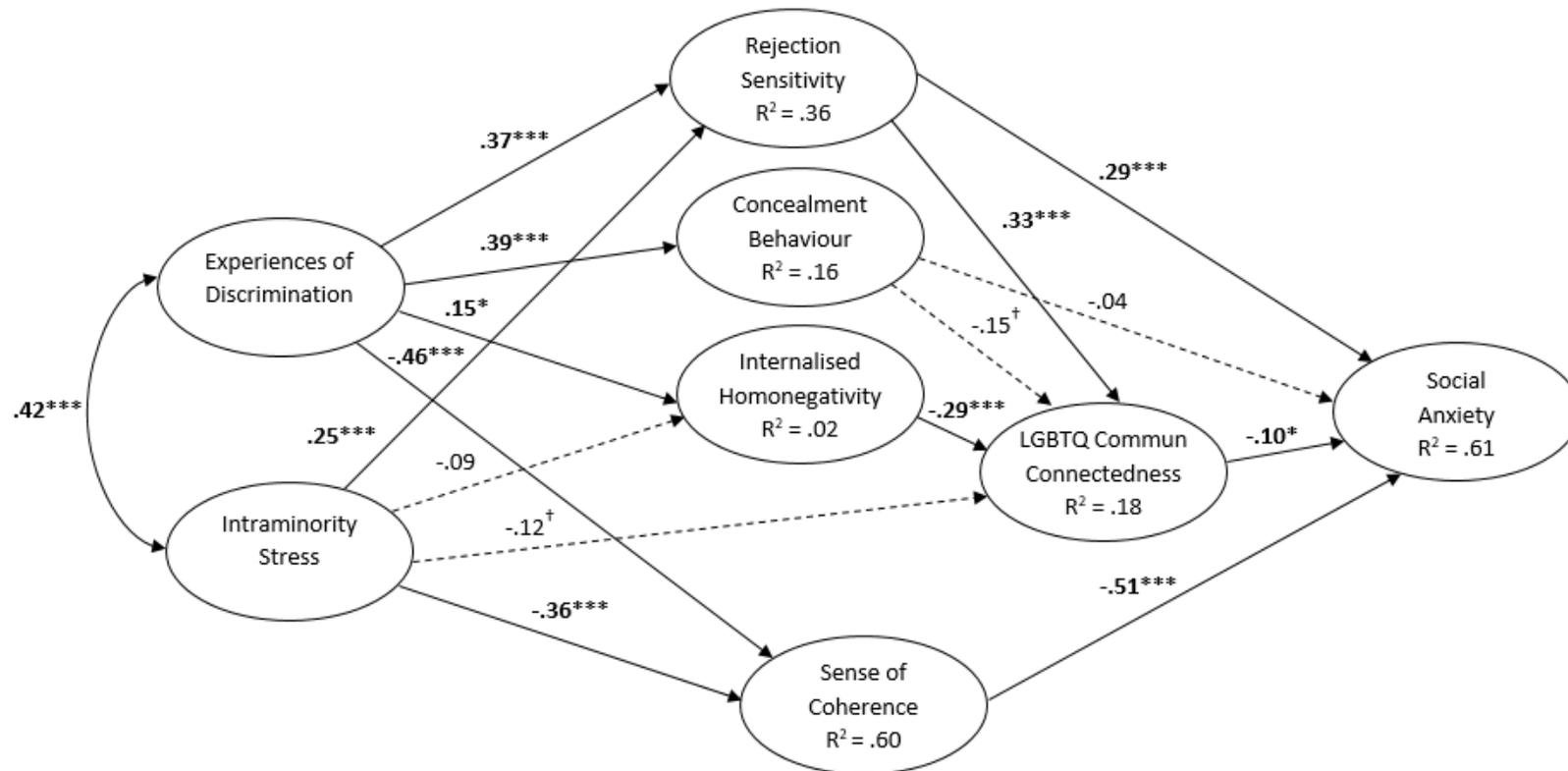


Figure 5.2: Structural Model for Sexual Minority Women. Solid lines indicate significant pathways, whereas dashed lines indicate non-significant pathways. Commun = Community. The following paths from the covariates to endogenous variables were estimated but are not depicted in the above figure to facilitate readability: from age to sense of coherence ($\beta = .20^{**}$), rejection sensitivity ($\beta = -.17^{**}$), and social anxiety ($\beta = -.03$); from sexual identity to social anxiety ($\beta = -.03$); from income to social anxiety ($\beta = -.07$); from relationship status to social anxiety ($\beta = -.10^*$); from employment to social anxiety ($\beta = .00$); from education to social anxiety ($\beta = -.05$).

*** $p < .001$. ** $p < .01$. * $p < .05$. $^{\dagger}p < .10$.

Table 5.8

Indirect Path Estimates to Social Anxiety Among Sexual Minority Women with Bootstrapped SEs and CIs

Path	<i>B</i>	<i>SE</i>	95% CI	β	<i>p</i>
ED → RS → SA	.146	.032	[.088, .215]	.109	<.001
ED → RS → LGBTQCC → SA	-.016	.009	[-.037, -.002]	-.012	.022
ED → CB → SA	-.022	.029	[-.079, .033]	-.016	.399
ED → CB → LGBTQCC → SA	.008	.005	[.001, .024]	.006	.033
ED → IH → LGBTQCC → SA	.006	.004	[.001, .019]	.004	.019
ED → SOC → SA	.313	.045	[.229, .407]	.235	<.001
IMS → RS → SA	.147	.045	[.070, .246]	.073	<.001
IMS → RS → LGBTQCC → SA	-.016	.009	[-.038, -.003]	-.008	.016
IMS → IH → LGBTQCC → SA	-.005	.004	[-.018, .000]	-.002	.052
IMS → LGBTQCC → SA	.023	.019	[-.001, .077]	.011	.067
IMS → SOC → SA	.369	.061	[.260, .496]	.184	<.001

Note. ED = experiences of discrimination; RS = rejection sensitivity; SA = social anxiety; LGBTQCC = LGBTQ community connectedness; CB = concealment behaviour; IH = internalized homonegativity; SOC = sense of coherence; IMS = intraminority stress.

5.4.3.2 Sexual Minority Men

The fit indices were the following for the initial structural model: $\chi^2(12, N = 256) = 60.00, p < .001, CFI = .96, RMSEA = .11$ (90% CI [.08, .15]), *SRMR* = .04. Whilst the *CFI* and *SRMR* indices fulfilled the criteria for model fit, the *RMSEA* index did not, and the chi-square value equaled the cut-off point. The non-significant paths (ED → IH) and (IH → SA) were removed to obtain model fit. Following the removal of these paths, the original conceptual model is still represented as the paths (ED → Proximal Minority Stress) and (Proximal Minority Stress → SA) have been maintained through the inclusion of the paths (ED → RS and ED → CB) and (RS → SA and CB → SA) respectively. Having consulted the modification indices, the sense of coherence endogenous variable was predicted by the covariate income. In addition to the proximal minority stress constructs (i.e., RS ↔ IH [$\beta = .12$], RS ↔ CB [$\beta = .19$], and IH ↔ CB [$\beta = .57$]), three pairs of error terms were also correlated (i.e., SOC ↔ RS [$\beta = -.27$], SOC ↔ IH [$\beta = -.19$], and SOC ↔ CB [$\beta = -.20$]). The fit indices for the final structural model indicated excellent model fit: $\chi^2(10, N = 256) = 18.00, p = .06, CFI = .99, RMSEA = .06$ (90% CI [.00, .10]), *SRMR* = .03.

Fourteen of the fifteen direct paths in the final structural model demonstrated significant effects. All three direct paths from experiences of discrimination (i.e., ED → RS [$\beta = .36, p$

< .001], $ED \rightarrow CB$ [$\beta = .18, p < .01$], and $ED \rightarrow SOC$ [$\beta = -.51, p = .001$]) and all five direct paths from intraminority stress (i.e., $IMS \rightarrow RS$ [$\beta = .28, p < .001$], $IMS \rightarrow CB$ [$\beta = .22, p < .001$], $IMS \rightarrow IH$ [$\beta = .38, p < .001$], $IMS \rightarrow LGBTQCC$ [$\beta = -.13, p < .05$]) and $IMS \rightarrow SOC$ [$\beta = -.32, p = .07$]) were significant. Both direct paths from rejection sensitivity were significant (i.e., $RS \rightarrow LGBTQCC$ [$\beta = .26, p < .001$] and $RS \rightarrow SA$ [$\beta = .27, p < .001$]), although, similarly to the analysis with sexual minority women, the former demonstrated a positive association despite being hypothesised to demonstrate a negative association. The two direct paths from concealment behaviour were significant (i.e., $CB \rightarrow LGBTQCC$ [$\beta = -.28, p < .001$] and $CB \rightarrow SA$ [$\beta = .11, p < .05$]), as was the direct path ($IH \rightarrow LGBTQCC$ [$\beta = -.32, p < .001$]). Finally, there was a non-significant direct path from LGBTQ community connectedness ($LGBTQCC \rightarrow SA$; $\beta = -.06, p = .29$), and a significant direct path from sense of coherence ($SOC \rightarrow SA$; $\beta = -.41, p < .001$), to social anxiety.

The model tested for sexual minority men accounted for 47% of social anxiety variance (see Figure 5.3), and results signified five significant indirect pathways to social anxiety (see Table 5.9). Specifically, for hypothesised Path A X F, the indirect path ($ED \rightarrow RS \rightarrow SA$) was significant ($\beta = .096, p < .001$), whereas the indirect path ($ED \rightarrow CB \rightarrow SA$) was not ($\beta = .020, p = .056$). The indirect path ($ED \rightarrow IH \rightarrow SA$) was not estimated due to the removal of the non-significant paths ($ED \rightarrow IH$) and ($IH \rightarrow SA$) in the final model. Concerning hypothesised Path C X F, the indirect paths ($IMS \rightarrow RS \rightarrow SA$; $\beta = .074, p < .001$) and ($IMS \rightarrow CB \rightarrow SA$; $\beta = .025, p < .05$) were significant, whereas the indirect path ($IMS \rightarrow IH \rightarrow SA$) was not estimated due to the removal of the non-significant path ($IH \rightarrow SA$) from the final model. Both the indirect paths related to Path B X H ($ED \rightarrow SOC \rightarrow SA$; $\beta = .208, p < .001$) and E X H ($IMS \rightarrow SOC \rightarrow SA$; $\beta = .131, p < .001$) were significant. Two paths related to hypothesised path A X G X I were non-significant ($ED \rightarrow RS \rightarrow LGBTQCC \rightarrow SA$; $\beta = -.005, p = .239$; $ED \rightarrow CB \rightarrow LGBTQCC \rightarrow SA$; $\beta = .003, p = .188$), whereas one was not estimated ($ED \rightarrow IH \rightarrow LGBTQCC \rightarrow SA$) due to the removal of the non-significant path ($ED \rightarrow IH$). All three indirect paths related to hypothesised path C X G X I were non-significant ($IMS \rightarrow RS \rightarrow LGBTQCC \rightarrow SA$; $\beta = -.004, p = .231$; $IMS \rightarrow CB \rightarrow LGBTQCC \rightarrow SA$; $\beta = .003, p = .196$; $IMS \rightarrow IH \rightarrow LGBTQCC \rightarrow SA$; $\beta = .007, p = .261$). Finally, for hypothesised path D X I, the indirect path ($IMS \rightarrow LGBTQCC \rightarrow SA$) was non-significant ($\beta = .007, p = .220$).

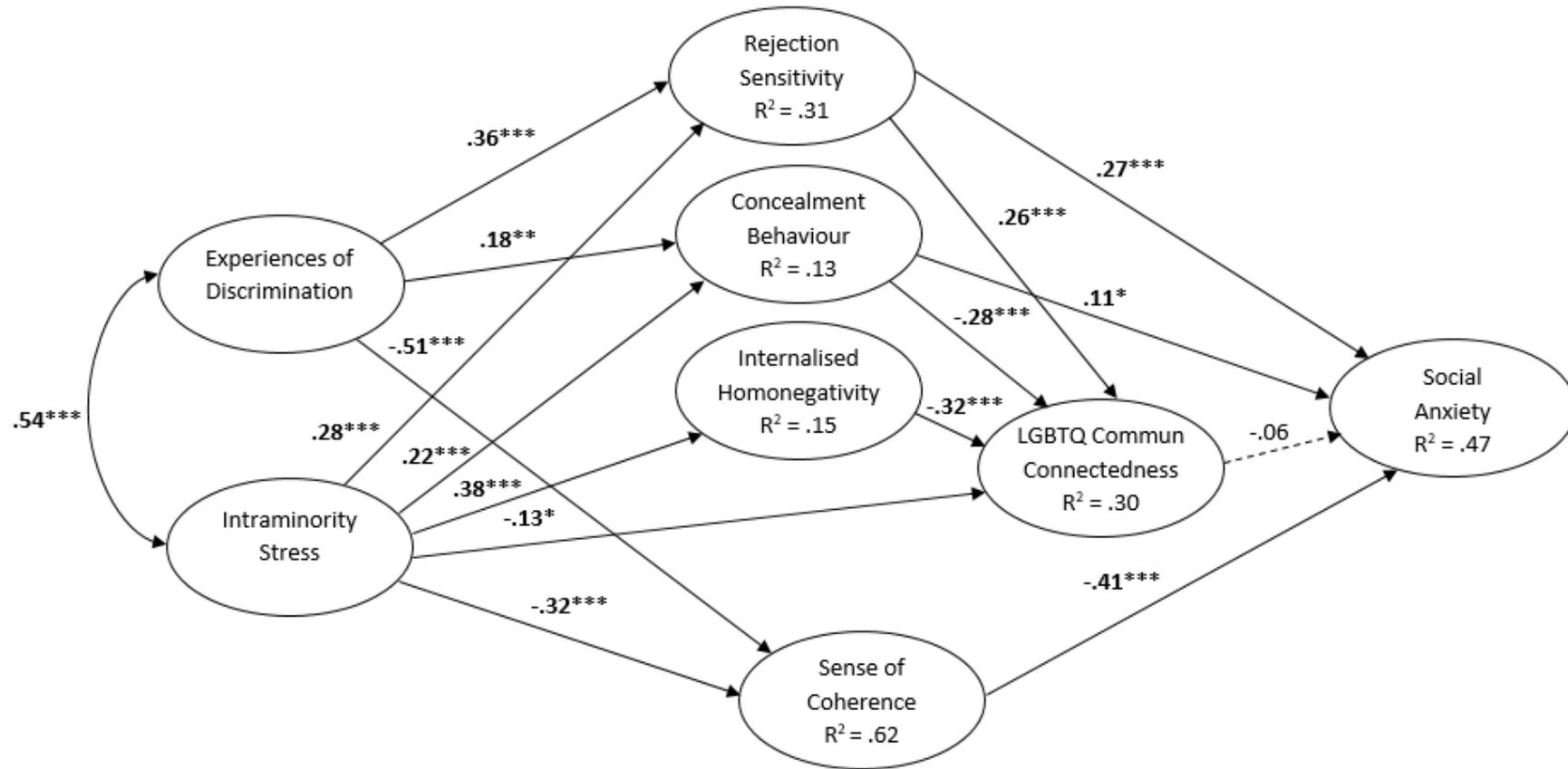


Figure 5.3: Structural Model for Sexual Minority Men. Solid lines indicate significant pathways, whereas dashed lines indicate non-significant pathways. Commun = Community. The following paths from the covariate to endogenous variables were estimated but are not depicted in the above figure to facilitate readability: from income to sense of coherence ($\beta = .14^{**}$) and social anxiety ($\beta = -.05$).

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

Table 5.9

Indirect Path Estimates to Social Anxiety Among Sexual Minority Men with Bootstrapped SEs and CIs

Path	<i>B</i>	<i>SE</i>	95% CI	β	<i>p</i>
ED → RS → SA	.143	.045	[.067, .246]	.096	<.001
ED → RS → LGBTQCC → SA	-.008	.009	[-.029, .006]	-.005	.239
ED → CB → SA	.030	.022	[-.001, .093]	.020	.056
ED → CB → LGBTQCC → SA	.004	.005	[-.003, .019]	.003	.188
ED → SOC → SA	.308	.056	[.205, .424]	.208	<.001
IMS → RS → SA	.109	.042	[.042, .214]	.074	<.001
IMS → RS → LGBTQCC → SA	-.006	.007	[-.023, .005]	-.004	.231
IMS → CB → SA	.036	.026	[.000, .106]	.025	.048
IMS → CB → LGBTQCC → SA	.005	.006	[-.004, .022]	.003	.196
IMS → IH → LGBTQCC → SA	.010	.011	[-.009, .034]	.007	.261
IMS → LGBTQCC → SA	.011	.014	[-.008, .050]	.007	.220
IMS → SOC → SA	.194	.044	[.115, .282]	.131	<.001

Note. ED = experiences of discrimination; RS = rejection sensitivity; SA = social anxiety; LGBTQCC = LGBTQ community connectedness; CB = concealment behaviour; IH = internalized homonegativity; SOC = sense of coherence; IMS = intraminority stress.

5.5 Summary of Quantitative Findings

The present chapter has provided quantitative evidence regarding the determinants (i.e., both risk and protective factors) of social anxiety among sexual minority women and men residing in the Republic of Ireland. The sample for the phase one study, over half of which reside in Dublin, are primarily young adults (i.e., ages 18-30), white Irish, and highly educated. The range of sexual identities is notably more diverse among sexual minority women, in that lesbian, bisexual, and emerging identity women are represented, whereas the vast majority of sexual minority men identified as gay. Social anxiety levels varied across regions in Ireland in which participants resided, and higher levels of social avoidance were evident in those that resided outside of Dublin.

The analyses pertaining to objective one highlighted differences in social anxiety levels across sexual minority subgroups. Sexual minority women reported higher levels of social fear and avoidance than sexual minority men. Bisexual and emerging identity women reported higher scores than lesbian women on social anxiety measures, whilst no such sexual identity group differences were evident among sexual minority men, nor were any sexual attraction group differences apparent among sexual minority women or men. In terms of sexual behaviour subgroups, there was evidence of heightened social anxiety among women

with “only opposite-gender partner(s)” and women who “didn’t have sex” when compared to women with “only same-gender partner(s)” and “same- and opposite-gender partner(s)”. Sexual minority men who “didn’t have sex” reported higher social fear than those with “same- and opposite-gender partner(s)”.

The models tested as part of the objective two analyses revealed salient determinants of social anxiety among sexual minority women and men. Both models explained a considerable amount of social anxiety variance for women and men. Both traditional minority stressors and intraminority stress arose as salient risk factors for social anxiety. Of all the proximal minority stress processes, rejection sensitivity appeared to represent the primary risk factor for social anxiety. Significant pathways to social anxiety through heightened rejection sensitivity from both measures of distal stress (i.e., experiences of discrimination and intraminority stress) were present for sexual minority women and men. For sexual minority men only, there was a significant path from intraminority stress to social anxiety through increased concealment behaviour. LGBTQ community connectedness significantly linked proximal minority stressors to social anxiety among sexual minority women, but not men. Interestingly, there was a negative direct effect between both internalised homonegativity and concealment behaviour, and LGBTQ community connectedness (i.e., as hypothesised), but a positive direct effect between rejection sensitivity and LGBTQ community connectedness (i.e., the opposite direction to the hypothesis). Further, sense of coherence presented as an important form of individual-level resilience to social anxiety, in that there were significant pathways to social anxiety from both measures of distal stress through a reduced sense of coherence.

The following chapter will discuss the quantitative findings in greater detail in accordance with the results obtained from the analyses associated with both of the objectives.

Chapter 6 Quantitative Discussion

6.1 Introduction

This chapter details a critical discussion of the findings pertaining to the phase one quantitative study. The findings pertaining to the two objectives will be discussed separately in the context of related research and relevant theoretical positions. Firstly, the discussion will focus on the objective one findings related to social anxiety across sexual minority subgroups. The determinants of social anxiety highlighted in the testing of the extensive models of risk and protective factors for sexual minority women and men will then be discussed. Lastly, the notable strengths and limitations of the current study, as well as the influence of the phase one findings on the phase two study will be considered.

6.2 Objective 1: Social Anxiety Across Sexual Minority Subgroups

Key findings from the objective one analyses have advanced the understanding of potential differences in social anxiety symptoms across sexual minority subgroups. Sexual minority women were found to report higher social anxiety symptoms than sexual minority men. Identifying this difference emphasises the importance of providing distinct analyses for both groups when examining potential social anxiety disparities between sexual orientation subgroups, which has been overlooked by previous studies in this area. Further, by including measures of the three dimensions of sexual orientation in the analyses, sexual orientation subgroups that are particularly at risk for elevated social anxiety symptoms are highlighted. The groups include, bisexual and emerging identity women, sexual minority women with only opposite-gender sexual partner(s), and sexual minority women and men who didn't have sex. The nuanced information these findings provide will now be discussed.

Findings supported the objective one hypothesis that sexual minority women will report significantly higher social anxiety than sexual minority men. Specifically, sexual minority women reported elevated levels of social fear and avoidance when compared to their men counterparts. This is consistent with previous research that demonstrated gender differences in non-probability samples of sexual minority young adults (Baiocco et al., 2014; Cohen, Blasey, et al., 2016), in which sexual minority women demonstrated higher levels of social anxiety symptoms. As such, these results reflect established gender differences in SAD prevalence rates in the general population (Asher et al., 2017; Stein et al., 2017). Explanations for this gender difference can be derived from a theoretical standpoint that is not specific to social anxiety or sexual minority mental health. Self-construal theory (Cross

et al., 2011; Cross & Madson, 1997) postulates that women and men construe themselves dissimilarly, in that women have a greater tendency to develop and maintain an interdependent self-construal, whereas men tend to develop and maintain an independent self-construal. Thus, in accordance with this theoretical standpoint, women's sense of self is more reliant on their interpersonal relationships. Therefore, sexual minority women in the current sample could fear and avoid social situations to a higher degree as potentially negative consequences from interpersonal interactions yield a greater deleterious impact on their sense of self and everyday functioning. Future research could incorporate measures related to this standpoint to further elucidate the mechanisms behind social anxiety gender differences among sexual minority individuals.

Whilst this finding agrees with previous research utilising non-probability samples of young sexual minority adults (Baiocco et al., 2014; Cohen, Blasey, et al., 2016), it contrasts with studies that used probability sampling to determine SAD prevalence across gender and sexual orientation subgroups (Bostwick et al., 2010; Kerridge et al., 2017). Both of these studies demonstrated lower levels of SAD prevalence in lesbian women compared to gay men, whereas the current findings highlight elevated social anxiety symptoms in sexual minority women compared to men (i.e., including lesbian women compared to gay men). These conflicting findings may be indicative of the divergent age breakdown of the current sample and these nationally representative samples (i.e., sexual minority individuals were considerably younger in the current sample). This is notable as the gender difference in social anxiety symptoms in the general population is greater during adolescence and young adulthood, and reduces during later life (Asher et al., 2017). Further, research has demonstrated that sexual minority men's social anxiety symptoms may actually increase over time (Pachankis, Sullivan, Feinstein, & Newcomb, 2018). Therefore, in contrast to the sexual minority men in the current sample (whose social anxiety symptoms may increase over time), it is plausible that the majority of sexual minority women in the current sample were living through a stage in their life course (i.e., young adulthood) in which they were more susceptible to experiencing social anxiety symptoms (Asher et al., 2017). Thus, the social anxiety gender disparity was amplified. Gender differences might not be so pronounced in a sample that grants greater representation to older sexual minority individuals.

Among sexual minority women, the hypothesis that those who identify as bisexual or with an emerging identity will report higher social anxiety than lesbian women was partially supported. Precisely, bisexual women reported higher levels of social fear than lesbian

women, and emerging identity women reported higher social avoidance than lesbian women. Indeed, this finding confirms previous research regarding heightened SAD prevalence (Bostwick et al., 2010; Kerridge et al., 2017) and social anxiety symptoms (Wadsworth & Hayes-Skelton, 2015) in bisexual and emerging identity women compared to their lesbian counterparts. It is posited that bisexual individuals report greater psychological distress than gay/lesbian individuals because they experience bisexual-specific minority processes such as anti-bisexual stigma, bisexual erasure, and paucity of bisexual affirmative support (Bostwick et al., 2010; Jorm et al., 2002). Recent empirical enquiries supported this position in demonstrating links between bisexual-specific distal (i.e., experiences of discrimination and stigma due to bisexual identity) and proximal stressors (i.e., internalised stressors stemming from the stigmatization of bisexuality), and psychological distress for bisexual individuals (Brewster et al., 2013; Brewster & Moradi, 2010; MacLeod et al., 2015). Perhaps through encountering both general sexual minority stressors and bisexual-specific minority stressors, bisexual women apply a higher SET value to a greater variety of social-stimuli across a greater range of social situations. For instance, when socialising at the wider-community level, bisexual and lesbian women may engage in deleterious primary cognitive processes to detect social-evaluative threat pertaining to their sexual minority identity. However, bisexual women might also engage in these processes to detect social-evaluative threat pertaining to their specific bisexual identity when socialising at both the wider- and within-community level (e.g., hypervigilance toward lesbian women leaving a room due to their presence). By comparison, lesbian women could be less likely to engage in such cognitive processes at the within-community level. Further, a recent study demonstrated that anti-bisexual stigma predicted generalised anxiety and depression through proximal stressors (increased internalised binegativity and sexual identity uncertainty), decreases in identification as bisexual, and bisexual visibility management strategies among bisexual women (Dyar & London, 2018). These bisexual-specific minority stress processes (e.g., bisexual visibility management strategies) emulate safety behaviours known to maintain social anxiety (Piccirillo et al., 2016; Wong & Rapee, 2016) and could partially explain the elevated levels of other internalising mental health symptoms, such as social anxiety, in bisexual women compared their lesbian counterparts.

Similar to bisexual women, it is suggested that emerging identity women face additional sexual minority stress when compared to lesbian women (Borgogna et al., 2019). Experiences of discrimination at the within-community level from gay/lesbian counterparts, and stereotypes questioning the legitimacy of emerging identities (Feinstein & Dyar, 2017)

might contribute to elevated social anxiety levels in this sexual identity subgroup. For instance, as emerging identities are less well known or less “mainstream” in wider society (Borgogna et al., 2019), emerging identity women could anticipate being ridiculed or negatively evaluated should they disclose their sexual identity to others, both at the wider- and within-community level. In order to evade this feared possibility, emerging identity women may avoid certain social interactions, or engage in emerging identity-specific processes (e.g., not correcting individuals who assume they identify as lesbian/bisexual).

For sexual minority men, the findings did not support the hypothesis that bisexual and emerging identity men will report higher social anxiety than gay men. Specifically, there were no social anxiety differences across sexual identity subgroups among sexual minority men. It is important to note that these results must be interpreted with caution. The vast majority of sexual minority men in the current sample identified as gay, thus it is possible that the smaller number of men in both the bisexual and emerging identity groups precluded significant findings. Regardless, the current findings emphasise the importance of segregating by gender when assessing social anxiety across sexual orientation subgroups among sexual minority individuals. For instance, it is plausible that Wadsworth and Hayes-Skelton’s (2015) finding that bisexual and emerging identity individuals reported higher social anxiety than gay/lesbian individuals was driven by the large proportion (60%) of their sample that identified as sexual minority women. Equally, Akibar et al.’s (2019) non-significant findings regarding social anxiety differences across sexual minority identity subgroups (i.e., all genders combined) may misrepresent potential significant differences within each gender identity subgroup. While this is speculative, the current findings, as well as evidence from research with general (Stein et al., 2017) and sexual minority populations (Cohen, Blasey, et al., 2016), suggest salient gender differences in social anxiety. Therefore, distinct analyses should be performed for all gender groups in future research.

For both sexual minority women and men, the hypothesis that sexual minority individuals who are “only attracted to same-gender” would report lower social anxiety than those who are “mostly attracted to same-gender”, “equally attracted to all genders”, and “mostly attracted to opposite-gender” was not supported by the findings. In fact, for sexual minority women and men, there were no social anxiety differences between any sexual attraction subgroups. The absence of significant social anxiety differences across sexual attraction subgroups agrees with previous research assessing social anxiety symptoms in a non-probability sample of sexual minority individuals (i.e., all genders combined; Akibar et al., 2019). This finding is also consistent with a study examining SAD prevalence across sexual

attraction subgroups in a nationally representative sample for sexual minority men (Bostwick et al., 2010). Once more, this finding pertaining to sexual minority men should be interpreted with caution due to the small number of men who indicated that they were “equally attracted to all genders” and “mostly attracted to opposite-gender”, the latter of which were not included in the analysis. In contradiction to the current results, the same study reported lower lifetime SAD prevalence in women “only attracted to same-gender” when compared to other sexual minority attraction subgroups (Bostwick et al., 2010). It is conceivable that this discrepancy is reflective of the previously mentioned young age of the current sample, or the divergent methods in which social anxiety was assessed (i.e., lifetime SAD diagnosis vs current social anxiety symptoms).

In terms of sexual behavior subgroups, the hypothesis that sexual minority women with “only same-gender partner(s)” will report lower social anxiety than women with “both same- and opposite-gender partner(s)” and “only opposite-gender partner(s)” was partially supported by the current findings. Specifically, women with “only opposite-gender partner(s)” reported higher social fear than women with “only same-gender partner(s)”, and higher fear of negative evaluation than women with “only same-gender partner(s)” and “same- and opposite-gender partner(s)”. The concept of sexual orientation discordance offers a viable explanation for the elevated level of social anxiety symptoms among sexual minority women with “only same-gender partner(s)”. Sexual orientation discordance describes within-person incongruence between sexual identity, attraction, and behaviour (Lourie & Needham, 2017). In line with self-discrepancy theory (E. T. Higgins, 1987) and identity-discrepancy theory (Large & Marcussen, 2000; Marcussen & Large, 2003), dissonance between actual and ought selves can result in mental health problems. Therefore, it is plausible that the conflict between sexual minority women’s sexual behaviour (i.e., only possessing opposite-gender partners”) and their sexual identity (i.e., non-heterosexual) may confer risk for social anxiety. Indeed, this group’s heightened fears of negative evaluation may pertain to fears of others questioning the legitimacy of their sexual minority identity. The current novel findings add to previous research exemplifying that sexual orientation discordance is associated with externalising mental health symptoms (i.e., hazardous drinking) among sexual minority women (Talley et al., 2015), by conferring this incongruence as a potential risk factor for social anxiety, an internalising mental health problem.

Among sexual minority men, the hypothesis that men with “only same-gender partner(s)” will report lower social anxiety than men with “both same- and opposite-gender partner(s)”

and “only opposite-gender partner(s)” was not supported by the current findings. The latter group were excluded from the analyses due to low group numbers. Again, this result must be interpreted with caution due to the vast majority of sexual minority men categorised as having “only same-gender partner(s)”. Nonetheless, there were some significant social anxiety differences for sexual minority men across sexual behavior subgroups. In fact, among sexual minority women and men, those who “didn’t have sex” reported higher social anxiety than other sexual behavior subgroups. Precisely, sexual minority women who “didn’t have sex” reported higher social fear and avoidance than women with “only same-gender partner(s)”, and sexual minority men who “didn’t have sex” reported higher social fear than men with “same- and opposite-gender partner(s)”. Previous research established similarly heightened levels of lifetime SAD prevalence among women and men with no previous sexual partners (Bostwick et al., 2010). It is important to consider the potential complexities regarding the directional relationship underpinning this finding. Social anxiety symptoms are linked to erectile dysfunction and premature ejaculation among men (Blumentals et al., 2004; Corretti et al., 2006; Figueira et al., 2001), and reduced sexual desire among women (Pyke, 2020). Further, social anxiety compromises pleasurable sexual experiences among young adult women and men, and is associated with a reduced frequency of sexual experiences for young adult women only (Kashdan et al., 2011). A daily diary study also revealed that pleasure and intimacy associated with sexual activity may mitigate social anxiety maintenance processes among young adult women and men (Kashdan et al., 2014). It is therefore plausible that social anxiety symptoms, and the associated sexual outcomes, are preventing sexual minority individuals who “didn’t have sex” from engaging in sexual activity, or, that the lacking sexual activity of those in the “didn’t have sex” group is a determinant of their heightened social anxiety (i.e., through diminishing pleasure and intimacy). As all this research was conducted with predominantly heterosexual samples, the potential intricacies of this relationship among sexual minority individuals requires further exploration.

6.3 Objective 2: Models of Risk and Protective Factors for Social Anxiety

This phase one quantitative study assessed models of the determinants (i.e., both risk and protective factors) of social anxiety among sexual minority women and men in order to provide researchers, clinicians, and policy makers with guidance on the potential sources and mechanisms of this mental health condition disproportionately experienced by sexual minority individuals. This empirical enquiry advances social anxiety research in sexual minority populations in several ways. In assessing the determinants of social anxiety for

sexual minority individuals, the phase one study included variables related to all the primary constructs of minority stress theory (Meyer, 2003) as extended by Hatzenbuehler (2009) to the universal cognitive, coping, and interpersonal risk factors of psychopathology that are elevated among sexual minority individuals. By integrating the novel theory of intraminority gay community stress (Pachankis, Clark, et al., 2020), the current study represents the first examination of this construct among sexual minority women, and, in a social anxiety context for women and men. Further, by incorporating a focus on resilience factors (i.e., sense of coherence and LGBTQ community connectedness), the limited knowledge base pertaining to promotive social functioning among sexual minority individuals has also been extended. This phase one study found that for both sexual minority women and men, increased rejection sensitivity and a diminished sense of coherence served as potential linking mechanisms of the association between distal stressors (i.e., experiences of discrimination and intraminority stress) and social anxiety. In sexual minority women only, the study additionally found indirect sequential pathways from experiences of discrimination to social anxiety via increased internalised homonegativity and concealment behaviour and decreased connectedness to the LGBTQ community. Among men, there was an indirect path from intraminority stress to social anxiety via increased concealment behaviour.

In terms of hypothesised pathway A X F (i.e., a positive pathway from experiences of discrimination to social anxiety via higher levels of proximal minority stress), findings partially supported the related hypothesised pathways. Precisely, for both sexual minority women and men, findings supported the hypothesis that increased experiences of discrimination, would stimulate heightened rejection sensitivity, and thus would be associated with social anxiety. However, also consistent across both gender groups, findings did not support the two hypothesised pathways from increased experiences of discrimination to heightened concealment behaviour to social anxiety, and from increased experiences of discrimination to heightened internalised homonegativity to social anxiety. The latter of these pathways was not estimated for sexual minority women or men due to the removal of the non-significant paths from internalised homonegativity to social anxiety in each model.

The pivotal role of rejection sensitivity in linking experiences of discrimination to social anxiety coheres with previous results (Feinstein et al., 2012), suggesting that rejection sensitivity may be the primary proximal minority stress process linking distal stressors to social anxiety. Rejection sensitivity comprises both cognitive (expectations of rejection) and affective (anxiety related to rejection) mechanisms that closely map on to maintenance factors of social anxiety highlighted in Wong and Rapee's (2016) IAM model. In fact, by its

nature, rejection sensitivity encompasses a form of sexual minority-specific anticipatory processing, in that it involves repetitive thinking prior to, and negative biased evaluation of, social-evaluative situations (Wong et al., 2019), with a specific focus on social-evaluative stimuli pertaining to one's sexual minority status (Dyar et al., 2016; Pachankis et al., 2008). Thus, just as the induction of anticipatory processing results in higher levels of social anxiety symptoms for individuals experiencing elevated social anxiety (Mills, Grant, Judah, & White, 2014; Wong & Moulds, 2011), it is expected that rejection sensitivity should stimulate social anxiety symptoms for sexual minority individuals. In their daily lives, sexual minority individuals encountering regular experiences of discrimination may perceive many social situations at the wider-community level as potentially threatening and develop hypervigilance toward further potential rejection. This hypervigilance may manifest as primary (e.g., self-focus and attention toward threat) and secondary (e.g., post-event processing) cognitive processes associated with social anxiety (Wong & Rapee, 2016), and, in turn, stimulate a general fear of negative evaluation from heterosexual individuals. The results of this study suggest that, for sexual minority individuals, these processes might occur through, or be exacerbated by, sexual minority-specific processes. Specifically, during anxiety-provoking scenarios in the company of heterosexual individuals, sexual minority individuals' heightened rejection sensitivity might encourage excessive self-focus on negative internal stimuli (e.g., their belief that they will experience rejection based on their sexual orientation) and an attention toward threat/interpretation bias (e.g., attend to heteronormative social-evaluative threat stimuli in order to confirm their beliefs).

The current findings partially supported the hypothesised pathway C X F (i.e., a positive pathway from intraminority stress to social anxiety via higher levels of proximal minority stress). Specifically, for both sexual minority women and men, findings supported the hypothesised positive indirect pathway from intraminority stress to social anxiety via increased rejection sensitivity. The findings did not support the indirect pathways from intraminority stress to social anxiety via increased internalised homonegativity (i.e., for both gender groups) or the indirect pathway from intraminority stress to social anxiety via increased concealment behaviour (i.e., for sexual minority women only). The results of this study cohere with previous research with sexual minority women (e.g., Boyle & Omoto, 2014) and men (Pachankis, Clark, et al., 2020) in confirming the role of intraminority stress as a determinant of psychological distress, and for the first time, link intraminority stress to social anxiety. It is interesting to note how intraminority stress – stress stemming through interactions with fellow sexual minority individuals – stimulates a sexual minority-specific

deleterious proximal process such as sexual orientation related rejection sensitivity, that centres around feelings of threat due to expected rejection from heterosexual individuals. In reporting intraminority stress, sexual minority individuals are citing fellow same-gender sexual minority community members as agents of their personal stress. Through sharing commonalities with their fellow same-gender sexual minority community members (i.e., their agents of stress), it is possible that sexual minority individuals fear that they themselves will function as an agent for stress/annoyance for heterosexual individuals in the wider community. Thus, sexual minority individuals might anticipate rejection from heterosexual individuals and subsequently experience social anxiety. Previous research advocated the salience of exploring the social context in which rejection is experienced (Romero-Canyas et al., 2010). In fact, there has been a recent empirical call to explore the role of contextual factors in sexual minority individuals' experiences of rejection sensitivity (i.e., anxious expectations of rejection from fellow sexual minority individuals vs heterosexuals; Feinstein, 2020). The current findings elucidate the role of contextual factors pertaining to both rejection sensitivity and social anxiety; however, further research is required to delve deeper into the complexities behind these relationships.

Relatedly, there was also a positive pathway from intraminority stress to social anxiety via increased concealment behaviour for sexual minority men only. Through perceiving their social interactions at the within-community level as stressful, sexual minority men might be encouraged to engage in concealment behaviour (e.g., avoiding contact with fellow sexual minority men; Jackson & Mohr, 2016), and experience subsequent social anxiety. Whether this social anxiety primarily relates to their interactions with fellow sexual minority men, or extends to all social interactions requires further investigation. Perhaps, it is the case that sexual minority men are deterred from socialising with fellow sexual minority men due to explicit experiences of intraminority stress, for example, witnessing other sexual minority men judging their peers harshly. Negative peer experiences are important etiological factors for social anxiety as outlined in the IAM model (Wong & Rapee, 2016). These experiences might stimulate concealment behaviour, which in itself could be portrayed as a sexual minority-specific safety behaviour, and result in sexual minority men fearing and avoiding social interactions at the within-community level. Equally, as it is probable that men who are highly concealed interact less with fellow sexual minority men, their intraminority stress and resulting social anxiety might be based on negative stereotypes of sexual minority men (e.g., all sexual minority men are bitchy; A. Brooks, 2016) rather than actual lived intraminority stress experiences. Indeed, research has shown that heightened self-

stereotyping in gay men (i.e., personal beliefs regarding the negative stereotypes related to the gay community) predicts internalising mental health symptoms (Hinton et al., 2019). Therefore, the nature of intraminority stress (i.e., based on actual experiences vs vicarious experiences vs perceptions/stereotypes) as a determinant of social anxiety necessitates further empirical dissection.

For both sexual minority women and men, the present findings fully supported hypothesised pathway B X H (i.e., a positive pathway from experiences of discrimination to social anxiety via a diminished sense of coherence). Specifically, more frequent experiences of discrimination were associated with a reduced sense of coherence, which in turn, was associated with heightened social anxiety. This finding aligns with Hatzenbuehler's (2009) psychological mediation framework (i.e., that diminished general psychological processes mediate the association between minority stress and psychological distress) and previous research highlighting sense of coherence as a protective factor for psychological distress among gay men (Lyons et al., 2014) and sexual minority (i.e., both women and men) university students (Roberts, 2018). Further, this represents an important addition to the nascent body of literature assessing the role of general psychological processes as determinants of social anxiety among sexual minority individuals. It is also important to note that sense of coherence held negative associations with all minority stress and social anxiety measures, establishing that the protective functionality of this form of individual-level resilience extends to sexual minority stress processes and social anxiety.

The ameliorative effects of high sense of coherence on stigma related processes have been established in other stigmatised populations, for instance, individuals diagnosed with schizophrenia or affective disorders (Świtaj et al., 2017). This is somewhat unsurprising given the consistently endorsed role of sense of coherence as both a coping mechanism for stress and a promotive tool to enhance mental health (Eriksson & Lindström, 2006, 2011). Although there is scant research assessing sense of coherence among sexual minority individuals, it is proposed that a strong sense of coherence may encourage a greater competency in dealing with heterosexist stigma (Meyer, 2015). The small existing body of empirical research in this area (Lyons et al., 2014; Roberts, 2018) suggests that sense of coherence is a salient form of individual-level resilience that protects against sexual minority stress processes and internalising mental health symptoms. The phase one findings make a salient contribution to the knowledge base in suggesting for the first time that this protective function of sense of coherence extends to social anxiety. Indeed, the psychological benefits of sense of coherence were also established in a highly stigmatised subgroup of sexual

minority individuals (i.e., older gay men living with HIV), encompassed by its positive association with proactive coping (Matacotta, 2012). Sexual minority individuals with a strong sense of coherence may have a greater capacity to overcome potential stress related to their social interactions with heterosexual individuals. According to Antonosky (1987), a strong sense of coherence can improve access to generalised resistance resources that enhance one's ability to effectively manage social tension. Thus, through possessing a greater understanding of their social environment and related social-evaluative stimuli (i.e., comprehensibility), sexual minority individuals with a strong sense of coherence may have a greater ability to comprehend sources of heteronormative discrimination and manage these potential stressors with suitable coping mechanisms (i.e., manageability encompassed by accessing generalised resistance resources and adapting to social situations). Further, despite the plausibility of encountering heteronormative stigma, their optimistic outlook on life (i.e., meaningfulness) might stimulate their willingness to continually socially engage with individuals. As a result, they may deem social-evaluative stimuli related to social interactions with heterosexual counterparts as less threatening, and avoid feelings of social anxiety.

For both sexual minority women and men, the present findings fully supported hypothesised pathway E X H (i.e., a positive pathway from intraminority stress to social anxiety via a diminished sense of coherence). Specifically, higher levels of intraminority stress were associated with a reduced sense of coherence, which in turn, was associated with heightened social anxiety symptoms. Sexual minority individuals with a strong sense of coherence could possess a better understanding of the source of potential stressors within the sexual minority community (Antonovsky, 1987). Their heightened sense of optimism and control over life may protect them against the potentially deleterious consequences of status hierarchies and community ideals upheld at the within-community level. They may therefore not internalise negative experiences with their sexual minority peers, but rather avail themselves of robust coping mechanisms in the face of such stressors to avoid social anxious thoughts, feelings, and behaviours.

While this is the first study to demonstrate the relationship between sense of coherence and intraminority stress, the reasons as to why the protective function of this individual-level form of resilience extends to social interactions at the within-community level may be quite similar to those aforementioned in a traditional minority stress context. For sexual minority individuals with lower sense of coherence levels, the within-community stress highlighted by intraminority stress theory (Pachankis, Clark, et al., 2020), including the competition for,

and the exclusion associated with, attaining social, sexual, and romantic capital might lead to social anxiety in several ways. First, in lacking the general resistance resources associated with sense of coherence (Antonovsky, 1987), this group might be more likely to engage in deleterious behavioural processes, such as avoidance, escape, or safety behaviours, rather than beneficial coping when faced with a potentially stressful social interaction with sexual minority peers (i.e., lack of manageability). Second, sexual minority individuals with a diminished sense of coherence may be less likely to understand (i.e., lack of comprehensibility) the potential foundation of intraminority stress (i.e., other sexual minority individuals socialising in accordance with perceived hierarchies), and therefore engage in cognitive processes to detect social-evaluative threat when interacting with peers. Third, due to the pessimistic outlook on life associated with reduced sense of coherence (i.e., lack of meaningfulness), this group may be more likely to perceive their social performance at the within-community level as deficient. In accordance with the IAM model (Wong & Rapee, 2016), all of the above processes would serve to heighten their SET value and subsequent social anxiety symptoms.

With regard to pathway A X G X I (i.e., a positive sequential pathway from experiences of discrimination to social anxiety via higher levels of proximal minority stress and reduced LGBTQ community connectedness), the findings partially supported the hypothesis for sexual minority women only. Specifically, more frequent experiences of discrimination were sequentially associated with increased proximal minority stress (i.e., internalised homonegativity and concealment behaviour) and reduced LGBTQ community connectedness, which in turn was associated with heightened social anxiety. It appears that a lack of connection to other sexual minority individuals may leave sexual minority women vulnerable to experiencing the deleterious effects of these proximal minority stressors and subsequent social anxiety. Other studies have highlighted the association between lower social support and social anxiety among sexual minority women (Mason et al., 2017; Potoczniak et al., 2007), and the important role that LGBTQ community connectedness plays in mediating the association between proximal minority stress and psychological distress (Puckett et al., 2015). Sexual minority women with less connection to their peers potentially miss the opportunity to avail themselves of important coping resources in the face of heterosexist stigma and internalising mental health difficulties (Frost & Meyer, 2012; Hanley & McLaren, 2015; Meyer, 2003; Zimmerman et al., 2015). Further, predominantly socialising in heteronormative environments and avoiding social interaction with other sexual minority individuals may hinder the development of specific within-community

social skills (e.g., ease in holding conversations with other sexual minority individuals). Given previous evidence that bisexual and lesbian women may participate in different communities within the LGBTQ community (e.g., lesbian women communities may be larger and uphold more rigid social ideals; Heath & Mulligan, 2008), sexual minority women's navigation of, and connectedness to, these sub-communities and their associated ideals in the context of social anxiety warrants further exploration.

As the direct effect between LGBTQ community connectedness and social anxiety was not significant for the sexual minority men's model, the findings did not support the hypothesised pathways A X G X I (i.e., a positive sequential pathway from experiences of discrimination to social anxiety via higher levels of proximal minority stress and reduced LGBTQ community connectedness) or C X G X I (i.e., a positive sequential pathway from intraminority stress to social anxiety via higher levels of proximal minority stress and reduced LGBTQ community connectedness) for sexual minority men. Our finding contradicts previous findings showing community connectedness to protect against internalizing mental health symptoms among samples containing sexual minority men (Kertzner et al., 2009; Petruzzella et al., 2019; Puckett et al., 2015); however, these contrasting results may reflect the heterogeneous conceptualisations of mental health outcomes between the current study and previous research (i.e., social anxiety vs generalized anxiety and depressive symptoms). The current sample resided in the Republic of Ireland, with one quarter living in rural areas with no large urban areas in close proximity. Therefore, participants' time spent socialising with other sexual minority individuals may also be limited. In line with existing theory (Hatzenbuehler, 2009; Meyer, 2003), utilising social support from fellow sexual minority community members may offer protection against social anxiety for some sexual minority men. However, whether these potential ameliorative effects extend to all social contexts (e.g., within-community and the wider-community) is yet to be uncovered.

Two further pathways involving rejection sensitivity, related to hypothesised pathways A X G X I (i.e., a positive sequential pathway from experiences of discrimination to social anxiety via higher levels of proximal minority stress and reduced LGBTQ community connectedness) and C X G X I (i.e., a positive sequential pathway from intraminority stress to social anxiety via higher levels of proximal minority stress and reduced LGBTQ community connectedness) were significant among sexual minority women. However, the hypothesised negative direct effect from rejection sensitivity to LGBTQ community connectedness was positive within each of these pathways. In fact, the same positive direct

effect from rejection sensitivity to LGBTQ community connectedness was observed in the sexual minority men's model, although contrary to the women, this effect was not involved in any significant pathways to social anxiety. Whilst this finding is somewhat surprising, there are plausible explanations for rejection sensitivity's divergent relationship with LGBTQ community connectedness when compared to the other proximal minority stress processes. As previously discussed (Puckett et al., 2015), the internalisation of negative self-views and negative views of the sexual minority community is likely to prevent sexual minority individuals who experience high internalised homonegativity from engaging with their peers and developing feelings of connectedness to the LGBTQ community. Further, facets of concealment behaviour (e.g., avoiding contact with other members of the LGBTQ community; Jackson & Mohr, 2016) would seem to directly impede the development of feelings of connectedness to other sexual minority individuals. By contrast, in acknowledging that the social world is not benevolent for all sexual minority individuals, it has been suggested that in certain contexts rejection sensitivity may serve as a protective factor for this population (Feinstein, 2020). Previous research suggests that the identification of stressors or threatening social-evaluative stimuli might afford individuals with an opportunity to cope (Feldman & Hayes, 2005). Therefore, for sexual minority women, especially those who encounter heteronormative processes on a regular basis, rejection sensitivity may allow them to detect potentially threatening social-evaluative stimuli and adapt accordingly (i.e., seek support at the within-community level), and experience less social anxiety. The nuances underpinning this pathway require further examination. Notwithstanding, while in this specific context rejection sensitivity may serve a protective function, at least for sexual minority women, it remains a key deleterious process linking distal stress to social anxiety for both sexual minority women and men.

The hypothesised pathway D X I (i.e., a positive pathway from intraminority stress to social anxiety via reduced LGBTQ community connectedness) was not supported by the findings for either group. For sexual minority men, this non-significant pathway reflects the aforementioned lack of direct effect between LGBTQ community connectedness and social anxiety. By contrast, for sexual minority women, there was a non-significant direct effect between intraminority stress and LGBTQ community connectedness. Indeed, the relationship between these two variables may be quite complex and function in different ways for specific sexual minority women. For sexual minority women reporting high intraminority stress, the stress experienced as a result of competition and exclusion within the community might lead to them feeling disconnected from their fellow sexual minority

peers. However, it is also plausible that sexual minority women reporting low intraminority stress may be doing so because they are not socially involved in the LGBTQ community. For example, a sexual minority women's social network may consist solely of heterosexual friends. Through her lack of interaction with other sexual minority women, she may evade any experiences of intraminority stress whilst also not feeling specifically connected to the wider LGBTQ community.

To summarise, the objective two findings elucidated both risk and protective factors for social anxiety among sexual minority men and women. Both forms of distal stress (experiences of discrimination and intraminority stress) are risk factors for social anxiety within this population. Of all proximal minority stress processes, rejection sensitivity is particularly integral in linking both distal stressors to social anxiety. Sense of coherence emerged as a salient protective factor for social anxiety for both groups, whereas LGBTQ community connectedness emerged as an important protective factor for sexual minority women.

6.4 Strengths and Limitations

The current study advanced previous studies (e.g., Akibar et al., 2019; Wadsworth & Hayes-Skelton, 2015) by assessing multiple social anxiety outcome variables across both gender *and* a diverse range of sexual orientation subgroups (i.e., identity, attraction, and behaviour subgroups). Findings highlighted specific subgroups of sexual minority individuals that may be at risk for experiencing heightened social anxiety symptoms, for instance, bisexual and emerging identity women, and sexual minority individuals who are not engaging in sex. Indeed, these results emphasise at risk subgroups that should be prioritised in future treatment studies in the area.

The primary strength of this phase one study is that, to the researcher's knowledge, it represents the most extensive quantitative investigation of the determinants of social anxiety among sexual minority individuals to date. Each of the models explained a considerable amount of social anxiety variance for both sexual minority women and men, and advanced theoretical knowledge of this phenomenon in several ways. First, through including all of the principle traditional minority stress processes (Meyer, 2003), findings emphasise the distinct roles of these processes as determinants of social anxiety among sexual minority individuals (e.g., the pivotal role of rejection sensitivity as a linking mechanism between distal stress and social anxiety). Second, the present study advances previous research influenced by Hatzenbuehler's (2009) psychological mediation framework (Feinstein et al.,

2012) by highlighting sexual minority-specific processes and general psychological processes (i.e., sense of coherence) as linking mechanisms between distal stress processes and social anxiety. Third, by highlighting the saliency of sense of coherence (i.e., for both sexual minority women and men) and LGBTQ community connectedness (i.e., for sexual minority women), the current study answers recent calls to examine individual- and community-level resilience as determinants of mental health among sexual minority individuals (de Lira & de Morais, 2018; Lyons, 2015; Meyer, 2015). Further, the current investigation aids in filling the empirical void assessing protective factors of social anxiety among sexual minority individuals. Finally, as one of very few examinations of intraminority stress as applied to sexual minority mental health, and the first to assess the construct in a social anxiety context, the present findings accentuate the important contribution of intraminority stress to both sexual minority women and men's experiences of social anxiety. To gain a more complete depiction of this population's elevated levels of social anxiety, future empirical efforts should acknowledge the contribution of stress resulting from social experiences and interpersonal interactions at the within-community level. The meaningful information the phase one study offers for those in research, clinical, and policy development settings is further considered in chapter eleven.

Despite the notable strengths outlined above, the phase one study results should also be interpreted in light of several limitations. First, the cross-sectional nature of the findings inhibited the ability to make causal inferences among study variables; however, results provide an empirical foundation for future longitudinal examinations. Second, as this study represented the first use of the intraminority stress as applied to sexual minority women, associations (and lack thereof) with this variable must be interpreted with caution as the scale had only been previously validated with men. Past research undertook a similar approach in adjusting Pachankis et al.'s (2008) Gay-Related Rejection Sensitivity Scale, originally developed for sexual minority men, in order to assess the rejection sensitivity construct among sexual minority women (e.g., Feinstein et al., 2012). Additionally, Feinstein et al.'s (2012) findings influenced the eventual development of a rejection sensitivity scale specified for sexual minority women (Dyar et al., 2016). Therefore, by building on previous research demonstrating that sexual minority women also encounter within-community stress (e.g., Boyle & Omoto, 2014), the present study suggests the potential benefits of future research to develop and validate an intraminority stress measure specifically for sexual minority women. Third, the phase one results could be affected by range restriction on certain measures (i.e., concealment behaviour and internalised homonegativity), similar to studies

of sexual minority individuals in other Western societies (Jackson & Mohr, 2016; Lea et al., 2014). Given known biases on non-probability sampling (Kuyper et al., 2016), the current sample likely underrepresents the experiences of sexual minority individuals who engage in more concealment behaviour and are experiencing higher levels of internalised homonegativity. Indeed, the reliance on social media as a primary source of recruitment may have precluded older sexual minority individuals from participation. Fourth, the Republic of Ireland represents a unique social climate for sexual minority individuals when compared to other countries. The favourable attitude of the general Irish public toward sexual individuals increased dramatically over a short space of time (A. Higgins et al., 2016), which culminated in the passing of marriage equality through popular vote in 2015. Therefore, the above models require testing both in countries that encompass diverse social climates, for example, those with less favourable attitudes toward sexual minority individuals, and those in which favourable public attitudes have increased gradually. Fifth, it is also important to note that the Everyday Discrimination Scale was not adapted to specifically assess heterosexist discrimination (i.e., experiences of everyday discrimination were assessed). However, previous research has demonstrated associations between the version utilised in the current study and social anxiety in sexual minority samples (e.g., Mason & Lewis, 2016) and showed that over three-quarters of sexual minority individuals attribute their experiences of discrimination to their sexual orientation when answering this scale (Johnson Holm, 2020). Finally, the sample was primarily white, and gay (i.e., for the sexual minority men portion), calling for future tests of this model among a more diverse sample, including those who are a racial/ethnic minority, and men who identify as bisexual, or adopt an emerging identity. Indeed, it is also important to build on the current findings regarding social anxiety across sexual orientation subgroups by recruiting a larger sample that is representative of all sexual orientation subgroups, especially among sexual minority men.

6.5 Implications of the Quantitative Findings for the Qualitative Phase

The findings of the phase one quantitative study highlighted several determinants (i.e., both risk and protective) of social anxiety among sexual minority individuals that warrant a qualitative elucidation. In fact, many of the statistical pathways to social anxiety were demonstrated empirically for the first time. Phase one findings also emphasised the importance of both traditional minority stress and intraminority processes as risk factors for social anxiety among sexual minority individuals. This suggested the importance of delving into the social interactions of sexual minority individuals at both the wider- and within-

community levels in the qualitative phase to decipher how these might contribute to their overall experiences of social anxiety.

With regard to protective factors to social anxiety, the quantitative findings advocate the exploration of both individual- and community-level resilience. Sense of coherence represents a potentially salient protective factor to social anxiety, therefore other general psychological processes (i.e., coping/emotional regulation, social/interpersonal, and cognitive processes) were identified as warranting further exploration in the qualitative study. The potential positive social interactions with, and support from, other sexual minority individuals, and the plausible role of these processes in relieving social anxiety were also highlighted as important to explore under a qualitative lens. Lastly, the process that sexual minority individuals followed (e.g., treatment seeking) to acquire coping mechanisms to aid in alleviating their social anxiety also warrant further elucidation.

6.6 Conclusions of the Quantitative Phase

To summarise, the quantitative phase of the present mixed methods study yielded several salient findings pertaining to determinants of social anxiety among sexual minority individuals. These findings advance knowledge pertaining to potential social anxiety disparities across sexual orientation subgroups and the risk and protective factors associated with social anxiety for sexual minority women and men. The findings of the present study suggested that both traditional minority stressors and intraminority stressors are associated with social anxiety among sexual minority individuals through stimulating deleterious sexual minority-specific internal processes (i.e., primarily rejection sensitivity) and diminishing general psychological processes (i.e., sense of coherence).

In conclusion, to the researcher's knowledge, the first phase of the present mixed methods study denotes the most extensive quantitative investigation of the determinants of social anxiety among sexual minority individuals to date. The second phase of the current mixed methods study will expand on these findings by elucidating for the first time the experience of social anxiety among sexual minority individuals in a qualitative investigation that foregrounds their perspective, and provides context to situate the quantitative findings (i.e., through highlighting vivid examples of sexual minority women and men's experiences of social anxiety at both the wider- and within-community levels).

Chapter 7 Phase Two: Qualitative Method

7.1 Introduction

The chapter outlines the method used for the second phase of the current mixed methods study. Specifically, the following methodological details are included: 1) study design; 2) phase two aims and objectives; 3) phase two participants (i.e., selection criteria and recruitment processes); 4) procedure; 5) interview materials; 6) ethical considerations; 7) data analysis; and 8) the role of the researcher.

7.2 Qualitative Study Design

The second phase of this sequential explanatory mixed methods study involved qualitative semi-structured one-on-one interviews with sexual minority adults residing in the Republic of Ireland who believe social anxiety is a personal issue in their life.

7.3 Aim and Objectives for Phase Two

This section outlines the aim and objectives associated with phase two.

7.3.1 Restatement of Phase Two Aim

Through conducting interviews, the overarching aim of phase two was to explore the experience of social anxiety among sexual minority individuals who believe social anxiety is a personal issue in their lives.

7.3.2 Phase Two Objectives and Background

Phase two holds the following objectives:

1. To illuminate how social anxiety manifests among sexual minority individuals.

Social anxiety symptoms exist across behavioural, cognitive, and physiological/bodily domains (American Psychiatric Association, 2013; Heimberg et al., 2010). Indeed, all three of these symptom typologies are proposed to play important roles in maintaining a high SET value in social-evaluative situations (Wong & Rapee, 2016). As noted in the systematic review findings in chapter two, there is sparse quantitative literature investigating the general cognitive and behavioural maintenance process of social anxiety for sexual minority individuals, and related qualitative explorations are lacking. In addition, to the researcher's knowledge, no studies have thus far accounted for the potential role of bodily symptoms in sexual minority individuals' experiences of social anxiety. Therefore, to fill these voids in

the knowledge base, that are largely present due to a lack of studies utilising social anxiety-specific frameworks to assess the current phenomenon, the first objective of the phase two study is to highlight how social anxiety manifests among sexual minority individuals.

2. To uncover the contexts in which sexual minority individuals experience social anxiety.

In relation to the phase one study findings, it is salient to analytically delve into sexual minority individuals' social experiences at the within- and wider-community levels. Undertaking such an approach will further elucidate the statistical relationships pertaining to intraminority stress, traditional minority stress, and social anxiety revealed in phase one. Barring the initial development of the GCSS (Pachankis, Clark, et al., 2020), this represents the first qualitative exploration using intraminority stress theory. Whilst other studies have utilised qualitative methods to explore the experiences of minority stress among sexual minority women and men (e.g., Bjorkman & Malterud, 2012; Holloway et al., 2015; Synnes & Malterud, 2019), phase two will be the first to do so for social anxiety.

3. To explore how sexual minority individuals cope with social anxiety.

Beyond the few studies demonstrating a negative association between social support and social anxiety for both sexual minority women (e.g., Mason et al., 2017) and men (e.g., Burns et al., 2012a), there is a notable void in the current knowledge based pertaining to coping mechanisms. Further, as highlighted in chapter two (section 2.5.5), there is very little evidence regarding efficacious interventions in this area. For these reasons, it is thought that fulfilling the above objective may provide some initial guidance to aid future treatment studies in this area.

4. To explore how social anxiety impacts sexual minority individuals' daily lives.

As highlighted in chapter one (section 1.2), elevated social anxiety symptoms can have a deleterious impact on several facets of everyday functioning. Indeed, Wong and Rapee's (2016) IAM model emphasises the impact of social anxiety in terms of life interference. Yet, the impact of social anxiety on sexual minority individuals' lives remains largely unexplored. Phase two strives to provide the groundwork pertaining to this overlooked facet of the experience of social anxiety within this population.

7.4 Phase Two Participants

Twenty-one sexual minority adults participated in the phase two one-on-one interviews. The sociodemographic information related to these participants is outlined in the next chapter (section 8.2).

7.4.1 Selection Criteria

The inclusion criteria were as follows:

1. The individual must identify as a sexual minority (i.e., they must identify as gay/lesbian, bisexual, or with an emerging identity label).
2. The individual must identify as cisgender.
3. The individual must be aged 18 years or older.
4. The individual must believe that social anxiety is an issue for them in their personal life.

The exclusion criteria were as follows:

1. Individuals not fluent in the English language.
2. Individuals residing outside of the Republic of Ireland.

The phase two inclusion criterion related solely to sexual identity rather than identity, attraction, and behaviour as all participants included in the final analyses for phase one indicated a sexual minority identity. Therefore, the researcher wished to maintain this consistency for the phase two sample. Participants were required to believe social anxiety is an issue in their personal life. While focusing on all sexual minority individuals (i.e., regardless of whether they believe social anxiety is an issue in their personal life) may prove beneficial in elucidating resilience factors to social anxiety, focusing on those who believe social anxiety is a personal issue in their life more closely aligns with the objectives outlined above, and represents a favourable starting point for the first qualitative study in this area. For example, the target group may be more likely to experience social anxiety symptoms and recall recent social occurrences in which they felt anxious; thus, enabling the illumination of manifestations of social anxiety (objective 1) among sexual minority individuals and the contexts in which social anxiety is experienced (objective 2). Further, in order to maintain consistency with phase one, participants were required to identify as cisgender and reside in the Republic of Ireland.

7.4.2 Recruitment

The researcher utilised two different recruitment routes in order to recruit potential participants for phase two: 1) voluntary participant pool from phase one and 2) Facebook Ad.

7.4.2.1 Route 1: Voluntary Phase One Participant Pool

As detailed in chapter four (section 4.5), phase one participants could actively volunteer their interest in participation in phase two via a two-step process: 1) endorsing a statement of interest in further studies associated with the project and 2) voluntarily providing their email address for future contact. In total, 207 phase one participants actively volunteered their participation for phase two. The researcher emailed these phase one participants (see example in Appendix G.1) thanking them once again for their participation in the phase one study and provided the phase two study details including the aims and inclusion criteria in the main body of the email, and also attached the phase two plain language statement (see Appendix H.1). In order to manage the organisation of interviews, these potential phase two participants were emailed individually on a staggered basis between May 27th and September 4th 2019. The potential phase two participants were informed that they could express their interest by replying directly to the email. In the event that an individual replied expressing interest, further emails were exchanged between the researcher and potential participant to arrange a suitable interview medium (i.e., face-to-face or telephone), venue (i.e., for face-to-face interviews), date, and time.

7.4.2.2 Route 2: Paid Facebook Advertising

The same project Facebook page “Anxiety in Sexual Minorities Study” used for phase one recruitment, was also used to facilitate recruitment for phase two of this study (see Appendix C.1). Once again, the recruitment was employed in the form of paid Facebook adverts conducted from the project Facebook page. For phase two, one advert was created on the 15th October 2019, and targeted individuals based on their age (i.e., 18+), location (i.e., Republic of Ireland), interests (e.g., same-sex relationship and Grindr), and gender (i.e., men). Sexual minority men were targeted as just seven men from the phase one participant pool had participated in phase two. The advert consisted of a recruitment poster communicating the study inclusion criteria and the research team contact details (see Appendix G.2).

7.5 Procedure

The researcher conducted semi-structured individual interviews with 21 sexual minority adults who believed that social anxiety was a personal issue in their life to explore their experiences of social anxiety. The semi-structured interviews were conducted between 10th June and 25th October 2019 via a medium (i.e., face-to-face or telephone), and at a time, date, and location (i.e., for face-to-face interviews) most convenient for participants. Of the 21 participants, 14 participated in telephone interviews, five participated in face-to-face interviews in a private interview room at Dublin City University, and two participated in face-to-face interviews in a private interview room in a co-working space building located in Dublin city. With participant consent, all interviews were recorded via a digital recording device in order to enable subsequent transcription and analysis.

For the face-to-face interviews, the researcher met the participant at the reception of the building in which the interview was taking place at a previously specified time and guided them to the interview room. The participant was provided with water and informed of the locations of the nearest restroom and exit (i.e., in the case of an emergency) prior to beginning the interview. The researcher then provided the participant with a hard copy of the plain language statement (see Appendix H.1; previously attached in the recruitment email) and allowed sufficient time for them to re-read the document and ask any questions regarding the study. The participant then completed the informed consent form by hand (see Appendix H.2). For all seven participants who participated in face-to-face interviews, informed consent was provided as they endorsed (i.e., answered Yes) to all nine statements on the informed consent form and provided their signature. The researcher then provided the participant with a hard copy of the demographics form (see Appendix H.3) and the BFNE (Leary, 1983; see Appendix H.4) which they also completed by hand. Once these forms were completed, the researcher checked that the participant was satisfied and comfortable, and then informed the participant that the interview was about to commence and the recording would begin. The interview consisted of questions contained within the interview topic guide (see Appendix H.5) and questions that arose based on participant responses. The length of the interview was dependent on the level of interaction between the participant and researcher, and the amount of information the participant wished to share. After ending the interview, the researcher asked the participant if they were feeling ok, and provided a debriefing form (i.e., containing contact details of LGBT Ireland and Samaritans Ireland; see Appendix H.6). The participant was then thanked for their participation and accompanied to the building exit by the researcher.

For the telephone interviews, a signed informed consent form was returned by the participant via email prior to arranging an interview time. All 14 participants who participated in telephone interviews provided informed consent by returning a signed copy of the informed consent form in which they endorsed all nine statements. The researcher rang the participant from a DCU landline on the contact number they provided by email when returning the informed consent form. To begin the call, the researcher asked the participant if they had any questions related to the plain language statement or the study. With the participant's consent, the recording of the interview then began. In order for the telephone participants to complete the demographics form and the BFNE, the researcher then read aloud the questions and response options contained within each form, and completed the form by hand based on the participant's answers. The interview then followed the same procedure outlined for the face-to-face participants; however, the telephone participants were emailed a copy of the debriefing form rather than provided with a hard copy.

7.6 Interview Materials

Demographic information was collected using a demographics form (see Appendix H.3). The BFNE (Leary, 1983; see Appendix H.4) was used to assess social anxiety symptoms (see section 4.6.3.2 for further details). All semi-structured interviews with sexual minority women and men were guided by the same interview topic guide (see Appendix H.5). This interview topic guide was developed based on both the systematic review and phase one findings and the theoretical frameworks underpinning this mixed methods study (Hatzenbuehler, 2009; Meyer, 2003; Pachankis, Clark, et al., 2020; Wong & Rapee, 2016), and aimed to achieve the phase two objectives. The questions were designed to elucidate information related to the experience (i.e., both current and retrospective) of social anxiety among sexual minority individuals: the manifestations of social anxiety and social contexts in which anxiety is experienced, how sexual minority individuals cope with social anxiety, and the impact of social anxiety on sexual minority individuals' everyday functioning. When developing the interview topic guide, the researcher aimed to formulate non-restrictive questions that would facilitate an open discussion of participants' experiences of social anxiety and thus yield rich data to fulfil the phase two objectives.

7.7 Ethical Considerations

Ethical approval for phase two of this mixed methods study was obtained from Dublin City University Research Ethics Committee (see Appendix I.1). The key issues considered for the second phase of this study included the issues of participant vulnerability/potential harm

to participants, risk to the researcher, consent, anonymity and confidentiality, and data storage.

In terms of participant vulnerability/potential harm to participants, it is important to acknowledge that participants were recruited on the basis that they believe social anxiety is a personal issue in their life. Given the sensitive issues that the interviews focused on (e.g., previous experiences of social anxiety and minority stress processes), and the fact that they experience social anxiety, it was possible that some participants would become distressed during or after the interview. This possibility was clearly communicated in the plain language statement (see Appendix H.1). Participants were also informed (i.e., verbally prior to the beginning of the interview and in the plain language statement) that they were free to stop the interview at any stage during the process and withdraw their participation without giving a reason. The contact details of free support services (i.e., LGBT Ireland and Samaritans Ireland) were shared prior to the interview within the plain language statement, and after the interview on the debriefing form (see Appendix H.6). At the time of the interviews, the researcher had over three years' experience providing support to individuals in times of distress (i.e., via telephone and face-to-face), and therefore had the necessary skillset to provide support should participants become upset. A specific protocol was developed for the researcher to follow in the event that a participant became upset or exhibited signs of distress (see Appendix I.2).

Although no specific risks to the researcher existed for the phase two study, the following protocol was developed to ensure researcher safety in instances in which the face-to-face interviews were conducted off-site (i.e., not on the DCU campus). Both of the researcher's supervisors were informed of the data collection schedule at the beginning of each week, including location of data collection. The researcher had his mobile phone switched on, fully charged, and had access to his supervisors' contact numbers (i.e., both office and mobile numbers) during face-to-face interviews. Additionally, the researcher planned his route to off-site locations prior to the interview, and informed his supervisors by text messages when the interviews began and finished. Should the researcher have felt uncomfortable during an interview or believed that his safety was compromised, he would have excused himself from the interview and returned to DCU. Further, the researcher would report any issues that arose during interviews to his supervisors immediately.

In relation to informed consent, all phase two participants were provided with the plain language statement (see Appendix H.1), and given the opportunity to ask the researcher any

questions they may have about the process. All participants provided informed consent by returning a signed copy of the informed consent form in which they endorsed all nine statements on the form (see Appendix H.2). Those who participated in telephone interviews returned the completed informed consent forms by email, whilst those who participated in face-to-face interviews completed hard copies of the informed consent form by hand.

The plain language statement (see Appendix H.1) communicated to participants that absolute confidentiality cannot be provided (i.e., if the researcher deems the participant is at risk of harming themselves or others, or if a child protection issue arises). The possibility for data to be subject to subpoena, freedom of information claim, or mandated reporting by some professions was also outlined. All interviews were recorded using an electronic recording device. For telephone interviews, the participant was placed on speakerphone in order to enable recording. The resulting mp3 files were then uploaded to the researcher's password protected Google Drive. Audio files of interviews, transcribed interviews and all documents associated with the analysis process were stored on the researcher's password protected Google Drive. Hard copies of the informed consent documents were stored in a locked filing cabinet, whereas the data from the hard copies of the demographic forms and BFNE (i.e., for face-to-face participants) were transferred to SPSS by the researcher immediately after the interviews finished and the hard copies were then placed in a confidential shredding bin. Apart from signed informed consent documents, no documentation associated with this research contained the name, address, or contact details of participants. Audio-recorded data collected during this study is potentially identifiable. Participant codes were created in electronic copies of all transcripts of the semi-structured interviews. Identifiable data was removed from all quotes used in the results section of this thesis and in the dissemination of results from this study in order to protect participants' identity. The data will be retained for a maximum period of five years (i.e., from time of interviews) on the researchers Google Drive in order to ensure sufficient time for analysis and dissemination of findings in peer-reviewed journals. The data will be destroyed after this time period by the researcher. All electronic copies of transcripts and audio files will be permanently deleted from the Google Drive.

7.8 Data Analysis

The qualitative data collected through the semi-structured interviews were analysed using thematic analysis, a flexible and increasingly popular method of qualitative data analysis in psychological research that consists of detecting repeated patterns of meaning within a

dataset (Braun & Clarke, 2006, 2013; Clarke et al., 2019). Specifically, reflexive thematic analysis was used (Clarke et al., 2019), whereby coding was primarily inductive (i.e., not pure induction but principally data-driven whilst also influenced by theoretical standpoints), coding was completed by one individual (i.e., the researcher), and the themes were generated from the codes. In line with the paradigm underpinning this mixed methods study, a pragmatic approach to coding was undertaken whereby a combination of semantic (i.e., surface meaning of the data) and latent (i.e., conceptual interpretation of the data) codes were generated. Braun and Clarke's six-step thematic analysis framework, a systematic and rigorous approach to qualitative analysis, was utilised by the researcher and consisted of the following phases: 1) familiarisation with the data, 2) generating initial codes, 3) generating initial themes, 4) reviewing potential themes, 5) defining and naming themes, and 6) producing the report. Thematic analysis is particularly suitable for mixed methods research due to its flexible nature, and can be implemented in a trustworthy and rigorous manner in a mixed methods study when the above phases are followed systematically (Nowell et al., 2017).

First, the researcher listened to the audio files and then familiarised himself further with the data by reading each of the transcribed transcripts multiple times (i.e., phase one). For one round of the re-reading process, sexual minority women and men's transcripts were re-read separately. This approach assisted the researcher to gain an initial insight into whether different information was being communicated across the two groups. Having completed phase one, the researcher noted many commonalities across the women's and men's transcripts; however, there were also certain differences between the groups (e.g., the nature of their socially anxious experiences at the within-community level). Once phase one was completed, all interview transcripts were transferred to NVivo 12 software to enable effective management of the data for phases two to six. In line with the phase one quantitative study (i.e., separate models ran for women and men) and the researcher's familiarisation with the data, the researcher then generated the initial codes separately for each gender group by coding each transcript line-by-line using NVivo, and collating data related to each of the generated codes (phase two). In line with the topic guide (and questions within), each interview was coded in full in relation to all four of the objectives (see section 7.3.2). Examples of coded data extracts are outlined in Appendices J.1. Phase three consisted of collating codes and organising them into initial themes and sub-themes. During this stage, it was clear that the vast majority of codes and related extracts were similar between sexual minority women and men, and common initial themes were generated to represent both

groups. When dissecting initial themes into sub-themes, it was clear that there were certain distinctions between the experiences of women and men. In these cases, unique initial sub-themes were generated for each group. At this stage, the initial themes and sub-themes were also arranged in terms of the objectives (see section 7.3.2) they were fulfilling. Phase four consisted of the themes and sub-themes being reviewed by the researcher; this process involved re-visiting coded extracts and the original transcripts, and repeated discussions with his supervisors (see thematic findings in Appendix J.2). Next, the themes and sub-themes were named and defined in accordance with the data each represented (phase five). Lastly, the thematic analysis concluded with the development of a written report (phase six), therein the researcher combined his own analytic narrative with salient data extracts from the interviews in order to fulfil the phase two objectives. The six phases of thematic analysis were completed with the view to addressing the phase two aim and associated objectives.

7.9 The Role of the Researcher

It is widely acknowledged that the researcher is a central figure who plays an active role in collecting, selecting, and analysing of data in a qualitative study (Finlay, 2003). For this reason, it is now expected that the qualitative researcher in psychology should engage in reflexive processes as reflexivity is integral to qualitative work (Lazard & McAvoy, 2020). Indeed, in line with suggestions (Bourke, 2014; Morrow, 2005), reflexivity was an iterative process that I engaged in throughout all stages of data collection and analyses to acknowledge and manage my potential biases.

Whilst engaging in all of the stages associated with the phase two study, it was crucial for me to acknowledge the positions that I hold in relation to participants, and to remain mindful of my own privileges, personal views, and past experiences. I was conscious that my interaction with the participants, the data formed from these interactions, and my analysis of the data, would be influenced by my age (i.e., 26-27 at the time of the interviews), educational level (i.e., highly educated), gender (i.e., cisgender man), sexual identity (i.e., gay), and other sociodemographic variables (e.g., White ethnicity, residing in Dublin, and non-religious). Further I was also aware that my own attitudes and expectations (e.g., regarding participants' involvement in the sexual minority community) could shape my engagement in all stages of the phase two study.

The most challenging aspect of the phase two recruitment and collection processes for me was the style in which I was presenting myself to, and communicating with, the participants. In line with their intended aims (i.e., to clearly communicate the details of the study), the

recruitment email (Appendix G.1) and plain language statement (Appendix H.1) appeared quite formal. I was wary that this first point of contact may have established me as the ‘expert’ in the eyes of the participant, and dehumanised me to a certain extent. I grappled with this concern in the early stages of both the recruitment and data collection processes. To counterbalance this concern, in subsequent communicative exchanges via (email or telephone) with potential participants, I ensured that my tone was warm and I appeared open to any questions or queries. At all times, I was very conscious that the phase two participants indicated that social anxiety was a personal issue in their life, and that the interview itself might be quite daunting. For the first few interviews I may have overcompensated in attempting to ensure participants were comfortable. For instance, after the first four interviews I reflected that I was engaging in small-talk with participants to build rapport and appear friendly prior to the interview. However, engaging in unstructured small-talk is often feared by individuals experiencing social anxiety symptoms (Fang et al., 2013). For this reason, for the remaining 17 interviews I did not take a ‘one size fits all’ approach, and used my best judgement when deciding whether or not to engage in small-talk. At the beginning of the interview, I emphasised that everyone experiences social anxiety symptoms to a certain degree and there are no incorrect answers to the questions I will ask. Thinking back, this was my attempt to try and narrow any potential perceptions as me as the ‘expert’ and to put the participants at ease.

Upon reflection, when considering the insider/outsider positions that I shared with participants, the variable of gender was often at the forefront of my mind. I shared insider positions with all of the men participants in relation to gender and sexual identity. While I saw the advantages of this fact (i.e., our mutual statuses may put the participant at ease), I was also conscious of the potential disadvantages in holding such an insider position. It was plausible that a bi-directional assumption of shared attitudes, perspectives, and experiences could occur between myself and the gay men participating in phase two. I thought about how such assumptions could impede the data generated in the interviews. For example, a participant may infer my knowledge on a certain subject and refrain from sharing rich data related to their personal experience. I remained vigilant to such occurrences during the interviews with men. On the contrary, I was especially conscious of my outsider position as a man, asking sexual minority women about sensitive subjects. At times I questioned my rightfulness as a man in research exploring the personal experiences of women. In addition, it was important to note that my perception of sexual minority women’s social experiences and communities have been influenced by close friendships that I have with sexual minority

women (all of whom identify as lesbian). For these reasons, I believe that I may have been more hesitant in the earlier interviews with sexual minority women. However, I believe that the reflective process enabled me to overcome my concerns, my self-assurance increased with time, and I developed the ability to approach the interviews with women in the same sensitive but non-hesitant approach that I undertook when interviewing the sexual minority men.

With my background as an assistant psychologist supporting individuals with elevated social anxiety symptoms in a therapeutic setting, and as a volunteer worker providing peer support for sexual minority individuals, I was conscious of maintaining my role as a researcher during the interviews. I was very aware of finding the balance between facilitating rapport building with the participants (e.g., responding empathetically if they made a personal disclosure) whilst remaining focused on the research questions at hand (i.e., not slipping into a therapeutic role). I reflected on this process and recognised instances in the earlier interviews in which the interactions between myself and the participants got slightly off the topic of social anxiety. For further interviews, this enabled me to carefully phrase questions that both acknowledged participants' emotionality but remained focused on the phenomenon at hand.

My processes of reflection were equally important during the stages of analyses. When generating the themes from the data, I remained conscious of representing the participants' personal stories and ensuring their voices were heard. Naturally, I remembered some interviews more distinctly than others and felt more of a connection to certain participants as they had openly recalled challenging personal experiences. For instance, some participants' stories were at the forefront of my mind as we had established good rapport, the conversation flowed easily, and they shared vivid and rich examples of their experiences of social anxiety. When completing the analyses, I was wary of not overemphasising the importance of their stories in comparison to participants who shared less information pertaining to past social events.

7.10 Conclusion

This chapter outlined the qualitative method used in the second phase of the current mixed methods study. The qualitative findings will be presented in the next chapter.

Chapter 8 Phase Two: Qualitative Findings

8.1 Introduction

This chapter outlines the findings from the second phase of this mixed methods study which consisted of one-on-one interviews with sexual minority individuals who believe social anxiety is a personal issue in their lives, with the aim to explore their experience of social anxiety. The qualitative findings are then detailed in line with the phase two objectives: the manifestations of social anxiety, the contexts in which sexual minority individuals experience social anxiety, how sexual minority individuals cope with social anxiety, and the impact of social anxiety on sexual minority individuals' everyday lives.

8.2 Sample Description

In total, 21 interviews were analysed within phase two. Table 8.1 presents details of the 21 participants. Two-thirds ($n = 14$) of participants completed the interviews via telephone, whilst the remaining seven completed the interviews face-to-face.

8.2.1 Completion Rate

The researcher received 42 replies from the 207 individuals emailed via the phase one participant pool. Sixteen of these individuals met the inclusion criteria and are included in the phase two analysis. The remaining 26 individuals either did not believe social anxiety was a personal issue in their life ($n = 10$) or ceased replying to the researcher during the recruitment process ($n = 16$). Nine individuals made contact with the researcher via the Facebook advertisement. Five of these individuals met the inclusion criteria and are included in the phase two analysis, whilst the remaining four ceased replying to the researcher during the recruitment process.

8.2.2 Participant Sociodemographic and Characteristics

Participants' ages ranged from 18 to 65 ($M = 30.10$, $SD = 11.24$). Twelve participants identified as cisgender men and nine identified as cisgender women. All men in the sample identified as gay, whereas five women identified as lesbian, three as bisexual, and one as pansexual. The mean duration of interviews was 47 min 04s ($SD = 6$ min 26 seconds), with a range of 33 min 58s to 56 min 50s. Total scores on the BFNE and BFNE-S (both scores are provided to facilitate comparisons with previous studies) ranged from 30-57 ($M = 45.95$, $SD = 7.18$) and 18-38 ($M = 29.71$, $SD = 4.79$) respectively. These scores are markedly higher

than other sexual minority samples (Feinstein et al., 2012; Meidlinger & Hope, 2014), and are similar to studies with samples of individuals with a SAD diagnosis (Anderson et al., 2013; Werner et al., 2012). Further, an independent samples t-test revealed there was no significant difference in BFNE-S scores between women ($M = 31.56, SD = 3.57$) and men ($M = 28.33, SD = 5.25$), $t(19) = -1.58, p = .13$. Seventeen participants described their current residence as urban versus four as rural, and 19 were white Irish, whilst the remaining two were white European.

Table 8.1

Phase Two Participant Sociodemographics and Characteristics

Pseudonym	Age	Gender Identity ^a	Sexual Identity	Residence	Race/ Ethnicity	BFNE Total	BFNE- S Total
Aoife	21	Woman	Bisexual	Urban	White Irish	45	29
Sean	25	Man	Gay	Urban	White Irish	48	31
Patrick	30	Man	Gay	Urban	White Irish	48	32
Niamh	27	Woman	Lesbian	Urban	White Irish	53	34
Aisling	38	Woman	Bisexual	Urban	White Irish	39	27
Orla	43	Woman	Lesbian	Urban	White Irish	57	38
Shannon	26	Woman	Lesbian	Urban	Other White	42	29
Liam	65	Man	Gay	Rural	White Irish	30	18
Kayleigh	19	Woman	Lesbian	Urban	Other White	53	33
Darragh	19	Man	Gay	Urban	White Irish	48	30
Cillian	23	Man	Gay	Urban	White Irish	31	20
Fiona	40	Woman	Bisexual	Urban	White Irish	52	32
Sorcha	24	Woman	Pansexual	Rural	White Irish	51	34
Nessa	31	Woman	Lesbian	Urban	White Irish	45	28
Aidan	35	Man	Gay	Urban	White Irish	46	32
Shane	39	Man	Gay	Rural	White Irish	48	31
Ronan	21	Man	Gay	Urban	White Irish	55	35
Niall	26	Man	Gay	Urban	White Irish	39	24
Brian	22	Man	Gay	Urban	White Irish	42	26
Donal	18	Man	Gay	Rural	White Irish	51	32
Barry	40	Man	Gay	Urban	White Irish	42	29

Table 8.1

Phase Two Participant Sociodemographics and Characteristics

Pseudonym	Age	Gender	Sexual Identity ^a	Residence	Race/ Ethnicity	BFNE Total	BFNE- S Total
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Note. BFNE = Brief Fear of Negative Evaluation Scale; BFNE-S = Brief Fear of Negative Evaluation Scale (Straightforward worded items only).

^a All participants identified as cisgender.

8.3 Findings

The analysis resulted in the development of eleven themes, eight of which contain sub-themes. Throughout the results section data extracts support the analytic narrative and are annotated with the respective participant’s pseudonym (see Table 8.1). All themes and sub-themes will be outlined below in accordance to their respective research question.

8.3.1 How Does Social Anxiety Manifest Among Sexual Minority Individuals?

The three themes (see Figure 8.1) that represent the manifestations of social anxiety symptoms among sexual minority individuals are *Deleterious thinking*, *Forging social safety*, and *Bodily botheration*.

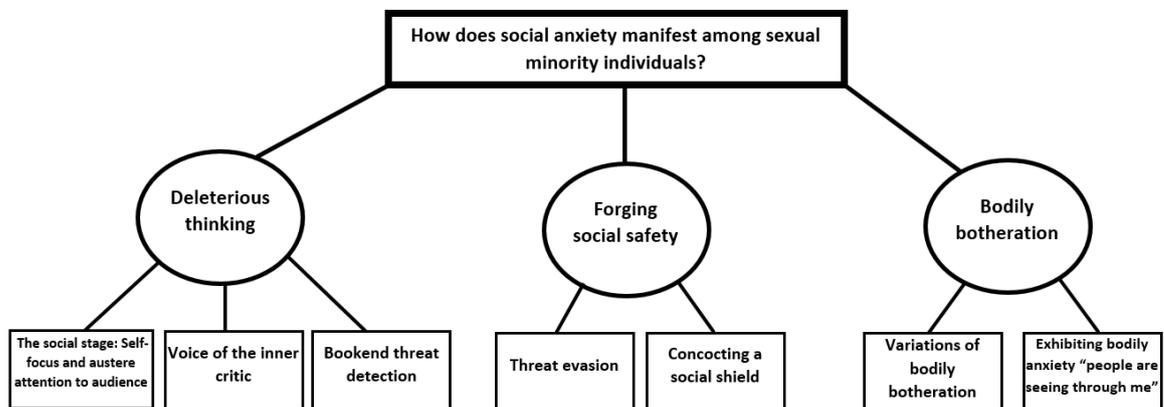


Figure 8.1: Themes and Sub-themes Pertaining to the Manifestations of Social Anxiety.

8.3.1.1 Theme: Deleterious thinking

This theme represents deleterious thought processes that were evidently present in sexual minority individuals’ experiences of social anxiety and served as cognitive manifestations of social anxiety. *The social stage: Self-focus and austere attention to audience* emphasises participants’ engagement in self-focus and their attentional bias toward social threat (i.e.,

toward a perceived audience), both of which contribute to their perception of social environments as threatening “*I think the unwanted attention with me, it made me want to crawl into a hole and not talk to anybody*” (Darragh). The sub-theme of ***Voice of the inner critic*** describes the presence of a deprecating inner narrative during social situations “*I’d be thinking like, ‘why can’t I make any bit of conversation about this?’ and I’d just be incredibly anxious over that*” (Donal). Lastly, the sub-theme of ***Bookend threat detection*** details the cognitive manifestations of social anxiety that are present before “*Even at a social party, if I knew two people, I didn’t know anybody else, I would be very anxious because, those two people have got to go and do their thing, have me hanging out of them all night*” (Fiona) and after “*What I’m mainly guilty of is dwelling on the little things that really aren’t important in the scheme of things*” (Patrick) sexual minority individuals experience a social-evaluative event, both of which appear designed to detect threatening social-evaluative stimuli in social environments.

○ ***Subtheme: The social stage: Self-focus and austere attention to audience***

For many participants, perceiving themselves as becoming the centre of attention in social environments encouraged deleterious thinking through both heightened self-focus and a hypervigilance toward gaining their audience’s (i.e., the individual or group of individuals they are interacting with) approval “*how they are measuring me? Or listening to me? Or agreeing with me? And, whether they think that I’m full of shit or they actually respect my opinion. So it’s more like a hyper consciousness of it.*” (Nessa). In many circumstances, the concluding product of this self-focused attention was the belief that the audience have negatively evaluated the participant “*So an idea would pop into my head, and it could be that maybe I get the impression that somebody doesn’t like me*” (Patrick). For Brian, self-focus was particularly pronounced in environments deemed to be heteronormative (e.g., the gym):

in the university gym (...) often times I’ve gone there would be like a particular sports team in or whatever, and like, you just feel that you’re being, I don’t know if it’s me, but kind of feel like I’m being watched. Not in a like, “oh he’s changing his clothes, lets watch him” but a kind of a “you’re not one of us”.

From the above extract, it is also apparent that Brian’s self-focus coincides with a negatively biased attentional processes (i.e., toward the sport team members), both of which contribute to a sense of being negatively evaluated.

For some participants, self-focus on one's social behaviour and deleterious attention toward others' interpretation of this behaviour was present as they described completing everyday tasks (e.g., travelling on public transport), as shared by Sean:

I would be on a bus going into town, and there might be three or four people on the bus, and they might be all little old ladies or mothers with children, and I would just be like, "I'm sitting weird, I'm taking up too much space". Or like, "they're noticing me for some reason, why are they noticing me?"

Aisling shared a description of perceiving herself "*in the spotlight*" on a social stage:

And so, this idea of being in the spotlight (...) you're conditioned to think that it's a terrible experience and that it's one that you won't be able to walk away from. That it won't be just some transitory thing that a person will make a snap judgement and they'll have to get on with their life and you will get on with yours.

In relation to the above example, Aisling acknowledged that her fears are out of proportion to the threat posed "*For some reason this is some terrible disaster that you are experiencing*". Some participants perceived that their sexual orientation was the primary reason as to why they are the subject of others' attention "*being gay, it's kind of like you are under a microscope; I feel like people are watching you a lot*" (Donal). Further, participants perceived that some heterosexual individuals can be overly inquisitive regarding certain personal topics of conversation which can result in heightened self-focus and experiencing unwanted attention. Aoife discussed this concept in relation to be asked about her sex life "*like purely heterosexual people, like to come to this kind of interest almost. They'd be like 'oh how does that work?'. And you're like, I don't think I should have to explain myself to someone*". In line, Ronan recalled a recent experience in which he felt particularly socially anxious, that appeared to be driven by intense self-focus and his focus on threatening social-evaluative stimuli (i.e., other patrons' gazes):

I met someone in a café and I felt very self-conscious of people knew I was there on a date with a guy (...) The concept of someone else in the café would look over and say, "oh there's two guys on a date". And I was very self-conscious and insecure of that.

- ***Subtheme: Voice of the inner critic***

Participants detailed the presence of a hostile and deprecating critical internal narrative (i.e., the voice of their inner critic) "*you're stupid, you're stupid, you should have saw that*"

(Sean). Contending with this narrative is a persistent experience for some participants across many social settings, as described by Patrick:

I'm overly critical of myself. But in any task I do or any social setting, when it comes to meeting somebody for the first time or building existing relationships, it is something that I'm constantly aware of and that would be on my mind.

These critical narratives seemed to focus on particular facets of social performance. For Nessa, the focus was on the merit of her social contributions "*if I was telling a story to someone on the left or right of me, that 'Oh maybe that story was boring' or 'I shouldn't have told that joke'*". The voice of the inner critic also appeared to communicate the potential repercussions of social performance deficits (e.g., unwanted attention) "*that inner editor is like that internal voice, it's 'don't say that! don't say that or someone will look at you!'*" (Aisling). Participants shared an awareness that their inner critic intensifies feelings of social anxiety "*also I know that, I'm pretty sure that if I am checking that's bad, it just kind of feeds into the anxiety*" (Ronan) and is persistent in its nature "*And it's a vicious circle so because I'm aware that I'm overly critical it makes me analyse those feelings more than I should sometimes*" (Patrick).

Some participants portrayed their inner critic as persistently attempting to gauge how, and if, other individuals are evaluating them "*Eh and so it creates then this internal narrative, eh where I'm constantly trying to interpret how other people are like, eh, how people are interpreting me so to speak*" (Nessa). For Sorcha, this particular type of narrative appeared to arise when interacting with heterosexual individuals "*Eh, I'm socially anxious about are they thinking 'Am I weird or not?'*", and was fuelled by fears of being negatively evaluated as '*different*' to the heterosexual majority. The voice of Aidan's inner critic was particularly pronounced around his sexual minority peers, focused on his apparent differences with this group, and his perceived social performance deficits "*Well straightaway I put it down to a fault of my own as in is it something that I did or some sort of vibe that I'm giving out*".

○ ***Subtheme: Bookend threat detection***

It was clear from participant's narratives that cognitive manifestations of social anxiety did not solely arise during the social-evaluative situations. "*I think before and during would be fairly similar and it's just that point of the interaction where it really spikes. But I think going into it, yeah, my levels definitely increase*" (Orla). Similarly, Brian described his thought processes prior to a pending social engagement:

if something is on during the day, if I start to think about it and more than think about it in a planning sense, thinking about it like thinking about like who's going to be there (...) I'll start to feel kind of like a little bit queasy and unwell. And then often times those feelings will completely dispel when I'm actually at the event.

Shannon shared her thought processes related to an upcoming trip. All of the unanswered questions that arose as a result of these processes appeared to foster feelings of social anxiety:

I wish I could Google all the people that are going to be with me in the damn room for the whole week, because now I'm anxious because I don't know who they are. (...) What kind of people they are, where they're from, how long they're going to be there, are they noisy at night? All these little things. I don't know. So I think it would really help to know, so I would just know what to expect.

Relatedly, Orla reflected on a recent experience while on a trip with her partner "*we were shown around the first day by the owner and stuff, and it's a communal breakfast table, like a big breakfast table, for ten people or whatever. And I was like, 'Oh no!'*". The presence of a communal breakfast table stimulated a fearful reaction in Orla, as she anticipated having to interact with strangers the next morning.

For some participants, the threat detection associated with anticipatory processing directly related to their sexual orientation, as outlined by Shane:

If I'm going out to a bar, a pub, just a regular pub with my partner and friends and stuff, I would feel social anxiety because I would worry that people would spot I'm gay, cause an issue. So, I have a little bit of anxiety about, you know? "Do I fit in? Do I blend in? Do I look gay, or, am I sounding gay?" and "Is this going to be a problem?"

Here, Shane's thought processes seemed to centre on whether the other patrons of this "*regular pub*" would identify him as a sexual minority and negatively evaluate or discriminate against him on this basis.

The presence of cognitive manifestations of social anxiety after experiences of social-evaluative situations were also evident in participants' accounts "*Yes, like 'I'm in the right!' and then 'Was I actually in the right?' 'Maybe I should have let it pass?' And this can go the whole way home.*" (Fiona). Indeed, it appeared that this post-event processing focused on whether or not others are negatively evaluating participants based on their social

performance “‘*Should I have said that?*’ or ‘*What’s that person now thinking of me because I said that?*’ ‘*How will I fix it, if something has been ruptured there?*’” (Sorcha). For some participants, these thought processes can arise even after a relatively positive social experience in which they did not feel particularly socially anxious, as exemplified by Ronan:

I’ll just go somewhere and just get hyper and then if the anxiety goes down a bit, I get very hyper and giddy and I’m just doing stuff. And then generally later I’ll end up feeling scared I weirded them out or I’m weird and stuff.

The focus of post-event processing was not confined to recent social events either, Orla explained reliving social-evaluative experiences from her school years:

Oh, I think about it for ages, like ages. I still think about things that happened in primary school and secondary school. I’m 43 and that’s a long time ago now. But it still can go round and round and round in my head. It’s just the fact that they might be thinking about me because of something that I did in a sort of stupid embarrassing way as opposed to the fact that they just met me and then forgot about me because it didn’t mean anything.

For some participants, post-event processing pertaining to occupational performance anxiety was particularly evident. Fiona discussed re-analysing a social interaction with a colleague in which she was forthright regarding her opinion “*And then I’m going home, ‘Oh god I’m going to get sacked!’ because I’m after telling him he shouldn’t have done that and now he’s in a mood with me*”. Sean described engaging in similar thought processes related to a technological error that occurred in his workplace:

And I even rang my mother, and I was like, “I know it wasn’t my fault, but it feels like it was my fault.” And even when she was like, “yeah it definitely wasn’t your fault”, it still took, more or less basically until I woke up the following morning for me to like feel better about it.

8.3.1.2 Theme: Forging social safety

This theme encompasses the behavioural manifestations of social anxiety among sexual minority men and women “*I’m always stuck in a corner, sort of very quiet (...) I would be as far away from the life and soul of the party*” (Liam). All of these behaviours intend to eliminate social threat (e.g., via escape or engaging in safety behaviours); yet, ultimately maintain a high SET value. The sub-theme of ***Threat evasion*** captures the primary/initial behavioural manifestations of social anxiety when participants are confronted with

threatening social-evaluative stimuli. These processes are exemplified by the avoidance of “*I just ended up avoiding situations all the time, or people*” (Niamh), and escape from “*I’ll find any excuse to leave the room or conversation*” (Cillian) social-evaluative situations. The sub-theme ***Concocting a social shield*** encapsulates secondary behavioural strategies, or, safety behaviours designed to eliminate social-evaluative threat in instances where avoidance and escape are not possible “*I start fidgeting, I’m actually doing it right now, (...) I take out the phone, I love phones, I’d be looking at that and nobody can see me*” (Fiona).

- ***Subtheme: Threat evasion***

The majority of participants stated that they outright avoid social-evaluative situations where possible, or escape such scenarios after an initial exposure to social-evaluative stimuli. For some, avoidance of all social situations is always preferred “*Eh, I normally tell people that if I couldn’t leave my house, I’d be happy*” (Orla). However, this is not always feasible “*In a way, but I don’t put myself into situations where I need to unless it’s unavoidable*” (Fiona). Other participants highlighted particular situational demands (e.g., the presence of acquaintances) that may increase their avoidant behaviours, as outlined by Niall “*I’d typically avoid being with people like extended friends, people that I don’t know. Like I’ll hang out with my friends, but I won’t go and hang out with their friends*”. Participants recalled engaging in avoidance behaviours in a variety of social environments, including school/university changing rooms “*I’d be trying to avoid it more than anything, I’d be like, I’ll just get changed in the bathroom and I’ll just not do PE, that kind of thing*” (Darragh), and extended family functions “*I try to just avoid them most of the time as much as I can. It’s, I just don’t know how to navigate them*” (Shannon).

Across interviews, participants discussed avoiding social situations at the within-community level. Despite wishing to expand her sexual minority social support network, Fiona voiced limiting her interactions with bisexual peers to online environments “*I often put down interested in Facebook [referring to expressing interest in attending a brick-and-mortar event] going up until the day it happens, and then I’m not going*”. Other participants purposely avoid sexual minority venues in order to evade the threat of judgement from peers, as voiced by Shane:

Eh, well probably the great institution of the gay bar. Eh, I’d avoid them like the plague (...) I think it was the one place where I might have felt that sort of judgement from strangers, because there is such thing as being compartmentalised into boxes (...) there’s a lot of implicit judgement in that.

In challenging themselves to persevere through social anxiety, and resist outright avoidance, participants occasionally enter social-evaluative situations “*No, it’s just, like most of the time I do have fun, I enjoy myself, but sometimes I’m just like ‘Guys, can we go home? I can’t do this’*” (Shannon) and escape if their anxiety intensifies. “*In the kind of fight-flight-freeze kind of idea, I would always flee. It would be a case of either run to a café, run home*” (Sean). Similarly, Aoife discussed enduring anxiety provoking interactions with her university peers before escaping after a short period of time due to social discomfort:

I kind of tended to keep a little to myself more than I should have because I just wasn’t comfortable kind of (...) like engaging in conversation with people outside of class. I’d kind of stay for five minutes to be polite and then kind of leave because (...) I don’t really think I kind of fit in in this conversation at the moment, so I would just leave.

Darragh shared an experience in which he immediately escaped a university party after a heterosexual student ridiculed his sexual orientation in front of a group of peers “*I just said ‘something was wrong with one of my friends and I’m just going to their house’ before we went out and I just left. Tried to play it off very cool or whatever*”. This appeared to be a typical behavioural response when heterosexist social-evaluative threats are detected “*Honestly like when they are hostile then, yeah, I’m kind of like wanting to run away all the time*” (Niamh).

Nessa discussed instances in which she overcame her initial social anxiety to attend social events at the within-community level, only to escape early as her anxiety levels rose:

I probably left well before most of the other ones made the move. Because for me it was, it wouldn’t be something that I would linger too long at. Even though the whole point of joining in the group is to actually make gay friends.

Similarly, Shane recalled escaping gay bars due to his heightened levels of social discomfort “*So, I just, it was too much for me to even stay, not that anyone said anything, eh but I just felt completely uncomfortable there to the point where I had to leave*”.

○ ***Subtheme: Concocting a social shield***

Throughout participants’ accounts, the use of actions designed to prevent feared social outcomes and forge social safety (i.e., through the use of safety behaviours) were plentiful. Indeed, safety behaviours often manifested in social situations in which avoidance/escape were perceived as being inaccessible. Participants concocted a social shield by remaining on

the periphery of social situations; this consisted of both occupying a physical social space on the periphery of the room “*So, I probably just would sidle onto the side of the room and stay there*” (Fiona) and declining to contribute to social interactions “*I just kind of very quietly do not commit to anything in the conversation, so I’ll just kind of sit there and not say anything*” (Cillian). The social periphery represented a safer territory for Shannon and her fears relate to the potential breach of this safe space “*I’m just afraid to talk to people, and, just like I’m like the girl standing in the corner. I’m like ‘I’m not here.’ Just like observing everyone, but I’m not here. Like ‘please don’t talk to me’*”. For Sorcha, contributing less in social interactions counteracts her fears of negative evaluation from others, especially when surrounded by strangers:

Eh, so if I’m kind of new in a group, I tend to just not really talk and observe what’s going on. Eh, and usually that the reason for that is that I’m afraid that people might think that I’m, I’m saying something stupid. That they think I’m odd, or weird.

Nessa discussed socialising at the within-community level, but only with sexual minority men “*I would come across as like a fag-hag, all my friends were guys and you know I didn’t have a lesbian network or that*” as she shielded herself from feared interactions with fellow sexual minority women. For Barry, concocting a social shield and forging a safe social space at the within-community level was inconceivable “*So, I’ve sort of narrowed it down to the people I sort of like trust who I know are there for me. Eh so, I’ve stopped going out and I’ve stopped sort of socialising with other gays*”. By contrast, others concocted a safe social shield (i.e., from heterosexist social-evaluative threat) by solely socialising with other sexual minority individuals “*So, the amount of straight friends I have is less and I guess I avoid actually having friendships with them. Or like having friendships with non-gay people, to just not think about it as much.*” (Niamh).

Participants also discussed utilising a wide range of impression management strategies encompassed by behaviours intended to maintain a positive impression with others, as voiced by Cillian:

With my peers at large, I was always very wary about preserving their, their positive impression of me, the positive attitude towards me. Because I did have a good reputation with them, I was considered you know friendly and acceptable and a decent guy. I was always very careful to maintain that and not cause any issues.

In order to maintain positive impressions from peers, participants discussed efforts to present a more sociable self, whilst suppressing any indicators of anxiety “*I would appear quite*

confident and outgoing but it's more a façade" (Shane). Engaging in impression management strategies in order to concoct a social shield was exemplified by a variety of behaviours *"I'm quite happy to change my opinion, which is always quite strong, about theirs"* (Orla). In line, Patrick discussed adapting to social interactions and relationships dependent on the perceived desires of others *"I would have been one of these people that changed exactly who I was to become who I thought they wanted me to be"*, he elaborated *"So I would ask you what type of music you liked and then it turned out I loved the same type of music"*. Across interviews, safety behaviours conducive to *"people pleasing"* were presented as a necessary strategy to shield participants from negative evaluation, thus forging a safer social space. Relatedly, humour was heavily relied upon in social situations in which participants anticipated negative evaluation. Aoife described using humour when enduring discomfort during interactions with heterosexual individuals *"Yeah, like I would try and, if I feel awkward and stuff that I would make jokes (...) I'd kind of use humour to hide any awkwardness that I'd feel"*. Cillian also recounted using humour to mask his sensitivity to heterosexist teasing in school and university with aim of maintaining a good impression with his peers; thus, shielding himself from an escalation in the severity of potential mistreatment:

And I never took anything they said, like I never took offence to it on the surface level. Even if it was something they said, was not the nicest and I didn't like it, I would just kind of laugh it off. So, that I would be a good sport about it all.

8.3.1.3 Theme: Bodily botheration

This theme reflects the unpleasant experiences of bodily anxiety symptoms, and participants' interpretation and awareness of these symptoms during social situations. Participants identified bodily symptoms as integral components of their experiences of social anxiety *"Oh, depending on how severe (...) a pain in my stomach to a cramp in my stomach, sweats, the shakes"* (Sean) *"Yeah I change temperature, and if it's really bad, I get a tingle down my arms"* (Fiona) and this is described in the sub-theme **Variations of bodily botheration**. The sub-theme **Exhibiting anxiety: "people are seeing through me now"** focuses on participants' fears of others noticing their bodily demonstrations of anxiety *"I'd be very embarrassed myself, but just other people noticing it as well"* (Darragh).

○ **Subtheme: Variations of bodily botheration**

Participants described experiencing a variety of bodily anxiety symptoms during social-evaluative situations, these included shaking, blushing, tension, nausea, headaches, racing

heart, trouble breathing, hot flushes, and sweating. Participants' accounts suggested that they experience bodily hyperarousal both before entering social situations "*I'll start to feel like the back of my head tighten up*" (Brian) and during social interactions "*So like, if I want to say something and I'm kind of considering saying it, my heart will start racing and I'll get red and I feel my body temperature increase*" (Sorcha). Further, Shannon described physiological arousal that coincides with cognitive (e.g., racing thoughts) and behavioural (e.g., escape) manifestations of social anxiety:

Well I either start sweating like a pig, or my hands are completely cold and my heart is racing and, I don't know, my mind is going completely crazy! I can't concentrate or focus on anything. I have trouble breathing, so I basically just need to leave for a while.

Niamh recalled feelings of tension due to social anxiety, that often manifest as distinct symptoms of discomfort, or in extreme cases, pain:

Yeah, like [pauses] as if someone is like poking you in the back or something like between your shoulders. So, then I kind of always like felt like really uncomfortable or something like I couldn't stand right or sit right or something and like had a weird pain.

Liam recollected an occurrence from the past that evidenced his severe experiences of tension due to social anxiety "*My hands would be like that, I remember just one time out with a group of lads and I was just tense and I had a glass in my hand and the glass just shattered*". Kayleigh explained that she often experiences numerous bodily anxiety symptoms concurrently "*Yes, so usually it's around like, feeling like my throat is closing up, or like I don't have enough air in my lungs to breathe and like, my stomach is churning*". Indeed, it was conveyed that these bodily symptoms can be overwhelming, and may culminate in sensations of panic "*Eh, so, I'd kind of get jittery. Like if I was sitting down, I'd be kind of like shaking my legs or fidgeting with my hands and then I'm usually like getting a panic attack*" (Aoife).

Some participants experience milder bodily symptoms of social anxiety "*Eh, I guess kind of I feel like kind of heat (...) kind of like in my chest or back, around my torso anyway that's where, I feel hot in those areas when I'm feeling that level of discomfort*" (Cillian), and these are only experienced in extraordinary circumstances "*But in extreme situations like you might get, I'd say my heart might race or I'd feel a bit restless or might get like blush, hot flush or whatever*" (Nessa).

○ *Subtheme: Exhibiting bodily anxiety: “people are seeing through me”*

Across responses, participants communicated a distinct fear related to others observing their bodily anxiety symptoms. While this sub-theme relates to concepts discussed throughout the theme *Deleterious thinking*, such as self-focus and being thrust into the social spotlight, it is distinguished as the fears discussed herein pertain specifically to displaying bodily symptoms of anxiety. Protecting the “*façade*” of a socially confident individual seemed paramount for participants as they navigate their social world. Demonstrating bodily anxiety symptoms directly confronts this façade, and others noticing these symptoms, diminishes it further “*then I panic that it will get worse, and then with that panicking I can't monitor as much. I'm acting. So, then there's the aspect of 'wait people can see that you're feeling really anxious! Oh no!'*” (Kayleigh). The perception that others are detecting bodily anxiety symptoms appears to exacerbate physiological arousal further, which in turn, curtails participants’ ability to self-monitor and maintain their desired social “*façade*”. The following extract from Barry’s narrative evidences his fears pertaining to displaying bodily anxiety symptoms:

Oh yeah, I'm a very acute blusher. (...) Eh, when it comes to me personally, as a person, I know that the blushing is triggered in that way, in the sense of you know, “has someone seen me for who I am? Have I been caught out?”

Shane also reported extreme social discomfort when others directly acknowledge his bodily anxiety symptoms as this is perceived to place a lens on his social deficits:

a bit sweaty on the brow, which is the worse one because that can be visible. People say, “Oh, are you alright?”, or “Are you worried about something?”, and of course you are, and it just kind of makes it a bit worse and you're like, “No, no, I'm fine, I'm just you know, hot”

For Darragh, this recognition appears to have several repercussions including embarrassment and further discomfort “*It's just kind of shit (...) so you feel kind of embarrassed and a bit like your dignity is being a bit stripped or something. Showing off that you are really uncomfortable in the situation*”.

8.3.2 What are the Contexts in Which Sexual Minority Individuals Experience Social Anxiety?

The two themes (see Figure 8.2) that encompass the context in which sexual minority individuals experience social anxiety are *The sexual minority community, a double-edged sword* and *Navigating “the heteronormative society we live in”*.

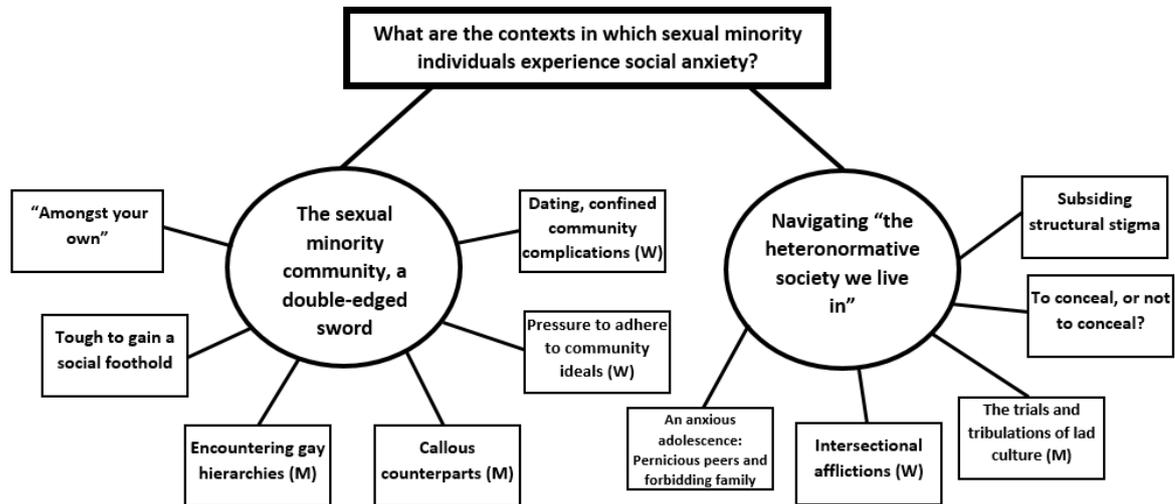


Figure 8.2: Themes and Sub-themes Pertaining to the Contexts in Which Social Anxiety is Experienced.

Note. (W) denotes sub-themes specific to sexual minority women and (M) denotes sub-themes specific to sexual minority men.

8.3.2.1 Theme: *The sexual minority community, a double-edged sword.*

This theme relates to sexual minority individuals’ social experiences within the context of the sexual minority community, their perceptions of the sexual minority community’s social climate, and how these contribute to their experiences of social anxiety. Both sexual minority women “*lifting each other up kind of thing, that’s within the community*” (Sorcha) and sexual minority men “*it is a great sense of community, (...) you are not alone, other people are like you*” (Darragh) described positive experiences engaging with sexual minority peers that help to reduce experiences of social anxiety. These experiences, which closely relate to feelings of connectedness to the sexual minority community, are encompassed by the sub-theme “*Amongst your own*”. Alongside favourable experiences, participants also endorsed distinct experiences at the within-community level that seemed to exacerbate social anxiety; *Tough to gain a social foothold* describes boundaries faced by sexual minority women “*It’s that I don’t have all that much exposure to it*” (Nessa) and men “*I think that’s part of the reason I don’t fit in the gay community*” (Aidan) in attempting to socialise with, and build support networks consisting of, fellow sexual minority peers. Two sub-themes are specific to sexual

minority men, both of which closely relate to social anxiety experienced in an intraminority stress context: *Encountering gay hierarchies “innately judged by the gay glitterati”* comprises social stressors experienced within the boundaries of the gay community that distinctly relate to status hierarchies (e.g., pertaining to physical attractiveness and masculinity “if you’re not deemed as desirable you might as well just fuck off kind of thing” (Shane), and *Callous counterparts* refers to the adverse social experiences related to the perceivably cattish nature of the gay community. Two sub-themes are specific to sexual minority women: *Pressure to adhere to community ideals: “You’re not queer enough”* delves into sexual minority women’s social experiences in an intraminority stress context and encompasses their social strain related to perceived self-discrepancies of “queerness” with the ideal norms of the sexual minority women’s community, and *Dating, confined community complications* highlights experiences of social anxiety pertaining to potential romantic relationships “you don’t know if it’s like romantic or a friendship or not” (Niamh), and the intersection of limited social circles and seeking romantic relationships within the sexual minority women’s community.

- *Subtheme: “Amongst your own”*

Interactions with fellow sexual minority peers served as a respite from the social anxiety characteristically experienced whilst socialising at the wider-community level “within the community sort of being there for each other” (Sorcha). Sean discussed feelings of instinctual social comfort when surrounded by sexual minority peers:

Fellow queer peers generally would never have caused me much anxiety. (...) even if they don’t have much in common with you, because they have that kind of one key thing in common, you almost feel like, “okay, you’re in a group”. (...) it’s almost like a protective sort of, almost clan relationship, where you just feel instinctively more comfortable because you’re amongst your own.

This context of group membership fosters feelings of belongingness “It’s kind of like a common ground, but something that you don’t have to get into” (Aoife). Indeed, participants frequently described feelings of social acceptance from their sexual minority peers; this acceptance seemed to displace social anxiety in several ways, including; reducing behavioural manifestations “I suppose if it’s with friends that I know very well or people from my own community, then I don’t have to censor myself” (Orla), and promoting self-acceptance of one’s own sexual identity “because it reminds me like that this is valid, it’s good, it’s ok, it’s celebrate, people are proud and I can be that” (Sorcha). Barry discussed

social opportunities that the sexual minority community offers in building social relationships effortlessly when abroad “*I can fly to anywhere in the world and go to a gay bar and hang around people in less than ten minutes or fifteen minutes, it sort of gives you that sort of ‘I’m one of you’ feelings*”.

Sexual minority venues and events represent social sanctuaries for some participants. Fiona recalled pleasant social experiences within the sexual minority community in which she was momentarily liberated from social anxiety:

But I have been to [gay bar name] and it was lovely, and I went to Pride when the sun was out (...). I just felt so accepted. (...) anyone would come up and you can talk to anyone and you just know you get each other. You don’t actually have to be anxious.

Aidan also relayed a positive social experience attending a retreat specifically for gay men “*there was just this reassurance that we’re there to support each other, there was a reassurance that there was no judgement, that it’s safe*” that enabled him to disengage from his regular fears of negative evaluation.

Numerous participants recollected that the sexual minority community served as an important social resource during periods in their lives in which their social anxiety was particularly heightened. Liam described his experiences frequenting gay discos “*So, they were places I felt yeah, very much more comfortable. You know just like, you’re at home, this is the place where I can be me.*” Outside of these events Liam experienced severe levels of social anxiety whilst attempting to conceal his gay identity, whereas being amongst his sexual minority peers offered exceptional experiences in which he could be relieved of his social fears. Donal illustrated that in building a social support network of sexual minority peers in a university setting, he feels somewhat supported should he experience negative interactions with other peers “*find out that there is people in your year (...) that were identified the same way as you. (...) if you do need help, if people are bullying you, there is places for you to go*”. Niamh also stated that the camaraderie with fellow sexual minority peers is exemplified by a mutual understanding of the heteronormative social stressors they encounter:

Because I think also other people experience the same things and that’s kind of nice to know as well, and also that people don’t judge you as much. (...) if you have a situation where like you just leave or something, people kind of, they’re more

understanding. (...) Like I could actually explain that to friends who are gay, but I don't think I could explain that to people who don't get why I would do that.

Donal also described being reassured that his sexual minority peers navigate heteronormative social-evaluative stimuli, thus, they understand his fears, and represent a social resource in social-evaluative situations:

because LGBT people understand, I think they have the same mind set as I would, well most of them would anyway. (...) that's just my experience of talking to people who are LGBT, people would be analysing you, how you dress, how you talk whatever. And heterosexual people don't really have that problem.

Overall, the aforementioned benefits of socialising with sexual minority peers nurtures the perception of the sexual minority community as a “*safe space*” for some participants in offering shelter from judgement pertaining to social behaviour (e.g., acting “*weird*”) and social performance deficits (e.g., not understanding sarcastic humour):

I trust myself and trust those around me enough to not feel that anxious because I think in general (...) people within the LGBT community aren't half as quick as others to judge you for how you act, or what you do, or if you're coming off as weird or whatever. (...) all of the people in the community seem to be a lot more considerate of just everything. Like if you don't talk a lot or you don't seem to be picking up on sarcasm or things like that, they just kind of accept it. So, I like situations like that where, like, safe spaces are like LGBT only spaces, where yeah, because I feel a lot more comfortable and a lot more accepted. (Kayleigh)

- ***Subtheme: Tough to gain a social foothold***

Whilst the favourable cuts of the sexual minority community's social sword are highlighted through the sub-theme “*Amongst your own*”, accessing these within-community resources can prove challenging for some “*I did join the LGBT society when I was studying my undergrad, and I was very anxious going in there*” (Sorcha). Several obstacles to gaining a social foothold within the sexual minority community were highlighted, including not having any existing close friendships with other sexual minority individuals “*I don't know everyone because I am only coming into that community, or started circulating that community only very recently, you know?*” (Liam). Ronan reported having friendship networks solely comprising of heterosexual individuals, and perceived a lack of opportunity to build friendships at the within-community level:

I basically have never really had experience of hanging around with other LGBT people. Because, all my friends I have made in school and college were straight, because they wouldn't go to any LGBT places or anything, I never got opportunities to meet other LGBT people. And like the only way I end up talking to other people is through Grindr or Tinder. But that's more in a like a chat to them as if you are on a date or something. Or rather than just to get to know people as friends. So, never had LGBT friends.

Nessa reported relying on existing heterosexual friends as support when socialising at sexual minority events *“And so often what I'm doing, is I'm bringing them into the community rather than engaging with the community itself (...) I don't feel like I'm a big part of it”* which she ultimately perceives as a barrier to making social connections at the within-community level. Whilst Fiona voiced some success in building friendships with fellow sexual minority individuals through online communities, she shared her social fears pertaining to socialising in brick-and-mortar spaces:

That wouldn't be as good as it is online, that the people that I might speak to online wouldn't be bothered, or wouldn't even be there. (...) it's not at all sensible, but there is a whole bunch of us not going because we are afraid to meet each other.

The hesitancy to engage with other sexual minority individuals seemed to garner both a fear of the unknown and of interpersonal interactions at the within-community level. In fact, due to a paucity of socialising in sexual minority social spaces, some participants felt they lack specific social skills required to engage with their sexual minority peers:

Like being surrounded by a load of gay people, I find quit overwhelming but not even gay, but people in the LGBTQ community. I find that very overwhelming because I'm not used to it, like at all. I have only ever been away with one other gay person. And then if I'm with like 4 or 5 of them, too much for me, I don't know how to act. I feel quite uncomfortable or something, I don't know why. (Darragh)

- ***Subtheme: Encountering gay hierarchies “innately judged by the gay glitterati”***

This sub-theme encompasses the less favourable side of the sexual minority community's double-edged sword for sexual minority men, and represents their experiences of social anxiety in an intraminority stress context. When describing distinct stressors that exacerbate social anxiety at the within-community level, sexual minority men almost exclusively focused on negative social experiences with, and adverse perceptions of, other sexual

minority men (i.e., not sexual minority women). Despite the within-community social benefits illustrated through *“Amongst your own”*, men participants perceived the gay community as upholding austere norms of status (i.e., based on appearance and masculinity), that sustain social hierarchies. Social anxiety is commonly elicited during social-evaluative situations in which sexual minority men perceive themselves as falling short of these ideals, as voiced by Shane:

Because I, rightly or wrongly have an assumption that a lot of gay people value certain characteristics and appearances to be more important than other things. So, I feel a bit more objectified in say a gay nightclub, or a gay bar and I don't feel comfortable with that because I don't feel I conform to what gay men find attractive at this time.

For many men, physical attractiveness ideals are the most conspicuous, centre around levels of muscularity *“Now everybody’s in the gym and there's just sort of a weird invisible pecking order so I think that’s where it is”* (Barry) and thinness *“there’s skinny and then there’s gay skinny, so you cannot, you absolutely cannot be overweight (...) that’s kind of where I’m getting this concept of like needing to suck my tummy in despite the fact I’m not heavy”* (Brian), and generate fears of negative appearance evaluation from other sexual minority men. Such fears are most apparent in social spaces at the within-community level, as described by Sean *“I think gay bars, even if they are more relaxed atmospheres, have that sort of implicit judging someone upon their appearance or things like that”*. In fact, Shane shared that he solely experienced fears of negative evaluation based on appearance in gay venues *“generally I wouldn’t be too uncomfortable with my appearance but if I was going out to a gay venue I would be very self-conscious about my appearance”*. Similarly, Barry shared a recent experience in which he felt judged by fellow sexual minority men based on his placement in the aforementioned appearance *“pecking order”*:

“He’s one of the fat birds”, and I went to a social gathering with them and it was like they just couldn’t understand why I was there (...) there seems to be a little bit of like aggression. As in I've made myself part of the group and “who the hell are you?”, that sort of thing. But that can make me socially anxious.

As well as physical attractiveness, sexual minority men also discussed the presence of masculinity hierarchies within the gay community *“this whole ‘masc for masc’ nonsense”* (Niall), which also contributed to their experiences of social anxiety. Indeed, these different hierarchies are not experienced in isolation, rather they overlap and co-exist *“that extra*

judgement of not just who you are, but also, eh you know based on sexually if they are into you, if they're not, if you're camp, if you're not" (Barry). Additionally, Donal shared that he expects to be mistreated on the basis of being considered as more feminine, by more masculine sexual minority men:

Well I'd identify as more of a feminine man per se, (...) but more dominant males would be kind of using derogatory terms towards you. Would call you names maybe if you were, if they met you on a night out or whatever. So, sometimes just the way they'd speak to you would be totally different to the way they speak to someone like themselves.

This seemed to further sustain the perception of being different to, and not fitting in with, sexual minority men who occupy a preeminent position on the masculinity hierarchy. Further, Niall recalled a recent overt experience of rejection based on the perceived masculinity hierarchy from a sexual minority man:

I was out with my friends at a pub, like bar place and I was having a dance or whatever. (...) someone messaged me then like maybe a few days later and said, (...) they weren't interested because they saw me out dancing and thought I was "a bit gay!" Ok cool, like why did you have to take the time to message me to say that?

○ ***Subtheme: Callous counterparts***

In conjunction with the perceived presence of status hierarchies within the gay community, many men also perceived a proportion of other sexual minority men to be bitchy and hostile "*I don't know where it comes from, it's just kind of old school bitchiness really and it would make you feel quite uncomfortable going in*" (Darragh). Additionally, the relatively smaller size of the gay communities in Ireland presented particular challenges for sexual minority men "*it's very clannish and it would be, if you do start speaking to anyone it's 'Oh, do you know him? Do you know him? Do you know him?' 'Well he thinks this about you'*" (Patrick). In some cases, past experiences witnessing gay men frequently negatively evaluate others established this viewpoint, as described by Shane:

I found that a lot of the guys I worked with who were gay, they weren't particularly nice to be around, they were quite bitchy, backstabbing. A lot of putting other people down as a form of entertainment. And that's what I found, this in gay culture, you know? You get a group of guys and they pass judgement on anybody else around the bar.

The perceived judgemental nature of fellow sexual minority men affirmed their stature as a potential social-evaluative threat “*it takes you so long to get to the party and come out and find the community, only to realise that everything that has been said by these people hurts 10 times more*” (Niall). Barry stated that his peers deliver negative evaluative affirmations in a considerably more explicit manner than heterosexual individuals:

The social anxiety thing can be. I mean, you know what the gay community can be like somethings? They’ll let you know if they don’t like you. Whereas in a straight situation they can be a bit more subtle (...) like I have my back up before I even realise it’s up, because I know that people are more forthright with how they feel about you.

Fears of such unequivocal negative evaluations appeared to be driven by anticipation of rejection from, and the avoidance of, social interactions with other gay men, as voiced by Aidan:

But the real reason was there was three other gay guys that I knew going to it and two of them I just can’t stand. All three of them would treat me like shit, they’d blank me, like they’d deliberately go out of the way not to speak to me. It’s almost that kind of playground, childish mean girl approach, you know? And they were the main reason I didn’t go to the wedding, because they were there. I said, I’m a 35-year-old man and I’m always being dictated by these particular guys.

These gay-specific social-evaluative experiences seemed to transcend brick-and-mortar gay venues “*the likes of Grindr (...) people treat each other horribly*” (Aidan), as participants discussed adverse online experiences using dating/sexual networking apps:

But people behind the screen, and say, and say hateful things to you. It would be through definitely through dating apps. I’d say would be where I find the most like bullying or I’d feel anxious about how I am. (Donal)

○ ***Subtheme: Pressure to adhere to community ideals: “You’re not queer enough”***

Several sexual minority women shared the view that the sexual minority women’s community is governed by palpable social norms, and that perceived shortcomings in adhering to these norms can contribute to social anxiety. One such social norm discussed is explicitly portraying one’s sexual orientation through personal style, as described by Aisling “*you often feel as a queer woman that there’s a kind of narrative that you should be (...) exploring more, being androgynous, or your boy side, or whatever (...) it’s just like I don’t*

really feel like doing it". This community ideal does not coincide with some participants' personal preferences. The resultant perceived self-discrepancies can contribute to sexual minority women engaging in self-focus and stimulate fears of negative evaluation from fellow sexual minority peers, as illustrated by Sorcha:

Because I don't always present physically as someone whose very alternative, I don't have mad coloured hair, I could quite easily pass for someone who is straight. So sometimes, I think that people might look at me and go, "Like, what are you doing here?"

Sorcha also described changing her appearance in attempting to conform to this perceived dress code "*but I definitely did sort of change my dress a little bit*" in order to avoid feared negative evaluation from sexual minority peers "*so it's sort of being aware that are you being judged that the fact that I might not look stereotypical however I identify*". In describing her thought processes prior to attending a social event at the within-community level, Aisling illustrated a negatively biased assessment of the discomfort her appearance (i.e., not appearing queer enough) may cause sexual minority peers:

I sometimes find that I feel like I'm worried that when I get there I, people have this sort of way of deriving comfort from all of these signals that people are sending out and my signal is "I'm being me". So, that's not a queer-specific signal and therefore I kind of worry that somebody will feel kind of anxious and then I'll feel anxious.

Beyond personal style, sexual minority women also discussed a perceived pressure to endorse additional values such as being extremely overt in disclosing one's sexual minority status to others, as voiced by Orla:

Oh, that you're not cool enough (...) Because I pass [referring to passing as heterosexual] that you're not sort of shoving it down people's throats. I sometimes feel like if you're not out there, sort of going "Hello, my name is [participant name], I'm queer, do you have a problem with that?"

Failure to meet this perceived normative standard sustains Orla's fears of negative evaluation from sexual minority peers related to both authenticity "*you're not queer enough*" and worthiness of community membership "*you're not standing up for everyone else*". Other women recounted avoidance behaviours through ceasing involvement in sexual minority women communities (i.e., perceived to be predominantly lesbian) due to their extreme anti-heterosexual values "*I have actually left a few communities online for kind of slamming the*

straight community (...) they would all have been predominately women who like women. And they were kind of going, 'Oh the straights are at it again'" (Sorcha).

The perception of intragroup tension based on sexual identity was also apparent across sexual minority women's interviews "*in-fighting like between different groups (...) like different letters of the LGBT acronym as well*" (Niamh). Indeed, bisexual and emerging identity women communicated the perception that lesbian-specific ideals dominate the sexual minority women's community which is pertinent to their within-community experiences of social anxiety. Despite having very limited experiences socialising in-person within the sexual minority women's community, Fiona affirmed "*there are some areas where bis aren't welcome*". This sentiment was shared by other bisexual women "*I don't feel like I'm gay enough kind of, do you know?*" (Aoife). Exemplifying the experience of navigating lesbian dominant norms "*What if I'm not? What if I'm in the wrong place*", Aoife questioned her place in the sexual minority women's community as she does not endorse a strictly lesbian identity. Indeed, Aoife stated that bisexual individuals are underrepresented at the within-community level, and the legitimacy of their identity is questioned by other community members:

Like if you go to Pride like you don't really see that many people with bisexual flags. (...) people would be very judgemental of me because people who kind of, "are they really?", or "are they just jumping on the bandwagon a little bit?" So, like there is a lot of internalised judgement as well on my part.

Bisexual women's expectation of negative evaluation from lesbian peers appeared to feed into the tendency to avoid social events within the sexual minority women's community "*I don't go to those places, because I have read that the gays say you are not gay enough*" (Fiona). This avoidance prevented some bisexual women participants from having social experiences with other sexual minority women. Yet, avoidance is the preferred option compared to potentially facing bisexual-specific social stressors "*if I went to the places that they didn't think that bi existed, then that would be worse*" (Fiona). Lesbian women, such as Niamh, also shared experiences of social discomfort in witnessing intragroup conflict at the within-community level "*like a lot of energy spent on arguing between like lesbians and bi women*" which in turn increases her tendency to engage in self-monitoring processes "*I think it just makes me really conscious of what to say and what not to say*".

○ *Subtheme: Dating, confined community complications*

This sub-theme focuses on the social strain that sexual minority women discussed pertaining to dating at the within-community level. Specifically, women highlighted an anxious navigation of small social groups within sexual minority women's communities in which romantic and friendship networks may overlap and collide. Nessa reported specific social fears pertaining to dating within the sexual minority women's community and her interactions with other sexual minority women:

If you are dealing with other lesbian women, you know potentially you have somebody there that you think is pretty hot. That, you know, if there is flirting involved or potential for flirting, it always feels like the stakes are that wee bit higher.

Emphasising the increased importance assigned to interactions with potential romantic partners, sexual minority women communicated being most at ease engaging with gay men "*it's much easier when it's like a group of gay men because you're not going to date any of them*" (Niamh). Herein, fears regarding negative social performance evaluation seemed to diminish as there is mutual romantic disinterest "*There isn't a sexual element to anything. So you make a tit of yourself, it doesn't matter, you don't fancy them, they don't fancy you*" (Nessa).

Sexual minority women also portrayed dating as a complicated process due to the confines of the smaller sexual minority women's communities that are characteristic to Ireland "*it's a very kind of small community so like if you do go out with someone or like go on a date with someone, the likelihood of someone else having gone out with that person is very high as well*" (Aoife). The process of attempting to acquire a romantic partner in this restricted dating pool raised certain fears for Aoife "*So, that would kind of freak me out a little bit being like, oh about so many links between different people you know and that kind of stresses me out a little bit as well*". Within the boundaries of these smaller communities, participants perceived the likelihood of having mutual friends, acquaintances, or past romantic partners with potential romantic interests as high; these plausible intersections are often realised and exacerbate social anxiety, as Nessa described:

I had an interaction on Tinder with this girl, we had matched a few days ago, I sent her a message on Sunday (...). Eh, but she said "appears we have mutual acquaintances, which puts me in a strange spot, so good luck out there!" (...) then I asked ok, "who is it that we know in common?" And she, she didn't answer or wouldn't answer. But the funny thing is that, I then, like I spent, I tried to push it out

of my mind, but that was very much at the back of my mind for hours. Because there was, ok I was trying to think “Ok, does that mean that in some way connected to an ex? Or is it somebody like, or is something shared or?”. That is like the worse nightmare for somebody like me.

Nessa elaborated that intersections of current dating life with either past dating life, or mutual social circles, grants potential romantic partners the opportunity to negatively evaluate her in advance of meeting in-person “*that feeling of people like potentially knowing you, or knowing of you and having a perception from that. That, that definitely has an impact*”.

8.3.2.2 Theme: Navigating “the heteronormative society we live in”

This theme encompasses the social experiences of sexual minority individuals in a wider-community context (i.e., outside of sexual minority communities), their encountering of heteronormative standards in this context, and how this contributes to their experiences of social anxiety and related processes. In terms of encountering heterosexist discrimination, there were commonalities in the experiences of sexual minority women and men (e.g., bullying based on sexual orientation during school years and difficult family relationships) that are captured by the sub-theme ***An anxious adolescence: Pernicious peers and forbidding family***. However, distinctions between sexual minority women’s (e.g., intersectionality of heteronormativity and misogyny) and men’s (e.g., shortcomings in upholding perceived standards of masculinity) current experiences were also evident. For this reason, two distinct sub-themes were developed to represent each group’s current experiences: ***Intersectional afflictions*** (sexual minority women) and ***The trials and tribulations of lad culture*** (sexual minority men only). ***To conceal or not to conceal?*** describes the coming out experiences of sexual minority women and men, their current engagement in concealment behaviours due to heteronormative contextual demands, and how these relate to social anxiety. ***Subsiding structural stigma*** reflects participants’ perceptions on societal progress (e.g., diminishing structural stigma) and its potential role in their experiences of social anxiety.

- ***Sub-theme: An anxious adolescence: Pernicious peers and forbidding family***

In reflecting on childhood experiences, sexual minority women described negative peer experiences during their school years “*I’d say I probably was bullied a bit in primary school (...) And I kind of felt myself retreat a bit that point*” (Sorcha). For many, these instances

corresponded with the initial display of behaviours associated with social anxiety (e.g., social withdrawal) and occurred in a heteronormative context:

I don't know, you see I had friends, but in the end we kind of stopped talking and then I kind of realised I'm gay. I wasn't the only one gay in the class, but they started picking on me. (Shannon)

Importantly, an intersectionality of discriminations characterised some women's experiences of victimisation during their school years, whereby they were also targeted by peers for reasons other than being labelled as a sexual minority (e.g., being an immigrant or having a non-Irish accent) as described by Kayleigh *"I suppose being an immigrant as well and having a slightly different accent and whatever, eh I wasn't really liked a lot by the other people in my year and they needed someone to pick on"*.

Sexual minority women recognised the contribution of negative peer experiences during their youth to their current levels of social anxiety *"I'm just starting to realise that, or maybe I have always realised that it obviously comes from school. Comes from people who think they are all that"* (Fiona). For many sexual minority women these negative peer experiences coincided with the initial stages of their sexual identity development (e.g., realising they may be attracted to women). In fact, Orla recalled being initially unbothered by her experiences of same-gender attraction, only to realise that being open about these attractions may leave her vulnerable to negative peer experiences. This encouraged Orla to engage in concealment behaviour:

I always knew that I just found everybody beautiful, or everybody lovely, or everybody pretty, or whatever it was. And that it didn't bother me if I found one of my female schoolmates attractive or whatever. And I just presumed everybody was like that. And then I suppose you realise that that's not the case. And you realise that things that are perceived as different are an easy target for comment, or for exclusion, or bullying, or anything like that. So, therefore, you don't say it or you don't comment on it.

Similar to sexual minority women, sexual minority men cited early adolescence as the onset of their social anxiety *"My social anxiety was very very high during secondary school"* (Darragh). Throughout early adolescence, many sexual minority men began to feel different to the majority of their peers. These feelings were often realised through gender nonconforming behaviours *"Didn't really fit in, didn't understand why everyone was so into*

like football and that kind of stuff. Wanted to hang around my sisters” (Barry) and a lack of sexual attraction toward women, as voiced by Cillian:

when you were 14 or 15 years old it was all the boys together talking and they were like, “Oh who did you shift [Irish slang for kiss] at the last GAA disco?” or whatever (...) I never went to one of the discos because I knew that at that time I was gay and didn’t want to shift any of the girls (...) so I avoided the discos because I knew if I went, I’d be under pressure to do that.

Comparing themselves to other boys seemed to confirm their shortcomings in fulfilling the perceived expectations of masculinity upheld by heteronormative social environments (e.g., their schools) and evoked feelings of being inferior to their heterosexual peers *“always knew something was different about me, when you are younger you don’t know what that is and there is an inherent thought of weakness to it”* (Niall).

As they navigated their heteronormative school environments, sexual minority men experienced bullying on the basis of their sexual orientation *“I got badly bullied in school. Got really humiliated directly relating to being gay”* (Aidan) and recalled being regularly singled out by peers *“It just kind of meant there was constant picking, there was constantly going to be ‘oh there’s [participant name], he’s the gay lad from [town name]”* (Darragh). These experiences appeared to be frequent for many men, especially for those who felt their gay identity was less concealable, thereby granting the perpetrators an obvious target. Niall recalled such experiences *“a lot of it was bullying and stuff like that (...) always sticking out like a sore thumb and being a bit, I don’t know, visibly gay as a younger person (...) so was a pattern for me”*.

In recalling his school environment, Ronan described a space that fostered heterosexist bullying, and this was reflected in the discourse between students *“if someone wanted to insult someone, you’d call them gay or even like they would have called someone a faggot”* and teaching staff’s attitudes toward sexual minority issues *“And the referendum ended up being mentioned and one of the teachers were like, ‘oh yeah, I’m voting no, they shouldn’t be allowed marry, it’s different’”*. Several sexual minority men described the amplification of experiences of bullying and anxiety in specific contexts that were deemed to uphold rigid standards of masculinity (e.g., PE class) as exemplified by Darragh:

Well things like going in for PE and getting changed and stuff, not everyone, but a lot of the lads would turn away from me (...) But those classes just gave me such bad

anxiety, because I'm going to have to go into this room with all the lads and just have them be very cautious that I'm there in the room with them.

The enduring impact of experiences of bullying, specifically more severe negative peer experiences, was described by Aidan:

There was one particular guy who made my life hell in school and my sister actually bumped into him last week on the train and he said, "Oh, I went to school with your brother [participant name], we used to be great friends", but when I heard his name mentioned, I almost was 14 or 15 again. I had that anxiety. It was literally, it was real in that moment as it was when I was 15. The last memory that I have of him was dragging me down the corridor telling everyone to, "kick the faggot", and you know in a headlock, and everyone having a go and having a kick at me, and just overly humiliating me.

Sexual minority women also recounted experiencing family members make negative affirmations pertaining to sexual minority orientation during their childhood and adolescent years. Nessa recalled sharing her first childhood "*crush*" with her cousins (i.e., a woman cartoon character):

because obviously the cartoon element of it, it was not necessarily a match met in heaven! but I remember their reaction to the fact that it was a female rather than a male (...) they were kind of like laughing, going "absolutely not going to happen, you are a girl, she's a girl, it's not going to work."

Whilst this example is conceivably a more innocent childhood experience, Nessa stated this contributed to her concerns of being different to other girls "*used to kind of reinforce that feeling of, 'Well that's not normal behaviour' and 'You know, maybe I am gay?'*". In addition, Fiona shared an experience in which her father denounced bisexuality:

when I was figuring out that bi existed, I was into David Bowie. And I just started talking about the music with my dad and he went "Ah no, he's an arsehole, he thinks he's bi and there is no such thing". That conversation stopped right there.

Such events seemed to affirm the legitimacy of fears related to rejection from family, and encouraged participants to refrain from disclosing their sexual identity to family members.

In congruence with sexual minority women, sexual minority men also discussed the presence of adverse parent experiences related to sexual orientation during their adolescence. Prior to

disclosing his gay sexual identity, Ronan recalled witnessing his parent conveying an unfavourable attitude toward the sexual minority community:

And my mum had the remote and she opened up the menu of the categories and there was LGBT films and she made some comment, “Oh that shouldn’t be there!” as if that was inappropriate. And she was basically reacting it to the same way as if she had sat down with her family to watch a movie and it had offered her pornography.

Aidan shared that he experienced an overtly negative reaction from his parents after disclosing his gay identity:

They didn’t understand what being gay was. Certainly, my mother didn’t, she thought it was disgusting kind of thing. (...) It was just kind of, it was seen as disgusting and the comments from people in school, just in general it was almost people confirming that what I was was disgusting, and that certainly was internalised.

Through multiple sources, including family, participants received affirmations that their minority sexual orientation was undesirable, or in extreme cases repulsive, which seemed to contribute to the development of a socially anxious self. Many sexual minority men described how they internalised these heterosexist views during their adolescence “*you are just like ‘why was I born like this, I don’t want this. It’s not something I asked for, it’s something that has been thrown on me’*” (Darragh). The lasting impact of past periods of intense self-stigma were evident in how some men currently view themselves, as evidence by Aidan:

this comes from what I've been exposed to and the experiences I had growing up that, I've been basically pretty much told indirectly that being gay means that you're not a man. I know that's factually incorrect but there is elements of me that still probably think that way. That you're a lesser man because of it.

- ***Sub-theme: Intersectional afflictions***

In contrast to their men counterparts, sexual minority women’s recollections of recent social anxiety inducing events highlighted that their experiences of discrimination are often heteronormative *and* misogynistic in nature. Thus, whilst sexual minority men may contend with heterosexist social-evaluative stimuli, sexual minority women vie with these as well as misogynistic social-evaluative stimuli, which add to their perception of the social world as hosting dual social threats. In line, Nessa described a recent interaction in which she was ridiculed by a man on the basis of having a relationship with another woman:

I was weighing up the chances of being murdered versus trying to live an authentic life (...) I was in an Uber on my own, and the Uber driver was asking me questions about relationships, and I used gender neutral pronouns for my responses. And so it got to the point where I was like “fuck it, I’m just going to say it” and express that the, my ex-wife was in fact a woman. And to which he then started to ask about “Did I not miss men?” and “Wouldn’t it be better if there was like a third person involved?!”

Other women shared similar experiences. Kayleigh recalled her social fears regarding being asked to justify her same-gender attraction to a group of heterosexual men:

I said “I have a girlfriend” and then they just the whole, “but have you ever had a boyfriend?”. So, and like the “how do you know?” and it was just really uncomfortable, because I couldn’t escape it either. They were sitting at the bar as well which just kind of forced me to keep talking to them and yeah, it’s trying to avoid that I guess and it’s also just, you never know exactly how far they’re going to go with the comments. You don’t know if it’s just going to be the uncomfortable questions or if it’s going to get as far as “oh, you are ruining traditional families” or something like that.

it’s the fear that I’m going to have to have that conversation with them. But if they’re like “oh it’s just not natural” or “but how do you know that you’re not attracted to men?” – it’s the worry that I’ll have to go through all of that again and have to deal with really uncomfortable questions and comments that I just don’t want to deal with.

Other women shared concerns regarding their levels of uncertainty as to other’s adverse attitudes toward sexual minority women, as voiced by Niamh, an individual who conceals her minority sexual orientation from colleagues:

people love telling me how easy it is to identify the gays (...) people do just express like “I don’t understand this PC culture sort of stuff” to me all the time. (...) so like then in that situation I just kind of expect that they’re really hostile to anything like that.

When Niamh elaborated, it appeared that her fears of negative evaluation were maintained by uncertainty regarding others’ attitudes toward the sexual minority community “*even really small aspects of your life to some people they’re like horrifying (...) And it’s never who you expect that it is sometimes*”. In keeping with these concerns, Orla shared that she

fears personal topics of conversation “*I don’t know what questions they’re going to ask (...) they ask about partners or if you’re married and all that kind of stuff*” as her own contributions may oppose the heteronormative assumptions of others.

○ ***Sub-theme: The trials and tribulations of lad culture***

When discussing contextual demands that currently elicit social anxiety, sexual minority men continually cited interacting with heterosexual men as the preeminent threat. They perceived the social world as one which upholds standards of heteronormativity and social anxiety is commonly experienced around heterosexual men as they consistently impose these standards on participants, as described by Brian:

it’s just lads and they all play rugby and hurling and sport. So there’s all that culture too. (...) I know the lad patriarchy culture just makes me kind of feel a little bit uncomfortable in a large group and then if I see one or two of them walking around through campus together, I nod politely but like inside I’m screaming, I don’t really find it comfortable. I don’t like being in their presence.

Indeed, social interactions with heterosexual men seemed to be feared due to a perceived lack of mutual interests “*I don’t fit in there as well. Like, a lot of them will drift into conversations about Manchester United or Liverpool or whatever*” (Liam) and inability to contribute “*it would bring up my anxiety quite high with a group of lads and not knowing what to talk about or something*” (Darragh). These feelings of not fitting in appeared to increase the perceived likelihood of experiencing negative evaluation by heterosexual men “*other men is where your differences of being gay I guess, coming to the foreground, and then you are picked on (...) the comparison between other men*” (Niall). It was also apparent that social anxiety symptoms may manifest on both a cognitive and behavioural level in the presence of heterosexual men, as discussed by Barry:

I try to figure out who’s going, I calculate in my head how anxious I’ll be, and then I’ll actually let them know whether I’ll go or not. Because a lot of guys, the straight guys, from the tech teams (...) they talk about football and they can’t understand why you don’t understand football and that kind of thing. (...) I basically elude myself from social situations just to avoid having to feel awkward in anyway.

A specific fear that heterosexual men will sexualise certain behaviours and deem sexual minority men to be sexual deviants was also communicated. This particular fear seemed to elicit self-monitoring behaviours “*like I definitely wouldn’t say that somebody was*

physically fit or whatever” (Liam) when interacting with heterosexual men, and might also amplify the social threat represented by specific environments that are more easily sexualised, as illustrated by Darragh:

Even going to the bathrooms on a night out (...) I can get quite anxious thinking about going in. I’d always have that bit of a fear, I tend not to use urinals on a night out, I don’t know why? I’m just afraid in case somebody would be like, “oh he’s looking at me or something” and just I have the fear of using them.

Collectively, sexual minority men’s experiences of discrimination (i.e., with their heterosexual peers as the perpetrators) appeared to be less frequent during adulthood than those experienced during adolescence. Nevertheless, these experiences still occur, often in a “*lad culture*” context, and remain pertinent in eliciting social anxiety. Patrick recalled a recent experience of heterosexist discrimination:

I was kind of on edge at the end of the night waiting for a taxi and the partner leaned in and gave me a kiss. And there were a group of people nearby and we ended up having a can of Fanta thrown at us. Which had a really negative effect on my levels of anxiousness and for a few days. I wasn’t great after it.

This example also highlighted specific contexts that may elicit social anxiety for sexual minority men “*the likes of crowds of younger males that, I think because of that incident reaffirmed it in my head that people don’t, or every person isn’t okay with it. That I’m very conscious of it now*” (Patrick).

Younger sexual minority men (i.e., under 30) also recalled recent experiences of heterosexist verbal discrimination delivered by heterosexual men in nightlife environments, as voiced by Donal “*I have had people call me names or whatever when I’m out (...) The general ones, ‘faggot or gay’*” and Darragh:

I have gone to a pre drinks before college and just a group of lads, a few lads I didn’t know (...) one kind of shouts, “oh, are you gay” and I’m like “yeah” and then he started laughing about it to his friends. I didn’t know what to do, I was like, I haven’t done anything, I was just asked a question and I answered it. (...) I didn’t ask for this, I’m just trying to enjoy my pre drinks or whatever. I just felt so under pressure.

○ *Sub-theme: To conceal, or not to conceal?*

Across their lifespan, when navigating the heteronormative social world, participants emphasised the integral role of sexual orientation concealment in their experiences of social anxiety. Concealment behaviours were particularly evident in retrospective accounts of their adolescent years. During these years, concealment was portrayed as a temporary, but necessary, tactic to avoid heterosexist bullying “*so keep your head down until you’re in third level at least, and then look you can deal with all this*” (Brian). These concealment behaviours were also driven by sexual identity uncertainty, and social comparisons to peers as described by Nessa:

there was nearly the sense of hiding while I was still coming to grips with whether I was gay or straight, kind of hiding. Making sure that nobody would figure it out. Or, you know, making sure that was I behaving normally, was I being too close with female friends?

Participants recalled carefully managing their disclosure of sexual orientation to reduce the likelihood of encountering heterosexist negative evaluations “*it was definitely something I did very slowly and very carefully. Because again I was very conscious of the fact that it was something that could definitely be seen as controversial*” (Cillian). The conscientious management of sexual orientation disclosure was evident far beyond adolescence, Niamh shared that she conceals her lesbian identity from family at present in fear of potentially negative repercussions “*I would have been worried then about (...) whether it would get back to my family*”.

Initial sexual orientation disclosures to others alleviated social anxiety for some “*Now that I’m out to everybody I’m a lot more relaxed*” (Liam) and helped relieve stress associated with maintaining concealment behaviours, as voiced by Cillian:

when I went to college I was able to instantly start off with that being part of my identity and never have to worry about hiding it. Which I think was the right move. Again it was probably, it was a strategic move, that way I wouldn’t have to cope with any anxiety around it in college.

Indeed, some participants described how favourable reactions to their disclosures enabled them to become more socially integrated in heteronormative environments “*I am well able to make comments and they can be (...), the straightest guys out there, you know? And they are just so accepting*” (Liam), whereas less favourable responses may affirm their fears of

socially interacting with heterosexuals “*One of them even said to me (...) ‘because you’re not like one of those really camp homosexuals that like, I appreciate we can still be friends.’ I’m like ‘thanks?’*” (Brian).

Decisions as to whether or not to disclose sexual orientation in social interactions are described as anxiety provoking due to the uncertainty regarding others’ attitudes “*I suppose at times I would (...) be in groups and I’d think ‘Should I mention that? Or should I not mention that?’ Because you don’t know how people might react to it*” (Sorcha). In line, certain topics of conversations can elicit social anxiety “*any topic of relationships or anything related to that somewhat, I’d suddenly feel really anxious*” (Cillian).

The perceived heteronormative nature of the social world was portrayed as taxing by Orla “*it’s the presumption that everybody is hetero. So, I find that in one way tiring, and in another way annoying*”. Further, Brian discussed being steered “*back into the closet*” when specific contextual demands are encountered (e.g., social transitions and interacting with strangers):

because you don’t know where these people are from, you don’t know what their upbringings are like (...). So I kind of went, in college, I’d say I went back into the closet and then, at the time, I was like, eh, oh “*this is kind of a step backwards, why are you doing this to yourself?*”

Niamh described adapting to the perceived heteronormative demands of specific friend groups “*like I just kind of had two separate lives*” and concealed her lesbian identity from her past friends (i.e., individuals who she had friendships with during adolescence). Circumstantially, Niamh encountered these past friends whilst socialising with her current sexual minority friends. This collision of two social worlds appeared to evoke social anxiety:

the people that I ran into there, I knew when I was younger, like much younger. So, then I was like, do I really want them to be like “*What are you doing hanging around with a bunch of gays?*”

Among sexual minority men, the utilisation of concealment behaviours to cover traits or mannerisms deemed to indicate femininity are especially relevant to their experiences of social anxiety. Once more, contextual demands prompt the use of these behaviours, the most preeminent of which is the company of heterosexual men, as shared by Darragh:

I’d be like, sitting my legs crossed, but if I’m in a room full of lads, I feel might judge me, my legs are uncrossed far apart. Little things like that. I won’t sit up as straight

when I'm in a room that I'd feel a bit more uncomfortable in, I'd slouch more, things like that. I talk differently I slow down my speech when I feel uncomfortable with who I'm with.

Conversely, Darragh described a social event in which suppressive contextual demands are absent *“a few people you meet on a night out and you are having a great buzz, I might be really flamboyant then and not give a fuck, if there is really nice people or whatever”*. Niall also discussed altering his appearance *“I won't dress how I'd normally dress”* and mannerisms *“I will interactions with just random people like shop tellers and stuff like that (...) I'll kind of straighten myself out”* to conform to the perceived expectations of heteronormative society when completing everyday errands.

The vast majority of participants discussed utilising concealment behaviours through avoiding public displays of affection with their romantic partners. This serves as a deterrent for both potential heterosexist discrimination *“I'm kind of like just out with my girlfriend and we're on a date or something and like when we're holding hands, there's the fear. The fear that someone will do something or say something”* (Kayleigh) and unwanted attention *“there are certain environments and situations where I hold my partner's hand, you tend to become the centre of attention”* (Patrick). Public displays of affection were portrayed as invitations for the heterosexual majority public to cast judgement (e.g., through a disapproving facial expression). Furthermore, public displays of affection are a prominent concern for participants if experienced as uncomfortable by others:

he was kind of like going for a goodbye kiss, and I just felt really awkward, because I was out in public. And I just got very anxious, even though I didn't know anyone I knew was around me, it was complete strangers, like “oh god, people will see”.
(Ronan)

Although some participants described being generally open regarding their sexual orientation, their disinclination to be affectionate in public served as a reminder that their sexual minority status still plays a pertinent role in their experiences of social anxiety. Interestingly, this experience also extends to individuals who never experienced prominent heterosexist discrimination *“I know it's still a possibility of there being problems because of my sexuality, because we don't feel comfortable with that (...) eh it's like still something that's constantly on your mind”* (Sean).

○ *Sub-theme: Subsiding structural stigma*

When reflecting on their navigation of the heteronormative social world, participants noted the importance of policy and public attitude changes in favour of the sexual minority community “*the stigma around it isn’t as bad anymore, it’s more acceptable in Ireland now these days, that it would have been years ago*” (Donal), and emphasised the acceleration of this progression in recent times “*But I think Ireland’s moved on a huge amount in the last couple of years*” (Orla). Specifically, Cillian mentioned the passing of same-sex marriage by popular vote in 2015, and its alleviating impact on his fears of negative evaluation from others:

I did tend to still negatively view the world at large, the general public, the Irish people (...) they’ll never accept it. But seeing the marriage referendum and how that kind of worked out in our favour in the end. Eh, I suppose I did take confidence in that, and it did leave me to being even more kind of accepting and confident in being publicly who I am, because I wasn’t worried about the majority (...). So, I guess I did take confidence in it and it did have a positive effect on social anxiety.

Subsiding structural stigma, such as the passing of policy and legislation in favour of sexual minority individuals “*I know that I’m protected in law which is enough for me to feel comfortable in most situations*” (Shane) empowers some participants to feel less anxious in their interpersonal interactions. For many this fosters a social environment in which they may be partially relieved of their social fears and openly express their sexual identity, as shared by Patrick “*Because it’s such an on trend topic right now (...) it doesn’t affect me as much because I love speaking about being gay and I love being gay and I’m a very proud gay man*”. However, the link between perceived progression in societal acceptance and reduced social anxiety was less apparent for others “*I think the society has really changed, I don’t think it has impacted on my behaviour*” (Nessa). In fact, some participants acknowledged that their social fears related to heteronormative discrimination are most likely out of proportion to threats present in society nowadays “*So, I think it’s getting better, so maybe it’s more us checking because of past experience or because of fear, than that actual feeling or that actual reaction that we’re going to get nowadays*” (Orla). The challenge of fully realising perceived advances in societal acceptance was particularly announced by some older participants (i.e., aged 40 and older) who grew up in an Irish society that held a more hostile public view toward the sexual minority community, as shared by Liam:

I had been living in this sort of internal closet for so long that it's very hard to get my mind to get out and to open up. Like, I mean I'm still getting used to the idea that nobody gives a fuck! You know, that's just like, "What, nobody cares?" (...) it's just weird.

There was a clear divergence in perceptions as to the degree of change in the Irish public's attitude toward the sexual minority community "*From outside, I'm not sure if I have actually seen anything specifically positive. Eh, no I wouldn't say that I have*" (Sorcha). For Ronan, the assertion that the passing of the same-sex marriage referendum reflects a substantive change in public attitudes and behaviour is a misconception:

I feel like a lot of people think there is no issue with homophobia since the referendum. But there still is, and I would feel most people support gay people on paper, but not reality. Whereas, they would say they support, and they probably think they support people equally, but then when it comes to a situation they'll like, they'll be uncomfortable around gay people.

Whilst acknowledging some progress, Donal asserted that the victimisation of sexual minority individuals is still a prominent issue amongst younger generations, and this has not been miraculously solved by recent structural progress "*LGBT growing up. It's still not like we just waltz through our lives without any bullying, there is some there, 100%*". Patrick shared his belief that heteronormativity still prevails in Irish society to a certain degree, and this sustains his fears of negative evaluation from contingents of the general public "*I'm very aware that there are, most of my anxieties now stem from sexuality still. I'm very aware that there are people out there who don't understand it and who aren't okay with it*".

8.3.3 How do Sexual Minority Individuals Cope With Social Anxiety?

Two themes (see Figure 8.3) *Safeguarding with support* and *Thwarting threats with techniques* detail healthy coping mechanisms that participants discussed utilising to cope with social anxiety. One theme *Diluting social inhibitions* details an unhealthy coping mechanism that some participants described (i.e., relying on alcohol and other substances) when faced with social anxiety.

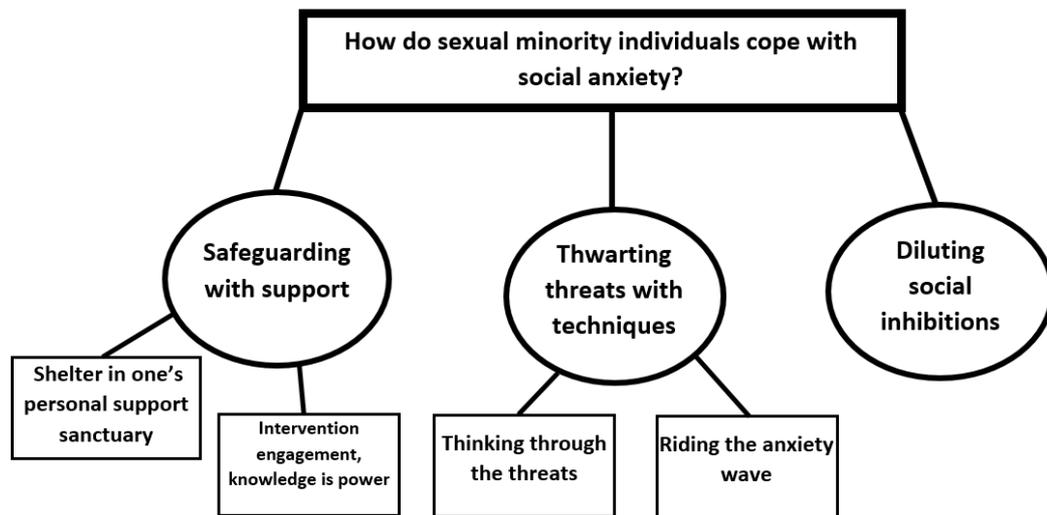


Figure 8.3. Themes and Sub-themes Pertaining to Coping with Social Anxiety.

8.3.3.1 Theme: *Safeguarding with support*

This theme encompasses the personal and formal supports utilised by sexual minority individuals to cope with social anxiety. The protective function of personal social support networks in reducing social anxiety was prominent across sexual minority women and men’s accounts “*It’s just a bit of reinforcement. So, if something would go wrong (...) that there would be someone to kind of back you up*” (Aoife). The sub-theme *Shelter in one’s personal support sanctuary* covers the vital supportive roles of friends, family, and romantic partners in enabling participants to cope with social anxiety “*Definitely a close friend group and family kind of rallying around as well*” (Donal). Many participants also discussed the experience of engaging in formal support interventions, namely of a therapeutic nature, with the aim of strengthening their capacity to cope with social anxiety “*I’ve done a lot of workshops, a lot of different meditation groups, a lot of different weekends away and different therapy groups (...) I think that all of those things, that fed into me lessening that anxiety socially*” (Aidan), the role of these interventions in equipping participants to cope with social anxiety is represented by the sub-theme *Intervention engagement, knowledge is power*.

- *Sub-theme: Shelter in one’s personal support sanctuary*

Social support from close friends offered some participants respite from their usual feelings of social anxiety, as described by Patrick “*A lot of it can depend on who we’re with, so if I’m with a group of friends and I know everyone it tends to be just second nature*”. Friends represented a source of comfort as they are familiar “*I know them; they know me*” (Sorcha).

For Sean, this familiarity coincides with an understanding of his social fears and his anxiety can heighten in instances in which friend support is inaccessible:

I have three or four people that I can tell anything to. And no matter how little it might seem on paper; they get that this is probably like a big thing for you. So they'll appreciate that. Yeah, having those things in place definitely helps, because I know (...) where I've gone away on my own and I haven't been able to tap that kind of support base, I'll feel that kind of anxiety building like.

For many, interactions with close friends were deemed a social “*sanctuary*” (Fiona), which shelters against the grasp of the fears typically present when surrounded by acquaintances and strangers “*they know that I'm not strange or weird*” (Sorcha). In the past, Barry refined his social support network and relied on close friends which helped to alleviate his social fears “*it doesn't really matter about all the people you meet and try to be friends with, so long as you have a social circle that is small enough that you can depend on those people*”.

When coping with anxiety raised by anticipatory processing, Shannon expressed that she uses positive affirmations regarding friend support:

let's say in two weeks' time on Friday there would be a party I'm supposed to go. So I would be like thinking of it and would be like “Okay, I can do this. I know it's going to happen. I know there will be people. Maybe I'm not going to know them – that's okay. My friend will be there. I can count on her.”

Kayleigh described taking shelter in her friend's support sanctuary when her social fears arise during social events:

I can just say “I'm really, really anxious right now, I need to just take a minute and take a break” and they'll be accepting of it and will go out with me and like help me calm down. It's just kind of that there is someone, there just is one person that won't judge me and that will stay by my side.

For some participants, the support of a significant other was deemed as imperative in coping with social anxiety “*my husband, yeah, really like helps me so much*” (Barry). Many participants are comforted by the definite assurance of another individual to engage with in social situations “*I know I can talk to him, he's not going to say 'feck off' and leave me*” (Fiona) and rely on more “*outgoing*” partners when encountering social-evaluative situations “*And my partner's incredibly outgoing, so I suppose that helps tremendously. She drags me along to things and stuff*” (Orla).

Subtheme: Intervention engagement, knowledge is power

Accessing formal supports safeguarded participants from social anxiety and helped them to cope. Participants have accessed a wide variety of interventions to gain a great understanding of their experiences of social anxiety. In terms of psychological interventions, counselling based-interventions appeared to be helpful in promoting participants' awareness of social anxiety "*Well I've been just going to counselling (...) and just like trying to manage it because I would be more aware of it*" (Kayleigh). In Barry's case, attending counselling sessions enabled him to gain insight into his social anxiety, which in turn, aided in understanding his social behaviours:

It's like night and day. (...) but there'd be a lot of time that I've thought about something and halfway through the conversation I've realised where, why I was feeling that way and where that feeling was coming from. Why I'm doing, you know, doing certain behaviours

The process of understanding and being empowered to manage social anxiety was exemplified by participants' regular accessing of counselling interventions "*I go for regular sessions to just keep my awareness of it up and I've learned how to deal with the anxieties I face in my life*" (Patrick).

Aisling discussed a newfound understanding of her physiological manifestations of social anxiety "*So, I'm now at a low grade that I'm aware that I am experiencing, like that sort of elevation. But I'm not taking the bite into it*" and the benefits of this knowledge in managing her own emotions and expectations "*it's about my psychological state and my ability to manage my own expectations of myself and allow things to be very complicated and messy*" having accessed talk therapies (e.g., CBT) and mindfulness-based interventions. When asked what helps him to cope with social anxiety, Liam detailed the benefit of a peer support group (i.e., with other sexual minority men previously married to women) and meeting others with previous similar experiences "*I have met a lot of people that are going through the same, particularly in the support group that I am with*". As a result of engaging in therapeutic interventions, participants discussed acquiring knowledge pertaining to specific coping mechanisms "*I would have learned a lot of the, like cognitive behavioural therapy type coping mechanisms, like body scans*" (Sean). Indeed, engaging in interventions empowered participants to implement an array of coping mechanisms such as breathing exercises, meditations, and other grounding techniques (for further details see theme ***Thwarting threats with techniques***).

Nonetheless, the success of therapeutic interventions was not unanimous among participants' experiences "*I've tried the whole CBT and DBT and they just haven't worked for me*" (Aoife). For some participants, the intensity of anxiety during social-evaluative situations hinders their abilities to successfully recall and use the knowledge they acquired during therapy "*I tend to forget, or I don't feel up for it. Because a lot of them involve (...) as you are coping with it, like your anxiety will rise and fall. So I don't feel able to do the rise*" (Ronan). Thus, whilst many participants were empowered in coping with social anxiety by virtue of the knowledge they acquired through therapeutic interventions, the benefits for others were less apparent.

8.3.3.2 Theme: Thwarting threats with techniques

This theme represents the practices and techniques used by participants to counteract social anxiety and diminish the threats represented by social-evaluative stimuli. The specific utilisation of rational and favourable thoughts to counteract cognitive maintenance processes of social anxiety "*in five years, and I won't even remember what I was worried about*" (Fiona) is represented by the sub-theme **Thinking through the threats**. Participants also described attempts to negate the behavioural manifestations of social anxiety (i.e., avoidance and escape), through exposing themselves to social-evaluative stimuli "*in the last few years have tried to just face things just kind of head on and actually deal with it as opposed to any kind of form of avoidance*" (Aidan); these endeavours are encompassed by the sub-theme **Riding the anxiety wave**.

○ **Subtheme: Thinking through the threats**

Participants described engaging in advantageous techniques that helped to counteract their social anxiety including meditations "*I found that extremely helpful, just simple meditations to do*" (Donal), and other grounding techniques "*Five things you see, four things you hear, three things you smell and so on. And by the time you get to one thing, you are kind of a bit more grounded*" (Fiona). Aisling recognised the limitations of her past cognitive distortions:

I was thinking of everything in such a black and white way. So, if you sort of take that sort of thing, if you carry it over, then a lot of the stuff is just people being anxious and finding a thing to be anxious about.

Donal shared his process for coping with the cognitive manifestations of social anxiety:

It would be guided meditation (...) I find that extremely helpful just to feel like or to visualise it like leaving you and just those problems just getting off your back (...) when I was extremely social anxious at the beginning of the year I'd use it a lot. But I still do it maybe once a week just to kind of reset myself type thing, to get rid of the bad thoughts and bring in the good ones, you know?

A specific technique employed by several participants during social-evaluative situations is to assess the importance, or lack thereof, of a social stressor from a long-term perspective, as exemplified by Patrick *"I've kind of learned that it's not something that I'm going to be thinking about in five years' time, so it's not worth five minutes thinking about now"*. This approach seemed effective in diminishing Patrick's focus toward threatening social-evaluative stimuli *"Because I'm the type of person that overanalyses everything. It's a way of me analysing it very quickly and determining it's not important and then being able to put it away and move on"*

The usefulness of cognitive techniques (e.g., assessing the proportion of favourable vs unfavourable social interactions in a day) also extended to coping with social anxiety after experiencing a social-evaluative event, as described by Aoife *"If I say the wrong thing or something, just be like 'right that was one time out of 24 hours. (...) it doesn't mean that it was like a bad day socially as a whole'*. Equivalently, for Orla, acknowledging that the consequences of previous social-evaluative situations were rarely extreme also helped to ease her social anxiety *"I haven't died of embarrassment (...) And that nobody has actually turned around and pointed and laughed hysterically for too long"*. Some participants affirmed that their ability to effectively use cognitive techniques has improved though garnering life experience with age, as discussed by Barry:

it's only from having 40 years of you know life, having past that things always go up and down. And that's why now even in social situations, or anxious situations, or social anxiety situations, for me it used to be "I'm going to die". Now it's just I'm much more level headed about it. It's like well look, "you're not going to die, everything is fine". So, I think with age it gets better.

- ***Subtheme: Riding the anxiety wave***

Whilst patterns of avoidant behaviour were preeminent across all interviews, on occasions participants described purposefully enduring social-evaluative situations, which in turn, appeared to garner greater confidence in coping with social anxiety *"You just have to power*

through really. It's all down to practice again and it's just one of those you can't avoid" (Aoife). For Aisling, exposure to social-evaluative stimuli represents an opportunity to improve her social interaction skills:

you just sort of allow yourself to be in that situation, and just talk to somebody. And talk from yourself and people will often, when you take a more active role communicating, will mirror. So, you're most likely to get that more authentic thing and you're getting real communication off somebody and that is a privilege that not everybody gets to experience every day. So, being grateful for what you can get and knowing that you can improve.

Purposefully enduring social-evaluative situations also allows disconfirming evidence to be gathered as to the degree of threat represented by previously feared stimuli and the importance (or lack thereof) of perceived performance deficits *"And you know if I want to try something new with lots of people who I don't know, I kind of force myself because I realise it's never really as bad as you imagine"* (Shane). Examples of the benefits of gradual exposing oneself to feared social situations are also evident:

But I suppose it's those small little steps that every time you do it. "And I survived". A couple of years ago, I used to force myself to go into tiny little shops when I was out in town. I'd go right, come on, you're going to do three of them today. And I'd walk in, I'd walk round. "Do you need anything?" "No, it's fine", and run out. (Orla)

Sean voiced the benefits of self-exposure to feared social-stimuli in occupational settings:

in there [referring to professional environment] I'm literally greeting people and I'm talking to people. Like, legitimate persons of influence and power and things like that, but because I've gotten used to it, because of coping mechanisms I learned through therapy and things like that, it is nowhere near, eh, it's not near the agoraphobic level that it used to be.

Similarly, Sorcha recalled volunteering to deliver a presentation to colleagues as part of a recent work placement. While this was an anxiety provoking challenge *"my initial feeling was, 'No I don't want to do it!'"*, she realised the potential value in overcoming such a test *"But, I said I would do it because I knew it would benefit me and challenge me to come out of myself even more"*. Although self-exposure to feared social situations appeared to yield benefits in reducing social anxiety, participants also acknowledged that experiencing anxiety is inevitable whilst taking these proactive steps *"if I start feeling very anxious I try to just*

stop myself from leaving and hope that if I stick it through I'll feel less anxious the next time" (Ronan). For Aisling, acknowledging this anxiety as a natural reaction allows her to cope *"I'm not fully engaging with it. I'm just sort of allowing myself to feel a level of anxiety but not being reactive and exacerbating it"* and preserve through waves of anxiety:

when it comes to stuff that's more inside your everyday experience (...) then what you can do is allow the experience to be like a wave. So, when you're standing in the water and a wave comes towards you, you can stand there and it will, and push against it and the wave will like crash against you and you'll feel the full force of the wave. Or, in that moment you can pull yourself in a little, protect yourself, and just go through the wave.

8.3.3.3 Theme: Diluting social inhibitions

A reliance on substance use to cope with social anxiety and dilute the threats of social-evaluative stimuli was also evident across interviews, and is captured by the current theme. Some participants reported using cigarette/nicotine products to counteract their social anxiety, as discussed by Shane:

In fact, smoking, especially when the smoking ban came in, that was very useful if I was feeling a bit pressured socially. I could escape to the smoking area quite legitimately without raising too many questions. So, that was a huge crutch for me. And now with vaping that would be the same thing because you can't vape indoors anywhere either.

Brian similarly utilised cigarette smoking as *"a stress relief"* and a coping mechanism to counteract unwanted attention and facilitate concealment behaviour *"because it's such a small town, pretty much everyone smokes (...) So again, you blend in a little bit more."*

For both sexual minority women and men, alcohol appeared to be the substance most frequently relied upon to counteract social anxiety *"probably alcohol, I think I probably do rely on drinking at social events to make me feel more relaxed"* (Nessa). Barry reported that alcohol consumption is an instinctual coping response when faced with social anxiety *"So, drinking to basically have Dutch courage to be social (...) the main thing is alcohol, so I mean as soon as there's social anxiety, I instantly turn to, eh, turn to alcohol"*. Sorcha voiced consuming alcohol to cope with anxiety prior to social events:

I had to have a drink before I went to bed. I went to the bar and had a glass of wine, eh just to calm the nerves. Because that obviously meant introducing yourself and talking about yourself and that, was just hell for me.

Sorcha consumed a moderate amount of alcohol to dilute the anxiety she felt the night before attending a conference (i.e., one in which she would be surrounded by other sexual minority individuals). Reliance on more severe levels of alcohol consumption was evident among sexual minority men “*Oh I better, if I’m going to this party, I need to be drunk*” (Niall). For Aidan, the utilisation of alcohol as a coping mechanism was particularly present during intensive periods of social anxiety:

So, certainly in terms of social anxiety, was at an absolute peak during that time. So much so that I wouldn’t, if I did go out, I’d nearly have to get blind drunk just to kind of cope with being in the situation.

Indeed, it appeared that extreme alcohol use was particularly present during heightened periods of minority stress (e.g., during periods in which participants concealed their sexual identity) “*I did drink too much, I drink less now that I’m out [referring to sexual orientation] (...), before I would drink to just. You know? Just drink!*” (Liam). Niall described using illicit substances at “*sex parties*” attended by sexual minority men in order to cope with fears of negative evaluation from his peers “*There is times where I found myself in those situations completely embracing the situation and like taking the fucking drugs, because I’m so socially anxious and that would completely medicate that*”.

8.3.4 How Does Social Anxiety Impact Sexual Minority Individuals’ Daily Lives?

Three themes (see Figure 8.4) *Obstacles in career path*, *Behind the social pack*, and *Emotional Toll* represent the educational/occupational, social, and emotional impact of social anxiety on sexual minority individuals’ lives respectively.

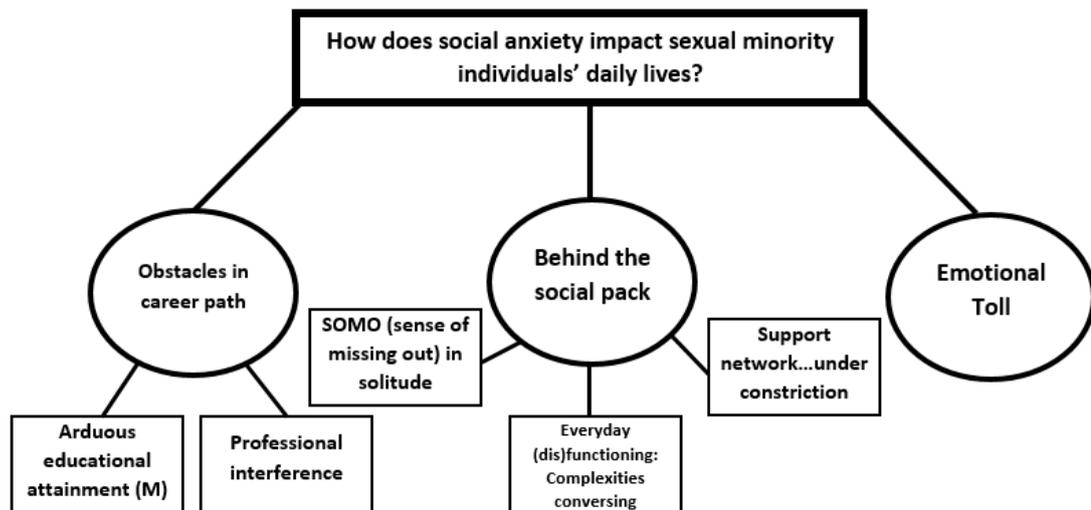


Figure 8.4: Themes and Sub-themes Pertaining to the Impact of Social Anxiety.
Note. (M) denotes sub-theme specific to sexual minority men.

8.3.4.1 Theme: *Obstacles in career path*

This theme addresses the impact that social anxiety has exhibited on the career path of sexual minority individuals. Discussed solely among sexual minority men, the sub-theme *Arduous educational attainment* covers the experiences of educational challenges (e.g., absenteeism and hindered progression) in relation to social anxiety. The impact of social anxiety on the professional lives of sexual minority women and men was also notable and is encompassed by the sub-theme *Professional interference*.

- *Subtheme: Arduous educational attainment*

Across interviews with sexual minority men, the impact of social anxiety on educational functioning was apparent. Some men discussed either dropping out of secondary education “*I dropped out of school at 15*” (Aidan) or hindered progression through secondary education “*I ended up having to leave school and repeat the leaving cert*” (Barry). This pattern continued to third level education for some. Brian explained that his intermittent absence from university was due to feelings of overwhelming anxiety:

It really can have varying impact (...) one day it can be like nothing and then other days I can really feel like “God, I’m not going to college”. I just feel like “Oh, fuck, I’m not doing it anymore, it’s too much”.

Ronan discussed deferring his third level education as the prospect of navigating the university social environment was deemed as too threatening “*I have been on leave from*

college (...). And I reckon a big factor was just socialising”. Sean gave a similar description of the negative impact of social anxiety on his university experience:

I nearly dropped out of school for a few months, because the anxiety of dealing with people was so much. And then eh, after secondary school I started in a further education college, studying [subject names], and eh I did a year there, and I was going to do the second part of the course. And, eh the literally, it was just pure social anxiety, there was no pressure in the college, there was no one causing any problems for me (...). But still, every day I would dread, I’d often skip classes.

○ ***Subtheme: Professional interference***

Many participants distinguished between the social and performance (i.e., specifically related to tasks pertaining to their job role) sides of work, and struggles across both domains were evident. It was clear that social anxiety impacted on participant’s ability to engage with colleagues on a daily basis “*I’m not dealing with our clients or customers, but even with our teammates, sometimes it’s too much*” (Shannon). As described by Orla, social anxiety appeared to impede on colleague interactions as these individuals might be unfamiliar:

So, every morning walking up to work, I take a big deep breath and go, “okay, there might be people in here and it might not be people that you know particularly well” (...) So, I wouldn’t know everybody as well as other people or I wouldn’t socialise with them as much. So, I just have to go, “it’s okay, you just say good morning and just keep walking”.

Participants also shared struggles to perform specific occupational tasks that involve public speaking (e.g., a presentation), as voiced by Sorcha:

And it was a topic I found very interesting, so I wanted to say a lot. But, most of the time it was just my heart racing and, do you know? My mind was going blank. And when I did say something I said it all wrong, I missed out stuff. It was only just afterwards, I thought ‘oh shit I should have said that, that and that’, and I made a complete arse of myself.

It was also apparent that certain situational factors (e.g., number of colleagues present) may influence the impact that social anxiety has on participants’ professional functioning “*I mean I’ve given presentations to upward of 500 people at work and you know, a little bit nervous at that whereas the next day I could be at a meeting with four people and be terrified, you*

know?” (Aidan). Barry perceived that he had no control over his anxiety levels, and more severe social anxiety was deemed detrimental to his professional performance:

It’s random, sometimes I feel like, the weird thing is it can sometimes push me to be way better than I normally am and sometimes it can push me to being an absolute wreck. So, for me there's this sort of, like I've no clue what's going to happen and that gives me more anxiety. I suppose I've no control over it then.

Ultimately, in some instances the impact of social anxiety led to absenteeism from work “*last year I had a bit of a melt down and took four months off work*” (Aidan).

8.3.4.2 Theme: *Behind the social pack*

This theme encompasses how social anxiety has impacted on sexual minority individuals’ social lives, “*the fact that I’m a bit anxious in social situations would impact kind of my social life*” (Sorcha). Participants voiced perceptions of socially lagging behind when compared to others. The impact of social anxiety appeared to be threefold in that participants felt socially isolated and sensed missing out on social events (sub-theme: ***SOMO [sense of missing out] in solitude***), proclaimed to have perceived social skills deficits (sub-theme ***Everyday (dis)functioning: complexities conversing***), and faced difficulties in creating and maintaining a social support network (sub-theme: ***Social support network...under constriction***). Accumulatively, perceptions of missing out, having social skills deficits, and difficulties in building social relationships contributed to an overall sense of being ***Behind the social pack***.

- ***Subtheme: SOMO (sense of missing out) in solitude***

Participants described experiences of social isolation during periods of heightened social anxiety, both in adolescence “*15 or 16 is when I just became really socially anxious. I just kind of isolated myself a lot around that time*” (Aoife) and nowadays “*being kind of trapped in the house*” (Aisling). Resulting feelings of isolation were apparent in some participants’ accounts, and boundaries in attempting to overcome this solitude were identified “*I don’t have many close friends around, so I don’t really have anyone to ask to go with me, and I wouldn’t go on my own out*” (Sorcha). Shannon communicated dissatisfaction with the restrictive impacts of social anxiety on her social functioning, and expressed frustration in missing out on social activities and excursions “*sometimes it’s like I’m scrolling down my Instagram and I’m like ‘I want to go to this place as well’ and I’m like ‘Damn, I can’t’*”. This sense of missing out was apparent as participants reflected on their levels of social

activity both in the wider- and within-community level, as exemplified by Brian's view on joining college sports clubs and LGBTQ societies:

I wouldn't have thought about taking up the likes of [sport name] for third level and then I thought, "well no, this is where all these will be hanging out, so I won't be hanging out there" (...) I am also reluctant to join any kind of [LGBTQ society type] or anything associated with it because I just feel like, "oh that's where they'll all be hanging out and they all know each other".

○ ***Subtheme: Everyday (dis)functioning: Complexities conversing***

Throughout the interviews, participants communicated a sense of being ***Behind the social pack*** through possessing social skills deficits. Perceived deficiencies related to social functioning were commonly reported and a particular emphasis was placed on difficulties socially interacting at a desirable level "*So I am not comfortable going up to someone and starting a conversation*" (Fiona). Social anxiety seemed to impede participants' ability to initiate conversations with others, especially strangers, and this was a profound struggle for many participants, as described by Nessa:

For me to go there and mingle with strangers or meet new people or whatever, would be like, eh, like unlikely to occur. I would have to really push myself out of the comfort zone to do something like that.

Aidan voiced his concerns regarding maintaining conversations with peers, that are exacerbated by feelings of anxiety "*then like you know 15, 20 minutes later I can kind of, the anxiety kind of starts then as 'Oh shit, now what are we going to talk about?'* (...) *I hate kind of social awkward silences*". The process of conversing with strangers or acquaintances was deemed as strenuously complex for some as they believed that they lacked the necessary social skills, as exemplified by Kayleigh:

I'm very bad at reading body language and social cues and things like that. So with people that I know I'm kind of used to the social cues that they give off and I can sort of manoeuvre them. I don't have that with people that I don't know.

The social skills deficits that arise from social anxiety appeared to impact participants' everyday functioning. The social aspects of everyday tasks pose particular challenges for many, and confronting such challenges can seem like an ominous task "*there are certain things that do, I find myself getting very anxious about in a social context and when that happens I'm like, not, I'm fairly useless*" (Cillian). Across the interviews, there was a clear

expression that social anxiety impedes the completion of everyday tasks (e.g., shopping), as interacting with staff in these environments can be extremely daunting. Such experiences were described by Cillian “*like dealing with customer service if I’m going up to a desk to ask someone for something*” and Shannon “*I can’t even ask the shop assistant in the store about the thing I want to buy (...) my Mum does it for me*”. Orla discussed relying on her partner to purchase goods at a market as she lacked confidence in her social skills:

we were talking about going to the [name of market] because I’m juicing at the moment (...) I asked [partner name] if she’d come with me because I just wouldn’t be able to do that on my own. I’d go in and I wouldn’t know where to start. I wouldn’t know who to talk to. I wouldn’t feel confident walking up to people going, “Can I have a box of x, y, or z”, or anything like that.

As voiced by Kayleigh, the stressful navigation of daily social interactions is deemed to be extremely draining and out of proportion to actual threats faced “*Because just any situation, just going to a shop, leaving my house, even being in my house I’m interacting with the people I live with. Everything just requires a lot more mental effort and energy than it should*”.

- ***Subtheme: Support network...under constriction***

Social anxiety appeared to constrict some participants’ ability to establish a support network “*I found it difficult to make friends and I found it difficult to meet new people*” (Shane). This restrictive impact of social anxiety was especially pronounced when entering novel social environments, as described by Brian:

I suppose I recently started a new college course and I am in like mixing and starting to mingle with the new group of new people. I actually found that like rather difficult, I guess to kind of fit in (...) I hadn’t really thought so much of it and then it kind of flared up.

Indeed, Nessa stated the main boundary to building a network of friends is her perceived inability to do so “*I think my ability to make friends probably has taken a hit, like that’s probably been more challenging*”. Shannon viewed her social anxiety as burdensome and was wary of the inconvenience it may place on potential friends:

Now I’m just like, every time I meet someone new it takes me kind of time to decide if they’re going to be my friend or not. Also because of my social anxiety

because I'm like "Would they understand? Would they be okay with that? Could they deal with this shit?"

Liam explained that his social anxiety has prohibited him from initiating friendships for much of his life "*I don't know, I just find it difficult to reach out and things like that, you know? Because I have always stopped myself making contacts with people that I would like to meet*". As well as difficulties in initiating friendships, others described struggles in sustaining existing friendships (i.e., related to fears of negative evaluation from friends) "*I feel very like constantly anxious that they don't like me, they don't want me*" (Ronan).

The inhibiting nature of social anxiety extended to building a support network with a romantic partner for some participants "*Whereas with me I was meeting up and I felt like, I don't know what is, what stuff you do or don't do*" (Ronan). Shannon also shared her levels of social discomfort pertaining to dating:

Eh, it takes me ages to feel comfortable around other people. So whenever I go for a date, I would need to go for like 200 dates to feel comfortable around the person and I think they can pick up on that. Sometimes I tell them in advance, but it never helped.

8.3.4.3 Theme: Emotional toll

Overall, social anxiety appeared to take a marked emotional toll on participants "*it is emotionally taxing*" (Aisling). Namely, feelings of emotional exhaustion were discussed "*it's like you have all the blood from your veins, it's like the whole energy, it's like gone away*" (Shannon), and it was clear that engaging in both the behavioural (i.e., highlighted in **Forging social safety**) "*I have to be on show and I have to be alert and everything, and not everybody understands that it is mentally tiring*" (Orla) and cognitive (i.e., highlighted in **Deleterious thinking**) "*it's almost like all the thinking in my head takes the physical energy out of my body as well*" (Patrick) manifestations of social anxiety contributed to this emotional fatigue.

Several sexual minority women discussed feeling overly empathetic toward others as a result of their heightened social anxiety "*I feel like I'm hyperconscious of social situations, maybe like that I'm too empathetic*" (Nessa). Aisling explained her fears of offending fellow sexual minority individuals, which are compounded with empathy through understanding the hardships her fellow community members may face:

But you're still worried that people are living these sort of more complex lives and are probably earning less money, having problems getting through things. You don't know what you're going to trespass on and you don't want to do things that would hurt vulnerable people, because you know what it's like to be vulnerable.

In addition, Kayleigh explained that she is often upset by others' use of humour toward her in daily interactions, and fears that she might cause similar upset "*I tend to be quite worried about doing that as well, because even though I never mean to hurt anyone, eh I would worry that I would accidentally*". It appears that these overly empathetic tendencies may be linked to a hypervigilance toward hurting/offending others, which in turn might add to the emotional toll (e.g., worry) experienced by sexual minority women.

Amongst some participants, in the past social anxiety has led to profound sadness "*I felt very low*" (Sean). Aoife described social anxiety as a catalyst for other mental health difficulties such as depression:

so I think social anxiety would have been the catalyst for my other mental health problems when I started to realise that all was not okay. So, when I was like 15 or 16 is when I just became really socially anxious. I just kind of isolated myself a lot around that time and then from that kind of came more like generalised anxiety and depression and stuff.

Donal further described a depressive emotive state related to his fears of negative evaluation from others:

It would be like, I'd tense up and try not to cry sometimes, because it's quite sad, when you don't know why people aren't talking to you, but you have a fair idea, so it's all in your own head like.

Indeed, Sean recounted an isolated incident in which intense anxiety focused on the potential social threats impending in university was interrupted with thoughts of suicide:

And on that morning, that kind of fight or flight kind of thing kicked in – but instead of wanting to flee home or flee to a café or something like that, my brain literally just had a flash of "go over the quay wall" [laughs]. And like, it totally shook me.

For some the impact of social anxiety was intensified by comorbid depression, and culminated in attempts of suicide, as described by Donal "*I was extremely, extremely anxious, I couldn't leave my house, I was down in myself, there was a lot of pressure on me*

and it just led to that” and Aidan “I tried to take my own life a couple of times and was hospitalised on a number of occasions”.

Chapter 9 Phase Two: Qualitative Discussion

9.1 Introduction

The aim of the qualitative phase was to explore the experience of social anxiety among sexual minority individuals who believe social anxiety is a personal issue in their lives. This chapter includes a discussion of the qualitative findings as related to the manifestations of social anxiety, the context in which sexual minority individuals experiences social anxiety, how sexual minority individuals cope with social anxiety, and the impact that social anxiety has had on their daily lives. Additionally, this chapter outlines the strengths and limitations associated with the phase two study.

This phase two study was the first to use a qualitative lens to explore the experience of social anxiety among sexual minority individuals, and by this virtue uncovered pertinent facets of this phenomenon that were previously unexplored. This qualitative enquiry advances the current knowledge base in several ways. By illuminating how social anxiety manifests for sexual minority individuals, the current study represented the first to emphasise the pertinent role of cognitive, behavioural, and bodily symptoms in the experience of social anxiety within this at risk population (themes: *Deleterious thinking*, *Forging social safety*, and *Bodily botheration*). In doing so, the importance of the cognitive and behavioural processes of the IAM model (Wong & Rapee, 2016) in sexual minority individuals' experiences of social anxiety was highlighted for the first time. Indeed, this finding clarifies the usefulness of employing a social anxiety-specific framework to understand this mental health burden among sexual minority individuals. By uncovering the contexts in which sexual minority women and men experience social anxiety (themes: *The sexual minority community, a double-edged sword* and *Navigating "the heteronormative society we live in"*), the current study advanced the understanding of the distinct experiences of social anxiety, and the divergent social-evaluative stimuli present, at the within- and wider-community level. In addition, this phase two study sheds light on both beneficial and unfavourable coping strategies used by this population when faced with social anxiety (themes: *Safeguarding with support*, *Thwarting threats with techniques*, and *Diluting social inhibitions*). Lastly, for the first time, nuanced information has been provided with regards to the far reaching impact of this mental health burden on sexual minority individuals' daily lives (themes: *Obstacles in career path*, *Behind the social pack*, and *Emotional toll*).

9.2 The Manifestations of Social Anxiety

The current phase two study was the first to illuminate the manifestations of social anxiety among sexual minority individuals across cognitive, behavioural, and bodily domains. Moreover, the use of a qualitative approach provided rich accounts of these three symptom typologies. The findings not only highlight particular situations in which social anxiety may manifest for sexual minority individuals, but also highlights the integral role of components of the IAM model (Wong & Rapee, 2016) in participants' experiences of this mental health burden.

In terms of the cognitive manifestations of social anxiety, participants primarily described intense self-focus and biased attention toward threatening stimuli, grappling with their inner critic, and the presence of repetitive thinking before and after social situations. Indeed, these manifestations reflect cognitive processes of the IAM model that maintain social anxiety (Wong & Rapee, 2016). Previous experimental research has suggested that becoming the centre of attention (i.e., in front of a virtual audience) elicits social fear in individuals experiencing high social anxiety symptoms (Chen et al., 2015; Cornwell et al., 2012). These findings align with the experiences of participants in the current sample who described discomfort in becoming the centre of attention across an array of situations. Indeed, for socially anxious individuals, deleterious self-focus and biased attention toward threat are not confined to performance type situations (Peyre et al., 2016). Many participants highlighted the presence of cognitive manifestations of social anxiety whilst completing everyday tasks. Importantly, in these circumstances their sexual minority status was not always at the forefront of their focus. However, the findings also generated novel insight into participants' experiences that are specific to their sexual minority status. For some, self-focus and attention to threat were particularly present in social environments that contained heteronormative social stimuli. Further, in congruence with research indicating that socially anxious individuals are disproportionately self-critical (Cox et al., 2000, 2004) and self-criticism is associated with increased social anxiety among sexual minority individuals (Puckett et al., 2015), the presence of an inner critical narrative was clear in sexual minority individuals' narratives. In participants' accounts, the inner critic was characterised as a deprecating voice that emerged in interactions with heterosexuals and sexual minority peers, meaning it was preeminent at both the within- and wider-community.

As per the assertions of Wong and Rapee's IAM model (i.e., that anticipatory processing and post-event processing maintain a high SET value), secondary cognitive processes were

alluded to in the participants' narratives. Previous research has found that anticipatory processing increases negative self-imagery and maladaptive self-beliefs (Chiupka et al., 2012; Wong & Moulds, 2011). The current findings suggest that sexual minority individuals' anticipatory processing often focused on negative images of the self or anticipations of high social demands, poor social performance, and subsequent rejection. It appeared that for some participants, anticipatory processing was a key mechanism in stimulating the avoidance of social events at the within-community level. For others, anticipatory processing tended to focus on the detection of heteronormative social-evaluative stimuli. Indeed, sexual orientation-based rejection sensitivity could be portrayed as a sexual minority-specific version of anticipatory processing in that it is characterised by repetitive thinking concerning heteronormative rejection. Similarly, post-event processing also appeared to be a key cognitive manifestation of social anxiety as many participants voiced repeatedly recalling past social events, in some cases from years previous, that served to maintain their social anxiety levels.

Both sexual minority women and men recounted profound patterns of avoidance and escape, and the utilisation of safety behaviours when faced with particular social-evaluative stimuli (e.g., the presence of strangers or acquaintances). In keeping with this, Heeren and McNally (2018) utilised the network approach (Borsboom & Cramer, 2013) to SAD symptomatology in a recent study; in a sample of individuals diagnosed with SAD, the researchers found that the most central nodes (i.e., symptoms that have the strongest connections to other symptoms and are therefore integral in maintaining the disorder) related to fear and avoidance of interactions with unfamiliar people. Endorsing the adverse effects of minority stress processes (Hatzenbuehler, 2009; Meyer, 2003), participants also illustrated avoidance and escape behaviours when faced with heteronormative social-evaluative stimuli. For instance, one sexual minority woman described immediately trying to escape social interactions in which she suspects a person might have an unfavourable heterosexist attitude. A pattern of avoidance behaviours at the within-community level were also apparent across narratives and the nature of these behaviours appeared to differ. For example, some participants discussed possessing close sexual minority friends, whilst avoiding socialising within LGBTQ venues (e.g., a gay bar) as they applied a high SET value to such environments.

Participants described using a variety of safety behaviours, including altering their social support network, dependent on the social stressors they believed were contributing most to their social anxiety. For example, some discussed ceasing socialising at the within-community level due to experiences of intraminority stress, whilst others described

befriending only fellow sexual minority individuals to avoid potential exposure to heteronormative social-evaluative stimuli. There is an ongoing debate as to what constitutes an adaptive behaviour versus a safety behaviour in social anxiety research (e.g., Piccirillo et al., 2016). To exemplify the plausible role of safety behaviours in maintaining social anxiety, the instance of the sexual minority individual altering their social support network to consist solely of heterosexual individuals (i.e., in order to avoid intraminority stress) will now be outlined further. First, this individual might now be prevented from experiencing positive social interactions at the within-community level to disconfirm potential distorted beliefs that all sexual minority individuals are socially hostile. Next, should this individual have a positive social experience at the within-community level (e.g., in a circumstance where they bring heterosexual friends to a gay bar), they may attribute this success to the presence of their heterosexual friends rather than their own capabilities to successfully interact with sexual minority peers. Lastly, there may be certain situations in which this individual is compelled to socialise at the within-community level without access to their heterosexual support network, and this may prove to be a particularly anxiety provoking given their lack of prior experience in such circumstances.

A rich insight was also gained into the bodily manifestations of social anxiety across participants' narratives. Wong and Rapee (2016) emphasise that heightened self-focus strengthens one's ability to detect internal threat responses (i.e., physiological signals of social anxiety such as blushing), which in turn maintains a high SET value. When recalling previous experiences of social anxiety, some participants communicated profound fears of others noticing their bodily anxiety symptoms. A recent systematic review indicated that socially anxious individuals have negatively biased perceptions of their bodily symptoms (Siess et al., 2014). Further, experimental research utilising a social stress paradigm also demonstrated no significant difference in individuals with SAD and non-socially anxious controls in terms of biological stress responses, yet, the former group self-reported significantly higher anxiety before, during, and after the social stress task (Klumbies et al., 2014). Thus, it is plausible that participants' self-appraisals of bodily anxiety symptoms play a more pertinent role in maintaining social anxiety than their objective levels of physiological arousal. Participants discussed how fears of others observing their anxiety symptoms hinders successful impression management (i.e., the portrayal of a non-socially anxious individual). Fears of losing control (i.e., of physiological symptoms) may be especially pertinent here as they have been shown to stimulate cognitive and behavioural maintenance processes of social anxiety (Kelly-Turner & Radomsky, 2020).

9.3 The Context in Which Social Anxiety is Experienced

Through delving into sexual minority individuals' accounts of social experiences at the within-community level, the findings revealed that there are both positive and negative aspects to interpersonal interactions with fellow sexual minority peers. The findings suggested that processes unique to social experiences within the sexual minority community context serve to both alleviate *and* exacerbate social anxiety. These promotive and adverse facets of the sexual minority community advocate for both community-level resilience (Frost & Meyer, 2012; Meyer, 2015) and intraminority stressors (e.g., Boyle & Omoto, 2014; Pachankis, Clark, et al., 2020) as salient factors that influence sexual minority individuals' experiences of social anxiety. Additionally, sexual minority individuals' social experiences in a wider-community context were pertinent to their socially anxious experiences. In support of minority stress theory (Meyer, 2003), participants portrayed themselves as a minority operating within a heteronormative social world. Indeed, they discussed the encountering of individual, interpersonal, and structural heterosexist stigma as pertinent to their experiences of social anxiety across the lifespan.

Participants portrayed sexual minority spaces (i.e., environments primarily occupied by fellow sexual minority individuals) as offering social comfort. In many instances, these feelings of social comfort were described as instinctual, and mirroring previous research (Formby, 2017; Parmenter et al., 2020b), seemed to be based on perceived commonalities with, and acceptance from, sexual minority peers. Sharing a common sexual minority identity appeared to provide a beneficial social foundation which can help sexual minority individuals develop bonds with like-minded peers across an array of social environments (Ceatha et al., 2019; Formby, 2017). In these cases, it appeared that fellow sexual minority peers did not represent threatening social-evaluative stimuli, rather they were portrayed as agents that relieve social stress. Socialising within the community offered some participants temporary relief from social anxiety, and friendships with fellow sexual minority individuals appeared to aid in combating minority stressors known to stimulate social anxiety. Some participants articulated feelings of comfort in sexual minority social spaces during times in which they concealed their sexual orientation from the majority of their friends and family. In such instances, it appeared that participants could disengage from both sexual minority-specific behavioural (e.g., covering behaviours) and cognitive processes (e.g., rejection sensitivity) that would normally persist in heteronormative social environments. These experiences provided rare moments in which participants' feelings of social comfort appeared to override fears of negative evaluation. Moreover, the findings also illustrated that

forging social relationships with other sexual minority individuals' can be useful in diminishing the deleterious impact of minority stressors (e.g., heterosexist bullying). The ameliorative effect of these relationships appeared to be based on shared experiences and a mutual understanding of the challenges associated with navigating heteronormative social-evaluative stimuli. In support of the potential utility of community resilience in relieving social anxiety (Frost & Meyer, 2012; Meyer, 2015; Puckett et al., 2015), it seemed that interpersonal relationships with sexual minority peers might offer astute feelings of togetherness and adept social support that may not be provided by other interpersonal relationships.

The current findings suggest a divergence in the nature of adverse social experiences at the within-community level between sexual minority women and men. In keeping with intraminority stress theory (Pachankis, Clark, et al., 2020), the current findings support the presence of perceived status-based hierarchies within the sexual minority men's community. Specifically, hierarchies based on attractiveness appeared integral to sexual minority men's experiences of social anxiety, mirroring research highlighting the salience of social appearance anxiety within this population (Hart et al., 2015). The influence of status-based hierarchies were most pronounced in recollections of past social experiences in venues primarily occupied by other sexual minority men (e.g., gay bars). These specific experiences of social anxiety at the within-community level can be understood through the assertions of Wong and Rapee's (2016) IAM model. The men in this sample recalled explicit experiences of discrimination (negative peer experiences) based on their physical appearance; this alone would serve to maintain an extreme SET value applied to interactions with their peers. Additionally, sexual minority men evidenced engagement in cognitive (e.g., anticipating rejection based on physical appearance and detecting the threatening presence of peers who occupy a higher space on the hierarchy) and behavioural maintenance processes of social anxiety (e.g., safety behaviours such as "*suck my tummy in*") that specifically relate to physical appearance. Other researchers have reported the positive relationship between body dissatisfaction and social anxiety among sexual minority men (Blashill, 2010; Blashill & Vander Wal, 2009; Hart et al., 2015). Therefore, it is plausible that this may reflect the social struggles of those men who deem themselves to occupy a subordinate position on the appearance based hierarchy.

The men in this sample also described hierarchies based on masculinity that served to increase their feelings of social anxiety. It became clear that the status-based hierarchies (i.e., of appearance and masculinity) are not always encountered in isolation, but may compound

to add to sexual minority men's socially anxious experiences. Aligned with Pachankis, Clark, et al.'s (2020) experimental findings that rejection by high-status peers (i.e., attractive and masculine gay men) results in greater feelings of implicit exclusion, the highest SET value seemed to be applied to high-status peers. Multiple theoretical standpoints offer reasoning as to why this may be the case. Under the lens of Vandello et al.'s (2008) theory of precarious manhood (one of the theoretical foundations upon which intraminority stress theory is based), low-status (i.e., perceive themselves as unattractive and effeminate) sexual minority men may feel especially threatened by high-status men and view interactions with this group as a challenge to their masculinity. Further, their self-perceived failure to preserve their masculine status within the community may result in social and mental health difficulties such as social anxiety. In accordance with hegemonic masculinity theory, (Connell, 1987; Connell & Messerschmidt, 2005) through possessing less masculine capital than their high-status peers, low-status sexual minority men have less social power (Ravenhill & de Visser, 2017), and are relegated to a lower position within the social hierarchy. The potential struggles of low-status sexual minority men to gain social and sexual capital is signified by contemporary research. Masculine appearing sexual minority men are desired over effeminate appearing men in terms of sexual partner selection (Casalheira & Smith, 2020), gay men show less interest in interacting with effeminate peers when threatened in their masculinity (Hunt et al., 2016), and gay men exhibit anti-effeminacy attitudes (Ravenhill & de Visser, 2019). Converging the above research evidence, it appears that low-status men could encounter negative evaluation from peers on a more consistent basis than their high-status peers, which would serve to maintain their heightened levels of social anxiety.

Rather than encountering status hierarchies based on physical attractiveness and masculinity, sexual minority women described community ideals that centred around upholding and protecting an overtly queer identity; perceived failure to adhere to these ideals appeared to contribute to social anxiety. This finding coincides with previous work suggesting that young sexual minority women perceive community social norms, and their perceived failure to uphold these norms is associated with heightened internalising mental health symptoms (Boyle & Omoto, 2014). Consistent with an existing body of literature (Clarke & Spence, 2013; Clarke & Turner, 2007; Huxley et al., 2014; Krakauer & Rose, 2002), the navigation of perceived pressures to appear as an authentic queer woman through personal style was evident. Beyond clothing and appearance practices, sexual minority women also communicated pressures to adhere to social and political views within the sexual minority

women's community. It seemed as if some sexual minority women contend with adhering to these perceived ideals, or being authentic to their own views and desires. Fears associated with the choosing the latter option relate to scrutiny from peers based on appearing "heteronormative".

Sexual minority women also perceived that the social climate of the sexual minority women's community may encourage intragroup conflict between sexual identity subgroups, which also appeared to contribute to their experiences of social anxiety. In fact, bisexual and emerging identity women participants articulated the pressure to adhere to lesbian ideals and fear negative evaluation on the basis of their identification with a non-lesbian sexual identity. Recent research demonstrated that lesbian women possess negative perceptions (e.g., sexual orientation instability) of their same-gender bisexual peers (Matsick & Rubin, 2018) and bisexual women experience more negative emotions when surrounded by sexual minority peers than lesbian women as they encounter bi-phobic practices (Belmonte & Holmes, 2016). Qualitative explorations delved deeper into this issue; bisexual women portray lesbian community spaces as unwelcoming through upholding biphobic ideals and perpetuating negative bisexual stereotypes (Hayfield et al., 2014; Lehavot et al., 2009), which in turn can foster tensions between lesbian and bisexual women (Hartman, 2006). Interestingly, none of the four bisexual or emerging identity women in the current sample relayed explicit in-person experiences of discrimination from lesbian women, yet perceived a high likelihood of such an event occurring. Bisexual women may have access to fewer community resources or encounter resources that are tailored to lesbian women (Heath & Mulligan, 2008), this in turn might add to difficulties in acquiring community-level resilience to buffer social anxiety. Indeed, bisexual and emerging identity women in the current sample illustrated a preference to avoid social events within the sexual minority community in fear that attendance would stimulate further feelings of internalised binegativity and result in exposure to bisexual erasure. In line, a recent systematic review highlighted that a paucity of bisexual-affirmative support and bisexual invisibility and erasure are key contributors to poor mental health outcomes within this sub-population (Ross et al., 2018).

Wong and Rapee's (2016) IAM model emphasises the importance of negative peer experiences during childhood and adolescence as determinants of social anxiety later in life. Additionally, in a sample of sexual and gender minority adults, past school bullying was associated with current elevations in social anxiety (Greene et al., 2014). The importance of these experiences were reflected in the current sample. In response to the opening interview

question “Tell me about your experience of social anxiety”, many participants automatically began to relay negative social experiences during their adolescence. Struggles with peers during school years were exemplified by rejection, being ostracised, and social isolation. Whilst both sexual minority women and men discussed negative peer experiences, sexual minority women attributed their victimisation to their sexual orientation, as well as other minority statuses (e.g., being an immigrant) and characteristics (e.g., shy or reserved). By contrast, sexual minority men directly attributed all of their negative peer experiences to their sexual orientation and relayed more frequent and severe instances of homophobic bullying (e.g., physical violence or being called a homophobic slur). Previous work suggests that during adolescence, sexual minority boys are victimised due to their sexual orientation in school settings more frequently than their sexual minority girl peers (Chesir-Teran & Hughes, 2009; Collier et al., 2013; van der Star et al., 2020). Further, the frequency of heterosexist victimisation proliferates as sexual minority boys progress through school, whereas these events diminish over time for sexual minority girls (Poteat et al., 2012).

It has been suggested that gender non-conforming behaviours may establish sexual minority boys in particular as targets for homophobic bullying (van der Star et al., 2020). Research supports this proposition as sexual minority boys are at a higher risk of victimisation due to gender non-conformity (D’Augelli et al., 2006), whereas the nature of stigma-related bullying specific to sexual minority girls is less clear (Poteat & Russell, 2013). Indeed, sexual minority women depicted the school environment as socially hostile; however, their portrayals of the school environment as heteronormative was inconsistent. For sexual minority men, the school environment was vividly portrayed as one which upheld the principles of hegemonic masculinity as outlined by Connell (1987) and Connell and Messerschmidt (2005). Homosexuality violated these principles and therefore placed the sexual minority or gender non-conforming boy at risk for victimisation. Exemplifying this, sexual minority men recalled feeling particularly socially anxious in social environments that demanded the display of masculine behaviours such as PE class (i.e., participating in sport). Based on these adverse peer experiences, it seemed that participants began to develop negative beliefs about the self and social-evaluative situations. It is possible that such negative self-beliefs that are known to contribute to social anxiety (Clark & Wells, 1995; Wong et al., 2014), were more generalised for sexual minority women (e.g., “My peers think I’m socially inferior”) and were sexual orientation related for sexual minority men (e.g., “My peers think I’m inferior because I am gay”).

Displays of parent heterosexist attitudes during adolescence also appeared to shape participants' experiences of social anxiety. Wong and Rapee (2016) highlight negative aspects to parent relationships during childhood and adolescence as a salient etiological factors for social anxiety. A recent meta-analysis indicated that sexual minority youth report lower levels of parental support and attachment than heterosexual youth (Montano et al., 2018). Further, longitudinal research among sexual minority adolescents and young adults signifies that psychologically secure peer and parental attachment protect against psychological distress in later adolescence and young adulthood (Starks et al., 2015). The negative affirmations delivered by parents were portrayed as both direct (e.g., a denouncement of the participant's sexual orientation after disclosure) and indirect (e.g., participant witnessing a derogatory remark or expression of disgust toward the sexual minority community). The current findings support that both adverse peer *and* parental experiences are internalised by the young sexual minority individual, and this process might influence their interpretation of the broader social world as heteronormative and threatening. In fact, the emphasis of internalised homonegativity - which hold positives associations with social anxiety (e.g., Dyar et al., 2016; Lingiardi et al., 2012; Puckett et al., 2015) – was especially prominent during adolescence and for sexual minority men. In line with both the IAM model (Wong & Rapee, 2016) and theories of sexual minority stress (Hatzenbuehler, 2009; Meyer, 2003), these adverse social experiences may increase the SET value applied to social interactions during adolescence, through increased proximal minority stressors (e.g., internalised homonegativity and rejection sensitivity), and reduced social support. This, in turn, might leave sexual minority individuals vulnerable to, and hypervigilant toward, negative social experiences in adulthood (Robinson et al., 2013).

Both sexual minority women and men maintained that to some degree they are still faced with a heteronormative social world nowadays and must withstand related heteronormative social stimuli. Yet, the current findings have highlighted novel divergences in the paths both gender groups navigate when contending with these social stressors. Sexual minority women appeared to apply a specifically high SET value to interactions with strangers. Intolerance of uncertainty, defined as the dispositional characteristic whereby individuals experience fear related to future unknowns (Carleton, 2016a, 2016b) is known to predict social anxiety symptoms (Shapiro et al., 2020). Individuals high in intolerance of uncertainty have a tendency to interpret uncertainty as threatening. This may be especially important for sexual minority women, who may anticipate rejection, ridicule, or objectification from unfamiliar persons based on their sexual orientation *and* gender (Dyar et al., 2016). For instance,

previous qualitative work highlighted that sexual minority women experience sexual objectification rooted in both their gender and sexual orientation (Chmielewski, 2017; Serpe et al., 2020), including harassment in public environments from strangers. Indeed, women in the current sample recalled social interactions in which men objectified their sexual identity, questioning its stability and doubting their lack of attraction toward men. Therefore, as they navigate the intersections of a heteronormative and misogynistic social world, it is plausible that sexual minority women contend with different social-evaluative stimuli compared to their men counterparts.

Similarly, it appeared that in certain circumstances, sexual minority men applied an extreme SET value to social interactions with heterosexual men. However, for men, it appeared that this was exemplified most in social environments in which principles of hegemonic masculinity (Connell, 1987; Connell & Messerschmidt, 2005) or “*lad culture*” are emphasised. Within these feared environments, participants implied that the likelihood of experiencing discrimination or rejection based on their sexual orientation was very high (i.e., heightened rejection sensitivity). In fact, sexual minority men’s accounts of feared social situations mirrored some of those assessed in Pachankis et al.’s (2008) measure of rejection sensitivity (e.g., locker room environments or talking about sport with straight colleagues). For some sexual minority men, heightened rejection sensitivity and subsequent social anxiety appeared to be a product of experiences of heterosexist discrimination. For instance, some detailed overt recent experiences of heterosexist discrimination (e.g., physical assault after a public display of affection and being called a homophobic slur in a nightclub) delivered by heterosexual men. Whilst these experiences were not portrayed as an everyday occurrence, it seems that they serve as a reminder that there are still some individuals, especially heterosexual men, that hold unfavourable attitudes toward sexual minority men, thus a high SET value is maintained.

In accordance with theories of minority stress (Hatzenbuehler, 2009; Meyer, 2003), and agreeing with a body of research revealing that concealment is associated with heightened social anxiety (e.g., Dyar et al., 2016; Mason & Lewis, 2016; Meidlinger & Hope, 2014; Pachankis & Goldfried, 2006), sexual orientation concealment appeared to play a pertinent role in participants’ experiences of social anxiety. The current findings grant novel insight into the pivotal role of concealment during periods across the lifespan in which social anxiety was particularly heightened, and how sexual minority individuals currently engage in concealment behaviours in response to specific social-evaluative stimuli (i.e., often of a heteronormative nature). As noted in participants’ narratives, it appeared that many were

navigating social environments, primarily during adolescence, that were in fact hostile to sexual minority individuals (i.e., feared experiences of heterosexist discrimination were realised). Concealment in these circumstances might be characteristic of a healthy adaptive coping mechanism in preventing the manifestation of heterosexist discrimination (Pachankis, Mahon, et al., 2020). Yet, the current findings revealed that participants' engagement in concealment behaviours remained intact nowadays, despite residing in a progressive society such as the Republic of Ireland (A. Higgins et al., 2016). Therefore, it could be argued that sexual minority individuals' current concealment behaviours emerge due to a negatively biased assessment of potential heterosexist social-evaluative stimuli in their social environments. Thus, based on the current findings and the assertions of the IAM model (Wong & Rapee, 2016), it may be the case that concealment (e.g., adjusting one's mannerisms to be perceived as heterosexual by others) acts as a sexual minority-specific secondary behavioural process that maintains social anxiety.

The current study unveiled that sexual minority individuals engage in various concealment behaviours on a daily basis in response to social-evaluative stimuli, and for the first time highlighted these processes as pertinent to their experiences of social anxiety. Previous research asserts that sexual orientation concealment supersedes a singular disclosure event, rather it symbolises recurring events in which the sexual minority individual must respond to contextual demands (Beals et al., 2009; Chaudoir & Fisher, 2010). Further, recent qualitative work by Malterud and Bjorkman (2016) illuminated that sexual minority individuals (i.e., inclusive of those who consider themselves to be out of "*the closet*") utilise a diverse range of concealment behaviours in response to certain persons and social environments. After first disclosing their sexual orientation, participants in the current sample described personal decision making regarding whether or not to retreat back into "*the closet*" when interacting with specific individuals in specific social environments (e.g., novel environments might present specific demands such as the presence of strangers). Indeed, when entering novel social environments, participants often discussed reverting to the use of concealment behaviours (e.g., avoiding topics of conversation related to romantic relationships). Importantly, the findings also offer novel insight into the interplay of proximal minority stress processes as sexual minority individuals respond to specific social demands. For instance, it appeared that participants' anticipation of rejection in social situations (i.e., their rejection sensitivity) was dependent on certain situational factors (e.g., presence of heterosexual men), and concealment behaviours would be utilised in unison with high levels of rejection sensitivity.

Changing levels of structural stigma are also pertinent to sexual minority individuals' experiences of social anxiety. Structural stigma is signified by laws and policies that fail to preserve the equal rights of sexual minority individuals, and prejudiced public attitudes toward the sexual minority community (Hatzenbuehler, 2016). Sexual minority individuals residing in countries with elevated structural stigma demonstrate higher levels of minority stress and lower levels of life satisfaction than their peers in low structural stigma countries (Pachankis & Bränström, 2018). The Republic of Ireland has made significant strides in combating structural stigma in recent years as reflected by vastly improved public attitudes toward the sexual minority community and the passing of same-sex marriage by popular vote in 2015 (A. Higgins et al., 2016). It appeared that this rapidly changing social landscape had a favourable impact on some sexual minority individuals' levels of social anxiety. Specifically, the results of the same-sex marriage referendum were cited as a milestone in alleviating social fears. For many, this message of public acceptance was a stark contrast to the peer rejection they suffered earlier in life, and enabled the realisation that the extreme SET value they apply to some interactions with heterosexual people may be somewhat unfounded. Other participants acknowledged these advances, yet stated their heightened social anxiety remains unchanged. Indeed, Pachankis and Bränström (2018) suggest that there may be a time lag in improved mental health levels of minority groups after advances in tackling structural stigma. This may be especially relevant for older sexual minority individuals who grew up in a highly stigmatised society. By contrast, few participants communicated that whilst there have been political advances, the favourable public attitude toward sexual minority individuals is a misconception.

The current findings have demonstrated the differing contexts in which sexual minority individuals experience social anxiety. At the within-community level, the participants' stories highlight that connection to their peers can help to protect from social anxiety; however, concurrently they contend with social stressors related to interacting with their peers that contribute to manifestation of socially anxious experiences. These phase two findings also emphasised that sexual minority individuals' navigation of social-evaluative stimuli within a broader heteronormative social world represents an integral component of their experiences of social anxiety.

9.4 Coping with Social Anxiety

The phase two findings have provided astute insight into how sexual minority individuals cope with their experiences of social anxiety. This area had hitherto been largely overlooked,

and for the first time, the voices of sexual minority individuals who believe social anxiety is an issue in their personal life have been heard on this issue. While it was found that family and romantic partners were portrayed as support figures, friends were the central support figures that acted as a safeguard for participants during socially anxious experiences. Their supportive role appeared to be twofold as their presence can lessen the SET value applied to a social situation, and when social-evaluative threats are encountered, their perceptive support can help alleviate the extremity of the socially anxious experience. The role of formal supports (i.e., primarily psychotherapeutic interventions) was also pertinent to sexual minority individual's experiences of coping. Participants expressed feeling empowered to cope with social anxiety by virtue of comprehending the nature of the social stressors they battle with. Furthermore, for the first time, the qualitative findings have exemplified the cognitive and behavioural techniques used by sexual minority individuals to thwart social threats. Lastly, as well as unveiling the above advantageous outlets used to cope with social anxiety, the phase two findings also illuminate how sexual minority individuals may in some circumstances rely on the anxiolytic effects of substances (i.e., primarily alcohol) in social-evaluative situations.

Utilising their social support network was an integral coping mechanism that enabled sexual minority individuals to cope with their experiences of social anxiety. Social support is an imperative resource in promoting the successful coping of social anxiety. Exemplifying this, a recent meta-analysis signified that heightened friendship quality was prospectively associated with less social anxiety in adolescents (Chiu et al., 2021). In line, cognitive models of social anxiety (e.g., Clark & Wells, 1995; Heimberg et al., 2010) suggest that positive peer relationships and interactions may serve as contradicting evidence to counter the negative social beliefs associated with social anxiety and stimulate positive social beliefs (e.g., "I am socially appealing"). In the current participants' accounts detailing the navigation of unfamiliar social-evaluative stimuli, close friends were portrayed as a familiar social resource. This familiarity was personified by friends being accustomed to the social-evaluative threat stimuli that typically evoke social anxiety among participants, and with this knowledge, they could provide astute support. Previous work has indicated that although social anxiety is negatively associated with social support frequency, it holds a positive association with the importance prescribed to social support (Coyle & Malecki, 2018). Thus, while participants' social avoidant behaviours might prevent them from accessing social support on a regular basis, they plausibly comprehend the salience of utilising social support to cope in certain social situations. Similarly, some participants explicitly detailed how social

support could counteract their engagement in behavioural (e.g., discouragement of avoidance behaviours) and cognitive (e.g., irrationalising fears related to anticipatory processing) maintenance processes associated with social anxiety. Consequently, the salience of social support in buffering social anxiety appeared to extend beyond in-the-moment experiences of anxiety.

The importance of social support as a coping mechanism for social anxiety is also reflected in studies of sexual minority individuals (Burns et al., 2012a; Mason et al., 2017; Potoczniak et al., 2007). For instance, Mason et al. (2017) demonstrated an indirect path from heterosexist discrimination to social anxiety via reduced social support from family. Additional research found that social support specifically focused on coping with minority stress helps to reduce psychological distress among sexual minority individuals (Doty et al., 2010). Further, the importance of social support in combating minority stress and internalising mental health symptoms was recently explored using qualitative methods by Bry et al. (2018) in a sample of highly resilient sexual and gender minority young adults. Bry et al.'s (2018) participants asserted that experiences of minority stress are somewhat inevitable, and advocated a variety of strategies that assist one to function favourably in a heteronormative society (e.g., building a dependable social support network), rather than aiming to alter the heteronormative social environment itself. Indeed, this proactive viewpoint may be applied to a social anxiety. Clinicians working with socially anxious sexual minority clients could both encourage the acceptance that heterosexist social stressors may be encountered on certain occasions, and work toward building a dependable support network to act as a shelter from minority stress. This, in turn, may offer sexual minority individuals a suitable coping outlet as they navigate their social world.

In addition to accessing informal social supports, participants also articulated accessing formal supports in the shape of therapeutic interventions. Predominantly, participants described beneficial therapeutic experiences in which they acquired knowledge, which in turn, empowered coping with social anxiety. The literature reflects the utility of psychoeducation (e.g., delivering information to clients regarding the development and maintenance of a psychological disorder and the principles behind its treatment; Nordmo et al., 2015) as a viable component in therapeutic interventions that successfully reduce social anxiety (e.g., Butler et al., 2021). Indeed, it appeared that learning about the nature of social anxiety and its aetiological factors provided a foundation of knowledge that the participants utilised to cope with social anxiety. Advocating the potential applicability of peer support interventions in reducing social anxiety within sexual minority populations (Reisner et al.,

2011), one participant shared the benefits of acquiring knowledge through sharing a therapeutic space and exchanging experiences with fellow sexual minority individuals. The participants' positive experiences with psychotherapeutic interventions emphasise the importance of adding to the dearth of literature assessing the efficacy of interventions in this area.

The participants acknowledged a variety of coping techniques implemented before, during, and after social-evaluative situations, including healthy cognitive coping mechanisms for social anxiety. Recognising cognitive distortions and replacing them with rational thoughts appeared to be an imperative coping mechanism as it degenerated cognitive maintenance processes associated with social anxiety. In fact, in keeping with a previous longitudinal study that illustrated the effectiveness of cognitive techniques in reducing post-event processing (Katz et al., 2019), participants illuminated the salience of becoming aware of deleterious thoughts, and reframing those thoughts in order to mitigate anxiety associated with post-event processing. Disengagement from deleterious thoughts also seemed to assist in reducing the perceived salience of social performance deficits. For instance, when reflecting on self-proclaimed deficits during social interactions (e.g., saying the “wrong” thing in conversation), instead of becoming anxious, some viewed these events with a long-term perspective (i.e., it will have little importance once time has passed). In line with research that indicates a negative association between age and social anxiety among sexual minority women and men (e.g., Burns et al., 2012a; Mason et al., 2017), some participants asserted that their ability to counteract deleterious thinking has improved over time. However, it was apparent that these healthy cognitive coping mechanisms are not always readily accessible, especially in social-evaluative situations associated with an extreme SET value. It would be useful for future research in this area to elucidate how sexual minority individuals may be empowered to access such techniques before, during, and after social situations at both the within- and wider-community levels.

Participants also gave examples of behaviours (i.e., exposing themselves to feared social-evaluative stimuli) that promoted healthy coping with social anxiety and shared the advantages of resisting avoidance and participating in social situations. Such benefits included acquiring social skills, developing social connections to other individuals, and enhanced performance in occupational settings. Hart et al.'s (2014) case series study advocated the utility of in-vivo exposure in reducing social anxiety among sexual minority men. Further, a recent meta-analysis demonstrated that virtual reality exposure therapy is effective in reducing social anxiety symptoms (Chesham et al., 2018). In fact, contemporary

research signifies that virtual reality exposure therapy might be more efficacious in tackling social anxiety than traditional in-vivo exposure (Bouchard et al., 2017; Kampmann et al., 2016). These findings may be especially pertinent when considering the social experiences of the current sample at the within-community level. Many participants cited intraminority stressors as salient contributors to their experiences of social anxiety despite minimal interactions with other sexual minority individuals (i.e., this stress is based on isolated incidents or the perception that the sexual minority community is socially hostile). It may be the case that avoidance behaviours both perpetuate the salience attributed to isolated intraminority stress incidents and preserve the high SET value applied to interactions within the sexual minority community. As anxious individuals often evidence a reluctance toward engaging with in-vivo exposure (Bush, 2008), virtual reality exposure therapy may be particularly viable for targeting social anxiety experienced in an intraminority stress context. This could be a less daunting approach for those sexual minority individuals who are reluctant to socialise with other sexual minority persons, and provide an opportunity to challenge perceptions of sexual minority community as socially hostile.

The link between elevated social anxiety and increased substance use is well-documented in the literature (e.g., Aurora & Coifman, 2021; Lemyre et al., 2019). For instance, epidemiological research illustrated a frequent co-occurrence of SAD and alcohol use disorder, and SAD precedes alcohol use disorder in four of five comorbid cases (Buckner et al., 2008; Grant et al., 2005; Schneier et al., 2010). It is suggested that individuals experiencing high social anxiety might utilise alcohol for its anxiolytic effects; thus, enabling them to endure social-evaluative situations (Abrams et al., 2001). In line, the reliance on substance use (i.e., primarily alcohol consumption) as a coping mechanism for social anxiety was evident in the phase two findings. The existing body of research pertaining to social anxiety and alcohol use within the sexual minority community is notably limited and communicates mixed evidence. A non-significant association between social anxiety and alcohol abuse was reported among sexual minority men (Pachankis, Sullivan, & Moore, 2018), whereas hazardous alcohol use was associated with elevated social anxiety among lesbian women (Mason & Lewis, 2019). Nonetheless, the current findings illustrated particularly severe levels of alcohol consumption during periods of heightened minority stress. In these instances, hazardous alcohol use was used to cope with anxieties pertaining to a variety of minority stress processes (e.g., expectations of heterosexist discrimination and concealment of sexual identity).

In terms of coping with social anxiety at the within-community level, alcohol consumption might be particularly accessible as a coping mechanism. Socialising at the within-community level often takes place in venues (e.g., gay or lesbian bars) where heavy drinking is common and normalised (Gruskin et al., 2007; LeBeau & Jellison, 2009; Parks & Hughes, 2007). Additionally, increased time spent in gay/lesbian bars and involvement in activities at the within-community level demonstrated associations with alcohol abuse (Baiocco et al., 2010; Trocki et al., 2005). Indeed, some participants in the current study continually recalled social experiences in these venues and portrayed them as an epicentre of intraminority stress and social anxiety. The current findings also suggest that sexual minority individuals seek the anxiolytic effect of alcohol to counteract social anxiety associated with intraminority stressors. Thus, sexual minority individuals might be encouraged to use alcohol to cope as they perceive heavy alcohol consumption as a community norm (i.e., they are unlikely to experience negative evaluation based on this behaviour). These qualitative findings shed novel light on substance use as a coping mechanism for social anxiety in both wider- and within-community contexts, and encourage further research into this complex issue.

The phase two findings have filled notable gaps in the knowledge base as to how sexual minority individuals who believe social anxiety is an issue in their personal life cope with social anxiety. It is clear that the participants did not passively experience the burden of social anxiety, but were proactive in their attempts to cope. Indeed, these findings emphasise the value of exploring strength-based variables and everyday strategies to fully comprehend how this population navigate stressors in their social world, cope with social anxiety healthily, and enhance their social wellbeing.

9.5 The Impact of Social Anxiety

This phase two study is the first to use an in-depth qualitative interview approach to assess the potential impact of social anxiety on sexual minority individuals' daily lives. The findings suggest that the impact of social anxiety is wide-ranging and debilitated participants' everyday functioning across multiple domains. Also, the findings highlighted that the impeding nature of social anxiety was present in participants' everyday experiences from adolescence to the present day. Namely, the attenuating imprint of social anxiety arose when participants discussed the professional, social, and emotional facets of their everyday lives. By situating sexual minority individuals' struggles with social anxiety in professional, social, and emotional contexts, this qualitative exploration has provided a novel and in-depth contribution to the knowledge base.

There was a deleterious impact of social anxiety on educational functioning discussed primarily by sexual minority men. This finding coincides with longitudinal research illustrating that social anxiety has a more severe impact on educational functioning for adolescent boys when compared to girls (Ranta et al., 2016). Moreover, the findings provide some novel nuanced insight into the inverse relationship between educational attainment and social anxiety previously reported among sexual minority men (e.g., Burns et al., 2012a). The university or school environment was portrayed as socially daunting as these environments demand one to engage in multiple interactions (e.g., with classmates or lecturers) on a daily basis. Ultimately, in some instances, it appeared that an extreme SET value was applied to the university setting as a whole, which in turn encouraged avoidance behaviour specific to educational environments (e.g., absenteeism or deferral). Within the current sample, it is plausible that this gender distinction relates to variances in experiences of minority stress events. Experiences of heterosexist discrimination in educational settings were recollected across both gender groups. However, severe instances of heterosexist discrimination (e.g., verbal and physical assault) within educational environments were more common in sexual minority men's narratives. Previous studies established that oppressive and heteronormative university campus climates can place sexual minority individuals at risk for mental health difficulties (Silverschanz et al., 2008; Woodford et al., 2014). Based on their severe past experiences of heterosexist discrimination in educational settings, sexual minority men could apply a more extreme SET value to educational environments (i.e., view such environments as highly heteronormative). Therefore, their subsequent feelings of social anxiety may have a greater impact and lead to increased avoidance in the shape of absenteeism, and in extreme instances, deferral or dropout. Nonetheless, with this area of research in its infancy, these potential gender divergences require further exploration.

Sexual minority women and men's social anxiety related conflicts with occupational functioning also featured prominently. This finding reflected previous research that demonstrated a relationship between social anxiety and several aspects of diminished occupational functioning including protracted unemployment (Moitra et al., 2011; Tolman et al., 2009), difficulties in workplace adjustment (Bruch et al., 2003), hindered progression (Stein & Kean, 2000), and elevated rates of absenteeism (Wittchen et al., 2000). Workplace environments presented challenges to sexual minority individuals through presenting specific contextual demands. Although some discussed having a workplace social support network, co-workers were primarily portrayed as acquaintances rather than close friends in

participants' narratives. An interaction between the impeding impact of social anxiety on both social *and* occupational functioning was also apparent. Those who struggle to establish friendships in the workplace might be prevented from attaining the ameliorative benefits of a close companion during anxious experiences (J. K. Morgan et al., 2017; Pontari, 2009). Instead, if co-workers remain unfamiliar, in accordance with previous research related to intolerance of uncertainty (Carleton, 2016a, 2016b; Shapiro et al., 2020), this unfamiliarity could plausibly maintain anxiety in the workplace (i.e., a high SET value might be applied to colleague interactions). Further, sexual minority individuals may experience typical regular fears of uncertainty compounded by sexual minority-specific fears of uncertainty (i.e., pertaining to potential heterosexist discrimination from colleagues; DeSouza et al., 2017; Ragins & Cornwell, 2001).

The impact of social anxiety was arguably most evident when participants described their social functioning. Social functional impairments due to social anxiety are highlighted in the knowledge base (Aderka et al., 2012), and include impairment in close relationships such as friendships (Alden & Taylor, 2010; Davila & Beck, 2002; Schneier et al., 1994) and intimate relationships (Sparrevoorn & Rapee, 2009). The impact of social anxiety on participants' social lives appeared to be threefold in that it diminished their perceived capability to build effective social support networks, contributed to a sense of missing out and existing somewhat in solitude, and aroused difficulties in completing everyday tasks that require social interaction. Many voiced difficulties in establishing new friendships and as a result, social demands related to life transitions (e.g., starting university) were particularly challenging. Others also voiced hardships in maintaining existing friendships. In support, previous work has suggested that socially anxious individuals experience difficulties in establishing *and* maintaining interpersonal relationships (Davidson et al., 2011). Perceived burdensomeness (i.e., the sense of being a burden to others), a feeling that is commonly experienced in socially anxious individuals (Duffy et al., 2020), was expressed by some participants. The findings revealed that rather than placing a social "burden" on others (e.g., having to provide support), some participants withdrew from related social processes. This, in turn, appeared to contribute to a sense of missing out and loneliness. In keeping with this finding, research supports that social isolation and loneliness are associated with social anxiety among sexual minority populations (Hart et al., 2019; Hatzenbuehler et al., 2011).

In their accounts, participants shared feelings of frustration that social anxiety prevents them from availing of social opportunities (e.g., joining social or sports clubs at the within-community level). Of course, this is not to convey that participants had no existing social

support networks. Yet, the findings yield novel insight into how social anxiety may constrict sexual minority individuals' willingness to consistently rely upon or engage in effortful attempts to expand their social resources. It is plausible that these individuals may experience positive interactions and access salient social resources to a particular degree. However, the impact of social anxiety might prevent such individuals from accessing these resources on a consistent enough basis to counteract feelings of social isolation and loneliness.

Participants in the current study expressed that social anxiety had an emotional impact on their everyday lives; this was primarily realised through emotional exhaustion and feelings of negative affect and heightened empathy. For the first time in a sexual minority sample, the findings suggested that emotional exhaustion may be a product of the demands of cognitive and behavioural manifestations of social anxiety. Engaging in these demanding processes might result in self-control depletion, as distinguished by the exhaustion of one's capability to regulate energy, attention, and tolerance of social-evaluative stress (Finkel et al., 2006; Vohs et al., 2005). There are limits to the extent that one can expend energy and attention, or maintain self-control. Thus, it is plausible that participants' effortful exertions to detect social-evaluative threat and manage their impressions during interpersonal interactions might deplete their resources and result in feelings of emotional exhaustion. A large base of literature now signifies heightened negative affect (e.g., Farmer & Kashdan, 2014; Hofmann, 2007) and reduced positive affect (e.g., Brown et al., 1998; Kashdan, 2007) in those with SAD. Furthermore, as illustrated in the chapter two findings, social anxiety and depression were consistently correlated in sexual minority samples (e.g., Burns et al., 2012a; Dyar et al., 2016; Feinstein et al., 2012). Converging the above evidence, it comes somewhat expected that participants' narratives spoke to the deleterious impact of social anxiety as a proponent of a depressive state. In alignment with longitudinal research signifying that individuals with SAD are three times more likely to develop depression when compared to controls without SAD (Beesdo et al., 2007; Stein et al., 2001), participants primarily described their social anxiety symptoms as predating their experiences of depressive emotions.

For some sexual minority men participants, these feelings culminated in suicidal ideation, and in two cases, suicide attempts. The relationship between social anxiety and suicide ideation is well documented; for example, a longitudinal study in a clinical sample of adolescents demonstrated that baseline social anxiety directly and indirectly (i.e., through loneliness) predicted 18-month post-baseline suicide ideation (Gallagher et al., 2014).

Advocating the stance of the interpersonal-psychological theory of suicide (Joiner, 2005), contemporary studies indicated that social anxiety is indirectly associated with suicidal ideation via perceived burdensomeness and thwarted belongingness (i.e., the sense of being alienated from others; Arditte et al., 2016; Buckner et al., 2017). Under Joiner's theoretical lens, one could postulate that sexual minority men's socially anxious experiences related to heterosexist discrimination and intraminority stress result in feelings of alienation at the wider- and within-community levels, thus, leaving them vulnerable to suicidal ideation. Given that social anxiety is also related to suicide attempts (Chartrand et al., 2012) and that recent meta-analyses indicated elevated levels of suicide ideation and attempts among sexual minority populations (Liu, 2019; Salway et al., 2019), this specific area requires deeper exploration.

Several sexual minority women described the impact of social anxiety on their empathy levels in that they perceive themselves to be overly empathetic to the point which it could be considered burdensome. This aligns with a recent study indicating that elevated social anxiety symptoms predict greater cognitive empathy among women but not men (Berg et al., 2020). Research by Arditte Hall et al. (2020) detailed a study design consisting of participants reading vignettes in which a second-person narrator elicited positive (e.g., happiness) or negative (e.g., disgust) emotions from another person. Herein, findings suggested a positive association between social anxiety and empathy forecasting biases for negative emotions, such that participants reporting high social anxiety estimated that the other person in the vignette would experience more extreme and lengthy disgust. Relatedly, in environments in which social-evaluative stimuli are present, Auyeung and Alden (2016) demonstrated an association between social anxiety and accuracy for others social pain (i.e., fear and dejection related to aversive social experiences). Thus, it is conceivable that, due to both their experiences of social anxiety and related empathy, sexual minority women in the current sample may fear of negative evaluation from others *and* fear potentially causing social discomfort for others. This, in turn, would serve to further increase the variety of social-evaluative stimuli that may evoke social stress.

Whilst social anxiety has been understood as a serious mental health burden for sexual minority populations for some time, the potential impact of this burden on the daily lives of this group, and their individual experiences of this impact, was somewhat disregarded in the literature. Through delving deep into the personal experiences of the participants using a qualitative approach, the attenuating impact of this social strain is now better understood. The findings have also revealed potential differences in the impact of social anxiety between

sexual minority women (e.g., empathy) and men (e.g., suicidal ideation and attempts). As mentioned above, social anxiety related adversities surfaced across three primary domains: professional, social, and emotional. Of course, these domains overlap in one's everyday existence, meaning that social anxiety may be particularly pervasive and act as a serious preventative of optimal daily functioning.

9.6 Strengths and Limitations

There are prominent strengths associated with the second phase of this mixed methods study marked by several novel additions to the current knowledge base. Notably, to the researcher's knowledge, this represents the first qualitative investigation of the experience of social anxiety among sexual minority individuals. This study represents the first to integrate domineering (Hatzenbuehler, 2009; Meyer, 2003) and prevailing (Pachankis, Clark, et al., 2020) theoretical frameworks in sexual minority mental health research with Wong and Rapee's (2016) IAM model (i.e., a contemporary social anxiety-specific framework), which aided in uncovering novel evidence regarding the experience of social anxiety within this population. The rich data yielded from this study situated the experiences of this prominent mental burden in real life accounts for the first time. By doing this, the above findings have yielded rich information as to the general and sexual minority-specific processes, as well as the contextual factors, that contribute to social anxiety. The current findings have uncovered novel insight into the social-evaluative stimuli that sexual minority individuals encounter in both wider- and within-community contexts, and how they serve to maintain a high SET value and social anxiety. Further, at the within-community level, sexual minority women and men might face divergent social stressors that contribute to their social anxious experiences in an intraminority stress context. This finding is pertinent to advancing future scholarship in this burgeoning area of research. This qualitative study also emphasised the salience of exploring processes across the lifespan in order to understand sexual minority individuals' experiences of minority stress (i.e., especially during adolescence) and how they contribute to their current levels of social anxiety. Lastly, the findings contain astute detail pertaining to the impact of (i.e., across professional, social, and emotional domains), and the coping mechanisms (i.e., formal and informal supports, cognitive and behavioural techniques, and reliance on substances, namely alcohol) used to deal with social anxiety within this population; these two areas had thus far been overlooked in the literature.

As well as the abovementioned strengths, there are limitations to the current phase that should be acknowledged when interpreting the current findings. First, this study explored

social anxiety in a non-clinical sample (i.e., a diagnosis of SAD was not required as an inclusion criterion). However, participants were recruited on the basis that they believe social anxiety is an issue in their life, and scores on the BFNE were similar to clinical samples (Anderson et al., 2013; Werner et al., 2012). Nonetheless, the current sample may represent a particular sub-set of sexual minority individuals who experience social anxiety as they were comfortable to complete an interview regarding their experiences. Future qualitative studies aiming to elucidate the social experiences of sexual minority individuals diagnosed with SAD may prove beneficial. Second, the cultural homogeneity of the phase two sample should be acknowledged (i.e., all participants were White, and all but two participants were Irish). Sexual minority individuals of colour encounter intersectional social stressors (i.e., based on race and sexual orientation; English et al., 2018; Jackson et al., 2020) that could contribute to social anxiety; however, this not captured by the current analysis. Third, all sexual minority men who participated in phase two identified as gay. The perceived hostile social climate toward bisexual and emerging identity women that was pertinent to sexual minority women's experiences of social anxiety may also extend to sexual minority men's communities. Future qualitative studies should aim to recruit bisexual and emerging identity men to explore this possibility.

9.7 Conclusions of the Qualitative Phase

To summarise, the qualitative phase of the present mixed methods study elucidated several facets of sexual minority individuals' experiences of social anxiety for the first time. These findings illustrated the interplay between minority stress, intraminority stress, and cognitive and behavioural maintenance processes of social anxiety in sexual minority individuals' experiences of social anxiety. Whilst sexual minority individuals contend with similar social-evaluative stimuli (e.g., presence of strangers or acquaintances) that are known to evoke social anxiety in the general population, it appears that their navigation of sexual minority-specific stimuli is particularly salient to their experiences of social anxiety. From a young age the current sample encountered structural-, interpersonal-, and individual-level sexual minority stigma, all of which play a pertinent role in shaping their current social interactions. Later in life they came across the sexual minority community, which is multifaceted in its offering of both unique resilience *and* stress related to social anxiety. Indeed, the findings offer a more robust understanding of the experience of social anxiety among sexual minority individuals by highlighting the multidimensional contexts in which this mental health burden may emanate. Ultimately, this novel insight could be harnessed to promote successful management of heteronormative and intraminority stress related

stressors, and help sexual minority individuals prosper in their social, professional, and emotional functioning. With the aim to provide a deeper consideration of the key findings of this mixed methods study, the next chapter will integrate the current qualitative findings with the phase one quantitative findings.

Chapter 10 Integrative Findings and Discussion

10.1 Introduction

While the phase one and two findings have been discussed separately in chapters six and nine respectively, this chapter will critically integrate the findings from both phases to achieve the aim of this mixed methods study (i.e., to elucidate the determinants of, and explore the experience of, social anxiety among sexual minority individuals). Undertaking this approach will enable a greater understanding of the agreements and contradictions between each phase and ensure that the statistical findings are set in the participants' social experiences. Collectively, this will promote a richer understanding of the topic of focus.

10.2 Integrating the Findings From Phase One and Phase Two

As aforementioned in chapter three (section 3.5.1.4), the triangulation protocol was utilised to integrate the findings from phase one and two. This section follows the processes outlined by O'Cathain et al. (2010) and Farmer et al. (2006), and examines the quantitative and qualitative findings as to whether they are convergent, complementary, silent, or dissonant.

10.2.1 Convergence

There were notable consistencies in the phase one and phase two findings of the current mixed methods study in terms of the determinants and experience of social anxiety among sexual minority individuals. First, across both phases, the salience of intraminority stressors as contributors to social anxiety was evident for sexual minority men. Second, the integral role of LGBTQ community connectedness in protecting sexual minority women from social anxiety was clear in terms of both the quantitative and qualitative findings. Last, for both sexual minority women and men, their current experiences of discrimination and navigation of heterosexist social-evaluative stimuli were pertinent risk factors for social anxiety.

Across the two phases of this study, sexual minority men emphasised the importance of intraminority stress as a determinant of social anxiety and an integral component of their socially anxious experiences. In phase one, intraminority stress was involved in three significant pathways to social anxiety (i.e., through increased rejection sensitivity and concealment behaviour, and through decreased sense of coherence). Indeed, specific pathways from intraminority stress to social anxiety (e.g., through increased concealment behaviour) identified in phase one were evident in sexual minority men's narratives. For instance, based on negative social experiences at the within-community level, some men

described avoiding social contact with fellow sexual minority men (i.e., a facet of concealment behaviour highlighted by Jackson & Mohr, 2016). In turn, this seemed to sustain a high SET value applied to interpersonal interactions with their peers. In line with the phase one assessment of intraminority stress, sexual minority men referred to the presence of social hierarchies or a “*pecking order*” based on self-perceived attractiveness and masculinity, and social rejection or exclusion produced by these hierarchies were salient to sexual minority men’s experiences of social anxiety. High-status men represented a significant threat for participants as fears of negative evaluation were deemed to be more probably realised in their presence. The phase two findings provided an understanding that these experiences might lead to socially anxious sexual minority men applying a high SET value to the sexual minority men’s community as a whole. Further, it is now understood that these adverse social experiences transcend brick-and-mortar venues and extend to online communities.

For sexual minority women, in phases one and two of the current study, LGBTQ connectedness emerged as a salient protective factor associated with social anxiety. The phase one model of the determinants of social anxiety highlighted a negative direct effect between LGBTQ community connectedness and social anxiety. Further, phase two emphasised that some sexual minority women find a social refuge at the within-community level and avail of astute support from their peers. This finding resonates with quantitative literature that supports sexual minority-specific community-level resilience as a protective factor for internalising mental health symptoms (Frost & Meyer, 2012; Kertzner et al., 2009), including social anxiety symptoms (Puckett et al., 2015), and qualitative literature that signifies that positive social experiences at the within-community level promote social wellbeing (Ceatha et al., 2019; Parmenter et al., 2020b). From converging the findings across both phases, the ameliorative effect of LGBTQ community connectedness on social anxiety among women is further elucidated. It appears that some women establish safe social environments within the sexual minority community based on social bonds with peers, which enables a reprieve from social anxiety typically experienced elsewhere.

Finally, across both the quantitative and qualitative findings, current experiences of discrimination were highlighted as a salient factor associated with social anxiety for both sexual minority women and men. In the phase one models, significant paths (e.g., through increased rejection sensitivity and decreased sense of coherence) to social anxiety from experiences of discrimination were highlighted. The phase two narratives situated these associations in an explicit heteronormative context and outlined specific heterosexist social-

evaluative stimuli that sexual minority individuals contend with. For instance, among sexual minority men, it was clear that high levels of sexual orientation related rejection sensitivity may be elicited by experiences of discrimination in highly heteronormative social environments in which principles of hegemonic masculinity are upheld. As a result of discrimination, certain social stimuli and social environments may have a particularly high SET value for this group (e.g., presence of heterosexual men or heteronormative topics of conversation). Among sexual minority women's narratives, their experiences of discrimination at the intersection of sexual orientation and gender were situated in specific contexts (e.g., occupational settings), and certain social stimuli (e.g., presence of strangers) were identified as particularly threatening, and served to increased their social anxiety levels via heightened rejection sensitivity.

10.2.2 Complementarity

Several complementary findings across the study phases were evident in relation to the aim of this mixed methods study. First, both phases offered different perspectives to the variations in social anxiety across gender and sexual orientation subgroups. Second, phase one highlighted rejection sensitivity as a key linking mechanism between distal stressors and social anxiety, and phase two provided complementary evidence as to why this might be. Third, intraminority stress was highlighted as a key risk factor for social anxiety among sexual minority women in phase one, and phase two complemented this finding in providing perceptive information as to the nature, source, and role of intraminority stress in women's socially anxious experiences. Last, phase one highlighted sense of coherence as a protective factor for social anxiety, whilst phase two emphasised the specific role this individual-level resilience may play in counteracting social-evaluative stimuli.

Each phase of the study offered a unique contribution to the knowledge base with regard to differences in social anxiety symptoms between sexual minority women and men. Phase one demonstrated higher levels of social anxiety symptoms among sexual minority women compared to their men counterparts, whereas phase two highlighted possible explanations for this disparity. Phase two outlined that sexual minority women may experience additional stress with regard to intersectionality of discrimination (i.e., based on sexual orientation and gender), and therefore might engage in cognitive maintenance processes of social anxiety in order to detect and eliminate social-evaluative threat across a greater array of social environments (i.e., those deemed to be heteronormative and/or misogynistic). This complements previous research in young adult sexual minority samples in which sexual

minority women report higher levels of social anxiety than their men counterparts (Baiocco et al., 2014; Cohen, Blasey, et al., 2016). Similarly, in terms of social anxiety differences across subgroups of sexual minority women, phase one and two offer complementary findings. Phase one highlighted higher levels of social anxiety symptoms in bisexual and emerging identity women when compared to their lesbian counterparts, whilst phase two provided some contextual evidence that may relate to this disparity. In accordance with previous research (e.g., Hayfield et al., 2014; Heath & Mulligan, 2008), bisexual and emerging women in the current study described feeling excluded from sexual minority women's communities in which lesbian ideals and norms are dominant. As a product of social exclusion at both wider- and within-community levels, bisexual and emerging identity women might feel socially anxious across a great array of social environments.

Of all the proximal minority stress processes, rejection sensitivity was perhaps the most preeminent in stimulating sexual minority individuals' social anxiety across both the quantitative and qualitative phases. In the phase one models, rejection sensitivity linked both experiences of discrimination and intraminority stress to social anxiety, whereas the anxious expectation of rejection based on sexual orientation was a prominent feature within both sexual minority women's and men's narratives. The qualitative findings offered a complementary insight into this relationship. Rejection sensitivity appeared to intertwine with cognitive maintenance processes of social anxiety such as anticipatory processing and biased attention toward threat, all of which functioned to detect social-evaluative threat. Further, the qualitative findings provided some evidence as to the potentially protective function of rejection sensitivity in certain contexts as suggested in phase one (i.e., positive direct effect with LGBTQ community connectedness) and in previous scholarship (e.g., Feinstein, 2020; Feldman & Hayes, 2005). For instance, some phase two participants who dealt with high levels of rejection sensitivity appeared to build strong social support networks of fellow sexual minority peers in order to cope with social anxiety.

In terms of intraminority stressors among sexual minority women, the study phases offered complementary findings. It was clear that stressful social experiences at the within-community level act as an integral determinant of social anxiety for women. For example, in phase one there were numerous significant pathways to social anxiety from intraminority stress (e.g., through increased rejection sensitivity and reduced sense of coherence), and stress inducing pressures pertaining to interactions with fellow sexual minority women were represented in the qualitative findings. While certain aspects of women's intraminority stress in phase two aligned with the phase one conceptualisation of the construct (e.g., competition

for social resources and exclusion), phase two offered an additional perspective on this group's experiences of within-community stressors. Instead of encountering status-based hierarchies, phase two women participants' described battling anxiety inducing social pressures to conform to ideals and norms promoted within the sexual minority women's communities. Further, these ideals and norms were portrayed as being upheld by lesbian women, and this was pivotal to the socially anxious experiences of bisexual and emerging identity women in phase two. The qualitative findings informed an understanding of how intraminority stress may manifest as a risk factor (as revealed by phase one) for social anxiety experienced at the within-community level.

Both phases of the mixed methods study highlighted the prominent role of sense of coherence as an individual-level resilience factor to social anxiety, although by differing means. In phase one, sense of coherence was a clear linking mechanism to social anxiety from both forms of distal stress, such that sexual minority individuals with low sense of coherence were vulnerable to social anxiety as a result of experiences of stress at both the within- and wider community-levels. The phase two narratives delved deeper into this relationship, and the role of sense of coherence could be observed across several themes. For example, in social-evaluative situations with a high SET value (e.g., instances in which heteronormative discrimination or intraminority stress are anticipated), participants could not access general resistance resources to counteract social stress. Instead, they often relied on avoidance or escape from these potentially threatening scenarios, which are known to maintain social anxiety. In voicing how they cope with social anxiety, some participants described acquiring knowledge and resources, and implementing related coping skills (e.g., engaging in rational thinking and resisting escape), that would serve to increase their sense of coherence. Through accessing various psychological interventions, some participants acquired knowledge as to the nature of social anxiety and associated stressors (i.e., increased comprehensibility). Additionally, through implementing cognitive and behavioural techniques and accessing social support through friends, family, or partners, participants appeared to cope with social anxiety more effectively (i.e., increased manageability).

10.2.3 Silences

There were several notable silences across the quantitative and qualitative findings. These silences were exemplified by minority stress processes in youth, non-sexual minority-specific processes that maintain social anxiety (i.e., as per Wong & Rapee's IAM model),

non-sexual minority-specific social support, unhealthy coping mechanisms, and the impact of social anxiety on everyday functioning.

Whilst minority stress processes were highlighted as risk factors in phase one, the pertinence of minority stress processes during adolescence was solely evidenced in the phase two narratives. This aligns with previous research endorsing a life course approach to fully comprehend the role of minority stressors as determinants of sexual minority individuals' current mental health (e.g., Greene et al., 2014; van der Star et al., 2020). For many sexual minority individuals, the qualitative phase uncovered notable experiences of heterosexist discrimination during youth and adolescence, which in turn contributed to social anxiety. The IAM model (Wong & Rapee, 2016) signifies that aetiological factors, such as negative peer experiences, are crucial during this stage of the life course, and influence the SET value applied to social situations later in life. Therefore, phase two promoted the consideration of minority stress processes across the lifespan as a determinant of socially anxious experiences within this population, which was silent in the phase one findings.

Also of note, the non-sexual minority-specific cognitive (e.g., self-focus and post-event processing) and behavioural (e.g., escape and safety behaviours) maintenance processes highlighted within the IAM model (Wong & Rapee, 2016) were present in the phase two narratives; these processes were not included in the phase one models. It was evident that these maintenance processes arise and stimulate social anxiety in both sexual minority-specific (e.g., heteronormative social environment and within-community social interactions) and non-sexual minority-specific (e.g., entering any novel social environment) contexts. Moreover, whilst these maintenance processes were not incorporated into phase one, the phase two narratives emphasised the overlap between sexual minority stress and IAM processes.

In terms of protective factors for social anxiety, phase two emphasised the role of general social support from friends, family, and partners. Perceived levels of social support (Mason et al., 2017; Potoczniak et al., 2007) and social support satisfaction (Burns et al., 2012a; Meidlinger & Hope, 2014) have demonstrated inverse relationships with social anxiety in prior research with both sexual minority women and men. Phase two elucidated that sexual minority individuals access supports at the wider-community level (i.e., non-sexual minority-specific support) that can aid in coping with in-the-moment experiences of social anxiety and prevent engagement in maintenance processes of social anxiety. This protective factor was not accounted for in the phase one models that solely focused on sexual minority-

specific community-level resilience. This finding endorses a broad approach in future studies, accounting for supports at the within- and wider-community level, when assessing protective factors for social anxiety and exploring positive social experiences.

There was an additional silence in relation to coping with social anxiety between the quantitative and qualitative findings. Both phases accentuated healthy coping mechanisms; for instance, comprehending and managing stressors through a high sense of coherence in phase one, and utilising specific cognitive and behavioural techniques in phase two. Yet, the phase two narratives also underscored an unhealthy coping mechanism represented by a reliance on alcohol and other substances to deal with socially anxious experiences. Alcohol as a coping mechanism for social anxiety is underexplored in sexual minority populations. However, the current qualitative findings and previous studies (Gruskin et al., 2007; LeBeau & Jellison, 2009) advocate further focus on this issue as it may be a coping mechanism that is specifically accessible at the within-community level.

In terms of the impact of social anxiety on sexual minority individuals' everyday lives, the qualitative findings highlighted deleterious consequences across several domains of functioning that were absent from the quantitative findings. Phase two revealed the educational and professional struggles, specific social difficulties, and the emotional hardship experienced by some of the participants as a result of social anxiety. These findings filled a void in the knowledge base pertaining to the impact of social anxiety within this population and demonstrated that the deleterious impact of this internalising mental health difficulty is similar to that experienced by the wider population (e.g., Aderka et al., 2012).

10.2.4 Dissonance

There was notable dissonance between the quantitative and qualitative findings regarding the function of internalised homonegativity in a social anxiety context. In the phase one models there was no significant direct effect from internalised homonegativity to social anxiety; thus, the hypothesised direct path from internalised homonegativity to social anxiety was removed from both models in order to obtain model fit. Despite this, the phase two narratives, especially those of sexual minority men, signified that the internalisation of heterosexist societal attitudes plays a pertinent part in their experiences of social anxiety. It is plausible that the measure used to assess internalised homonegativity in phase one (Herek et al., 2009), does not fully encompass the current experience of this construct in a progressive society such as the Republic of Ireland. The items included in this measure (e.g., "I wish I weren't gay/lesbian/bisexual/sexual minority") seemed to more closely align with

the past experiences of participants (e.g., during adolescence), rather than their current experiences in which internalised homonegativity likely functions in less extreme manner.

Similarly, there was evident dissonance between the phase one and phase two findings regarding concealment behaviour. In the qualitative findings, concealment behaviour appeared to be an integral process related to both sexual minority women's and men's socially anxious experiences. Participants voiced engaging in concealment behaviour when faced with certain social stimuli (e.g., conversing with strangers). Further, sexual minority men in particular described using covering behaviours (e.g., deepening their voice) to defer the detection of their sexual identity by others. Nonetheless, in phase one, among men, concealment behaviour only linked intraminority stress, but not experiences of discrimination, to social anxiety. In addition, the direct effect between concealment behaviour and social anxiety was non-significant for women. The measure of concealment used in phase one (Jackson & Mohr, 2016) assesses the use of concealment behaviours over the previous two-week period. Assessing this proximal minority stress process over this finite time period offers a plausible explanation for the dissonance between the two phases. Had concealment behaviour been assessed over a longer period of time in phase one, it may have played a more integral role as a risk factor in the models, and mirrored the engagement in concealment behaviour evidenced in phase two (i.e., when participants were asked to reflect on socially anxious experiences over an unrestricted period of time).

Whilst there was no significant pathway to social anxiety involving LGBTQ community connectedness for sexual minority men in phase one, some men emphasised the importance of positive social experiences with their peers in alleviating social anxiety through the phase two narratives. Within their narratives, specific social opportunities and support (i.e., based on mutual understanding and past experiences) at the within-community level were identified. Two principle reasons may offer clarity regarding this discrepancy. First, the measure of LGBTQ connectedness used in phase one (Frost & Meyer, 2012) largely focuses on feelings of connection to the community as a whole; this may not reflect feelings of connection toward specific sexual minority individuals (i.e., a close friend or friend group) that were salient to men's positive experiences in phase two. Second, discovering social comfort and connectedness through sexual minority peers was not unanimous across all men's phase two narratives, some portrayed the sexual minority community exclusively as a source of stress. Therefore, the lack of a significant effect between LGBTQ community connectedness and social anxiety illustrated in phase one could have been driven by these divergent experiences.

10.3 Discussion of Key Findings of the Present Study

The key findings from phases one and two of the current study have been critically discussed in chapters six and nine respectively. The function of this section is to explicate the overall key findings of this mixed methods study. First, the rationale for carrying out the present study will be reconsidered and its overarching aim reiterated. Following this, the key findings will be discussed in accordance with the aim.

Social anxiety is a pernicious and debilitating mental health difficulty commonly experienced in the general population (American Psychiatric Association, 2013; Morrison & Heimberg, 2013). Sexual minority individuals report elevated social anxiety symptoms and are more at risk for SAD than their heterosexual counterparts (e.g., Akibar et al., 2019; Bostwick et al., 2010; Kerridge et al., 2017; Pachankis & Goldfried, 2006). A limited body of research pointed toward specific sexual minority subgroups (e.g., bisexual individuals) who may be particularly vulnerable, although this area of scholarship requires further clarification.

Prior to conducting the current study, the existing knowledge base primarily emphasised the role of minority stress processes (Meyer, 2003) as risk factors for social anxiety. Nonetheless, certain interrelationships within sexual minority stress theories remained underexplored. For instance, in line with Hatzenbuehler's (2009) psychological mediation framework, the role of proximal minority stressors (i.e., rejection sensitivity, concealment behaviour, and internalised homonegativity) and diminished general psychological processes as linking mechanisms between experiences of discrimination and social anxiety required further exploration. There was also a notable paucity of strengths-based research in this area. As a result, knowledge pertaining to both individual- and community-level resilience to social anxiety was in its infancy. In addition, a burgeoning area of research called attention to the potential role of within-community stressors (Pachankis, Clark, et al., 2020) as determinants of social anxiety within this population. Also of note, social anxiety maintenance processes as highlighted in the IAM model (Wong & Rapee, 2016) were yet to be explored in a sexual minority context.

Perhaps the most protuberant void in the knowledge base was the dearth of qualitative studies exploring social anxiety among sexual minority individuals. Therefore, knowledge pertaining to the experience of social anxiety (i.e., the manifestations of social anxiety, contexts in which social anxiety is experienced, specific coping mechanisms used, and the impact of social anxiety) was lacking.

Taking the above into account, the overarching aim of this mixed methods study was to elucidate the determinants of, and explore the experience of, social anxiety among sexual minority individuals. To achieve this aim, the current study utilised theories of traditional sexual minority stress (Hatzenbuehler, 2009; Meyer, 2003), intraminority stress (Pachankis, Clark, et al., 2020) and social anxiety (Wong & Rapee, 2016). A more comprehensive understanding of this markedly under researched phenomenon was vital to advance clinical interventions aiming to reduce debilitating symptoms in socially anxious sexual minority individuals.

By integrating the quantitative and qualitative findings, a rich and thorough understanding of the complex phenomenon has been gained. This mixed methods approach generated key findings pertaining to sexual minority subgroups at risk for social anxiety, minority stressors across the lifespan as determinants of social anxiety, the multifaceted sexual minority community: a source of social strength and stress, and the road to resilience: a sense of coherence and support.

10.3.1 Sexual Minority Subgroups at Risk for Social Anxiety

The present mixed methods study signified that social anxiety is a prominent mental health burden for all sexual minority individuals regardless of gender or sexual orientation. For example, in the current sample gay men reported the lowest social anxiety symptoms of any sexual identity subgroup, yet their social anxiety levels remained strikingly raised when compared to previous samples of gay men (e.g., Burns et al., 2012b). Participation bias might offer an explanation as to the heightened levels of social anxiety across the current sample. Whilst phase one recruitment materials outlined that the study was interested in hearing from all sexual minority individuals (i.e., regardless of anxiety levels), those who experience elevated anxiety may have been more likely to participate given their personal interest in the research topic. Nonetheless, the current findings add to the literature indicating that social anxiety prevails as an oppressive mental health concern in sexual minority communities.

One of the notable shortcomings in recent studies (e.g., Akibar et al., 2019; Wadsworth & Hayes-Skelton, 2015) assessing sexual orientation differences in social anxiety symptoms, was the lacking recognition of gender in the analyses. Indeed, this PhD thesis clarifies that gender differences are important for social anxiety. Overall, sexual minority women reported elevated social anxiety symptoms when compared to their men counterparts. This mixed methods study situates these gender differences in experiences of social anxiety and places a lens on the differing social-evaluative stimuli that sexual minority women and men

encounter. For example, in their everyday lives, sexual minority women encounter social-evaluative stimuli related to heteronormativity and misogyny, whereas their men counterparts are plausibly less likely to fear negative evaluation based on their gender.

Further research is required to decipher whether specific sexual minority subgroups of men are more at risk for social anxiety symptoms. The lacking significant effect of both sexual identity and attraction may indeed reflect the homogeneity of the sexual minority men sample (i.e., the vast majority indicating a gay identity and being only attracted to the same gender). Future research should endeavour to recruit a more diverse sample in terms of sexual orientation to advance knowledge in this area. Adding to a burgeoning area of research (Hartman, 2006; Hayfield et al., 2014; Heath & Mulligan, 2008), the findings suggest that bisexual and emerging identity women encounter exclusion processes at the within-community level, and for the first time, this mixed methods study highlights the role of these processes in contributing to experiences of social anxiety. The supportive role of sexual minority women's communities might be more tailored for lesbian women than their bisexual and emerging identity peers. As a result, the latter groups contend with an excess of social-evaluative stimuli at the within-community level. Future scholarship should focus on cultivating supports at the within-community level that address the excess stressors experienced by these subgroups on the basis of their sexual identity.

10.3.2 Minority Stressors Across the Lifespan as Determinants of Social Anxiety

This mixed methods study emphasises the importance of minority stress processes, as highlighted by Meyer (2003) and Hatzenbuehler (2009), as determinants of social anxiety in sexual minority populations. Further, this mixed methods study provides evidence regarding the salience of these traditional sexual minority stress processes as contributors to socially anxious experiences in this group. The IAM model (Wong & Rapee, 2016) points to the importance of early life experiences as aetiological factors for social anxiety in adulthood. Despite this, there has been limited attention toward minority stress processes during adolescence and youth in this area. The current mixed methods study has addressed this gap by highlighting the prominence of sexual minority stress processes in sexual minority individuals' early experiences, and emphasising that these processes are also determinants of this mental health burden in sexual minority adults (i.e., as signified by the phase one models).

Specifically, participants acknowledged the importance of negative peer experiences (e.g., heterosexist bullying) in shaping their social experiences during youth. Adolescence

represents a critical period for sexual identity development and the emergence of social anxiety symptoms (Beesdo et al., 2007; J. Wang et al., 2007). Research indicates that youth and early adolescence are the life course stages in which discrimination and victimisation are most frequent for sexual minority individuals, and they tend to reduce as late adolescence and early adulthood commence (Birkett et al., 2015; Swann et al., 2019). Additionally, van Beusekom et al. (2016) found that in secondary school students, gender nonconformity was associated with social anxiety via verbal heterosexist discrimination, and Greene et al. (2014) demonstrated that heterosexist bullying during school was predictive of social anxiety in adult life among sexual and gender minority adults. Considered together, these findings, along with those of the current mixed methods study, clarify the importance of minority stress processes during youth and adolescence as risk factors for social anxiety; thus, it is suggested that future studies should employ life course approaches to further comprehend this phenomenon.

Based on these negative social experiences that occurred within heteronormative social environments early in life, sexual minority individuals appear to experience intense proximal minority stress processes compounded by general cognitive and behavioural processes (i.e., of the IAM model) during this sensitive developmental period. For instance, intense feelings of internalised homonegativity appeared to establish negative self-beliefs and self-focus, and these cognitive processes are integral to the development and maintenance of social anxiety (Clark & Wells, 1995; Wong et al., 2014). The findings also advocate that many sexual minority individuals spent the majority of their youth and adolescence concealing their sexual orientation (i.e., through non-disclosure) which may also establish additional patterns of social avoidance. Furthermore, the navigation of heteronormative social-evaluative stimuli appeared to arouse intense sexual orientation related rejection sensitivity, the components of which overlap with both primary (i.e., biased attention toward threat) and secondary (i.e., anticipatory processing) maintenance processes of social anxiety as outlined by Wong and Rapee (2016).

Taking the above into account, sexual minority individuals are likely to apply an extreme SET value to many social situations during their youth and adolescence, and it is also likely that this tendency would persist into adulthood. This may partially account for the current study's findings that distal and proximal minority stress processes act as risk factors for social anxiety in an adult sexual minority sample. Indeed, whilst the frequency of discrimination and intensity of proximal stressors may reduce over time, both phases of the present study insinuate that minority stress processes remain intact during adulthood and

continue to place this population at risk for social anxiety. Based on previous negative social experiences, participants appeared to be hypervigilant to social threats in specific contexts (e.g., those deemed to be especially heteronormative and situations where many heterosexual men are present) in which negative evaluation is deemed probable. In this way, rejection sensitivity might operate as the principle sexual-minority specific process that maintains social anxiety in adulthood. Clinicians working with socially anxious sexual minority clients should explore both current and retrospective minority stress experiences in order to dissect the maladaptive cognitive and behavioural processes that contribute to social anxiety.

10.3.3 The Multifaceted Sexual Minority Community: A Source of Social Strength and Stress

As outlined above, the current findings uphold the principles of minority stress theories (Hatzenbuehler, 2009; Meyer, 2003). Even in a progressive society (i.e., one in which levels of structural stigma have reduced) such as the Republic of Ireland, sexual minority individuals experience additional stressors based on their minority status, and these processes are pertinent to consider when examining social anxiety. Yet, in order to fully comprehend the elevated rates of social anxiety within these populations, the current study confirms that it is not sufficient to solely examine this phenomenon in a traditional minority stress context. In fact, the greatest original contribution of this PhD thesis is arguably the unveiling of mechanisms and experiences at the within-community level as important contributors to social anxiety. This mixed methods study emphasises one must now acknowledge that sexual minority individuals' interactions with one another, and their perceptions of the community as a whole, can function as a source of stress. This stress, coupled with traditional minority stress, adds to their socially anxious experiences. Notwithstanding, in support of LGBTQ community connectedness as a protective factor of social anxiety (Frost & Meyer, 2012), the phase one findings endorse the beneficial function of this form of community-level resilience among women, whereas phase two findings elucidate the salience of positive interpersonal relationships with sexual minority peers in promoting healthy social functioning for both women and men. Therefore, it appears that the sexual minority community has a dual role in that it both perpetuates unique social stressors and offers community-level resilience.

Due to the predominantly early onset of social anxiety (Beesdo et al., 2007; J. Wang et al., 2007), many sexual minority women and men may already be dealing with elevated symptoms by the time they are exposed to the sexual minority community. Indeed, the current findings suggest that forging a social support network of sexual minority peers is no

easy task for individuals who may already have tendencies to avoid social situations. For instance, the avoidance of within-community social events resulted in some participants' social circles consisting solely of heterosexual individuals, despite wishes to build friendships with their peers. Others appeared to be focused on potential threats proposed by interactions with their peers (e.g., their lacking specific social skills or common interests) which propagate further social avoidance or anxiety experienced at the within-community level. By contrast, a proportion of sexual minority individuals, perhaps driven by previous experiences of heterosexist discrimination, appear propelled to establish social connections with their peers. This finding adds to the growing body of research elucidating the importance of positive social experiences at the within-community level in promoting healthy social functioning (e.g., Ceatha et al., 2019; DiFulvio, 2011; Frost & Meyer, 2012; Parmenter et al., 2020b) and sheds new light on specific related mechanisms in a social anxiety context. For some, the sexual minority community is a salient social resource and offers safe environments in which their social anxiety levels may dissipate.

At the same time, the findings are clear in also portraying the sexual minority community as a source of social stress. Indeed, phase one emphasised that intraminority stress might lead to social anxiety through both increased deleterious proximal processes and diminished general psychological processes for both sexual minority women and men. Further, the phase two findings enabled one to appreciate the distinguished stressful social experiences at the within-community level across both gender groups. In line with intraminority stress theory (Pachankis, Clark, et al., 2020), social anxiety appears to be exacerbated for sexual minority men when they are faced with prejudicial status-based hierarchies. Such hierarchies are deemed to foster a community in which members are quick to negatively evaluate one another on the basis of status. Therefore, a high SET value is applied to certain individuals (i.e., high-status men) and environments (e.g., gay bars). On the other hand, and in line with Boyle and Omoto's (2014) work, sexual minority women in the current study appeared to navigate communities in which certain social ideals are upheld. Perceived pressure to conform to these ideals resulted in socially anxious experiences as women weigh up whether or not to present their authentic self, and potentially risk negative evaluation from peers.

Whilst scholarship pertaining to intraminority stressors remains in its infancy, it is crucial to raise awareness of these processes as determinants of social anxiety. Future qualitative research should endeavour to delve deeper into the distinct experiences of those who forge salient interpersonal relationships with their peers and those who apply a high SET value to interactions with fellow sexual minority individuals. Indeed, the phase two findings indicate

that interpersonal-level resilience (i.e., social bonds with sexual minority peers) may be a more salient protective factor of social anxiety than community-level resilience (i.e., feelings of connection to the community as a whole). This offers a possible explanation for the lacking role of LGBTQ community connectedness as a protective factor (phase one finding) for social anxiety among sexual minority men. Yet, future research is required for clarification.

10.3.4 The Road to Resilience: A Sense of Coherence and Support

This mixed methods study has uncovered novel information in relation to processes that encourage resilience to social anxiety. Moreover, the current mixed methods study answers recent calls to incorporate a focus on resilience in sexual minority mental health research (e.g., de Lira & de Morais, 2018; Lyons, 2015). This study's findings emphasise social anxiety as a significant mental health burden for sexual minority individuals with debilitating consequences. Phase one signified that a diminished sense of coherence links both experiences of discrimination and intraminority stress to social anxiety. Therefore, in line with Antonovsky's (1987) conceptualisation of sense of coherence and recent sexual minority mental health scholarship (Lyons et al., 2014; Roberts, 2018), a high sense of coherence appears to empower sexual minority individuals to cope with social stressors at both the wider- and within-community levels and fend off social anxiety. That is, those with increased sense of coherence are enabled to efficiently utilise coping mechanisms in response to diverse social demands. Further, their repertoire of general resistance resources facilitates a flexible approach to cope with stress across a variety of social situations. Thus, when faced with a potential social threat, rather than engaging in avoidance or escape behaviours, or deleterious self-focus, sexual minority individuals with high a sense of coherence may adapt efficiently and successfully confront the social demand.

The phase two findings greatly advanced the understanding of resilience to social anxiety among sexual minority individuals and offered insight into how this group make efforts to build a sense of coherence to cope with social anxiety. For many participants, a vital aspect to this journey was availing of formal supports in the shape of psychological/therapeutic interventions (e.g., counselling, CBT, and mindfulness-based therapies). Through accessing such interventions, participants acquired knowledge as to the nature of social anxiety and its related stressors, as well as specific techniques to facilitate healthy coping. These techniques provided participants with resources to combat deleterious maintenance processes of social anxiety. For example, recognising cognitive distortions, which is cited as a key process in

reducing social anxiety (Goldin et al., 2016; Hedman et al., 2013), enabled participants to disengage from self-focus and biased attention toward threat, and resist avoidance and escape behaviours. Taking the above into account, it is clear how psychoeducation and the acquiring of healthy cognitive and behavioural techniques could contribute to increasing individual-level resilience such as sense of coherence. Psychoeducation directly addresses the understanding of social anxiety symptoms, and associated risk and protective factors. Further, learning techniques to combat cognitive and behavioural maintenance processes allows sexual minority individuals to start to build a repertoire of adaptive coping mechanisms when faced with social-evaluative stimuli. This would appear to be conducive to increasing both comprehensibility and manageability, two core pillars of sense of coherence (Antonovsky, 1987).

The current mixed methods study's findings signify the importance of social support at the within- and wider-community level in facilitating resilience to social anxiety. Social support is continually found to have an inverse relationship with social anxiety for both sexual minority women and men (e.g., Burns et al., 2012a; Mason et al., 2017; Potoczniak et al., 2007) and the present findings indicate that friends might be the principal agents of this support, yet family and partners also play a salient role. Close friends seemed to encourage the manageability of social-evaluative stimuli, prevent engagement in escape behaviours, and provide support to disconfirm social fears. Further, the protective function of social support was present across sexual minority-specific (e.g., when faced with heterosexist verbal abuse) and non-sexual minority-specific (e.g., attending a party) social contexts. In line with previous research (Bry et al., 2018; Doty et al., 2010), it would appear that building a strong social support network provides sexual minority individuals with social armour to shield off the potentially deleterious impacts of social anxiety. This could otherwise be portrayed as structuring dependable general resistance resources (as outlined by Antonovsky, 1987) to fend off minority stress and social anxiety.

10.4 Conclusions

The mixed method sequential explanatory design utilised in this PhD thesis allowed for a comprehensive investigation of this profound mental health burden in an at risk population. The integration of the quantitative and qualitative findings highlighted that both phases were largely convergent and complementary; yet, there was also notable silences and dissonance between the phases. The integrative analysis emphasised for the first time the importance of traditional minority stress theories (Hatzenbuehler, 2009; Meyer, 2003), intraminority stress

theory (Pachankis, Clark, et al., 2020), and the IAM model (Wong & Rapee, 2016) in explicating the determinants and experience of social anxiety among sexual minority individuals. The rich and detailed accounts of sexual minority individuals not only gave a unique and nuanced understanding of their experience of social anxiety but also advanced the understanding of the mechanisms of the models tested in phase one. Overall, the key findings of this mixed methods study 1) uncover specific sexual minority subgroups most at risk for social anxiety; 2) highlight the salience of minority stress processes across the lifespan as both determinants and key processes involved in the experience of social anxiety; 3) explicate the multifaceted role of the sexual minority community as a source of social strength and stress; and 4) pave the road to resilience which may aid clinicians working with socially anxious sexual minority clients. The last chapter of this PhD thesis will signify the original contributions of this mixed methods study, as well as outlining its implications.

Chapter 11 Conclusions

11.1 Introduction

To conclude this PhD thesis, the original contribution of the mixed method study will be considered in terms of theoretical knowledge, empirical evidence, method, research context, and practical implications. The implications of the current research will then be highlighted with regards to clinical practice, future research, and policy. Lastly, the overarching concluding remarks will be outlined.

11.2 The Original Contribution of the Present Study

This thesis contributes to theory (i.e., theoretical knowledge), empirical evidence, method, research context (i.e., the setting in which the research was undertaken), and practical implications (i.e., how the findings may be utilised in applied settings), all of which are outlined in Table 11.1.

In terms of theoretical knowledge, the current study provides an original contribution to the field through developing and testing a model of the determinants of social anxiety among sexual minority individuals. To the researcher's knowledge, this represents the most extensive model in the field and elucidates both risk and protective factors for social anxiety among this population. To date, this model represents the most sophisticated amalgamation of domineering theoretical frameworks of traditional sexual minority stress (Hatzenbuehler, 2009; Meyer, 2003) and the emerging theoretical position of intraminority stress (Pachankis, Clark, et al., 2020) in sexual minority mental health research. Furthermore, through exploring the experience of social anxiety among sexual minority individuals, and the context in which their socially anxious experiences arise, the present study also highlighted how traditional minority stress and intraminority stress processes overlap with the etiological and maintenance factors of the IAM model (Wong & Rapee, 2016), a contemporary cognitive and behavioural framework for the development of elevated social anxiety symptoms. This study represents the first empirical effort to combine sexual minority-specific and contemporary cognitive behavioural theoretical frameworks in order to comprehensively understand social anxiety within this population.

Several salient original contributions to empirical evidence are represented by the present study's findings. The qualitative study's findings highlight the presence of both cognitive and behavioural processes (i.e., mechanisms highlighted in the IAM model; Wong & Rapee,

2016) as pertinent maintenance processes of sexual minority individuals' social anxiety. Further, these findings are the first to elucidate sexual minority individuals' experiences of bodily anxiety symptoms. The models of determinants of social anxiety among sexual minority women and men unveiled several novel statistical pathways to social anxiety that had not previously been shown in the literature. First, the present study's findings add to previous research demonstrating heightened rejection sensitivity as a linking mechanism between experiences of discrimination and social anxiety among sexual minority women and men (Feinstein et al., 2012), and are the first to demonstrate this process as a linking mechanism between intraminority stress and social anxiety within this population. Second, the current study's findings signifying a diminished sense of coherence as a linking mechanism between both experiences of discrimination and intraminority stress, and social anxiety, are entirely novel. Third, the phase one study finding of a significant indirect pathway from intraminority stress to increased concealment behaviour to social anxiety among sexual minority men is a novel contribution to empirical evidence. Fourth, among sexual minority women, the present study is the first to reveal significant sequential pathways from 1) experiences of discrimination to heightened proximal minority stress (i.e., internalised homonegativity and concealment behaviour) to reduced LGBTQ community connectedness to social anxiety and 2) from both experiences of discrimination and intraminority stress to heightened rejection sensitivity to increased LGBTQ community connectedness to reduced social anxiety. Overall, the phase one findings make significant contributions to empirical evidence pertaining to social anxiety among sexual minority individuals through novel demonstrations of intraminority stress as a risk factor, sense of coherence as a protective factor, and the differing mechanisms of proximal minority stress processes as linking mechanisms. Additionally, it is the first to signify specific subgroups within sexual minority populations that report the highest social anxiety symptoms (e.g., the sexual behaviour subgroup who did not have sex). A novel finding was also revealed in terms of bisexual and emerging identity women (i.e., the analyses segregated sexual minority women and men unlike previous empirical efforts) reporting higher social anxiety symptoms (i.e., scores on screening measures rather than SAD prevalence) than lesbian women.

Perhaps the most notable novel contribution of the phase two study is the evidence pertaining to unique experiences of social anxiety within this population at the within- and wider-community levels. In focusing on social anxiety, the detailed accounts of the beneficial social offerings of the sexual minority community and the challenges in building a social support network of sexual minority peers are original contributions to the current evidence.

Furthermore, the intricate divergence in sexual minority women's and men's experiences of social anxiety in an intraminority stress context at the within-community level had not previously been explored in depth. The present study's findings also provide novel evidence regarding sexual minority individuals' experiences of traditional minority stress in adolescence, and how such experiences related to their social anxiety levels. Further, the present study provides evidence as to contextual and situational factors that play a pertinent role in this population's navigation of social situations at the within- and wider-community levels. Such factors are exemplified by the presence of heterosexual men, strangers/acquaintances, and occupational settings. The current findings also provide novel insight into how sexual minority individuals use their social support network and formal methods of support (e.g., therapeutic interventions), and their application of specific techniques, to cope with social anxiety. Lastly, hearing the voices of sexual minority individuals has granted a breadth and depth of insight into the impact of social anxiety on occupational, social, and emotional domains of everyday functioning that heretofore has not been available.

Regarding the method employed, this is the first study to adopt a mixed methods design to explore social anxiety among sexual minority individuals. Thus, for the first time this has granted a voice to those that were previously overlooked in qualitative research. In terms of the instruments, the current study was the first to adjust and validate the GCSS (Pachankis, Clark, et al., 2020) to be used in sexual minority women samples. Indeed, the adjusted scale may be used in future research or stimulate the development of an intraminority stress scale developed specifically for sexual minority women. The current study contributes to the knowledge base pertaining to the utilisation of mixed methods in sexual minority mental health research. Salient information has been uncovered pertaining to the implementation of a sequential explanatory mixed method design in achieving the aims and objectives of the current study. The study's design allowed for the quantitative phase to establish pertinent statistical relationships related to social anxiety that could be further explored in the qualitative phase. Further, the phase one study provided a participant pool from which the phase two participants could be recruited. The researcher expects that information contained within this thesis (e.g., the recruitment processes, approach to a research area with a dearth of qualitative literature, integration of sexual minority-specific and non-sexual minority-specific theoretical frameworks, and the acknowledged strengths and limitations), will support research teams in designing future mixed methods studies of sexual minority mental health.

Focusing on the research context, to the researcher's knowledge, this study represents the first empirical effort to examine social anxiety among sexual minority individuals in an Irish context. Also, as mentioned previously, to the researcher's knowledge, this is the first study to qualitatively explore this phenomenon. Further, whilst previous research had examined aspects of intraminority stress among sexual minority women (e.g., Boyle & Omoto, 2014), this represents the first study to investigate this construct (i.e., in accordance with intraminority stress theory) as it relates to social anxiety among sexual minority women.

Lastly, the current study provides novel insights into the determinants, and experience of, social anxiety among sexual minority individuals, which represents an important contribution to knowledge of practice. While the findings have implications at an international level (see section 11.3), they are of particular importance when considering the levels of discrimination and mental health difficulties experienced within the Irish sexual minority community (A. Higgins et al., 2016; Pizmony-Levy & BeLonGTo, 2019). Creating safe social environments and improving the health (i.e., including mental health) of sexual minority youth and adults is at the forefront of the Irish government's agenda (Department of Children and Youth Affairs, 2018; Department of Justice and Equality, 2019). This research will be instrumental in contributing to future related agendas as policy makers may utilise the statistical and rich qualitative findings contained herein to provide support for the sexual minority community. Further, the current findings may serve as an important resource for mental health practitioners working with sexual minority clients as they may incorporate the information pertaining to resilience/coping mechanisms (e.g., sense of coherence, social support network, and empowering aspects of sexual minority community membership) in their therapeutic approach. The implications of the current research study are considered in greater detail in section 11.3.

Table 11.1*Original Contribution of the Present Study*

Domains of Contribution	Supported	Developed	New
Theoretical Knowledge	<p><i>Provides theoretical support for:</i></p> <ul style="list-style-type: none"> • Minority stress theory (Meyer, 2003). • The psychological mediation framework (Hatzenbuehler, 2009). • Intraminority stress theory (Pachankis, Clark, et al., 2020). • The integrated aetiological and maintenance model of social anxiety disorder (Wong & Rapee, 2016). 	<p><i>Advances knowledge relating to:</i></p> <ul style="list-style-type: none"> • Minority stress theory (Meyer, 2003). • The psychological mediation framework (Hatzenbuehler, 2009). • Intraminority stress theory (Pachankis, Clark, et al., 2020). • The integrated aetiological and maintenance model of social anxiety disorder (Wong & Rapee, 2016). 	<p><i>Creates new theoretical support for:</i></p> <ul style="list-style-type: none"> • The integration of traditional sexual minority stress (Hatzenbuehler, 2009; Meyer, 2003), intraminority stress (Pachankis, Clark, et al., 2020), and social anxiety-specific cognitive-behavioural (Wong & Rapee, 2016) theories to understand social anxiety among sexual minority individuals.
Empirical Evidence	<p><i>Supports existing empirical evidence relating to:</i></p> <ul style="list-style-type: none"> • Gender differences in social anxiety. • Minority stress processes as determinants of social anxiety. • Diminished general psychological processes as determinants of social anxiety. 	<p><i>Develops upon empirical evidence by:</i></p> <ul style="list-style-type: none"> • Highlighting the differing functions of proximal minority stress processes as determinants of social anxiety. • Emphasising intraminority stress as a salient determinant of internalising mental health symptoms within this population. • Elucidating the role of LGBTQ community connectedness and positive interactions with sexual minority peers in a social anxiety context. • Advancing understanding of how social support is used to cope with social anxiety. 	<p><i>Creates new empirical evidence relating to:</i></p> <ul style="list-style-type: none"> • Specific sexual minority subgroups at risk for elevated social anxiety symptoms (i.e., bisexual and emerging identity women and those that did not have sex). • Intraminority stress as a determinant of social anxiety for sexual minority women and their divergent experiences of within-community stress when compared to men. • Sense of coherence as a protective factor for social anxiety among sexual minority individuals.

Table 11.1

Original Contribution of the Present Study

Domains of Contribution	Supported	Developed	New
			<ul style="list-style-type: none">• Cognitive and behavioural maintenance processes (Wong & Rapee, 2016) of social anxiety among sexual minority individuals.• Unique socially anxious experiences at the within- and wider-community level.• Experiences of minority stress and social anxiety across the lifespan.• Situational and contextual factors related to social anxiety among sexual minority individuals.• The role of therapeutic interventions in advancing knowledge to cope with social anxiety.• Sexual minority individuals' application of cognitive and behavioural techniques to cope with social anxiety.• The impact of social anxiety on sexual minority individuals' educational, occupational, social, and emotional functioning.

Table 11.1*Original Contribution of the Present Study*

Domains of Contribution	Supported	Developed	New
Methodological Approaches	<p><i>Supports methodological approaches employing:</i></p> <ul style="list-style-type: none"> • The utilisation of mixed methods in sexual minority mental health research. • The utilisation of a sequential explanatory design in sexual minority mental health research. 		<p><i>Contributes new methodological approaches via:</i></p> <ul style="list-style-type: none"> • The design and implementation of a qualitative study pertaining to social anxiety within this population. • The validation and utilisation of an adapted GCSS scale for sexual minority women.
Research Context	<p><i>Supports research in the following contexts:</i></p> <ul style="list-style-type: none"> • Research investigating elevated mental health difficulties within sexual minority populations. • Strengths based research investigating resilience to mental health difficulties among sexual minority individuals. 	<p><i>Further develops research in the following contexts:</i></p> <ul style="list-style-type: none"> • Research investigating social wellbeing in sexual minority individuals in a minority stress context with a specific focus on social anxiety. 	<p><i>Signifies unique research context by:</i></p> <ul style="list-style-type: none"> • Representing the first study (internationally) to explore intraminority stress in a social anxiety context. • Representing the first study of social anxiety within sexual minority populations in an Irish context.
Practical Implications	<p><i>Supports practical implications for:</i></p> <ul style="list-style-type: none"> • The need for a campaign highlighting both the adverse and beneficial function of the sexual minority community in a social anxiety context. 	<p><i>Further develops practical implications for:</i></p> <ul style="list-style-type: none"> • The role of mental health professionals in delivering psychoeducation and tailored care for sexual minority individuals suffering with social anxiety. 	<p><i>Provides the following unique practical implications:</i></p> <ul style="list-style-type: none"> • Pertinent novel information suggests the development and testing of a tailored therapeutic intervention to tackle social anxiety.

Table 11.1

Original Contribution of the Present Study

Domains of Contribution	Supported	Developed	New
			<ul style="list-style-type: none">• The current study's findings can contribute to future mental health policy.

11.3 Study Implications

The current research is ground breaking in its extensive investigation of social anxiety in this at risk sexual minority population. The findings are comprised of novel information pertaining to the determinants and experience of social anxiety and therefore have salient implications for stakeholders in clinical, research, and policy making settings.

11.3.1 Clinical Implications

Recent meta-analyses signify that CBT is a particularly effective therapeutic intervention for reducing social anxiety symptoms in the general population (Acarturk et al., 2009; Mayo-Wilson et al., 2014). As revealed by the systematic review (see section 2.5.5), the knowledge base pertaining to effective psychological interventions is notably limited for sexual minority men and women. The limited studies among men signified that interventions using CBT principles are effective in reducing social anxiety symptoms (Hart et al., 2014; Reisner et al., 2011; Walsh & Hope, 2010). Since the search strategy for the systematic review was run, Hart et al. (2020) demonstrated the efficacy of the same integrated CBT intervention used in their previous study (Hart et al., 2014) in reducing social anxiety symptoms, condomless anal sex, and problematic alcohol use in a larger sample of sexual minority men ($n = 21$). In addition, sexual minority-affirmative CBT, a therapeutic intervention designed to address minority stress processes, shows significant reductions in mental health difficulties in pilot tests with sexual minority men (Pachankis, Hatzenbuehler, et al., 2015) and women (Pachankis, McConocha, et al., 2020). The findings suggest that clinicians working with sexual minority clients with social anxiety should explore intraminority stressors, as well as traditional minority stressors, when following existing sexual minority-affirmative CBT protocols (e.g., Burton et al., 2019; Pachankis, Hatzenbuehler, et al., 2015; Pachankis, McConocha, et al., 2020). For instance, clinicians could also explain how intraminority stress may have links with clients' emotions, increase awareness of intraminority stress reactions, and work to develop healthy coping mechanisms (e.g., alternative appraisals and eradicate maladaptive emotion-driven behaviours experienced at the within-community level). Due to the infancy of intraminority stress as an empirical construct, there is likely also a need to provide specific training (i.e., that addresses within-community stressors) to clinicians working with social anxious sexual minority clients.

The findings also highlight that the relationship between a client's sense of coherence and their social anxiety may warrant exploration in a clinical setting. Previous research demonstrated that one's sense of coherence is not fixed and can alter over time (Hakanen et

al., 2007), and that sense of coherence could be strengthened through therapeutic interventions such as mindfulness-based strategies (Weissbecker et al., 2002) and CBT (Berger et al., 2009). Therefore, it might prove beneficial for clinicians to include thorough psychoeducation components pertaining to general stressors, traditional minority stress processes, and intraminority stress processes in order to increase clients' comprehensibility of the stressors they navigate. Further, clinicians should focus on helping their sexual minority client to build and sustain secure social support networks; the current findings suggest that building networks at both the within- and wider-community level might be especially effective in tackling social anxiety. Healthy cognitive and behavioural techniques to prevent engagement maintenance processes of social anxiety should also be developed. These additional supports and healthy coping mechanisms (i.e., general resistance resources; Antonovsky, 1987) may stimulate increased manageability in clients and decrease the SET value applied to interactions with both heterosexual and sexual minority individuals. Lastly, clinicians should strive to explore means of increasing sense of purpose and fulfilment in sexual minority clients suffering with social anxiety (i.e., heightening meaningfulness). The above approach is conducive to increasing sense of coherence and might intervene on the distal stress processes that stimulate social anxiety. Studies utilising experimental techniques (e.g., randomised controlled trials) are required in this area. Future research could examine the efficacy of an enhanced version of sexual minority-affirmative CBT (also acknowledging intraminority stressors) in strengthening sense of coherence and reducing social anxiety in sexual minority clients with elevated social anxiety symptoms.

In working towards testing interventions to reduce social anxiety symptoms in sexual minority individuals, it should be acknowledged that further research is required to fill current knowledge gaps. Indeed, both quantitative and qualitative, or mixed methods studies, are essential to inform the development of randomised controlled trials of specific interventions in this area. Importantly, the participants in these studies should represent a diverse array of stakeholders. In accordance with Craig et al.'s (2019) guidelines, stakeholder engagement is key to the effective development of complex interventions. In the current case, stakeholders are not only represented by clinicians, but also all relevant educators and providers, policy makers, and first and foremost, the members of the sexual minority community themselves. The non-involvement of any of the above parties risks an intervention not being considered from all relevant perspectives (i.e., all voices are not heard). Therefore, it is vital that all stakeholders are involved in research contributing the development and evaluation of social anxiety interventions for sexual minority populations.

Engagement with a diverse and multidisciplinary group of stakeholders offers many benefits including an enhanced understanding of the issue at hand, improved knowledge of the wider context, and a chance to elucidate specific areas for change (Moore et al., 2015).

With the current topic in mind, it is likely that outcomes of psychological interventions for social anxiety in sexual minority individuals will partially depend on the quality of clinician delivery and the level of client engagement. Yet, it is equally important to acknowledge that this client operates socially at the wider- and within-community levels and will therefore be impacted by relevant policy and the social climate of sexual minority communities. Further, existing healthcare policy is also likely to be associated with the clinicians' training pertaining to sexual minority-specific issues. Thus, to increase the likelihood of successful outcomes from such interventions, the involvement of additional stakeholders (e.g., social and health policy makers, LGBTQ advocacy, community, and charity organisation) in intervention development phases is key. The collaborative involvement of multiple and diverse stakeholders in the production phases of interventions represents a distancing from interventions being developed in an exclusive manner by research academics, and a gravitating toward the creation of socially and scientifically robust interventions by partnership (Greenhalgh et al., 2019). Further, the involvement of diverse stakeholders should extend beyond the development stage of social anxiety interventions for sexual minority populations, and the social and scientific collaboration ought to continue into the feasibility, evaluation, and implementation stages.

11.3.2 Research Implications

Whilst the present study has made notable contributions in both elucidating the determinants and exploring the experience of social anxiety among sexual minority individuals, notable gaps remain in the knowledge base for future studies in this area to address. To further clarify specific sexual minority subgroups most at risk for social anxiety, future empirical efforts should actively recruit a larger sample of sexual minority individuals. Further, the recruitment strategy should be tailored to ensure that underrepresented groups in the current study (e.g., men identifying as bisexual or emerging identity) are adequately represented.

As emphasised by the systematic review findings, there is prominent homogeneity in this area in terms of research design (i.e., domineering approach is quantitative and cross-sectional). Longitudinal research designs should be used to examine the viability of the phase one models over time. Only then could one begin to infer causality between the risk and protective factors highlighted in the quantitative study and social anxiety. For most

individuals, social anxiety symptoms have an onset during early adolescence (Beesdo et al., 2007; J. Wang et al., 2007). Sexual minority individuals' initial awareness of their same-sex sexual attraction (Calzo et al., 2011; Floyd & Stein, 2002; Martos et al., 2015) and their first experiences of sexual minority stressors (Goldbach et al., 2014; Russell et al., 2011) also typically occur during this developmentally sensitive period. First encounters of intraminority stressors are likely to occur later in adolescence or emerging adulthood. It is therefore possible that a sexual minority adolescent's pre-existing social anxiety may amplify the impact of minority stressors or vice versa. With this in mind, future investigations should utilise longitudinal designs, and recruit both sexual minority adolescents and adults, with the aim to elucidate the temporal relationships between the variables included in our models. In addition, future quantitative studies in sexual minority adults should also consider assessing retrospective levels of minority stress processes (i.e., during youth and adolescence).

Further qualitative studies are also required in the area to delve deeper into the findings revealed by the first qualitative exploration of social anxiety within this population. Once more, it is salient for future studies to recruit a diverse sample of sexual minority individuals. This approach will enable researchers to explicate on the unique socially anxious experiences revealed between lesbian and bisexual/emerging identity women in this study. It may also prove valuable to explore the socially anxious experiences of sexual minority individuals with a SAD diagnosis. This group's impairment is the greatest and a qualitative exploration of such a sample may yield novel findings not uncovered in this PhD thesis. Equally, it could prove beneficial to explore the past and present social experiences of sexual minority individuals with low social anxiety. Examining such a group might reveal factors that could be utilised in order to encourage promotive social functioning among sexual minority women and men.

11.3.3 Policy Implications

The current study's findings could be used to influence further policy amendment and development to improve the social experiences of sexual minority populations and empower promotive social functioning amongst its members. Although the current research sample consisted of sexual minority adults, the findings should be used to inform future national strategies to improve the wellbeing of sexual minority youth. Recently, the Department of Children and Youth Affairs (2018) published the LGBTI+ National Youth Strategy; the strategy held the following strategic goals: 1) fostering supportive and inclusive

environments for young sexual and gender minority individuals; 2) enhancing the health of this population across physical, mental, and sexual domains; and 3) establishing the research and data environment to improve the understanding of young sexual and gender minority lives. In endeavouring to achieve these goals, early interventions (e.g., to tackle heterosexist bullying) and related educational campaigns are recommended. These interventions could be implemented in both primary and secondary school environments and could aid in fostering supportive environments for youth who may currently, or in the future, identify as a sexual or gender minority. The implementation of such programmes during this critical period may prevent social anxiety through improving peer experiences and decreasing minority stress processes.

The current study findings should also influence the development of novel, or the extension of existing, national strategies to improve the lives of sexual minority adults. The National LGBTI+ Inclusion Strategy (Department of Justice and Equality, 2019) was developed by the Irish government with the vision to establishing Ireland as a country in which all individuals, regardless of their sexual orientation, are offered the opportunity to flourish and live fulfilling lives. Further, the mission statement includes an emphasis on improving the quality of life of sexual and gender minority individuals in Irish society. Indeed, through highlighting sexual minority-specific processes and stressors that lead to social anxiety, the present findings could be utilised to support many facets of the action plan associated with the strategy. For example, creating more inclusive Irish workplaces to enable sexual minority individuals to be their authentic selves in work, and ensuring community supports are easily accessible to sexual minority individuals. To achieve the latter action plan, efforts should also be made to raise awareness of the stressors that can contribute to social anxiety at the within-community level (e.g., through psychoeducation and public awareness campaigns). Further, measures need to be taken to ensure that the infrastructure within the sexual minority community is welcoming to all of its members, regardless of status, sexual orientation, gender identity, or racial/ethnic background.

11.4 Strengths and Limitations

Overall, there are noteworthy strengths associated with the current mixed methods study. The broad aim of the systematic review resulted in a collation of the published research evidence across the four objectives for the first time. This collation was not only useful in highlighting what is currently known about social anxiety in sexual minority populations, but also emphasised the outstanding gaps in the current published knowledge base. A

strength of the latter contribution might be encouraging social anxiety research into under researched subpopulations (e.g., sexual minority women), the use of more diverse research designs (e.g., qualitative or mixed methods), and placing more of an empirical focus on resilience in future studies. The findings of the current mixed methods study emphasised that participants' social interactions with the wider population and their sexual minority peers are integral to their experiences of social anxiety. Moreover, sexual minority-specific processes across multiple social contexts and general psychological processes have been illuminated as important processes that contribute to social anxiety. Indeed, this reflects the current study's strength of tackling the overriding research questions with a multidimensional theoretical lens. It is hoped that researchers in the future will also integrate theoretical frameworks from sexual minority mental health and social anxiety scholarship to further elucidate facets of this complex phenomenon. While salient distal and proximal stressors associated with social anxiety were indicated by the current study's findings, knowledge pertaining to resilience in this area has also been advanced. Indeed, a key strength of the current study was spotlighting individual- and community-level resilience as protective factors for social anxiety, and elucidating how participants seek to build their resilience at both of these levels.

Whilst the current mixed methods study has made advances across multiple domains (e.g., theoretical knowledge and empirical evidence), it also holds some limitations that are important to consider. The systematic review was limited to studies published in English in peer-reviewed journals; therefore, the collation of existing evidence was not entirely exhaustive. With regards to the quantitative study, future studies testing models of risk and protective factors of social anxiety should aim to recruit larger samples of sexual minority individuals that are more representative of the diversity of sexual identities within the sexual minority community (e.g., individuals, especially sexual minority men, who identify as bisexual or adopt an emerging identity). As previously discussed, the current study's focus on resilience represents a core strength, nonetheless, there are some potential shortcomings to consider when focusing on the measures of resilience that were chosen. In line with the findings of Colpitts and Gahagan's (2016) recent scoping review, it could be argued that assessing sense of coherence, a measure developed with presumably predominantly heterosexual samples, is questionable in that it may not account for the unique factors that contribute to sexual minority populations' resilience. Further, it could also be contended that LGBTQ community connectedness primarily accounts for broader interpersonal resilience at the within-community level; thus, overlooking other salient forms of resilience. With the

aim of further elucidating protective factors of social anxiety, future studies should incorporate an intersectional lens and account for the potential role of structural-, social-, and individual-level resilience specific to sexual minority populations. Lastly, the exclusion of participants who do not believe social anxiety is an issue in their life from the qualitative study also yields some drawbacks. Previous research demonstrates that valuable knowledge is uncovered when focusing on those who are displaying high levels of resilience; Bry et al.'s (2018) study exhibited this in a minority stress context. It may therefore prove advantageous for subsequent qualitative work to explore the social experiences of sexual minority individuals who report lower levels of social anxiety symptoms.

11.5 Conclusion

This PhD thesis represents the first mixed methods investigation (including the first qualitative exploration) of social anxiety among sexual minority individuals. The systematic review was the first to synthesise all quantitative associations with social anxiety among sexual minority individuals and also revealed the dearth of qualitative research in this area. A two-phased mixed methods sequential explanatory design was then utilised to: 1) elucidate the determinants of social anxiety among sexual minority individuals; and 2) explore the experience of social anxiety among sexual minority individuals. The present study represents an original contribution to the knowledge base because it emphasises that both traditional minority stress and intraminority stress processes are salient social anxiety risk factors for both women and men within sexual minority populations. In addition, the function of both sexual minority-specific proximal minority stress processes (i.e., namely rejection sensitivity) and diminished general psychological processes (i.e., sense of coherence) as linking mechanisms between distal stress and social anxiety has been emphasised. Furthermore, the role of general cognitive and behavioural processes in maintaining experiences of social anxiety in general and sexual minority-specific contexts has been emphasised for the first time. Indeed, the findings provide primary evidence as to the unique social-evaluative stimuli encountered by this population at the within- and wider-community levels across their life course. Such stimuli appear to encourage social anxiety and thus impact promotive functioning across educational, occupational, social, and emotional domains. However, this study also provides novel findings regarding protective factors and suggestions to build resilience, which should assist clinicians working with socially anxious sexual minority clients to tackle this prominent mental health burden. The findings also have important research and policy implications that could contribute to fostering inclusive social

environments at the within- and wider-community levels, and tackle the persistent and widespread mental health issue that is social anxiety.

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Appendices

Appendix A: PsycINFO Search Strategy

Field labels

- exp/ = exploded controlled term
- / = non exploded controlled term
- .mp = title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]

* = truncation of word for alternate endings

1. Bisexuality/
2. exp Homosexuality/
3. Same Sex Intercourse/
4. Same Sex Couples/
5. Same Sex Marriage/
6. Sexual Minority Groups/
7. (queer* or LGB* or LGBTQ or LGBQ or LGBTQI or GLB or LGB or LGBT or GLBT or homosexual* or lesbian* or gay* or bisexual* or bi-sexual* or "sexual minorit*" or "sexual orientation*" or bicurious or lesbigay* or "men who have sex with men" or MSM or MSMW or "men loving men" or "same sex" or "same sex couple*" or "same sex relation*" or "women loving women" or "women who have sex with women" or WSW or "same gender loving" or "same-gender loving" or "same-gender-loving" or asexual* or demisexual* or pansexual* or polysexual* or polyamor*).mp.
8. Social Anxiety/
9. Social Phobia/
10. ("social phobia*" or "social anxiety" or "social fear*" or "public speaking anxiety" or "performance anxiety" or "interaction anxiety" or "fear of negative evaluation" or "social sensitivity" or "taijin kyofusho" or "social distress" or "social avoidance" or "test anxiety").mp.
11. 1 or 2 or 3 or 4 or 5 or 6 or 7
12. 8 or 9 or 10
13. 11 and 12

Appendix B.1

Characteristics of Included Studies

Study ID	Author(s); Location	Aim(s)	Recruitment and Sample Characteristics	Social Anxiety Measure(s); CCAT Score
1	Akibar et al. (2019); USA.	Examine the extent to which social anxiety differed by dimensions of sexual identity, attraction, romantic, and sexual history.	$N = 1,133$ emerging adults recruited through a participant pool system (i.e., to earn course credit), as well as from other university courses; age: 18-29 (20.24 ± 1.80); cisgender women ($n = 873$), cisgender men ($n = 253$), transgender men ($n = 6$), transgender women ($n = 1$); gay/lesbian ($n = 50$), bisexual ($n = 83$), pansexual ($n = 23$), asexual ($n = 9$), questioning/unsure ($n = 22$); heterosexual ($n = 947$); 46.8% White.	<ul style="list-style-type: none"> • Social Interaction Anxiety Scale (Mattick & Clarke, 1998) • Social Phobia Scale (Mattick & Clarke, 1998) • 73%
2	Baiocco et al. (2014); Italy.	Investigate differences between heterosexual and lesbian/gay young adults regarding best friendship patterns, wellbeing, and social anxiety.	$N = 1,100$ young adults recruited from LGBT organisations, a sporting organisation, and student societies; age: 18-26 ($M_{women} = 21.36 \pm 2.36$; $M_{men} = 21.48 \pm 2.09$); lesbian women ($n = 169$), heterosexual women ($n = 504$), gay men ($n = 217$), heterosexual men ($n = 210$).	<ul style="list-style-type: none"> • Social Anxiety subscale (Selfhout et al., 2009) of the revised version of the Screen for Child Anxiety-Related Emotional Disorders (Hale et al., 2005) • 63%
3	Balsam et al. (2015); USA.	Explore ethnic/racial differences in trauma exposure, sexual identity, mental health, and substance use in a non-probability national sample of young adult sexual minority women.	$N = 967$ young adult sexual minority women recruited through Facebook advertisements and Craigslist; age: 18-25 (20.90 ± 2.09); lesbian ($n = 406$), bisexual ($n = 561$); 75.5% White.	<ul style="list-style-type: none"> • Social Interaction Anxiety Scale • 75%
4	Batchelder et al. (2019); USA.	Test bivariate relationships between four clinical diagnoses (substance use disorder; major depressive disorder,	$N = 290$ HIV-negative MSM recruited through advertising and outreach to bars, clubs, cruising areas, and community venues in	<ul style="list-style-type: none"> • The Mini-International Neuropsychiatric Interview (Sheehan et al., 1998)

Appendix B.1

Characteristics of Included Studies

Study ID	Author(s); Location	Aim(s)	Recruitment and Sample Characteristics	Social Anxiety Measure(s); CCAT Score
		posttraumatic stress disorder, and anxiety disorders) and their additive and interactive effects on three health indicators (i.e., high-risk sex, visiting the emergency room, and sexually transmitted infections) in HIV-negative MSM with trauma histories.	addition to social media and sexual networking apps; age: 18-67 (37.95±11.68); 67.9% White.	<ul style="list-style-type: none"> • 88%
5	Blashill (2010); Blashill & Vander Wal (2009); USA.	Assess the relative uniqueness of components of male body image (i.e., muscle, body fat, and height dissatisfaction) in the prediction of indices of psychological distress (i.e., depression, eating restraint, eating concerns, and social anxiety) among gay men. Examine the role of negative affect and social anxiety in the relationship between gender role conflict and eating disorder symptomatology and body dissatisfaction.	<i>N</i> = 228 gay men recruited through online gay discussion and email lists; age: 18-75 (31.07±12.66); 76.3% White.	<ul style="list-style-type: none"> • Brief Fear of Negative Evaluation Scale straightforwardly worded items (Leary, 1983) • 63%; 63%
5a	Blashill & Vander Wal (2010); USA.	Examine the mediational impact of gender role conflict on the relationship between social anxiety and depression.	<i>N</i> = 162 gay men recruited through online gay discussion and email groups; age: 18-75 (32.26±13.01); 75.9% White.	<ul style="list-style-type: none"> • Brief Fear of Negative Evaluation Scale straightforwardly worded items • 60%
6	Bostwick et al. (2010); Hatzenbuehler, Keyes, et al. (2009);	Examine the associations among 3 dimensions of sexual orientation (identity, attraction, and behaviour), lifetime and 12-month mood and anxiety disorders, and sex.	<i>N</i> = 34,653 adults recruited as part of a longitudinal population-based study; age: 20-24 (<i>n</i> = 2,183), 25-44 (<i>n</i> = 13,333), 45-64 (<i>n</i> = 11,960), ≥65 (<i>n</i> = 7,177); women (<i>n</i> = 20, 089), men (<i>n</i> = 14,564); lesbian/gay (<i>n</i>	<ul style="list-style-type: none"> • Alcohol Use Disorder and Associated Disabilities Interview Schedule-IV (Grant et al., 2001) • 75%; 85%; 73%

Appendix B.1

Characteristics of Included Studies

Study ID	Author(s); Location	Aim(s)	Recruitment and Sample Characteristics	Social Anxiety Measure(s); CCAT Score
	Hatzenbuehler et al. (2011); USA.	Investigate the modifying effect of state-level policies on the association between lesbian, gay, or bisexual status and the prevalence of psychiatric disorders. Examine risk modifiers at the social/contextual level that may protect lesbian, gay, and bisexual individuals from the development of psychiatric disorders.	= 335), bisexual ($n = 242$), questioning/not sure ($n = 170$), heterosexual ($n = 33,598$); 70.9% White.	
6a	J. H. Lee et al. (2015); USA.	Compare heterosexual and sexual minority men on the prevalence of diagnostic co-occurring psychiatric and drug use disorders among men with alcohol use disorder. Examine whether disparities in the prevalence of co-occurring disorders persist after adjustment for potential sociodemographic confounders.	$N = 6,899$ men with alcohol use disorder recruited as part of a longitudinal population-based study; age: 18-24 ($n = 979$), 25-44 ($n = 3,039$), 45-64 ($n = 2,214$), ≥ 65 ($n = 667$); sexual minority men ($n = 176$), heterosexual men ($n = 6,732$); 77.0% White.	<ul style="list-style-type: none"> • Alcohol Use Disorder and Associated Disabilities Interview Schedule-IV • 80%
6b	Mereish et al. (2015); USA.	Examine sexual orientation disparities in co-occurring psychiatric and drug use disorders between sexual minority women and heterosexual women with alcohol use disorders.	$N = 4,342$ women with alcohol use disorder recruited as part of a longitudinal population-based study; age _{sexualminority} : 18-24 ($n = 33$), 25-44 ($n = 118$), 45-64 ($n = 36$), ≥ 65 ($n = 2$); age _{heterosexual} : 18-24 ($n = 576$), 25-44 ($n = 2,169$), 45-64 ($n = 1,175$), ≥ 65 ($n = 231$); sexual minority ($n = 191$), heterosexual ($n = 4,151$); race/ethnicity _{sexualminority} = 72.4% White; race/ethnicity _{heterosexual} = 80.7% White.	<ul style="list-style-type: none"> • Alcohol Use Disorder and Associated Disabilities Interview Schedule-IV • 88%

Appendix B.1

Characteristics of Included Studies

Study ID	Author(s); Location	Aim(s)	Recruitment and Sample Characteristics	Social Anxiety Measure(s); CCAT Score
7	Burns et al. (2012a, 2012b); USA.	Examine relationships between gay men's attributions for discrimination and their satisfaction with social support. Examine cognitions regarding perceived discriminatory events as moderators of the effect of these events on mental health, namely social anxiety.	$N = 307$ gay men recruited from listservs for LGB community, student and faculty groups, and snowball recruitment; age: 18-84 (31.6 ± 13.7); 75.6% White.	<ul style="list-style-type: none"> • Liebowitz Social Anxiety Scale (Liebowitz, 1987) • 90%; 83%
8	Cathey et al. (2014); USA.	Investigate whether perceived discrimination on the basis of ethnic group membership and/or sexual orientation predicts social anxiety and whether use of an avoidant coping method exacerbates social anxiety in response to discrimination.	$N = 439$ adults recruited through website advertisements, posts on email discussion lists, and snowball emailing; age: 18-82 (33.8 ± 11.6); women ($n = 302$), men ($n = 133$), transgender ($n = 4$); gay/lesbian ($n = 75$), bisexual ($n = 61$), heterosexual ($n = 303$); 75.3% White.	<ul style="list-style-type: none"> • Social Interaction Anxiety Scale • 55%
9	Cohen, Blasey, et al. (2016); USA.	Investigate the symptoms of generalised anxiety disorder, social anxiety disorder, panic disorder, posttraumatic stress disorder, and depression in sexual minority young adults relative to their heterosexual peers. Investigate sexual orientation concealment as a predictor of anxiety and related disorders.	$N = 314$ undergraduate students recruited from introductory psychology classes; age: 18.8 ± 1.10 ; sexual minority women ($n = 97$), heterosexual women ($n = 104$), sexual minority men ($n = 60$), heterosexual men ($n = 53$); gay ($n = 27$), lesbian ($n = 7$), bisexual ($n = 71$), queer ($n = 5$), questioning ($n = 47$), heterosexual ($n = 157$); 71.3% White.	<ul style="list-style-type: none"> • Social Phobia Diagnostic Questionnaire (Newman et al., 2003) • 73%
10	Cohen, Feinstein, et al. (2016); USA.	Examine the associations between rejection sensitivity and specific types of mood and anxiety disorder symptoms (depression, social anxiety, generalised anxiety, panic, and posttraumatic stress) among young	$N = 101$ sexual minority men undergraduate students recruited from two universities; age: 21.41 ± 3.62 ; gay ($n = 76$), mostly gay ($n = 13$), bisexual ($n = 12$); 61.4% White.	<ul style="list-style-type: none"> • Social Phobia Diagnostic Questionnaire • 65%

Appendix B.1

Characteristics of Included Studies

Study ID	Author(s); Location	Aim(s)	Recruitment and Sample Characteristics	Social Anxiety Measure(s); CCAT Score
		gay and bisexual men and to examine the extent to which a latent transdiagnostic internalising factor mediated these associations.		
11	Dyar et al. (2016); USA.	Develop a measure of sexual orientation rejection sensitivity for sexual minority women and to examine its preliminary reliability and validity.	$N = 300$ sexual minority women recruited from websites (e.g., Craigslist) as well as listservs and LGB Facebook groups; age 18-60 (26.8 ± 8.5); lesbians ($n = 113$), bisexual ($n = 106$), queer ($n = 69$), women identifying with other sexual identity labels ($n = 12$); 76.3% White.	<ul style="list-style-type: none"> • Brief Fear of Negative Evaluation Scale • 83%
12	Feinstein et al. (2012); USA.	Examine potential mechanisms through which experiences of discrimination influence depressive and social anxiety symptoms.	$N = 467$ sexual minority adults recruited through listservs and websites (e.g., Facebook, Craigslist) targeting LGB individuals; lesbian women ($n = 218$), gay men ($n = 249$); age: 18-72 (31.24 ± 11.67); 76.0% White.	<ul style="list-style-type: none"> • Brief Fear of Negative Evaluation Scale Revised version (Carleton et al., 2007) • 78%
13	Fletcher et al. (2018); USA.	Provide associations between current diagnostic mental health disorder and the severity of current substance use disorder among methamphetamine-using MSM.	$N = 285$ methamphetamine using MSM enrolled in a study designed to reduce methamphetamine use and sexual risk behaviours; age: 42.0 ± 11.0 ; gay ($n = 191$), other sexual identity ($n = 94$); 44% African American/Black, 25% Hispanic/Latino (% White not included).	<ul style="list-style-type: none"> • The Structured Clinical Interview for DSM-V (First et al., 2015) • 78%
14	Gilman et al. (2001); USA.	Examine the risk of psychiatric disorders among individuals with same-sex sexual partners.	$N = 4,910$ recruited as part of a population-based household survey; age: 15-54 ($M_{WSW} = 32.7 \pm 8.1$; $M_{WSMonly} = 33.9 \pm 9.9$; $M_{MSM} = 34.0 \pm 8.5$; $M_{MSWonly} = 33.5 \pm 10.1$);	<ul style="list-style-type: none"> • Composite International Diagnostic Instrument DSM-III-R version (World Health Organization, 1990)

Appendix B.1

Characteristics of Included Studies

Study ID	Author(s); Location	Aim(s)	Recruitment and Sample Characteristics	Social Anxiety Measure(s); CCAT Score
			WSW ($n = 51$), WSM only ($n = 2,475$), MSM ($n = 74$), MSW only ($n = 2,310$); 77.0% White.	<ul style="list-style-type: none"> • 68%
15	Hart & Heimberg (2005); USA.	Examine whether the relationship between social anxiety and unprotected intercourse is mediated by decreased communication about condom use and lower social support.	$N = 100$ young sexual minority men recruited from LGB after school groups and LGB university societies; age: 16-21 (18.84 ± 1.49); gay ($n = 86$), bisexual ($n = 14$); 46% White.	<ul style="list-style-type: none"> • Social Interaction Anxiety Scale • Social Phobia Scale • 60%
16	Hart, James, et al. (2008); USA.	Examine associations between social anxiety and unprotected sexual transmission risk among HIV-positive men.	$N = 206$ HIV-positive men recruited from a large public HIV community clinic; age: 41.9 ± 6.6 ; MSM ($n = 84$), MSW ($n = 52$), abstinent ($n = 70$); 8% White.	<ul style="list-style-type: none"> • Liebowitz Social Anxiety Scale • Social Interaction Anxiety Scale • Social Phobia Scale • 60%
17	Hart et al. (2019); Canada.	Test the psychometric properties of the Gender Nonconformity Teasing Scale.	$N = 298$ equivalent numbers of HIV-positive and HIV-negative sexual minority men recruited through community venues, advertisements in print media, and from another research study; age interquartile range: 38.5-50 ($Mdn = 44$); gay ($n = 271$), bisexual ($n = 27$); 75.0% White.	<ul style="list-style-type: none"> • Social Interaction Anxiety Scale • Liebowitz Social Anxiety Scale • 80%
18	Hart et al. (2015); Canada.	Examine the psychometric properties of a measure of anxiety about being evaluated for one's overall appearance (i.e., Social Appearance Anxiety Scale) in a racially diverse sample of sexual minority men of colour.	$N = 389$ sexual minority men of colour recruited through sexual health services, community, health and social service agencies, hospital listservs, social media advertisements, and posters and flyers at bath houses, bars and clubs frequented by sexual minority men; age = 19-59	<ul style="list-style-type: none"> • Social Appearance Anxiety Scale (Hart, Flora, et al., 2008) • 83%

Appendix B.1

Characteristics of Included Studies

Study ID	Author(s); Location	Aim(s)	Recruitment and Sample Characteristics	Social Anxiety Measure(s); CCAT Score
19	Hart et al. (2014); Canada.	Present a pilot of an integrated treatment designed for gay and bisexual men who report both social anxiety and risky sexual behaviour that addresses both problems concurrently.	(33±8.56); gay ($n = 317$), bisexual ($n = 60$, missing ($n = 12$); 0% White. $N = 3$ gay men recruited through gay venues and a gay newspaper; age: 26-40 (33.67±7.09); 33.3% White.	<ul style="list-style-type: none"> • The Mini-International Neuropsychiatric Interview • Anxiety Disorders Interview Schedule-IV-Lifetime (Brown et al., 1994)- Social Phobia Section • Liebowitz Social Anxiety Scale • 73%
20	Jacobson et al. (2016); Israel.	Examine the independent and interactive effects of gender atypicality and sexual orientation on levels of state anxiety immediately following a stressful social interaction task.	$N = 36$ men recruited through advertisements in universities, an LGBT association, and social media sites; age _{gay} : 26.83±3.63, age _{heterosexual} : 24.72±1.40; gay ($n = 18$), heterosexual ($n = 18$).	<ul style="list-style-type: none"> • Liebowitz Social Anxiety Scale • 60%
21	Kerridge et al. (2017); Rodriguez-Seijas et al. (2019); USA.	Present current nationally representative data on the prevalence, sociodemographic correlates and risk of DSM-5 substance use disorders and other psychiatric disorders among sexual minorities relative to heterosexuals, and among sexual minorities by gender. Explore how possessing both racial/ethnic <i>and</i> sexual minority statuses is related to the prevalence of common psychiatric and substance use disorders.	$N = 36,309$ adults recruited as part of a longitudinal population-based survey; age: 18-29 ($n = 8,126$), 30-44 ($n = 10,135$), 45-64 ($n = 12,242$), ≥65 ($n = 5,806$); lesbian women ($n = 265$), bisexual women ($n = 422$), questioning/not sure women ($n = 130$), heterosexual women ($n = 19,454$), gay men ($n = 321$), bisexual men ($n = 144$), questioning/not sure men ($n = 69$), heterosexual men ($n = 15,190$); 66.1% White.	<ul style="list-style-type: none"> • Alcohol Use Disorder and Associated Disabilities Interview Schedule-V (Grant et al., 2011) • 83%; 88%

Appendix B.1

Characteristics of Included Studies

Study ID	Author(s); Location	Aim(s)	Recruitment and Sample Characteristics	Social Anxiety Measure(s); CCAT Score
22	Kurdek (1996); USA.	Examine factors related to the deterioration of relationship quality in lesbian and gay couples over a period of five years.	$N = 212$, 106 gay/lesbian couples recruited through gay/lesbian periodicals, newsletters, and personal contacts; mean age at year 1 _{lesbian women} : 40.17, mean age at year 1 _{gay men} : 41.68; lesbian women ($n = 92$), gay men ($n = 120$); 93% White.	<ul style="list-style-type: none"> • Social anxiety subscale of the Self-Consciousness Scale (Fenigstein et al., 1975) • 60%
23	Lingiardi et al. (2012); Italy.	Propose a new measure of internalised sexual stigma for lesbians and gay men that assesses three dimensions of internalised homonegativity: identity, social discomfort, and sexuality.	$N = 366$ sexual minority adults recruited through internet advertisements and LGBT associations; age: 25.83 ± 5.50 ; lesbian women ($n = 186$), gay men ($n = 180$).	<ul style="list-style-type: none"> • The Social Phobia Inventory (Connor et al., 2000) • 68%
24	Mason & Lewis (2016); USA and Puerto Rico.	Examine social anxiety and body shame as sequential mediators of the association between minority stress and binge eating among young adult lesbian women.	$N = 496$ lesbian women recruited through Facebook advertising, LGBT websites, and organisations; age: 18-30 (21.92 ± 2.85); 77.2% White.	<ul style="list-style-type: none"> • The State Social Anxiety Questionnaire (Kashdan & Steger, 2006) • 90%
24a	Mason et al. (2017); Mason & Lewis (2019); USA.	Develop a model in which discrimination and disordered eating were connected via mediators of social support, affect (i.e., general negative affect and social anxiety), and weight discrepancy. Examine behavioural and health related patterns among lesbian women and elucidate how these patterns are associated with general discrimination, sexual minority stress, affect, and social support.	$N = 436$ lesbian women recruited through Facebook advertising, LGBT websites, and organisations; age: 18-30 (21.97 ± 2.88); 77.3% White.	<ul style="list-style-type: none"> • The State Social Anxiety Questionnaire • 83%; 73%

Appendix B.1

Characteristics of Included Studies

Study ID	Author(s); Location	Aim(s)	Recruitment and Sample Characteristics	Social Anxiety Measure(s); CCAT Score
25	Meidlinger & Hope (2014); USA.	Describe the development and initial validation of a new outness scale. Explore the associations of the subscales of a new outness scale to minority stress constructs and psychological outcomes.	$N = 149$ sexual minority individuals recruited through LGB-affiliated listservs; age: 19-66 (28.93 ± 11.07); cisgender women ($n = 73$), transgender women ($n = 1$), cisgender men ($n = 73$), transgender men ($n = 2$); lesbian women ($n = 44$), mostly lesbian women ($n = 12$), bisexual women ($n = 18$), gay men ($n = 58$), mostly gay men ($n = 11$), bisexual men ($n = 6$); 87.2% White.	<ul style="list-style-type: none"> • Brief Fear of Negative Evaluation Scale • 75%
26	Meyer, Dietrich, et al. (2008); USA.	Assess the prevalence of psychiatric disorders in ethnically diverse gay, lesbian, and bisexual individuals.	$N = 388$ sexual minority adults recruited by direction solicitation by outreach workers in diverse venues and snowball referrals; age: 18-29 ($n = 172$), 30-44 ($n = 171$), 45-59 ($n = 45$); women ($n = 195$), men ($n = 193$); lesbian/gay ($n = 318$), bisexual ($n = 70$); 34.0% White.	<ul style="list-style-type: none"> • Composite International Diagnostic Instrument DSM-IV Version • 60%
27	Mimiaga et al. (2009); Reisner et al. (2009); USA.	Assess the psychosocial and behavioural predictors of partner notification use after exposure to HIV/STIs among MSM. Assess the presence of post-traumatic stress disorder symptoms in response to stressful or traumatic life events and their impact on HIV risk behaviours and associated psychosocial variables among MSM.	$N = 189$ MSM (57% HIV-positive) recruited through a sexual health clinic and respondent-driven sampling; age: 19-66 (41.48 ± 8.47); 34.0% White.	<ul style="list-style-type: none"> • The Social Phobia Inventory • 68%; 65%
28	O'Cleirigh et al. (2015); O'Cleirigh et	Identify the prevalence of psychiatric symptoms and substance abuse in HIV-positive MSM and to estimate the proportion of those who had been	$N = 503$ HIV-positive MSM recruited through a community healthcare centre; age: 41.9 ± 8.3 ; 75.1% White.	<ul style="list-style-type: none"> • The Mini-Social Phobia Inventory (Connor et al., 2001) • 63%; 78%

Appendix B.1

Characteristics of Included Studies

Study ID	Author(s); Location	Aim(s)	Recruitment and Sample Characteristics	Social Anxiety Measure(s); CCAT Score
	al. (2013); USA.	diagnosed within their primary medical care setting. Evaluate whether specific anxiety disorders increased the likelihood of sexual transmission risk behaviour in younger versus older HIV-positive MSM.		
29	Pachankis & Goldfried (2006); USA.	Examine the occurrence and correlates of social anxiety symptomatology in gay and heterosexual men.	$N = 174$ undergraduate men recruited from undergraduate psychology class and LGB university organisations; age _{gay} : 18-24 (20.4±1.3), age _{heterosexual} : 18-24 (20.1±1.7); gay ($n = 87$), heterosexual ($n = 87$); 73.6% White.	<ul style="list-style-type: none"> • Social Interaction Anxiety Scale • Social Phobia Scale • Fear of Negative Evaluation Scale (Watson & Friend, 1969) • Inventory of Anxiousness (Endler et al., 1962) modified version • 78%
30	Pachankis et al. (2008); USA.	Extend the rejection sensitivity construct to the mental health concerns of gay men through developing the Gay-Related Rejection Sensitivity Scale.	$N = 149$ sexual minority men recruited from a primarily gay public park in New York City; age: 35.46±10.15; gay ($n = 140$), bisexual but mostly gay ($n = 7$), queer ($n = 2$); 77.9% White.	<ul style="list-style-type: none"> • Brief Fear of Negative Evaluation Scale • 80%
31	Pachankis, Sullivan, Feinstein, & Newcomb, (2018); USA.	Investigate longitudinal trajectories of stigma (i.e., enacted, anticipated, internalised, and concealed); stress-sensitive mental health disorder symptoms (i.e., depression and social anxiety); and their associations across	$N = 128$ sexual minority men university students recruited from large public and private universities; age at T1: 18-27 (20.72±2.08); gay ($n = 104$), bisexual but mostly gay ($n = 17$), bisexual ($n = 1$), queer ($n = 6$); 71.9% White.	<ul style="list-style-type: none"> • The Social Interaction Anxiety Scale • 83%

Appendix B.1

Characteristics of Included Studies

Study ID	Author(s); Location	Aim(s)	Recruitment and Sample Characteristics	Social Anxiety Measure(s); CCAT Score
31a	Pachankis, Sullivan, & Moore (2018); USA.	Utilise a longitudinal design across 7 years of sexual minority men's young adulthood to examine prospective associations among parental reactions to their sexual minority son's sexual orientation, unfinished business, and mental health.	<i>N</i> = 113 sexual minority men university students recruited from large public and private universities; age at T1: 18-27 (20.78±2.08); gay (<i>n</i> = 92), bisexual but mostly gay (<i>n</i> = 15), bisexual (<i>n</i> = 1), queer (<i>n</i> = 5); 70.8% White.	<ul style="list-style-type: none"> • The Social Interaction Anxiety Scale • 80%
32	Potoczniak et al. (2007); USA.	Examine a model in which the relationship between social anxiety and two dimensions of ego identity (commitment and exploration) was expected to be mediated by social support and self-concealment.	<i>N</i> = 347 sexual minority individuals recruited through advertisements on various listservs, discussion groups and Internet-based newsgroups; age: 18-74 (29.92±10.87); lesbian women (<i>n</i> = 98), bisexual women (<i>n</i> = 51), gay men (<i>n</i> = 160), bisexual men (<i>n</i> = 38); 92.0% White.	<ul style="list-style-type: none"> • Social anxiety subscale of the Self Consciousness Scale Revised (Scheier & Carver, 1985) • 85%
33	Puckett et al. (2015); USA.	Examine the role of self-criticism and lack of connectedness with other sexual minorities in explaining the relation between internalised homonegativity and psychological distress.	<i>N</i> = 436 sexual minority adults recruited online via emailed advertisements to LGB groups and community organisations; mean age: 39.00; women (<i>n</i> = 260), transgender women (<i>n</i> = 8), men (<i>n</i> = 136), transgender men (<i>n</i> = 6), genderqueer (<i>n</i> = 21), other (<i>n</i> = 5); gay/lesbian (<i>n</i> = 274), bisexual (<i>n</i> = 76), queer (<i>n</i> = 51), questioning (<i>n</i> = 14), other (<i>n</i> = 21); 80.0% White.	<ul style="list-style-type: none"> • The Social Interaction Anxiety Scale – 6 (Peters et al., 2012) • 78%
33a	Puckett et al. (2016); USA.	Examine the role of gender expression in relation to minority stressors and mental	<i>N</i> = 383 sexual minority adults recruited online via emailed advertisements to LGB	<ul style="list-style-type: none"> • Social Interaction Anxiety Scale -6

Appendix B.1

Characteristics of Included Studies

Study ID	Author(s); Location	Aim(s)	Recruitment and Sample Characteristics	Social Anxiety Measure(s); CCAT Score
		health in cisgender sexual minority individuals.	groups and community organisations; age: 18-80 (39.3±13.4); cisgender women ($n = 251$), cisgender men ($n = 132$); gay/lesbian ($n = 261$), bisexual ($n = 64$), queer ($n = 30$), questioning ($n = 14$), other ($n = 14$); 79.6% White.	<ul style="list-style-type: none"> • 70%
34	Reilly & Rudd (2007); USA.	Explore the relationship between social anxiety and appearance management behaviours, including both routine and non-routine, among gay and straight men.	$N = 67$ men recruited through a project website; age: 19-78 (34.00); gay ($n = 34$), heterosexual ($n = 33$); participants mostly White (% not included).	<ul style="list-style-type: none"> • Liebowitz Social Anxiety Scale • 43%
35	Reisner et al. (2011); USA.	Examine the initial efficacy of “40 & Forward,” a manualised group intervention developed to reduce HIV sexual risk for gay and bisexual men age 40 and older who self-report problems with depression, isolation /loneliness, and social anxiety.	$N = 84$ sexual minority men recruited through word-of-mouth, community events, discussion lists and community based organisations; age: 40-79 (51.21±7.43); 85% White.	<ul style="list-style-type: none"> • Social Interaction Anxiety Scale • Brief Fear of Negative Evaluation Scale • 83%
36	Rubio & Green (2009); Philippines.	Examine potential differences between self-identified Filipino gay and heterosexual men in their endorsement of expectations of masculinity in the Philippines, their conformity behaviour relevant to these expectations, their experiences of gender role conflict, and their general mental health.	$N = 810$ male undergraduate students recruited on campus through flyer distribution; age: 18-30 (20.0±1.53); gay ($n = 43$), heterosexual ($n = 767$); 0% White.	<ul style="list-style-type: none"> • Social Avoidance and Distress Scale (Watson & Friend, 1969) • 68%
37	Sandfort et al. (2001); The Netherlands.	Examine differences between heterosexually and homosexually active subjects in 12-month and lifetime	$N = 5,998$ individuals recruited as part of population based study; age: 18-64 ($M_{WSW} = 38.6$; $M_{WSMonly} = 40.0$; $M_{MSM} = 39.2$; $M_{MSWonly}$	<ul style="list-style-type: none"> • Composite International Diagnostic Instrument DSM-III-R version

Appendix B.1

Characteristics of Included Studies

Study ID	Author(s); Location	Aim(s)	Recruitment and Sample Characteristics	Social Anxiety Measure(s); CCAT Score
		prevalence of DSM-III-R mood, anxiety, and substance use disorders.	= 40.0); WSW ($n = 43$), WSM only ($n = 3,077$), MSM ($n = 82$), MSW only ($n = 2,796$).	<ul style="list-style-type: none"> • 85%
38	Sandfort et al. (2014); The Netherlands.	Compare whether sexual orientation related disparities in the prevalence of psychiatric disorders are similar based on homosexual behaviour versus attraction and test whether, with increased acceptance of homosexuality, these disparities have diminished over time.	$N = 5,328$ individuals recruited as part of population based study; age: 18-64 ($M_{WSW} = 38.8$; $M_{WSMonly} = 40.9$; $M_{MSM} = 41.5$; $M_{MSWonly} = 42.0$); WSW ($n = 57$), WSM only ($n = 2,832$), MSM ($n = 60$), MSW only ($n = 2,379$).	<ul style="list-style-type: none"> • Composite International Diagnostic Instrument DSM-IV Version (Kessler & Üstün, 2004) • 75%
39	Schmitt & Kurdek (1984); USA.	Examine the relationship between social anxiety and measures of trait anxiety, self-concept, locus of control, repression-sensitization, and depression.	$N = 154$ heterosexual undergraduate students recruited through an introductory psychology course, and gay/lesbian individuals recruited through a social network system; age _{gay/lesbian} : 33.00 ± 9.30 , age _{heterosexual} : 19.92 ± 3.39 ; lesbian women ($n = 11$), heterosexual women ($n = 53$), gay men ($n = 51$), heterosexual men ($n = 39$).	<ul style="list-style-type: none"> • Social anxiety subscale of the Self-Consciousness Scale. • 40%
39a	Schmitt & Kurdek (1987); USA.	Examine the personality correlates of a positive gay identity (communicating one's sexual preference to others and being comfortable being gay) and involvement in a relationship.	$N = 51$ gay men recruited through a social network system; age: 32.78 ± 9.31 (used non-gay standardisation samples from other studies for comparison).	<ul style="list-style-type: none"> • Social anxiety subscale of the Self-Consciousness Scale • 48%
40	Schope (2004); USA.	Investigate the closet processes, locus of control, fear of negative evaluation, and discrimination in gay men.	$N = 443$ gay men recruited through gay community organisations, coming out	<ul style="list-style-type: none"> • Brief Fear of Negative Evaluation Scale • 43%

Appendix B.1

Characteristics of Included Studies

Study ID	Author(s); Location	Aim(s)	Recruitment and Sample Characteristics	Social Anxiety Measure(s); CCAT Score
41	Schope (2005); USA.	Examine how gay men and lesbian women perceive the aging process.	groups and gay religious organisations; age: 40.00±11.60; 91.0% White. N = 183 sexual minority adults recruited through university organisations and at a Gay Pride parade; mean age: 37.68; lesbian women (n = 109), gay men (n = 74); 94.0% White.	<ul style="list-style-type: none"> • Altered version of Brief Fear of Negative Evaluation Scale designed to assess fear of negative evaluation from same-gender sexual minority individuals. • 40%
42	Shoptaw et al., (2003); USA.	Examine the prevalence of specific psychiatric comorbidity, lifetime sexually transmitted infections, and self-reported high-risk sexual behaviours at admission to treatment for methamphetamine dependent gay and bisexual men.	N = 162 methamphetamine dependent MSM (majority HIV-positive) recruited from gay-specific sex and drug-related venues; age: 18-65 (36.00±6.00); 80.0% White.	<ul style="list-style-type: none"> • The Structured Clinical Inventory for DSM-IV (Spitzer et al., 1995) • 60%
43	Shulman & Hope (2016); USA.	Identify items in the Social Phobia and Anxiety Inventory that would be appropriate in assessing social anxiety for everyone, regardless of sexual orientation or gender identity.	N = 280 adults recruited through the Amazon Mechanical Turk system; age: 36.41±12.80; cisgender women (n = 183), cisgender men (n = 87), transgender (n = 4), gender queer/gender fluid (n = 4), agender (n = 1); gay/lesbian (n = 35), bisexual (n = 42), other (n = 11), heterosexual (n = 189); 70.4% White.	<ul style="list-style-type: none"> • The Social Phobia and Anxiety Inventory (Turner et al., 1989) • 68%
44	Wadsworth & Hayes-Skelton (2015); USA.	Investigate levels of social anxiety in participants who identify as lesbian/gay, bisexual, and heterosexual, as well as	N = 180 adults recruited via a flier emailed and posted on campus in a northeastern university; age = 18-66 (27.53±10.4);	<ul style="list-style-type: none"> • Liebowitz Social Anxiety Scale • 65%

Appendix B.1

Characteristics of Included Studies

Study ID	Author(s); Location	Aim(s)	Recruitment and Sample Characteristics	Social Anxiety Measure(s); CCAT Score
		those who endorse the write-in response option.	women ($n = 108$), men ($n = 60$), non-binary ($n = 12$); gay/lesbian ($n = 43$), bisexual ($n = 55$), queer ($n = 5$), questioning ($n = 5$), unspecified ($n = 8$), pansexual ($n = 2$), additional identities ($n = 8$), heterosexual ($n = 54$); 71.5% White.	
45	Walsh & Hope (2010); USA.	Exemplify a specific application of evidence-based principles (shifting to sexual identity issues) to cognitive and behavioural treatment for social anxiety.	$N = 1$ 23-year-old White gay man recruited from a university training clinic for problems with anxiety.	<ul style="list-style-type: none"> • Brief Fear of Negative Evaluation Scale • 75%
46	J. Wang et al. (2007); Switzerland.	Present a psychiatric epidemiological profile for five mood, anxiety, and alcohol/drug use disorders among a community sample of gay men.	$N = 571$ gay men and other MSM recruited through gay organisations, venues and chatrooms; age: ≤ 24 ($n = 96$), 25-34 ($n = 173$), 35-44 ($n = 194$), 45-54 ($n = 67$), ≥ 55 ($n = 28$).	<ul style="list-style-type: none"> • Composite International Diagnostic Instrument DSM-IV Version • 80%

Note. This table details the characteristics of the 46 included studies ($k = 46$) and papers ($k = 61$). Papers related to the same study that also use identical samples are presented on one row and are allocated one Study ID (e.g., Burns et al., 2012a, 2012b). Papers related to the same study that use different samples (i.e., one uses a subset of a larger sample detailed in another) are presented on unique rows; in these cases, the paper(s) detailing the largest sample are allocated a Study ID consisting of solely a number, whilst the other paper(s) are allocated a study ID consisting of a number and a letter (e.g., Puckett et al., 2015, 2016); CCAT = Crowe Critical Appraisal Tool; LGBT = Lesbian, gay, bisexual, and transgender; LGB = Lesbian, gay, and bisexual; MSM = men who have sex with men; MSW = men who have sex with women; WSW = women who have sex with women; WSM = women who have sex with men.

Appendix B.2

Bivariate Correlations Involving Social Anxiety

Theme	Sub-theme	Variable	Study	<i>r</i>		
Sexual minority stress processes	Heterosexist discrimination	Current heterosexist discrimination	Burns et al. (2012a, 2012b)	.22**		
			Dyar et al. (2016)	.02		
			Feinstein et al. (2012)	.23***		
			Mason et al. (2017)	.13**		
			Pachankis, Sullivan, Feinstein, & Newcomb (2018) (cross-wave)	.10		
		Antigay bullying during youth	Puckett et al. (2016)	.01		
			Hart et al. (2019) – LSAS	.01		
			Hart et al. (2019) – SIAS	.19***		
			Attributions for heterosexist discrimination	Other blame attributions	Burns et al. (2012a, 2012b)	-.07
				Self-blame attributions	Burns et al. (2012a, 2012b)	.26**
	Importance attributions	Burns et al. (2012a, 2012b)		.21**		
	Global attributions	Burns et al. (2012a, 2012b)		.29**		
	Controllability attributions	Burns et al. (2012b)		-.03		
	Internalised homonegativity	Internalised homonegativity	Burns et al. (2012a, 2012b)	.37**		
			Dyar et al. (2016)	.15**		
			Feinstein et al. (2012)	.24***		
			Hart et al. (2019) - LSAS	.55***		
			Hart et al. (2019) - SIAS	.59***		
			Hart et al. (2015)	.19**		
			Lingiardi et al. (2012) – lesbian women	.37**		
Lingiardi et al. (2012) – gay men			.47**			
Mason & Lewis (2016)			.29**			
Meidlinger & Hope (2014)			.30**			
Pachankis, Sullivan, Feinstein, & Newcomb, (2018) (cross-wave)	.17					
Puckett et al. (2015)	.22**					

Appendix B.2

Bivariate Correlations Involving Social Anxiety

Theme	Sub-theme	Variable	Study	<i>r</i>
	Sexual identity concealment	Concealment behaviour	Dyar et al. (2016)	.15**
			Meidlinger & Hope (2014) – OI	.36**
			Meidlinger & Hope (2014) – NOS-C	.45**
			Schmitt & Kurdek (1987)	.09
		Lack of openness	Mason et al. (2017)	.23**
			Meidlinger & Hope (2014)	.33**
			Pachankis & Goldfried (2006) – SIAS	.24*
			Pachankis & Goldfried (2006) – SPS	.23*
			Pachankis & Goldfried (2006) – FNE	.23*
			Pachankis & Goldfried (2006) – IA	.28*
			Pachankis, Sullivan, Feinstein, & Newcomb, (2018) (cross-wave)	.30***
			Puckett et al. (2016)	.26**
		Lack of public knowledge	Meidlinger & Hope (2014)	.34**
		Concealment motivation	Dyar et al. (2016)	.22**
			Mason & Lewis (2016)	.28**
	Sexual orientation related rejection sensitivity	Sexual orientation related rejection sensitivity	Cohen, Feinstein, et al. (2016)	.40***
			Dyar et al. (2016) – SMWRSS	.39**
			Dyar et al. (2016) – Adapted G-RRSS	.23**
			Feinstein et al. (2012)	.28***
			Meidlinger & Hope (2014)	.36**
			Pachankis et al. (2008)	.39**
			Pachankis, Sullivan, Feinstein, & Newcomb, (2018) (cross-wave)	.23**
			Puckett et al. (2016)	.23**

Appendix B.2

Bivariate Correlations Involving Social Anxiety

Theme	Sub-theme	Variable	Study	<i>r</i>
	Sexual identity development	Years since coming out	Akibar et al. (2019)	.05
		Increased contact with LGB peers but reluctance to disclose to heterosexuals	Burns et al. (2012b)	.32**
		Acceptance concerns	Dyar et al. (2016)	.54**
			Mason & Lewis (2016)	.43**
		Difficulty processing sexual identity	Dyar et al. (2016)	.31**
			Mason & Lewis (2016)	.27**
		Comfort being gay	Pachankis & Goldfried (2006) – SIAS	-.28*
			Pachankis & Goldfried (2006) – SPS	-.24*
			Pachankis & Goldfried (2006) – FNE	-.25*
			Pachankis & Goldfried (2006) – IA	-.11
			Schmitt & Kurdek (1987)	-.28*
		Full integration into gay and straight culture	Burns et al. (2012b)	-.34**
		Salience of sexual orientation	Dyar et al. (2016)	.26**
		Centrality of sexual orientation	Dyar et al. (2016)	.18**
General psychological processes (Social)	Social support	Social support satisfaction	Burns et al. (2012a)	-.32**
			Hart & Heimberg (2005) - SIAS	-.41**
			Hart & Heimberg (2005) - SPS	.27**
			Meidlinger & Hope (2014)	-.22**
		Perceived social support (general)	Hart et al. (2015)	-.31**
			Potoczniak et al. (2007)	-.27**
		Perceived social support (family)	Mason et al. (2017)	-.30**
		Perceived social support (friends)	Mason et al. (2017)	-.30**
		Loneliness	Hart et al. (2019) - LSAS	.17**
			Hart et al. (2019) - SIAS	.23***
	Romantic relationships	Dissolution of relationship	Kurdek (1996)	.11

Appendix B.2

Bivariate Correlations Involving Social Anxiety

Theme	Sub-theme	Variable	Study	<i>r</i>
		Lack of relationship	Schmitt & Kurdek (1987)	.18
		Duration of relationship	Schmitt & Kurdek (1987)	-.15
		Not living with partner	Schmitt & Kurdek (1987)	.08
		Change in relationship positivity	Kurdek (1996)	-.07
		Change in relationship autonomy	Kurdek (1996)	-.09
	Parental relationships	Maternal unfinished business	Pachankis, Sullivan, & Moore (2018) (cross-wave)	.26**
		Paternal unfinished business	Pachankis, Sullivan, & Moore (2018) (cross-wave)	.20*
		Maternal rejection	Pachankis, Sullivan, & Moore (2018) (cross-wave)	-.10
		Paternal rejection	Pachankis, Sullivan, & Moore (2018) (cross-wave)	-.11
General psychological processes (Cognitive)	General cognitive processes	Self-criticism	Puckett et al. (2015)	.41**
		Personal rejection sensitivity	Dyar et al. (2016)	.29**
		Positive self-concept	Schmitt & Kurdek (1984)	-.45**
		Internal locus of control	Schmitt & Kurdek (1984)	-.31**
		Dealing with threat through intellectualisation, obsession and ruminative worry	Schmitt & Kurdek (1984)	.48**
Internalising mental health symptoms	Generalised anxiety	Trait anxiety	Burns et al. (2012a)	.59**
			Hart et al. (2019) - LSAS	.47***
			Hart et al. (2019) - SIAS	.58***
			Schmitt & Kurdek (1984)	.48**
		Generalised anxiety disorder symptoms	Cohen, Feinstein, et al. (2016)	.61***
			Dyar et al. (2016)	.45**
			Hart et al. (2019) - LSAS	.41***
			Hart et al. (2019) - SIAS	.39***
			Hart et al. (2015)	.42**
	Depression	Depressive symptoms (general)	Blashill (2010); Blashill & Vander Wal (2009)	.56**

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Bivariate Correlations Involving Social Anxiety

Theme	Sub-theme	Variable	Study	<i>r</i>
			Burns et al. (2012a)	.34**
			Cohen, Feinstein et al. (2016)	.52***
			Dyar et al. (2016)	.37**
			Feinstein et al. (2012)	.38***
			Hart et al. (2019) – LSAS x CES-D	.47***
			Hart et al. (2019) – LSAS x HAM-D	.36***
			Hart et al. (2019) – SIAS x HAM-D	.37***
			Hart et al. (2019) – SIAS x CES-D	.55***
			Hart et al. (2015)	.31**
			Pachankis, Sullivan, Feinstein, & Newcomb, (2018) (cross-wave)	.42***
			Puckett et al. (2015)	.49**
			Schmitt & Kurdek (1984)	.14
		Depressive symptoms (cognitions)	Burns et al. (2012a)	.49**
		Major depressive episode	Fletcher et al. (2018)	.67***
	Eating disorders	Eating disorder symptoms (cognitive, emotional, and behavioural)	Blashill (2010); Blashill & Vander Wal (2009)	.48**
			Hart et al. (2015)	.32**
			Mason et al. (2017)	.37**
		Binge eating	Mason & Lewis (2016)	.36**
		Loss of control	Mason et al. (2017)	.26**
		Overeating	Mason et al. (2017)	.14**
	Internalising mental health (general)	Negative affect	Meidlinger & Hope (2014)	.62**
			Mason et al. (2017)	.60**
		Positive affect	Burns et al. (2012a)	-.51**
			Meidlinger & Hope (2014)	-.35**
		Psychological distress	Puckett et al. (2015)	.56**
		Suicide risk	Fletcher et al. (2018)	.50***

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Bivariate Correlations Involving Social Anxiety

Theme	Sub-theme	Variable	Study	<i>r</i>	
340		Self-esteem	Pachankis & Goldfried (2006) – SIAS	-.33**	
			Pachankis & Goldfried (2006) – SPS	-.41***	
			Pachankis & Goldfried (2006) – FNE	-.58***	
			Pachankis & Goldfried (2006) – IA	-.44***	
	Externalising mental health symptoms	Other anxiety disorder symptoms	Panic disorder symptoms	Cohen, Feinstein, et al. (2016)	.39**
		Trauma-and stressor-related symptoms	Posttraumatic stress disorder symptoms	Cohen, Feinstein, et al. (2016)	.57**
		Obsessive-compulsive disorder	Obsessive-compulsive disorder	Fletcher et al. (2018)	.59***
	Externalising mental health symptoms	Externalising mental health symptoms	Antisocial personality disorder	Fletcher et al. (2018)	.36***
			Alcohol abuse	Pachankis, Sullivan, & Moore (2018) (cross-wave)	.17
	Body image and related variables	Body image	Body dissatisfaction	Blashill (2010); Blashill & Vander Wal (2009)	.51**
				Hart et al. (2015)	.56**
				Mason & Lewis (2016)	.49**
				Hart et al. (2015)	.32**
	Gender roles	Body weight calculations	Ideal weight discrepancy	Mason et al. (2017)	.12*
Body mass index			Mason & Lewis (2016)	.05	
Gender nonconformity		Childhood gender nonconformity	Feinstein et al. (2012)	.10*	
			Pachankis & Goldfried (2006) – SIAS	-.02	
		Current gender nonconformity	Pachankis & Goldfried (2006) – SPS	.11	
			Pachankis & Goldfried (2006) – FNE	.09	
Masculinity nonconformity	Masculinity nonconformity	Pachankis & Goldfried (2006) – IA	.35***		
		Puckett et al. (2016)	.13**		
			Rubio & Green (2009)	.42***	

Appendix B.2

Bivariate Correlations Involving Social Anxiety

Theme	Sub-theme	Variable	Study	<i>r</i>	
		Belief men should not uphold traditional masculinity	Rubio & Green (2009)	.30	
		Teasing related to childhood gender nonconformity	Hart et al. (2019) – LSAS Hart et al. (2019) – SIAS	.25*** .36***	
	Gender role conflict	Restrictive emotionality	Blashill (2010); Blashill & Vander Wal (2009)	.42**	
		Restrictive affection	Blashill (2010); Blashill & Vander Wal (2009)	.46**	
		Work concern	Blashill (2010); Blashill & Vander Wal (2009)	.20**	
		Success concern	Blashill (2010); Blashill & Vander Wal (2009)	.32**	
	Gender rejection sensitivity	Gender rejection sensitivity	Dyar et al. (2016)	.33**	
341	Sexual practices	Condomless anal sex	Any condomless anal sex	Hart & Heimberg (2005) - SPS Hart & Heimberg (2005) - SIAS	.22* -.02
		Condomless insertive anal sex	Hart & Heimberg (2005) - SPS Hart & Heimberg (2005) - SIAS	.21* .05	
		Condomless receptive anal sex	Hart & Heimberg (2005) - SPS Hart & Heimberg (2005) - SIAS	.20 .01	
		Any anal sex (with or without a condom)	Hart & Heimberg (2005) - SPS Hart & Heimberg (2005) - SIAS	.07 -.13	
	Other sexual practices	Sexual objectification	Hart et al. (2015)	.17**	
		Pornography consumption	Hart et al. (2015)	.06	
	Sociodemographics	Age	Age	Blashill & Vander Wal (2009) Burns et al. (2012a) Mason et al. (2017) Schope (2005) – lesbian women Schope (2005) – gay men Schmitt & Kurdek (1984)	-.35*** -.21** -.15** -.25** -.21* -.30**

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Bivariate Correlations Involving Social Anxiety

Theme	Sub-theme	Variable	Study	<i>r</i>
	Education	Education	Burns et al. (2012a)	-.27**
			Mason et al. (2017)	-.10*
Other discrimination	Current experiences of discrimination	Everyday discrimination	Mason & Lewis (2016)	.39**
		Experiences of racism	Hart et al. (2015)	.36**
		Heterosexist and ethnic discrimination combined	Cathey et al. (2014) – white	.35**
			Cathey et al. (2014) – ethnic minority	.17**
		Weight discrimination	Mason et al. (2017)	.23**
	Childhood discrimination	Experiences of childhood teasing	Hart et al. (2019)- LSAS	.33***
		Experiences of childhood teasing	Hart et al. (2019)- SIAS	.46***
Other variables	Quality of life	Quality of life	Meidlinger & Hope (2014)	-.39**
	Ego identity dimensions	Ego identity commitment	Potoczniak et al. (2007)	-.16**
		Ego identity exploration	Potoczniak et al. (2007)	.06
	Self-concealment	Self-concealment (not specific to sexual orientation)	Potoczniak et al. (2007)	.36**
	Personality	Neuroticism	Kurdek (1996)	.47**
	Community resilience	LGBTQ Community Connectedness	Puckett et al. (2015)	-.26**

Note. Additional information related to scales used is provided for studies that reported more than one correlation pertaining to the same relationship. LSAS = Liebowitz Social Anxiety Scale; SIAS = Social Interaction Anxiety Scale; OI = Outness Inventory (Mohr & Fassinger, 2000); NOS-C = Nebraska Outness Scale Concealment subscale (Meidlinger & Hope, 2014); SPS = Social Phobia Scale; FNE = Fear of Negative Evaluation Scale; IA = Inventory of Anxiousness; SMWSS = Sexual Minority Women's Rejection Sensitivity Scale (Dyar et al., 2016); G-RRSS = Gay-Related Rejection Sensitivity Scale (Pachankis et al., 2008); CES-D =

Appendix B.2

Bivariate Correlations Involving Social Anxiety

Theme	Sub-theme	Variable	Study	<i>r</i>
Center for Epidemiologic Studies–Depression Scale (Radloff, 1977); HAM-D = Hamilton Depression Rating Scale (Hamilton, 1960, 1969). * <i>p</i> < .05. ** <i>p</i> < .01. *** <i>p</i> < .001.				

Appendix C.1: Project Facebook Page

The screenshot shows the Facebook page for the 'Anxiety in Sexual Minorities Study'. The page header includes navigation options like 'Page', 'Inbox', 'Notifications', 'Insights', 'Publishing Tools', 'Promotions', 'Settings', and 'Help'. The main content area features a large circular graphic with the text 'ANXIETY IN SEXUAL MINORITIES STUDY' in the center, surrounded by a rainbow-colored border. To the left of this graphic is the DCU logo, and to the right is the '#LoveIrish Research' logo, which includes a heart, a map of Ireland, and a magnifying glass. Below the main graphic is a post creation area with options for 'Write a post...', 'Photo Album', and 'Live Video'. A community information box for 'Community in Dublin, Ireland' is visible on the right, showing a 5.0 star rating and 'Always Open' status. The page also includes a navigation menu on the left with options like 'Home', 'Events', 'Reviews', 'About', and 'Jobs'.

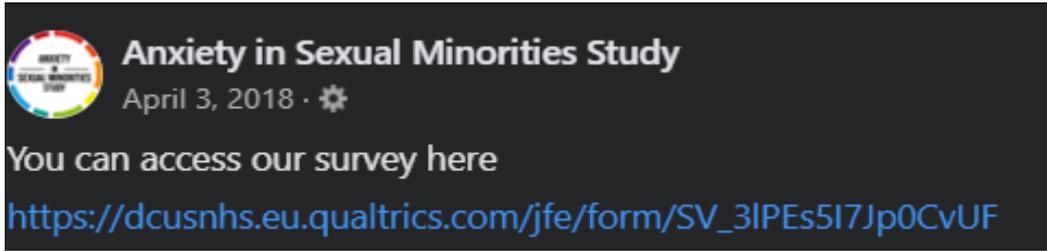
Our Research

 ANXIETY IN SEXUAL MINORITIES STUDY · TUESDAY, APRIL 3, 2018

Previous studies have shown that sexual minority individuals experience social anxiety at higher levels than the general population. The aim of the *Anxiety in Sexual Minorities Study* is to build on existing research and uncover potential variables that are contributing to this phenomenon.

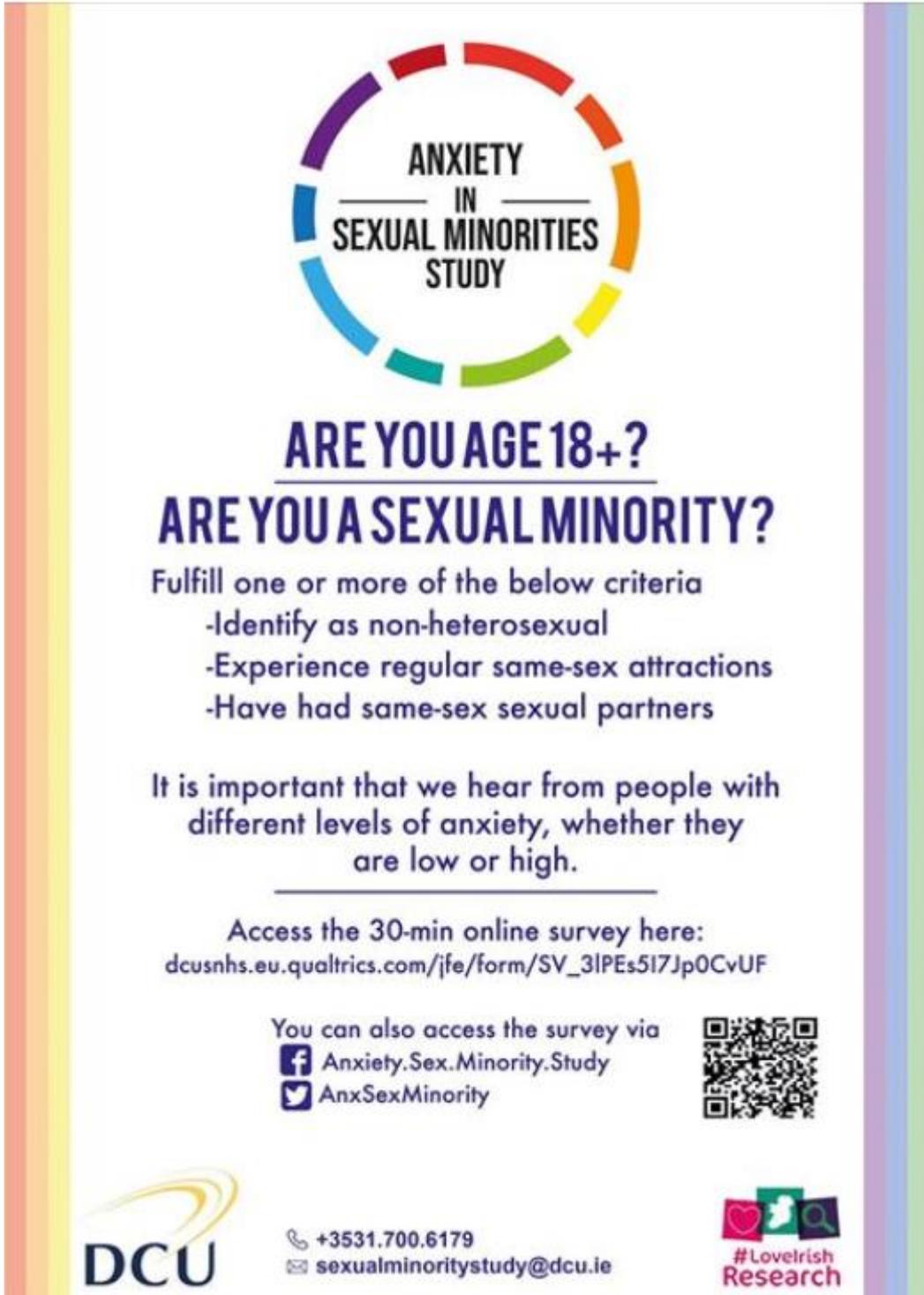
We are seeking to recruit sexual minority adults (individuals 18+ who either identify as non-heterosexual and/or experience regular same-sex attractions and/or have had same-sex sexual partners in the past year) to complete a once-off **30 minute online survey**.

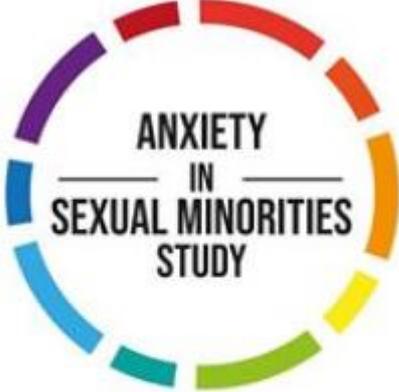
Appendix C.2: Phase One Facebook Recruitment Advertisement 1



 **Anxiety in Sexual Minorities Study**
April 3, 2018 · 🌟

You can access our survey here
https://dcusnhs.eu.qualtrics.com/jfe/form/SV_3lPEs5l7Jp0CvUF




**ANXIETY
IN
SEXUAL MINORITIES
STUDY**

ARE YOU AGE 18+?
ARE YOU A SEXUAL MINORITY?

Fulfill one or more of the below criteria

- Identify as non-heterosexual
- Experience regular same-sex attractions
- Have had same-sex sexual partners

It is important that we hear from people with different levels of anxiety, whether they are low or high.

Access the 30-min online survey here:
dcusnhs.eu.qualtrics.com/jfe/form/SV_3lPEs5l7Jp0CvUF

You can also access the survey via

-  Anxiety.Sex.Minority.Study
-  AnxSexMinority



 **DCU**

+3531.700.6179
sexualminoritystudy@dcu.ie

 **#LoveIrish
Research**

Appendix C.3: Phase One Facebook Recruitment Advertisement 2



 **Anxiety in Sexual Minorities Study** April 22, 2018 ·  ...

500 completed responses!

Thank you to everyone who has taken the time to complete/share our survey so far.

The survey link can be accessed below... [See More](#)

 **500**

DCUSNHS.EU.QUALTRICS.COM

Anxiety in Sexual Minorities Study
Anxiety in Sexual Minorities Study

[Learn More](#)

Appendix C.4: Phase One Recruitment Email to LGBTQ Organisation

 **Conor Mahon** <conor.mahon24@mail.dcu.ie> 5 Apr ☆
to lgbt ▾

Dear NUIM LGBT Soc Committee,

I'm Conor Mahon, a PhD candidate based in DCU. I am contacting you in relation to our study entitled *Anxiety in Sexual Minorities Study*. The study is being carried out by myself, Professor Pamela Gallagher (Professor of Psychology), and Dr Gemma Kiernan (Associate Professor of Psychotherapy). Our study is funded by the Irish Research Council and has received ethical approval from the DCU Research Ethics Committee.

The overall aim of our research is to further develop an understanding of social anxiety in sexual minority adults (the definition of sexual minority is detailed in the recruitment poster attached), and the factors that may be related to it. Participation involves the completion of an online survey; this survey takes roughly 25-30 mins to complete.

We were wondering if it would be possible for you to share information related to our study to your members (i.e., via your Facebook page, mailing list, or wherever you deem appropriate). Any sexual minority adult regardless of their anxiety level is eligible to complete the survey. We would greatly appreciate any assistance you may be able to give. I've inserted a direct link to the survey and the project Facebook page below.

Direct link to the survey

http://dcusnhs.eu.qualtrics.com/jfe/form/SV_3lPEs5I7Jp0CvUF

Project Facebook Page

<https://www.facebook.com/Anxiety.Sex.Minority.Study/>

If you have any questions or need additional info please don't hesitate in contacting me. Thanks a mill for your time.

All the best,

Conor

Conor Mahon BSc.
Irish Research Council PhD Candidate
Principal Investigator Anxiety in Sexual Minorities Study
School of Nursing & Human Sciences
Dublin City University

Tel: +3537006179
Project email: sexualminoritystudy@dcu.ie



Appendix C.5: Phase One Recruitment Email to Individuals with large Numbers of Sexual Minority Followers on Social Media

Anxiety in Sexual Minorities Study  Inbox x



Conor Mahon <conor.mahon24@mail.dcu.ie>

12 Apr 2018, 12:29



to [redacted]

Dear [redacted]

Conor Mahon here, I'm a PhD candidate based in DCU. I am contacting you in relation to our study entitled *Anxiety in Sexual Minorities Study*. The study is being carried out by myself, Professor Pamela Gallagher (Professor of Psychology), and Dr Gemma Kiernan (Associate Professor of Psychotherapy).

The overall aim of our research is to further develop an understanding of social anxiety in sexual minority adults, and the factors that may be related to it. After the findings of the LGBTIreland study a couple of years back, I thought it appropriate to further study mental health difficulties in our community and chose to focus on one of the more prevalent issues in social anxiety. For those who wish to be involved, their participation in the study involves the completion of a 30 min online survey.

I'm familiar with all the great work you've done for the LGBTQ community during the Yes Vote campaign and beyond, and as someone with a large LGBTQ following, I was wondering if it would be possible for you to share information related to our study to your followers. If this is something you may be able to help out with in any capacity, I'd be delighted to chat with you further. I've attached our recruitment poster and a link to the project Facebook page to give you a little more info. Thanks a mill for your time.

All the best,

Conor

<https://www.facebook.com/Anxiety.Sex.Minority.Study/>

Conor Mahon BSc.
Irish Research Council PhD Candidate
Principal Investigator Anxiety in Sexual Minorities Study
School of Nursing & Human Sciences
Dublin City University

Tel: +3537006179

Project email: sexualminoritystudy@dcu.ie



Appendix C.6: Gay Community News Recruitment Article Shared on Project Facebook Page

Anxiety in Sexual Minorities Study
April 18, 2018 · ⚙️

Thankful to [GCN](#) for featuring a short article related to our research

GCN
April 18, 2018 · 🌐

Take part in the biggest study on social anxiety in sexual minorities carried out in Ireland by completing the survey

gen

GCN.IE
Survey On Social Anxiety In Irish LGBT+ Community Hopes To Shed Light On Undocumented Issue

Appendix C.7: HeadStuff Webpage Hosting “Conor Mahon: Anxiety In Sexual Minorities” Podcast Episode

Home > Sparking Change with Dil > #44 | Conor Mahon: Anxiety in Sexual Minorities



On this episode of [Sparking Change](#), Dil is joined by Conor Mahon. Conor is the principal investigator in the [Anxiety in Sexual Minorities Study](#), at DCU.

In this episode, Conor and Dil cover a broad range of topics, including the correlation between social anxiety and sexual orientation, the discrimination that can go on within the LGBTQI+ community, and the issue of internalised homophobia, as well as safety behaviours in response to social anxiety, and how to cope with such behaviours.

Complete the survey for Conor’s study [here](#), and keep up to date with the study [here](#). Go to [lgbt.ie](#) for information on peer support groups, or call 1890 929 539 for the LGBTQI+ helpline.

Appendix D.1: Phase One Plain Language Statement

Welcome to the Anxiety in Sexual Minorities Study



Plain Language Statement

Title of Research Study: Anxiety in Sexual Minorities Study

Principal Investigator: Mr. Conor Mahon (email: sexualminoritystudy@dcu.ie; Tel: +3531 700 6179)

Co-investigators: Prof Pamela Gallagher (Tel: +3531 700 8958), Dr Gemma Kiernan (Tel: +3531 700 8542)

Introduction

Thank you for showing interest in this study. You are being invited to take part in this online survey (funded by the Irish Research Council), which is being conducted by Conor Mahon, as part of his PhD project in the School of Nursing and Human Sciences in Dublin City University (DCU). Before deciding whether or not to participate, please read the following information carefully. If you have any further questions or require additional information, please do not hesitate in contacting the research team (details provided above).

This study has received ethical approval from the Research Ethics Committee of Dublin City University.

Background and aims of the study

Social anxiety (the fear and avoidance of social and/or performance situations) is experienced commonly in the general population, including sexual minorities (those who identify as non-heterosexual and/or experience regular same-sex attractions and/or have had same-sex sexual partners). We are interested in learning more about social anxiety in sexual minorities, and what kinds of stressors and outcomes are related to it.

Am I eligible to take part in the study?

To take part in this study, you need to be aged 18 years or older, be fluent in the English language and identify as non-heterosexual and/or experience regular same-sex attractions and/or have had same-sex sexual partners.

What does participation in the study involve?

If you agree to take part in this study, you will be asked to answer some questions about socio-demographics, social anxiety, stressors experienced within and outside the sexual minority community and social networks.

You are not required to provide your name or address or any other personally identifiable information about yourself. At the end of the survey, you will be asked if you are interested in participating in further studies associated with this project. If you indicate your interest, you are asked to provide an email address as a future point of contact. This is entirely voluntary, you are free to complete this online survey and not provide your email address for future contact. The online survey takes approximately 30-35 minutes to complete. Only the research team will have access to the data and all information will be kept confidential at all times.

Are there any risks associated with the study?

This survey addresses some sensitive issues, such as social anxiety and experiences of discrimination. If at any stage during the completion of the survey, you feel upset or concerned, you can withdraw without completing it and you are not required to give any reason for your decision. If you want to discuss these potential concerns any further, you might wish to contact the LGBT Ireland helpline (Tel: 1890 929 539, Online chat support: <http://www.lgbt.ie/>) or the Samaritans Helpline (Tel: 116 123).

Are there any benefits (direct or indirect) to my involvement in the study?

The information you and others provide will advance our understanding of social anxiety in sexual minority individuals. It may also, in the future, provide important information for the development of interventions tackling social anxiety in sexual minorities.

How will the information I provide be protected? How will my identity be protected?

If you agree to take part, you will be asked to complete an online survey. Your answers will remain entirely anonymous, unless you express interest in participating in further studies related to this project, and provide your email address. This is entirely voluntary, you are free to complete this online survey and not provide your email address for future contact. Findings published from this study in reports and journal articles will not contain any personally identifiable information. Confidentiality of information provided can only be protected within the limitations of the law.

What will happen to the data?

The data collected for this survey will be summarised and will be presented in a PhD thesis to be submitted to DCU. The data, in an anonymised form, may also be published in journals or reports, or presented at conferences. Information will be stored confidentially under password protection on the principal investigator's encrypted laptop. A one-page summary of the findings from the survey will be made available on the project Facebook page (<https://www.facebook.com/Anxiety.Sex.Minority.Study/>). Any email addresses provided for future studies will be kept securely on a separate file on the principal investigator's password protected, encrypted laptop. This file and all of the email addresses within it will be destroyed by the principal investigator upon completion of this project.

Involvement in the study is voluntary and you have the right to withdraw

Participation in this study is completely voluntary, you can withdraw before starting the survey or during its completion, without having to provide a reason. It will not be possible to withdraw your information after full completion of the survey as the research team will have no way of identifying your survey answers from others.

What to do if there are concerns about the study

If you have any concern about this study and wish to contact an independent person, please contact: The Secretary, Dublin City University Research Ethics Committee, c/o Office of the Vice-President for Research, Dublin City University, Dublin 9.

You may also contact the project co-investigators Prof Pamela Gallagher (Tel: 01 700 8958) and/or Dr Gemma Kiernan (Tel: 01 700 8542).

What should I do now?

If you are interested in completing the study, please proceed to the Informed Consent Form by clicking the arrow below



Appendix D.2: Phase One Informed Consent Form



Informed Consent Form

Title of Research Study: Anxiety in Sexual Minorities Study

Principle Investigator: Mr. Conor Mahon (email: sexualminoritystudy@dcu.ie; Tel: +3531 700 6179)

Co-investigators: Prof Pamela Gallagher (Tel: +3531 700 8958), Dr Gemma Kiernan (Tel: +3531 700 8542)

Background and aims of the study: Social anxiety (the fear and avoidance of social and/or performance situations) is experienced commonly in the general population, including sexual minorities (those who identify as non-heterosexual and/or experience regular same-sex attractions and/or have had same-sex sexual partners). We are interested in learning more about social anxiety in sexual minorities, and what kinds of stressors and outcomes are related to it.

Participant – please complete the following [Select Yes or No for each question]

	Yes	No
1. I have read the plain language statement	<input type="radio"/>	<input type="radio"/>
2. I understand the information provided	<input type="radio"/>	<input type="radio"/>
3. I know who to contact to ask questions and discuss this study	<input type="radio"/>	<input type="radio"/>
4. I am aged 18 or above	<input type="radio"/>	<input type="radio"/>
5. I am a sexual minority (somebody who identifies as non-heterosexual, and/or experiences regular same-sex attraction, and/or has had same-sex sexual partners)	<input type="radio"/>	<input type="radio"/>
6. I understand my participation is entirely voluntary	<input type="radio"/>	<input type="radio"/>
7. I am aware that I may withdraw at any stage right up until the point at which I complete the survey and submit my data to the research team, without giving reason	<input type="radio"/>	<input type="radio"/>
8. I am aware that confidentiality of information provided can only be protected within the limitations of the law	<input type="radio"/>	<input type="radio"/>
9. I have read and understand the information on this form and consent to take part in this study	<input type="radio"/>	<input type="radio"/>



Survey Completion 100%

Appendix D.3: Message to Individuals who did not Endorse all Informed Consent Statements

As you did not answer yes to all 9 statements in the informed consent form, you are not eligible to complete this survey. Thank you for your time.

←

→

0% 100%

Survey Completion

Appendix D.4: Concluding Section of Survey: Further Participation and Support



Would you be interested in participating in further studies associated with this project? This may consist of further online activities and/or telephone interviews.

(Please note that by expressing your interest now you are in no way obliged to participate in future studies when contacted)

- Yes
 No



0% 100%
Survey Completion

As you have expressed interest in participating in further studies associated with this project, we require an email address in order to contact you in the future.

(Please note that if you provide an email address your survey answers are **no longer anonymous**. They are, however, **100% confidential** and can only be viewed by the project research team)

- I am happy to provide an email address (please type in to space provided)

- I do not wish to provide an email address

Support Services

If you are concerned/upset by any of the topics covered in the survey and want to discuss these concerns any further, you may wish to contact:

The LGBT Ireland Helpline

Tel: 1890 929 539

Online Web Chat Support: <http://www.lgbt.ie/>

Samaritan's Helpline

Tel: 116 123

Text: +353 872609090

Email: jo@samaritans.ie (Republic of Ireland)

Email: jo@samaritans.org (Northern Ireland)

Appendix E.1: Survey Measures: Participant Sociodemographic Characteristics



How did you hear about this survey?

- Facebook
- Twitter
- Through a friend
- Through a LGBT organisation/club I'm associated with
- Through a non-LGBT organisation/club I'm associated with
- A social influencer I follow shared it
- In a LGBT venue (e.g., a bar)
- At a Pride event
- In a newspaper/magazine
- On a dating app
- Other (please specify)

What age are you?

In which country were you born?

Survey Completion
0% 100%

In which county were you primarily raised?

In which country do you currently live?

Survey Completion
0% 100%

In which county do you currently live?

What is your ethnicity?

What is your current relationship status?

- Single
- In a relationship (but not married)
- Married

What was your sex assigned at birth?

- Male
- Female
- Intersex

What is your current gender identity?

(Cisgender describes a person whose gender identity matches the sex they were assigned at birth. For example, someone who is born female and identifies as a woman would be considered a cisgender woman)

- Cisgender man
- Cisgender woman
- Transgender man
- Transgender woman
- Genderqueer/non-binary
- Other (please specify)

Which of these categories best describes you?

- Heterosexual/Straight
- Gay/Lesbian
- Bisexual
- Queer
- Pansexual
- Asexual
- Questioning/Unsure
- Other (please specify)



People differ in their sexual attraction to other people. Which category best describes your feelings?

- Only attracted to same gender
- Mostly attracted to same gender
- Equally attracted to all genders
- Mostly attracted to opposite gender
- Only attracted to opposite gender

Please complete the following phrase as relevant to you

During the past year,

- I only had sex with same gender partners(s)
- I only had sex with opposite gender partners(s)
- I had sex with both same and opposite gender partner(s)
- I had sex with non-binary partner(s)
- I didn't have sex

What is your employment status?

- Full-time
- Part-time
- Student
- On disability
- Unemployed
- Retired

What is your highest educational attainment?

- No secondary/high school
- Some secondary/high school
- Finished secondary/high school
- Some university (includes current undergraduate students)
- University degree
- Masters degree or above

Which best describes your total yearly personal income during the last year?

- Less than €10,000
- €10,000- €24,999
- €25,000- €39,999
- €40,000- €59,999
- €60,000- €79,999
- €80,000 and above

Appendix E.2: Survey Measures: The Liebowitz Social Anxiety Scale (Fresco et al., 2001; Liebowitz, 1987)



Social anxiety

This measure assesses the way that social anxiety plays a role in your life across a variety of situations. Read each situation carefully and answer two questions about that situation (parts a and b).

Part a asks how **anxious or fearful you feel** in the situation. Part b asks how **often you avoid** the situation. If you come across a situation that you ordinarily do not experience, imagine "what if you were faced with that situation" and then, rate the degree to which you would...

fear this hypothetical situation

(0- None, 1- Mild, 2-Moderate, 3-Severe)

and how often you would tend to **avoid** it

(Never [0%], Occasionally [1-33%], Often [34-66%], Usually [67-100%]).

Please base your ratings on the way these situations have affected you in the last week.

Fill out the following scale with the most suitable answer provided below.

1. Telephoning in public.

1a. How fearful do you feel in this situation?

- 0- None
- 1- Mild
- 2- Moderate
- 3- Severe

1b. How often do you avoid this situation?

- Never (0%)
- Occasionally (1-33%)
- Often (34-66%)
- Usually (67-100%)

2. Participating in small groups.

2a. How fearful do you feel in this situation?

- 0- None
- 1- Mild
- 2- Moderate
- 3- Severe

2b. How often do you avoid this situation?

- Never (0%)
 - Occasionally (1-33%)
 - Often (34-66%)
 - Usually (67-100%)
-

3. Eating in public places.

3a. How fearful are you in this situation?

- 0- None
- 1- Mild
- 2- Moderate
- 3- Severe

3b. How often do you avoid this situation?

- Never (0%)
- Occasionally (1-33%)
- Often (34-66%)
- Usually (67-100%)

4. Drinking with others in public places.

4a. How fearful are you in this situation?

- 0- None
- 1- Mild
- 2- Moderate
- 3- Severe

4b. How often do you avoid this situation?

- Never (0%)
 - Occasionally (1-33%)
 - Often (34-66%)
 - Usually (67-100%)
-

5. Talking to people in authority.

5a. How fearful are you in this situation?

- 0- None
- 1- Mild
- 2- Moderate
- 3- Severe

5b. How often do you avoid this situation?

- Never (0%)
- Occasionally (1-33%)
- Often (34-66%)
- Usually (67-100%)

6. Acting, performing or speaking in front of an audience.

6a. How fearful are you in this situation?

- 0- None
- 1- Mild
- 2- Moderate
- 3- Severe

6b. How often do you avoid this situation?

- Never (0%)
 - Occasionally (1-33%)
 - Often (34-66%)
 - Usually (67-100%)
-

7. Going to a party.

7a. How fearful are you in this situation?

- 0- None
- 1- Mild
- 2- Moderate
- 3- Severe

7b. How often do you avoid this situation?

- Never (0%)
- Occasionally (1-33%)
- Often (34-66%)
- Usually (67-100%)

8. Working while being observed.

8a. How fearful are you in this situation?

- 0- None
- 1- Mild
- 2- Moderate
- 3- Severe

8b. How often do you avoid this situation?

- Never (0%)
 - Occasionally (1-33%)
 - Often (34-66%)
 - Usually (67-100%)
-

9. Writing while being observed.

9a. How fearful are you in this situation?

- 0- None
- 1- Mild
- 2- Moderate
- 3- Severe

9b. How often do you avoid this situation?

- Never (0%)
- Occasionally (1-33%)
- Often (34-66%)
- Usually (67-100%)

10. Calling someone you don't know very well.

10a. How fearful are you in this situation?

- 0- None
- 1- Mild
- 2- Moderate
- 3- Severe

10b. How often do you avoid this situation?

- Never (0%)
 - Occasionally (1-33%)
 - Often (34-66%)
 - Usually (67-100%)
-

11. Talking with people you don't know very well.

11a. How fearful are you in this situation?

- 0-None
- 1- Mild
- 2- Moderate
- 3- Severe

11b. How often do you avoid this situation?

- Never (0%)
- Occasionally (1-33%)
- Often (34-66%)
- Usually (67-100%)

12. Meeting strangers.

12a. How fearful are you in this situation?

- 0- None
- 1- Mild
- 2- Moderate
- 3- Severe

12b. How often do you avoid this situation?

- Never (0%)
 - Occasionally (1-33%)
 - Often (34-66%)
 - Usually (67-100%)
-

13. Urinating in a public bathroom.

13a. How fearful are you in this situation?

- 0- None
- 1- Mild
- 2- Moderate
- 3- Severe

13b. How often do you avoid this situation?

- Never (0%)
- Occasionally (1-33%)
- Often (34-66%)
- Usually (67-100%)

14. Entering a room when others are already seated.

14a. How fearful are you in this situation?

- 0- None
- 1- Mild
- 2- Moderate
- 3- Severe

11b. How often do you avoid this situation?

- Never (0%)
- Occasionally (1-33%)
- Often (34-66%)
- Usually (67-100%)

12. Meeting strangers.

12a. How fearful are you in this situation?

- 0- None
- 1- Mild
- 2- Moderate
- 3- Severe

12b. How often do you avoid this situation?

- Never (0%)
 - Occasionally (1-33%)
 - Often (34-66%)
 - Usually (67-100%)
-

13. Urinating in a public bathroom.

13a. How fearful are you in this situation?

- 0- None
- 1- Mild
- 2- Moderate
- 3- Severe

13b. How often do you avoid this situation?

- Never (0%)
- Occasionally (1-33%)
- Often (34-66%)
- Usually (67-100%)

14. Entering a room when others are already seated.

14a. How fearful are you in this situation?

- 0- None
- 1- Mild
- 2- Moderate
- 3- Severe

14b. How often do you avoid this situation?

- Never (0%)
 - Occasionally (1-33%)
 - Often (34-66%)
 - Usually (67-100%)
-

15. Being the centre of attention.

15a. How fearful are you in this situation?

- 0- None
- 1- Mild
- 2- Moderate
- 3- Severe

15b. How often do you avoid this situation?

- Never (0%)
- Occasionally (1-33%)
- Often (34-66%)
- Usually (67-100%)

16. Speaking up at a meeting.

16a. How fearful are you in this situation?

- 0- None
- 1- Mild
- 2- Moderate
- 3- Severe

16b. How often do you avoid this situation?

- Never (0%)
 - Occasionally (1-33%)
 - Often (34-66%)
 - Usually (67-100%)
-

17. Taking a test of your ability, skill, or knowledge.

17a. How fearful are you in this situation?

- 0- None
- 1- Mild
- 2- Moderate
- 3- Severe

17b. How often do you avoid this situation?

- Never (0%)
- Occasionally (1-33%)
- Often (34-66%)
- Usually (67-100%)

18. Expressing a disagreement or disapproval to people you don't know very well.

18a. How fearful are you in this situation?

- 0- None
- 1- Mild
- 2- Moderate
- 3- Severe

18b. How often do you avoid this situation?

- Never (0%)
 - Occasionally (1-33%)
 - Often (34-66%)
 - Usually (67-100%)
-

19. Looking at people you don't know very well in the eyes.

19a. How fearful are you in this situation?

- 0- None
- 1- Mild
- 2- Moderate
- 3- Severe

19b. How often do you avoid this situation?

- Never (0%)
- Occasionally (1-33%)
- Often (34-66%)
- Usually (67-100%)

20. Giving a prepared oral talk to a group.

20a. How fearful are you in this situation?

- 0- None
- 1- Mild
- 2- Moderate
- 3- Severe

20b. How often do you avoid this situation?

- Never (0%)
 - Occasionally (1-33%)
 - Often (34-66%)
 - Usually (67-100%)
-

21. Trying to make someone's acquaintance for the purposes of a romantic/sexual relationship.

21a. How fearful are you in this situation?

- 0- None
- 1- Mild
- 2- Moderate
- 3- Severe

21b. How often do you avoid this situation?

- Never (0%)
- Occasionally (1-33%)
- Often (34-66%)
- Usually (67-100%)

22. Returning goods to a shop/store for a refund.

22a. How fearful are you in this situation?

- 0- None
- 1- Mild
- 2- Moderate
- 3- Severe

22b. How often do you avoid this situation?

- Never (0%)
 - Occasionally (1-33%)
 - Often (34-66%)
 - Usually (67-100%)
-

23. Giving/hosting a party.

23a. How fearful are you in this situation?

- 0- None
- 1- Mild
- 2- Moderate
- 3- Severe

23b. How often do you avoid this situation?

- Never (0%)
- Occasionally (1-33%)
- Often (34-66%)
- Usually (67-100%)

24. Resisting a high-pressure salesperson.

24a. How fearful are you in this situation?

- 0- None
- 1- Mild
- 2- Moderate
- 3- Severe

24b. How often do you avoid this situation?

- Never (0%)
- Occasionally (1-33%)
- Often (34-66%)
- Usually (67-100%)



Appendix E.3: Survey Measures: The Brief Fear of Negative Evaluation Scale (Leary, 1983)

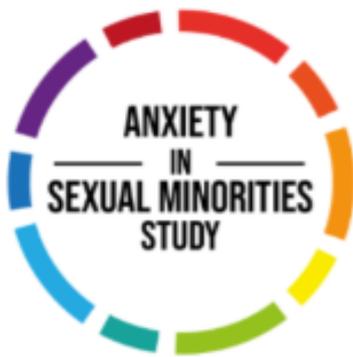
Fear of negative evaluation

Read each of the following statements carefully and indicate how characteristic of you they are according to the following scale

- 1= Not at all characteristic of me
- 2= Slightly characteristic of me
- 3= Moderately characteristic of me
- 4= Very characteristic of me
- 5= Extremely characteristic of me

	1- Not at all characteristic of me	2- Slightly characteristic of me	3- Moderately characteristic of me	4- Very characteristic of me	5- Extremely characteristic of me
1. I worry about what other people will think of me even when I know it doesn't make a difference.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. I am unconcerned even if I know people are forming an unfavourable impression of me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. I am frequently afraid of other people noticing my shortcomings.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. I rarely worry about what kind of impression I am making on someone.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	1- Not at all characteristic of me	2- Slightly characteristic of me	3- Moderately characteristic of me	4- Very characteristic of me	5- Extremely characteristic of me
5. I am afraid that others will not approve of me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. I am afraid that people will find fault with me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Other people's opinions of me do not bother me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. When I am talking to someone, I worry about what they may be thinking about me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	1- Not at all characteristic of me	2- Slightly characteristic of me	3- Moderately characteristic of me	4- Very characteristic of me	5- Extremely characteristic of me
9. I am usually worried about what kind of impression I make.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. If I know someone is judging me, it has little effect on me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Sometimes I think I am too concerned with what other people think of me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. I often worry that I will say or do the wrong things.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Appendix E.4: Survey Measures: The Everyday Discrimination Scale (D. R. Williams et al., 1997)



Everyday Discrimination

In your day-to-day life, how often do any of the following things happen to you? Please indicate your answer using the scale below

- 1- Never
- 2- Less than once a year
- 3- A few times a year
- 4- A few times a month
- 5- At least once a week
- 6- Almost every day

	1- Never	2- Less than once a year	3- A few times a year	4- A few times a month	5- At least once a week	6- Almost every day
1. You are treated with less courtesy than other people are.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. You are treated with less respect than other people are.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. You receive poorer service than other people at restaurants or shops/stores.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. People act as if they think you're not smart.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. People act as if they are afraid of you.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	1- Never	2- Less than once a year	3- A few times a year	4- A few times a month	5- At least once a week	6- Almost every day
6. People act as if they think you are dishonest.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. People act as if they're better than you.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. You are called names or insulted.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. You are threatened or harassed.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Appendix E.5: Survey Measures: The Revised Internalized Homophobia Scale,
Sexual Minority Women Version (Herek et al., 2009)**



Please indicate your agreement with the following statements using the scale below

- 1- Strongly Disagree
- 2- Somewhat Disagree
- 3- Neither Agree or Disagree
- 4- Somewhat Agree
- 5- Strongly Agree

	1- Strongly Disagree	2- Somewhat Disagree	3- Neither Agree or Disagree	4- Somewhat Agree	5- Strongly Agree
1. I wish I weren't lesbian/bisexual/a sexual minority.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. I have tried to stop being attracted to women in general.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. If someone offered me the chance to be completely heterosexual, I would accept the chance.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. I feel that being lesbian/bisexual/a sexual minority is a personal shortcoming for me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. I would like to get professional help in order to change my sexual orientation from lesbian/bisexual/non-heterosexual to straight.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



Appendix E.6: Survey Measures: The Revised Internalized Homophobia Scale, Sexual Minority Men Version (Herek et al., 2009)



Please indicate your agreement with the following statements using the scale below

- 1- Strongly Disagree
- 2- Somewhat Disagree
- 3- Neither Agree or Disagree
- 4- Somewhat Agree
- 5- Strongly Agree

	1- Strongly Disagree	2- Somewhat Disagree	3- Neither Agree or Disagree	4- Somewhat Agree	5- Strongly Agree
1. I wish I weren't gay/bisexual/ a sexual minority.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. I have tried to stop being attracted to men in general.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. If someone offered me the chance to be completely heterosexual, I would accept the chance.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. I feel that being gay/bisexual/ a sexual minority is a personal shortcoming for me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. I would like to get professional help in order to change my sexual orientation from gay/bisexual/non-heterosexual to straight.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



Appendix E.7: Survey Measures: The Sexual Orientation Concealment Scale (Jackson & Mohr, 2016)

The following six items concern behaviours sexual minority people sometimes use to hide their sexual orientation. Please rate each item to complete the following phrase:

In the last 2 weeks, I have . . .

- 1- Not at all
- 2- A little bit
- 3- Somewhat
- 4- Very much
- 5- All the time

	1- Not at all	2- A little bit	3- Somewhat	4- Very much	5- All the time
1. . . . concealed my sexual orientation by telling someone that I was straight or denying that I was LGBTQ/a sexual minority.	<input type="radio"/>				
2. . . . concealed my sexual orientation by avoiding contact with other LGBTQ/sexual minority individuals.	<input type="radio"/>				
3. . . . avoided the subjects of sex, love attraction, or relationships to conceal my sexual orientation.	<input type="radio"/>				
	1- Not at all	2- A little bit	3- Somewhat	4- Very much	5- All the time
4. . . . allowed others to assume I am straight without correcting them.	<input type="radio"/>				
5. . . . altered my appearance, mannerisms, or activities in an attempt to "pass" as straight.	<input type="radio"/>				
6. . . . remained silent while witnessing anti-gay remarks, jokes, or activities because I did not want to be labelled as LGBTQ/a sexual minority by those involved.	<input type="radio"/>				

Appendix E.8: Survey Measures: The Sexual Minority Women's Rejection Sensitivity Scale (Dyar et al., 2016)

Please read the following descriptions of situations and answer the two questions that follow each one. Imagine each situation as vividly as you can, as if you were actually there.

1. You and your female partner are having dinner together at a restaurant. A male customer approaches your table.

1a. How anxious/concerned would you be that the man might sexually harass you because of your sexual orientation?

- 1- Very Unconcerned
- 2
- 3
- 4
- 5
- 6
- 7- Very Concerned

1b. How likely is it that the man will sexually harass you because of your sexual orientation?

- 1- Very Unlikely
- 2
- 3
- 4
- 5
- 6
- 7- Very Likely

2. You and your female partner are leaving a shop/store together holding hands. A car drives by and the driver honks the horn loudly several times.

2a. How anxious/concerned would you be that the driver might have honked because of your sexual orientation?

- 1- Very Unconcerned
- 2
- 3
- 4
- 5
- 6
- 7- Very Concerned

3. You are on a date with a woman at a restaurant. Your waiter provides you and your date with poor service.

3a. How anxious/concerned would you be that the poor service may have been because of your sexual orientation?

- 1- Very Unconcerned
- 2
- 3
- 4
- 5
- 6
- 7- Very Concerned

3b. How likely is it that the poor service was because of your sexual orientation?

- 1- Very Unlikely
- 2
- 3
- 4
- 5
- 6
- 7- Very Likely

4. You and your female partner are walking together holding hands. Several men are gathered on a corner outside a bar.

4a. How anxious/concerned would you be that you may be harassed or assaulted because of your sexual orientation?

- 1- Very Unconcerned
- 2
- 3
- 4
- 5
- 6
- 7- Very Concerned

4b. How likely is it that you will be harassed or assaulted because of your sexual orientation?

- 1- Very Unlikely
- 2
- 3
- 4
- 5
- 6
- 7- Very Likely

5. You are at a bar with a female friend and an intoxicated male approaches you and attempts to flirt with you. You turn him down and he reacts angrily, calling you a “dyke.”

5a. How anxious/concerned would you be that he might physically assault you because of your sexual orientation?

- 1- Very Unconcerned
- 2
- 3
- 4
- 5
- 6
- 7- Very Concerned

5b. How likely is it that he will physically assault you because of your sexual orientation?

- 1- Very Unlikely
- 2
- 3
- 4
- 5
- 6
- 7- Very Likely

6. You and your female partner are looking to buy a house. After looking at a house together with the agent, the agent fails to schedule an appointment to view another house that she represents.

6a. How anxious/concerned would you be that the realtor may have failed to schedule an appointment because of your sexual orientation?

- 1- Very Unconcerned
- 2
- 3
- 4
- 5
- 6
- 7- Very Concerned

6b. How likely is it that the agent failed to schedule an appointment because of your sexual orientation?

- 1- Very Unlikely
- 2
- 3
- 4
- 5
- 6
- 7- Very Likely

7. A few of your female coworkers regularly try to set you up with men but they never try to set you up with women.

7a. How anxious/concerned would you be that they may be doing this because they don't accept your sexual orientation?

- 1- Very Unconcerned
- 2
- 3
- 4
- 5
- 6
- 7- Very Concerned

7b. How likely is it that they are doing this because of your sexual orientation?

- 1- Very Unlikely
- 2
- 3
- 4
- 5
- 6
- 7- Very Likely

8. You are hanging out with a group of heterosexual female coworkers, and the subject turns to boyfriends and husbands.

8a. How anxious/concerned would you be that they may treat you differently because of your sexual orientation?

- 1- Very Unconcerned
- 2
- 3
- 4
- 5
- 6
- 7- Very Concerned

8b. How likely is it that they would treat you differently because of your sexual orientation?

- 1- Very Unlikely
- 2
- 3
- 4
- 5
- 6
- 7- Very Likely

9. A new female friend of yours makes negative remarks about lesbians.

9a. How anxious/concerned would you be that she may not want to be friends if she knew of your sexual orientation?

- 1- Very Unconcerned
- 2
- 3
- 4
- 5
- 6
- 7- Very Concerned

9b. How likely is it that she wouldn't want to be friends if she knew of your sexual orientation?

- 1- Very Likely
- 2
- 3
- 4
- 5
- 6
- 7- Very Likely

10. You disclose your sexual orientation to a new friend. Your friend doesn't express concern about it, but your friendship soon drifts apart.

10a. How anxious/concerned would you be that the drifting apart of this friendship is because of your sexual orientation?

- 1- Very Unconcerned
- 2
- 3
- 4
- 5
- 6
- 7- Very Concerned

10b. How likely is it that your friendship drifted apart because of your sexual orientation?

- 1- Very Unlikely
- 2
- 3
- 4
- 5
- 6
- 7- Very Likely

11. You walk into the locker room at the gym and begin to change. A woman near you moves to a different part of the locker room.

11a. How anxious/concerned would you be that she may have moved because of your sexual orientation?

- 1- Very Unconcerned
- 2
- 3
- 4
- 5
- 6
- 7- Very Concerned

11b. How likely is it that she moved because of your sexual orientation?

- 1- Very Unlikely
- 2
- 3
- 4
- 5
- 6
- 7- Very Likely

12. Your supervisor begins raising concerns about your performance at work for the first time after you bring your female partner to a company picnic.

12a. How anxious/concerned would you be that your supervisor may be raising concerns about your performance at work because of your sexual orientation?

- 1- Very Unconcerned
- 2
- 3
- 4
- 5
- 6
- 7- Very Concerned

12b. How likely is it that your supervisor is raising concerns about your performance at work because of your sexual orientation?

- 1- Very Unlikely
- 2
- 3
- 4
- 5
- 6
- 7- Very Likely

13. You notice your relatives looking at you and your female partner at a family reunion, but they don't come over to talk to you.

13a. How anxious/concerned would you be that they may not have come over to talk to you because of your sexual orientation?

- 1- Very Unconcerned
- 2
- 3
- 4
- 5
- 6
- 7- Very Concerned

13b. How likely is it that they didn't come over to talk to you because of your sexual orientation?

- 1- Very Unlikely
- 2
- 3
- 4
- 5
- 6
- 7- Very Likely

14. You and your female partner are getting married. Several of your coworkers do not come to the wedding ceremony.

14a. How anxious/concerned would you be that they may not have come because of your sexual orientation?

- 1- Very Unconcerned
- 2
- 3
- 4
- 5
- 6
- 7- Very Concerned

14b. How likely is it that they did not come because of your sexual orientation?

- 1- Very Unlikely
- 2
- 3
- 4
- 5
- 6
- 7- Very Likely

15. The principal at your child's primary/elementary school has never spoken to you and your partner at school events, but you often see him speaking with other parents.

15a. How anxious/ concerned would you be that he may not have spoken to you because of your sexual orientation?

- 1- Very Unconcerned
- 2
- 3
- 4
- 5
- 6
- 7- Very Concerned

15b. How likely is that he doesn't speak to you because of your sexual orientation?

- 1- Very Unlikely
- 2
- 3
- 4
- 5
- 6
- 7- Very Likely

16. During a lecture on sexual orientation, your professor includes several stereotypes about lesbian and bisexual women as if they were facts. After the lecture, you approach the professor and politely point out the incorrect aspects of the lecture. You receive a lower grade than you expected in the class.

16a. How anxious/concerned would you be that you may have received a lower grade in the class because of your sexual orientation?

- 1- Very Unconcerned
- 2
- 3
- 4
- 5
- 6
- 7- Very Concerned

16b. How likely is it that you received a lower grade in the class because of your sexual orientation?

- 1- Very Unlikely
- 2
- 3
- 4
- 5
- 6
- 7- Very Likely



Appendix E.9: Survey Measures: The Gay-Related Rejection Sensitivity Scale (Pachankis et al., 2008)



Please read the following descriptions of situations and answer the two questions (parts a and b) that follow each one. Imagine each situation as vividly as you can, as if you were actually there:

1. You bring a male partner to a family reunion. Two of your old-fashioned aunts don't come talk to you even though they see you.

1a. How concerned or anxious would you be that they don't talk to you because of your sexual orientation?

- 1- Very unconcerned
- 2
- 3
- 4
- 5
- 6- Very concerned

1b. How likely is it that they didn't talk to you because of your sexual orientation?

- 1- Very unlikely
- 2
- 3
- 4
- 5
- 6- Very likely

2. A 3-year old child of a distant relative is crawling on your lap. His mom comes to take him away.

2a. How concerned or anxious would you be that the mom took him away because of your sexual orientation?

- 1- Very unconcerned
- 2
- 3
- 4
- 5
- 6- Very concerned

2b. How likely is it that the mom took him away because of your sexual orientation?

- 1- Very unlikely
- 2
- 3
- 4
- 5
- 6- Very likely

3. You've been dating someone for a few years now, and you receive a wedding invitation to a straight friend's wedding. The invite was addressed only to you, not you and a guest.

3a. How concerned or anxious would you be that the invite was addressed only to you because of your sexual orientation?

- 1- Very unconcerned
- 2
- 3
- 4
- 5
- 6- Very concerned

3b. How likely is it that the invite was addressed only to you because of your sexual orientation?

- 1- Very unlikely
- 2
- 3
- 4
- 5
- 6- Very likely

4. You go to a job interview and the interviewer asks if you are married. You say that you and your partner have been together for 5 years. You later find out that you don't get the job.

4a. How concerned or anxious would you be that you didn't get the job because of your sexual orientation?

- 1- Very unconcerned
- 2
- 3
- 4
- 5
- 6- Very concerned

4b. How likely is it that you didn't get the job because of your sexual orientation?

- 1- Very unlikely
- 2
- 3
- 4
- 5
- 6- Very likely

5. You are going to have surgery, and the doctor tells you that he would like to give you an HIV test.

5a. How concerned or anxious would you be that he gave you an HIV test because of your sexual orientation?

- 1- Very unconcerned
- 2
- 3
- 4
- 5
- 6- Very concerned

5b. How likely is it that he gave you an HIV test because of your sexual orientation?

- 1- Very unlikely
- 2
- 3
- 4
- 5
- 6- Very likely

6. You go to donate blood and the person who is supposed to draw your blood turns to her co-worker and says, "Why don't you take this one?"

6a. How concerned or anxious would you be that she asked her co-worker to draw your blood because of your sexual orientation?

- 1- Very unconcerned
- 2
- 3
- 4
- 5
- 6- Very concerned

6b. How likely is it that she asked her co-worker to draw your blood because of your sexual orientation?

- 1- Very unlikely
- 2
- 3
- 4
- 5
- 6- Very likely

7. You go get an STD check-up, and the man taking your sexual history is rude towards you.

7a. How concerned or anxious would you be that he is rude towards you because of your sexual orientation?

- 1- Very unconcerned
- 2
- 3
- 4
- 5
- 6- Very concerned

7b. How likely is it that he is rude towards you because of your sexual orientation?

- 1- Very unlikely
- 2
- 3
- 4
- 5
- 6- Very likely

8. You bring a guy you are dating to a fancy restaurant of straight patrons, and you are seated away from everyone else in a back corner of the restaurant.

8a. How concerned or anxious would you be that you were seated there because of your sexual orientation?

- 1- Very unconcerned
- 2
- 3
- 4
- 5
- 6- Very concerned

8b. How likely is it that you were seated there because of your sexual orientation?

- 1- Very unlikely
- 2
- 3
- 4
- 5
- 6- Very likely

9. Only you and a group of macho men are on public transport late at night. They look in your direction and laugh.

9a. How concerned or anxious would you be that they are laughing at you because of your sexual orientation?

- 1- Very unconcerned
- 2
- 3
- 4
- 5
- 6- Very concerned

9b. How likely is it that they are laughing at you because of your sexual orientation?

- 1- Very unlikely
- 2
- 3
- 4
- 5
- 6- Very likely

10. You and your partner are on a road trip and decide to check into a hotel in a rural town. The sign out front says there are vacancies. The two of you go inside, and the woman at the front desk says that there are no rooms left.

10a. How concerned or anxious would you be that she lied to you because of your sexual orientation?

- 1- Very unconcerned
- 2
- 3
- 4
- 5
- 6- Very concerned

10b. How likely is it that she lied to you because of your sexual orientation?

- 1- Very unlikely
- 2
- 3
- 4
- 5
- 6- Very likely

11. You go to a party and you and your partner are the only gay/sexual minority people there. No one seems interested in talking to you.

11a. How concerned or anxious would you be that no one talks to you because of your sexual orientation?

- 1- Very unconcerned
- 2
- 3
- 4
- 5
- 6- Very concerned

11b. How likely is it that no one talked to you because of your sexual orientation?

- 1- Very unlikely
- 2
- 3
- 4
- 5
- 6- Very likely

12. You are in a locker room in a straight gym. One guy nearby moves to another area to change clothes.

12a. How concerned or anxious would you be that he moved to another area to change because of your sexual orientation?

- 1- Very unconcerned
- 2
- 3
- 4
- 5
- 6- Very concerned

12b. How likely is it that he moved to another area to change because of your sexual orientation?

- 1- Very unlikely
- 2
- 3
- 4
- 5
- 6- Very likely

13. Some straight colleagues are talking about sport. You force yourself to join the conversation, and they dismiss your input.

13a. How concerned or anxious would you be that they dismissed your input because of your sexual orientation?

- 1- Very unconcerned
- 2
- 3
- 4
- 5
- 6- Very concerned

13b. How likely is it that they dismissed your input because of your sexual orientation?

- 1- Very unlikely
- 2
- 3
- 4
- 5
- 6- Very likely

14. Your colleagues are celebrating a co-worker's birthday at a restaurant. You are not invited.

14a. How concerned or anxious would you be that they did not invite you because of your sexual orientation?

- 1- Very unconcerned
- 2
- 3
- 4
- 5
- 6- Very concerned

14b. How likely is it that they did not invite you because of your sexual orientation?

- 1- Very unlikely
- 2
- 3
- 4
- 5
- 6- Very likely

Appendix E.10: Survey Measures: The Intraminority Gay Community Stress Scale (Pachankis, Clark, et al., 2020).

Potential issues within the gay community

This measure presents some statements related to the **gay community/male sexual minority community**.

In Part a, you are asked to rate how much you believe the statement to be true

- 1= Strongly Agree
- 2= Somewhat Agree
- 3= Neither Agree or Disagree
- 4= Somewhat Disagree
- 5= Strongly Disagree

In Part B, you are asked to rate how much this potential aspect of the gay community causes you stress

- 1= Not at all stressed or bothered
- 2= A small bit stressed or bothered
- 3= Quite stressed or bothered
- 4= Very stressed or bothered
- 5= Extremely stressed or bothered

We understand the **gay community** can mean different things to different people. Please answer the following questions in regard to your perception of the mainstream gay community.

1. The mainstream gay community overly values stylish clothes and up-to-date fashion.

1a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

1b. How stressed/bothered are you by this potential aspect of the mainstream gay community?

- 1- Not at all stressed or bothered
- 2- A small bit stressed or bothered
- 3- Quite Stressed or bothered
- 4- Very stressed or bothered
- 5- Extremely stressed or bothered

2. The mainstream gay community overly values men who are wealthy.

2a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

2b. How stressed/bothered are you by this potential aspect of the mainstream gay community?

- 1- Not at all stressed or bothered
 - 2- A small bit stressed or bothered
 - 3- Quite Stressed or bothered
 - 4- Very stressed or bothered
 - 5- Extremely stressed or bothered
-

3. The mainstream gay community sexually objectifies men of colour.

3a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

3b. How stressed/bothered are you by this potential aspect of the mainstream gay community?

- 1- Not at all stressed or bothered
- 2- A small bit stressed or bothered
- 3- Quite Stressed or bothered
- 4- Very stressed or bothered
- 5- Extremely stressed or bothered

4. The mainstream gay community values having a high status job.

4a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

4b. How stressed/bothered are you by this potential aspect of the mainstream gay community?

- 1- Not at all stressed or bothered
 - 2- A small bit stressed or bothered
 - 3- Quite Stressed or bothered
 - 4- Very stressed or bothered
 - 5- Extremely stressed or bothered
-

5. The mainstream gay community is overly focused on sex.

5a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

5b. How stressed/bothered are you by this potential aspect of the mainstream gay community?

- 1- Not at all stressed or bothered
- 2- A small bit stressed or bothered
- 3- Quite Stressed or bothered
- 4- Very stressed or bothered
- 5- Extremely stressed or bothered

6. It is difficult to maintain a romantic relationship in the mainstream gay community.

6a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

6b. How stressed/bothered are you by this potential aspect of the mainstream gay community?

- 1- Not at all stressed or bothered
- 2- A small bit stressed or bothered
- 3- Quite Stressed or bothered
- 4- Very stressed or bothered
- 5- Extremely stressed or bothered

7. The mainstream gay community overly values men who are powerful and high status.

7a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

7b. How stressed/bothered are you by this potential aspect of the mainstream gay community?

- 1- Not at all stressed or bothered
- 2- A small bit stressed or bothered
- 3- Quite Stressed or bothered
- 4- Very stressed or bothered
- 5- Extremely stressed or bothered

8. The mainstream gay community values sex over meaningful relationships.

8a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

8b. How stressed/bothered are you by this potential aspect of the mainstream gay community?

- 1- Not at all stressed or bothered
- 2- A small bit stressed or bothered
- 3- Quite Stressed or bothered
- 4- Very stressed or bothered
- 5- Extremely stressed or bothered

9. In the mainstream gay community, everyone has sex with each other.

9a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

9b. How stressed/bothered are you by this potential aspect of the mainstream gay community?

- 1- Not at all stressed or bothered
- 2- A small bit stressed or bothered
- 3- Quite Stressed or bothered
- 4- Very stressed or bothered
- 5- Extremely stressed or bothered

10. The mainstream gay community is overly gossipy.

10a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

10b. How stressed/bothered are you by this potential aspect of the mainstream gay community?

- 1- Not at all stressed or bothered
- 2- A small bit stressed or bothered
- 3- Quite Stressed or bothered
- 4- Very stressed or bothered
- 5- Extremely stressed or bothered

11. The mainstream gay community is overly cliquey.

11a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

11b. How stressed/bothered are you by this potential aspect of the mainstream gay community?

- 1- Not at all stressed or bothered
- 2- A small bit stressed or bothered
- 3- Quite Stressed or bothered
- 4- Very stressed or bothered
- 5- Extremely stressed or bothered

12. The mainstream gay community has a culture of competition and jealousy.

12a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

12b. How stressed/bothered are you by this potential aspect of the mainstream gay community?

- 1- Not at all stressed or bothered
 - 2- A small bit stressed or bothered
 - 3- Quite Stressed or bothered
 - 4- Very stressed or bothered
 - 5- Extremely stressed or bothered
-

13. The mainstream gay community is overly materialistic.

13a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

13b. How stressed/bothered are you by this potential aspect of the mainstream gay community?

- 1- Not at all stressed or bothered
- 2- A small bit stressed or bothered
- 3- Quite Stressed or bothered
- 4- Very stressed or bothered
- 5- Extremely stressed or bothered

14. In the mainstream gay community, there is a lot of fighting, bickering and cattiness.

14a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

14b. How stressed/bothered are you by this potential aspect of the mainstream gay community?

- 1- Not at all stressed or bothered
 - 2- A small bit stressed or bothered
 - 3- Quite Stressed or bothered
 - 4- Very stressed or bothered
 - 5- Extremely stressed or bothered
-

15. The mainstream gay community is overly judgmental.

15a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

15b. How stressed/bothered are you by this potential aspect of the mainstream gay community?

- 1- Not at all stressed or bothered
- 2- A small bit stressed or bothered
- 3- Quite Stressed or bothered
- 4- Very stressed or bothered
- 5- Extremely stressed or bothered

16. The mainstream gay community is overly preoccupied with hook-up/dating apps.

16a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

16b. How stressed/bothered are you by this potential aspect of the mainstream gay community?

- 1- Not at all stressed or bothered
- 2- A small bit stressed or bothered
- 3- Quite Stressed or bothered
- 4- Very stressed or bothered
- 5- Extremely stressed or bothered

17. In the mainstream gay community, there is a lot of mistrust among friends.

17a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

17b. How stressed/bothered are you by this potential aspect of the mainstream gay community?

- 1- Not at all stressed or bothered
- 2- A small bit stressed or bothered
- 3- Quite Stressed or bothered
- 4- Very stressed or bothered
- 5- Extremely stressed or bothered

18. In the mainstream gay community, there is a lot of risky sex.

18a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

18b. How stressed/bothered are you by this potential aspect of the mainstream gay community?

- 1- Not at all stressed or bothered
- 2- A small bit stressed or bothered
- 3- Quite Stressed or bothered
- 4- Very stressed or bothered
- 5- Extremely stressed or bothered

19. The mainstream gay community discriminates against its members who have HIV/AIDS.

19a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

19b. How stressed/bothered are you by this potential aspect of the mainstream gay community?

- 1- Not at all stressed or bothered
- 2- A small bit stressed or bothered
- 3- Quite Stressed or bothered
- 4- Very stressed or bothered
- 5- Extremely stressed or bothered

20. The mainstream gay community is racist.

20a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

20b. How stressed/bothered are you by this potential aspect of the mainstream gay community?

- 1- Not at all stressed or bothered
 - 2- A small bit stressed or bothered
 - 3- Quite Stressed or bothered
 - 4- Very stressed or bothered
 - 5- Extremely stressed or bothered
-

Appendix E.11: Survey Measures: The Adjusted Intraminority Gay Community Stress Scale for Sexual Minority Women

Potential issues within the LBQ community

This measure presents some statements related to the Lesbian, Bisexual and Queer (LBQ) community/female sexual minority community.

In Part a, you are asked to rate how much you believe the statement to be true

- 1= Strongly Agree
- 2= Somewhat Agree
- 3= Neither Agree or Disagree
- 4= Somewhat Disagree
- 5= Strongly Disagree

In Part B, you are asked to rate how much this potential aspect of the LBQ community causes you stress

- 1= Not at all stressed or bothered
- 2= A small bit stressed or bothered
- 3= Quite stressed or bothered
- 4= Very stressed or bothered
- 5= Extremely stressed or bothered

We understand the LBQ community can mean different things to different people. Please answer the following questions in regard to your perception of the mainstream LBQ community.

1. The mainstream LBQ community overly values stylish clothes and up-to-date fashion.

1a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

1b. How stressed/bothered are you by this potential aspect of the mainstream LBQ community?

- 1- Not at all stressed or bothered
- 2- A small bit stressed or bothered
- 3- Quite Stressed or bothered
- 4- Very stressed or bothered
- 5- Extremely stressed or bothered

2. The mainstream LBQ community overly values women who are wealthy.

2a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

2b. How stressed/bothered are you by this potential aspect of the mainstream LBQ community?

- 1- Not at all stressed or bothered
 - 2- A small bit stressed or bothered
 - 3- Quite Stressed or bothered
 - 4- Very stressed or bothered
 - 5- Extremely stressed or bothered
-

3. The mainstream LBQ community sexually objectifies women of colour.

3a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

3b. How stressed/bothered are you by this potential aspect of the mainstream LBQ community?

- 1- Not at all stressed or bothered
- 2- A small bit stressed or bothered
- 3- Quite Stressed or bothered
- 4- Very stressed or bothered
- 5- Extremely stressed or bothered

4. The mainstream LBQ community values having a high status job.

4a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

4b. How stressed/bothered are you by this potential aspect of the mainstream LBQ community?

- 1- Not at all stressed or bothered
 - 2- A small bit stressed or bothered
 - 3- Quite Stressed or bothered
 - 4- Very stressed or bothered
 - 5- Extremely stressed or bothered
-

5. The mainstream LBQ community is overly focused on sex.

5a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

5b. How stressed/bothered are you by this potential aspect of the mainstream LBQ community?

- 1- Not at all stressed or bothered
- 2- A small bit stressed or bothered
- 3- Quite Stressed or bothered
- 4- Very stressed or bothered
- 5- Extremely stressed or bothered

6. It is difficult to maintain a romantic relationship in the mainstream LBQ community.

6a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

6b. How stressed/bothered are you by this potential aspect of the mainstream LBQ community?

- 1- Not at all stressed or bothered
- 2- A small bit stressed or bothered
- 3- Quite Stressed or bothered
- 4- Very stressed or bothered
- 5- Extremely stressed or bothered

7. The mainstream LBQ community overly values women who are powerful and high status.

7a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

7b. How stressed/bothered are you by this potential aspect of the mainstream LBQ community?

- 1- Not at all stressed or bothered
- 2- A small bit stressed or bothered
- 3- Quite Stressed or bothered
- 4- Very stressed or bothered
- 5- Extremely stressed or bothered

8. The mainstream LBQ community values sex over meaningful relationships.

8a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

8b. How stressed/bothered are you by this potential aspect of the mainstream LBQ community?

- 1- Not at all stressed or bothered
 - 2- A small bit stressed or bothered
 - 3- Quite Stressed or bothered
 - 4- Very stressed or bothered
 - 5- Extremely stressed or bothered
-

9. In the mainstream LBQ community, everyone has sex with each other.

9a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

9b. How stressed/bothered are you by this potential aspect of the mainstream LBQ community?

- 1- Not at all stressed or bothered
- 2- A small bit stressed or bothered
- 3- Quite Stressed or bothered
- 4- Very stressed or bothered
- 5- Extremely stressed or bothered

10. The mainstream LBQ community is overly gossipy.

10a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

10b. How stressed/bothered are you by this potential aspect of the mainstream LBQ community?

- 1- Not at all stressed or bothered
- 2- A small bit stressed or bothered
- 3- Quite Stressed or bothered
- 4- Very stressed or bothered
- 5- Extremely stressed or bothered

11. The mainstream LBQ community is overly cliquey.

11a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

11b. How stressed/bothered are you by this potential aspect of the mainstream LBQ community?

- 1- Not at all stressed or bothered
- 2- A small bit stressed or bothered
- 3- Quite Stressed or bothered
- 4- Very stressed or bothered
- 5- Extremely stressed or bothered

12. The mainstream LBQ community has a culture of competition and jealousy.

12a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

12b. How stressed/bothered are you by this potential aspect of the mainstream LBQ community?

- 1- Not at all stressed or bothered
 - 2- A small bit stressed or bothered
 - 3- Quite Stressed or bothered
 - 4- Very stressed or bothered
 - 5- Extremely stressed or bothered
-

13. The mainstream LBQ community is overly materialistic.

13a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

13b. How stressed/bothered are you by this potential aspect of the mainstream LBQ community?

- 1- Not at all stressed or bothered
- 2- A small bit stressed or bothered
- 3- Quite Stressed or bothered
- 4- Very stressed or bothered
- 5- Extremely stressed or bothered

14. In the mainstream LBQ community, there is a lot of fighting, bickering and cattiness.

14a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

14b. How stressed/bothered are you by this potential aspect of the mainstream LBQ community?

- 1- Not at all stressed or bothered
 - 2- A small bit stressed or bothered
 - 3- Quite Stressed or bothered
 - 4- Very stressed or bothered
 - 5- Extremely stressed or bothered
-

15. The mainstream LBQ community is overly judgmental.

15a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

15b. How stressed/bothered are you by this potential aspect of the mainstream LBQ community?

- 1- Not at all stressed or bothered
- 2- A small bit stressed or bothered
- 3- Quite Stressed or bothered
- 4- Very stressed or bothered
- 5- Extremely stressed or bothered

16. The mainstream LBQ community is overly preoccupied with hook-up/dating apps.

16a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

16b. How stressed/bothered are you by this potential aspect of the mainstream LBQ community?

- 1- Not at all stressed or bothered
- 2- A small bit stressed or bothered
- 3- Quite Stressed or bothered
- 4- Very stressed or bothered
- 5- Extremely stressed or bothered



17. In the mainstream LBQ community, there is a lot of mistrust among friends.

17a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

17b. How stressed/bothered are you by this potential aspect of the mainstream LBQ community?

- 1- Not at all stressed or bothered
- 2- A small bit stressed or bothered
- 3- Quite Stressed or bothered
- 4- Very stressed or bothered
- 5- Extremely stressed or bothered

18. In the mainstream LBQ community, there is a lot of risky sex.

18a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

18b. How stressed/bothered are you by this potential aspect of the mainstream LBQ community?

- 1- Not at all stressed or bothered
 - 2- A small bit stressed or bothered
 - 3- Quite Stressed or bothered
 - 4- Very stressed or bothered
 - 5- Extremely stressed or bothered
-

19. The mainstream LBQ community discriminates against its members who have HIV/AIDS.

19a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

19b. How stressed/bothered are you by this potential aspect of the mainstream LBQ community?

- 1- Not at all stressed or bothered
- 2- A small bit stressed or bothered
- 3- Quite Stressed or bothered
- 4- Very stressed or bothered
- 5- Extremely stressed or bothered

20. The mainstream LBQ community is racist.

20a. How much do you agree that the following is true?

- 1- Strongly Agree
- 2- Somewhat Agree
- 3- Neither Agree or Disagree
- 4- Somewhat Disagree
- 5- Strongly Disagree

20b. How stressed/bothered are you by this potential aspect of the mainstream LBQ community?

- 1- Not at all stressed or bothered
 - 2- A small bit stressed or bothered
 - 3- Quite Stressed or bothered
 - 4- Very stressed or bothered
 - 5- Extremely stressed or bothered
-

Appendix E.12

Items and Factor Loadings of the Adjusted Intra-minority Gay Community Stress Scale for Sexual Minority Women

Item	Original 20-item scale structure				Modified 19-item scale suppressing loadings below 0.5			
	Competition	Exclusion	Sex	Status	Competition	Exclusion	Sex	Status
In the mainstream LBQ community, there is a lot of fighting, bickering and cattiness.	.87	.01	-.04	.00	.86	–	–	–
The mainstream LBQ community is overly gossipy.	.82	-.06	.04	-.09	.83	–	–	–
The mainstream LBQ community is overly cliquy.	.79	-.10	.04	-.01	.79	–	–	–
The mainstream LBQ community has a culture of competition and jealousy.	.77	-.03	.10	.07	.76	–	–	–
The mainstream LBQ community is overly judgmental.	.69	.10	.03	.12	.69	–	–	–
In the mainstream LBQ community, there is a lot of mistrust among friends.	.68	.18	.04	-.09	.68	–	–	–
The mainstream LBQ community is overly materialistic.	.60	.00	.02	.26	.55	–	–	–
The mainstream LBQ community is racist.	-.01	.86	.00	.01	–	.88	–	–
The mainstream LBQ community discriminates against its members who have HIV/AIDS.	-.08	.81	.20	-.08	–	.79	–	–
The mainstream LBQ community sexually objectifies women of colour.	.01	.74	-.08	.16	–	.74	–	–
In the mainstream LBQ community, there is a lot of risky sex.	.24	.54	.23	-.31	–	–	–	–
The mainstream LBQ community is overly focused on sex.	-.18	.09	.80	.28	–	–	.78	–
The mainstream LBQ community values sex over meaningful relationships.	.10	.13	.77	-.01	–	–	.77	–

Appendix E.12

Items and Factor Loadings of the Adjusted Intra-minority Gay Community Stress Scale for Sexual Minority Women

Item	Original 20-item scale structure				Modified 19-item scale suppressing loadings below 0.5			
	Competition	Exclusion	Sex	Status	Competition	Exclusion	Sex	Status
In the mainstream LBQ community, everyone has sex with each other.	.08	.02	.68	-.17	–	–	.69	–
It is difficult to maintain a romantic relationship in the mainstream LBQ community.	.14	.00	.61	.05	–	–	.60	–
The mainstream LBQ community is overly preoccupied with hook-up/dating apps.	.26	-.05	.56	-.02	–	–	.56	–
The mainstream LBQ community overly values stylish clothes and up-to-date fashion.	.08	-.15	.32	.70	–	–	–	.73
The mainstream LBQ community overly values women who are wealthy.	.16	.39	-.14	.54	–	–	–	.63
The mainstream LBQ community overly values having a high status job	.24	.34	-.02	.48	–	–	–	.56
The mainstream LBQ community overly values women who are powerful and high status.	.20	.35	.05	.46	–	–	–	.52

**Appendix E.13: Survey Measures: LGBTQCC Sexual Minority Women Version
(Frost & Meyer, 2012)**

LGBTQ community

These questions are about the LGBTQ community in your area. By LGBTQ, we don't mean any particular neighbourhood or social group, but in general, groups of LGBTQ individuals.

Please indicate your agreement with the following statements

- 1- Agree Strongly**
- 2- Somewhat Agree**
- 3- Somewhat Disagree**
- 4- Disagree Strongly**

	1- Agree Strongly	2- Somewhat Agree	3- Somewhat Disagree	4- Disagree Strongly
1. You feel you're a part of the LGBTQ community.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Participating in the LGBTQ community is a positive thing for you.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. You feel a bond with the LGBTQ community.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. You are proud of the LGBTQ community.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. It is important for you to be politically active in the LGBTQ community.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. If we work together, sexual minorities can solve problems in the LGBTQ community.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. You feel that any problems faced by the LGBTQ community are also your own problems.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. You feel a bond with fellow sexual minority women.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



Appendix E.14: Survey Measures: LGBTQCC Sexual Minority Men Version (Frost & Meyer, 2012)

LGBTQ community

These questions are about the LGBTQ community in your area. By LGBTQ, we don't mean any particular neighbourhood or social group, but in general, groups of LGBTQ individuals.

Please indicate your agreement with the following statements

- 1- Agree Strongly
- 2- Somewhat Agree
- 3- Somewhat Disagree
- 4- Disagree Strongly

	1- Agree Strongly	2- Somewhat Agree	3- Somewhat Disagree	4- Disagree Strongly
1. You feel you're a part of the LGBTQ community.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Participating in the LGBTQ community is a positive thing for you.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. You feel a bond with the LGBTQ community.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. You are proud of the LGBTQ community.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. It is important for you to be politically active in the LGBTQ community.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. If we work together, sexual minorities can solve problems in the LGBTQ community.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. You feel that any problems faced by the LGBTQ community are also your own problems.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. You feel a bond with fellow sexual minority men.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



Appendix E.15: Sense of Coherence Scale short version (Antonovsky, 1987)

Here is a series of questions related to various aspects of our lives. Each question has seven possible answers.

Please mark the number that expresses your answer (**1 and 7 represent the extreme answers**).

1. Do you have the feeling that you are in an unfamiliar situation and don't know what to do?

- 1- Very often
- 2
- 3
- 4
- 5
- 6
- 7- Very seldom or never

2. Do you have very mixed-up feelings and ideas?

- 1- Very often
- 2
- 3
- 4
- 5
- 6
- 7- Very seldom or never

3. How often do you have feelings that you're not sure you can keep under control?

- 1- Very often
- 2
- 3
- 4
- 5
- 6
- 7- Very seldom or never

4. Does it happen that you have feelings inside you would rather not feel?

- 1- Very often
- 2
- 3
- 4
- 5
- 6
- 7- Very seldom or never

5. Do you have the feeling that you're being treated unfairly?

- 1- Very often
- 2
- 3
- 4
- 5
- 6
- 7- Very seldom or never

6. Do you have the feeling that you don't really care about what goes on around you?

- 1- Very often
- 2
- 3
- 4
- 5
- 6
- 7- Very seldom or never



7. When something happened, have you generally found that you:

- 1- Overestimated or Underestimated It's Importance
- 2
- 3
- 4
- 5
- 6
- 7- Saw things in the right proportion

8. Until now your life has had:

- 1- No clear goals or purpose at all
- 2
- 3
- 4
- 5
- 6
- 7- Very clear goals and purpose



**9. Doing the things you do every day is: a source of deep pleasure and satisfaction
- a source of pain and boredom**

- 1- A source of deep pleasure and satisfaction
- 2
- 3
- 4
- 5
- 6
- 7- A source of pain and boredom

**10. Has it happened in the past that you were surprised by the behaviour of people
whom you thought you knew well?**

- 1- Never happened
 - 2
 - 3
 - 4
 - 5
 - 6
 - 7- Always happened
-

11. Has it happened that people whom you counted on disappointed you?

- 1- Never happened
- 2
- 3
- 4
- 5
- 6
- 7- Always happened

**12. How often do you have the feeling that there's little meaning in the things you
do in your daily life?**

- 1- Very often
 - 2
 - 3
 - 4
 - 5
 - 6
 - 7- Very seldom or never
-

13. Many people sometimes feel like losers in certain situations. How often have you felt this way in the past?

- 1- Very often
- 2
- 3
- 4
- 5
- 6
- 7- Very seldom or never

Appendix F: Letter of Ethical Approval for Phase One from DCU REC

Ollscoil Chathair Bhaile Átha Cliath
Dublin City University



Mr Conor Mahon
School of Nursing and Human Sciences

1 February 2018

REC Reference: DCUREC/2018/004
Proposal Title: The Experience and Context of Social Anxiety in Sexual Minorities
Applicant(s): Mr Conor Mahon, Prof Pamela Gallagher, Dr Gemma Kiernan

Dear Conor,

Further to expedited review, the DCU Research Ethics Committee approves this research proposal.

Materials used to recruit participants should note that ethical approval for this project has been obtained from the Dublin City University Research Ethics Committee.

Should substantial modifications to the research protocol be required at a later stage, a further amendment submission should be made to the REC.

Yours sincerely,

A handwritten signature in blue ink that reads 'Dónal O'Gorman'.

Dr Dónal O'Gorman
Chairperson
DCU Research Ethics Committee



Taighde & Nuálaíocht Tacaíocht
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E research@dcu.ie
www.dcu.ie

Appendix G.1: Phase Two Recruitment Email to Voluntary Participant Pool



Conor Mahon <conor.mahon24@mail.dcu.ie>

4 Sep 2019, 15:45



to [REDACTED]

Dear participant,

Firstly, we would like to thank you for completing the online survey associated with our research project last year. At the end of this survey you expressed an interest in taking part in further studies associated with our research project. We are getting in contact with you today as we are now recruiting participants for the next stage of the research project.

The next phase of our study aims to learn more about social anxiety in sexual minorities (i.e., individuals who identify as non-heterosexual), and the factors that contribute to sexual minorities' experience of social anxiety through carrying out one-on-one interviews. Depending on your preference these interviews may take place over the phone or face-to-face (either at DCU or a location that suits you). We are interested in interviewing individuals who meet all of the below criteria

1. Aged 18 or above
2. Identify as a sexual minority (non-heterosexual)
3. Believe social anxiety is an issue in their life
4. Speak fluent English
5. Currently live in Ireland

Please find more detailed information about this study in the Plain Language Statement (attached). If you meet the above criteria and are interested in taking part, you may express your interest by replying to this email address. Also, please feel free to contact us with any queries or questions.

All the best,

Conor Mahon

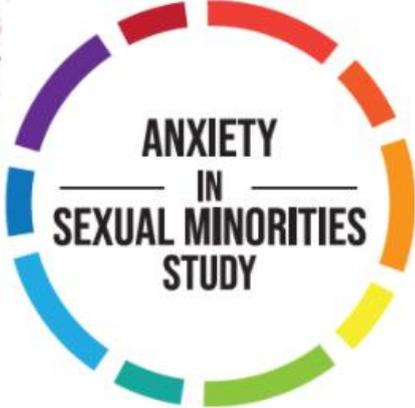
Conor Mahon

Irish Research Council PhD Candidate | School of Psychology | Dublin City University
conor.mahon24@mail.dcu.ie | +353 1700 6170 | www.dcu.ie/psychology

School of Psychology | H101E | Faculty of Science and Health | Dublin City University |
Glasnevin Campus | Dublin 9 | Ireland



Appendix G.2: Phase Two Facebook Recruitment Advertisement



**Are you a sexual minority man?
(Identify as non-heterosexual)
Are you aged 18+?
Do you think social anxiety is an issue in your life?**

We are interested in hearing from you.
To register your interest to partake in an interview,
please contact us via phone or email.

  **+3531 700 6179**
 **conor.mahon24@mail.dcu.ie**

 **#LoveIrish
Research**



Appendix H.1: Phase Two Plain Language Statement



Plain Language Statement

Title of Research Study: Social Anxiety in Sexual Minorities Study

Principle Investigator: Mr. Conor Mahon (email: conor.mahon24@mail.dcu.ie; Tel: 01 700 6179)

Co-investigators: Prof Pamela Gallagher (Tel: 01 700 8958), Dr Gemma Kieman (Tel: 01 700 8542)

Introduction: Thank you for showing interest in this study. You are being invited to take part in this study (funded by the Irish Research Council), which is being conducted by Conor Mahon, as part of his PhD project in the School of Nursing and Human Sciences in Dublin City University (DCU). Before deciding whether or not to participate, please read the following information carefully. If you have any further questions, or require additional information, please do not hesitate in contacting the research team (details provided above).

This study has received ethical approval from the Research Ethics Committee of Dublin City University.

Background and aims of the study: Social anxiety (the fear and avoidance of social and/or performance situations) is experienced at higher levels by sexual minority individuals (those who identify as non-heterosexual) when compared to their heterosexual counterparts. This area of research remains underexplored; we are interested in learning more about social anxiety in sexual minorities, and what factors contribute to sexual minorities' experiences of social anxiety.

Am I eligible to take part in the study? To take part in this study, you need to 1) be aged 18 years or older, 2) identify as a sexual minority, 3) believe social anxiety is an issue for you, 4) be fluent in English and 5) live in Ireland.

What does participation in the study involve? If you agree to take part in this study, you will be asked to participate in a one-on-one interview. Depending on your preference, you may complete the interview face-to-face (i.e., in a private room in DCU or a location that is convenient for you), or over the telephone. At the start of the interview, you will be asked to complete a short questionnaire on demographic details and social anxiety. Mr. Conor Mahon will deliver the one-on-one interview and you will be asked questions related to your experiences of social anxiety and the factors that contribute to this experience. The duration of the interview is estimated to be one hour. All interviews will be recorded and transcribed. Only the research team will have access to the data and all information will be kept confidential within the limitations of the law.

Are there any risks associated with the study? There is a possibility you may become upset by the nature of the questions asked, or, by recollecting a previous experience in which you felt socially anxious. If at any stage during the interview, you feel upset or concerned, you can withdraw before completion and you are not required to give any reason for your decision. If you want to discuss these potential concerns any further, support services are available through LGBT Ireland (Online instant messaging support: www.lgbt.ie Helpline: 1890 929 539) or the Samaritans Helpline (Tel: 116 123).

Are there any benefits (direct or indirect) to my involvement in the study? The information you and others provide will advance our understanding of social anxiety in sexual minority individuals. It may also provide important information for the development of future supports tackling social anxiety in sexual minorities.

How will the information I provide be protected? How will my identity be protected? This study complies with the EU General Data Protection Regulation. If you agree to take part in this study, you

will be asked to partake in a one-on-one interview. Audio-recorded data collected during the interview will be potentially identifiable. There is a small risk that some of the information you provide will identify you (e.g., quotes used). Anonymity cannot ever be guaranteed 100% but the research team will make every effort made towards it. Only the research team will have access to this data and identifiable information will be removed during the transcription process. Findings published from this study in reports and journal articles will not contain any personally identifiable information. Confidentiality of information provided can only be protected within the limitations of the law. Should the interviewer believe that you are a danger to yourself or others, or, if a child protection issue arises, confidentiality will not be protected. It is also possible for data to be subject to subpoena, freedom of information claim or mandated reporting by some professions.

What will happen to the data? The data collected for this study will be summarised and will be presented in a PhD thesis to be submitted to DCU. The data, in an anonymised form, may also be published in journals or reports, presented at conferences, or communicated to mental health professionals. Information will be stored confidentially for up to 5 years under password protection on the principal investigators' online drive. After this period, all electronic files will be destroyed permanently. A one-page summary of the findings from the survey will be made available on the project Facebook page.

Involvement in the study is voluntary and you have the right to withdraw: Participation in this study is completely voluntary, you can withdraw before starting the interview or during its completion, without having to provide a reason. It will not be possible to withdraw your information after it has been combined with other participant data as the research team will have no way of identifying your data from others.

What to do if there are concerns about the study: If you have any concern about this study and wish to contact an independent person, please contact: The Secretary, Dublin City University Research Ethics Committee, c/o Office of the Vice-President for Research, Dublin City University, Dublin 9.

You may also contact the project co-investigators Prof Pamela Gallagher (Tel: 01 700 8958) and/or Dr Gemma Kiernan (Tel: 01 700 8542).

Appendix H.2: Phase Two Informed Consent Form



Title of Research Study: Social Anxiety in Sexual Minorities Study

Principle Investigator: Mr. Conor Mahon (email: conor.mahon24@mail.dcu.ie; Tel: 01 700 6179)

Co-investigators: Prof Pamela Gallagher (Tel: 01 700 8958), Dr Gemma Kiernan (Tel: 01 700 8542)

Background and aims of the study: Social anxiety (the fear and avoidance of social and/or performance situations) is experienced at higher levels by sexual minority individuals (those who identify as non-heterosexual) when compared to their heterosexual counterparts. This area of research remains underexplored; we are interested in learning more about social anxiety in sexual minorities, and what factors contribute to sexual minorities' experiences of social anxiety.

Participant – please complete the following [tick Yes or No for each question]

- | | | | | |
|--|--------------------------|-----|--------------------------|----|
| I have read the plain language statement | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| I understand the information provided | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| I know who to contact to ask questions and discuss this study | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| I am aged 18 or above | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| I am a sexual minority | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| I understand my participation is entirely voluntary | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| I am aware that I may withdraw at any stage right up until the point at which my interview data is combined with other participants' data, without giving reason | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| I am aware that confidentiality of information provided can only be protected within the limitations of the law | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| I have read and understand the information on this form and consent to take part in this study | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

Participant's Signature: _____

Name in Block Capitals: _____

Date: _____

Appendix H.3: Phase Two Demographics Form

What age are you?	
What country are you living in?	
What is your nationality?	
Would you describe your current residence as urban or rural?	
What is your ethnicity? (please circle one)	White Irish Irish Traveller Other White Black Irish or Black African Other Black Chinese Other Asian Other/Multiracial
What is your relationship status? (please circle one)	Single Partnered
What was your sex assigned at birth? (please circle one)	Female Male Intersex
What is your current gender identity? (please circle one) Cisgender describes a person whose gender identity matches the sex they were assigned at birth. For example, someone who is born female, and identifies as a woman, would be considered a cisgender woman	Cisgender man Cisgender woman Transgender man Transgender woman Genderqueer/non-binary Other (please specify) _____
Which of these categories best describes you? (please circle one)	Gay Lesbian Bisexual Queer Questioning/Unsure Other (please specify) _____

Appendix H.4: Hard Copy of the Brief Fear of Negative Evaluation Scale (Leary, 1983)

**Brief Fear of Negative Evaluation Scale
Leary (1983)**

Read each of the following statements carefully and indicate how characteristic it is of you according to the following scale:

- 1 = Not at all characteristic of me
- 2 = Slightly characteristic of me
- 3 = Moderately characteristic of me
- 4 = Very characteristic of me
- 5 = Extremely characteristic of me

- _____ 1. I worry about what other people will think of me even when I know it doesn't make any difference.
- _____ 2. I am unconcerned even if I know people are forming an unfavorable impression of me.
- _____ 3. I am frequently afraid of other people noticing my shortcomings.
- _____ 4. I rarely worry about what kind of impression I am making on someone.
- _____ 5. I am afraid others will not approve of me.
- _____ 6. I am afraid that people will find fault with me.
- _____ 7. Other people's opinions of me do not bother me.
- _____ 8. When I am talking to someone, I worry about what they may be thinking about me.
- _____ 9. I am usually worried about what kind of impression I make.
- _____ 10. If I know someone is judging me, it has little effect on me.
- _____ 11. Sometimes I think I am too concerned with what other people think of me.
- _____ 12. I often worry that I will say or do the wrong things.

From: Leary, M. R. (1983). A brief version of the Fear of Negative Evaluation Scale. *Personality and Social Psychology Bulletin*, 9, 371-376.

Appendix H.5: The Semi-Structured Interview Topic Guide

Starter Question: Could you please tell me about your personal experience of social anxiety?

What happens? What are your symptoms? What happens in your head? What happens in your body?

How long have you experienced social anxiety for?

In what situations are you most likely to experience social anxiety?

Could you describe the most recent scenario/situation in which you felt highly socially anxious?

What were you thinking in this moment?

What triggers your social anxiety?

Are there any scenarios that make you feel socially anxious that you purposively avoid? Could you describe them for me?

Are there any stressors or factors that contribute to your social anxiety?

Tell me a little bit more about [insert stressor] and how that makes you feel socially anxious

How does social anxiety impact your life?

Do you think being [insert sexual orientation] plays a role in your experience of social anxiety? Could you tell me a little more about that?

Is being a [insert sexual orientation] ... something that impacts your experience of social anxiety?

Could you tell me about your social experiences within the LGBTQ community?

Do you feel more anxious surrounded by LGBTQ peers or in the general population?

Are there any particular stressors within the LGBTQ community that make you feel socially anxious?

Is there an aspect of the LGBTQ community that may protect you from feeling socially anxious?

What helps protect against your experience of social anxiety?

Are there any barriers to accessing [insert named protective factors]?

What makes it difficult to deal with social anxiety?

How do you cope with social anxiety?

How have you gotten to this point? (i.e., if participant is now coping better).

Have you noticed any difference in the social climate towards sexual minorities in Ireland?

Has this played a role in your experience of social anxiety?

Clean-up question: Do you have any final thoughts? Or, is there something I haven't asked you about that you think is relevant?

Wellbeing question: How are you feeling now having completed the interview?

Appendix H.6: The Phase Two Debriefing Form



Social Anxiety in Sexual Minorities Study

Thank you for taking the time to participate in our research study. We really appreciate it and we hope it was a positive experience for you.

If you have been affected by any of the issues discussed in the interview, or wish to access a support service, please do not hesitate to contact LGBT Ireland. LGBT Ireland provides support for LGBTQ+ people via a low cost telephone helpline and/or a free online instant messaging support platform. All LGBT Ireland volunteers have received mental health training. We have also provided the contact details for Samaritan's Ireland.

LGBT Ireland

Website: <https://lgbt.ie/>

Online instant messaging support: <https://lgbt.ie/instant-messaging-support-service/>

Helpline: 1890 929 539

Samaritans Ireland

Website: <https://www.samaritans.org/?nation=ireland>

Helpline: 116123

Appendix I.1: Letter of Ethical Approval for Phase Two from DCU REC

Ollscoil Chathair Bhaile Átha Cliath
Dublin City University



Mr Conor Mahon
School of Nursing and Human Sciences

2nd May 2019

REC Reference: DCUREC/2019/086

Proposal Title: The Experiences and Context of Social Anxiety in Sexual Minorities

Applicant(s): Mr Conor Mahon

Dear Conor,

Further to full committee review, the DCU Research Ethics Committee approves this research proposal.

Materials used to recruit participants should note that ethical approval for this project has been obtained from the Dublin City University Research Ethics Committee.

Should substantial modifications to the research protocol be required at a later stage, a further amendment submission should be made to the REC.

Yours sincerely,

A handwritten signature in black ink that reads 'Mark Philbin'.

Dr Mark Philbin
Interim Chairperson
DCU Research Ethics Committee



Taighde & Nuálaíocht Tacaíocht
Ollscoil Chathair Bhaile Átha Cliath,
Baile Átha Cliath, Éire

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Appendix I.2: Phase Two Protocol for Supporting a Distressed Participant

There is a chance that a participant may become upset or distressed during data collection. As the sexual minority adults who participate in the interviews will have volunteered their participation on the basis that social anxiety is an issue for them, they may find the interview itself anxiety provoking. The protocol to deal with these potential issues is outlined below.

Protocol if a participant becomes distressed/upset during an interview

The principal investigator will remain alert for both verbal and non-verbal (i.e., for face-to-face interviews) indicators of distress during interviews. Should a participant become upset/distressed, the principal investigator will adopt the following protocol:

- Respond in a sensitive manner to the participant by stopping all conversation related to the research questions and check in with the participant (e.g., "Are you feeling ok? You sound upset").
- Acknowledge the participant's distress, demonstrate empathy toward the participant where appropriate (within the boundaries of the researcher role), and give the participant time to deal with their feelings of distress accordingly.
- Remind participants that they are not obliged to complete the interview and may cease participation whenever they wish.
- Only recommence the interview if the participant is no longer distressed and indicates they wish to continue.
- Remind participants of the support services provided by LGBT Ireland and Samaritans Ireland.
- At the end of the interviews participants will be given a debriefing sheet with the contact details of LGBT Ireland and Samaritans Ireland.

Appendix J.1: Coding Sample

[Click to edit](#)

So just to get started, one of the criteria coming forward, was that you believe that social anxiety is an issue in your life. So could you just start off in your own words to me, tell me about your personal experience of social anxiety?

Yes definitely social anxiety is a problem in my life. I have had treatment for it, eh I have had counselling for social anxiety. Because I think it's because being gay it's kind of like you are under a microscope, I feel like people are watching you a lot more than they would maybe if you weren't. I don't know if that's true or not at all? But I feel like it is definitely a problem. Because I think people watch how you act and watch how you talk more, for the way you are like. People are very critical of you, especially down here anyway I feel.

Ok, and so can you pinpoint a time in your life when you first noticed that social anxiety was an issue for you?

I'd say it was about 6th year, which was last year. Eh, people just started to become more critical as I was growing older and starting to move into college, they kind of started to watch how I was acting, as I was to grow into myself a bit more. And I just found it, thought me a lot and people would be watching and criticising and kind of talking behind you I'd feel. And I just feel very anxious of what they would be saying or whatever, like you know?

Coding Density

P21_CM

Unwillingly in the spotlight

Accessed therapeutic intervention

Structural change

Perceived audience (unwanted attention)

Lad culture (not accepting)

Friend support (protective)

Family support

Breathing exercises

Sexual ID - makes you target

Uncertainty regarding others/prejudice

LGBT community (resource in difficult times)

Accessed therapeutic intervention (beneficial effects)

Religious ethos

Learn to manage (implement techniques)

Experiences of discrimination (verbal abuse)

Learn to manage (using resources)

Feel different to straight men (don't fit in)

Strangers (uncertainty re attitude)

Social (sensitive to other stressors)

Self-monitoring (flamboyancy)

Gay men are bitchy

Attention to threat (body lang)

Negative cognitions (emotor)

Appendix J.2

Thematic Findings

Research question	Theme	Sub-theme	Codes
How does social anxiety manifest among sexual minority individuals?	Deleterious thinking	Voice of the inner critic	Inner critic (underperforming) Inner critic (overanalyse) Negative cognitions (racing thoughts) Negative cognitions (catastrophising) Detect judgment regarding worthiness Meet others' expectations
		The social stage: Self-focus and austere attention to audience	Perceived audience (wary of performance) Perceived audience (aware of other's opinions) Perceived audience (unwanted attention) Unwillingly in the spotlight Attention to threat Identifying self as outsider exacerbates SA (social disadvantage)
		Bookend threat detection	Anticipatory processing (rehearsal) Anticipatory processing (discomfort) Post-event processing
		Forging social safety	Threat evasion
	Concocting a social shield		Safety behaviour (distraction) Safety behaviour (command other's attention) Humour to buffer SA Play it safe to avoid threatening stimuli Stay on periphery Self-monitoring (appeal to others) People pleasing Plan ahead (preserve energy) Plan ahead (gain knowledge of environment)
	Bodily botheration	Variations of bodily botheration	Physiological symptoms
		Exhibiting bodily anxiety "people are seeing through me"	Physiological (fear other's noticing)

Appendix J.2

Thematic Findings

Research question	Theme	Sub-theme	Codes	
What are the contexts in which sexual minority individuals experience social anxiety?	The sexual minority community, a double-edged sword	Amongst your own	Comradery with other LGBT people Comfortable around LGBT peers Amongst your own LGBT community (resource in difficult times) LGBT community is safe space LGBT community more accepting	
		Tough to gain a social foothold	Not associated with LGBT community Tough to infiltrate LGBT community (not welcoming) Tough to infiltrate LGBT community (don't know anyone) Tough to infiltrate LGBT community (hesitant) Discomfort around LGBT peers (don't know how to act) Gay men (can't relate) Gay men (don't have same interests)	
		Encountering gay hierarchies "innately judged by the gay glitterati" (M) Callous counterparts (M)	Gay hierarchies (physical attractiveness) Gay hierarchies (masculinity) Gay hierarchies (sub-communities) Gay negative evaluation hurts more Gay men are bitchy Gay men are cliquey Gay men are intimidating	
		Pressure to adhere to community ideals (W)	Pressure to adhere to community ideals Tough to infiltrate LGBT community (being bi) Biphobia (within community) Lesbian vs bi	
		Dating, confined community complications (W)	Sexual minority environment, higher stakes Small community (everybody knows each other) Friends as potential romantic partners Gay men no threat (mutual disinterest)	
		Navigating "the heteronormative society we live in"	An anxious adolescence: Pernicious peers and forbidding family	Bullying in school (physical) Bullying in school (social pariah) Bullying in school (verbal abuse) Indirect discrimination (bullying school)

Appendix J.2

Thematic Findings

Research question	Theme	Sub-theme	Codes
			Felt different in school
			Self-stigma
			Family (homophobic attitudes)
			Negative parent relationship
			Felt different in school (isolated)
			Felt different in school (didn't fit in)
			Sexual ID (felt different when young)
			Struggles with peers as child
			Childhood (affirmations gay is not ok)
		The trials and tribulations of lad culture (M)	Lad culture (don't fit in)
			Lad culture (facilitates homophobia)
			Lad culture (exacerbates SA)
			Lad culture (not accepting)
			Lad culture (micro aggression)
			Fear straight men perceive attraction
			Discrimination (verbal abuse by men)
			Discrimination (physical abuse by men)
			Indirect discrimination (slurs/unfavourable attitudes)
		Intersectional afflictions (W)	Discrimination (ridiculed for being sexual minority woman)
			Justifying sexuality to others
			Being hit on by heterosexual men
			Uncertainty regarding others prejudice
		To conceal, or not to conceal?	Self-monitoring (flamboyancy)
			Self-monitoring (PDA)
			Self-monitoring (maintain straight ID)
			Self-monitoring (talk interests)
			Self-monitoring (work)
			Coming out (revert back to closet)
			Coming out (stayed in closet)
			Coming out (don't disclose)
			Coming out (constant decisions)
			Coming out (relieved social stress)

Appendix J.2

Thematic Findings

Research question	Theme	Sub-theme	Codes
How do sexual minority individuals cope with social anxiety?	Safeguarding with support	Subsiding structural stigma	Society acceptance is growing Structural change Positive impact of marriage referendum Society acceptance (growing but slowly) Society acceptance (homophobic cracks) Influence of past society
		Shelter in one's personal support sanctuary	Friend support (protective) Friend support (comfortable) Friend support (bring anxiety down in moment) Peer acceptance Spouse support Family support School support
		Intervention engagement, knowledge is power	Accessed therapeutic intervention Attend therapy (counselling) Accessed support group Accessed therapeutic intervention (beneficial effects) Meditation group Mindfulness Learn to manage SA (understand it better) Learn to manage (using resources) Increased self-efficacy Outcomes of therapy (did not work)
	Thwarting threats with techniques	Thinking through the threats	Learn to manage (implement cognitive techniques) Engage in rational thinking Recognise negative cognitions Manage inner critic
		Riding the anxiety wave	Persevere (face things head on) Persevere (sit through anxiety) Practice/exposure (improves social abilities) Practice/exposure (professional) Learn to manage (exposure)

Appendix J.2

Thematic Findings

Research question	Theme	Sub-theme	Codes	
How does social anxiety impact sexual minority individuals' daily lives?	Diluting social inhibitions		Substance (alcohol to cope) Substance (smoking) Substance (chemsex)	
	Behind the social pack	SOMO (sense of missing out) in solitude	Social impact (withdrawal) Social impact (missing out)	
		Everyday (dis)functioning: Complexities conversing	Daily functioning is a struggle Social impact (lack skills) Struggle to initiate conversation Struggle to maintain conversation Prevents stating opinions or defending self Social impact (sensitive to other stressors) Social impact (inadequacy)	
		Support network...under constriction	Social impact (trouble making friends) Struggle to initiate social plans Social repercussions (fear losing friends) Social impact (dating) Romantic relationships (difficulties due to SA)	
	Emotional toll		Emotional (exhausted) Emotional (down) Emotional (overly empathetic) Fear offending others Comorbid mental illness (intertwined with depression) Comorbid mental illness (suicide) Major life events (suicide attempt)	
	Obstacles in career path	Arduous educational attainment (M)		Educational impact (hindered progression) Educational impact (absenteeism)
			Professional interference	Professional struggles (day to day) Professional struggles (hindered progression) Performance deficits (work)

Note. (W) denotes sub-themes specific to sexual minority women and (M) denotes sub-themes specific to sexual minority men.