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“Shame, Doubt and Sadness”: A Qualitative Investigation of the Experience of Self-Stigma in Adolescents with Diverse Sexual Orientations

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Abstract: Many adolescents with diverse sexual orientations lead happy and fulfilled lives. However, evidence consistently suggests elevated rates of mental health difficulties in this population relative to heterosexual peers, and internalization of stigma (i.e., self-stigma) is implicated in these elevated rates. This study aimed to understand and describe the lived experience of self-stigma with respect to participants’ sexual orientations. To do this, N = 21 semi-structured interviews were conducted with adolescents aged 14–18 who are attracted to the same gender, asking about how their stigma experiences affected their views of their sexual orientation, and themselves. A community reference group of young people with diverse sexual orientations was also consulted in the development of the study, and interpretation of the themes. Through thematic analysis of the self-stigma data and the consultation process, four themes were developed: (1) stigma is a precursor to self-stigma; (2) acceptance is a precursor to self-acceptance; (3) contents of self-stigma, characterized by two subthemes: (i) self-shame (comprised of feelings of abnormality, self-disgust and/or being a ‘bad’ person) and (ii) self-invalidation; and (4) self-stigma is painful and can be damaging. There is a contrast between the way that internalized homophobia is operationalized, and the way self-stigma was characterized in this study with young people, and conceptualizing and measuring self-stigma may need to be updated. Based on the analysis, we suggest four ways to address self-stigma and its impacts: (1) individual intervention; (2) increasing acceptance in families and communities; (3) providing respectful and normalizing sexuality education and information; and (4) overcoming community stigma.

Keywords: stigma; self-stigma; qualitative; sexual orientation

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1. Introduction

Experiencing stigma is detrimental to the mental wellbeing of people with diverse sexual orientations (for example, people who identify as lesbian, gay, bisexual, or pan-sexual) [1,2]. Stigma occurs when societal norms define particular attributes, such as same-gender attraction, as “abnormal, shameful or otherwise undesirable” [3,4]. The root of the issue is therefore not the stigmatized individual themselves, but their context. Stigma is theorized to affect people with diverse sexual orientations in a variety of ways, including direct experiences of prejudice, structural discrimination, and abuse, as well as more indirect expressions of stigma such as leading sexuality diverse individuals to expect rejection from their peers, and leading them to conceal their sexuality from others, resulting in stress and distress [5]. At the individual level, understanding exactly how stigma affects people is needed to develop approaches to remedying the issue effectively, and reducing the disproportionate burden of mental health difficulties experienced by this group [1,6]. Given that this disparity emerges early in youth, and may peak in adolescence, answering these questions in young adolescent populations is of particular concern [7].

1.1. Internalized Homophobia and Conceptual Uncertainty

There is a long history of understanding at least some of the disproportionate mental health difficulties experienced by people with diverse sexual orientations, in terms of their experience of internalizing the stigma that they experience externally, also referred to as internalized homophobia [8–11]. Minority stress theory, and more recently, the psychological mediation framework, positions internalized homophobia as one of several stigma-based stressors that influence mental health in young people with diverse sexual orientations, and potentially the most damaging [1,5]. Empirical research has demonstrated associations with depression and anxiety, psychological distress, suicidal ideation, body dissatisfaction, and physical health outcomes, including in adolescents (for reviews, see [11–14]). These findings suggest that internalized homophobia is likely to be impactful and clinically relevant in the lives of adolescents with diverse sexual orientations, and, therefore, a potentially helpful target for intervention.

Our ability to translate this potential is hampered by the fact that internalized homophobia's definition and conceptualization remain inconsistent. In research, it is usually explicitly defined in a way that is consistent with what the broader stigma literature would refer to as 'self-stigma', that is, the internalization of negative attitudes about diverse sexual orientations and the application of those attitudes to oneself [11,15]. In practice, however, internalized homophobia is usually operationally defined in such a way to include other constructs than self-stigma alone [12,13], such as: fear of stigma (worry that stigma may be encountered; [16,17]); and attitudes to and decisions about disclosure (whether one's sexual orientation is openly known or hidden; [17,18]). Additionally (and perhaps in doing so), internalized homophobia research may also conflate outcomes of self-stigma (social avoidance, desire to change sexual orientation), rather than on self-stigma content (the beliefs about one's sexual orientation that precede these outcomes, and that would theoretically be the main target of intervention).

There is certainly value in understanding the impact of a range of stigma-related constructs on wellbeing; however, their amalgamation under the single term internalized homophobia makes it difficult to tease apart exactly what aspect of stigma is being discussed, and what has been measured in research to date. Failing to distinguish between these constructs in their conceptualization and measurement diminishes our specificity in understanding how stigma/self-stigma affects individuals, and how to intervene appropriately. This is not merely an academic exercise; rather, different aspects of internalized homophobia require different strategies and solutions (e.g., attitudes about disclosing would have different solutions to self-stigma beliefs, even though these are related). Overall, it is likely to be helpful, both theoretically and practically, to develop a deeper understanding of how the constructs that fall under internalized homophobia each individually affect members of this population.

1.2. Self-Stigma in Adolescents with Diverse Sexual Orientations

In this study, we have decided to focus on the self-stigma construct specifically for two reasons: (1) that this construct, although unclear in its operationalization, has typically been understood as the main, defining facet of internalized homophobia, and its most "insidious" [5]; and (2) in the broader stigma literature, the direction of stigmatizing attitudes towards oneself has been found to be a highly distressing experience, with significant impacts on mental health and with potential for intervention e.g., [19].

As it is understood in the broader literature, self-stigma is a cognitive construct comprising negative attitudes toward the stigmatized aspect of oneself, thought to occur when one observes stigma in their environment, accepts it, and applies it to oneself [20–23]; for example, coming to believe that one's sexual orientation is disgusting after seeing others react to it with disgust. Self-stigma can have detrimental consequences for an individual that may be cognitive (e.g., reduced self-esteem), affective (e.g., distress), and/or behavioral (e.g., social withdrawal; [4,21,22]). Not everyone who experiences stigma will develop self-stigma, and it is possible to instead disagree with the public stigma [23]. Although

most self-stigma research pertains to self-stigma in individuals living with mental illness, the same general conceptualization can be applied to any stigmatized population [3].

Reviewing the literature with the above definition in mind makes it apparent that our understanding of self-stigma for this population is currently lacking. To our knowledge, there is no research that specifically explores how people with diverse sexual orientations experience self-stigma, nor is there any coherent description of what the content of self-stigma is for this group (that is, what negative beliefs people have about their sexuality), outside of one study in adult women describing a belief of diverse sexual orientations being “wrong” [24]. These problems are in addition to more practical concerns, such as the tendency of the field of sexual diversity to focus on adult gay men [13], and the mooring of this subfield in historical contexts that may be largely irrelevant to youth today, who have grown up in a different social world to their predecessors [25]. Self-stigma is likely to be a deeply painful experience, and is potentially a highly important one, to understanding the lives of people with diverse sexual orientations [5], and it warrants investigation in current society that is not hampered by these conceptual uncertainties and practical concerns.

1.3. The Current Study

Taken together, research into self-stigma in adolescents with diverse sexual orientations needs to be resituated, and the ideal place to begin to achieve this is deriving from the lived experiences of the population itself. The goal of the study was to develop a better understanding of the experience of self-stigma as a discrete cognitive construct in adolescents with diverse sexual orientations. Given that the study is therefore driven by an a priori theoretical understanding of what self-stigma is, with a desire to understand how this construct plays out for this population, a theoretical thematic analysis approach was chosen [26]. Specifically, we aimed to answer the research question: how do adolescents with diverse sexual orientations experience self-stigma?

2. Method

2.1. Participants

Twenty-one adolescents with diverse sexual orientations (aged 14–18 years, $M_{\text{age}} = 16.19$, $SD = 0.98$) participated in the study. Most participants described themselves as either male ($n = 9$) or female ($n = 9$), and as either gay or homosexual ($n = 7$), lesbian ($n = 6$) or bisexual ($n = 6$).

Participants were recruited through targeted sampling; flyers and newsletters in LGBTIQ+ youth community organizations in Perth, Western Australia, and a brief period of targeted advertising on Facebook and Instagram. Recruitment lasted 4 months and was ongoing until the themes appeared stable and adequately represented by a variety of participants.

2.2. Procedure

Ethics approval was granted by the University of Western Australia human research ethics committee. The development of the study and interpretation of the results was conducted alongside a community reference group of seven young people with diverse sexualities. Prior to the development of the interview schedule, members of the research team met with the reference group to discuss the plans for the study and receive community feedback. The group helped develop the questions for the interview protocol, with the aim of being respectful and sensitive. Following the completion of the interviews and data analysis, the themes from the interviews were discussed with the group to evaluate their appropriateness, relevance, and sensitivity. The outcomes of this discussion are described in the results section.

The questions in the semi-structured interview protocol were designed to explore the participants’: (1) individual and social context (e.g., how do you describe your sexual orientation? Do other people know about your sexual orientation?); (2) experience of external stigma (e.g., have you experienced stigma about being gay/lesbian/bisexual?);

and (3) experience of self-stigma (e.g., sometimes experiencing or fearing stigma can affect the way that people see themselves. At times, do you feel any of this stigma about yourself?). Probing questions and prompts were used to encourage participants to elaborate on their responses to these questions (e.g., can you give me an example of a time where you felt this way?). Interviews were conducted by the first author. Although we asked participants about stigma to contextualize self-stigma questions, only the content and analysis relevant to self-stigma is reported for this study.

A variety of options were provided to enable participation. Participants completed the interview in person ($n = 2$), over the phone ($n = 12$), or via instant messaging using WhatsApp messenger ($n = 7$). The opportunity to complete the interview over video chat was also offered but not requested by any participants. Interviews via instant messaging were offered specifically due to concerns that potential participants, particularly those most vulnerable, may fear being overheard by their families and not take part in the study as a result, which would lead to concerns about a biased sample. Further, our reference group of adolescents with diverse sexual orientations suggested that text messaging is a highly used form of communication that would enable participation. WhatsApp was chosen specifically for this purpose due to its relative familiarity, ease of use, and default end-to-end encryption. Interviews via instant messaging showed lower word volume than in-person and phone interviews, consistent with previous observations to this effect [27]; however, the thematic content of the interviews was consistent regardless of interview mode.

Participants provided written consent prior to taking part in the interviews. Parental consent for participants under 18 years was not sought or required for participation, due to the possibility of doing so leading to harm or leading to a biased sample, with children of unsupportive parents being unlikely to participate were their consent required. The age, 14, was chosen as the lower bound for participant recruitment for the practical reason that this was the lowest age for which the ethics board would agree to waive the need for parental consent. The need for avoiding parental consent was strongly reinforced by the members of our community reference group, and is a well-established and recommended protocol in the literature for this population [28]. In the same vein, all participants were given the option of participating in the interviews anonymously, such as by using a pseudonym. Immediately prior to conducting all interviews, participants were asked to affirm that it was safe for them to participate at that point in time.

2.3. Data Analyses

The qualitative data was primarily analyzed by the first author, who is a clinical psychology trainee and gay, cisgender young male, with clinical experience working with lesbian, gay, bisexual, and queer young people, and lived experience of stigma and self-stigma. The analysis was aided by the last author, who is a heterosexual, middle-aged, cisgender female, clinical psychologist, and university academic, with qualitative and quantitative research expertise in mental health stigma and self-stigma. We note two consequences of the first author's context that affect the study: (1) participants were aware the interviewer was also a young person with a diverse sexual orientation who may have shared experiences; and (2) some experiences described by the participants were shared by the first author, and some experiences were markedly different and unfamiliar. In anticipation of these factors, we approached the study with full recognition that the first author's experiences and context could not possibly be removed from the process, and resultantly abandoned the notion of taking a positivist or objectivist approach to the data analysis very early in the study's development, instead leaning into a constructivist, subjective approach.

Further, given both the first and last author's immersion in the stigma and self-stigma literatures, we inevitably and intentionally approached the analysis with a pre-conceived broad definition of self-stigma, as well as the assumption that both stigma and self-stigma would be experienced in some fashion. We acknowledge that significant aspects of the analytic process were therefore theoretically informed. In particular, the interview protocol

was intrinsically developed with this understanding of these constructs in mind. In keeping with the aim of developing a new understanding of how self-stigma is experienced in this group, however, themes in the data with regard to the experience of self-stigma and its content for this group were generated inductively, without regard for previous research and thought on the topic in this particular population.

The transcribed data was analyzed primarily by the first author using Braun and Clarke's thematic analysis method [26]. This method was chosen due to its ability to support the above constraints of: (1) requiring a constructivist, subjective approach; and (2) the ability to acknowledge and bring our previous understanding of self-stigma to the analysis in what Braun and Clarke term theoretical thematic analysis. Analysis began with familiarization with the data. All interviews were conducted and transcribed verbatim by the first author, with the goals of immersion and enhancing adequacy of interpretation [29]. To enhance the trustworthiness of the approach, early stages of analysis began with reflexive journaling during this process, which continued for the duration of the analysis [29]. Analysis continued with the application of simple initial codes to the data. This was completed by both the first and last author, with the aims of developing a more nuanced understanding of the themes in the data through comparing our shared and divergent interpretations, as informed by our different personal contexts, and establishing inter-rater reliability. These codes were iteratively collapsed and combined, following which the codes were sorted and categorized into overarching themes, with emerging theme decisions made in consultation with the last author. To further build trustworthiness, these themes were reviewed with the full research team and revised, before presenting them to the youth reference group, who provided feedback and interpretation as discussed below.

3. Results

Thematic analysis of the data resulted in the development of the following four key themes, describing how adolescents with diverse sexual orientations experience self-stigma: (1) stigma is a precursor to self-stigma; (2) acceptance is a precursor to self-acceptance; (3) the content of self-stigma is characterized predominantly by self-shame or self-invalidation; and (4) self-stigma can be painful and damaging. No trends were noted in the expressed data based on sexual orientation or gender.

There were two contexts noted relevant to understanding the lived experience of self-stigma for these participants. First, all participants were aware of external stigma, and although its form, frequency, and impact, varied greatly, this stigma was omnipresent in the lives of most of the young people interviewed. External stigma could be experienced directly and explicitly: *"There were many times people told me I should kill myself or that I would be better off dead"*. More often, however, participants described that they were aware of stigma in society, but rarely experienced it in a direct and targeted way: *"My day-to-day experience at school it isn't really acknowledged by other people, and everyone seems pretty neutral about it, at least as far as I know"* and *"So you're hearing the stigma, but it was never directly aimed at me"*. It was sometimes highlighted that although direct stigma was rare for some individuals, stigma could still be sensed in some fashion: *"It's just sort of, there's sort of a . . . I dunno how to say it, it's sort of an atmosphere of like, not being accepting about it, I guess . . . Like, they really . . . it's never really explicit but it's very heavily implied, I think"* and *"I dunno, there's kind of like an uncomfortable silence whenever things related to the LGBT community are mentioned"*.

The study's reference group raised an additional and crucial contextual factor of the isolation and sense of difference experienced by adolescents with diverse sexual orientations. This was not initially interpreted by the researchers as a contextual factor; however, after being raised by the reference group, the interviews were read again and support for this context was found: *"Like, um, and I think it's because you feel so alone when you're young and you're LGBT. You feel so alone. No one else is like this. No one else is feeling this"*, and *"I feel like . . . you just feel not, like, you're part of, like, you know, the school community in a way. And you feel like a bit um, yeah, just a bit detached. And it does get to me a bit"*. Some participants had

known peers or family with openly diverse sexual orientations around them when they identified their own sexual orientation, but most did not. For many, if not most participants, their sexual orientation was therefore a trait that represented an objective difference from those around them; something of which they could be aware, and feel isolated by, even in the absence of direct and targeted stigma. In the absence of other people like them, these participants were left with the difficult task of making meaning of this difference alone. The influence of stigma, and resultantly of self-stigma, must be considered in light of this isolating experience.

3.1. Theme 1: Stigma Is a Precursor to Self-Stigma

Regardless of whether they could point to specific experiences that led to their self-stigma or not, none of the participants described the origin of their self-stigma being within themselves; rather, self-stigma was described as a consequence of stigma that they had directly or indirectly experienced from others. In some cases, individuals could point to specific hypotheses about where their self-stigma came from: *“I have a feeling my dad is quietly homophobic because he also put the idea in me that two boys kissing was gross which took a while to get rid of”* and, *“[My parents] would always hide my siblings and I from queer movies and books, and if there was a gay couple in public, we would be told to look the other way . . . It really hurt and it led me to think of the LGBTQ+ community as a bad thing”*. The development of self-stigma was commonly described as occurring in a passive, or even subconscious way, albeit still arising from external sources: *“I absorbed a lot of those messages from a very young age, as well as lesbian being used as an insult before I even knew what that properly meant. I kind of just subconsciously knew that being anything other than straight wasn’t normal”*.

Some participants referred to their younger selves, during which time they were developing awareness of their sexual orientation, as a particularly vulnerable period for stigmatizing messages to be “absorbed”:

“Even though that they may have been joking about things, that to people who are new to coming out, like, looking back we see that you mean like, jokes and things and comments with like, no ill-intent, but to someone that’s like, new to it all, it can really hurt and really affect them. You know, it’s like a baby, you know? Like, the first few years—really critical. It’s like that. You know, the things you say, anything you do really sticks to the little baby gays. Little me”.

Stigmatizing messages were often the first and only perspectives participants experienced about their sexual orientation, and in the absence of competing accepting messages, the stigma was internalized: *“And there’s just no resources, so I got most of my information online and online they say, you know, there’s a lot of hate for bisexual people”* and, *“And that’s kind of the first reaction. You’re not hearing, “It’s ok” first. You’re hearing, “Oh yeah, it’s probably a phase”*.

The necessity of stigma in developing self-stigma was particularly apparent for some participants who were aware of their sexual orientation before they were aware of stigma. To these participants, in the absence of the awareness of stigma, their sexual orientation was inconsequential, and no self-stigma was experienced: *“I didn’t think anything about it, it was just, “Ooh, she’s pretty, I like her”, and I just thought it was normal”*. However, once they became aware of the stigma, their attitudes towards their sexuality seemed to become more negative: *“When, more when I got into Year 5, Year 6 and even high school, I was like, “Ah, ok maybe it isn’t normal”, and, “I guess I didn’t really think about it until sort of mid-way through primary school. Because then of course it starts to be an issue. Um, and I was like”, “Hmm, this isn’t red-hot”. And then I suppose I went into the closet rather than starting there”*.

3.2. Theme 2: Acceptance Is a Precursor to Self-Acceptance

The opposite of stigma was conceptualized as acceptance, and the opposite of self-stigma was self-acceptance. Awareness and experiences of stigma did not always lead to self-stigma, and stigma could instead be rejected. All participants could identify awareness of stigma in at least some sphere of their lives; however, for most participants this stigma was not significantly internalized. It appeared that acceptance from others in at least

some sphere of their lives could counteract the internalization of stigma and lead to self-acceptance instead: *“I feel a lot more comfortable in myself as I am surrounded by mostly supportive peers. I have learnt to love myself for who I am”* and:

“I think that I was, I got lucky I got born into a community and a family that was willing to accept me wholeheartedly no matter what. So, it’s been easy for me, and so it’s always been an easy thing for me to accept about myself, because someone taught me to accept it by accepting me first”.

Normalization was crucial in developing self-acceptance, rather than self-stigma. Just as self-stigma could derive from the stigmatizing environment, so too could self-acceptance be absorbed from an accepting and normalizing environment. With acceptance and support from others, stigma could be brushed off rather than internalized, and self-stigma that was already learned could be unlearned: *“It’s so normalized in my group, that I just brush it off bc I know there’ll always be homophobes but I’m fairly safe in my circles and know that being a lesbian isn’t inherently weird or bad”*.

Some participants also emphasized resources and information being more of a contributing factor towards developing self-acceptance than interpersonal support specifically: *“Sometimes I would find myself feeling wrong for feeling some of these things, but um, because it’s such a, um, explored issue on the internet and things like that, it has a lot of resources, I knew that it was alright for me to feel that way”* and, *“Now I’m a lot more self-assured because I’ve sought out a lot of queer fiction which makes me proud of my identity”*. Part of the utility of resources and information appears to be that it normalized and promoted a sense of connection even if these things were not accessible in their immediate environment. Although stigma can get beneath the skin, the participants could contend with this process in a variety of ways and make meaning of their difference in healthier ways.

As a contrast to this theme, although acceptance from others seemed to be a crucial factor in developing self-acceptance, some individuals also highlighted their own agency in rejecting stigma:

“At first it really bothered me but over years of just soul searching I realized that I’m not a monster others make me out to be and I had to build a thick skin that is a part of me now . . . I never had the support of others in fighting the stigma put against me, so I had to do it by myself”.

3.3. Theme 3: The Content and Experience of Self-Stigma Is Characterized by Self-Shame or Self-Invalidation

Before describing the subthemes, it is worth noting the substantial variation in the extent to which self-stigma was experienced in the lives of the participants. Some participants could recall times in their lives where they had strong belief in self-stigmatizing attitudes about their sexual orientation, although most did not strongly and consciously hold these beliefs in the present. Some ($n = 7$) participants did not feel they had experienced self-stigma at all: *“No. I haven’t. I’m gonna say no. I’ve held my ground. I think I’ve just been lucky enough to have this kind of socialized understanding that I’m fine to be me”*. Some participants did not identify with self-stigmatizing beliefs, but described self-stigma occurring on a more unconscious level, and experiencing conflict between these ingrained beliefs and what they consciously believe to be true: *“It’s like I know I’m not doing anything wrong but deep down I’m afraid I am disgusting or a bad person like I was told . . . I do have to remind myself a lot that it’s okay to feel the way I do”*.

In the present, the way stigma was internalized in many participants’ lives may be more accurately described as self-doubt than self-stigma per se: *“I don’t know much weight I actually have given them, but I definitely have worried about that sort of stuff. More . . . Actually . . . Not so much actually believing it, but more worrying that if that sort of stuff’s true”*. Internalizing stigma in the form of self-doubt, rather than occurring as a stable belief about oneself, could occur as a fleeting moment of worry or questioning oneself: *“Sometimes I just think maybe kissing girls is bad?”*. For some, this occurred in response to external triggers: *“Um, like on good days I’ll just tell them to f off or stop staring at me, and I’ll feel confident about it but on other days it really affects me, thinking there’s something wrong”*. Sometimes stigma could be warded off, but at other times it would get beneath the skin and participants

would experience doubt. It was not entirely clear whether self-doubt was a precursor to developing self-stigma, or rather a separate way of reacting to stigma entirely.

If internalized, the content of self-stigma varied depending on the content of the stigma to which they were exposed. There was substantial variation in the content of the self-stigma described by participants, and individuals would subscribe to some self-stigmatizing beliefs but not others. Overall, self-stigma occurred on continua, varying between individuals and within individuals over time. There was rarely a simple, binary divide between self-stigma and self-acceptance, and many individuals occupied space in between, expressing both at different times. When experienced, self-stigma itself could also appear in one of two primary forms: self-shame and self-invalidation.

3.3.1. Subtheme A. Self-Stigma as Self-Shame

One of the two ways in which self-stigma was characterized for adolescents with diverse sexual orientations was by self-shame. For participants experiencing self-shame, their self-stigma was embodied by a sense that there was something wrong with their sexual orientation, making it an unwanted defect: *"It still affects how down I look upon myself, because it's a big part of me and I sometimes feel like it's a wrong part of me"*. Self-shame could be experienced in a variety of ways, drawn together by the thread of the sexuality being negative, and therefore shameful, in some way, and individuals experiencing themselves negatively and with shame as a result: *"At the time it felt wrong in that I was seeing myself as some sort of monster"*.

Participants could experience self-shame about their sexual orientation for three thematically distinct reasons. For some individuals, self-shame was experienced as a result of feeling abnormal, weird, or unnatural: *"I felt like I wasn't normal, or was able to fit in the same way"*. Others experienced self-shame as a result of believing their sexual orientation to be "disgusting" or "gross": *"But like, there's something about seeing two men sometimes, very rarely, and it just kind of repulses me"*. Finally, participants could experience self-shame due to feeling that their sexual orientation makes them a "bad person". This form of self-shame was most commonly described in the context of feeling like a "predator" around their heterosexual peers, often with guilt: *"I guess I just feel like guilty for no reason. Like, if I walk at the beach or something, or even in a bathroom or change room or something, I just feel like I shouldn't be there. I'm doing something wrong"*. Despite their semantic differences, all three of these experiences of self-stigma (feeling abnormal, believing their sexual orientation to be "disgusting", and feeling like a "bad person") were associated with feelings of shame.

For a subset of participants, self-shame could be directed more so at a sense of gender non-conformity that they associated with their sexual orientation, rather than with their sexual orientation itself: *"For me to express femininity, is like a negative thing, it's a really awful thing. I have that like, instinctively. Like, I shouldn't be acting this way"*. Despite trying to separate the two, some participants felt that their gender expression was intrinsically connected to their sexual orientation, making self-shame directed at one directed at the other too: *"I was like, 'Do I bring up the gender stuff?', because it's not really sexual orientation, but then it kind of is? It's kind of a bit of a by-product of it all in a sense"*. Most participants, however, did not mention their gender expression in this context.

3.3.2. Subtheme B. Self-Stigma as Self-Invalidation

The second way in which self-stigma could be characterized was by self-invalidation. Individuals experiencing self-invalidation of their sexual orientation would deny its authenticity: *"Sometimes my mind convinces me", "You're putting it on for show" and, "It's all like, performative. Like, it isn't legitimate. I'll think about that"*. As opposed to viewing their sexual orientation as a negative characteristic, participants experiencing self-stigma as self-invalidation would deny their own experiences entirely and view their sexual orientation as pretend, inauthentic, or transitory. This judgment was frequently associated with ideas of "looking for attention", being "just a phase", or otherwise being a choice that the individual has made, rendering it invalid and untrue: *"Then it feels like it's a choice as well. So, it feels*

like, um, I'm choosing to like girls". Participants who described their sexual orientation as bisexual could experience self-invalidation in ways unique to bisexuality specifically, such as by believing that they had to "*pick a side*", and thereby that their bisexuality specifically is invalid, but being gay or lesbian may be valid. However, self-invalidation was not unique to bisexuality, and other individuals describing themselves as gay or lesbian could self-invalidate their sexual orientation as well: "*...and you're like, oh my god am I even a lesbian? Am I faking this?*".

Shame could be an outcome of self-invalidation, but less commonly so than for self-shame. Despite the similar circumstances in which self-invalidation and self-shame arose, and the similarities in negative self-views, it was more common that participants experienced only one to a strong degree than both. This contributed to their separation into different subthemes in the analysis. The validity of these subthemes as discrete forms of self-stigma was also supported by our reference group members.

To clarify further, it is crucial to note that self-invalidation as we describe it here was thematically distinct from denying one's sexual orientation deliberately, such as due to wanting to be straight, which some participants also described: "*There is a part of me [that wants to be straight], and I think it's only because of my family situation. I think, yeah, I feel like I should be what's classified as 'normal'*". Self-invalidation arose from experiences of invalidation from others (Theme 1), while wanting to change one's own sexual orientation could arise from a number of factors, including self-shame, desire to avoid stigma, and reasons unrelated to stigma altogether, such as wanting greater ease in finding a romantic partner. Unlike those who discussed wanting to change their sexual orientation, self-stigma as self-invalidation was not a chosen or desired state, and individuals self-invalidating their sexual orientation experienced distress, rather than relief, over their denial of their sexual orientation: "*It was not fun and made me feel really fake and sad*".

3.4. Theme 4: Self-Stigma Can Be Painful and Damaging

Self-stigma was described as emotionally painful, with the potential to cause significant damage to participants' mental health. As previously discussed, most participants did not identify with self-stigmatizing beliefs in a stable and long-term way in the present, and for these individuals the occasional experience of self-stigma was uncomfortable but was overall not a pressing concern for their current mental health. For a small number of participants for whom self-stigma was a persistent experience ($n = 4$), however, self-stigma contributed to serious mental health difficulties currently or in the near past. One young person recounted their experience of self-stigma as such:

"Like, it was really bad. Like I couldn't get out of bed to shower. I think it was the end of like, school, for like a month. And then, then I remember I wouldn't do any of my work, like, I'd just sit in class. I couldn't write anything, 'cos I was like, it was like, you know, what's the point, kind of thing".

Another participant described the period in which they felt that their sexual orientation was "*unnatural*" as "*some of the darkest places [they've] been in*". Three participants directly tied their experience of self-stigma to thoughts of suicide. For one participant, this led to self-harm and several suicide attempts:

"I'd just keep saying how I wasn't, I'm not right, I shouldn't be here. Like, this is wrong, and I should kill myself... I became, I started self-harming when I was twelve and I only just recently stopped a couple months ago. And um, I tried killing myself a couple times".

Although not the most pressing concern for all participants with diverse sexual orientation, for some select individuals, self-stigma was an incredibly damaging influence on their mental health and hope for the future.

One notable consequence of self-stigma, which may contribute to its effect on mental health, was loss of self-esteem and self-worth. Once stigmatizing beliefs were internalized and self-directed, having diverse sexual orientation became something that made them tarnished and unacceptable. For example, one participant described his self-stigma "*like it was slowly chipping away at [his] self-worth*". Other participants described self-stigma as

being associated with a sense of devaluing or feeling bad about themselves, and for some individuals, self-stigma compromised their self-image to the point that they expressed self-hatred: *"I really hated who I was for a while and tried to force myself to become interested in guys"*. Loss of self-esteem was described primarily by participants who experienced self-stigma to a significant degree, as opposed to those who experienced only fleeting thoughts, and there also seemed to be a greater presence of self-esteem loss among individuals expressing self-shame, rather than self-invalidation. Strongly experiencing one's sexual orientation as tainted could lead to experiencing the whole self as tainted, too.

As self-stigma was described as a consequence of external stigma, it could be difficult to tease apart mental health difficulties arising from self-stigma versus stigma from other sources. However, one participant described that even once removed from the stigma that developed it, the self-stigma alone remained a negative influence on their mental health, indicating independent contribution to these issues over time: *"It was really horrible. Even once I changed schools and didn't have bullying to worry about, my identity and the way I saw myself continued to have an impact on my self-esteem and overall emotional state"*.

4. Discussion

Twenty-one adolescents with diverse sexual orientations, aged 14–18, were interviewed with the aim of understanding their lived experience of self-stigma. We took a thematic analytic approach to understand how stigma affects the way adolescents with diverse sexual orientations see themselves, and what impact this has. Four core themes were derived from the data: (1) stigma is a precursor to self-stigma; (2) acceptance is a precursor to self-acceptance; (3) experience and contents of self-stigma is characterized by subthemes of self-shame or self-invalidation; and (4) self-stigma is painful and can be damaging. Taken together, self-stigma was relevant and impactful to the lives of many of the young people interviewed. For many of the participants, however, self-stigma was not a permanent experience and therefore not a permanent scar on mental wellbeing. Self-stigma seemed to be most impactful when they were younger, less certain of their sexual orientation, and more isolated from others who are like them. Self-stigma was also most impactful when stigma was experienced more strongly too, but not always. Several participants described that as these things changed, self-acceptance would develop in self-stigma's place, gradually removing the consequences of self-stigma on mental health and self-esteem over time.

This study was the first to focus on comprehensively describing the content of self-stigma for adolescents with diverse sexual orientations. As with self-stigma in other populations, the current findings support characterizing self-stigma as a multidimensional construct [19,30]. Participants described experiencing self-stigma in the form of either self-shame or self-invalidation, and self-shame itself could be experienced as either abnormality, disgust, or being a "bad person". This picture of self-stigma is considerably more complex and multifaceted than has previously been portrayed in the literature for sexuality-diverse people. Future research with regards to self-stigma in adolescents with diverse sexual orientations may benefit from recognizing and characterizing this complexity and multidimensionality in their models and approaches.

Self-stigma has previously been described as the most "insidious" stressor affecting the mental health of people with diverse sexual orientations [5]. This study largely supports positioning self-stigma as an important contributor to understanding why some adolescents with diverse sexual orientations experience mental health difficulties. Self-stigma was not an inevitable experience, and our emphasis on describing self-stigma in the context of this study may create the illusion that this experience was pervasive. We emphasize that this is not the case: one third of the individuals interviewed did not ascribe to self-stigmatizing beliefs in any substantial way. Instead, they experienced acceptance of their sexual orientation. Among those who did not experience self-acceptance, however, self-stigma was a toxic and painful influence on their self-image, mental health, and wellbeing, to the extent that it could preface suicidal thoughts and behavior. Although a problem

that could therefore easily be toxic to young people's mental health, self-stigma also had somewhat attainable antidotes: acceptance, information, and normalization. This highlights the need for continued efforts to promote acceptance for young people with diverse sexual orientations, as negative experiences with self and others remain present and damaging factors in the lives of young people with diverse sexual orientations.

We understand self-stigma to arise from experiences and awareness of stigma, a conclusion which is in line with the existing literature on these constructs in a range of populations, such as people with mental illness and their carers e.g., [19,22]. However, this association does not appear to be direct and isolated, as severity of stigma experiences and awareness did not always appear to be entirely in line with the severity of one's self-stigma, and these discrepancies highlight the potential for other mechanisms to be involved in this relationship. These may be they external, or internal, risk and protective factors. This is in line with Hatzenbuehler's psychological mediation framework [1], highlighting that stigma experiences, while fundamental to understanding health in adolescents with diverse sexual orientations, are insufficient alone to explain variations in mental health among this group, and overall discrepancies compared to their heterosexual peers. The study therefore implicates self-stigma as a possible, but not inevitable, consequence of experiences and awareness of stigma. In some individuals, this consequence may help explain the deleterious impact of stigma on mental health. Identifying those experiencing stigma is unlikely to be sufficient to identify those in need of support for self-stigma, and quantitative research is needed to further describe these potential associations and causal pathways.

Returning to the subject of the conceptual uncertainty surrounding internalized homophobia, there was a contrast between the way that internalized homophobia is operationalized, and the way self-stigma was characterized in this study. For example, a near-ubiquitous operationalization of internalized homophobia to date has been a desire to change one's sexual orientation and/or actual efforts to do so (note that although some of these references appear dated, these measures remain in use; [16,17,31–33]). However, this study illuminated reasons for wanting to change their sexual orientation other than due to self-stigma; a significant number of the participants who articulated these desires or behaviors did so due to the desire to escape stigma (such as wanting to be accepted by their family), or for practical reasons, such as finding it easier to find a romantic partner. This calls into question the validity of using indices of desires/behaviors as metrics of self-stigma, and questions the validity of many existing internalized homophobia measures for the purposes of measuring self-stigma. Future development of measurement tools, in line with the themes of this study, will allow us to better capture self-stigma experiences, and better quantify their association with mental health and other factors. Future research may also seek to investigate how the community discusses these constructs, to more thoroughly understand if separating self-stigma from internalized homophobia is a meaningful distinction for community members as well.

To our knowledge, this study is the first to describe the experience of self-stigma in adolescents with diverse sexual orientations. Future research is needed to expand on how this construct is situated among other contextual factors. As self-stigma was intrinsically linked to the social environment, we suggest caution in applying these themes to adolescents in other places and cultures. Other than age, gender, and sexual orientation, we sought no other demographic information from participants. This decision was made to make the interview process as safe and unidentifiable as possible for participants; however, this also restricted our ability to make any inference about other individual/cultural factors that may have affected the participants' experiences, such as race, ethnicity, religion, and socioeconomic status. How these factors frame individuals' experiences of self-stigma remains to be explored in future studies. The most notable, though unavoidable, limitation of the current study is the potential for selection bias in the sample; individuals experiencing self-stigma to a severe degree could have been less likely to decide to participate in a study asking them to discuss their sexual orientation. We attempted to limit this by allowing adolescents to participate confidentially, largely unidentifiably, and without

parental consent, and we were able to speak to some adolescents who reported severe self-stigma; however, it is unknown how representative the sample is of the proportionality of this experience in the broader population. We also note the limitation that some of the questions asked in the semi-structured interview protocol were closed-ended (e.g., at times, do you feel any of this stigma about yourself?), rather than open-ended. This decision was made with the knowledge that self-stigma may not be a universal experience, and to avoid invalidating participants we sought to allow them the opportunity to be upfront about this. Other studies of self-stigma have structured their interview protocols in a similar way e.g., [19]. We attempted to mitigate the effect of this on the richness of the data we elicited by seeking elaboration with open-ended prompts based on their responses; however, we acknowledge that this question structure is unconventional to general recommendations for qualitative research [29].

Despite these limitations, this study's findings clearly implicate self-stigma as an important avenue for future research in addressing mental health difficulties in adolescents with diverse sexual orientations. Given the damage that self-stigma can cause, the fundamental end-point of this research must be intervening. Analysis of the lived experience interviews suggests four ways to address self-stigma and its impacts, ranging from individual to global levels of intervention: (1) providing access to psychotherapeutic intervention to address self-stigma and its impact on mental health on an individual level; (2) increasing acceptance of adolescents with diverse sexual orientations in their immediate families and communities; (3) readily providing resources, such as information, with support and respect to young people; and (4) defeating stigma itself on a broader societal level.

Given that it results from stigma, self-stigma can be seen as a social and cultural issue; however, it is experienced individually, and individual support may therefore be one channel of intervention. Previous research in other populations has found cognitive-behavioral interventions to be helpful in reducing self-stigma and associated distress [34]. Research has also previously shown that interventions targeted for young people with diverse sexual orientations are preferable for this group [35,36], and adaptations of these interventions may therefore be needed for them to be suitable for this purpose. Given the apparent importance of social acceptance in developing self-acceptance in lieu of self-stigma, therapeutic strategies in a group context with peers with diverse sexual orientations may be particularly helpful ways of engaging adolescents who are struggling with these difficulties. Finally, given that isolation was implicated in self-stigma, interventions that are accessible remotely, such as digital interventions, are worth exploring [37]. Preliminary research has sought to develop psychotherapeutic strategies to reduce internalized homophobia with "promising" results; however, these strategies require further development and evidence [38,39].

Beyond the individual level, given the importance of acceptance in developing self-acceptance and potentially buffering against stigma and self-stigma, increasing acceptance is another cogent pathway to self-stigma intervention. In addition, and in a similar vein, self-stigma may be addressed by increasing access to information and resources. Providing better sexuality education, promoting visible and relatable role models (whether real-life or in fiction), and providing accessible and visible channels of peer support, are all ways in which these goals may be achieved within communities. Schools and online communities are likely to be ideal environments for such intervention to take place, given the importance of these spheres to the adolescents interviewed. It is crucial that, through these channels, adolescents have access to messages that challenge the stigma, i.e., that diverse sexual orientations are normal, natural, acceptable, and valid.

Although we can understand and address this issue on an individual and community levels in these ways, we also emphasize that the issue of self-stigma ultimately lies with broader society, not adolescents themselves. The most crucial pathway to reducing self-stigma and its impacts is defeating stigma itself, as nobody identified self-stigma as occurring without exposure to stigma. Although society has progressed significantly in its treatment of sexual orientation, this study and the stories told by its participants make it

apparent that the issue is not resolved. Changes are still needed in all levels of society to better accept and support adolescents with diverse sexual orientations, to prevent harm resulting from stigma and self-stigma.

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