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The influence of structural stigma and rejection sensitivity on young sexual minority men's daily tobacco and alcohol use

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ABSTRACT

Stigma occurs at both individual and structural levels, but existing research tends to examine the effect of individual and structural forms of stigma in isolation, rather than considering potential synergistic effects. To address this gap, our study examined whether stigma at the individual level, namely gay-related rejection sensitivity, interacts with structural stigma to predict substance use among young sexual minority men. Sexual minority ($n = 119$) participants completed online measures of our constructs (e.g., rejection sensitivity). Participants currently resided across a broad array of geographic areas (i.e., 24 U.S. states), and had attended high school in 28 states, allowing us to capture sufficient variance in current and past forms of structural stigma, defined as (1) a lack of state-level policies providing equal opportunities for heterosexual and sexual minority individuals and (2) negative state-aggregated attitudes toward sexual minorities. To measure daily substance use, we utilized a daily diary approach, whereby all participants were asked to indicate whether they used tobacco or alcohol on nine consecutive days. Results indicated that structural stigma interacted with rejection sensitivity to predict tobacco and alcohol use, and that this relationship depended on the developmental timing of exposure to structural stigma. In contrast, rejection sensitivity did not mediate the relationship between structural stigma and substance use. These results suggest that psychological predispositions, such as rejection sensitivity, interact with features of the social environment, such as structural stigma, to predict important health behaviors among young sexual minority men. These results add to a growing body of research documenting the multiple levels through which stigma interacts to produce negative health outcomes among sexual minority individuals.

Introduction

Stigma has traditionally been conceptualized as being transmitted by individuals (Crocker, Major, & Steele, 1998), and multiple lines of evidence indicate that individual forms of stigma contribute to a variety of negative outcomes among members of stigmatized groups (Major, Mendes, & Dovidio, 2013; Major & O'Brien, 2005; Pachankis, 2007). At the same time, recent research suggests that social structures, policies, and institutions can also produce stigma, a process that has been termed "structural stigma" (Link & Phelan, 2001). One operationalization of structural stigma is state policies that differentially target members of stigmatized groups (Corrigan, Markovwitz, & Watson, 2004). For example, some state laws deny sexual minority individuals access to the same opportunities afforded heterosexuals, such as marriage and adoption, thus serving to mark members of this group as less-than-equal (e.g., Eskridge & Spedale, 2006). Researchers have hypothesized that these broader structural forms of stigma are likely fundamental contributors to unequal health outcomes between members of stigmatized and non-stigmatized groups (Link, Yang, Phelan, & Collins, 2004), and a burgeoning line of research has begun to support this hypothesis (e.g., Hatzenbuehler, 2010; Lucachko, Hatzenbuehler, & Keyes, 2013; Miller, Bunn, & Solomon, 2012).

Despite the recognition that stigma occurs at multiple levels, there is a paucity of research that examines relationships between structural and individual-level stigma processes, with some notable exceptions (Gee, 2002). The lack of research results, in part, from the fact that the stigma field typically examines social- and individual-level processes in isolation (Hatzenbuehler, 2009). Combining both levels of stigma in a single study, however, would allow for the possibility of uncovering the individual-level stigma

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processes with which structural stigma interacts to deplete health, as well as of identifying individual-level stigma processes through which structural stigma creates negative health outcomes. The present study, therefore, proposes to examine whether: (1) structural forms of stigma and psychological processes of stigma independently predict negative health outcomes among sexual minority individuals; (2) structural and psychological forms of stigma interact to predict negative health outcomes for sexual minority individuals; and (3) psychological forms of stigma mediate the relationship between structural stigma and health among sexual minorities. This study focuses on daily substance use as its primary health outcome given that sexual minority individuals are at significantly higher risk, compared with heterosexual individuals, of using substances, including tobacco (Gruskin, Greenwood, Matevia, Pollack, & Bye, 2007) and alcohol (Drabble, Midanik, & Trocki, 2005; McCabe, Hughes, Bostwick, West, & Boyd, 2009).

The psychological form of stigma that we focus on in the current study is *rejection sensitivity*, which refers to chronic anxious expectations of rejection enacted to guard against potential threat. Stigma-based rejection sensitivity describes the psychological process through which some individuals learn to anxiously anticipate rejection because of previous experiences with prejudice and discrimination toward their group membership (Mendoza-Denton, Downey, Purdie, Davis, & Pietrzak, 2002). Despite sometimes representing a functional adaptation to stigmatizing social environments, rejection sensitivity has been associated with negative interpersonal and health outcomes (e.g., Downey, Freitas, Michaelis, & Khouri, 1998; Feinstein, Goldfried, & Davila, 2012). For example, African American college students on predominantly white college campuses who are high in race-based rejection sensitivity have been prospectively shown to exhibit less institutional trust, greater difficulty transitioning to college, and a decline in course grades compared to those who are low in race-based rejection sensitivity (Mendoza-Denton, Purdie, Downey, & Davis, 2002). Similarly, a daily diary approach recently demonstrated that women who were high in gender-based rejection sensitivity and worked in an historically male academic setting were more likely to avoid expressing themselves in response to negative gender-related events than women who indicated lower levels of gender-based rejection sensitivity (London, Downey, Romero-Canyas, Rattan, & Tyson, 2012). The results of this latter study showed that anger and alienation represent at least two costs of such self-silencing. Similarly, among sexual minority men, sexual orientation-based rejection sensitivity predicts ongoing self-silencing (Pachankis, Goldfried, & Ramrattan, 2008) in addition to poorer immune functioning in those with HIV (Cole, Kemeny, & Taylor, 1997).

Theories of stigma-based rejection sensitivity suggest that rejection sensitivity is formed in early interpersonal contexts, for example in the context of prejudice or exclusion by others because of one's racial group membership (Mendoza-Denton et al., 2002) or in the context of parental rejection of one's identity in the case of stigmatized sexual orientations (Pachankis et al., 2008). However, not all stigmatized individuals are rejection sensitive, and for those who are rejection sensitive, not all contexts evoke anxious expectations of rejection. Indeed, for stigmatized individuals who possess a high degree of rejection sensitivity, whether they will anxiously expect rejection at any given time depends on the possibility of rejection embedded in their social environment. As Mendoza-Denton et al. (2002) note, "anxious rejection expectations are activated only in those situations in which rejection is possible, meaning applicable as well as personally salient" (p. 897). As such, the tendency to anxiously perceive rejection, and therefore to engage in unhealthy coping responses, is expected to occur only in potentially threatening environments among those who are predisposed to rejection sensitivity because of past experiences with stigma (e.g., social exclusion, parental rejection). However, this possibility has not been empirically established, as rejection sensitivity has been solely examined in the context of individual- or interpersonal-level factors, such as internalized homophobia and parental rejection of one's sexual orientation (Pachankis et al., 2008). The present study addresses this gap in the literature by examining the possibility that structural stigma moderates rejection sensitivity's negative impact on an important health outcome, namely substance use. Specifically, we explore whether rejection sensitivity increases the likelihood that structural stigma contributes to substance use in sexual minority men.

While the timing of environmental influences is important to health (e.g., Bronfenbrenner & Evans, 2000; Pollitt, Rose, & Kaufman, 2005), most examinations of structural stigma's impact on health examine stigma exposure at one point in time (e.g., Hatzenbuehler, Keyes, & Hasin, 2009). It could be argued that sexual minorities' exposure to structural stigma at one point in the life course (e.g., during adolescence, when feelings of same-sex attraction are first experienced) might have different effects on health than exposure to structural stigma at another point in the life course (e.g., during young adulthood, when a sexual minority identity is being formed), as has been shown in research regarding the influence of exposure to adverse socioeconomic conditions on health (Claussen, Smith, & Thelle, 2003). We therefore measure structural stigma in participants' current environments and also in their past environments in order to determine whether the developmental timing of structural stigma affects health.

Further, rejection sensitivity may uniquely interact with structural stigma exposure at various points in development to influence health outcomes. Sensitivity to possible rejection becomes particularly salient during adolescence (Gunnar, Wewerka, Frenn, Long, & Griggs, 2009; Westenberg, Drewes, Goedhart, Siebelink, & Treffers, 2004), and rejection during this time predicts mental health problems across the lifespan (Lev-Wiesel, Nuttman-Shwartz, & Sternberg, 2006). Adolescents who become aware of a stigmatized personal status during this developmental period and who are particularly sensitive to rejection of their stigma may be particularly likely to develop unhealthy coping strategies to fend off expected rejection in potentially threatening contexts (Downey, Bonica, & Rincon, 1999). In this way, rejection sensitivity might serve to make some stigmatized individuals particularly vulnerable to the negative effects of structural stigma depending on when they encounter structural stigma at various points in development. Including an objective measure of structural stigma in two contexts at two different points in time (i.e., high school and college) allows us to investigate whether rejection sensitivity heightens the influence that structural stigma exposure during adolescence and early adulthood might have on young sexual minority men's substance use.

In addition to modifying the relationship between structural stigma and health, individual forms of stigma may represent mechanisms through which structural forms of stigma contribute to adverse health outcomes. Consistent with this idea, it is plausible that individuals who live in highly stigmatizing environments are more likely to develop sensitivity to status-based rejection, which in turn would increase risk for negative health outcomes, including substance use. In this case, structural stigma would be causally related to greater rejection sensitivity, and would explain *why* structural stigma is related to poor health. This is in contrast to a moderation model, in which structural stigma interacts with rejection sensitivity to predict poor health.

In summary, based on previous conceptualizations of rejection sensitivity (Mendoza-Denton et al., 2002; Pachankis et al., 2008),