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EXPLORING THE POTENTIAL EFFECT OF DOUBLE STIGMA ON GENERAL AND SEXUAL WELL-BEING OF GAYS AND LESBIANS IN SLOVENIA

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Master Programme in
Clinical and Health Psychology
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Statement of Authorship

I declare to be the author of this work, which is unique and unprecedented. Authors and works consulted are properly cited in the text and are included in the list of references.

Signature

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Eva Štrukelj

Acknowledgements

I should like at this time to mention a few whose participation was of special importance. Foremost, I would like to express sincere gratitude to my mentor Prof. Jean-Christophe Giger, PhD for the opportunity to work on this exciting topic, for his cooperation, patience, time, and support of my master thesis.

Several individuals deserve to be acknowledged as well, including Blažka Plahutnik Baloh, MSc, Miran Šolinc, MSc, and Rok Podkrajšek, PhD, experienced professionals within the field, who were an indispensable source of knowledge and suggestions during the time of research. Besides them, I would like to thank the Slovenian Association of Sexology, Legebitra, The Students' Cultural Centre (ŠKUC), ŠKUC Magnus, ŠKUC LL, Plushivisti, DIH, and Kvartir for their support in promoting the surveys.

A quite big number of other people have been incredibly helpful by their interest, ideas, and critical comments at one time or another. Seriously, it would be a very long list if I was to put all your names down individually, but I hope that the present paper will serve as a sufficient prove that your efforts to help me were not in vain.

Last but not least, my appreciation goes to each participant who completed the online questionnaires. Without the people willing to participate in the surveys research is not possible. Thank you for deciding to contribute.

Abstract

The present paper is a summary of two studies carried out as a part of the Master Programme in Clinical and Health Psychology. The aim of Study 1 was to adapt and validate an instrument intended to measure a specific faucet of well-being—sexual self-esteem—to Slovenian language. The analysis of the psychometric properties (N = 435) indicated that the Slovenian version of Sexual Self-Esteem Inventory—Short Form was adequate and reliable. Based on these results, the instrument was deemed suitable for Study 2. Study 2 dealt with two principal objectives and was, thus, divided in two parts. The objective of Part 1 was to adapt and validate an instrument assessing stigmatising attitudes towards people living with HIV. Based on a sample of 302 people, the instrument provided sufficient evidence for its utility. The objective of Study 2—Part 2 (i.e., the main study) was to examine whether an important relationship exists between stigma towards homosexuality and HIV related stigma. A hypothesis of the 'double stigma effect' on general well-being (evaluated via depression) and sexual self-esteem was also tested. The analyses conducted on the final sample of 95 same-sex oriented Slovenians and subsample of men (n = 39) showed no significant correlations between the two stigmas. The results of the female participants (n = 53) did show a weak but significant association. No significant relations were observed between any of the two stigmas and depression. With regards to sexual health, a significant negative relationship was observed between the levels of internalised homophobia and sexual self-esteem. It was found that the presence of the former can be understood as a predictor of several dimensions of sexual well-being of homosexually oriented Slovenians. The hypothesis of the effect of the double stigma on both general and sexual well-being was rejected.

Keywords: stigma, homosexuality, internalised homophobia, HIV, sexual self-esteem, depression

Resumo

O trabalho presente é um resumo de dois estudos realizados como parte do Mestrado em Psicologia Clínica e da Saúde. O objetivo principal do Estudo 1 foi adaptar e validar um instrumento destinado a medir uma faceta específica do bem-estar—a autoestima sexual— para a língua eslovena. A análise das propriedades psicométricas (N = 435) indicou, que a versão eslovena do *Sexual Self-Esteem Inventory—Short Form* era adequada e confiável. Com base nesses resultados, o instrumento foi considerado adequado para o Estudo 2. O Estudo 2 tratou de dois objetivos principais e foi, portanto, dividido em duas partes. O objetivo da Parte 1 foi adaptar e validar um instrumento que avalia as atitudes estigmatizantes em relação às pessoas que vivem com o HIV. Na amostra de 302 indivíduos, o instrumento forneceu evidências para sua utilidade. O objetivo do Estudo 2—Parte 2 (ou seja, do estudo principal) foi examinar se existe uma relação significante entre o estigma em relação à homossexualidade e o estigma relacionado ao HIV. A hipótese do 'efeito do estigma duplo' no bem-estar geral (avaliado através da depressão) e na autoestima sexual também foi testada. As análises realizadas na amostra final de 95 Eslovenos homossexuais e na subamostra de homens (n = 39) não mostraram correlações significativas entre os dois estigmas. Os resultados dos participantes do sexo feminino (n = 53) mostraram uma associação fraca, mas significativa. Nenhuma relação significativa foi observada entre qualquer um dos dois estigmas e depressão. Com relação à saúde sexual, observou-se uma relação negativa significativa entre os níveis de homofobia internalizada e a autoestima sexual. Verificou-se que a presença do primeiro pode ser entendida como um preditor de várias dimensões do bem-estar sexual dos gays e lésbicas Eslovenos. A hipótese do efeito do estigma duplo no bem-estar geral e sexual foi rejeitada.

Palavras-chave: estigma, homossexualidade, homofobia internalizada, HIV, autoestima sexual, depressão

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List of Abbreviations

ARSS.....AIDS Related Stigma Scale

CES—D.....Center for Epidemiological Studies—Depression

HIV.....Human Immunodeficiency Virus

ILGA.....The International Lesbian, Gay, Bisexual and Trans and Intersex Association

M.....Mean

MSM.....Men Who Have Sex with Men

PCA.....Principal Component Analysis

PLWH.....People Living with HIV

SAT—S.....Stigmatising Attitudes Towards People Living with HIV

SD.....Standard Deviation

SHAS.....STI/HIV Anxiety Scale

SIHS.....Short Internalised Homonegativity Scale

SSEI—SF.....Sexual Self-Esteem Inventory—Short Form

STI.....Sexually Transmitted Infection

ŠKUC.....The Students' Cultural Centre

UNAIDS.....Joint United Nations Programme on HIV/AIDS

WHO.....World Health Organisation

Introduction

Stigma and stigmatisation are social, interactive phenomena. They are used to denote the common aspect of socially disqualifying attitudes. These attitudes can be based on a variety of personal/social characteristics, traits, or attributes. What characteristics, traits, or attributes are considered to be determining 'a negative social identity' depends on the society and its culture (e.g., van Laar & Levin, 2006). These characteristics, traits, or attributes can be any, real or perceived (Crocker, Major, & Steele, 1998; Goffman, 1963), and are essentially arbitrary (van Laar & Levin, 2006).

In various past and present cultures, same-sex relationships and sexual behaviours have been looked down upon. And despite the noticeable changes in terms of understanding and acceptance of *homosexuality* (i.e., the experience of being sexually and/or romantically attracted to the person of the same sex), gays and lesbians remain to be stigmatised worldwide (International Lesbian, Gay, Bisexual and Trans and Intersex Association—ILGA, 2016). *Homophobia* or devaluation of homosexuality is present in Slovenia as well (Kuhar & Švab, 2009).

The stigma and taboo surrounding the non-heterosexual life-style seem to be somewhat engrained in a majority of global educational practices, legislative practices, medical practices, spiritual teachings, and the media around the globe. For a comment on the situation in Slovenia on the matter see Kuhar and Švab (2009). On this behalf it is reasonable to assume that every person, regardless of sexual orientation, develops some level of homophobia (Szymanski & Kashubeck-West, 2008). *Internalised homophobia* is a term used to denote the presence of negative attitudes towards homosexuality in same-sex oriented people. Prior studies suggest that this stigma concept can be understood as a significant stressor for gays and lesbians (Bobbe, 2002; Meyer, 1995; Williamson, 2000). Being recognised as such, internalised homophobia became an important guideline tool for working with gays and lesbians and for preventing the well-known negative effects of being stigmatised on the individual and social level (Berg, Weatherburn, Ross, & Schmidt, 2017).

The aim of the present thesis was to build upon the aspect of the homosexual experience in two ways. Firstly, by exploring the possible correlates between internalised homophobia and human immunodeficiency virus (*HIV*) related attitudes. Since HIV epidemic in Slovenia is disproportionately affecting the community of men who have sex with men (MSM, Ćosić et al., 2016; Joint United Nations Programme on HIV/AIDS—UNAIDS, 2018), it was hypothesised that negative attitudes towards the people living with HIV (PLWH) might play a role in shaping the attitudes towards gay men and homosexuality and possibly propel homophobia. Secondly, the goal of this thesis was to investigate whether either of the two

stigmas relate with the general and sexual well-being of the homosexually oriented group. More specifically, the present paper explored the idea whether HIV stigma and/or internalised homophobia relate with two distinct psychological constructs: *depression* and *sexual self-esteem*. Understanding such relations is of theoretical importance and can be used to further guide the practical work (i.e., prevention and intervention) focusing on the community.

A more in-depth knowledge about how and what homosexually oriented individuals endorse in their beliefs systems about the world, about their sexuality, and about themselves, is needed in order to be able to provide the homosexually oriented community with adequate services in case of need. Also, a better understanding of the symbolic correlates that might be contributing to the stigma surrounding homosexuality is necessary if we wish to diminish these devaluating attitudes on the social and on the individual level. In line with the latter, *double stigma* effect and other theoretical models investigating distinct yet related attitudes concerning homosexually oriented men and women deserve more attention.

1 Attitudes Towards Homosexuality

Anthropological studies of tribal societies, observations of the mating behaviours in other species, and the biopsychology behind human attraction suggest that it is reasonable to assume, that the interest to become sexually engaged with individuals of the same sex exists since the beginning of the earliest human tribal or clan lines (Lehmiller, 2014). However, in various past and present cultures, same-sex relationships and sexual behaviours have been looked down upon, devalued, seen as immoral, criminal, and, medically speaking, pathological or 'unnatural' (Pickett, 2009).

It was not until the middle of the 20th century that the scientific literature started accumulating evidence that there is nothing 'wrong' with homosexually oriented individuals (e.g., Hooker, 1957) and that feelings of attraction towards the same sex are not as rare as once thought (e.g., Kinsey, Pomeroy, & Martin, 1948; Kinsey, 1953). Consequently, one might say that the positive shift in the attitudes towards homosexuality is relatively recent. Not surprisingly, due to a long and harsh social history (Pickett, 2009), the negative attitudes towards homosexuality are still commonly endorsed worldwide (e.g., ILGA, 2016).

Having an updated overview of the attitudes around the world is crucial to bear in mind in order to understand the situation of the homosexually oriented community. Statistical reports indicate that there is a big variance by region regarding the question of homosexuality. The results consistently suggest that the most favourable attitudes can be found in North America, in the European Union, and in much of Latin America (e.g., McCarthy, 2014; Pew Research Center, 2013). On the other hand, the most homophobic regions are the Middle East and Africa (e.g., ILGA, 2016).

Lamontagne and colleagues (2018) proposed a specific instrument to measure the levels of homophobic attitudes. This tool, called the *Homophobic Climate Index*, incorporates institutional and social components of homophobia and was used to assess the level of negative attitudes towards homosexuality in 158 countries. The results (see Figure 1) were fairly similar to those of Pew Research Centre (2013), Gallup (McCarthy; 2014), and ILGA (2016).

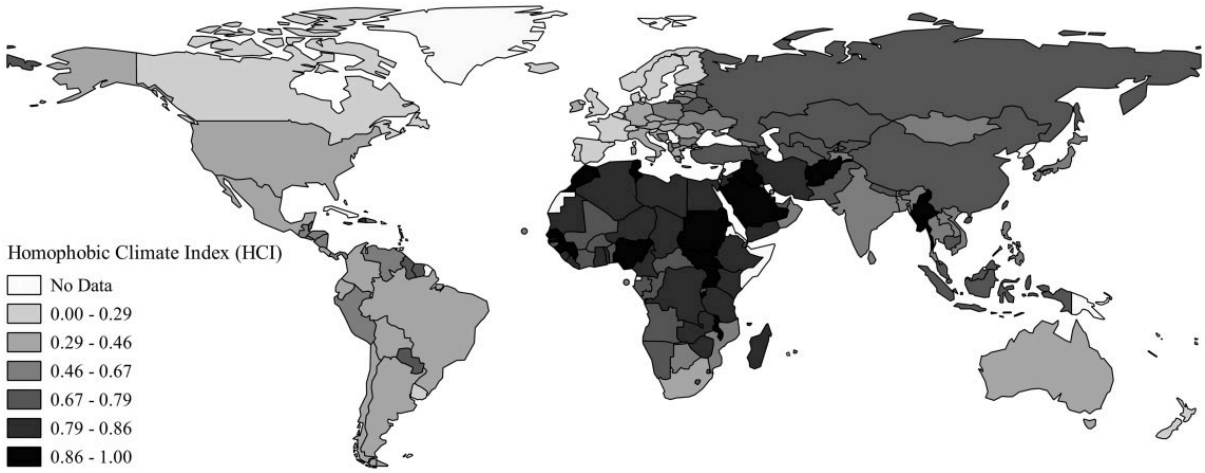

Figure 1. Homophobic Climate Index. From 'A socioecological measurement of homophobia for all countries and its public health impact' by Lamontagne and colleagues, 2018, *European Journal of Public Health,* p. 3. Copyright Lamontagne et al. Reprinted with permission.

In comparison to other European countries, the sociocultural climate in Slovenia is somewhat ambiguous concerning homosexuality. Based on Gallup's survey, 44% of residents answered that the country is a hostile place for gays and lesbians, 40% believed that the country is a good and safe environment, and 16% of the participants remained abstaining or unsure about the situation (McCarthy, 2014). Among its neighbouring countries, Austria and Italy demonstrated at least 10% more favourable responses, while other historically and economically associated regions (e.g., Croatia, Serbia, Bosnia and Hercegovina) tended to be more unsympathetic towards homosexuality in comparison to Slovenia. Considering the religious climate in Slovenia, in comparison to 27 other Catholic countries across the world, the country's ranking based on homophobic attitudes was also found to be somewhere in the middle (Adamczyk, 2017).

Based on the Article 63 of the Slovenian Constitution, discrimination of same-sex oriented individuals is banned (Republic of Slovenia, Constitutional Court, 2013). Since 2016, gays and lesbians can get their partnership legally acknowledged and enjoy the same rights as a married man and woman would, except regarding adoption and artificial insemination (Republic of Slovenia, Ministry of Labour, Family, Social Affairs and Equal Opportunities, 2016). However, the institutional practice and everyday life experiences of the homosexually oriented clearly indicate that homophobia is still present (Kuhar, 2016; Kuhar & Švab, 2009).

In other words, it is a part of the country's social reality that homosexuality is still either ignored or devalued.

A Slovenian national survey carried out by Kuhar (2016) indicated that every second homosexually oriented person experienced at least one homophobic event in their life. Most of these events involved a psychological attack (95%). Out of those who experienced some sort of violence, a quarter of them reported being physically abused and around six percent indicated that they were victims of sexual violence. Discrimination and violence were most likely to take place in a public space (e.g., bar, street, school, work).

To conclude, despite the support of the modern scientists who condemn the outmoded beliefs about homosexuality (based on unfounded assumptions grounded in stigma rather than science; Herek, 2009), the negative position towards homosexuality still remains evident in a variety of present cultures and societies (Lamontagne et al., 2018; ILGA, 2016; McCarthy; 2014; Pew Research Centre, 2013), including Slovenia (Kuhar, 2016; Kuhar & Švab, 2009). Lehmiller (2014) suggested a few facts, which might help understand the general assumption that the only 'normal' attraction is being attracted to the opposite sex. Firstly, human societies worldwide are *heteronormative*—living in a belief, that there are two types of humans, males and females, and all males are attracted to females and vice versa. Heteronormativity is backed up by the idea that the sole purpose of sex is evolutionary (i.e., to propagate the species). Secondly, the statistics focusing on sexual orientation indeed indicate that the majority of the human population is heterosexually oriented, which puts the homosexual community in a minority position. Lastly, Lehmiller says that ignoring the wide variety of phenomena associated with sexuality for the main part of history has had a long-lasting effect and, consequently, the modern societies have not yet endorsed the new ideology concerning sexuality.

1.1 Internalised Homophobia

The cultural and societal context in which the person lives plays a large role in determining one's attitude towards homosexuality. And, although it is believed that every homosexually oriented individual experiences their sexuality in their own way (Szymanski & Kashubeck-West, 2008), homophobia and heteronormativity remain a 'unifying experience' of gays and lesbians living worldwide (e.g., Lamontagne et al., 2018).

Internalised homophobia (both as a term and as a concept) was first introduced by Weinberg (1972) and Malyon (1982). Their definitions implied that the sexual minority of lesbians, gays, and bisexuals tends to adopt the general cultural position of assuming that homosexual attraction is not moral and/or normal. They also indicated that (internalised) homophobia is a consequence of the enforcement of traditional sexual norms, which lead to

intolerance of those who are different or act differently. Since then, internalised homophobia has been a popular subject within lesbian and gay academic circles (Williamson, 2000). A significant increase of studies and theories related to the field occurred in the beginning of the second millennia (Berg, Munthe-Kaas, & Ross, 2015; Berg et al., 2017) and today it is widely acknowledged that internalised homophobia presents an important aspect of the homosexual experience of gays and lesbians (Szymanski & Kashubeck-West, 2008).

Internalised homophobia has been found to work in two ways—it can be directed towards oneself or towards others. In other words, it can be internally and/or externally directed. Frost and Meyer, (2009) described the former as an intrapsychic conflict between the need of being heterosexual and the homosexual desires that one experiences. This internal conflict is thought to manifest itself in harbouring negative attitudes towards oneself and one's own homosexuality. The external direction concerns other homosexually oriented individuals and it manifests itself in the negative attitudes towards the homosexually oriented community and in distancing from the group (Herek, 2009). Other practical examples of how internalised homophobia affects homosexually oriented individuals include: fear of discovery, putting down and avoidance of heterosexually oriented people, poor self-esteem, poor relationship quality and distress regarding intimacy (Davies & Neal, 1996).

The overview of the current theories on internalised homophobia suggested three important indications. First, internalised homophobia is a global issue (Berg et al, 2015; Berg et al., 2017). Second, internalised homophobia is likely to affect each member of the homosexual community (ranging from mild to severe in its aftermath; Szymanski & Kashubeck-West, 2008). Third, internalised homophobia can negatively affect the psychosocial well-being of gays and lesbians (Berg et al., 2015; Berg et al., 2017; Szymanski & Kashubeck-West, 2008; Williamson, 2000). The research in Slovenia on the topic was found to be scarce. The only studies exploring internalised homophobia with psychometric tools was conducted in 2011 by Cigan, Kološa, and Orgunc and in 2013 by Cigan. These researchers did not include homosexually oriented women in their studies. The present paper aims to fill in this gap by investigating the levels of internalised homophobia in the sample of gay and lesbian Slovenians and by assessing the relationship of the stigma with other psychosocial constructs.

1.2 HIV and the Homosexual Community

Human Immunodeficiency virus, commonly known by its acronym, HIV, is an infective agent that attacks the cells of the immune system and gradually weakens its functioning against infections and diseases (Mahy, 2008). Transmission of the virus can occur through a variety of bodily fluids (blood, breast milk, semen, vaginal secretion) and it is associated with risk behaviours such as unprotected sexual contact (World Health

Organisation—WHO, 2016). The public health interventions have evolved significantly regarding this sexually transmitted infection (STI), and nowadays, HIV should no longer be seen as a 'death sentence' but rather as a chronical infection, which is possible to be controlled.

In many countries around the globe, HIV and its consequences have had a devastating impact on MSM (Earnshaw & Kalichman, 2014). The virus was first found within the latter community, moreover, the disease resulting from the infection with the virus was first named after this community—gay-related immune deficiency. Until today, MSM have remained one of the key populations associated with the virus. UNAIDS (2018) reported that in 2017, MSM were found to be 28 times more likely to be infected in comparison to the general population and the group accounted for 57% of all new infections in Western Europe. These statistics put MSM at the top of the affected populations in Europe and North America (Figure 2).

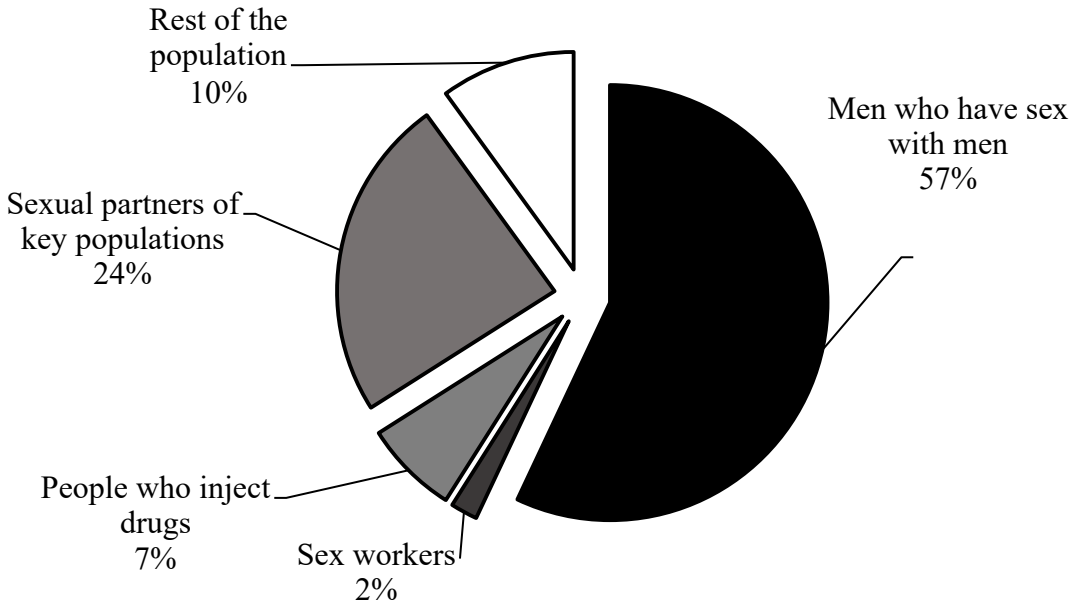

Figure 2. Key populations affected by HIV in Western and Central Europe and North America. From *UNAIDS data 2018* (p. 9), by UNAIDS, 2018 (http://www.unaids.org/en/resources/documents/2018/unaids-data-2018). Copyright (2018) by UNAIDS. Adapted with permission.

The situation in Slovenia is similar to these findings from UNAIDS (2018). According to the Nacionalni Inštitut za javno zdravje (i.e., National Institute for Public Health of the Republic of Slovenia; 2018), during the last 10 years the largest proportion of all new diagnoses was connected with MSM, ranging between 54% and 82%. Moreover, ever since the public and national health institutes have started to report the epidemic in Slovenia in 1998, MSM were found to be the most affected population. Based on the reports of the public health agency, it is also possible to observe that the numbers of testing as well as the newly found infections have been increasing throughout the years and in 2013, Slovenia reported the largest increase

in reporting HIV among MSM (86%) in Europe. In this ten-year span, 30–50 new infections were detected per year on average, out of which 25–45 were found among MSM. If this trend continues, it is estimated that the proportion of PLWH in Ljubljana, Slovenia, will overreach 10% of individuals in the gay scene (Ćosić et al., 2016).

Within the psychosocial field, HIV can be understood as a unique source of stress for gay men (Lewis, Derlega, Berndt, Morris, & Rose, 2002). Many MSM deal with the stress of having HIV, and those who are healthy are regularly confronted with the possibility of infection (Starks, Redina, Breslow, Parsons, & Golub, 2013). Homosexually oriented men and women are more likely to have experienced extensive losses in their personal and social networks as a result from the devastating effects that HIV has had on their close friends and acquaintances (Herek & Capitanio, 1999). Experiences of health-related concerns and multiple losses due to HIV are linked to high levels of mental distress (Folkman, Chesney, Collette, Boccellari, & Cooke, 1996). In relation to stigma, negative attitudes towards HIV and PLWH can be traced to the beginning of the epidemic (Herek, 2009). UNAIDS (2005) described HIV stigma as a process of devaluation of people either living with or being associated with HIV and AIDS. Due to the history of the HIV epidemic and due to the significant amount of the MSM community that has been disproportionately affected by the virus in various countries, the modern public continues to think of HIV and homosexuality together (Herek & Capitanio, 1999; Ruel & Campbell, 2006). This attitude has been observed within several countries (e.g., UNAIDS, 2005), including Slovenia (Cipot, 2016; Ćosić et al., 2016).

The importance of HIV related stigma in the gay community is based on three assumptions. First, as described, a significant amount of gay men is living with HIV and struggles with related stigma effects (UNAIDS, 2005). Second, imagining the consequences of an HIV diagnosis might be more common among MSM, because they consider themselves at a higher risk of contracting HIV (Starks et al., 2013). Third, the homosexually oriented people are more likely to know someone who is HIV-positive as well as to have witnessed the effects of societal stigma on individuals living with HIV (Starks et al., 2013).

Many researchers have found evidence for the negative effects of HIV stigma on the well-being of PLWH (see Chollier, Tomkinson, & Philibert, 2016). A large proportion of their studies focused on the MSM subgroups. More recently, scientists started investigating the effects of HIV stigma on the homosexual community as a whole. The overview presented by Smit and colleagues (2012) indicated that HIV stigma is sometimes even stronger within the community of gay men than within the heterosexual population. As such, HIV stigma could be interpreted as a significant stressor within the gay community which may negatively influence the well-being of the individuals within it, especially PLWH and those associated with them.

Concerning the females in the homosexual community, Szymanski and Kashubeck-West (2008) suggested that the lesbian side of the homosexual community tends to adopt negative attitudes towards PLWH as well. This might be due to the abundance of resources directed towards minimising the devastating effects of the virus. Within this perspective, the authors theorised that HIV may be understood as if it served to reinforce invisibility of the female homosexual subgroup and trivialise lesbian health issues. More studies are needed to confirm this idea since little is known about the attitudes towards PLWH among lesbians.

1.3 General and Sexual Well-being of Gays and Lesbians

In 2007, Iwasaki and Ristock indicated that gays and lesbians have been shown to be one of the most stressed population groups in North America. Due to the widely recognised effects of the imposed stress of stigma on the well-being of the homosexually oriented community, public mental health services and social workers should be able to provide evidence-based resources for helping the community achieve better quality of life and to prevent stress related health issues.

The contemporary literature from the field of mental health indicates that in largescale epidemiological surveys, most homosexually oriented individuals do not manifest heightened risk for psychopathology, suicidality, substance use, or psychological distress (e.g., Cochran & Mays, 2000). However, these same surveys support the fact emphasised by Iwasaki and Ristock (2007), stating that, in comparison to heterosexually oriented group, the tendency to report psychological distress is significantly higher within among same-sex oriented. This pattern has been observed among homosexually oriented men (Cochran & Mays, 2000; Cochran, Sullivan, & Mays, 2003; Sandfort, Graaf, & Bijjl, 2001) and women (Cochran et al., 2003; Sandfort, et al., 2001). Gays and lesbians were also found more likely than heterosexually oriented individuals to report past suicidal ideation and attempts (Balsam, Beauchaine, Mickey, & Rothblum, 2005; Sandfort et al., 2001). Greater risk of alcohol abuse was also suggested (Cochran & Mays, 2005; Sandfort et al., 2001). Overall, the available empirical data implies that although most homosexually oriented men and women function well, this population may be at heightened risk for lower levels of well-being.

Research from Weber (2008) implied that higher levels of distress have been reported among those homosexually oriented individuals who were found to have higher levels of internalised homophobia. Furthermore, Bobbe (2002) suggested that internalised homophobia is a more detrimental factor in terms of well-being than other interpersonal, external, overt forms of homophobia. Not surprisingly, in psychosocial interventions focusing on the well-being of gays and lesbians internalised homophobia is usually *the key concept* (Weber, 2008).

A significant relationship has also been observed between internalised homophobia and other negative psychosocial outcomes, including diminished self-esteem, demoralisation, and relationship instability (Frost & Meyer, 2009; Shidlo, 1994; Szymanski & Chung, 2003; Williamson, 2000). Based on the latter, it was further theorised that internalised homophobia undermines the individual's self-care and contributes to negative coping-mechanisms and risky behaviours (Williamson, 2000; Newcomb & Mustanski, 2010), including unprotected sexual intercourse (Stokes & Peterson, 1998).

Gregory M. Herek (2009), a renowned psychologist in the gay and lesbian academia, also proposed that internalised homophobia substantially limits the well-being of same-sex oriented. According to this author, internalised homophobia may hinder the person to engage in the community and it pushes the individual towards isolation. As such, the person is unable to endorse the homosexual collective identity, which would afford the individual with additional resources, beyond those available through a purely personal identity. The resources of the homosexual collective identity could be applied to reduce an individual's level of internalised stigma while fostering a positive collective identity (e.g., Frable, Wortman, & Joseph, 1997). Adopting a collective identity also increases the likelihood that sexual minority individuals will come out to their heterosexual family members, friends, and acquaintances (Herek, 2009). To the extent that significant others respond favourably, coming out can make additional social support available in the face of societal and personal stigma (e.g., Hershberger & D'Augelli, 1995; Luhtanen, 2003).

HIV was found to be another unique source of stress for the homosexual community (Lewis et al., 2002). Internalising the negative attitudes towards HIV has damaging effect on the well-being of same-sex oriented PLWH (Earnshaw & Kalichman, 2014), and is associated with increased depression, increased psychological distress, increased shame, increased anxiety, decreased self-esteem, decreased feeling of personal control, decreased hope, decreased physical health, decreased social support, decreased social integration, and increased social conflict (Rael & Hampanda, 2015)—therefore, it affects most spheres of the general well-being of same-sex oriented PLWH.

The idea that HIV stigma is present and an issue in the homosexual community at large is not new, but the studies investigating the levels of HIV stigma among the general same-sex oriented population are scarce and inconclusive. The effects of HIV stigma on seronegative same-sex oriented individuals within the community started receiving more attention in the past few years and there is a gap in the scientific understanding of the HIV stigma. This lack of research should be considered an issue regarding the fact that MSM live with the knowledge that they are among those at the highest risk of contracting HIV. In one of the rare studies,

Boone, Cook, and Wilson (2016) investigated the differences among gay PLWH and non-infected gay men and found that HIV stigma was related to psychological distress only for PLWH. On the other hand, Starks and colleagues (2013) concluded in their study that social concerns about HIV encompass the sexual reality of gay men and have adverse consequences on the mental health of same-sex oriented men. In the overview of the literature, no studies were found that would investigate the endorsement of prejudice towards PLWH among lesbians and its psychological correlates and its possible psychosocial consequences.

1.3.1 Depression. Mental health is an important component of well-being (WHO, 2014). Thus, mental distress and disorders arising from stigma could be understood as a sign of poor well-being and lesser quality of life. In the present paper, the term depression was used to denote a common state of poor well-being that negatively affects how a person feels, the way one thinks, and the way the person acts. It is characterised by feelings of sadness; lack of interest and pleasure; disturbed sleep; lack of energy; inability to concentrate; feelings of worthlessness; excessive guilt; changes in appetite; thoughts of death or suicide (American Psychological Association, 2018).

As presented earlier, internalised homophobia has been linked with various negative mental health outcomes, however, the positive relationship between the levels of stigma and depression seems to be among the most commonly observed (Newcomb & Mustanski, 2010; Williamson, 2000). Studies have consistently demonstrated that there is an important relationship between internalised homophobia and depressive symptoms (e.g., Igartua, Gill, & Montoro, 2003; Meyer, 1995; Shidlo, 1994). Furthermore, this association has been observed in various socio-cultural backgrounds. In a variety of studies, it was also suggested that depression might be seen as an antecedent of the negative coping mechanisms such as use of drugs and unprotected sex, as well as of diminished relationship quality (see Williamson, 2000). Since depression has so often been associated with internalised homophobia, some authors (e.g., Nungesser, 1983; Shidlo, 1994) have even considered it as a part of the concept itself.

The research on homosexually oriented PLWH indicates that HIV stigma is a determining factor in their psychological well-being (Earnshaw & Kalichman, 2014), whereas the research on the effects of HIV stigma on seronegative gays and lesbians is scarce and inconclusive (see Boone et al., 2016). The study of Starks and colleagues (2013) indicated that anticipated stigma of HIV contributes to the higher levels of experiencing negative affect (associated with depression) but Boone and collaborators (2016) found no such relation in their sample of seronegative gay men. Further studies are needed before concluding whether HIV

stigma plays a role in the life of the majority of same-sex oriented persons (regardless of the gender and HIV status) and whether it correlates with depression or not.

1.3.2 Sexual Self-Esteem. Self-esteem or the attitudes the person holds about oneself are, like depressive mood, associated with the well-being of the individual (WHO, 2014). Previous studies provided evidence for the idea that internalised homophobia has a negative impact on one's subjective perception of the self (see Newcomb & Mustanski, 2010).

Sexual self-esteem is a specific faucet of self-esteem. As a psychological construct, it is positively related with general self-esteem and well-being (Oattes & Offman, 2007). According to Zeanah and Schwarz (1996), it is multidimensional in its nature. These authors used the term to denote the tendency to either value or devalue one's own sexuality based on one's subjective assessment of the necessary skills to express and enjoy sexuality; the sense of one's sexual attractiveness, regardless of how others may perceive the person; the ability to direct and manage one's own sexual thoughts, feelings, behaviours, and interactions; and the congruence of one's sexual thoughts, feelings, and behaviours with one's moral standards and personal goals.

Although there are no available studies that investigated the relationship between internalised homophobia and sexual self-esteem, it seems reasonable to assume that sexual self-esteem is related to internalised homophobia based on two hypotheses. Since psychosocial researchers have observed the negative effect of internalised homophobia on the global self-esteem (see Newcomb & Mustanski, 2010), it is possible to expect a similar finding within the area of sexual self-esteem. Furthermore, the scientific literature was found to confirm the idea that internalised homophobia negatively influences several aspects of sexual self-esteem: body image (e.g., Bianchi, Piccoli, Zotti, & Fasoli; Pitman, 2008), relationship quality among gays and lesbians (e.g., Frost & Meyer, 2009), as well as sexual and intimacy disfunctions (Coleman, Rosses, & Strapko, 1992).

James (2011) highlighted that the environment, social interaction, and personal experience determine one's tendency to either value or devalue one's own sexuality. Negative experiences in sexuality such as bad sexual experiences and verbal accusations based on one's expression of sexuality can have a negative impact on one's sexual self-esteem (Mayers, Heller, & Heller, 2003). This is related with experiencing feelings of disappointment, dissatisfaction, confusion, sense of vulnerability and sense of insecurity (James, 2011). On the other hand, positive personal experiences and social interactions as well as accepting environment are thought to contribute to higher levels of sexual self-esteem which tend to relate with positive affective states such as pride, joy, satisfaction, and security (James, 2011). Since the sociocultural climate tends to devalue and criticise homosexuality and since gays and

lesbians portray this tendency as well (Szymanski & Kashubeck-West, 2008), this idea provided further indications that the sexual well-being of gays and lesbians might relate with internalised homophobia.

Regarding HIV, prior research suggested that HIV stigma significantly impairs the sexual self-esteem of PLWH (Rohleder, Mcdermott, & Cook, 2015). However, no studies were found whether HIV stigma (due to its symbolic association with MSM) affects the sexual well-being of the general homosexual community. Researches investigating sexually risky behaviours provided some hints that attitudes towards HIV might play an important role in sexual well-being (e.g., Zeanah & Schwarz, 1996); however, more studies are needed in order to assess the possible effect of HIV stigma on sexual health of the homosexually oriented population. Based on the finding that social concerns about HIV encompass the social reality of homosexually oriented population (Lewis et al., 2002; Starks et al., 2013), the question of HIV stigma is of important significance in terms of understanding the sexual well-being of gays and lesbians.

Since low sexual self-esteem is correlated with health issues, poor self-perception, low satisfaction with life, poor capacity to experience joy, depression, anxiety, suicidal ideation, diminished libido and sexual activity, diminished functioning (James, 2011), it is crucial to know the constructs that could be contributing to such state. Based on the empirical and theoretical literature, internalised homophobia and HIV could be considered as constructs related with poor sexual well-being of gays and lesbians.

1.3.3 Double Stigma. UNAIDS (2005), Herek and Capitanio (1999), and Ćosić et al. (2016) all argue that HIV prejudice remains largely fuelled by homophobia and vice versa. However, the relationship between the two stigmas requires practical research studies in order be considered evidence-based. Moreover, since HIV stigma could also be based on other factors such as concerns about risks of infection for oneself or loved ones (e.g., Herek and Capitanio, 1999; Pryor, Reeder, & McManus, 1991) or on attitudes toward other stigmatized groups, such as injecting drug users (Herek & Capitanio, 1999), the science should provide evidence for distinguishing among the negative attitudes associated with HIV. With this in mind, the concept of internalised homophobia seemed to deserve it place within the research on HIV stigma (Starks et al., 2013).

Only one study was found to empirically test the idea of the interplay between HIV related attitudes and internalised homophobia (i.e., Starks et al., 2013). This should be considered an issue regarding the theoretical literature on homosexual well-being which commonly addresses the two topics together (e.g., Ćosić et al., 2016; UNAIDS, 2018). In other words, the symbolical interlink between HIV and homosexuality in the perspective of the

modern society is fairly acknowledged; however, there is a lack of studies that would provide evidence that this symbolical interlink can be observed in the attitudes of gays and lesbians.

If the attitudes of the general and the homosexual community would confirm the tendency to endorse both HIV stigma and homophobia in a corresponding manner, gays and lesbians could suffer from the so-called double stigma effect. The latter stresses that when an individual is perceived as a possessor of more than one stigma, the psychosocial consequences of stigmatisation are thought to accumulate, resulting in an even worse state of well-being than if the person would be stigmatised based on one attribute (Szymanski & Kashubeck-West, 2008).

Starks and colleagues (2013) confirmed that gay men living with HIV suffer from higher levels of depression than seronegative gay men due to the double stigma effect. However, the possible intercorrelation between presence of HIV stigma, internalised homophobia, and well-being among homosexual community as a whole is poorly understood.

Since HIV has been widely associated with MSM, it seems reasonable to assume that people might stigmatise the gays and lesbians (especially the former) both on the basis of their homosexuality and on the basis of HIV. The idea of double stigma might in this case provide a useful framework for understanding the underlying factors of experiencing homosexuality both on the interpersonal and the intrapersonal level.

2 Overview and Hypotheses

Due to the socio-cultural climate in Slovenia that is still saturated with negative preconceptions about homosexuality (Kuhar, 2016), studies investigating the specific underlying factors behind these negative attitudes are crucial in order to understand the homosexual experience of individuals living in this Central European country. Psychological research focusing on the homosexually oriented community in Slovenia is limited with most of the contemporary literature coming from the field of sociology, social work, and law. Within these lines, internalised homophobia and the endorsement HIV stigma lack of evidence-based science, which could help to interpret the mechanisms behind the negative self- and homosexual community-related attitudes experienced by gays and lesbians.

Studies investigating mental health among Slovenian gays and lesbians is scarce as well. Thus, it is poorly understood whether the general Slovenian attitudes towards homosexuality have an impact on their general and sexual well-being. Since depression was found to be an internationally recognised companion of internalised homophobia (see Newcomb & Mutanski, 2010), it should be tested whether such relationship exist between the two in this country as well. Likewise, based on the overview on HIV by Ćosić and colleagues (2016), HIV is still widely associated with gay men. This relationship was found to be poorly

investigated (Starks et al., 2016) and deserves more attention in order to determine whether the generally endorsed beliefs about HIV and the homosexually oriented community has an impact on the well-being of gays and lesbians.

Apart from the strictly medical/physiological discourse, sexuality and sexual self-esteem are also often overlooked topics in Slovenian scientific literature. And since sexuality is becoming increasingly understood through the biopsychosocial model, the topic requires more attention from psychologists in order to equip the professionals within the field with the evidence-based theory that could be applied when helping those in need achieve sexual health. These theories should take into consideration the sociocultural environment (Zeanah & Schwarz, 1996). Internalised homophobia and HIV stigma could be considered as two specific sociocultural factors that might be adding to the unfavourable basis for sexual health of the homosexual community.

With the present study, we wished to acknowledge the lack of available information about the unique experiences of gays and lesbians in Slovenia and build upon the contemporary scientific literature based on four psychosocial constructs: internalised homophobia, stigma towards PLWH, depression, and sexual self-esteem. Two studies and ten hypotheses were developed based on the idea of exploring the homosexual experience in Slovenia and on the aim to investigate the potential effect of double stigma on of general and sexual well-being.

2.1 Study 1

2.1.1 Objectives. The objective of Study 1 was to adapt and validate the appropriateness and adequacy of the Sexual Self-Esteem Inventory—Short Form (Zeanah & Schwarz, 1996). Due to the lack of psychological research on sexuality in Slovenia, no such measure existed previously. Thus, one of the objectives was to provide the psychologists and other sexuality related professionals with an instrument that could indicate the level of sexual well-being of Slovenians. In addition, another objective of Study 1 was to end up with an instrument suitable for use in Study 2 and provide guidance for well-being related interventions focusing on the homosexual community.

2.1.2 Working Hypothesis. The working hypothesis of Study 1 was the following:

Hypothesis 1. The Slovenian version of Sexual Self-Esteem Inventory—Short Form will replicate the original structure of the instrument.

Sexual self-esteem is an important aspect of sexual and general well-being (Zeanah & Schwarz, 1996). Studies based on the longer version of the Sexual Self-Esteem Inventory have consistently replicated the original structure of the instrument even in different cultural environments such as Iran (e.g., Garousi et al., 2001 in Firoozi, Azmoude, & Asgharipoor,

2016) and Germany (Bornefeld-Ettmann et al., 2018). Thus, we expected to find no differences in the structure of the Slovenian version of instrument.

2.2 Study 2—Part 1

2.2.1 Objectives. The objective of Study 2—Part 1 was to adapt and validate the appropriateness and adequacy of the Stigmatizing attitudes towards people living with HIV—Short (SAT—S; Beaulieu, Adrien, Potvin, Dassa, & Comité consultatif sur les attitudes envers les PVVIH, 2014). There is a lack of psychological research on HIV related stigma in Slovenia and since MSM represent a disproportionally affected community, the levels of HIV among the homosexually oriented individuals requires attention. One of the objectives was to provide the psychologists and other sexuality related professionals with an instrument that could indicate the level of HIV prejudice in seropositive and seronegative population. In addition, another objective of Study 1 was to end up with an instrument suitable for use in Study 2—Part 2 in order to assess the levels of HIV stigma among gays and lesbians.

2.2.2 Working Hypothesis. The working hypothesis of Study 2—Part 1 was:

Hypothesis 2. The Slovenian version of Stigmatizing attitudes towards people living with HIV—Short will replicate the original structure of the instrument.

Stigmatizing attitudes towards people living with HIV—Short is a new instrument and was currently validated only on Canadian population (Beaulieu et al., 2014). Regardless, we expected that the instrument will be adequate for the use on Slovenian population due to its simplistic nature, straightforwardness, and contemporality of the items.

2.3 Study 2—Part 2

2.3.1 Objectives. The main question that this thesis pretended to answer addresses the homosexual experience of gays and lesbians living in Slovenia based on four distinct psychological constructs. The main objectives for conducting this kind of research was to fill in the gap in the available literature on experiencing homosexuality in Slovenia and to provide guidelines for future studies and practical work related with the population.

2.3.2 Working Hypotheses. As possible components of the homosexual experience, the following hypotheses were statistically tested:

Hypothesis 3. Gays and lesbians within our sample will not differ significantly on the aspect of internalised homophobia, HIV related prejudice, depression, and sexual self-esteem.

Although differences exist between gays and lesbians, due to their shared history and shared sexual orientation identification the two groups are commonly considered together in terms of theory, research, and practice (Szymanski & Kashubeck-West, 2008). Thus, we assumed that their experiences of homosexuality based on the four psychological constructs will not differ substantially.

Hypothesis 4. The individuals experiencing higher levels of internalised homophobia will portray higher levels of stigmatisation towards PLWH.

Due to the significant impact of the HIV epidemic on the population of men who have sex with men, HIV remains associated with homosexuality and can be understood as a specific prejudice related to homosexuality (Ćosić et al., 2016; Herek & Capitanio, 1999; UNAIDS, 2018). Studies investigating the relationship between the two concepts suggest that HIV stigma is dividing the group of gays and lesbians (e.g., Boone et al., 2016). Within these lines, we expected to find a significant positive relationship between these two types of stigma.

Hypothesis 5. The individuals with higher levels of internalised homophobia will present higher levels of depressive symptoms.

It was found that depression often accompanies internalised homophobia in various sociocultural climates (e.g., Newcomb & Mutanski, 2010). Only one study investigated the relationship between the two psychological concepts on Slovenian population and significant changes have occurred in terms of providing equality and equity to homosexual community (i.e., Cigan, 2013). Thus, new studies are needed but, based on previous observations, a significant positive correlation between depression and internalised homophobia was expected.

Hypothesis 6. The individuals with higher levels of prejudice towards PLWH will present higher levels of depressive symptoms.

The endorsement of negative prejudice towards PLWH can impact the well-being of homosexually oriented PLWH. Furthermore, negative attitudes towards HIV could disrupt the integration of any individual into the homosexual community and cause psychological distress (Ćosić et al., 2016; Herek & Capitanio, 1999; Smit et al., 2012; UNAIDS, 2018). Thus, we expected to find a significant positive correlation between the levels of HIV stigma and depression.

Hypothesis 7. The individuals with higher levels of internalised homophobia will present lower levels of sexual self-esteem.

Previous studies have suggested a negative impact of internalised homophobia on general self-esteem (see Newcomb & Mutanski, 2010) and an abundance of evidence exist that negative attitudes towards homosexuality negatively influence several aspects of sexual self-esteem: body image (e.g., Bianchi et al., 2016), relationship quality among gays and lesbians (e.g., Frost & Meyer, 2009), as well as sexual and intimacy disfunctions (Coleman, Rosses, & Strapko, 1992). Along these lines, we expected to find a significant negative association between internalised homophobia and sexual self-esteem.

Hypothesis 8. The individuals with higher levels of prejudice towards PLWH will present lower levels of sexual self-esteem.

As stated in Hypothesis 4, an important symbolical link exists between HIV and homosexuality. Fear and anxiety arising from HIV stigma can lead to avoidance of sexual interactions (Starks et al., 2013) and the latter are positively correlated with sexual self-esteem (James, 2011). Thus, we expected to find a significant negative correlation between the levels of sexual self-esteem and the levels of HIV related prejudice.

Hypothesis 9. The levels of internalised homophobia and HIV related attitudes are significant predictors for the level of depression experienced, both adding to higher levels of depression by the so-called double stigma effect.

Both internalised homophobia and HIV related stigma are associated with increased levels of the negative affect experienced by the homosexual community (Boone et al., 2016). Based on the idea of double stigma associated with homosexuality, the combination of the two were expected predict greater likelihood for depression.

Hypothesis 10. The levels of internalised homophobia and HIV related attitudes are significant predictors for the level of sexual self-esteem experienced, both adding to lower levels of depression by the so-called double stigma effect.

HIV stigma and internalized homophobia have an impact on the general well-being of the homosexually oriented individuals and are associated with some detrimental consequences of sexual well-being such as engaging in risky sexual behaviours (Herek, 2009). Thus, we proposed that sexual self-esteem will be dependent on the higher levels of internalised homophobia and HIV related stigma. Based on the idea of double stigma, the two will predict lower levels of sexual self-esteem than just one of them would.

3 Methods

3.1 Study 1

With the intent of exploring the potential effect of internalised homophobia and HIV related stigma on general and sexual well-being of gays and lesbians in Slovenia, in the first part of the research, Study 1 was conducted. The principal aim of Study 1 was to adapt and validate one of the measures that were later employed as a part of the main study—Study 2. More specifically, the main objectives of Study 1 were to ensure (1) the semantic equivalence of the translated items and (2) the adequacy of the psychometric properties of the Slovenian version of the instrument used for assessing sexual self-esteem.

3.1.1 Procedure. First, a backward and forward translation of our measure of interest was performed. Three independent translators were given the task of translating the items from the English original to Slovenian. Two of the translators were acquainted with the constructs that the instrument intends to measure, while one was not. A fourth unbiased translator was consulted to help the resolve the discrepancies between the three forward translations. This

same person was also involved in the backward translation of each item. In the last step of the translation process, two experts related to the field reviewed the final version of the instrument and helped achieve semantic, idiomatic, experiential, and conceptual equivalence of the original and the translated items.

Following the translation phase, an online survey was created in a free online programme En Klik Anketa—1KA. A general web link to the survey was generated (i.e., https://www.1ka.si/a/178649) with which the anonymity of the participants was assured. In the online survey, four measures were applied in the following order: Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965); Satisfaction with Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985); Sexual Self-Esteem Inventory—Short Form (SSEI—SF; Zeanah & Schwarz, 1996), sociodemographic questionnaire.

In the next step, a pilot study was carried out. The pilot testing included a small sample ($N = 10$). After the completion of the online survey, these participants were asked to elaborate, verbally or in a written form, what each item meant in order to assure that there is no confusion and ambiguity about the items.

After ensuring that the Slovenian items were unequivocal, the online survey was shared through various social media platforms (i.e., Facebook, Twitter, and online forums related to health and/or sexuality), through personal electronic mail database, and in person (by distributing invitation letters with the web link to the survey). In order to achieve a greater number of participants, the Slovenian Association of Sexology was asked for help—they shared the survey on their social media. Respondents were encouraged to share the survey; therefore, snowball sampling was applied. The average time for completing the survey was 19 min. The survey was available online from the 16th of July, 2018 until the 14th of January, 2019.

Following the collection of the data, the factorability of the Sexual Self-Esteem Inventory—Short Form was examined and analysed according to the guidelines proposed by Field (2013). Later, a statistical analysis was performed in order to evaluate the psychometric properties of the instrument (i.e., reliability and validity). The statistical analyses were conducted with IBM Statistical Package for the Social Sciences, Version 25.0 (IBM SPSS; IBM Coorporation, 2017).

3.1.2 Participants. The only criterium for participating in Study 1 was to be above the legal age of consent (i.e., 18 years old or older). Out of the 2.581 individuals who clicked on the survey, 626 started to fill it out. However, only 435 of these completed it which amounts for approximately 17%. The respondents who did not meet the requirement of completing the whole survey were excluded from the further analyses.

The final sample (N = 435) was comprised of 357 individuals between 18 and 35 years of age (82%). More than half of the final sample identified as female (n = 264; 61%), 158 participants were male (36%), seven individuals identified as non-binary (2%), and one person as a transgender male (i.e., less than 1%). The remaining five either did not wish to answer to the question or they identified with a gender not listed (1%). A vast majority of individuals (n = 360; 83%) identified as heterosexually oriented, 40 as bisexually oriented (9%), 15 as homosexually oriented (3%), and 12 as pansexually oriented (2.8%). Out of the seven participants remaining, five preferred not to answer, one identified as asexual, and one as queer. Besides age, gender, and sexual orientation, the following sociodemographic data was collected: highest education level achieved; current professional status; current relationship status (if in a relationship, they were also asked how long they have been in the relationship with their current partner); and the number of sexual partners they have had until today.

3.1.3 Materials. Study 1 was comprised of three scales and a sociodemographic questionnaire. The latter was described in the 'Participants' section and it was applied in Study 1 as the last. The remaining three instruments were applied in the online survey in the order presented below.

Rosenberg self-esteem scale (RSES; Rosenberg, 1965): This widely used self-report instrument estimates global self-worth by measuring both positive (e.g., 'I feel that I have a number of good qualities.') and negative feelings (e.g., 'At times I think I am no good at all.') about the self. The scale is believed to be unidimensional. It consists of ten items, which are answered using a four-point Likert scale format ranging from *strongly agree* to *strongly disagree*. The internal consistency for the Slovenian version of RSES, based on the research from Avsec (2007), is high (α = .81).

Satisfaction with life scale (SWLS; Diener et al., 1985): This short five-item self-report instrument is designed to measure global cognitive judgements of satisfaction with one's life. Participants rate each item in a form of a positive statement (e.g., 'If I could live my life over, I would change almost nothing.') on an agreement scale anchor with a seven-point Likert scale (ranging from *strongly agree, agree* to *strongly disagree*). The internal consistency for the Slovenian version of SWLS, based on the research from Plavčak (2009), is adequate with a Cronbach's alpha set at .78.

Sexual self-esteem inventory—Short Form (SSEI—SF; Zeanah & Schwarz, 1996): This multidimensional inventory was created with the aim of assessing one's self-appraisals of sexuality. Different domains of sexuality, including (a) skills and experience; (b) attractiveness; (c) control; (d) adaptation, and (e) moral judgement, are assessed through 35 items. Each domain consists of seven items. To respond to an item (e.g., 'I never feel bad about

my sexual behaviour.'), the participants are asked to indicate on a six-point Likert scale whether they *strongly disagree, disagree, slightly disagree, slightly agree*, or *agree*. The Cronbach's alphas in the original authors assessment were found to be .93; .94; .88; .85 and .90 respectively to the order above. This scale has not been used in Slovenian before and based on the translation phase and the pilot study (N = 10) all 35 items were included in the subsequent psychometric analysis of Sexual Self-Esteem Inventory—Short Form. The results of the latter are presented in the next section.

3.1.4 Results. In order to assess the underlying dimensions of the Sexual Self-Esteem Inventory—Short Form, a Principal Component Analysis (PCA) was conducted. The minimum amount of data for PCA proposed was satisfied with a final sample above 300 cases which is regarded as a good sample size for finding a stable factor solution (Comrey & Lee, 1992; Tabachnick & Fidell, 2007), providing a ratio over 12 cases per variable (i.e., item).

Initially, the factorability of the 35 Sexual Self-Esteem Inventory—Short Form items was examined. Several well-recognized criteria for the factorability (e.g., Field, 2013) were explored. Firstly, it was observed that all 35 items correlated at least .30 with at least one other item, suggesting reasonable factorability. Secondly, Kaiser-Meyer-Olkin measure of sampling adequacy was set at .93, above the commonly recommended value of .60, and result of Bartlett's test of sphericity was significant; $\chi^2(595) = 6890.74$, $p < .01$. Finally, the communalities were all above .40, further confirming that each item shared some common variance with other items. Given these overall indications, PCA was deemed to be suitable with all 35 items.

Initial Eigenvalues proposed the solution of six factors, explaining 57% of the total variance. Based on the Scree Plot analysis, a solution of five factors was indicated, which would, according to the corresponding Eigenvalue, explain almost 54% of the total variance. According to the Monte Carlo PCA for Parallel Analysis with the number of replications set at 150, we should have retained a four-factor solution. Considering the three solutions and the theoretical underlying of the concept of sexual self-esteem, we decided to examine all three proposed solutions using the Varimax Rotation Method.

The results of the PCA based on Varimax Rotation Method with six factors produced disorganized results with six items loading on more than one factor (with values below .40 were suppressed). When the number of factors was set to five, the results were clearer but still somewhat ambiguous. Four items were still loading on more than one factor, and the solution suggested only two items (i.e., ssei19 and ssei24) within the last underlying dimension. Since a factor with two items is not reliable enough (Field, 2013), a four-factor solution was deemed more appropriate.

When four-factor solution was conducted, four items still did not show a clear relationship to any of the underlying factors (i.e., the variables were still loading on more than one factor, despite the absolute value set at .40). To investigate the possible reason behind this uncertainty, the graphic representation of each item was analysed. Two out of four items (i.e., ssei5 and ssei22) presented ceiling effects in their histogram representations. All four items, written out next, were eventually excluded from the further analysis: ssei1: 'I wish I could relax in a sexual situation.'; ssei5: 'I feel guilty about my sexual thoughts and feelings.'; ssei22: 'I worry that some parts of my body would be disgusting to a sexual partner.'; ssei29: 'I am glad that feelings about sex have become a part of my life.'. The remaining 29 items underwent another PCA with four factors as the final factor solution (see Table 1, p. 22).

Table 1

Study 1. Principal Component Analysis for the Final 29 Items of the Slovenian Sexual Self-Esteem Inventory—Short Form (N = 435)

Item	Factor				Communality
	1	2	3	4	
ssei6	.78				.67
ssei31	.72				.57
ssei11	.67				.47
ssei21	.67				.54
ssei13	.66				.52
ssei16	.65				.57
ssei26	.58				.52
ssei4	.56				.44
ssei34	.55				.49
ssei9	.48				.39
ssei2		.84			.77
ssei32		.83			.75
ssei17		.75			.63
ssei12		.74			.63
ssei7		.72			.66
ssei27		.68			.54
ssei18			.72		.60
ssei33			.67		.48
ssei3			.66		.52
ssei23			.63		.56
ssei8			.62		.48
ssei28			.55		.48
ssei15				.63	.42
ssei35				.62	.44
ssei10				.60	.40
ssei20				.59	.45
ssei30				.59	.47
ssei25				.54	.43
ssei24				.49	.33
ssei14				.45	.30
ssei19				.42	.38

Note: Factor loadings below .40 were suppressed.

A semantic analysis of the 29 items was carried out to assess the similarities and discrepancies of the original five-factor structure of SSEI—SF and the suggested four-factor structure of the Slovenian version of the instrument. The labels for the underlying dimensions of sexual self-esteem proposed by Zeanah and Schwarz (1996) partially suited the extracted factors from the data in Study 1 (see Tables 2–5). Two out of four factors showed no ambiguities about their nature, thus, the name of the underlying dimensions was retained. For the remaining two factors in which the items presented a mix of previously identified dimensions, the labels were adapted in order to better represent the nature of the two dimensions.

Table 2

Study 1. Internal Structure of the Slovenian Sexual Self-Esteem Inventory—Short Form: Skills and Competence

Original factor	Item		New factor
	Code	Statement	
Adaptiveness	ssei4	I feel good about the place of sex in my life.	Skills and Competence
Skills and Experience	ssei6	I feel I am pretty good at sex.	Skills and Competence
Adaptiveness	ssei9	I like what I have learned about myself from my sexual experiences.	Skills and Competence
Skills and Experience	ssei11	I feel that ‘sexual techniques’ come easily to me.	Skills and Competence
Control	ssei13a	I feel I can usually judge how my partner will regard my wishes about how far to go sexually.	Skills and Competence
Skills and Experience	ssei16	Sexually, I feel like a failure. (R)	Skills and Competence
Skills and Experience	ssei21	I do pretty well at expressing myself sexually.	Skills and Competence
Skills and Experience	ssei26	I feel embarrassed about my lack of sexual experience. (R)	Skills and Competence
Skills and Experience	ssei31	I feel good about my ability to satisfy my sexual partner.	Skills and Competence
Adaptiveness	ssei34	In general, I feel my sexual experiences have given me a more positive view of myself.	Skills and Competence

Note: (R) denotes inverted items.

Table 3

Study 1. Internal Structure of the Slovenian Sexual Self-Esteem Inventory—Short Form: Attractiveness

Original factor	Item		New factor
	Code	Statement	
Attractiveness	ssei2	I am pleased with my physical appearance.	Attractiveness
Attractiveness	ssei7	I hate my body. (R)	Attractiveness
Attractiveness	ssei12	I am pleased with the way my body has developed.	Attractiveness
Attractiveness	ssei17	I would like to trade bodies with someone else. (R)	Attractiveness
Attractiveness	ssei27	I would be happier if I looked better. (R)	Attractiveness
Attractiveness	ssei32	I am proud of my body.	Attractiveness

Note: (R) denotes inverted items.

Table 4

Study 1. Internal Structure of the Slovenian Sexual Self-Esteem Inventory—Short Form: Control

Original factor	Item		New factor
	Code	Statement	
Control	ssei3	I feel emotionally vulnerable in a sexual encounter. (R)	Control
Control	ssei8	I am afraid of losing control sexually. (R)	Control
Control	ssei18	I feel physically vulnerable in a sexual encounter. (R)	Control
Control	ssei23	I worry that I won't be able to stop something I don't want to do in a sexual situation. (R)	Control
Control	ssei28	I worry that things will get out of hand because I can't always tell what my partner wants in a sexual situation. (R)	Control
Control	ssei33	I worry that I will be taken advantage of sexually. (R)	Control

Note: (R) denotes inverted items.

Table 5

Study 1. Internal Structure of the Slovenian Sexual Self-Esteem Inventory—Short Form: Morality and Adaptiveness

Original factor	Item		New factor
	Code	Statement	
Morality	ssei10	My sexual behaviours are in line with my moral values.	Morality and Adaptiveness
Adaptiveness	ssei14a	I don't feel ready for some of the things that I am doing sexually. (R)	Morality and Adaptiveness
Morality	ssei15	Some of the things I do in sexual situations are morally wrong. (R)	Morality and Adaptiveness
Morality	ssei20	I have punished myself for my sexual thoughts, feelings, and/or behaviours. (R)	Morality and Adaptiveness
Adaptiveness	ssei24	I wish sex were less a part of my life. (R)	Morality and Adaptiveness
Morality	ssei25	I feel embarrassed about my lack of sexual experience. (R)	Morality and Adaptiveness
Morality	ssei30	I never feel guilty about my sexual feelings.	Morality and Adaptiveness
Morality	ssei35	From a moral point of view, my sexual feelings are acceptable to me.	Morality and Adaptiveness

Note: (R) denotes inverted items.

Composite scores were created for each of the four factors, based on the mean scores. Higher scores indicated greater sexual self-esteem within the domain. Descriptive statistics for each instrument used (i.e., the number of items, means and standard deviations, two measures of variability) and internal consistency scores of each scale (i.e., Cronbach's alphas) are presented in Table 6..

Table 6

Study 1. Descriptive Statistics and Internal Consistency Scores (N = 435)

	Number of Items	*M* (*SD*)	Skewness	Kurtosis	α
Sexual Self-Esteem Inventory—Short Form	31	4.64 (.69)	–.69	.46	.92
Skills and Competence	10	4.51 (.85)	–1.05	1.54	.88
Attractiveness	6	4.36 (1.05)	–.78	.27	.88
Control	6	4.69 (.94)	–.85	.48	.81
Morality and Adaptiveness	9	4.95 (.73)	–.99	1.21	.78
Rosenberg Self-Esteem Scale	10	3.19 (.51)	–.82	.69	.84
Satisfaction with Life Scale	5	4.70 (1.26)	–.45	-.38	.86

Pearson correlation analysis was computed to explore the linear relationship between the four subscales (two-tailed). The data used met the necessary assumptions for performing the test proposed by Field (2013)—the variables were based on interval data and the sample data was normally distributed concerning Curran, West, and Finch (1996), which propose two as a limit for skewness and seven for the value of kurtosis. The results indicated significant correlations and the variability of the subscales was significantly related to the results of the participants in the other dimensions of Sexual Self-Esteem Inventory—Short Form.

Pearson correlation coefficients indicated significant positive correlations between all the four subscales, $.38 \leq r(433) \leq .55$, $p < .01$ (medium to large effect; Field, 2013), as well as the total scale $.72 \leq r(433) \leq .86$, $p < .01$ (large effects). The construct validity based on the same analysis suggested relationship of all the aforementioned scales with two theoretically related constructs—self-esteem (measured with Rosenberg Self-Esteem Scale) and well-being (measured with Satisfaction with Life Scale). The results of the Pearson correlation coefficients are presented in the Table 7.

Table 7

Study 1. Pearson's Correlation Coefficients (N = 435)

	1.	2.	3.	4.	5.	6.	7.
1. Sexual Self-Esteem Inventory—Short Form	—						
2. Skills and Competence	.86**	—					
3. Attractiveness	.72**	.50**	—				
4. Control	.76**	.55**	.40**	—			
5. Morality and Adaptiveness	.77**	.53**	.38**	.51**	—		
6. Rosenberg Self-Esteem Scale	.59**	.46**	.58**	.40**	.40**	—	
7. Satisfaction with Life Scale	.46**	.40**	.42**	.29**	.31**	.57**	—

Note: ** $p < .01$.

Overall, the correlation analyses indicated that the four factors are significantly related, which suggests that the constructs are of significant relationship. Furthermore, the constructs seem to be significantly related to two previously validated scales which measure theoretically similar constructs. Thus, the construct validity of the Slovenian version of the Sexual Self-Esteem Inventory—Short Form was deemed adequate.

3.1.5 Conclusions. Based on the PCA with Varimax Rotation, the Slovenian version of Sexual Self-Esteem Inventory—Short Form with 29 items assesses four underlying dimensions of sexual self-esteem. The Slovenian version did not replicate the original structure of the instrument; thus, Hypothesis 1 was rejected. However, the semantic analysis of the four obtained factors indicated many similarities to the original version of Sexual Self-Esteem Inventory—Short Form by Zeanah and Schwarz (1996).

The underlying dimensions of sexual self-esteem based on the Slovenian version of the instrument include: Skills and Competence, Attractiveness, Control, and Morality and Adaptiveness. The first factor intends to measure one's subjective assessment of the necessary skills to express and enjoy sexuality and consists of ten items. Attractiveness relates to the sense of one's sexual attractiveness, regardless how other may perceive the individual and is assessed through six items. Control factor consists of six items and measures the ability to direct and manage one's own sexual thought, feelings, behaviours, and interactions. The last factor comprised of nine items measures the congruence of one's sexual thoughts, feelings, and behaviours with one's own moral standards and personal goals. Two of the dimensions were clear regarding their nature (i.e., Attractiveness and Control), however the other two included items from more than one original dimension; thus, the names of the dimensions were slightly adapted.

Although the sample was good in terms of producing reliable results (N = 435), the differences found between the structure proposed by the original authors and the Slovenian version need to be further tested in order to confirm the dimension proposed with this study. Conducting another study and confirmatory factor analysis are suggested in order to resolve the question concerning the internal structure of the Slovenian version of Sexual Self-Esteem Inventory—Short Form.

An important limitation of this study was the lack of resources for conducting confirmatory factor analysis instead of PCA. Field (2013) reports about various authors (e.g., Cliff, 1987) implying that for the instruments with a defined factor structure confirmatory factor analysis should be used and not PCA. However, since our sample was relatively big and there were more than 20 variables, the differences in the results of PCA and confirmatory factor analysis should be minimal (see Stevens, 2002).

Due to an adequate number of participants for performing PCA, is reasonable to assume that the differences observed might be a result of the cultural specifics of our sample. Thus, further research is needed in order to determine the possible cultural aspects of these differences. A qualitative exploration of the nature of sexual self-esteem of the Slovenian population could provide better insight to this question. The differences found might be also a

result of the language specifics and the formulation of the items that was used. A research with a slightly modified translation could help resolve the question of the underlying factors in this manner.

3.2 Study 2

In order to assess the statistical value of the hypotheses, a second survey was developed. Study 2 had two main objectives: (1) to validate the measure of internalised HIV related prejudice and (2) to conduct statistical analyses of the main study. In order to explore the two objectives, Study 2 had two versions. The version to which the participants were assigned to was decided on their sexual orientation. The participants who identified themselves with an orientation not listed and those who did not wish to reveal it, were directed to the version of the survey designed for the validation of HIV prejudice scale. This version was composed of three scales measuring different aspects of HIV related attitudes—internalised prejudice towards PLWH, STI/HIV anxiety, and external perception of HIV stigma. The data and the analyses conducted for the validation of internalised prejudice towards PLWH is presented as Part 1 of Study 2.

The individuals who identified as homosexually oriented were directed to a longer version of the survey on which the present paper was based. Besides the HIV related instruments, this version included three additional scales for measuring depression, internalized homophobia, and sexual self-esteem. This version of the survey is presented as Part 2 of Survey 2. In order to ensure a large enough sample for the validation of internalised prejudice towards PLWH, the results of the homosexually oriented participants on the HIV related attitudes measures were included in Part 1 of Study 2. In other words, the data from the sample of gays and lesbians was used in Part 1 (i.e., the validation process) and Part 2 (i.e., the main study).

3.2.1 Part 1. The availability of psychosocial instruments for measuring HIV related attitudes in Slovenia is scarce. Thus, with the aim of measuring the internalization of the prejudice towards PLWH for the main study, three fairly distinct yet related instruments for assessing HIV related attitudes were translated to Slovenian. The validation process is presented in this section.

3.2.1.1 Procedure. The three instruments were chosen based on the construct of interest—HIV related attitudes: STD/HIV Anxiety Scale (Sales et al., 2009); Stigmatizing attitudes towards people living with HIV—Short (Beaulieu al., 2014); AIDS Related Stigma Scale (Kalichman et al., 2008). Backward and forward translation of the three HIV related attitudes measures was performed. The forward translation included four independent translators (two of them were not acquainted with the construct); backward translation was

performed by one investigator. Furthermore, three experts from the field reviewed the final selection of the translations.

After the translation was carried out, the three scales were put into a form of an online survey using the free online programme En Klik Anketa—1KA. A pilot study was performed based on a small sample of 14 participants. These individuals were asked to elaborate, verbally or in a written form, what each item meant. There were some items that caused confusion and ambiguity, but these issues were resolved after consultation with the experts from the field.

Following the final version of the items, the online survey was officially launched. It included: a sociodemographic questionnaire and the three HIV related attitudes instruments. As mentioned, the version for individuals who identify as homosexual was longer. It included the four mentioned measures as well, so that their responses could be used in the validation procedure. The survey was shared through the social media platforms (i.e., Facebook, Twitter), through personal electronic mail database, and in person (by distribution of invitation letters with the web link to the survey). Respondents were encouraged to share the survey; therefore, snowball sampling was applied. The average time for completing the survey was 9 minutes. Note, that this is an approximation for both versions of the survey. The survey was available from the tenth of November, 2018, until the 14th of January, 2019.

3.2.1.2 Participants. Once again, the only criterium to participate in the study was to be above the legal age of consent (i.e., 18 or above). Out of 1006 people who clicked on the survey, 302 have completed it. The average age of these participants was 30.57 (SD = 8.29; min = 18; max = 75). The majority identified themselves as female (n = 214; 70.9%), while 79 identified as male (26.2%), 3 identified as transgender women (1%), and one as a transgender man (.3%), the remaining five preferred not to answer or identified as something not listed (1.65%). The majority indicated that they are heterosexually oriented (n = 139; 46%), 103 that they are homosexually (34.1%), and 54 as bisexually (17.9%), the remaining six preferred not to answer or they stated a different orientation (1.99%). Around 30% of the participants was at the time single (n = 90) while 202 individuals stated being in some sort of a relationship (66.89%).

3.2.1.3 Materials. With the aim of validating the instrument for assessing internalised prejudice towards PLWH, four instruments were applied in the short version of the online survey in the following order: sociodemographic questionnaire, STD/HIV Anxiety Scale (Sales et al., 2009); Stigmatizing attitudes towards people living with HIV—Short (Beaulieu et al., 2014); an adapted version of AIDS Related Stigma Scale (Kalichman et al., 2008). In our survey, the optional responses to each item on all three scales ranged from one to seven in terms of the Likert scale.

STI/HIV Anxiety Scale (SHAS; Sales et al., 2009): This is a ten-item scale consisting of two subscales: sexually transmitted infections/HIV worry and pregnancy worry. The latter was not within our interest, therefore, we omitted it. The subscale of interest consists of eight items (e.g., 'In the past six months, how often did you worry that you might get the HIV virus?'). In the original version, each item requires a response on a four-point Likert scale, however, our participants were instructed to indicate the degree of frequency on a seven-point Likert scale ranging from *never* to *always.* The Cronbach's alpha for the STI/HIV worry subscale was .90 in the initial validation of the scale (as well as .92 and again .92 after a six- and twelve-month follow-up).

Stigmatizing attitudes towards people living with HIV—Short (SAT—S; Beaulieu et al., 2014): This is a 27-item scale which intends to measure stigmatizing attitudes towards people living with human immunodeficiency virus (HIV). It is composed of seven factors: concerns about occasional encounters; avoidance of personal contact; responsibility and blame; liberalism; non-discrimination; confidentiality of seropositive status, and criminalization of HIV transmission. For the purpose of our study, we used the items from the first two factors in order to assess the level of internalised prejudices against PLWH. Additionally, we slightly adapted the items—instead of referring to AIDS we transformed the term to HIV. For example, we changed the sentence 'I would not hug someone with AIDS' to 'I would not hug someone with HIV'. This summed up to a total of six items to which we applied a seven-point Likert scale format ranging from *strongly agree* to *strongly disagree*. The original scale was based on a four-point Likert scale and the internal consistency based on the original study indicated Cronbach's alpha .74 and .79 respectively to the sub factors' order set above.

AIDS-Related Stigma Scale (ARSS; Kalichman et al., 2008): Based on the internalised HIV related stigma, Kalichman and collaborators developed a six-item dichotomous scale for people living with HIV. The original authors validated the scale in three different countries and the internal consistency was acceptable in all three environments ($.72 < \alpha < .76$). For the purpose of our main study, we slightly adapted the items, because instead of measuring internalised HIV related stigma, we wanted to measure the general perception of how it is living in Slovenia with HIV. For example, the statement 'I hide my HIV status from others' was changed to 'People with HIV hide their status from others'. In addition, a general instruction was given within the survey: 'The next section refers to the general attitudes towards HIV. Please think about the Slovenian environment and evaluate how much do you agree or disagree with the following items'.

3.2.1.4 Results. With reaching the final sample of 302 individuals, the minimum amount of data for PCA was sufficed regarding all the three scales in need of validation. Based

on the recommendations for PCA from Comrey and Lee (1992) as well as Tabachnick and Fidell (2007) the sample size was good with the ratio of over 35 cases per variable (i.e., item), which suggested reliable stability for the analysis.

The results of the preparatory data analysis that were used as the criteria for factorability are reported in Table 8. The correlation matrix indicated that all items correlate significantly (above .30) with at least one other item within the same instrument. This suggested the factorability of the three instruments and that PCA is suitable for all the scales and all the corresponding items.

Table 8

Study 2—Part 1. Preparatory Data Analysis (N = 302)

	Number of items	Kaiser-Meyer-Olkin measure	Bartlett's test of sphericity
STI/HIV Anxiety Scale	8	.86	$\chi^2(28) = 1648.58$**
Stigmatising Attitudes Towards People Living with HIV—Short	6	.78	$\chi^2(15) = 450.89$**
AIDS Related Stigma Scale	6	.86	$\chi^2(15) = 933.849$**

Note: ** $p < .01$

We used PCA to identify and compute composite scores for the factors underlying the three scales. In the cases of STI/HIV Anxiety Scale and AIDS Related Stigma Scale, the two criteria that we used to investigate the number of underlying factors (i.e., Kaiser criteria and Scree Plot) suggested one factor solutions, explaining 63.12% and 63.21% of the variance respectively.

Regarding the instrument of our main interest, Stigmatising Attitudes Towards People Living with HIV—Short, the two aforementioned criteria suggested a two-factor solution, explaining 65.32% of the variance. This nicely replicated the two categories in the original, which are based on the semantic differences of the items. The first group replicated the dimension of Concerns about Occasional Encounters (3 items), while the other factor followed the Avoidance of Personal Contact subscale (3 items). Due to our results and the background of the SAT—S scale, we decided to perform a PCA with Varimax rotation method based on a two-factor solution. The result suggested the following: sat1, sat2, and sat3, as composites of the first factor and sat4, sat5, and sat6 as the second factor (see Table 9, p. 32).

Table 9

Study 2—Part 1. Principal Component Analysis for the Final 6 items of the Stigmatising Attitudes Towards People Living with HIV—Short (N = 302)

Item		Factor		Communality
Code	Statement	1	2	
sat1	Being around someone who has HIV does not bother me.	.74		.59
sat2	I would not be worried for my health if a co-worker had HIV.	.77		.61
sat3	It would not bother me if there was a boarding house for people with AIDS on my street.	.78		.63
sat4	I could not be friends with someone who has AIDS.		.83	.70
sat5	I would limit my contact with a person whom I know is infected with AIDS.		.79	.66
sat6	I would not hug someone with AIDS.		.82	.73

Note: Coefficients below .40 were suppressed.

Internal reliability scores of the three instruments (and the two subscales of Stigmatising Attitudes Towards People Living with HIV—Short) were assessed with Cronbach's alpha. All the scales indicated good internal reliabilities and only in STI/HIV Anxiety Scale, one item negatively impacted the overall alpha—if we were to delete the item shas6 (i.e., 'In the past six months, how often did you worry that you might already have the HIV virus?'), the alpha would be higher (.91).

Composite scores were created for each scale (including the two subscales of Stigmatising Attitudes Towards People Living with HIV—Short), based on the mean of the participants. The responses on each scale were ranged on a seven-point Likert scale. Higher scores on any of STI/HIV Anxiety scale indicate higher levels of anxiety in the past six months; higher scores on Stigmatising Attitudes Towards PLWH—Short indicate the tendency for more stigmatising internalised attitudes; higher scores on AIDS Related Stigma Scale Indicate higher external perception of stigma (i.e., more negatively biased environment for PLWH).

Descriptive statistics based on the composite scores are presented in Table 10. All the scales except for AIDS Related Stigma Scale indicated the tendency for more positive attitudes relating with HIV. AIDS Related Stigma Scale, on the other hand, was slightly negatively inclined. In the cases of AIDS Related Stigma Scale, Stigmatising Attitudes Towards PLWH—

Short, and the Concerns about Occasional Encounters, the skewness and kurtosis were within a tolerable range for assuming a normal distribution (e.g., Curran et al., 1996). For the second underlying factor of Stigmatising Attitudes Towards PLWH—Short (i.e., Avoidance of Personal Contact), the skewness score indicated an important incline towards the left side of the distribution (i.e., lower values of the scale). However, according to Kline (2011) the observed result was still within a tolerable range. The most skewed and leptokurtic data distribution and even considering the more tolerable range proposed by Kline (2011), the data were considered to deviate too much from a normal distribution.

Regarding the internal consistency scores obtained, which are also presented in Table 10, the subscale 'Concerns about Occasional Encounters' showed a result below the expected value of .70. However, the reliability based on Cronbach's alpha of the total scale (i.e., Stigmatising Attitudes Towards PLWH—Short) was deemed good. The internal consistency of other scales provided evidence that they are reliable.

Table 10

Study 2—Part 1. Descriptive Statistics and Internal Consistency Scores (N = 302)

	Number of Items	*M* (*SD*)	Skewness	Kurtosis	α
STI/HIV Anxiety Scale	8	1.39 (.73)	2.80	9.82	.91
Stigmatising Attitudes Towards PLWH—Short	6	1.95 (1.04)	1.17	.91	.74
Concerns about occasional encounters	3	2.30 (1.48)	1.15	.64	.68
Avoidance of personal contact	3	1.60 (.99)	2.25	5.83	.77
AIDS Related Stigma Scale	6	5.00 (1.02)	–.21	–.03	.88

For the purpose of construct validity, Pearson correlation analysis was conducted, and no significant correlations were found between any scales, except for the relation between Stigmatising Attitudes Towards PLWH—Short and its two subscales (see Table 11, p. 34).

Table 11

Study 2—Part 1. Pearson Correlation Coefficients (N = 302)

	1.	2.	3.	4.	5.
1. STI/HIV Anxiety Scale	—				
2.Stigmatising Attitudes Towards PLWH—Short	.06	—			
3. Concerns about Occasional Encounters	.04	.90**	—		
4. Avoidance of Personal Contact	.08	.76**	.40**	—	
5. AIDS Related Stigma Scale	.03	–.05	–.07	.01	—

Note: ** $p < .01$

3.2.1.5 Conclusions. The purpose of the analyses carried out as a Part 1 of Study 2 was to validate the Slovenian adaptation of the instrument called Stigmatizing attitudes towards people living with HIV—Short. Two other psychosocial instruments were adapted at the same time: STD/HIV Anxiety Scale (Sales et al., 2009) and AIDS Related Stigma Scale (Kalichman et al., 2008). All the scales were used based on their conceptual background related to HIV and their contemporality. Descriptive statistics, Cronbach's alphas, and Pearson correlation coefficients were examined.

The average scores on the STD/HIV Anxiety tended to be significantly skewed towards the lower end of the perceived anxiety. Furthermore, due to this observation, the data obtained was deemed too different from the expected normal distribution, which indicates that the scale might be too robust and not very useful. In terms of items of the scale that would mean that more subtle statements would probably be more appropriate. Rephrasing the items and adding more to the scale is encouraged for further studies focusing on worry regarding outcomes of sexual behaviour such as STI and HIV.

AIDS Related Stigma Scale, on the other hand, was slightly negatively inclined but not significantly. The distribution of the data on this scale indicated that the general perception of living in Slovenia with HIV is fairly ambiguous. The research concerning HIV stigma deserves more attention.

The main interest of the study was Stigmatizing attitudes towards people living with HIV—Short. Hypothesis 2 was accepted, because the original structure of the instrument was replicated. The internal consistency scores indicated a significant reliability of the instrument, however the underlying dimension 'Concerns about Occasional Encounters' presented a weak internal consistency.The distribution of the average scores was deemed normal but a non-significant tendency towards lower levels of internalised stigma towards PLWH can be observed. In the analysis of Pearson correlation coefficients, the only significant among the

main interest of the study and its two subscales. This observation was somewhat confusing, because significant relations were expected with these scales and the two other measures used in the study. However, due to other good psychometric properties of the scale it was concluded that the scale is still considered valid and that the constructs, although similar, are too distinct to correlate.

Since this study was based on a diversified population regarding their sexuality, further studies could investigate whether differences exist across gender, age, sexual orientation, etc. Enlarging the sample accordingly to the number of groups would be necessary (Field, 2013). For the purpose of the present thesis, no such analyses were performed.

3.2.2 Part 2. In this section, the procedure, participants, and the material used for the main study are presented. As noted in the beginning of Study 2, the scale Stigmatizing attitudes towards people living with HIV—Short had to be validated first (Study 2—Part 1). The sample of Study 2—Part 2 was also used in the process of its validation. However, Study 2 had two versions and the main study is based only on the longer version. The latter was accessible only to those who identified as homosexually oriented. In other words, the group of homosexually oriented men and women of Study 2 was used to investigate the relationship between internalised homophobia, internalised stigma towards PLWH and two aspects of well-being.

3.2.2.1 Procedure. The survey of our main study—the longer version of Study 2—included the following instruments: sociodemographic questionnaire, Center for Epidemiologic Studies Depression Scale (Radloff, 1977); STD/HIV Anxiety Scale (Sales et al., 2009); Stigmatizing attitudes towards people living with HIV—Short (Beaulieu et al., 2014); an adapted version of AIDS Related Stigma Scale (Kalichman et al., 2008); Short Internalised Homonegativity Scale (Currie, Cunningham, & Findlay, 2004); and Sexual Self-Esteem Inventory (Zeanah & Schwarz, 1996). The survey was shared through the social media platforms (i.e., Facebook, Twitter), and through personal electronic mail database. Several organisations were contacted with the aim of enlarging the number of participants who identify as homosexuals. Out of the organisations contacted, Legebitra, The Students' Cultural Centre (ŠKUC), ŠKUC Magnus, ŠKUC LL, Plushivisti, DIH, and Kvartir agreed to promote the survey on their social media platforms and through their e-mail databases. In addition, symbolic promotional material was distributed to their headquarters and put on display at their information desks with the aim of attracting their users. Respondents were encouraged to share the survey; therefore, snowball sampling was applied. The survey was available from the tenth of November 2018, until the 14th of January 2019.

Before testing the hypotheses of our main survey, a preliminary analysis of the HIV related instruments was performed (Part 1). After ensuring the reliability of the instrument of

our interest—Stigmatizing attitudes towards people living with HIV—Short, we proceeded with the analyses in IBM SPSS.

3.2.2.2 Participants. Out of 1006 people who clicked on the survey, there were 95 homosexually oriented individuals who completed the survey until the end. However, three of them identified as transgender women and were excluded from further analysis due to small number and lack of theoretical background on experiencing homophobia and HIV related issues within the transgender group. The mean age of the final sample ($N = 92$) was 30.96 ($SD = 8.064$; Min. = 18, Max. = 58). In this group, there were 39 who identified as men (42.4%) and 53 who identified as women (57.6%). A total of 30 people stated that they are single (32.61%), while 59 (64.13%) were in some sort of a relationship. Other sociodemographic information that were measured include the social status, highest education level achieved, number of sexual partners, and duration of the present relationship (if the person indicated that is in one).

3.2.2.3 Material. For the purpose of Study 2—Part 2, seven instruments were applied in the following order: sociodemographic questionnaire, Center for Epidemiologic Studies Depression Scale (Radloff, 1977); STD/HIV Anxiety Scale (Sales et al., 2009); Stigmatizing attitudes towards people living with HIV—Short (Beaulieu al., 2014); an adapted version of AIDS Related Stigma Scale (Kalichman et al., 2008); Short Internalised Homonegativity Scale (Currie, Cunningham, & Findlay, 2004); and Sexual Self-Esteem Inventory (Zeanah & Schwarz, 1996). For the purpose of the main study only four of these were used besides the sociodemographic questionnaire. Only the following four are presented below (for the two others see Study 2—Part 1).

Center for Epidemiologic Studies Depression Scale (CES—D; Radloff, 1977): This is a widely used scale that intends to measure the presence of depressive symptomatology but with a significant focus on the affective component. The scale uses four-point Likert anchor ranging from *rarely* to *most of the time* with the instruction that focuses on the experiences within the last week. The original and the Slovenian version of the scales consist of 20 items (e.g., 'I felt fearful.'). Some of them are expressing positive experiences and the other negative. The Slovenian validation indicated a Cronbach's alpha of .86 (Musek & Avsec, 2006).

Stigmatizing attitudes towards people living with HIV—Short (SAT—S; Beaulieu et al., 2014): This is a 27-item scale which intends to measure stigmatizing attitudes towards people living with human immunodeficiency virus (HIV). In the Slovenian version (see Study 2—Part 1) we used the items from the first two factors of the scale to develop an instrument assessing the level of internalized prejudices against PLWH. This summed up to a total of 6 items to which we applied a seven-point Likert scale format ranging from *strongly agree* to

strongly disagree. The original scale was based on a four-point Likert scale and the internal consistency based on the original study indicated a Cronbach's alpha .of 74 and .79 respectively to the sub factors' order set above. In our validation study (Study 2—Part 1) the alpha of the total scale was .74, .64 for the first subscale and .77 for the second subscale. Based on the latter, only the whole scale was considered in the statistical analyses.

Short Internalised Homonegativity Scale (SIHS; Currie et al., 2004): This instrument consists of 13 items to which the participants respond on a seven-point Likert scale ranging from *strongly disagree* to *strongly agree.* The scale is based on the items measuring individuals' attitudes towards the homosexual minority (e.g., 'Most gay men cannot sustain a long-term committed relationship.') and one's own homosexuality (e.g., 'I am comfortable about people finding out that I am gay.'). Cronbach's alpha reported for the Slovenian population was .74 (Cigan, 2013).

Sexual Self-Esteem Inventory—Short Form (SSEI—SF; Zeanah and Schwarz, 1996): In Study 1, this multidimensional inventory was adapted to a Slovenian version (for a more detailed description of the original see Study 1). The Slovenian version consists of 31 items spread across four domains: (1) Skills and Competence, (2) Attractiveness, (3) Control, and (4) Morality and Adaptiveness. To respond to an item (e.g., 'I never feel bad about my sexual behaviour.'), the participants are asked to indicate on a six-point scale whether they *strongly disagree, disagree, slightly disagree, slightly agree*, or *agree*. The Cronbach's from the validation study (i.e., Study 1) were found to be good: .88, .88, .81, and .78 respectively. The α of the total scale was .92.

4 Results

The focus of the main study (Study 2, Part 2), was to explore the four psychological aspects (i.e., internalised homophobia, stigmatisation of PLWH, depression, and sexual self-esteem) within the homosexually oriented individuals living in Slovenia. After obtaining a sufficient number of participants (N = 92), statistical analyses were conducted in order to characterise the sample and to deduce the underlying patterns and trends.

4.1 Characterisation of the Data

For assessing the nature of our sample, three main types of descriptive statistics were explored: measure of central tendency, measures of dispersion, and measures of variability. Composite scores were computed for each measurement that was used with the aim of testing our hypotheses, including: (1) Center for Epidemiologic Studies—Depression Scale; (2) Stigmatising Attitudes Towards PLWH—Short; (3) Short Internalised Homonegativity Scale; (4) Sexual Self-Esteem Inventory—Short Form. Composite scores were also computed for each subscale of the latter.

The central tendency was assessed via the means of the composite scores (*M*). The dispersion was investigated based on the standard deviations (*SD*), as well as on the minimum (Min.) and maximum (Max.) average scores of the participants observed. The variability analysis was based on skewness and kurtosis. Additionally, to guarantee the reliability of the applied scales, a common measure of internal consistency—Cronbach's alpha (α)—was calculated. The results are reported in Table 12.

Table 12

Study 2—Part 2. Descriptive statistics and Internal Consistency Scores (N = 92)

	Likert range	Min.	Max.	*M* (*SD*)	Skewness	Kurtosis	α
Center for Epidemiologic Studies—Depression Scale (20 items)	1–4	1.00	3.55	1.73 (.57)	1.19	1.00	.94
Stigmatising Attidudes Towards PLWH—Short (6 items)	1–7	1.00	6.17	1.72 (.94)	1.71	5.88	.75
Short Internalised Homonegativity Scale (13 items)	1–7	1.62	4.92	2.95 (.73)	.66	.13	.64
Sexual Self-Esteem Inventory—Short Form (31 items)	1–6	2.26	5.80	4.65 (.75)	–1.11	1.33	.93
Skills and Competence (10 items)		1.60	5.90	4.53 (.93)	–1.37	2.08	.91
Attractiveness (6 items)		1.00	6.00	4.11 (1.15)	–.79	.42	.89
Control (6 items)		1.83	6.00	4.80 (.93)	–.95	.78	.81
Morality and Adaptiveness (9 items)		2.56	6.00	5.14 (.70)	–1.31	1.92	.78

The overview of the descriptive statistics indicated two distinct trends. Firstly, the results suggested a negative trend for experiencing signs of depression (M = 1.73, SD = .57) and internalising prejudice towards PLWH (M = 1.72, SD = .94). The analysis of skewness provided further evidence for this observation, but the trend did not differ significantly from the usual standards for normal distribution (see Curran et al., 1996; Kline, 2011). The average on the Short Internalised Homonegativity Scale was set somewhere in the middle of the scale (M = 3.00, SD = .73) with an adequate score of skewness and kurtosis. Lastly, the analysis of the descriptive statistic in all categories assessing sexual self-esteem indicated adequate variability and positive trend, suggesting higher levels of sexual self-esteem. The highest average observed was on the domain of Morality and Adaptiveness (M = 5.14; SD = .70).

Regarding the reliability, except for the Short Internalised Homonegativity Scale, the analysis indicated good internal consistency of the instruments ($.75 \leq \alpha \leq .94$). The measure of internalised homophobia, on the other hand, presented the Cronbach's alpha of .64. Even if we removed some items, the α would not be significantly higher. Due to the fact that this scale

presented good psychometric properties in previous studies (Cigan et al., 2011; Cigan, 2013), we decided not to change it and proceed with caution in further analyses.

4.1.1 Differences in gender. In Hypothesis 3 it was proposed, that no differences will be found between the groups of males who identify as homosexually oriented and females who identify as homosexually oriented in terms of the age and the mean average scores of gays and lesbians. Thus, a two-tailed t-test for two independent groups was performed.

The assumptions for performing a t-test were sufficed—the data was measured at the interval level and the distribution was fairly normal according to the descriptive statistics. The confidence interval was set at 95%. The results are presented in the Table 13.

Table 13

Study 2—Part 2. Mean Comparison: Male (n = 39) and Female Subsamples (n = 53)

	Male *M* (*SD*)	Female *M* (*SD*)	*p*
Age	31.62 (9.48)	30.49 (6.97)	.52
Center for Epidemiologic Studies—Depression Scale (20 items)	1.75 (.57)	1.71 (.58)	.71
Stigmatising Attitudes Towards PLWH—Short	1.55 (.77)	1.84 (1.03)	.15
Short Internalised Homonegativity Scale	3.29 (.78)	2.70 (.59)	< .01 (L)
Sexual Self-Esteem Inventory—Short Form	4.51 (.67)	4.76 (.80)	.12
Skills and Competence	4.34 (.84)	4.66 (.98)	.11
Attractiveness	3.78 (1.20)	4.36 (1.06)	.02
Control	4.84 (.95)	4.77 (.93)	.72
Morality and Adaptiveness	5.05 (.72)	5.21 (.69)	.27

Note: (L) = Equal variances were not assumed.

The gays reported higher scores (M = 3.29, SD = .78) than lesbians (M = 2.70, SD = .57), $t(66.07) = 3.92$, $p < .01$ on Short Internalised Homonegativity Scale. However, Levene's test (L) indicated that the scores varied much more in the subsample of homosexual men than in the subsample of homosexual women, thus, we analysed the results according to this observation: $t_{obtained}(67.53) = 3.94$, $p < .01$. On the other hand, on average the gays reported significantly lower levels of attractiveness (M = 3.78, SD = 1.20) than lesbians (M = 4.36, SD = 1.06), $t(90) = –2.42$, $p = .02$. In other categories, no significant differences were found between the two groups.

In addition to the t-tests, an analysis based on the HIV prevalence and personal contact with PLWH was assessed. 54 people (58.7%) did not knew anyone living with HIV, 24 (26.1%) did know, and 14 said they do not know. Two of them (2.2%) said they are seropositive and only one stating not knowing the HIV status. The remaining 89 stated that they are

seronegative. Furthermore, due to our assumption on the HIV topic, that the lesbian and the gay community have equal proportions of contact with HIV, we present the bar graphs of the responses regarding having personal content with PLWH. All females responded that they do not have HIV and so did 36 (92.3%) men. Two reported living with HIV and one answered that he did not know his status.

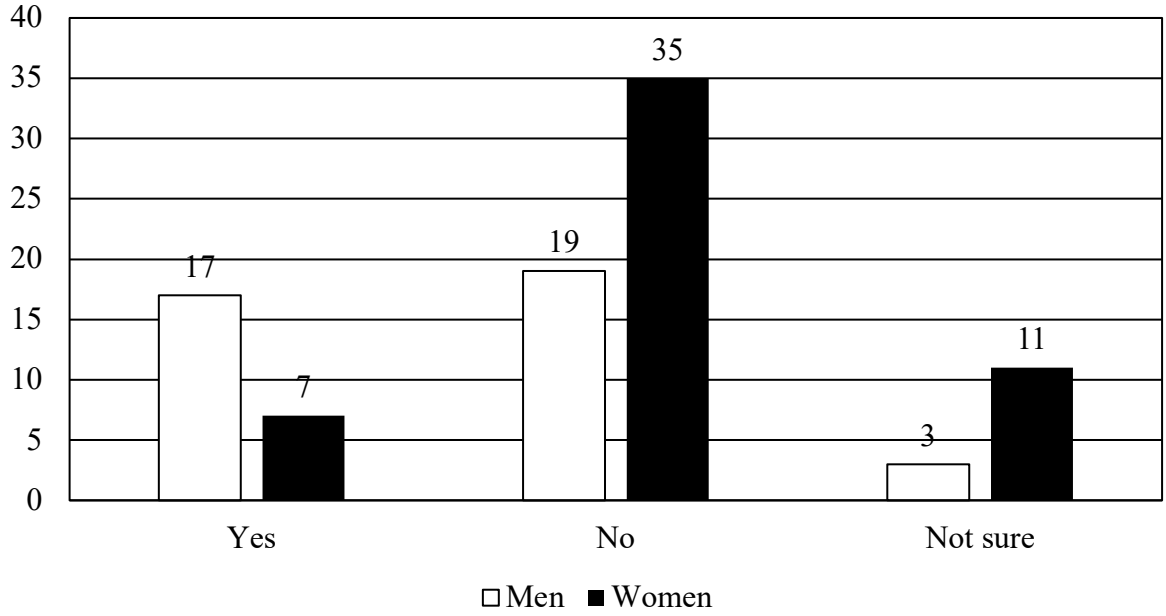

Figure 3. Data distribution regarding the question 'Do you personally know someone with HIV?' according to gender.

4.2 Correlation Analysis

A bivariate analysis of the intensity and the direction of the linear associations between the average results on different scales was performed based on the Pearson correlation coefficients. The intensity was interpreted in the following manner: ± .1 representing a small effect, ± .3 a medium effect, and ± .5 a large effect (Field, 2013). The results are presented in Table 14 (p. 41).

Table 14

Study 2—Part 2. Pearson Correlation Coefficients: Total Sample (N = 92)

	1.	2.	3.	4.	5.	6.	7.	8.
1. Center for Epidemiologic Studies—Depression Scale	—							
2. Stigmatising Attitudes Towards PLWH—Short	–.20	—						
3. Short Internalised Homonegativity Scale	.07	.20	—					
4. Sexual Self-Esteem Inventory—Short Form	–.46**	–.03	–.37**	—				
5. Skills and Competence	–.39**	–.03	–.29**	.91**	—			
6. Attractiveness	–.48**	.10	–.12	.74**	.61**	—		
7. Control	–.39**	–.09	–.29**	.78**	.59**	.40**	—	
8. Morality and Adaptiveness	–.20	–.14	–.48**	.78**	.63**	.32**	.60**	—

Note: ** $p < .01$.

The results on the depression scale had a medium size effect, correlating negatively and significantly with the results reported on Sexual Self-Esteem Inventory—Short Form, $r(90) = –.46$, $p < .01$; and three of its domains Skills and Experience, , $r(90) = –.39$, $p < .01$; Attractiveness, $r(90) = –.48$, $p < .01$; Control, , $r(90) = –.39$, $p < .01$. These results portray that different dimensions of sexual self-esteem relate negatively with depression or that the higher the level of depression observed, the lower the sexual self-esteem.

The results of internalised homophobia scale also correlated, in a small to medium size effect, significantly and negatively with sexual self-esteem, $r(90) = –.37$, $p < .01$; Skills and Experience, $r(90) = –.29$, $p < .01$;Control, $r(90) = –.29$, $p < .01$; and Morality and Adaptiveness, $r(90)= –.48$, $p < .01$. These results portray that different dimensions of sexual self-esteem relate negatively with internalised homophobia or that the higher the level of internalised homophobia observed, the lower the sexual self-esteem.

As expected, all the subscales of sexual self-esteem correlated significantly and positively between each other and with the total scale. Except for the dimension of Attractiveness, which correlated with Control and Morality and Adaptiveness in a medium size effect: $r(90) = –.40$, $p < .01$ and , $r(90) = –.32$, $p < .01$ (respectively), the other relations were large regarding the effect: $.59 \leq r(90) \leq .91$, $p < .01$.

4.2.1 Differences in gender. Since the analyses of the sample characteristics indicated significant differences on two of the scales, Pearson correlation analysis was computed also for each gender specifically. The assumption of normality was tested for each gender based on measures of variability and indicated normally distributed data in both samples according to Kline (2011) and Curran and colleagues (1996).

The correlations in the gay subsample are presented in Table 15 and were found to very similar to those observed in the total sample. A significant negative correlation was once again found between depression scale and the results reported on the same four scales of sexual self-esteem—Short Form (see Table 15). It is worth noting that the correlation detected between signs of depression and Attractiveness, $r(37) = –.54$, $p < .01$ was larger in its effect and that the correlations between depression and Skills and Experience, $r(37) = –.37$, $p < .01$, and Control, $r(37) = –.33$, $p < .05$, were statistically less significant than on the total sample.

On the sample of homosexually oriented males, the results on the Short Internalised Homonegativity Scale correlated significantly and negatively with the sexual self-esteem, $r(37) = –.32$, $p < .05$ (medium effect); $p < .01$; Control, $r(37) = –.39$, $p < .05$ (medium effect); and Morality and Adaptiveness, $r(37) = –.50$, $p < .01$ (large effect). In comparison to the results of the total scale, the first two correlations were statistically less significant, and no relationship was indicated between the levels of internalised homophobia and Skills and Competence. Morality and Adaptiveness was found to be the most correlated dimension of sexual self-esteem, which is a similar observation to the one from the total sample.

All of the subscales of sexual self-esteem correlated positively with the total scale. However, these correlations were fairly weaker in their effect, and no correlation was found between Attractiveness and Control as well as between Attractiveness and Morality and Adaptiveness.

Table 15

Study 2—Part 2: Pearson Correlation Coefficients: Male Subsample (n = 39)

	1.	2.	3.	4.	5.	6.	7.	8.
1. Center for Epidemiologic Studies—Depression Scale	—							
2. Stigmatising Attitudes Towards PLWH—Short	–.13	—						
3. Short Internalised Homonegativity Scale	.11	.27	—					
4. Sexual Self-Esteem Inventory—Short Form	–.47**	–.05	–.32*	—				
5. Skills and Competence	–.37**	–.07	–.15	.88**	—			
6. Attractiveness	–.54**	.57	.06	.67**	.58**	—		
7. Control	–.33*	–.17	–.39*	.65**	.38*	.17	—	
8. Morality and Adaptiveness	–.10	–.15	–.50**	.69**	.51**	.08	.48**	—

Note: * $p < .05$; ** $p < .01$.

The results of the lesbian subsample on depression scale showed similar significant correlations to the one observed in the total sample and the gay subsample (see Table 16). They correlated negatively and with a medium size effect with the results reported on Sexual Self-Esteem Inventory—Short Form, $r(51) = –.46$, $p < .01$; and the three previously found related

domains Skills and Experience, , $r(51) = –.41$, $p < .01$; Attractiveness, $r(51) = –.44$, $p < .01$; Control, , $r(51) = –.43$, $p < .01$. In addition, on this subsample a correlation between Morality and Adaptiveness was observed, $r(51) = –.28$, $p < .05$ but it was statistically and size-wise weaker in comparison to the others.

The results of internalised homophobia scale once again significantly and negatively correlated with the sexual self-esteem, $r(51) = –.37$, $p < .01$; Skills and Experience, $r(51) = -.33$, $p < .05$; and Morality and Adaptiveness, $r(51) = –.47$, $p < .01$. The effects size was medium. However, no significant correlation was observed with the dimension of control in comparison to the previous samples. Additionally, one other correlation was found which was not found to be significant before—the indication of a significant positive relation between internalised homophobia and stigmatising attitudes towards PLWH, $r(51) = –.33$, $p < .05$, which had a medium effect size.

On this subsample, all the subscales of sexual self-esteem correlated significantly and positively between each other and with the total scale, $.50 \leq r(90) \leq .92$, $p < .01$. The effect sizes were found to be large.

Table 16

Study 2—Part 2: Pearson Correlation Coefficients: Female Subsample (n = 53)

	1.	2.	3.	4.	5.	6.	7.	8.
1. Center for Epidemiologic Studies—Depression Scale	—							
2. Stigmatising Attitudes Towards PLWH—Short	–.23	—						
3. Short Internalised Homonegativity Scale	.02	.33*	—					
4. Sexual Self-Esteem Inventory—Short Form	–.46**	–.04	–.37**	—				
5. Skills and Competence	–.41**	–.05	–.33*	.92**	—			
6. Attractiveness	–.44**	.05	–.12	.78**	.61**	—		
7. Control	–.43**	–.02	–.27	.89**	.76**	.63**	—	
8. Morality and Adaptiveness	–.28*	–.17	–.47**	.84**	.71**	.50**	.71**	—

Note: * $p < .05$; ** $p < .01$.

4.3 Regression Analyses

Before conducting the linear regression analyses, the seven main assumptions that indicate whether our data is suitable for this type of analysis (Field, 2013) were explored—outliers, collinearity of data, independent errors, random normal distribution of errors, homoscedasticity, and linearity of data. For two of the participants who did not provide their age information, the age was replaced with mean.

Based on the Hypotheses 9 and Hypothesis 10, six multiple linear regression analyses were conducted where the two types of stigma scores were set as predictors. In addition, gender

and the year of birth were used in the first steps of the models as control variables (to test whether they have any effect on the dependent variables).

The suitability results were interpreted based on the guidelines described in Pallant (2005). An analysis of standard residuals was carried out to identify any outliers based on the criterium of 3.3, which showed that data contained no significant outliers in the following scales: Center for Epidemiologic Studies—Depression Scale; Stigmatising Attidudes Towards PLWH—Short; Short Internalised Homonegativity Scale; Attractiveness, Control, Morality and Adaptiveness. Participant 45 had to be removed from further analysis of Sexual Self-Esteem—Short Form and Skills and Competence in order to suffice the norm for the standard residuals. The final scores for the standard residuals were between –3.27 and 3.09.

Before and the omission of the Participant 45, the results of tolerance and VIF were: Gender (Tolerance = .78, VIF = 1.28); Year of Birth (Tolerance = .99, VIF = 1.02); Stigmatising Attitudes Towards PLWH—Short (Tolerance = .90, VIF = 1.12); Short Internalised Homonegativity Scale (Tolerance = .77, VIF = 1.30). The tolerance and VIF of the predictors did not change when rounding up the results to two decimals.

The final data met the assumption of independent errors ($1.80 \leq$ Durbin-Watson values ≤ 2.02) based on the criteria that it should be between 1 and 3. The histograms of standardized residuals for age, gender, internalized homophobia scale, and HIV related scale indicated approximately normally distributed errors. The P-P plots of standardized residuals suggested linear relationships of the measurements—they showed points that were not completely on the lines but close. The scatterplot of standardized values showed that the data met the assumption of homogeneity of variance and linearity. The data also met the assumption of non-zero variances.

4.3.1 Attitudes Related with Homosexuality and Depression. A standard multiple regression analysis was conducted to see how well the level of stigmatising attitudes towards PLWH and the average score on the Short Internalised Homonegativity Scale predicted the levels of negative affect measured by the Center for Epidemiologic Studies—Depression Scale. The result of the linear combination of the two predictors was not significantly related to the levels of depression (see Table 17, p. 45).

Table 17

Study 2—Part 2. Linear Regression Model Between Stigma Related Predictors and Depression (N = 92)

	B	*SE*	*β*	*t*
Model 1—Control				
(Constant)	–22.30	14.88		–1.50
Gender	–.06	.12	–.05	–.49
Year of Birth	.01	.01	.17	1.62
Result: R = .17; R^2 = .03; R^2_{adjusted} = .01; ΔR^2 = .03; $F(2,89)$ = 1.38; ΔF = 1.38				
Model 2				
(Constant)	–21.58	14.71		–1.47
Gender	.04	.14	.03	.28
Year of Birth	.01	.01	.16	1.57
Stigmatising Attitudes Towards HIV—Short	–.14	.07	–.23	–2.13*
Short Internalised Homonegativity Scale	.09	.09	.12	1.01
Result: R = .24 R^2 = .06; R^2_{adjusted} = .02; ΔR^2 = .03; $F(2,87)$ = 1.38; ΔF = 1.36				

Note: * $p < .05$.

4.3.2 Attitudes Related with Homosexuality and Sexual Self-Esteem. After the removal of Participant 45, the standard multiple regression analysis conducted in SPSS was used to evaluate if the level of stigmatising attitudes towards PLWH and the average score on the Short Internalised Homonegativity Scale predicted the total value of sexual self-esteem. The analysis of Model 1—Control suggested that age and gender significantly predicted the value of Sexual Self-Esteem—Short Form, $F(2,86) = 4.92$, $p < .01$. However, after adding the two stigma related scales in the model, the linear regression was even more significant, $F(2,86) = 6.06$, $p < .01$. Thus, we the latter was deemed to be the main result (see Table 18, p. 46). The multiple correlation coefficient was .47, indicating that approximately 22% of the variance of sexual self-esteem can be accounted by the year of birth and the score on Short Internalised Homonegativity Scale as predictors. The level of HIV related stigma was not a significant predictor.

Table 18

Study 2—Part 2. Linear Regression Model Between Stigma Related Predictors and Sexual Self-Esteem (N = 91)

	B	*SE*	*β*	*t*
Model 1				
(Constant)	46.75	17.94		2.61*
Gender	.32	.15	.22	2.20*
Year of Birth	–.02	.01	–.24	–2.37*
Result**: R = .32; R^2 = .10; $R^2_{adjusted}$ = .08; ΔR^2 = .10; $F(2,88)$ = 4.92; ΔF = 4.92**				
Model 2				
(Constant)	41.64	16.96		2.46*
Gender	.09	.15	.06	.60
Year of Birth	–.02	.01	–.20	–2.12*
Stigmatising Attitudes Towards HIV—Short Form	.02	.08	.03	.27
Short Internalised Homonegativity Scale	–.37	.11	–.39	–3.54**
Result**: R = .47 R^2 = .22; $R^2_{adjusted}$ = .18; ΔR^2 = .12; $F(2,86)$ = 6.06; ΔF = 6.58**				

Note: * $p < .05$; ** $p < .01$.

The regression equation for predicting the score on Sexual Self-Esteem—Short Form was:

Sexual Self-Esteem—Short Form score = – .02 x Year of Birth – .37 x
x Short Internalised Homonegativity Scale score – 41.64

4.3.3 Attitudes Related with Homosexuality and Skills and Competence. The standard multiple regression analysis conducted in SPSS was used to evaluate if the level of stigmatising attitudes towards PLWH and internalized homophobia predicted the score on Skills and Competence. Note, Participant 45 was excluded. The result of the linear regression was significant, $F(2,86) = 3.17$, $p = .02$ (see Table 19). The multiple correlation coefficient was .36, indicating that approximately 13% of the variance of Skills and Competence can be accounted by the score on Short Internalised Homonegativity Scale as a predictor. The level of HIV related stigma was not a significant predictor. The regression equation for predicting the score on Skills and Competence was:

Skills and Competence score = – .34 x Internalised Homonegativity Scale score – 28.71

Table 19

Study 2—Part 2. Linear Regression Between Predictors and Skills and Competence (N = 91)

	B	*SE*	*β*	*t*
Model 1				
(Constant)	33.41	22.75		1.47
Gender	.39	.18	.22	2.13*
Year of Birth	–.02	.01	–.13	–1.29
Result: $R = .25$; $R^2 = .06$; $R^2_{adjusted} = .04$; $\Delta R^2 = .06$; $F(2,88) = 2.95$; $\Delta F = 2.95$				
Model 2				
(Constant)	28.71	22.27		1.29
Gender	.20	.20	.11	.96
Year of Birth	–.01	.01	–.11	–1.05
Stigmatising Attitudes Towards HIV—Short Form	–.00	.10	–.00	–.04
Internalised Homonegativity Scale	–.34	.14	–.28	–2.43*
Result*: $R = .36$; $R^2 = .13$; $R^2_{adjusted} = .09$; $\Delta R^2 = .07$; $F(2,86) = 3.17$; $\Delta F = 3.24$*				

Note: * $p < .05$.

4.3.4 Attitudes Related with Homosexuality and Attractiveness. A standard multiple regression analysis was conducted to see how well the average score on the Stigmatising Attitudes Towards HIV—Short Form and the levels of internalised homophobia predicted the ratings the levels of self-perceived sexual attractiveness. The analysis of Model 1—Control suggested that age and gender significantly predicted the value of Attractiveness, $F(2,89) = 5.21$, $p < .01$. The multiple regression coefficient was .32, indicating that approximately 11% of the variance of Attractiveness can be accounted for the linear combination of Gender and Year of Birth. No other predictors were found to be significant in Model 2., based on the statistical significance of the models (see Table 20 on the next page), the following regression equation seemed more appropriate:

Attractiveness score = .61 x Gender – .03 x Year of Birth – 63.17

Table 20

Study 2—Part 2. Linear Regression Model Between Stigma Related Predictors and Attractiveness (N = 92)

	B	*SE*	*β*	*t*
Model 1—Control				
(Constant)	63.17	28.83		2.19*
Gender	.61	.23	.26	2.60*
Year of Birth	–.03	.02	–.21	–2.08*
Result**: R = .32; R^2 = .11; $R^2_{adjusted}$ = .09; ΔR^2 = .11; $F(2,89)$ = 5.21; ΔF = 5.21**				
Model 2				
(Constant)	62.94	29.17		2.16*
Gender	.56	.27	.24	2.09*
Year of Birth	–.03	.02	–.21	–2.04*
Stigmatising Attitudes Towards HIV—Short Form	.09	.13	.08	.70
Short Internalised Homonegativity Scale	–.04	.18	–.03	–.24
Result*: R = .33; R^2 = .11; $R^2_{adjusted}$ = .07; ΔR^2 = .01; $F(2,87)$ = 2.68; ΔF = .24				

Note: * $p < .05$; ** $p < .01$.

4.3.5 Attitudes Related with Homosexuality and Control. For the fifth time, standard multiple regression analysis was conducted to see how well the average score on the Stigmatising Attitudes Towards HIV—Short Form and on Short Internalised Homonegativity Scale predicted the ratings the levels of self-perceived control in relation to sexuality. The analysis of Model 1—Control suggested that age and gender are not significant predictors of Control, however the model with the two stigmas was found to significantly predict the value of Control, $F(2,87) = 3.77$, $p < .01$. The multiple regression coefficient for this was .38, indicating that approximately 15% of the variance of Control can be accounted for the linear combination of the year of birth and the score on Short Internalised Homonegativity Scale. The level of HIV related stigma was not a significant predictor. The regression equation for predicting the score on Control is written in the top of the next page.

Control score = – .02 x Year of Birth – .43 x Short Internalised Homonegativity score – 53.04

Table 21

Study 2—Part 2. Linear Regression Model Between Stigma Related Predictors and Control (N = 92)

	B	*SE*	*β*	*t*
Model 1—Control				
(Constant)	58.76	24.03		2.45*
Gender	–.04	.19	–.02	–.21
Year of Birth	–.03	.01	–.23	–2.24*
Result: R = .23; R^2 = .06; R^2_{adjusted} = .03; ΔR^2 = .06; $F(2,89)$ = 2.58; ΔF = 2.58				
Model 2				
(Constant)	53.04	24.01		2.29*
Gender	–.30	.21	–.16	–1.43
Year of Birth	–.02	.01	–.20	–2.00*
Stigmatising Attitudes Towards HIV—Short Form	.01	.10	.01	.13
Internalised Homonegativity Scale	–.43	.14	–.34	–3.00**
Result**: R = .38; R^2 = .15; R^2_{adjusted} = .11; ΔR^2 = .09; $F(2,87)$ = 3.77; ΔF = 4.75**				

Note: * $p < .05$; ** $p < .01$.

4.3.6 Attitudes Related with Homosexuality and Morality and Adaptiveness. The standard multiple regression analysis conducted in SPSS was used to evaluate if the level of stigmatising attitudes towards PLWH and the average score on the Short Internalised Homonegativity Scale predicted the total value of Morality and Adaptiveness. Firstly, the linear regression of our control model was found to be significantly related to one's moral standards and personal goals related to sexuality, $F(2,89) = 3.28$, $p = .04$, see Table 22. However, Model 2 in which the two stigmas were introduced was more significant, $F(2,87) = 8.23$, $p < .01$. Thus, we focused on the latter. The multiple correlation coefficient was .52, indicating that approximately 28% of the variance of Morality and Adaptiveness can be accounted by the year of birth and the score on Short Internalised Homonegativity Scale as predictors. The level of HIV related stigma was not a significant predictor. The results are presented in Table 22 (p. 50) and the regression equation for predicting the score on Morality and Adaptiveness was:

Morality and Adaptiveness score = – .47 x Short Internalised Homonegativity – .02 x
x Year of Birth – 39.83

Table 22

Study 2—Part 2. Linear Regression Model Between Stigma Related Predictors and Morality and Adaptiveness (N = 92)

	B	*SE*	*β*	*t*
Model 1				
(Constant)	46.18	17.98		2.57*
Gender	.19	.15	.13	1.28
Year of Birth	–.02	.01	–.24	–2.30*
Result: R = .26; R^2 = .07; R^2adjusted = .05; ΔR^2 = .07; $F(2,89)$ = 3.28; ΔF = 3.28*				
Model 2				
(Constant)	39.83	16.10		2.47*
Gender	–.09	.15	–.06	–.60
Year of Birth	–.02	.01	–.19	–2.05*
Stigmatising Attitudes Towards HIV—Short Form	–.02	.07	–.02	–.24
Short Internalised Homonegativity Scale	–.47	.10	–.49	–4.69**
Results: R = .52; R^2 = .28; R^2adjusted = .24; ΔR^2 = .21; $F(2,87)$ = 8.23; ΔF = 12.36**				

Note: * $p < .05$; ** $p < .01$.

5 Discussion

The research carried out as a part of this master thesis had essentially three aims: to adapt Sexual Self-Esteem Inventory—Short Form and assess the psychometric properties of the Slovenian version of the instrument (Study 1); to adapt Stigmatizing attitudes towards people living with HIV—Short and assess the psychometric properties of the Slovenian version of the psychometric measure (Study 2—Part 1); and to investigate the aspect of experiencing homosexuality through exploring the relationship of four psychosocial constructs: internalised homophobia, stigmatisation of PLWH, depression, and sexual self-esteem (Study 2—Part 2). The last aim mentioned presented the main aspect of this thesis and for the purpose of clarity, the discussion of the results obtained in Study 1 and Study 2—Part 1 are elaborated within the corresponding sections of the thesis. In short, Hypothesis 1 was rejected, and Hypothesis 2 was accepted. The present discussion is based solely on the Hypotheses 3–8 and results obtained in Study 2—Part 2.

5.1 Findings

Hypothesis 3 proposed that no significant differences in will be found between homosexually oriented men and women. However, a discrepancy between the genders has been observed on the scales measuring internalised homophobia and attractiveness (an underlying

dimension of sexual self-esteem). Gay men reported higher levels of internalised homophobia and lower levels of attractiveness than female participants. These findings were in contrast with the idea that gays and lesbians share similar experiences in terms of homosexuality and self-perceived attraction (e.g., Szymanski & Kashubeck-West, 2008). Overall, the Hypothesis 3 could be neither rejected nor accepted.

A significant positive correlation was expected to be observed between internalised homophobia and stigmatising attitudes towards PLWH in the results of gays, lesbians, and the sample as a whole. This hypothesis (i.e., Hypothesis 4) could only be confirmed in the lesbian subgroup. The assumption that HIV stigma is related with levels of internalised homophobia in the homosexual community as a whole (e.g., Szymanski & Kashubeck-West, 2008) was rejected.

Neither internalised homophobia nor HIV stigma were found to correlate with depression within the Slovenian sample of same-sex oriented men and women. Thus, both Hypothesis 5 and Hypothesis 6 were rejected. According to Herek (2009) gays and lesbians who are active within the homosexual communities typically portray higher levels of well-being. And since our study was mainly distributed with the help of such communities, it is likely that the participants of our study enjoy a healthy mental state.

Hypotheses 7 and 8 stated that sexual self-esteem is negatively associated with internalised homophobia and HIV stigma, respectively. The former was found to be significantly negatively associated with the level of sexual self-esteem and its various dimensions. Meaning, higher levels of internalised homophobia tended to relate with lower levels of sexual self-esteem. This provided further evidence for the assumption that sexual well-being of gays and lesbians relates with the attitudes that they endorse about homosexuality (e.g., Bianchi et al., 2016; Coleman et al., 1992; Frost & Meyer, 2009). Hypothesis 7 was thus empirically supported. On the other hand, no relationship was observed between levels of sexual self-esteem and HIV stigma among the homosexually oriented participants and Hypothesis 8 was thus rejected.

The last two hypotheses, Hypothesis 9 and Hypothesis 10, aimed to answer whether there is a double stigma effect at play in general and sexual well-being of gays and lesbians. Neither of the two hypotheses were empirically supported. However, the internalised homophobia turned out to be a significantly relevant predictor for the sexual self-esteem and for several domains within it: Skills and Competence, Control, and Morality and Adaptiveness. The effect of the predictor was negative, meaning that higher levels of internalised homophobia can be understood as a predictor of lower levels of sexual self-esteem. This adds to the evidence

suggesting that attitudes towards one's own homosexuality partially regulate the sexual well-being of gays and lesbians explain the paragraph above.

5.2 Limitations

The primary limitations of this study were: the sample size; the cross-sectional nature of the study; lack of more qualitative components; and the length of the survey. The sample size is statistically speaking small (Field, 2013) and should be enlarged. However, it is was found to be fairly complicated to attract a bigger number of participants, despite the effort of making the simple promotional material and of contacting gays and lesbians through various resources. The length of the survey could be considered a factor within this limitation. A shortened version could possibly enable to obtain a bigger sample and to prevent dropouts in the middle of the survey. The cross-sectional studies do not provide sufficient proof for evidence-based implications. The conclusions based on one-time observed phenomena should be avoided and this limitation should be taken into account when interpreting the results of the present research. At least two more limitations should be mentioned. The HIV related scales should be validated in advance, on a different sample. Last but not least, some instruments did not provide good evidence of their utility, thus, the findings regarding internalised homophobia and stigmatising attitudes towards PLWH should be considered with some hesitancy. Short Internalised Homonegativity Scale was deemed to be the most problematic because the internal consictency was weak and the variance between groups significantly different (i.e., bigger range was found on the gay subsample). Regarding the latter, the scale was originally developed for gay men, and might not reflect the subtle differences between individuals in the lesbian subgroup.

5.3 Practical Implications

The differences found between sexes in terms of internalised homophobia, attractiveness, and HIV stigma indicated that distinct services might be required that would fulfill the needs of both gays and lesbians. In line with the latter, it would be interesting to explore whether transgender and transsexual people who identify as homosexually oriented also portray distinct psychological states. Further research is needed in order to determine the effect of sex and/or gender on these three psychosocial constructs.

Although differences were observed between men and women, internalised homophobia seemed to be one of the factors that shape the sexual well-being of same-sex oriented people regardless of sex. This finding could be applicated in practice by providing homo-affirmative interventions for individuals who suffer from psychosexual problems. Furthermore, educational studies that would cover both topics in a related manner could be

considered in order to prevent poor sexual well-being of gays and lesbians who are distressed about experiencing homosexuality.

Based on the findings of this research, HIV stigma cannot be considered a factor in the general and sexual well-being of gays and lesbians in Slovenia. This fairly innovative idea might have been too far-fetched but the structure of Study 2 could be used to investigate whether the associations exist among the same-sex oriented PLWH. According to Boone and collaborations (2016), the double stigma might be more likely to affect only same-sex oriented individuals who are living with HIV and the latter should be explored within the Slovenian population.

6 Conclusions

The present research had three main objectives. As a result, there were three main general conclusions. The first two objectives were concerned with the adaptation and validation of four psychometric instruments. The first conclusion of the thesis was that the Slovenian Sexual Self-Esteem Inventory—Short Form should be considered an adequate and valid instrument. As such, it was deemed a useful tool for Slovenian sexual health practitioners, which have been lacking appropriate measures for assessing sexual well-being of the population. Nevertheless, additional studies are encouraged in order to confirm the observed structure of the instrument. The second conclusion was related to two HIV related instruments: Stigmatising Attitudes Towards PLWHA—Short and AIDS Related Stigma Scale. The scales provided evidence for their utility and should be seen as one of the first outsets for exploring the nature of HIV stigma in Slovenia. The fourth instrument that we tried to adapt, STI/HIV Anxiety Scale, showed a significantly biased distribution of answers. It was thus deemed too rigid to detect differences among the participants and in need of reworking. The third conclusion was the following: although we found theoretical implications for the interrelationship between internalised homophobia, HIV stigma, depression, and sexual self-esteem, the association of the concepts requires a more science-based background. This research provided some indications for the latter. Among the four psychosocial constructs, internalised homophobia and sexual self-esteem were found to be the most related ones. This observation should be taken into account in the practical work related with the homosexually oriented population.

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