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Racial Disparities in Health Behaviors and Conditions Among Lesbian and Bisexual Women: The Role of Internalized Stigma

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Abstract

There are documented disparities in physical health behaviors and conditions, such as physical activity and obesity, with regard to both race/ethnicity and sexual orientation. However, physical health disparities for lesbian and bisexual (LB) women who are also racial minorities are relatively unexplored. Minority stressors, such as internalized stigma, may account for disparities in such multiply marginalized populations. We sought to (1) characterize inequalities among non-Hispanic white and African American LB women and (2) examine the roles of internalized sexism and homophobia in disparities. Data on health behaviors (diet, physical activity); physical health (hypertension, diabetes, overweight/obesity); internalized sexism; and internalized homophobia were collected via a web-based survey. Recruitment ads were sent electronically to over 200 listservs, online groups, and organizations serving the lesbian, gay, and bisexual community in all 50 U.S. states. The analytic sample consisted of 954 white and 75 African American LB women. African American participants were more likely than white participants to report low fruit/vegetable intake and physical activity, a higher body mass index, and a history of diabetes and hypertension. There were no racial differences in internalized homophobia, but African American women reported higher levels of internalized sexism. Internalized sexism partially mediated racial disparities in physical activity and diabetes, but not in the other outcomes. Findings suggest that African American LB women may be at greater risk than their white counterparts for poor health and that internalized sexism may be a mediator of racial differences for certain behaviors and conditions.

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Introduction

The health disparities impacting marginalized groups such as women[1,2]; racial/ethnic minorities[3,4]; and lesbian, gay, and bisexual (LGB)[5] people have been attributed to societal inequity.[6,7] Further, the interplay of gender, race/ethnicity, and sexual orientation and its impact on health has gained increasing attention.[8,9] Little research has characterized disparities that may exist within lesbian and bisexual (LB) populations or potential contributing factors. One potential contributing factor toward poorer health might be internalization of negative societal attitudes toward one's own minority group (internalized stigma).[10–12] This study extends the literature by examining racial disparities in physical health among a sample of non-Hispanic African and white American LB women living in the United States and assessing the potentially mediating role of two types of internalized stigmas: internalized homophobia and internalized sexism.

Health disparities

The unequal distribution of health, called "health disparities," has been described by Healthy People 2020 as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage,"[7] such as institutionalized sexism, racism, and heterosexism. Women, LGB, and African American populations have been noted to have poorer health behaviors and to be more likely to suffer from some health conditions than male, heterosexual, and white counterparts, respectively. For example, women appear to be less physically active,[13] have a higher prevalence of obesity,[14] and experience poorer prognoses if diagnosed with hypertension and diabetes than men.[15,16]

Health disparities have further been documented within women across sexual orientation[17] and race/ethnicity.[18] Findings on sexual orientation disparities in cardiovascular disease and diabetes have been inconsistent, with some studies indicating differences and others not.[17,19–21] Nevertheless, LB women report lower vegetable intake[22–24] and physical activity[25] and are more likely to report overweight/obese status[26] than heterosexual women. Racial/ethnic minority women (e.g., Latina, Asian American, Native American) experience poorer health than white women[18]; the most well-documented differences have been found between white and African American women, with African American women reporting lower vegetable intake[27] and physical activity[28] as well as greater rates of obesity,[29] diabetes,[30] and hypertension.[31]

The majority of health disparity research has focused on sexual orientation (with mostly white samples) or race/ethnicity (with presumably mostly heterosexual samples), without taking both sexual orientation and race/ethnicity into account. Neither African American nor LB women are homogeneous groups and vary by age, geographic region, education, and income. African American LB women may be particularly vulnerable to poorer health outcomes given the additive impact of multiple social stressors tied to their gender, race/

ethnicity, and sexual orientation as well as unique forms of oppression (e.g., gendered racism, heterosexism within communities of color).[32,33]

Little research has examined African American LB women's physical health behaviors and conditions or compared them with their heterosexual and/or white counterparts. Mays and colleagues found greater rates of obesity for African American LB women relative to heterosexual African American women but similar rates of hypertension, heart disease, and diabetes.[34] It is worthwhile to note that obesity disparities by both race and sexual orientation are well documented, whereas consistent disparities in hypertension, heart disease, and diabetes have been found by race, but not by sexual orientation. No research to date has assessed racial/ethnic differences among LB women with regard to multiple health behaviors (e.g., diet, physical activity) and conditions (e.g., hypertension, diabetes) for which LB women and/or racial/ethnic minorities appear to be particularly at risk. On the one hand, it is possible that there are racial disparities in health behaviors and conditions among LB women similar to disparities seen in the general population. Disparities in hypertension and diabetes have been well documented for African Americans but not for sexual minorities. Given these findings, African American LB women may report greater rates of diabetes and hypertension than white LB women. On the other hand, because both African American and LB women are considered vulnerable groups with respect to rates of poorer diet, physical activity, and obesity, it is possible that these racial disparities among LB women may be less pronounced. Further studies assessing heterogeneity in health among racial/ ethnic and LGB populations are warranted to determine variation within and across groups.

Internalized stigma and health

In addition to documenting health disparities, it is imperative to assess contributing factors in order to develop appropriate and effective interventions. One potential contributing factor is stigma, an "enduring condition, status, or attribute that is negatively valued by a society and whose possession consequently discredits and disadvantages an individual."[35] In systems of oppression (e.g., sexism, racism, heterosexism), several levels of stigma exist and may impact individual health, including institutional, interpersonal, and internalized.[36] For example, systemic differences in economic and access opportunities may affect the types of health-risk behaviors and conditions women disproportionately experience.[37] Health disparities among women by race/ethnicity and sexual orientation have also been linked to systemic stressors related to heterosexism (e.g., discriminatory policies[38]) and the unique and persistent racism African Americans experience (e.g., residential hyper-segregation[39]). Health and well-being has also been linked to interpersonal discrimination based on gender,[40] sexual orientation,[41] and race.[42]

Internalization of negative societal attitudes described above toward one's own minority group (internalized stigma) may also negatively impact the health behaviors and conditions of marginalized communities. The most well-studied type of internalized stigma with regard to physical health behaviors and conditions is internalized racism among African American populations. Internalized racism has been linked to obesity[43,44] and glucose levels, an important indicator of diabetes.[45] Little research has addressed internalized stigma across

racial groups of women and assessed its role in health across groups. There are at least two types of internalized stigma that apply to LB women across race/ethnicity: internalized homophobia (antihomosexual attitudes toward the self) and internalized sexism (sexist attitudes toward the self). Internalized homophobia has been empirically linked to poorer psychological outcomes[46,47] and greater alcohol use[48] among women. Similarly, internalized sexism has been found to be related to poorer mental health among LB women.[11,49]

Regarding differences in these forms of internalized stigma, racial/ethnic minority LGB individuals may report greater internalized homophobia, potentially because of perceived homophobia within communities of color (e.g., homosexuality as a white concept) and racial discrimination within LGB communities.[50] Nevertheless, available literature has reported comparable levels of internalized homophobia across racial groups.[51,52] This research, however, has generally focused on gay and bisexual men or has grouped several racial/ethnic minority groups together.

We are aware of no studies that have compared internalized sexism between African and white American women. Striving for traditional femininity or a set of attributes and behaviors generally associated with women (e.g., stereotypic image and activities, deference, purity, caretaking, emotionality)[53] may be particularly important for African American women, who face gendered racism, including stereotypes of being unattractive, aggressive, and poor at mothering.[54–56] This may result in a greater pressure to adhere to traditional gender norms and elevated levels of internalized sexism. Racial differences in internalized stigma and pressures to adhere to traditional cultural norms may further potentially influence decisions related to health behaviors (e.g., food, exercise) and conditions.

The present Internet study aimed to (1) investigate differences in reported health behaviors (vegetable intake, physical activity) and conditions (obesity, diabetes, hypertension) between LB African American and white women, and (2) assess the potentially mediating roles of internalized homophobia and sexism in health disparities.

Materials and Methods

Data were collected via a web-based survey using Survey-Monkey. Fliers about the study, including a brief description and survey link, were sent electronically to approximately 200 listservs, website groups, and organizations serving the LGB community in all 50 U.S. states and the District of Columbia. Such listservs and groups were identified by searching online for key terms such as “lesbian” or “bisexual” groups in each state. Targeted advertising was used to sample LB women of color and bisexual women, with ads calling attention to these groups of women (e.g., “Seeking lesbian and bisexual women of color to participate in a study focusing on your life experiences”) being sent to online sites and listservs within these communities. Individuals following the study link were taken to an information statement that described the study’s purpose; requirements for participation (age 18 years or older; born biologically female; identification as lesbian, gay, bisexual, queer, or two-spirit; living in the United States); risks and benefits; and confidentiality. Those who agreed to participate

then completed the online survey, which took approximately 40 minutes and was followed by a listing of health resources. Participants who completed the survey could voluntarily enter a drawing to win one of five $50 prizes. This study was approved by the Institutional Review Board at the University of Washington.

Measures

Demographics—Demographic items included age, sexual orientation identity, education, and income. Racial/ethnic groups included non-Hispanic white/Caucasian, African American, Latina, Asian American, American Indian, Pacific Islander, and other race/ethnicity. For the purposes of this study, we only included women who self-identified as non-Hispanic African American or white/Caucasian.

Fruit/vegetable intake—Participants completed the Fruit and Vegetable section of the Food Screener,[57] which has been previously validated across sex as well as among white and African American samples.[58,59] Individuals indicated how often they ate seven foods (e.g., fruit juice, vegetable juice, green salad) with the following response categories: 0 = less than 1 a week; 1 = once a week; 2 = 2–3 times a week; 3 = 4–6 times a week; 4 = once a day; 5 = 2 or more a day. Cronbach's alpha for this scale was acceptable (0.61). Scores were dichotomized with the cut-off of 11, such that a score of < 11 indicated low fruit/vegetable intake, as has been used in previous research using this instrument.[57]

Physical activity—The International Physical Activity Questionnaire[60] includes six items assessing physical activity during the last 7 days (e.g., "How much time did you usually spend doing moderate physical activities?"), in terms of days per week, hours per day, and minutes per day. Continuous scores were calculated in terms of median minutes/week (metabolic energy [MET]-minutes/week). The scale has shown good validity among African American and white samples.[60–62] In line with official protocols (IPAQ website), individuals' scores were categorized as low (< 600 MET-min/week), moderate (600 MET-min/week), and high (3000 MET-min/week).

Body mass index—Body mass index (BMI) was calculated based on self-reported height and weight. BMI has been used as a reliable indicator for obesity across different racial/ethnic groups and can be examined continuously or categorically (underweight, normal, overweight, obese).[63,64] Preliminary findings suggested similar findings across categorical and continuous measures; to maintain simplicity, we report BMI as a continuous measure.

Physical health conditions—Participants were asked if they had ever been told by a doctor or other health professional if they had diabetes or hypertension (with each item scored as *yes* or *no*).

Internalized homophobia—The Internalized Homophobia scale[65] assesses the extent to which LB individuals reject their sexual orientation and are uneasy about their same-sex desires. It includes 10 items ranging on a Likert scale from 1 (never) to 4 (often). A sample item includes, "You have wished you weren't lesbian/gay/bisexual." Previous studies have demonstrated that the scale has good internal consistency and convergent validity,[66,67] and

the scale's short form has been previously used with African American LGB individuals.[52] In our sample, Cronbach's alpha was 0.82. Scores were calculated such that greater scores indicate more internalized homophobia.

Internalized sexism—The Passive Acceptance subscale of the Feminist Identity Composite scale was used to measure internalized sexism,[68] which includes eight items reflecting a denial of sexism and an unexamined acceptance of traditional gender role stereotypes. Sample items include, "I do not want to have equal status with men" and "I don't see much point in questioning the general expectation that men should be masculine and women should be feminine," with response categories ranging from 1 (strongly disagree) to 5 (strongly agree). This scale has been indicated as reliable and validated with multiple samples, including LB samples,[11,69] although we are not aware of its validation specifically with an African American sample. Cronbach's alpha for the current sample was 0.75. Scores were calculated such that greater scores indicate more internalized sexism.

Analytic plan

Analyses were conducted using SPSS, version 20. In all analyses, we controlled for demographic variables that were significantly related to race, which were age and education. For the first hypothesis, we regressed race onto diet, physical activity, obesity, hypertension, and diabetes. We used logistic regression for all outcomes, except physical activity, for which we used ordinal regression, and BMI, for which we used linear regression. We report significance for the dummy-coded race regression estimates with whites as the referent group. For the second hypothesis, we first examined associations between internalized stigma with health behaviors and conditions. We subsequently conducted mediation tests based on associations found among race, internalized stigma, and health behaviors and conditions. In these, the effect of race predicting the mediators (internalized stigma) was labeled A; and the effect of the mediator predicting outcomes was labeled B. We used the Preacher and Hayes method to calculate the mediated effect (A × B), which is the effect of race predicting outcomes as mediated by stigma. This method is considered superior relative to others for testing mediation among small to moderate sample sizes.[70,71] This bootstrap method is a nonparametric resampling procedure that involves sampling from the data set multiple times (5,000 for this study) and generating a sampling distribution. We calculated 95% confidence intervals (95% CI) of the mediated effect as follows:

$$\frac{a \times b}{a \times b + c'}.$$

Finally, we handled missing data (0.3–5% of main study variables) with listwise case deletions, which is considered an adequate manner of accommodating a relatively low percentage of missing data.[72]

Results

The analytic sample included 954 self-identified white and 75 African American LB women. Table 1 provides racial differences in sociodemographic variables. When assessing

potential covariates, we found racial differences in age, $F(1, 994) = 5.59$, $p = 0.02$; a nonsignificant trend with regard to education, $F(1, 994) = 3.60$, $p = 0.06$; and no significant differences in income, $F(1, 994) = 0.17$, $p = 0.68$. Thus, age and education were included as covariates in all subsequent analyses, including mediation models.

Table 2 demonstrates racial differences in health behaviors and conditions, after adjusting for age and education. African American women were more likely to report low fruit/ vegetable intake, the lowest level of physical inactivity, greater likelihood of diabetes and hypertension, and greater BMI.

To inform which mediation models to test, we first examined racial differences in internalized homophobia and sexism. African American women reported greater internalized sexism, but comparable levels of internalized homophobia (Table 2). Next, we assessed associations between internalized sexism and health behaviors and outcomes through linear (BMI), ordinal (physical activity), and logistic regressions (fruit/vegetable intake, diabetes, hypertension). Internalized sexism was significantly associated with physical activity, $B = -0.2$, 95% CI [−0.001, −0.4], $p = 0.05$, and diabetes, $OR = 2.2$, 95% CI [1.3, 3.7], $p = 0.002$. There was a nonsignificant trend between internalized sexism and BMI, $B = 0.76$, $SE = 0.4$, 95% CI [−0.1, 1.6], $p = 0.07$. Associations with fruit/ vegetable intake and hypertension were not significant (all p-values > 0.05).

Next, we conducted multiple mediation analyses to test if racial differences in physical activity and diabetes were mediated by internalized sexism. Findings suggested partial mediation (Table 3): African American women reported greater internalized sexism, which was associated with a greater likelihood of diabetes and lower physical activity (p-values < 0.05).

Discussion

This study was one of the first to examine racial disparities in health behaviors and conditions between African American and white LB women and evaluate the potential mediating role of internalized stigma. Relative to white counterparts, African American LB women reported lower fruit/vegetable intake and physical activity. They were also more likely to indicate a history of diabetes and hypertension as well as reported greater BMI. Findings from this preliminary Internet study parallel previous research findings documenting white versus African American disparities in the broader U.S. population.[18]

Similar to other studies,[51,52] we found no significant differences in internalized homophobia between racial groups. African American women in our sample did, however, report higher levels of internalized sexism. This finding is in contrast to some literature, which has suggested more flexible gender norms among African American samples.[73] More research is necessary, given that multiple simultaneous identities (e.g., age, geographic region) may influence gender norms, values, and practices among African Americans. Regarding our work, future research is needed to replicate this finding among LB samples. Our measure of internalized sexism focused specifically on passive acceptance of traditional gender roles and lack of awareness of sexism, rather than a belief in male superiority.[68,74,75] The latter is

also viewed as central to the concept of internalized sexism, and our preliminary findings suggest that more thorough assessment of this measure with multiply marginalized populations is needed. Qualitative research on internalized sexism among larger samples of African American LB women may be especially helpful, as this group may have unique manifestations of internalized sexism given their race and sexual orientation. Such work may lead to the development of tools that assess these unique forms of stigma and may allow for work that implements an intersectional perspective.

Internalized sexism partially mediated the association between race and both physical activity and diabetes in this sample. These findings are noteworthy, as previous research on internalized stigma and health (i.e., obesity, hypertension, diabetes-related conditions) has almost exclusively focused on internalized racism among international populations of African descent.[43–46] Internalized stigma may influence physical health through a disruption or dysregulation of biological stress pathways (e.g., cortisol[12]), although more research is needed to clarify the mechanisms through which the internalization of negative attitudes about one's group may impact physical well-being. Internalized stigma may further influence behavior in terms of decisions regarding diet and physical activity. Cultural norms and stereotypes have often aligned exercise and athleticism with masculinity, such that women who participate in physical activity and sports are thought to be gender atypical.[76] Female athletes have often been negatively described as sexual minorities because of their presumed masculine traits (e.g., athletes given the "lesbian label").[77] Given this, internalized sexism and adherence to traditional gender norms may contribute to decisions to not participate in physical activity. Research that assesses under what circumstances and in what ways internalized stigma impacts physical health behaviors is needed to clarify this relationship.

Other factors that may explain health disparities for African American LB women need to be considered, given the abundant literature implicating social determinants of health and the importance of institutional factors.[78–81] Two systemic factors that may contribute to differences in health behaviors and conditions that were not included in the current study's models were socioeconomic status and access to healthcare. Socioeconomic factors have been implicated in the relationship between race/ethnicity and income, wherein racial/ ethnic minorities in general have lower incomes and income is a strong predictor of health.[82] Our initial findings found no racial differences in individual income within our sample, which may be because of convenience-based sampling methods. Given this and our relatively small sample, we did not adjust for income in analyses, although education did differ by race and was included. Future studies with larger, more diverse, and more representative samples should examine the role of multiple socioeconomic factors, including individual and neighborhood socioeconomic status.[83] Healthcare access factors (e.g., insurance status) and neighborhood characteristics (e.g., recreational facilities) may also have a systemic impact on adverse outcomes (e.g., obesity, diet).[78] African American women are more likely to live in segregated, low-income neighborhoods, which have less access to facilities and fewer opportunities for exercise.[82] African Americans additionally have lower rates of insurance and source of usual care compared with white Americans, as well as lower quality of care once in the healthcare system.[18,82] Lower access to care has also been noted for LGB individuals relative to heterosexual populations and has been suggested to be particularly

poor for ethnic minorities who identify as LGB.[84] Further research that addresses the residence and systemic factors influencing African American LB women is warranted to understand their contributions to health disparities across race and sexual orientation.

Our work suggests that development, implementation, and dissemination of stigma reduction programs for African American LB women may be associated with physical health benefits. Programs may consider focusing on gender values and resulting health behavior and condition consequences in an effort to reduce internalized sexism as well as other forms of internalized stigma (racism, homophobia). Furthermore, interventions may target not only individuals but also communities, systems, and policies. For example, stigma reduction programs may incorporate reduction of internalized stigma among LB women as well as target reduction of interpersonal forms of stigma among their communities. Multilevel interventions addressing neighborhood and healthcare factors may benefit from consideration of how both race/ethnicity and sexual orientation influence access as well as decisions regarding health behaviors and subsequent conditions.

Interpretation of the findings needs to be tempered by methodological limitations of this preliminary Internet study. Most importantly, there were relatively few African American women in this current sample, despite attempts to oversample and specifically target women of color for the overall survey. It will be important for future research to replicate our findings with a larger sample of African American LB women. We focused on African American LB women, given the widespread, dramatic gaps across a number of health outcomes relative to white Americans.[18,27–31] Furthermore, with regard to relationships between stigma and health, African Americans experience particularly harsh societal oppression in the United States.[85–87] Nevertheless, there are health disparities experienced by other racial/ethnic minority groups and future research needs to examine potential disparities for these groups among LB women. Additionally, lesbian and bisexual women were grouped together in this study because of sample size limitations; future research should examine the impact of different sexual identities among ethnically diverse samples. Furthermore, data were based on self-report, and thus are subject to recall bias or social desirability concerns. The small convenience sample of women was highly educated and recruited solely on the Internet, and thus strong conclusions cannot be made about the generalizability of the data to the broader population. Finally, while we examined internalized homophobia and sexism, internalized racism was not assessed in this study, limiting our ability to assess fully the relationship between internalized stigma and health for African American LB women. This type of internalized stigma may be particularly salient for women of color and should be examined in future studies.

Although not intersectional in itself, this study provides a platform for several avenues of future research, especially those in line with intersectional theory and analysis. For example, future studies may address racial, gender, and sexual orientation-based differences in health through comparing individuals from a number of racial/ethnic backgrounds who identify as male and female as well as heterosexual and LGB in order to more thoroughly address which groups are at greatest risk for which health outcomes. Future work should also incorporate multiple indicators of socioeconomic status given their robust association with health and well-being.[88,89] Such work may include path and moderation analyses in order to

understand differences within and between groups and allow for greater comparison across different groups versus comparison to the traditionally used referent groups (e.g., white heterosexual counterparts). Furthermore, our work suggests the need to address and understand internalized stigma from the perspective of African American women who identify as lesbian/bisexual. Future research that assesses this assumption is warranted, especially as unique components of internalized sexism are likely, given the interlocking identities of multiply marginalized women (e.g., interaction of internalized racism and sexism).

Conclusions

Research on health disparities needs to consider the experiences of individuals from multiple marginalized backgrounds, such as sexual minority women of color. Findings from this Internet-based study demonstrated that LB women who are African American are at greater risk for poorer diet, poorer physical activity, greater BMI, and greater likelihood of diabetes and hypertension than their white LB counterparts and may benefit from targeted interventions. Moreover, internalized sexism partially mediated these disparities, highlighting the potential benefit of internalized sexism reduction programs for African American LB women.

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Table 1

Analysis of Variance and Chi-Square Tests of Sociodemographic Characteristics Across Race

Variable	White Americans (n = 954), M (*SE*)[c]	African Americans (n = 75), M (*SE*)[c]	*F* (1, 994)
Age (years)	34.27 (0.40)	30.69 (1.46)	5.59*
Income[a]	3.65 (0.07)	3.54 (0.25)	0.17
Education[b]	5.02 (0.06)	4.62 (0.21)	3.60
	% (n)	% (n)	$\chi^2(6)$
Sexual identity			1.80
Lesbian/gay	50.7 (483)	50.7 (38)	
Bisexual	29.1 (277)	34.7 (26)	
Other	20.2 (192)	14.7 (11)	

[a] 1 = < $10,000; 2 = $10,000–19,999; 3 = $20,000–29,999; 4 = $30,000–39,999; 5 = $40,000–59,999; 6 = $60,000–79,999; 7 = $80,000–99,999; 8 = $100,000–149,999; 9 = $150,000.

[b] 1 = no/some high school; 2 = high school/GED; 3 = some college, no degree; 4 = associate's degree; 5 = bachelor's degree; 6 = some graduate/professional school; 7 = advanced degree (MS, PhD).

[c] Indicates means and standard errors.

* $p < 0.05$.

Table 2

Age- and Education-Adjusted Racial Differences in Health Behaviors, Health Conditions, Internalized Homophobia, and Internalized Sexism

Variable	White Americans (n = 954), % (n)	African Americans (n = 75), % (n)	*aOR* [95% CI][a]
Low fruit/vegetable intake[b]	7.8 (74)	17.3 (13)	2.4 [1.2, 4.5]**
Physical activity[c]			0.7 [0.2, 1.1]**
Low	13.4 (128)	26.7 (20)	
Moderate	45.3 (432)	41.3 (31)	
High	41.3 (394)	32.0 (24)	
Diabetes[d]	3 (28)	12.7 (9)	2.9 [1.1, 4.7]**
Hypertension[d]	11.4 (106)	21.1 (15)	2.7 [1.4, 5.2]**
	M (*SE*)	M (*SE*)	*B* [95% CI][a]
Body mass index[e]	28.17 (0.25)	30.38 (0.94)	0.7 [0.3, 1.2]**
Internalized homophobia[f]	1.35 (0.02)	1.41 (0.06)	0.02 [−0.1, 0.05]
Internalized sexism[g]	1.65 (0.02)	1.94 (0.07)	0.08 [0.04, 0.11]***

[a] Age-adjusted odds ratios (*aOR*) and slope coefficients (*B*) are provided from multivariable logistic and linear regression models, respectively (**$p < 0.01$, ***$p < 0.001$).

[b] Scores of < 11 on the Fruit and Vegetable section of the Food Screener instrument.

[c] Categories were based on median minutes a week (MET-min/week), such that low was < 600 MET-min/week, moderate was 600–2,999 MET-min/week, and high was 3,000 + MET-min/week.

[d] On the basis of self-report.

[e] Continuous measures calculated from self-report measures of weight and height.

[f] Response categories were 1 = never, 2 = rarely, 3 = sometimes, 4 = often.

[g] Response categories ranged from 1 = strongly disagree to 5 = strongly agree. 95% CI, 95% confidence interval.

Table 3

Analysis of Internalized Sexism as a Mediator of Racial Differences in Health Behaviors and Conditions

	Bootstrap results for mediation effects,[a] 95% CI			
Model	***% Mediated effect[b]***	**A × B**	***Lower***	***Upper***
Physical activity	**14.6**	**0.01**	**0.002**	**0.03**
Diabetes	**12.0**	**0.05**	**0.01**	**0.12**

N = 929–945. Reported effects were calculated from models including internalized sexism and homophobia (total) as mediators (*A* × *B*). Boldface type highlights a significant effect as determined by the 95% bias corrected and accelerated confidence interval (95% CI).

[a] 5,000 resamples.

[b] Percent mediated is calculated as $\frac{a+b_{internalized\ sexism}}{a\times b_{total}+c'}$.