INTERNALIZED HOMOPHOBIA: A FACTOR IN DEPRESSION, ANXIETY, AND SUICIDE IN THE GAY AND LESBIAN POPULATION

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ABSTRACT

Two-hundred and twenty participants recruited through multiple sampling strategies completed a self-report questionnaire examining: (a) whether internalized homophobia predicts depressive and anxious symptoms, suicide, and substance abuse; and (b) the periods of gay-identity development which were particularly risky for suicide. Results indicate that internalized homophobia, particularly negative feelings towards one's own homosexuality (as measured by the Self subscale of the Nungesser Homosexual Attitudes Inventory), accounts for 18% of the variance in depressive scores and 13% of anxiety scores (using the Beck inventories). Internalized homophobia did not predict suicide independently from depression. The period of greatest risk for both suicidal ideation and suicide attempts was the period of disclosure of one's homosexuality to one's immediate family.

INTRODUCTION

The mental health of gay and lesbian individuals has been studied through multiple lenses over the last few decades. Initial studies were aimed at providing evidence to affirm or dispute the idea that homosexuality was an illness. It became evident that homosexuality in and of itself does not cause dysfunction, distress, or disability and, thus, could not be considered as a mental disorder (American Psychiatric Association, 1997; Krajeski, 1996). Later, studies began emerging claiming higher prevalence of depressive symptomatology and alcohol abuse (Cabaj, 1996). Though these studies were flawed by selection bias, they gave rise to a new kind of research. Discarding the hypothesis that homosexuality itself was a risk factor for mental illness, researchers began searching for factors that might cause increased distress in a homosexual population. This questioning was further fuelled by more recent literature which found higher suicide rates in gay youth (Schneider, Farberow, & Kruks, 1989; Remafedi, Farrow, & Deisher, 1991; Remafedi, French, Story, Resnick, & Blum, 1998; Garofalo, Wolf, Wissow, Woods, & Goodman, 1999; Fergusson, Horwood, & Beautrais, 1999).

Two main areas of study were: (a) the societal discrimination towards homosexuals, known as societal homophobia or heterosexism; and (b) the internalization of this discrimination, known as internalized homophobia. Heterosexism has been

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defined as "the ideological assumption that denies, denigrates, and stigmatizes any non-heterosexual form of behaviour, identity, relationship, or community" (Herek, 1990). In heterosexist society, there is an expectation that all are heterosexual until proof of the contrary. Homosexuality must therefore be markedly "deviant" from the heterosexual norm, or else go unrecognized. Internalized homophobia arises because of the difference between what a gay individual becomes and what his/her parents and society had expected or even demanded (i.e., heterosexuality). The gay man or lesbian experiences shame, guilt, or even self-loathing at not "living up" to the standard of heterosexuality.

The major developmental task in integrating positive identities as homosexual persons is thought to be reducing internalized homophobia by dispelling previously learned negative myths or stereotypes. Once they have done so, individuals will continue to recognize the existence of societal homophobia, but it will no longer resonate with them. They will be able to discount it, to give it minimal importance. It will no longer threaten their self-esteem.

Many authors have proposed stage models of homosexual identity formation whereby individuals go through a series of cognitive and behavioural shifts on their way to integrating a positive identity (Cass, 1984; Troiden, 1988; Chapman & Brannock, 1987; Fassinger & Miller, 1996). Implicit in all these models is the assumption that awareness of homosexual identity precedes a positive attitude about it. Other studies have ascertained the order in which developmental milestones occur (Kooden et al., 1979; Dank, 1971; Troiden, 1979; McDonald, 1982). Globally, it seems that awareness of same-sex attractions precede same-sex experiences which precede self-labelling as homosexual which precedes self-disclosure to others and positive attitudes towards one's gay identity. Thus, internalized homophobia affects individuals for a substantial time after the first awareness of same-sex eroticism.

Some authors consider internalized homophobia as a very narrow and specific construct while others give it a wide scope. The narrowest conceptualization, for example, would be negative feelings only towards one's own homosexual identity. Others have added social dimensions: attitudes towards disclosure of homosexuality, attitudes towards other homosexuals (Nungesser, 1983), perception of stigma associated with being homosexual, social comfort with gay individuals, and moral or religious acceptability of being homosexual (Ross & Rosser, 1996).

Though notions of heterosexism and internalized homophobia have been conceptualized in the context of homosexual identity development, they are applicable to any individual who does not identify as exclusively heterosexual. In fact, it is more useful to think of sexual orientation as a continuum rather than as three discrete categories (homosexual, bisexual, heterosexual). Individuals who identify as bisexual, just as those who identify as homosexual (with and without heterosexual eroticism) will all be affected by homophobia. Thus, when examining the effects of homophobia, it is most appropriate to study a population of "non-exclusively heterosexual" subjects. For the purposes of this paper, GLB (gay, lesbian, bisexual) will be the shorthand used to denote this population.

Correlation of Internalized Homophobia and Psychological Distress

No mater how it is defined, internalized homophobia consists of a set of negative feelings that a GLB person harbours about homosexuality. It follows that these feelings would have a negative impact on the person's psychological well being. Lower self-esteem, psychological distress manifested by depressive and

anxious symptoms, substance abuse, and suicidality may all be associated with internalized homophobia.

A handful of doctoral dissertations have demonstrated an inverse correlation between internalized homophobia and self-esteem in both gay men (Lima, Lo Presto, Sherman & Sobelman, 1993; Alexander, 1987) and lesbians (Burns, 1996; Burris, 1997). Other unpublished studies have shown a correlation between internalized homophobia and depressive symptomatology in gay men (Alexander, 1987; Levinson, 2000) and lesbians (Earle, 2000). Still other dissertations have found associations between internalized homophobia and alcohol abuse in gay men (Cherry, 1997) and lesbians (Burris, 1997). In one study, internalized homophobia was, in fact, found to be a better predictor of alcohol dependence than was self-esteem (Burris, 1997).

Published data on internalized homophobia is far scarcer. No studies have looked at internalized homophobia and psychological distress in women, and most of the studies of men were done in the context of HIV and AIDS (Lima et al., 1993; Nicholson & Long, 1990; Wagner, Brondolo, & Rabkin, 1996). For instance, Wagner and colleagues (1996) established a correlation (r = 0.32) between internalized homophobia (as measured by the Nungesser Homosexual Attitudes Inventory) and depression (measured with the Hamilton depression rating scale) in a cohort of HIV-positive gay men. They found no significant association of internalized homophobia and anxiety by clinician-rated measure (Hamilton Anxiety Rating Scale). However, both anxious and depressive symptoms as measured by self-report (Brief Symptom Inventory) correlated with internalized homophobia.

Dupras (1994) examined links between internalized homophobia and psychosexual tendencies in a Quebec cohort of 261 homosexual men, both seronegative and seropositive for HIV. He found, using the Multidimensional Sexuality Questionnaire and the Nungesser Homosexual Attitudes Inventory, that internalized homophobia was: (a) positively associated with dissatisfaction and anxiety about sexual relationships and with concern about sexual image, and (b) negatively associated with confidence and satisfaction with one's sexual relationships. He also found these associations to be more pronounced in seropositive respondents.

From reviewing this literature, one can reasonably state that internalized homophobia is correlated with various measures of psychological distress. However, published studies with respect to depressive and anxious symptoms are limited for men and are totally lacking for women. Only unpublished studies look at substance abuse, and no studies at all examine the link between suicide and internalized homophobia.

Starting in the early 1990s, various studies reported that lesbian, gay, and bisexual teens have higher attempted and completed suicide rates than their heterosexual counterparts (Remafedi et al., 1998; Garofalo et al., 1999; Fergusson et al., 1999). Elevated rates of suicidal behaviour have been reported in convenience samples of adult gay men. One must interpret these results with caution, however, because they are largely unrepresentative of the community as a whole. Bagley and Tremblay (1997) used stratified random sampling to produce a sample of homosexual and heterosexual males. Their findings indicated that homosexual and bisexual males were 13.9 times more at risk for a serious suicide attempt. The predominant reason hypothesized in their study was the stress of the coming out process.

The purpose of this study was to clarify whether internalized homophobia is correlated with depressive and anxious symptoms, suicide, and substance abuse. Also, because of the recently discovered high suicide rate in gay and lesbian youth, we attempted to find out what periods of gay identity development were particularly risky in terms of both suicide attempts and suicide ideation.

METHODS

Procedures and Participants

Because homosexuality is still subjected to discrimination, individuals who have same-sex sexual/romantic experiences do not always identify as GLB and, further, even when they do, they may not always be forthcoming about their sexual orientation. The invisibility of this population makes it impossible to know what a representative sample of the GLB population would look like. In this study, we aimed for as diverse a sample as possible, in terms of demographic factors as well as outcome measures. Thus, participants were recruited from both clinical and varied community settings.

Participants were recruited from the McGill University Sexual Identity Centre (MUSIC), a psychiatric out-patient clinic that caters to the GLB population as well as to those who are questioning their sexual orientation. Community patients were recruited through a variety of gay-identified and non-gay-identified sites. Surveys were distributed at university queer discussion groups, the gay and lesbian film festival, the lesbian and gay bookstore, women's sports teams, a university health clinic, and restaurants, bars, and cafés in the gay village and in the Plateau (a trendy neighbourhood with a highly diverse population). Further participants were recruited through friendship networks (a common way to recruit participants who have less contact with the gay community).

The questionnaire was announced as a study on mental health and sexuality. Copies were left in unmarked brown envelopes in strategic spots for pick up. These strategies were used to encourage participation from potential respondents that may have shied away from a gay-identified document. Self-addressed envelopes were included in the package for postal return. Participation was voluntary and anonymous.

Instruments

Sixteen multiple-choice and short-answer questions were designed to profile the sample in terms of age, gender, sexual orientation, socio-economic status, cultural background, relationship status, and living arrangements.

Psychological distress was measured with two standardized measures: the Beck Anxiety Inventory (BAI) (Beck, Epstein, Brown, & Steer, 1988) and the Beck Depression Inventory (BDI) (Beck, Steer, & Garbin, 1988). The Alcohol Use Disorders Identification Test (AUDIT) (Saunders, Aasland, Barbor, de la Fuente, & Grant, 1993) and the Drug Abuse Screening Test (DAST-10) (Skinner, 1982) were used to evaluate levels of alcohol and drug abuse. In addition, a four-question scale was designed for this study to get a more precise measure of suicidality in the preceding week. It was based on standard psychiatric questions regarding suicide (passive wish to die, suicidal thought, plan, and attempt). Two other questions enquired about a lifetime history of suicidality. Participants indicated the age at which they experienced suicidal thoughts or had made attempts.

Sexual orientation was assessed based on Kinsey's model (Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953). Participants rated their attractions/fantasies, behaviours, and identity along a 7-point continuum from "exclusively heterosexual" to "exclusively homosexual." Participants labelling themselves, their attractions, *and* their behaviour as "exclusively heterosexual" were excluded from the analysis. All others were included in what we have labelled as our GLB sample.

Internalized homophobia was measured using the standardized Nungesser Homosexual Attitudes Inventory (NHAI) (Nungesser, 1984). This is a 34 item self-administered measurement comprising three subscales: (a) attitude toward one's own homosexuality, (b) attitudes toward other homosexuals, and (c) attitudes toward self-disclosure. The NHAI was adapted for women by the authors. Modifying the gender of the statements was sufficient for most items, but four questions needed further alterations. The modified statements were intended to tap into the essence of the original question and reflect the same subscale.

For example, statements 13 and 30 ("Male homosexuals are overly promiscuous" and "When I think of coming out to peers, I am afraid they will pay more attention to my body movements and voice inflection") both reflect negative stereotypes of gay men. The first deals with behaviour, the second with appearances. Equivalent statements for lesbians were: "Lesbians are overly aggressive" and "When I think of coming out to peers, I am afraid they will pay more attention to the way I look and the way I act."

Finally, a 22-item questionnaire was designed for this study enquiring about the age participants first lived key events in their homosexual identity formation. It included four questions about cognitive changes over time (e.g. questioning heterosexuality, exploring homosexuality, labelling oneself as homosexual/bisexual), one question about first sexual relationship, two questions about when they began socializing with other homosexuals, and 11 questions about the timing of disclosure. These retrospective questions trace the subject's history of homosexual/bisexual development. They were based upon the commonalties of various stage models, but no assumptions were made about the co-occurrence of cognitions, experiences, and disclosure. In addition, the instruments included four questions about the participants' current state (cognitive, attitudinal, social, and disclosure).

All measures that were not available in a standardized French version were translated into French and subsequently validated by back translation to English.

Data Analysis

Descriptive statistics were first computed in order to ensure adequate variability within the sample in terms of demographic factors, internalized homophobia, and outcome measures (psychological symptoms). Cross-sectional data were examined by correlating outcome measures with internalized homophobia using Pearson's correlation with a Bonferroni correction in order to control for multiple comparisons. Once other known risk factors had been taken into account, multiple linear regression was performed on each outcome variable to evaluate the impact of internalized homophobia. Retrospective data were analysed using Pearson's correlation to compare ages of suicidal attempts and ideation to ages of milestones of psychosexual GLB identity development.

TABLE 1

Sociodemographics

	Number	Valid Percentage
Sex (*n*=197)		
Female	90	45.7
Male	107	54.3
Ethnic Origins (*n*=166)		
North American	80	48.2
Western European	54	32.5
Eastern European	13	7.8
Mother Tongue (*n*=197)		
French	92	46.7
English	85	43.1
Religion (*n*=174)		
Catholic	97	55.7
Protestant	18	10.3
Atheist/None	33	18.9
Importance of Religion (*n*=195)		
Very important	20	10.3
Important	40	20.5
A little important	62	31.8
Not at all important	73	37.4
Relationship Status (*n*=196)		
Single, not dating	74	37.8
Single, dating	22	11.2
Same-sex relationship	79	40.3
Opposite-sex relationship	14	7.1
Education (*n*=196)		
High school or less	20	10.2
Some college courses	85	43.4
Bachelor's degree	52	26.5
Graduate studies	39	19.9
Employment (*n*=195)		
Working	99	50.8
Unemployed	18	9.2
Unable to work	18	9.2
Student	53	27.2
Income (*n*=197)		
$0 – 11,999	82	41.6
$12,000 – 19,999	21	10.7
$20,000 – 39,999	54	27.4
$40,000 – 59,999	32	16.2
	Mean	***S.D.***
Age (*n*=197)	33	9.85

RESULTS

Description of Participants

Two hundred and twenty completed questionnaires were returned. Of these, 23 respondents were excluded from the analysis because they were exclusively heterosexual on measures of attraction, behaviour, and identity. This left a sample of 197 participants, of which 136 were recruited from the community and 61 from the McGill University Sexual Identity Centre (MUSIC).

Because it is impossible to ensure a representative sample of the GLB populations, demographics of our sample are presented in detail in Table 1, so that the reader may judge the comparability of our results to a population of interest. (For simplicity, items with less than 7% of respondents and "other" categories are omitted from the table).

Participants varied widely in most measures, as intended by recruitment design. The sample was divided roughly equally between men and women, between French and English speakers, and between people who were single and those who were in relationships. The average age of respondents was 33 years. Participation of minors was not sought for ethical reasons; thus, the age range of respondents was 18 to 63 years. However, almost all participants (95%) lived in or around large urban centres, and most were born in North America (84%), described western ethnic origins (81%), and were Christian (66%). As well, the sample was highly educated, with 46% having at least at Bachelor's degree and 27% in school at the time of study participation. Unfortunately, homogeneity of the sample on educational, cultural, and religious measures precludes exploration of how these attributes may modulate internalized homophobia.

Including participants recruited from a psychiatric clinic in the sample was intended to increase the range and variability of the scores on the psychological distress measures. This outcome was achieved for the BDI, BAI, and SSIS; but, due to the type of patients referred to MUSIC, too few people with drug and alcohol abuse were included in the sample. This led to low mean scores for the AUDIT and DAST, and so those correlations with internalized homophobia could not be determined.

Psychological Distress and Internalized Homophobia

The degree to which psychological distress is correlated with internalized homophobia is presented in Table 2. This analysis suggested that internalized homophobia is correlated with levels of depression, anxiety, and suicidal impulses. Furthermore, it appears that it is the attitudes about one's own sexuality (Self subscale) that is most closely correlated with these measures of distress. No statistically significant correlation was found between alcohol use and internalized homophobia.

Hierarchical stepwise regression models were computed to determine the relationship between internalized homophobia and these three significant measures. Socio-demographics other than age and gender were not found to be predictive of psychological distress in our sample and were, therefore, excluded from the final model. The order of entry of the predictor variables in the regression analyses for depression and for anxiety were as follows: (a) age and gender; (b) AUDIT and DAST scores; and (c) NHAI self, other, and disclosure subscales. Since depression and anxiety are known risk factors for suicide, the regression model for suicide (in the second step) included these two factors along with alcohol and drugs.

The results of the hierarchical multiple regressions predicting depression and anxiety (Table 3) indicate that internalized homophobia—more specifically, the negative feelings about one's own homosexuality (i.e., Self subscale)—accounts for 18% of the variance in depression scores (ΔR^2, $F(7,157) = 15.15$, $p < 0.001$) and 13% of the variance in anxiety scores (ΔR^2, $F(7,157) = 7.17$, $p < 0.001$). The Disclosure and Other subscales did not add to the model which, overall, was able to account for 41% of the variance in depressive scores and 25% of the variance in anxiety scores. For both depression and anxiety, gender and drug abuse were also significant predictors, but age and alcohol abuse were not.

In the multiple regression on suicide (Table 4), internalized homophobia was not significantly associated with suicide scores. Neither were any of the other factors entered into the model except for depression (ΔR^2, $F(6,158) = 19.66$, $p < 0.001$), which accounted for 36% of the variance.

TABLE 2

Pearson's Correlation of Psychological Distress and NHAI Scores

	Total Score	NHAI Sub-Scales		
		Self	**Other**	**Disclosure**
Beck Depression Inventory (BDI)	-0.457*	-0.514*	-0.381*	-0.314*
Beck Anxiety Inventory (BAI)	-0.329*	-0.355*	-0.251*	-0.259*
Alcohol Use Disorders Identification Test (AUDIT)	-0.146	-0.175	-0.035	-0.002
Severity of Suicidal Impulses Scale (SSIS)	-0.275*	-0.302*	-0.194	-0.159

* $p \leq 0.05$ (2-tailed, corrected for multiple comparisons)

TABLE 3

Results of Hierarchical Regressions Predicting Depression, Anxiety

	Depression			**Anxiety**		
Predictors	**R**	**ΔR^2**	**Beta**	**R**	**ΔR^2**	**Beta**
STEP 1:	.398	.158		.214	.046	
Age			.119			-.013
Gender			-.213*			-.122
STEP 2:	.483	.074		.347	.075	
Alcohol			.081			.057
Drugs			.202*			.231*
STEP 3:	.644	.181		.501	.130	
IH-self			-.512*			-.386*
IH-other			.141			.126
IH-disclosure			-.042			-.101

Beta weights are standardized
$p < 0.01$

TABLE 4

Results of Hierarchical Regressions Predicting Suicide

	Suicide		
Predictors	**R**	**ΔR^2**	**Beta**
STEP 1:	.267	.071	
Age			-.048
Gender			-.074
STEP 2:	.661	.366	
Depression			.538*
Anxiety			.153
Alcohol			.075
Drugs			.021
STEP 3:	.669	.011	
IH-self			-.067
IH-other			.121
IH-disclosure			-.076

Beta weights are standardized
$p < 0.01$

Age and Developmental Periods of Increased Suicide Risk

The data on suicide in this study warrants careful consideration. Overall, the rates of suicidality were alarmingly high. In the community sub-sample, life-time prevalence of suicidal ideation was 65% and of suicide attempts was 14%. Suicidal ideation in the week preceding participation in the study was 16%. Rates of suicidality in the clinic sub-sample were even higher (70% for suicidal ideation, 23% for suicide attempts, and 27% for suicidal ideation within the preceding week).

In order to elucidate the relationship between suicide and homosexuality further, current suicidality (SSIS) was compared to other questions relating to psychosocial adjustment to being GLB. In particular, personal attitudes towards one's homosexuality, as well as the perceived attitudes of family and work environments, were correlated with suicidality. Of known socio-demographic factors, only age and gender were related to current suicidality. However, once depression was accounted for, none of these variables showed a statistically significant relationship to suicide.

We compared the age at which participants had attempted suicide (M = 23.7 years) and contemplated suicide (M = 27.1 years) to developmental milestones in integrating a GLB identity. It seems that the period of disclosure of one's orientation, particularly to family members, was most risky for both suicidal ideation and attempts (Table 5). Suicidal ideation, but not attempts, was also associated with the beginning of socialization with other self-identified homosexual people. Cognitive shift related to self-labelling as GLB and first romantic relationships were not related to suicide.

TABLE 5

Milestones in Homosexual Identity Development and Suicidality

	Average Age	S.D.	Correlation with Suicide Attempt	Correlation with Suicidal Ideation
First considered not exclusively heterosexual (181)	15.8	6.5	0.32	0.18
First considered oneself probably homosexual/bisexual (181)	17.6	6.7	0.22	0.17
Definitely homosexual/bisexual (173)	20.3	7.7	0.1	0.22
First began to socialise with another homosexual person (193)	19.8	5.7	0.24	0.28*
Significant socialization with homosexual people (149)	22.5	6.7	0.26	0.35*
First same-sex romantic relationship (168)	21.2	7.0	0.33	0.12
Disclosed to gay friend (154)	22.0	7.2	0.50*	0.39*
Disclosed to straight friend (167)	22.5	6.8	0.46	0.39*
Disclosed to mother (134)	23.9	7.9	0.51[t]	0.46*
Disclosed to father (97)	23.6	7.2	0.46[t]	0.54*
Disclosed to sister (95)	25.7	8.0	0.58[t]	0.37
Disclosed to brother (100)	25.1	8.3	0.57[t]	0.49*
Disclosed to co-worker (137)	24.9	7.2	0.27	0.37*
Lifetime suicidal ideation (138)	27.1	10.1	0.55*	1.00
Lifetime suicide attempts (46)	23.7	8.4	1.00	0.55*

$p \leq 0.05$ (2-tailed), corrected for multiple comparisons

[t] trend at $p \leq 0.10$ (2-tailed), corrected for multiple comparisons

DISCUSSION

Psychological Hazards of Internalized Homophobia

Internalized homophobia is a stressor for all gay and lesbian people who are raised in western cultures. Belonging to a group about which one feels negatively is bound to impact one's mental health. This study has indeed showed a significant link between internalized homophobia and psychological distress, particularly depressive and anxious symptoms. Most interestingly, it is the Self subscale (i.e., the negative feelings about one's own homosexuality) which is most predictive of distress. It seems that negative attitudes towards other homosexuals or discomfort with disclosure are not so important. The Self subscale taps into comfort with one's homoerotic attractions, but mostly reflects feelings about a homosexual identity (such as being proud, glad, depressed, or self-critical).

This seemed intuitive to the authors when considering depression. It could be understood as a measure of worthlessness or low self-esteem specific to this population. The association of the self subscale to anxiety was more surprising. Our clinical impression was that anxiety was related to fear of being discovered to be GLB and, therefore, we expected the disclosure subscale to be more important. It seems that viewing oneself so negatively may create anxiety, whether or not there is a threat that the homosexuality is discovered. Shame is possible even when no one is watching.

Unlike previous research (Burris, 1997; Cherry, 1997), this study did not show an association between current drug or alcohol abuse and internalized homophobia. The absence of such a correlation may be due to the cross-sectional nature of the study, as well as characteristics of the sample population. The sample was relatively young (M = 33 years, SD = 9.85 years) and the rates of drug and alcohol abuse were low. A more complex longitudinal design—which includes measurement of current and lifetime rates of substance abuse—in a wider variety of clinical populations might be capable of detecting such a relationship.

Internalized homophobia failed to predict suicide once other forms of psychological distress were accounted for. It seems quite plausible, however, that internalized homophobia has an indirect effect on suicide by contributing to depression.

Retrospective data on suicide showed high rates of suicidal thinking and behaviour in our study population. Though our rates were similar to those reported in other studies of the gay and lesbian population (Schneider et al., 1989; Remafedi et al., 1991; Remafedi et al., 1998; Garofalo et al., 1999; Fergusson et al., 1999), they were markedly different from the general population. In Québec, the rate of lifetime suicidal ideation was reported to be 10%, with only 3-4% attempting suicide (Québec, 1988). Elsewhere in Canada, lifetime suicidal ideation was reported at 11.5% (Dyck, Bland, Newman, & Orn, 1988). Based on these numbers, our GLB sample from the community (excluding subjects recruited through MUSIC for whom the numbers are even higher) had about a 6 times greater risk for suicidal ideation and about a 4 times greater risk of suicide attempts.

The greatest risk for suicidal behaviours and thinking was when participants were in their mid-twenties. The association of suicidal ideation and attempts with disclosure of GLB identity to one's immediate family is food for thought. Families usually function as support systems when individuals go through difficult times. However, it seems that, in this instance, families add to the stress. At this stage, it is

likely that GLB young adults have not yet worked through their internalized homophobia and are thus ambivalent, at best, about their sexual orientation. Coming out may seem like a confession of one's shortcomings, and the shame may be unbearable. In this study, we did not examine the reactions of the families to the disclosure, but we could imagine that negative reactions might further increase the risk of suicide. In any case, it seems that a family intervention or, at very least, individual support for these young adults during this critical period may be life saving.

Suicide is but the tip of the iceberg. Our cross-sectional data suggest that internalized homophobia can lead to depression and, though depression does predict suicide, only 10% of people with depression will commit suicide (Kaplan & Sadock, 1998). Many distressed individuals will suffer other morbidity without ever considering suicide. Therefore, by using suicide as the only retrospective indicator of psychological distress, we are underestimating the psychological difficulties associated with the coming out period. We have not captured the distress that may have manifested as anxiety, depression, or substance use that did not lead to suicidal thinking.

Since internalized homophobia is worked through gradually throughout the process of GLB identity integration, and since internalized homophobia is predictive of psychological distress, it follows that the most psychologically difficult period would be the early stages in the identity formation process, when the internalized homophobia is at its highest. A study capturing the subjective experience during the coming-out stage would be illuminating—though it would be difficult to conduct given that individuals at this stage would not be likely to participate in any study that would risk labelling them as GLB.

Clinical Considerations

Why some people seem to work through their internalized homophobia quickly and relatively painlessly while others develop psychological symptoms remains unknown. Understanding how gender, culture, religion, locus of control, social networks, and personal upbringing influence this process may lead to specific strategies to help decrease internalized homophobia in gay and lesbian individuals. Community interventions aimed at societal heterosexism and homophobia will surely be of value. Until society is totally rid of homosexual prejudice, however, clinicians will have to be sensitive to the effects of internalized homophobia in their patients.

Exploring internalized homophobia as part of the assessment of psychological distress and, in the course of treatment of mood and anxiety disorders, clearly is essential—despite the patient's reassurance that they have "no problems with their sexuality." Comments such as "I'm ok being gay, I just don't think others need to know," "I think being gay is fine, but I don't understand why those flaming drag queens have to parade around," or "I don't have any homophobia, I have a realistic concern that telling my mother I am gay would kill her, she has a heart condition you know" might alert the mental health professional to unconscious internalized homophobia. With these patients, as with those who are more overtly homophobic, targeting internalized homophobia during psychotherapy seems like a promising avenue for treating mood and anxiety disorders. This type of targeting can be done regardless of the therapeutic model used.

In cognitive therapy, internalized homophobia can be treated as a dysfunctional cognition due to maladaptive assumptions, which can easily be disputed if its validity is tested. Asking a patient to brainstorm on the meaning of the words gay, lesbian, or bisexual will expose negative beliefs about homosexuality (e.g., gay = failure, gay = pedophile). Once these beliefs have been articulated and brought to conscious awareness, they can be contrasted with reality (i.e., "Many GLBs are successful— think of Ellen, Rosie, Melissa Etheridge, Michel Tremblay, Svend Robinson, etc." or "Ninety-five percent of paedophiles are heterosexual, so statistically there is no evidence to link paedophilia and homosexuality").

Socio-anthropological approaches would validate mourning of the heterosexual privileges which gays and lesbians are still denied (such as legal and social recognition of love relationships) and situate current discrimination in its geographical, political, temporal and cultural context. In so doing, one eliminates the argument that discrimination towards GLB individuals is "natural" and has "always been" (and is therefore justified).

In an interpersonal therapy model, internalized homophobia can be conceptualized as a role dispute, where the individual and his/her family have different expectations of the individual's romantic life (homosexual vs. heterosexual relationships). Therapy would then focus on validating the patient's desired role (e.g., being a same-sex partner) and identifying the stage of the dispute (renegotiation, impasse, or dissolution). The therapist would try to move the patient and her/his family out of the impasse by engaging in meaningful communication about the patient's GLB identity, eroticism, and relationships. If renegotiation fails, then the therapist will help the patient grieve the wished-for relationship and move on, seeking out more supportive/affirming relationships.

Various schools of psychoanalysis offer different understandings of internalized homophobia. In ego psychology, internalized homophobia may be understood as resulting from the ego's struggle between rules and desires. It would be the combination of id anxiety triggered by homosexual sex (erotophobia), and the superego anxiety resulting from social deviance (xenophobia) (Margolies, Becker, & Jackson-Brewer, 1987). The goal of therapy would thus be shaping the harsh superego into a more flexible psychic structure, one capable of accepting homosexual impulses. From an object-relations perspective, patients would come to feel negatively about their GLB sexuality because of rejection from a genital object. Patients would come to believe that their parent rejected them because of their homosexuality, often attributing all negative experiences to being GLB. Because of anxiety stemming from an erotically charged longing for closeness with the parental object, they further repress any positive aspects of the parent-child relationship, thus remembering only the negative. The remembered relationship is thus even more rejecting than it was in reality, and this harsh rejection acts as a confirmation of the badness of homosexual eroticism. Therapy would thus target a more realistic memory of the actual parent-child relationship, a conscious awareness for the longing for a same-sex parent, and an exploration of all the reasons this longing was not gratified (including parental shortcomings).

At MUSIC, we have developed a multi-modal group approach that combines psycho-education, working on defence mechanisms, and challenging maladaptive assumptions with the corrective emotional experience of belonging to a group of peers. Though this has been clinically promising, the efficacy of these techniques,

their impact on treating internalized homophobia, and their role as adjunctive treatment for the associated mental illnesses will need to be the object of future research.

RÉSUMÉ

Deux cent vingt participantes et participants, recrutés au moyen de diverses stratégies d'échantillonnage, ont complété un questionnaire autoadministré visant à établir (a) le lien entre l'homophobie intériorisée et la dépression, l'anxiété, l'abus de substances et le suicide et (b) les périodes du développement identitaire gai où le risque de comportements suicidaires est plus élevé. Les résultats indiquent que l'homophobie intériorisée, plus particulièrement les attitudes négatives face à sa propre homosexualité (telles que mesurées par l'échelle « Self » du Nungesser Homosexual Attitudes Inventory), explique 18% de la variabilité des scores dépressifs et 13% de la variabilité des scores d'anxiété (tels que mesurés par les inventaires de Beck). L'homophobie intériorisée n'influe pas, séparément de la dépression, sur le suicide. La période où le risque tant des idées que des tentatives suicidaires est le plus élevé correspond au moment du dévoilement de l'homosexualité à la famille immédiate.

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