

THE RELATIONSHIP BETWEEN INTERNALIZED HOMOPHOBIA
AND PSYCHOLOGICAL DISTRESS IN LESBIANS

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The true focus of revolutionary
change is never merely the
oppressive situations which we
seek to escape, but that piece of
oppressor which is planted deep
within each of us.

Audre Lorde

DEDICATION

This dissertation is dedicated to Darla Tubbs, Ph.D. You are profoundly missed.

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ABSTRACT

The Relationship between Internalized Homophobia and Psychological Distress in Lesbians

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Growing up and living in a homophobic society, lesbians are exposed to numerous negative attitudes, assumptions, and messages concerning homosexuality. Internalized homophobia refers to the incorporation of these homophobic beliefs within the lesbian's self-image. Internalized homophobia is assumed to be associated with psychological distress and as presenting a significant threat to healthy self-esteem and identity development in lesbians

The purpose of the present study was to examine the association between internalized homophobia and psychological distress in lesbians. Participants were self-identified lesbians residing in one of three cities: a small rural city; a mid-sized city; or a large metropolitan area. The data consisted of participant scores on the Symptom Checklist 90-Revised (SCL-90-R) and the Internalized Homophobia Scale for Lesbians (IHSL).

Results of this study indicated general internalized homophobia significantly correlated with overall psychological distress as well as with depression in lesbians. The findings also indicated that psychological

distress was associated with younger age, medication usage, lower income, negative attitudes toward other lesbians and non-white ethnicity. In addition, results indicated participants from the smallest city in the sample displayed significantly higher levels of internalized homophobia compared to participants from the other cities.

This research demonstrated internalized homophobia is a salient factor in the lives of lesbians and needs to be addressed when researching identity development and psychological functioning in lesbians. Additionally, this study pointed to the need for therapists who work with lesbians to have a clear understanding of internalized homophobia and skills in helping lesbians deal with this issue.

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CHAPTER I

Introduction

Growing up and living in a homophobic society, lesbians are exposed to numerous negative attitudes, assumptions, and messages concerning homosexuality. Internalized homophobia refers to the incorporation of these attitudes regarding homosexuality into one's self-image and identity as lesbian. Researchers have considered the internalization of cultural homophobia a normative event (Burns, 1996; Forstein, 1988; Gonsiorek, 1988; Loulan, 1984; Maylon, 1985; Pharr 1988; Sophie, 1987). Internalized homophobia can lead to feelings of guilt, shame and depression (Wagner, Brondolo, & Rabkin, 1996). Gonsiorek (1988) characterized internalized homophobia as "one of the greatest impediments to the mental health of gay and lesbian individuals" (p. 117).

A lesbian identity develops in a complex interaction between internal and external influences. For lesbians, the external influences include the stigma and oppression of homophobia expressed at cultural, institutional and interpersonal levels. These influences lead to the development of internalized homophobia, resulting in low self-esteem and

psychological distress. Most theories of lesbian identity development have assumed achieving a positive lesbian identity requires an examination of one's internalized homophobia and a resolution of the loss of self-esteem it carries (Kahn, 1991; Sophie, 1987; Walters & Simoni, 1993).

The literature regarding internalized homophobia has been primarily theoretical to date and the empirical research has focused predominantly on gay men. However, some recent empirical research has examined internalized homophobia in lesbians, including studies exploring internalized homophobia and its association with chemical dependency (Burris, 1996; Frock, 1997), relationship satisfaction (Cleff, 1994), and parenting choices (Burns, 1996). These findings are consistent with Rothblum's (1994) critique of the literature in which she noted that during the past two decades, research on lesbians and gays has focused on issues such as coming out, relationships, parenting, and chemical dependency. She noted the dearth of research focusing on the mental health of lesbians and gay men, including a lack of research addressing issues such as depression and anxiety, and stressed the importance of studying the processes related to mental health that are unique to lesbians and gay men.

The current study addressed the mental health needs of lesbians

by examining the association between internalized homophobia and psychological distress symptomatology in a diverse group of lesbians (i.e., ages, ethnicity, religious affiliation and socioeconomic status).

Participants in the current study were self-identified lesbians, age 18 and up, who reside in one of three cities in the Southwest: a large metropolitan area, a mid-sized city, or a small city. The data consisted of participant scores on the Internalized Homophobia Scale for Lesbians (IHSL; Szymanski & Chung, 1998) and the Symptom Checklist 90-Revised (SCL-90-R; Derogatis, 1994), as well as information obtained from a demographic data sheet.

The current study attempted to answer some basic questions regarding internalized homophobia as it impacts the mental health of lesbians. For example, are lesbians who exhibit more comfort with various aspects of their sexual identity (e.g., public identification as lesbian, connection with the lesbian community) at reduced risk for experiencing psychological distress (e.g., depression, anxiety) as compared to those who are struggling with their sexual identity? Is internalized homophobia linked to religious and moral ideology associated with depression? Is this form of internalized homophobia more prevalent in younger lesbians? Are older lesbians less comfortable with public recognition of their sexual identity than younger lesbians? If

so, does this place older lesbians at greater risk for experiencing anxiety?

These questions had not previously been addressed empirically and constituted a gap in the literature. Diamond and Wilsnack (1978) pointed out research is necessary to effectively develop and implement treatment strategies sensitive to the special needs of lesbians and that the replacement of myths and stereotypes with accurate information is particularly important in addressing treatment issues. Attempting to answer these questions can assist clinicians in reaching an understanding of additional variables potentially impacting the clinical symptomatology of lesbians. This understanding can assist both therapists and their clients in the exploration and resolution of sexual identity struggles and psychological distress. In addition, an increased empirical understanding of how internalized homophobia is associated with specific mental health issues in lesbians can positively impact treatment strategies and the therapeutic context by reframing psychological distress in lesbians who are struggling with sexual identity issues as a developmental process associated with the normative internalization of cultural homophobia. This understanding should ideally result in less pathologizing of the symptomatology of an already stigmatized group.

In this paper, the literature pertinent to the study of internalized homophobia and psychological distress in lesbians including homophobia as it manifests in our society, its impact on lesbian identity development and mental health, and assessment issues related to the measurement of internalized homophobia are reviewed. The literature review closes with the rationale for the study and the major research hypotheses. Following the rationale and research hypotheses, the methodology of the study and the instruments utilized have been detailed. Results and discussion conclude the work.

CHAPTER II

Review of the Literature

In this chapter the societal atmosphere in which lesbians and gays find themselves is examined, as well as some of the historical and current factors which contribute to that atmosphere. In addition, the literature pertinent to lesbian identity development will be reviewed, including an examination of both the theoretical and empirical underpinnings regarding internalized homophobia and discuss clinical issues facing members of the lesbian community. The development of measures designed to assess the presence of internalized homophobia in gay and lesbian individuals is also traced. Finally, the chapter concludes with the rationale for the current study and the major research hypotheses.

Societal/Cultural Atmosphere

In American culture, homosexuality has historically been viewed as abnormal, deviant, sinful, and as a mental illness. The expression of these ideas has been evident across many contexts within society; in its cultural norms, in its institutions, and in its individuals. The basis for these long-held beliefs can be traced to foundations within the larger

culture, including religious ideology, scientific inquiry, and political thought. An understanding of the atmosphere that confronts lesbians today requires an exploration of the historical context in which attitudes towards homosexuality have developed and persisted.

Judeo-Christian Ideology

Judeo-Christian thought has had an enormous impact on the manner in which homosexuality has been regarded in Western culture. Attitudes toward homosexuality have been heavily influenced by Judeo-Christian theology which views homosexuality as a sin (Morgan & Nerison, 1993). Bayer (1981) viewed Judeo-Christian philosophy as providing three bases for viewing homosexuality as sin: first, a belief that the anatomical design and complementary nature of female and male genitalia indicated procreative heterosexual intercourse was the only natural and God-ordained expression of sexuality; second, that heterosexual intercourse was the means to fulfill God's directive to "be fruitful and multiply;" and third, that Judeo-Christian theology has interpreted some Biblical scriptures as condemning homosexuality. For example, the destruction of Sodom and Gomorrah has commonly been interpreted as punishment for homosexual practices, although alternate interpretations infer what was being punished was the inhospitable behavior of its inhabitants (Day, 1987; Hilton, 1992).

Morgan and Nerison (1993) stated that early conceptualizations of homosexuality as sin continue to have a powerful influence on present attitudes. Haldeman (1994) asserted that the long history of negative bias toward homosexuality has contributed significantly to the wounding of lesbians and gay men. He continued by noting that for many lesbians and gays, self-affirmation and dignity are irreconcilable with membership in many religious institutions, particularly with those whose anti-gay tenets are used in an ongoing effort to delimit civil rights based on sexual orientation. The notion that homosexuality is freely chosen is often held by religious institutions as justification for labeling anti-discrimination statutes as "special rights." Haldeman argued that "For some lesbians and gay men who seek to maintain a relationship with their denominations, this attitude becomes the salt that is rubbed into the wound" (p. 888).

Anti-gay attitudes held by and anti-gay actions taken by religious institutions contribute to the sense of isolation and shame experienced by lesbians and gays. The experience of isolation and shame is no doubt intensified for those with strong current or historical ties to those religious institutions. Gay affirmative theologians have paralleled the work of gay identity development theorists with regard to the internalization of homophobia experienced by lesbians and gays living (or

worshipping) in an often hostile environment. Haldeman (1994) noted that while gay-affirmative psychotherapy seeks to soothe the effects of socio-cultural injuries, namely the contamination of psychosexual development with shame and self-negation, gay-affirmative theology seeks to heal the wounded spirit, allowing the individual to move forward in whatever spiritual path seems appropriate.

Scientific Thought

According to Bayer (1981), the influence of Judeo-Christian ideology could clearly be felt in the medical and scientific communities of the 19th century. Bayer wrote, "In the early decades of the 19th century, what medical discussions did take place clearly bore the mark of the more powerful religious tradition" (p. 18). However, a conceptual shift was taking place during much of the 19th century. Burris (1996) noted that a decline in the central importance of the church and the rise of science and psychology brought with it a period of challenge to the existing assumptions regarding homosexuality. Long-held assumptions were challenged and the emphasis in some scientific communities began to shift from the view of homosexuality as sin to that of sickness (Burris, 1996; Cruikshank, 1992).

Morgan and Nerison (1993) noted early scientific theories of homosexuality focused on seeking causes for the behavior, while other

authors noted as recently as the early 1970s, discussions of homosexuality still contained frequent references to “curing” the behavior (Alexander, 1986; Katz, 1976; Morin 1977). Cruikshank (1992) argued this shift resulted in conditions not much better for gays and lesbians than those when the church prevailed. Potential “cures” for homosexuality included castration, sterilization, sectioning the pubic nerve, and the relatively benign cold sitz bath (Morgan & Nerison, 1993). Morgan and Nerison noted lobotomy was used as a treatment as recently as 1948.

It was within this context focusing on the causes of homosexuality that Freud created his conceptualization of homosexuality. Freud believed everyone is bisexual and that exclusive homosexual behavior represented arrested development (Morgan & Nerison, 1993). Despite his belief that heterosexuality represented the end result of normal development, researchers noted Freud demonstrated an accepting attitude toward homosexuality relative to his peers (Bayer, 1981; Morgan & Nerison). For example, Bayer noted Freud did not believe homosexuality was an indication of degeneracy, that he was opposed to the rigid, condemnatory stance of his psychoanalytic contemporaries, and that he wrote that homosexuality probably did not need curing. Bayer continued by asserting the more pathologizing conceptualizations

of homosexuality can be attributed to post-Freudian psychoanalysts who rejected Freud's notion of inherent bisexuality and viewed homosexuality as an "attempt...to achieve sexual pleasure when the normal heterosexual outlet proved too threatening" (p. 29).

Freud stirred controversy among his contemporaries regarding homosexuality and the same can be said of Kinsey. The findings of Kinsey's 1948 study of male sexuality, while controversial at the time, had a significant impact on attitudes toward homosexuality (Morgan & Nerison, 1993). Kinsey concluded that homosexual behavior was more prevalent than previously thought and that normal sexuality could be conceptualized as a continuum rather than a dichotomy. In addition, Kinsey's study laid the groundwork for future research. Other researchers began to question the notion of homosexuality as unnatural (Ford & Beach, 1951) and to suggest gays and lesbians were no more pathological than heterosexuals (Hooker, 1957).

As a change in attitudes toward homosexuality began to take root in the scientific community, a Task Force on Homosexuality was appointed by the director of the National Institute of Mental Health (NIMH). The 1972 NIHM report acknowledged "human sexuality encompasses a broad range of behavior," and recognized that homosexuals cannot be considered a homogenous group (Morgan &

Nerison, 1993). In addition, the report noted that homosexuality was indeed a major problem for our society, but largely due to the injustice and suffering endured by homosexuals' isolation in a culture in which they are considered maladaptive and opprobrious (NIHM, 1972). The report recommended human sexuality training for mental health professionals, the provision of mental health services for homosexuals, and efforts towards changes in social policy that would create an environment more accepting of homosexuals. Unfortunately, the report also included a recommendation that efforts to understand the etiology of homosexuality continue so as to facilitate prevention. However, the results of the NIHM Task Force report made clear that some movement toward greater acceptance of homosexuality had been made by the mental health establishment (Morgan & Nerison).

While the NIHM Task Force was busy preparing its report, gay rights activists were also focusing on changing attitudes within the scientific and mental health community toward gays and lesbians. Members of the gay rights movement attended the 1970 American Psychiatric Association's convention and expressed their outrage during presentations in order to focus attention on their demand that the American Psychiatric Association and the profession of psychiatry develop an affirmative stance toward homosexuality. These activists also

requested they be allowed to conduct their own panel at the 1971 convention and used the panel to demand homosexuality be removed from the diagnostic nomenclature (Bayer, 1981; Morgan & Nerison, 1993). The efforts of the activists were rewarded when in 1973 the American Psychiatric Association voted to remove homosexuality from the Diagnostic and Statistical Manual II (DSM-II; 1973). Soon thereafter, the American Psychological Association (APA) issued a statement in support of the American Psychiatric Association resolution and adopted its own resolution stating homosexuality per se implied no impairment and urged all mental health professionals to take the lead in removing the stigma of mental illness associated with homosexuality (APA, cited in Morgan & Nerison, 1993).

After the removal of homosexuality from DSM-II, and despite the controversy it aroused, changes slowly began to appear in the professional literature. Morgan and Nerison (1993) conceptualized this period as a wave of activity occurring with three distinct foci within the conceptual and empirical work on gay and lesbian psychology.

First, researchers began to replicate earlier studies suggesting psychopathology is no more common among gays and lesbians than among the general population. For example, Adelman (1977) compared the Minnesota Multiphasic Personality Inventory (MMPI; Hathaway &

McKinley, 1942) profiles of lesbians and heterosexual women and found no differences on any of the clinical scales, with the exception of the Sc (Schizophrenia) scale. Adelman stated further analysis of the Sc subscales clearly indicated no differences on the pathological part of the scale, but rather a difference in degree of social alienation. Other studies whose results indicated that lesbians and gays did not display more psychopathology than heterosexuals in normative aspects of life included Bell and Weinberg (1978), Hart (1978), Kingdon, (1979), Oberstone and Sukonek (1976) and Riess, Safer, and Yotive (1974).

A second line of research focused on reframing the question of what causes homosexuality to a question of what causes sexual orientation in general. Storms (1981) developed the erotic orientation model, which proposed sexual orientation emerges from an interaction of sex drive development and social development. He hypothesized that the period in which sex drive development is at it strongest, either during the homosocial bonding period (before age 13) or the heterosocial bonding period (after age 13), significantly impacts sexual orientation. Other research which sought to understand the development of sexual orientation (both heterosexual and lesbian or gay) included the work of Browning (1984) and Money (1987), whose research studied the impact of both biological factors and socialization.

The third research focus was on the development of gay and lesbian affirmative psychotherapy models and on identifying essential issues in the treatment of gays and lesbians. Earlier research included work by Gonsiorek (1985), Martin (1982), Riddle and Sang (1978), Schoenberg, Goldberg and Shore (1985), and Sophie (1982). While the research of these individuals indicated that lesbians and gays face many of the same treatment issues as their heterosexual counterparts, they also highlighted areas of particular importance in working with lesbians and gays. These issues included coming out, social homophobia and internalized stigma or homophobia. Recent literature included: Falco's (1995) "Therapy with lesbians: The essentials" and Browning, Reynolds and Dworkin's (1991) Affirmative Psychotherapy for Lesbian Women. Each of these research lines began leading the profession of psychology to a greater theoretical and empirical understanding of the mental health needs of gays and lesbians and of the impact of oppression on the psychological functioning of these groups (Morgan & Nerison, 1993).

Social Policy

The context in which an individual exists is continually shaped by social policy. As Hartman (1996) stated, social policies "define opportunities and limitations, establish rights and protections, and set out the rules and mutual responsibilities included in the social contract

between citizens and state” (p.69). The relationship of lesbians and gay men with the bodies that develop and implement social policy has historically been particularly difficult and has created an ongoing impact in their daily experiences. Gays and lesbians have had limited protection or no protection under the law and have therefore lived in a largely wary relationship with the forces surrounding social policy. As Curry, Clifford, and Leonard (1994) wrote:

For eons, the law has been a force for oppression. The litany of codified homophobia includes sodomy laws, loitering laws, exclusion from the military, prohibitions against child custody--the list goes on and on. In addition, the law has permitted--and in some cases even encouraged--many other types of oppression, such as job and housing discrimination, and police entrapment. Obviously a legal system that makes people criminals because of sexual orientation doesn't engender trust (p. VIII).

Unfortunately, it is not necessary to look far into the past to see the manner in which social policy has been shaped and how it has affected the lives of gays and lesbians. As of 1992 in the United States, nearly one half of the states continued to outlaw private consensual homosexual behavior. The states' right to do so was upheld by the U.S. Supreme Court in the 1986 *Bowers v. Hardwick* decision. This decision

upheld the constitutionality of the Georgia sodomy statute. In another clear display of the link between legal philosophies and religious teachings, Justice White and Chief Justice Burger refused to find a constitutional right for adults to engage in private, consensual homosexual behavior (Herek & Berrill, 1992). The Justices based their decision on the existence of ancient legal proscriptions against sodomy and the firmly rooted Judeo-Christian condemnation of homosexuality. The existence of sodomy laws and the Supreme Court's refusal to render them unconstitutional has left the door open for selective prosecution and encouraged further discrimination in areas such as job protection and child-custody by groups who may legally base their actions on the implied criminality of gays and lesbians (Hartman, 1996).

Recent Developments

In the past ten years, the gay and lesbian community has experienced a number of ups and downs in its continuing encounters with religious institutions, social policy, and the mental health professions. Before addressing identity development in lesbians, the impact of the lesbian and gay civil rights movement, the women's movement, and the AIDS epidemic on the cultural context in which lesbians find themselves will be examined briefly.

The lesbian and gay civil rights movement. The symbolic beginning

of the lesbian and gay rights movement took place in a Greenwich Village bar, the Stonewall, in 1969 (Altman, 1971; Gross, 1991; Jay & Young, 1977; Morgan & Nerison, 1993; Morin, 1977; Salholz, 1989).

Lesbian and gay bar patrons, fed up with ongoing persecution by members of the New York City Police Department, took their frustration and anger to the streets and ignited the Stonewall Rebellion.

The goals of the movement were to gain the acceptance of homosexuality and to secure civil rights that would allow all lesbians and gays to live openly without fear of reprisal (Morgan & Nerison, 1993). A significant impact of the Stonewall Rebellion was that it provided the impetus for existing lesbian and gay political organizations to shift toward coalescing into a movement as opposed to operating independently as they had previously (Vaid, 1995). As Vaid notes, "The Stonewall generation of the 1970's built the frame of the lesbian and gay movement of the 1990s" (p. 56).

The women's movement. During the same period, the women's movement was questioning traditional gender roles and working to better understand how the multiple forms of expression and repression of women's sexuality were related to women's liberation (Golden, 1994; Morgan & Nerison, 1993). However, tension existed within the movement as to the place lesbians should occupy. As Pharr (1988) noted, "Despite

the leadership that lesbians had had in creating the movement, we were still asked to put the 'good of the movement' foremost and to be discreet about our sexual identity, our lives" (p. 27).

Golden noted attitudes toward lesbians began to change slowly in feminist communities, and as lesbians became more visible, it was more difficult to deny they were at the forefront of the women's movement. Despite these difficulties, the questioning of gender roles by the women's movement not only influenced the culture at large but also had a positive impact on the lesbian and gay rights movement. As Morgan and Nerison (1993) noted, "The women's movement helped to create a socio-political climate in which more positive views about homosexuality could take root" (p.136).

The AIDS epidemic. The arrival of AIDS profoundly changed the lives of lesbians and gay men as well as the shape of the lesbian and gay civil rights movement. Vaid (1995) wrote, "The AIDS epidemic so transformed the gay and lesbian political movement that, as with our personal lives, we can mark two distinct eras: life before AIDS and life after AIDS" (p.72). The lesbian and gay rights movement faced two immediate problems: first, it had to effect a shift in focus from securing civil rights to gaining attention from a national culture and political administration who did not care about gays and lesbians; second,

activists had to determine how to mobilize a community which continued to be largely closeted and invisible. Considerable effort was expended deciding how to strategically deal with the homophobia forming the basis for both of these problems (Vaid, 1995). As Gross (1991) noted, "The AIDS epidemic fundamentally affected the fate of gay people and dramatically reminded us of the deep-seated homophobia of American culture" (p. 376).

The AIDS epidemic brought about large-scale institutionalization and nationalization of lesbian and gay groups, as well as aggressive pursuit of the mainstream by lesbian and gay activists (Vaid, 1995). The human cost and the rising tide of anti-gay violence stemming from the beginning of the AIDS epidemic fueled the anger of those working to counter the ravages of AIDS. This group of individuals initiated the highly controversial practice of "outing" (Gross, 1991). "Outing," the deliberate revealing of the homosexual orientation or behavior of an individual, began in 1989 with the publication of a column titled "Peek-A-Boo" by Michelangelo Signorile in *OutWeek*, a gay and lesbian magazine. The article listed the names of 66 influential individuals without comment; none was necessary, the individuals were already familiar fixtures of gay gossip. The aim of activists employing the tactic of outing was twofold: to expose the hypocrisy of gay elected officials who

were working against the lesbian and gay movement's efforts to mobilize the government toward addressing the AIDS epidemic and to send a clear message to the public at large that gays and lesbians were everywhere by revealing the sexual identity of influential individuals across a variety of sectors (e.g., Malcolm Forbes, Rock Hudson). Outing of public figures was also an effort to counteract what Gross terms "inning," the practice of including items in magazine and newspaper columns designed to cover up the homosexuality of celebrities or other influential figures. At a time when the cost of the invisibility of gays and lesbians could be measured in human lives lost, Gross stated,

By staying in the closet, successful, prominent homosexuals in all walks of life help perpetuate the invisibility that fuels anti-gay stereotypes...their secrecy reinforces the belief that homosexuality is shameful, and...reduces the possibility of disconfirming this belief by providing positive examples of gay people. (p. 358)

Gross argued it is easy to understand why many activists felt they were at war and that outing was a logical strategy while they fought both the AIDS epidemic and the public responses which reflected and reinforced pervasive homophobia and contributed to a rise in anti-gay violence.

Current issues. During the 1990s, a flurry of activity impacting the lives of lesbians and gays has occurred. Current issues include an

emphasis on coming out which has permeated diverse sectors of the lesbian and gay community, claims by religious groups that they can “cure” homosexuality, and legislative activity at local, state and national levels.

On the heels of the outing controversy of the late 80s and early 90s, lesbians and gays began coming out in large numbers and across all social strata. Greater visibility brought with it benefits, such as more positive portrayals of lesbians and gays in television and film and increased access to role models for young lesbians and gays. However, increased visibility also created a backlash seen in actions taken by religious groups, legislation, and an enormous rise in violent hate crimes (National Coalition of Anti-Violence Programs [NCAVP], 1998).

The “ex-gay” ministry has been in existence since the mid 1970s, and its members claim they are able to “reorient” lesbians and gays into a heterosexual or celibate lifestyle. Haldeman (1994) stated fundamentalist Christian groups, such as Homosexuals Anonymous, Love In Action, and Exodus International, are the most visible purveyors of “conversion therapy” (i.e., systematic efforts to change sexual orientation). Operating under the auspices of the church, the groups fall outside of the jurisdiction of any professional organizations which could impose standards of ethical practice or hold them accountable for their

actions. He continued by noting that while the programs are largely unsuccessful, they also hold enormous symbolic power over many people, especially those who are naïve or experiencing shame regarding their sexual orientation. The promotion of such groups has occurred exclusively within large main-stream media outlets, such as newspapers, and has been characterized as a response to the increasing visibility of lesbians and gays as well as one which encourages the belief among the general public that homosexuality is wholly choiceful and can be changed if an individual so wishes.

Lesbians and gays have also experienced many losses and some gains in the legislative arena. Local anti-gay ordinances, state constitutional amendments, and national legislation have been proposed, and many have passed. Examples include the passage of Amendment 2 in Colorado in 1991 and the Defense of Marriage Act (DOMA), signed by President Clinton in 1996.

Colorado's Amendment 2 denied lesbians and gays basic protection under the law from discrimination in areas such as employment and housing. Further, the amendment overturned all existing local ordinances providing such protections within the state and banned any future ordinances of the kind. While eventually deemed unconstitutional by the Colorado Supreme Court, similar legislation continued to appear

in other municipalities (Curry, Clifford & Leonard, 1994).

DOMA was passed in response to efforts by lesbians and gays to gain access to same-sex marriage licenses. DOMA was designed to prevent gay-marriage advocates from using the U.S. Constitution to force states to recognize same-sex marriage. DOMA defined marriage as the legal union of one man and one woman and specified that no state would be required to recognize same-sex marriages from other states.

These broad social and cultural issues have been presented in order to understand the context within which psychological development of lesbian and gay individuals occurs. Identity development models and research are presented in the next section.

Identity Development

The process of adopting a lesbian identity involves adopting a non-traditional and stigmatized identity (Burns, 1996). Several stage models of homosexual identity development have been proposed (Cass, 1979; Chapman & Brannock, 1987; Coleman, 1982; de Monteflores & Schultz, 1978; Minton & McDonald, 1984; Sophie, 1985), most follow a common pattern.

Stage Models of Lesbian and Gay Sexual Identity Development

Stage models have typically assumed a developmental perspective and included developmental concepts outlined by Erickson (1956). For

example, most of the models have suggested identity is acquired through a developmental process and that each stage must be resolved before subsequent stages can be completed (Cass, 1979; Coleman, 1982; Minton & McDonald, 1984). In addition, most identity models have also assumed a process of interaction occurs between an individual and the social forces within her/his environment and that this interaction greatly influences the identity development process (Cass, 1979; Coleman, 1982; Chapman & Brannock, 1987).

Cass's (1979) model of lesbian and gay identity development incorporates six stages: "identity confusion," in which lesbian or gay thoughts, feelings or behavior present incongruent identity elements; "identity comparison" refers to the realization that the expectations and ideals accompanying a heterosexual identity are largely irrelevant and have not been replaced by other more appropriate expectations; during the "identity tolerance" stage, commitment to a lesbian or gay identity begins to increase and the relevant subculture is sought out; "identity acceptance" is characterized by continued and increasing contacts with the lesbian and/or gay subculture; "identity pride" refers to a period in which there is a dichotomization of the world into heterosexuals and homosexuals with a devaluation of the former; and the final stage, "identity synthesis," in which the personal and public sexual identities

are synthesized into one self-image.

Coleman (1982) proposed a five-stage model of identity development. The model begins with the “pre-coming out” stage in which individuals are not consciously aware of same-gender feelings; this is conceptualized as a defense mechanism which protects the individual from the rejection which would likely result from direct acknowledgement of such feelings. Tasks of the three middle stages include: beginning to come out or acknowledge lesbian or gay feelings and to share them with others; exploring and experimenting with the new sexual identity; and engaging in first relationships which combine emotional and physical attraction. The final stage is “integration,” in which an individual incorporates her/his public and private identities into one self-image.

One critique of early sexual identity models was that most were developed using male subjects and from a male-oriented paradigm (Burris, 1996). In 1985, Sophie created a four-stage model of identity development specific to lesbians. In her conceptualization, the development of a lesbian identity begins with an awareness of same gender feelings. A period of exploration ensues prior to the acceptance of a lesbian identity. The identity is then accepted and integrated in a process similar to other theories.

More recently, Chapman and Brannock (1987) proposed a five-

stage model of identity development specific to lesbians. Their model suggested that while the formation of a lesbian identity is highly variable, a lesbian orientation is present prior to the recognition of the incongruence between one's feelings and those of non-lesbians. The authors maintained the process of self-identification as lesbian and lifestyle commitment occurs through interaction with the non-lesbian environment. They argued that interactions with non-lesbians brings about a growing awareness of the "differences" between one's feelings/orientation and that of the non-homosexual environment and that self-labeling as lesbian occurs as a mean to achieve cognitive congruency.

In her review of the identity formation literature, Burns (1996) stated theorists see identity formation as a continual developmental process resulting in an integrated, positive and stable sense of self. Each of the models assumed adopting a lesbian or gay identity included making a self-identification, assigning meaning to that identification, and then sharing that identity with other members of the lesbian and gay community as well as with members of the general community (Brown, 1995). While Brown acknowledged stage models are limited by an inherent assumption that the sexual identity development process has one outcome, she also noted the strength of such models is their power

to explain and describe how the process of sexual identity development involves a constant interchange between internal reality and the external cultural context. Finally, Burris (1996) noted that while current models of identity development are not perfect, they do provide a useful means for examining the challenges lesbians face as they attempt to develop positive identities.

Stage Models of Ethnic Minority Identity Development and Dual Minority Identity Development

As with lesbians, members of ethnic minorities also face the challenge of integrating a positive identity for themselves in the midst of a largely devaluing culture. However, ethnic identity formation differs in some important ways. For example, as Burris (1996) wrote:

Members of an ethnic minority are raised in a family which is also a part of that ethnic group. They learn what it is to be a member of that minority. They are not forced to leave the family because they are members of that minority group. (p. 72-73)

An individual in an ethnic minority group, while no doubt exposed to negative messages regarding their ethnicity, also has the family group and larger minority culture to which they belong to serve as a buffer and assist them in integrating positive messages regarding their ethnic identity. However, the ethnic minority lesbian exists as a triple-minority

and therefore faces the burden of integrating a positive identity within the multiple levels of oppression and discrimination accompanying such status. As Greene (1994) noted, "They bear the additional task of integrating two major aspects of their identity when both are consciously devalued" (p. 248). She continued by noting ethnic minority lesbians internalize the same negative stereotypes about a lesbian or gay orientation as non-ethnic minority individuals do.

Morales (as cited in Morales, 1990) proposed an identity formation model that incorporated the dual minority status of lesbians. Morales' model incorporated five different states, each accompanied by decreasing anxiety as an individual learns to manage differences and the associated tension. The first state, "Denial of Conflicts," is characterized by minimization of the reality of discrimination experienced as an ethnic minority and the belief that sexual identity has limited consequences for one's life. In the second state, "Bisexual versus Lesbian/Gay," a preference for labeling oneself as bisexual rather than lesbian/gay is often accompanied by hopelessness and depression. State three, "Conflicts in Allegiances," is characterized by anxiety surrounding the need for the ethnic identity and sexual identity to remain separate so as to avoid betrayal of either. In state four, "Establishing Priorities in Allegiance," a primary identification with the ethnic identity prevails and

feelings of anger are often directed toward the lesbian/gay community based on rejection experienced there. In state five, "Integrating the Various Communities," the development of a multi-cultural perspective helps to ease the anxiety and sense of isolation experienced during the development of a lesbian or gay identity.

Morales (1990) asserted ethnic minority lesbians face additional challenges during the sexual identity formation process. For minority lesbians, coming-out often includes struggling with community loyalties. Morales noted that minority lesbians need to live in three rigidly defined and strongly independent communities: the lesbian and gay community, the ethnic community, and society at large. While each community meets basic needs, attempts to openly integrate and merge the different communities result in serious consequences. Conversely, maintaining oneself in three different worlds, each lacking support for a major aspect of an individual's identity, has the potential to inhibit one's ability to maximize her/his potential.

As both majority and minority group lesbians negotiate the various stages of sexual identity development, confrontations with societal and internalized homophobia invariably ensue. It is to these aspects of lesbian experience that we now turn.

Impact of Homophobia

In 1972, George Weinberg coined the term “homophobia” to refer to an irrational fear, hatred, and intolerance of gays and lesbians.

Homophobia is understood today to represent negative attitudes and assumptions about gays and lesbians (Sophie, 1987). Internalized homophobia represents the integration and acceptance of such negative attitudes within the identity of a lesbian or gay individual.

Experiences with homophobia at cultural, institutional and interpersonal levels form a significant aspect of the reciprocal interaction between the internal processes of an individual and the external environmental influences during the identity development process. In order to more clearly understand the impact of internalized homophobia on lesbians, it is necessary to examine the process by which internalized homophobia is maintained and strengthened by other manifestations of homophobia.

Cultural homophobia. Cultural homophobia is manifested primarily in social norms and practices that serve to legitimize the discrimination and oppression of lesbians. Cleff (1994) stated the primary tools for the creation and strengthening of cultural homophobia are maintaining a conspiracy of silence about lesbians and denying the existence of the lesbian and gay culture. Pharr (1988) stated lesbians are

defined in relation to the norm of heterosexuality, are viewed as falling outside that norm, and are therefore found lacking. They become the “other” and are seen as abnormal, inferior and deviant. She continued by noting:

The Other’s existence, everyday life, [and] achievements are kept unknown through invisibility. When we do not see the differently abled, the aged, gay men and lesbians, people of color on television, in movies...there is reinforcement of the idea that the Norm is the majority and others either do not exist or do not count.
(p. 58)

Ignoring or denying the contributions of lesbians, refusals to acknowledge their numerical strength, and keeping lesbians isolated from one another by denying them safe and visible meeting places are forms of oppression which contribute to internalized homophobia (Blumenfeld, 1992; Cleff, 1994).

Cultural homophobia is also manifested in stereotyping. Through stereotyping, lesbians are dehumanized and denied their individual characteristics and behaviors (Pharr, 1988). The pervasive presence of negative stereotypes in cultural norms and practices creates an atmosphere in which even before discovering one’s lesbian feelings or identity these messages have been readily internalized, complicating

attempts at integrating a stable and positive identity. In addition, as with other groups, stereotyping reinforces oppression by justifying discriminatory actions taken based on distortions or lack of knowledge and then placing the burden of blame on the oppressed.

Institutional homophobia. The previous discussions regarding religious ideology, political influences and cultural atmosphere provided many examples of homophobia as it occurs in institutions. What these institutions share is an effort to deny lesbians general group membership and its associated benefits, including recognition and protection. For example, no codified rites or rituals exist in mainstream religions which validate lesbian couples and DOMA ensures states can exercise the right to prevent lesbians from receiving civil recognition of their relationships (Cabaj, 1988a; Cleff, 1994). Brown (1988) observed this provides little to no support for a lesbian relationship and deprives lesbians of legal protections and social support. By not being allowed to marry, lesbian couples are denied many legal rights which come with marriage including: survivor's benefits; entrance into hospitals and other places restricted to "immediate family;" the power to make medical decisions in the event a partner is injured or incapacitated; automatic inheritance rights following the death of a partner; child-custody; family health coverage; tax benefits; and the ability to gain resident status for a non-

citizen spouse to avoid deportation. As a result, many lesbians feel unsafe revealing their sexual orientation to those whom are entrusted with their care, including physicians, attorneys and mental health practitioners (Cleff, 1994). Further, by remaining invisible, many lesbians unwittingly contribute to the maintenance of internal and external homophobia.

Interpersonal homophobia. In addition to the cultural and institutional manifestations of homophobia, lesbians must contend with homophobia in their interactions with individuals within their daily context. From those closest to them, such as family members, to strangers on the street or in the grocery store, interpersonal interactions often include homophobic responses. In addition, a significant interaction between identity development and interpersonal homophobia occurs in the repeated and often agonizing choices a lesbian must make regarding whether to come out or to pass (conceal a lesbian sexual orientation).

Passing can be motivated by either the accurate perception of a situation as potentially dangerous or by internalized homophobia (Margolies, Becker, & Jackson-Brewer, 1987). Passing provides protection from various forms of discrimination, but such protection is expensive. Passing involves the burden of managing a double identity:

the public self and the private self (Loewenstein, 1980). Managing dual identities creates the risk of losing sight of the differences between them, as well as an ongoing knowledge that acceptance is based on a lie (Margolies et al., 1987). Deceptive interactions are necessary to maintain this facade and the passing lesbian typically lives with some fear of discovery. If one lives with a constant fear of discovery, it stands to reason then that anxiety is the constant backdrop accompanying this fear.

Coming out presents different difficulties for lesbians. As Gross (1991) stated, "coming out entails sacrifice and danger; it often means facing hostility, rejection, and even violence from family, friends, and total strangers" (p.374). Coming out is rarely accomplished in a single step. More often, it is a gradual, even life-long process of careful evaluation and decisions regarding when, to whom and how to disclose a lesbian orientation.

One reason why coming out is so difficult is because it often opens the door to interpersonal homophobia, which then serves to reinforce internalized homophobia. Responses of family, friends, and others often involve attempts to quiet the individual who has decided to come out. As Gross (1991) explained, lesbians beginning the coming out process often find themselves held back at the threshold by others. He provided an

excellent description of typical reactions many lesbians and gays encounter, as well as the implication of such responses:

"I'm glad you told me and...it won't make any difference in the way I feel about you," many a lesbian...has been told by a parent, "but let's not tell your father (or mother, or grandparents), it would kill him (or her, or them)." Or, "I suppose it's better that you've told us, but please don't tell anyone else, or I don't know how we'll be able to handle the neighbors." All of these responses, of course, only reinforce the presumption that homosexuality is a dirty little secret. (p.374)

The message that parental love is negotiable has been noted to be one of the most potent reinforcers of internalized homophobia (Cleff, 1994). For most lesbians, the chances of an immediate positive parental response is minimal (Coleman, 1982). Temporary or permanent estrangement after disclosure is not uncommon and family members almost invariably must contend with their own grief process following disclosure. Parents typically grieve the loss of the image of their child as married and having children (Coleman, 1982). At the same time families must also face the challenge of confronting their own internalized negative stereotypes which have been applied to their loved one following disclosure (Scrivner & Eldridge, 1995).

In order to maintain connection with her family, a lesbian may engage in internally homophobic behaviors, such as denying the significance of relationships or excluding a partner from family events (Brown, 1988; Pearlman, 1989). The lesbian who actively hides her involvement with a lover faces the mounting anxiety and fear associated with the (often correctly) perceived consequences of being discovered (Lewis, 1984). Whether or not a lesbian decides to disclose her sexual identity to parents and family members, she must contend with the anxiety and fear accompanying either decision on an ongoing basis.

The increasing visibility of lesbians (and gays) has created an unprecedented rise in the number of hate crimes committed against them. The National Coalition of Anti-Violence Programs (NCAVP) monitors anti-gay violence across the country. The 1998 NCAVP report indicated anti-gay attacks have become more frequent and more violent. While instances of verbal harassment and intimidation declined, inpatient hospitalization of victims rose 103% and the use of weapons increased 25% (including a 71% increase in the use of firearms and a 150% increase in the use of motor vehicles). In addition, the number of actual or suspected anti-gay murders rose by 136%, from 14 in 1997 to 33 in 1998. One other statistic of note includes a 103% increase in the number of incidents occurring at or near lesbian and gay community

public events. Anti-gay incidents are another powerful reinforcer of internalized homophobia. As Herek and Berrill (1992) noted:

Every such incident carries a message to the victim and the entire community....Each anti-gay attack is, in effect, punishment for stepping outside culturally accepted norms and a warning to all gay and lesbian people to stay in "their place," the invisibility and self-hatred of the closet. (p. 3)

Survivors of and those witness to harassment and other anti-gay violence must often cope with negative feelings regarding their sexual identity resulting from its link with the sense of vulnerability and powerlessness that accompanies an attack.

Internalized Homophobia

Shidlo (1994) defined internalized homophobia as a set of negative attitudes and feelings associated with lesbian features within oneself, including same-gender sexual and affectional feelings or behavior and self-labeling as lesbian. Kahn (1991) maintained most theories of identity formation in gays and lesbians are based on the assumption that internalized homophobia and reactions to societal homophobia must be resolved for adequate integration and functioning to occur. She continued by noting such resolution requires cognitive restructuring of the meanings attached to one's lesbianism. Through this process, a

lesbian identity can begin to take on more positive meaning. This is a difficult and lengthy process as Hodges and Hutter (1977) observed, due to the fact that "We learn to loathe homosexuality before it becomes necessary to acknowledge our own" (p. 6). Gross (1991) pointed out lesbians and gays join their (homosexual) subculture much later in life than do those who are members of a racial or ethnic community and that this subcultural joining is accomplished secretly (at least in the beginning).

Internalized homophobia is expressed in a number of ways, both overt and covert. Margolies et al. (1987) stated that while expressions such as "I hate myself for being lesbian" are quite obvious, more subtle expressions of internalized homophobia include: fear of discovery; discomfort with those who are obviously lesbian or gay; rejection or denigration of heterosexuals; feeling superior to heterosexuals; the belief that lesbians are no different from heterosexual women; uneasiness with the idea of children being raised in a lesbian home; restricting attractions to unavailable women, heterosexuals, or those already partnered; and a history of short-term relationships.

For women in whom the awareness of a lesbian identity occurs at a later age, addressing one's internalized homophobia may be particularly difficult. For women coming out later in life, generational values may

make the process of recognizing lesbian interests particularly painful (Falco, 1991). In addition, women who begin the coming out process later in life are more likely to have been in a heterosexual marriage previously and to have grown children. These women must therefore contend with the additional challenges presented by this situation. Each of these issues may also make it more difficult for an older woman to publicly acknowledge her lesbianism. Older lesbians have been noted to be reluctant to be open about their sexual orientation with caregivers and to mistrust both caregiving and legal systems (Tully, 1989). They might also experience fear of disclosure based on concern that their children may be adversely affected or as a result of an internalized generational value which discourages open discussions of sexuality, particularly homosexuality.

Religiosity has been found to be an important predictor of negative responses toward lesbians and gays by heterosexuals (Herek, 1994). The same appears to be true for lesbians as well. Martin and Hetrick (1988) stated that the guilt and isolation of lesbians and gays are strengthened through the internalization of traditional religious views. Cimini (1992) found religiosity to be a significant predictor of internalized homophobia for lesbians. Internalized homophobia related to religious and moral concerns has also been found to be significantly higher for lesbians

under 30 (Frock, 1997).

There may be significant differences in the experience of internalized homophobia related to whether one resides in an urban or a rural area. However, research regarding gays and lesbians has focused almost exclusively on those residing in urban areas. One exception was research conducted by Cody and Welch (1997), who studied the life experiences and coping styles of gay men in a rural setting. Their qualitative study found that internalized homophobia was a significant theme in the lives of their participants. They theorized that the more restrictive, traditional attitudes regarding gender roles characteristic of many rural areas contributed to the difficulties in sexual identity development and high rates of internalized homophobia encountered in their sample. This conclusion was supported by Herek (1994) who noted that people with negative attitudes regarding homosexuality are more likely to hold traditional gender role expectations.

Given the widespread negative perception of homosexuality in our society, the internalization of homophobia and absorption of negative attitudes toward lesbianism is viewed as a normative process (Burns, 1996; Forstein, 1988; Gonsiorek, 1988; Loulan, 1984; Maylon, 1985; Pharr 1988; Sophie, 1987). The internalization of such homonegativity can result in layers of shame which, left unacknowledged and

unaddressed, can be a source of great psychological distress.

Clinical Issues

Internalized homophobia appears to have a significant negative impact on the mental health of lesbians. While the initial research regarding internalized homophobia focused on gay men, recent literature has begun to address the clinical significance of internalized homophobia for the mental health of lesbians (Cabaj, 1988b). Researchers hold internalized homophobia to be a major source of psychological distress and a central construct in the symptomatology and treatment of gay men and lesbians (Ross & Rosser, 1996; Sophie, 1987; Wagner, Serafini, Rabkin, Remien, & Williams, 1994).

Lesbians are faced with many of the same intra- and interpersonal concerns that non-lesbians experience, but they must also contend with issues uniquely related to living in a heterosexist and homophobic culture (Browning, Reynolds & Dworkin, 1991). In addition to the impact of internalized homophobia on identity development and coming out, internalized homophobia has been associated with many of the concerns that lesbians present with in mental health settings, including: self-esteem; relationship issues; chemical dependency; and negative affective states.

Self-Esteem

The loss of self-esteem is one of the most frequently mentioned effects of internalized homophobia in the theoretical literature (Cimini, 1992; Falco, 1995; Gonsiorek, 1988; Maylon, 1985). Sophie (1982) noted that as long as one holds a belief in the negative stereotype of lesbians, self-labeling as lesbian will entail a loss in self-esteem. While members of other stigmatized groups may also experience adverse effects on their self-esteem, unlike other groups, the important mediating factor of early and continuing contact with like others mentioned previously is missing for lesbians.

Results of empirical studies have also suggested a connection between internalized homophobia and self-esteem. Crocker and Major (1989) found that for those who experience stigma, self-blame results in lower self-esteem than for those who blame society. Alexander (1986) found a negative correlation between internalized homophobia and self-esteem in gay men. Walters and Simomi (1993) found attitudes regarding a lesbian or gay identity correlated with self-esteem after controlling for the effects of gender, age and education. They also noted that negative attitudes not only affect self-esteem but may also impact psychological functioning.

Relationship Issues

Lesbians are as likely as their heterosexual counterparts to be involved in committed relationships (Oberstone & Sukonek, 1976). However, their relationships receive much less social support and validation creating additional stresses and often reinforcing internalized homophobia. Societal censure and an ongoing negation and lack of affirmation are sources of major disruption in lesbian relationships (Pearlman, 1989). Falco (1995) noted the psychological suffering resulting from a lack of social support for one's relationship is profound and has the potential to keep couples in isolation or bring about the dissolution of the relationship. As Riddle and Sang (1978) asserted, "Relational problems may develop simply because a lesbian couple has no place to socialize where their relationship is acknowledged and affirmed" (p. 89). Isolation stemming from internalized homophobia or life in rural areas also serves to deprive many couples of the support for their relationship available in the lesbian community (Tanner, 1978). In addition, familial demands for secrecy may bring about the exclusion of partners from family events or the need to maintain a pretense of friendship during family visits (Sophie, 1982). These factors serve to complicate many of the issues typically faced by couples, such as differences in race, religion or culture, political and class differences, and

conflicts over money or family.

Chemical Dependency

Researchers have noted the pressures associated with social stigma combined with lesbian and gay community centralization around bars have resulted in high rates of alcohol abuse (Anderson & Henderson, 1985; D'Emilio, 1983). Struggles with internalized homophobia and identity issues can lead to increased alcohol consumption among lesbians in order to aid in coming out or in maintaining a concealed identity. Low-self esteem and the resulting anxiety, depression, and feelings of powerlessness have been frequently cited as contributing factors in the development of alcohol problems among lesbians (Anderson & Henderson, 1985; Diamond & Wilsnack, 1978; McKirnan & Peterson, 1989). Bicklehaupt (1990) identified alcoholism as the number one health issue for gay men and lesbians and stated alcoholism affects both gays and lesbians at a rate much higher than in the heterosexual population.

Researchers studying the lesbian community have placed the percentage of lesbian alcohol abusers or alcoholics between 27% and 35% (Finnegan & McNally, 1987). However, data from two large-scale studies conflict with the earlier research. The National Lesbian Health Care Survey (Bradford & Ryan, 1987) found similar drinking patterns

among matched heterosexual and lesbian women, with the exception of a higher rate of alcoholism among older lesbians (45 and older). In addition, a self-report survey by Bloomfield (1993) found no differences by sexual orientation in numbers of abstainers, light drinkers, or heavy drinkers. Bloomfield found only the category labeled "recovering alcoholic" to be associated with significant differences between lesbian, bisexual, and straight women. Thirteen percent of lesbians and bisexuals identified themselves as recovering alcoholics as compared to 3% of heterosexual women. Eliason (1996) stated that while critiques of previous studies often focus on their non-representative samples, Bloomfield's study is methodologically sound based on the large random sample used. Eliason suggested increases in lesbians' alternatives to bar socializing, along with increased awareness of alcohol problems in the lesbian and gay community in general, may be contributing to a trend reflecting higher numbers of lesbians in recovery and lower rates of self-reported drinking among younger lesbians.

In a study that examined the association of internalized homophobia with alcohol abuse in lesbians, ethnic minority participants were found to have higher rates of alcohol dependence than non-minority participants (Frock, 1997). This finding may be related to the additional stresses inherent in triple-minority group membership and suggests

attention should be paid to the implications of triple-minority membership in studies with lesbians.

While the Bradford and Ryan (1987) and Bloomfield (1993) studies were encouraging signs for the lesbian community, the literature base still reflects large numbers of researchers and clinicians who hold substance abuse problems to be more prevalent and more severe for lesbians and gays than for the heterosexual population (Hall, 1992; McKirnan & Peterson, 1989; McNally, 1989; Nicoloff & Stiglitz, 1987; Schilit, Clark, & Shallenberger, 1988; Stevens & Hall, 1988; Weathers, 1980).

Negative Affective States

Internalized homophobia has been cited as a significant contributor to depression and anxiety among both adolescent and adult lesbians and gay men (Cimini, 1992). Glaus (1988) maintained internalized homophobia is tied closely to negative affective states. Herbert, Hunt, and Dell (1994) reported the internalization of negative societal attitudes regarding homosexuality often results in low self-esteem, depression and anxiety among lesbians. In addition, Malyon (1985) argued that internalized homophobia is major variable in the development of certain symptomatic conditions among homosexuals. He theorized internalized homophobia causes depression and influences

identity formation, self-esteem and psychological integrity.

Like other minority groups, lesbians and gays must contend with pervasive negative societal attitudes and stigma. Meyer (1995) examined the effects of a stigmatizing environment within a stress framework and describes minority stress as “psychosocial stress derived from minority status” (p. 38). He contended that lesbians and gays (like members of other minority groups) are subjected to chronic stress related to their stigmatization. Long ago, Allport (1954) held that targets of prejudice may develop vigilance as a defensive coping strategy. Meyer noted that a high level of perceived stigma leads to a sustained and high level of vigilance with regard to interactions with dominant group members. High levels of perceived stigma have the potential to create chronic stress in the lives of lesbians and gays as they feel compelled to remain on guard against potential harm. Meyer’s 1995 study of the interaction of minority stress and mental health in gay men found that expectations of stigma, actual incidences of prejudice, and internalized homophobia predicted psychological distress in gay men.

Internalized homophobia has also been noted as a contributing factor in suicide attempts, particularly among adolescents. Remafeldi (1987) reported that 34% of a non-clinical sample of gay-identified adolescents had attempted suicide. This finding was supported by Savin-

Williams (1989) who reported lesbian and gay youths are two to three times more likely to commit suicide than heterosexual youths, and that 30% of all adolescent suicides are committed by lesbians and gays.

The mental health of lesbians was studied in the National Lesbian Health Care Survey, the most comprehensive study on the mental health of lesbians to date (Bradford & Ryan, 1987). Of the 1,925 lesbians participating, 35% indicated they had experienced a long period of depression or sadness. Current depression was reported by 11% of the sample and 11% reported they were currently receiving treatment for depression. Similar percentages were reported for anxiety, with slightly higher percentages noted by Latina respondents. In addition, 35% of the sample indicated they had rare thoughts of suicide and 19% reported such thoughts occasionally. Eighteen percent of the sample had attempted suicide at some point; African-American and Latina women reported more suicide attempts than White women (27%, 28% and 16%, respectively).

This literature review has shown a number of clear links between internalized stigma and psychological distress for lesbians. However, the relationship between the specific variable of internalized homophobia and psychological distress in lesbians has not been assessed empirically. This has been due in part to a lack of a measure designed to assess

internalized homophobia in lesbians. The following section examines the development of measures of internalized homophobia.

Measurement of Internalized Homophobia

In his 1994 analysis of conceptual and empirical issues in the measurement of internalized homophobia, Shidlo stated that when one uses the criteria of adequate face and content validity, most of the research in the area of internalized homophobia has not been very satisfactory. He noted the construct has typically been assessed using a single item or small pools of items with limited content validity and without a clearly theoretically driven basis for item selection. In addition, almost all of the research has focused on gay men to the exclusion of lesbians.

Shidlo (1994) reviewed the face and content validity of existing scales including: items created for an early empirical study by Weinberg and Williams (1975); the Internalized Homophobia Scale (IHP; Martin & Dean, 1987); the Nungesser Homosexuality Attitudes Inventory (NHAI; Nungesser, 1983); and the Internalized Homophobia Inventory (IHI; Alexander, 1986). Three additional scales, the Attitudes Toward Lesbians and Gay Men (ATLG; Herek, 1994), the Internalized Homophobia Scale (IHS; Ross & Rosser, 1996), and the Internalized Homophobia Scale for Lesbians (IHSL; Szymanski & Chung, 1998) have been created since

Shidlo's review. Each of these instruments will be reviewed briefly.

For their 1975 study, Weinberg and Williams created four sets of one and two item scales: (1) anxiety regarding homosexuality; (2) homosexual commitment; (3) conception of homosexuality as an illness; and (4) conception of choice over homosexuality. Shidlo (1994) reported that while the first three items or scales fall within the concept of internalized homophobia, the fourth item may or may not reflect a negative attitude toward homosexuality; whether one regards homosexuality as a choice or as genetically determined is not necessarily correlated with internalized homophobia.

The IHP (Martin & Dean, 1987) is a nine-item scale developed for gay men and was based on DSM-III (American Psychiatric Association, 1980) criteria for ego-dystonic homosexuality. Item content focused on the desire to avoid homosexual behavior and relationships and to engage in heterosexual behavior and feelings. Shidlo (1994) reports that the IHP had limited content validity. Because its items tap into the more extreme internalized homophobia associated with a desire to change one's orientation, the scale is vulnerable to underestimating moderate and/or subtle manifestations of internalized homophobia.

Nungesser's (1983) NHA1 consisted of 34 items and three subscales. Nungesser conceptualized internalized homophobia as

composed of three factors: (1) attitudes toward one's own homosexuality (Self); (2) attitudes toward homosexuality in general and toward other gay persons (Other); and (3) reaction toward others knowing about one's homosexuality (Disclosure). The NHAH represented a qualitative advance in the empirical study of internalized homophobia in gay men because its items tapped into both moderate and more extreme homophobic content (Shidlo, 1994). In addition, its tripartite system was the first to provide a differentiation between global attitudes toward homosexuality and attitudes toward one's own homosexuality. In other words, the NHAH was the first scale that could distinguish between gay individuals who might hold positive global attitudes toward homosexuality but negative attitudes toward their own homosexuality.

Herek (1994) developed the ATLG to assess attitudes individuals hold toward lesbians and gay men. The 20-item scale measures general tolerance or disapproval of lesbians and gay men and consists of two subscales; one measuring attitudes towards lesbians and one measuring attitudes towards gay men. In addition to being used with its original intent of assessing heterosexual's attitudes toward gay men and lesbians (Herek, 1994), the scale has also been used to assess internalized homophobia in lesbians and gay men (Lease, Cogdal, & Smith, 1995). Szymanski and Chung (1998) noted empirical data support the validity of

the ATLG in assessing heterosexual attitudes toward lesbians and gay men. However, they also suggested the instrument has limited content validity as a measure of internalized homophobia because it may underestimate the more subtle forms of internalized homophobia as expressed in gay men and lesbians.

Ross and Rosser (1996) stated that they developed the IHS as a response to the lack of a scale based on both the theoretical and clinical components of internalized homophobia in gay men. They developed the IHS by means of a factor analytic study. The scale contained 26 items derived from the clinical and theoretical literature regarding internalized homophobia. The scale included four subscales: (1) public identification as gay; (2) perception of stigma associated with being gay; (3) social comfort with gay men; and (4) moral and religious acceptability of being gay. Ross and Rosser (1996) stated that the four factors of the IHS exhibit significant concurrent validity when compared with criterion measures, with the most consistent responses coming from measures of concern with public identification as gay and comfort in gay social settings. They stated that because the variables selected for concurrent validity measurement were all outcomes of internalized homophobia identified clinically or theoretically, consistency with the IHS factors provides additional evidence the scale does in fact measure the construct

of internalized homophobia. Finally, Ross and Rosser suggested internalized homophobia is a measurable clinical construct and psychometrically displays both internal reliability and concurrent validity.

Szymanski and Chung (1998), however, identified several IHS (Ross & Rosser, 1996) items as problematic and stated they threaten the face validity of the measure. Szymanski and Chung identified a number of potential confounds. For example, they stated, "I prefer to have anonymous sexual partners" confounds internalized homophobia with intimacy difficulties; and "Discrimination against gay people is still common" confounds internalized homophobia with realistic perceptions of obstacles faced by lesbians and gays living in a homophobic society. The authors also noted the number of items in three of the subscales is low.

As of 1996, there were no published scales designed to specifically assess internalized homophobia in lesbians. All published scales focused on gay men, to the exclusion of lesbians (Shidlo, 1994; Szymanski & Chung, 1998). Szymanski and Chung noted most of the scales included items slanted toward gay male culture. The IHS (Ross & Rosser, 1996) item stating "I prefer to have anonymous sexual partners" is an example of this. Szymanski and Chung stated that from a theoretical and

practical standpoint, it is important to examine internalized homophobia not only together with, but also separate from gay men, as differences between gay men and lesbians impact identity formation in gays and lesbians.

In an effort to address these concerns, Szymanski and Chung (1998) developed the Internalized Homophobia Scale for Lesbians (IHSL). As the chosen instrument for the present study, the IHSL and its development will be presented in detail in the Methods section of this proposal. Having reviewed the literature and measurement issues pertinent to internalized homophobia in lesbians, the rationale and major research questions of the current study are presented.

Rationale and Research Questions

Rationale

With the exception of studies regarding alcohol abuse, empirical research on the mental health of lesbians is limited (Bradford, Ryan & Rothblum, 1994). The existing literature is primarily theoretical and clinical, including the writings regarding the impact of internalized homophobia on the mental health of lesbians. In 1987 Margolies et al. noted empirical studies on the effects of internalized homophobia had yet to be conducted, while also asserting it was safe to assume the burden of living in a hostile environment would produce discernible psychological

effects on lesbians.

In their review of the literature, Buhrke, Ben-Ezra, Hurley and Ruprecht (1992) found that over a 12-year period (1978-1989), only 26 (.39%) of 6,640 articles published in six major journals (Journal of Counseling Psychology, The Counseling Psychologist, Journal of Consulting and Clinical Psychology, Journal of Counseling and Development, Journal of Vocational Behavior, and Journal of College Student Development) were specifically related to lesbians or gay men. They stated, "Clearly at this rate research on issues concerning lesbian women...is underrepresented in counseling literature" (p. 94). They continued by noting research on lesbian and gay male issues represents less than 1% of each year's counseling publications, although lesbians and gay men represent 10% of the population by most estimates (Kinsey, Pomoroy, & Martin, 1948).

In addition to the relative scarcity of research articles published regarding lesbians and gays, the literature regarding lesbians and gays appears to focus on a relatively narrow range of issues. Rothblum (1994) stated the past 20 years have seen an increase in research focusing on issues such as coming out, relationships, chemical dependency and parenting. However, there has been comparatively little research on the mental health of lesbians and gay men, and Rothblum hypothesized

researchers have been reluctant to focus on the mental health problems of an already stigmatized population. She stressed the importance of studying the processes related to mental health that are unique to lesbians and gay men. The present study is an attempt to do so, specifically by examining internalized homophobia as it relates to psychological distress in lesbians.

Research Hypotheses

Based on the preceding review of the literature, the following hypotheses are offered for study:

1. General internalized homophobia will be positively correlated with current level of psychological distress.
2. General internalized homophobia will be positively correlated with depression.
3. Internalized homophobia related to religious and moral attitudes toward lesbianism will be positively correlated with depression.
4. Internalized homophobia related to public identification as lesbian will be positively correlated with generalized anxiety.
5. Lesbians aged 18-29 will exhibit greater levels of internalized homophobia related to religious and moral attitudes than either those of the other two age groups (30-39; 40+).
6. Lesbians aged 30-39 will exhibit less generalized internalized

homophobia than either of the other two age groups (18-29; 40+).

7. Lesbians 40 and older will exhibit more internalized homophobia related to public identification as lesbian than either of the other two age groups (18-29; 30-39).

8. An undetermined set of variables will predict psychological distress using the SCL-90-R Global Severity Index scores as the DV and the IHSL subscale scores, total score, and demographic variables as potential IV's.

CHAPTER III

Method

Participants

The sample was recruited primarily through word-of-mouth and snowball referral. Snowball sampling refers to a process in which individuals are recruited primarily through word-of-mouth in friendship, vocational and other networks, creating a chain of participants. Silber (1991) noted if one has connections, snowball sampling is a fairly effective method for locating individuals who might otherwise remain hidden. In addition, Loftin (1981) maintained access to hidden populations is often more dependent on an individual's place within the community as opposed to professional credentials. Having been a member of the lesbian community of each city at some point in my life, I was able to gain access to various networks of individuals I would not have been able to otherwise. On those occasions when unknown participants were recruited in person (e.g. large gatherings), I introduced myself as a lesbian doctoral student in counseling psychology who was conducting a study on the effects of the internalization of societal homophobia on the lives of lesbians.

Inclusion criteria required participants self-identified as lesbian and were at least 18 years of age. Participants were divided into three age groups (18-29, 30-39, 40+) and each group included a minimum of 60 participants. Through consultation with the department statistician, 60 participants per age group was determined to be a greater than sufficient number for the Pearson correlation, ANOVA and ANCOVA analyses included in the data analysis (B. Hamilton, personal communication, July 28, 1999). The mean age of participants was 36.19 years, (SD = 11.36). For a full description of all demographic variables, see Table 1.

Table 1

Demographic Variables: Means, Standard Deviations and Frequencies

	Age Group 1 (<u>n</u> = 63)		Age Group 2 (<u>n</u> = 66)		Age Group 3 (<u>n</u> = 71)		Total Sample (<u>N</u> = 66)	
	<u>Mean</u>	<u>SD</u>	<u>Mean</u>	<u>SD</u>	<u>Mean</u>	<u>SD</u>	<u>Mean</u>	<u>SD</u>
<u>Age</u>	23.60	3.65	34.78	2.90	48.67	6.68	36.19	11.36
<u>Education</u>	14.44	2.52	16.06	2.53	16.67	2.80	15.77	2.78
<u>Income</u>	28.66	27.26	48.90	28.43	57.07	72.10	45.74	49.73
	<u>Frequency</u>		<u>Frequency</u>		<u>Frequency</u>		<u>Frequency</u>	
<u>City</u>								
1. Dallas	49		41		53		143	
2. Austin	12		23		15		50	
3. San Angelo	2		2		3		7	

	Age Group 1 (<u>n</u> = 63)	Age Group 2 (<u>n</u> = 66)	Age Group 3 (<u>n</u> = 71)	Total Sample (<u>N</u> = 66)
	<u>Frequency</u>	<u>Frequency</u>	<u>Frequency</u>	<u>Frequency</u>
<u>Ethnicity</u>				
1. Caucasian	44	51	63	153
2. Af-Amer.	6	4	3	13
3. Hispanic	10	6	4	20
4. As-Amer.	1	1	0	2
5. Other/Mult.	2	4	1	7
<u>Religion</u>				
1. Catholic	15	9	11	35
2. Protestant	11	17	22	50
3. MCC	1	4	9	14
4. Jewish	2	2	3	7
5. Other	11	13	9	33
6. None	23	21	17	61
<u>Therapy</u>				
1. Yes	23	26	29	78
2. No	40	40	42	122
<u>Medication</u>				
1. Yes	13	15	24	52
2. No	50	51	47	148

Note. SD = Standard Deviation; Af-Amer. = African-American; As-Amer. = Asian-American; Other/Multi = Multi-ethnic; MCC = Metropolitan Community Church; Age in years; Education in years; Income in thousands of dollars.

Age, income and educational variables appear to reflect typical or expected sequences in American society (e.g. older persons have higher incomes and/or education than younger persons). Notable aspects of the demographics of this sample include the fact that it is largely Caucasian (78%), metropolitan (97%) and middle-class (average income \$45,740). Also of interest is that 39% of participants reported being in some form of therapy, with a smaller number (26%) taking some form of psychotropic medication.

Instruments

The assessment packet distributed to participants consisted of an informed consent letter (see Appendix A), a demographic data sheet, two questionnaires and a stamped, addressed return envelope. The informed consent letter explained the purpose, procedures, risks, and benefits of the study. The questionnaires were related to internalized homophobia and psychological distress symptomatology. The contents of the packets were placed in the following order: informed consent letter; demographic data sheet; internalized homophobia questionnaire; psychological

distress questionnaire; and the return envelope. Each return envelope was color-coded with a small dot on the return address label to indicate in which city the packet had been distributed.

Demographic Data Sheet

All participants were asked to complete a demographic data sheet regarding the following information: sexual identity; age; religious affiliation; ethnicity; socioeconomic status (years of education and annual income); and a brief history of individual or other therapy (e.g., inpatient, outpatient; individual, couples, group) (see Appendix B).

Symptom Checklist 90-Revised

The Symptom Checklist 90-Revised (SCL-90-R; see Appendix C) is a self-report inventory designed to reflect the psychological symptom patterns of respondents (Derogatis, 1994). The SCL-90-R provides a current, point-in-time measure of psychological symptom status and consists of 90 items rated on a five-point scale of distress (0-4) ranging from "Not at all" to "Extremely." The measure is designed to assess nine primary symptom dimensions and three global indices of distress. The primary symptom dimensions are as follows: Somatization (SOM); Obsessive-Compulsive (O-C); Interpersonal Sensitivity (I-S); Depression (DEP); Anxiety (ANX); Hostility (HOS); Phobic Anxiety (PHOB); Paranoid Ideation (PAR); and Psychoticism (PSY). The following global indices are

also measured: Global Severity Index (GSI); Positive Symptom Distress Index (PSDI); and Positive Symptom Total (PST). The indices were developed to indicate in a single score the depth of an individual's psychological distress. The SCL-90-R may be administered to individuals 13 years of age and older, requires a six-grade reading level, and takes between 12-15 minutes to complete.

Each dimension of the SCL-90-R (Derogatis, 1994) receives a separate score ranging from a low of 0 to a high of 24-48, depending on the particular scale. Higher scores indicate the presence of greater levels of symptomatology or distress along that dimension. Derogatis reported the nine dimensions were designed to assess the following (the range for each dimension is also noted): Somatization (SOM) reflects distress arising from perceptions of bodily dysfunction (0-48); Obsessive-Compulsive (O-C) indicates the presence of thoughts, impulses or actions that are experienced as unremitting, unwanted and irresistible (0-40); Interpersonal Sensitivity (I-S) reflects feelings of inadequacy and inferiority (0-36); Depression (DEP) indicates the presence symptoms such as loss of energy, hopelessness, and dysphoric mood (0-52); Anxiety (ANX) reflects general signs of anxiety including nervousness, tension and apprehension (0-40); Hostility (HOS) indicates thoughts, feelings or actions that are characteristic of the negative affective state of anger (0-

24); Phobic Anxiety (PHOB) indicates the presence of a persistent fear response which leads to avoidance or escape behavior (0-28); Paranoid Ideation (PAR) indicates paranoid behavior including projective thought, suspiciousness, and centrality (0-24); Psychoticism (PSY) indicates a withdrawn, schizoid lifestyle, as well as first-rank symptoms of schizophrenia such as hallucinations (0-40).

Internal consistency coefficients for the nine symptom dimensions were developed from two sources: data from 209 "symptomatic volunteers" and data from 103 psychiatric outpatients. Derogatis (1994) reported reliability coefficients (coefficient alphas) ranging from .77 to .90 from the two data sets.

Internalized Homophobia Scale for Lesbians

The Internalized Homophobia Scale for Lesbians (IHSL; see Appendix D) was developed by Szymanski and Chung (1998) to measure internalized homophobia in lesbians. A rational/theoretical approach was employed in the development of the measure: the 52 items and five dimensions or subscales included in the scale were derived from the clinical and theoretical literature and related published scales regarding internalized homophobia. Items are rated on a seven-point Likert scale (1-7) ranging from "strongly disagree" to "strongly agree."

In developing the IHSL, the authors generated an initial pool of 71

items (along five dimensions). The items were reviewed by five independent judges familiar with the lesbian literature and categorized into one of the five dimensions of internalized homophobia. Items were retained within the subscale only if four of the five judges placed it in the intended category.

Szymanski and Chung (1998) then gave the instrument to a sample of participants recruited to test the scale via an academic listserv and through networks of friends. Of 550 questionnaires distributed, 303 were completed (a response rate of 55%).

Items with low-corrected item-total correlations (defined as less than 35%) were eliminated from the pool, resulting in a 52-item measure (Szymanski & Chung, 1998). The reliability of the scale was computed via corrected item-total correlations and alpha coefficients for the total scale and subscales. The following alpha coefficients were reported: Total Scale, .94; Subscale 1, .87; Subscale 2, .92; Subscale 3, .79; Subscale 4, .74; and Subscale 5, .77. Validity was assessed via inter-scale correlations and correlations between the subscales and criterion measures of self-esteem and loneliness.

Szymanski and Chung (1998) reported that the pattern of correlations among the IHSL subscales indicate that each subscale is measuring a unique aspect of internalized homophobia. The five

subscales (dimensions) and the range of possible scores are as follows:

(1) connection with the lesbian community (0-91); (2) public identification as a lesbian (0-112); (3) personal feelings about being a lesbian (0-56); (4) moral and religious attitudes towards lesbianism (0-49); and (5) attitudes toward other lesbians (0-56). Higher subscale and total scores indicate the presence of elevated levels of internalized homophobia along the dimension being measured while lower scores indicate less internalized homophobia.

Procedure

Participants were recruited in the three cities. A packet containing the informed consent letter, the IHSL (Szymanski & Chung, 1998) and the SCL-90-R (Derogatis, 1994), and the demographic data questionnaire were distributed to participants at a location of their convenience. Distribution took place at a variety of locations, including individual residences or places of work in person or by mail, at gatherings for specific groups, and at an event for the community at large (Dallas only). Participants who volunteered were provided additional packets to share with friends. It was hoped that less-visible members of the lesbian community would be reached and included in the study via snowball sampling. A request for participants was placed on a listserv for local lesbians who responded by email requesting packets be mailed to them

at an address of their choosing. Distribution of packets continued until the required number of completed packets were returned.

The time necessary to complete the assessments and demographic data sheet was approximately 25-35 minutes. As in the distribution of packets, the completion of the packets took place at a time and location of the participant's choice. Participants were instructed to return the questionnaires and data sheet using a self-addressed, stamped envelope supplied by the investigator. Before the proposed study began, it was reviewed by the university Human Subjects Review Committee (HSRC) for approval. Upon approval by the HSRC and the Graduate School, data collection began. Every possible effort was made to maintain anonymity and confidentiality throughout the research process.

A total of 671 packets were distributed during a six-week period. A total of 234 packets were returned, resulting in a 34.8% return rate. Thirty-four packets were returned incomplete and were removed from the sample, resulting in a final useable sample of 200 subjects.

Statistical Analyses

Descriptive statistics were calculated for all variables. Regarding the demographics of the sample, frequencies were calculated for categorical variables (ethnicity, religious affiliation, therapy history) and means and standard deviations were calculated for interval level data

(age, income, years of education). The IHSL (Szymanski & Chung, 1998) and SCL-90-R (Derogatis, 1994) were scored, giving each participant a scale score that reflected their overall level of internalized homophobia and a score that delineated the current level or depth of psychological distress (Global Severity Index). The IHSL and SCL-90-R subscales were also scored. All these scores represented interval level data; thus, means and standard deviations were calculated for the total sample as well as by the three age groups of interest (18-29; 30-39; 40+). In addition, a correlation matrix was calculated for all interval level variables and the data set was explored for relevant relationships.

The three age groups were compared across demographic variables to determine if they were equivalent on years of education and annual income. The interval level variables were compared using one-way ANOVA procedures (e.g. group x years of education). The categorical variables (ethnicity, religious affiliation, therapy history) were compared using the Chi Square test of association. The purpose of examining group differences on demographic variables was to determine if any of these variables needed to be used as covariates in the analysis of the major hypotheses of the study.

The major hypotheses of the study and their respective analyses are noted below. If covariates were needed, ANOVA procedures were

modified to ANCOVA procedures.

<u>Hypothesis</u>	<u>Analysis</u>
1. Total IHSL scores will be positively correlated with SCL-90-R Global Severity Index scores.	Pearson Correlation
2. Total IHSL scores will be positively correlated with SCL-90-R Depression scores.	Pearson Correlation
3. IHSL Subscale 4 scores (religious and moral attitudes toward lesbians) will be positively correlated with SCL-90-R Depression scores.	Pearson Correlation
4. IHSL Subscale 2 scores (public identification as lesbian) will be positively correlated with SCL-90-R Anxiety scores.	Pearson Correlation
5. Lesbians aged 18-29 will score higher than either of the other two age groups on the IHSL Subscale 4 scores (religious and moral attitudes toward lesbians).	One-way ANCOVA (age group x IHSL Subscale 4)
6. Lesbians aged 30-39 will score lower than either of the other two age groups on the IHSL Total score.	One-way ANCOVA (age group x IHSL Total score)
7. Lesbians aged 40+ will score higher than either of the other two age groups on the IHSL	One-way ANCOVA (age group x

Subscale 2 (public identification as lesbian).

IHSL Subscale

2)

8. An undetermined set of variables will predict psychological distress, using the SCL-90-R Global Severity Index scores as

Exploratory Step-
Wise Multiple
Regression

The DV and the IHSL Subscale scores, Total score, and demographic variables as potential IV's.

CHAPTER IV

Results

Descriptive statistics

Descriptive statistics were computed for the three age groups and the total sample for all continuous variables. The IHSL and SCL-90-R were scored and demographic data were compiled ($N = 200$). Table 2 describes the IHSL Subscale scores and the IHSL total score

Table 2

IHSL Measure Total and Subscale Means and Standard Deviations

	<u>Age Group 1</u>		<u>Age Group 2</u>		<u>Age Group 3</u>		<u>Total Sample</u>	
	<u>Mean</u>	<u>SD</u>	<u>Mean</u>	<u>SD</u>	<u>Mean</u>	<u>SD</u>	<u>Mean</u>	<u>SD</u>
<u>IHSL One</u>	33.92	11.91	30.80	11.40	28.47	13.86	30.96	12.62
<u>IHSL Two</u>	41.33	19.26	39.75	16.02	43.04	20.56	41.42	18.71
<u>IHSL Three</u>	13.07	6.41	11.89	4.80	11.78	7.22	12.23	6.24
<u>IHSL Four</u>	10.81	4.74	10.74	4.73	10.53	6.64	10.69	5.46
<u>IHSL Five</u>	17.84	7.67	17.40	6.33	17.80	8.06	17.68	7.37
<u>IHSL Total</u>	117.14	37.64	110.60	32.63	111.36	46.05	112.93	39.28

Note. IHSL One = Subscale 1--Connection with the Lesbian Community

(possible range: 13-91); IHSL Two = Subscale 2--Public Identification as a Lesbian (possible range: 16-112); IHSL Three = Subscale 3--Personal Feelings about being a Lesbian (possible range: 8-56); IHSL Four = Subscale 4--Moral and Religious Attitudes Toward Lesbians (possible range: 7-49); IHSL Five = Subscale 5--Attitudes Toward Other Lesbians (possible range: 8-56); IHSL Total = Total Measure score (possible range: 52-364).

Of note in Table 2 are the group means for the IHSL Total, which showed little variation across all three age groups. In addition, all group means for IHSL Subscale 4 were very close to the minimum possible.

Table 3 describes the SCL-90-R Subscale and Global Indices scores. Of note in Table 3 is a slight decline in T-scores for all subscales and the Global Indices as age increased, although these differences were never larger than one standard deviation (and therefore not statistically significant). It is also of interest that no mean T-scores are at clinically elevated levels (T-scores less than 60 are considered within the normal range) with very slight exceptions noted for I-S, PSY and GSI scores for the youngest age group.

Table 3

SCL-90-R Global Indices and Subscale Means and Standard Deviations

	<u>Age Group 1</u>		<u>Age Group 2</u>		<u>Age Group 3</u>		<u>Total Sample</u>	
	<u>Mean</u>	<u>SD</u>	<u>Mean</u>	<u>SD</u>	<u>Mean</u>	<u>SD</u>	<u>Mean</u>	<u>SD</u>
<u>SOM</u>	56.20	11.21	53.63	7.93	51.42	10.10	53.66	9.97
<u>O-C</u>	59.38	10.89	56.19	10.28	54.64	9.34	56.65	10.30
<u>I-S</u>	60.38	9.92	57.45	10.09	53.63	10.05	57.02	10.35
<u>DEP</u>	59.33	10.68	56.28	9.38	53.95	10.34	56.42	10.33
<u>ANX</u>	55.50	11.10	53.16	11.80	49.49	10.46	52.60	11.34
<u>HOS</u>	58.34	12.00	55.00	10.61	50.91	9.42	54.60	11.05
<u>PHOB</u>	53.66	9.93	50.06	8.08	48.16	7.09	50.52	8.66
<u>PAR</u>	59.88	10.04	55.03	10.58	52.19	10.87	55.55	10.93
<u>PSY</u>	60.47	12.02	55.56	10.17	53.53	9.70	56.39	10.97
<u>GSI</u>	60.03	10.58	55.71	10.75	52.46	11.14	55.92	11.22
<u>PSDI</u>	58.49	10.41	52.86	9.84	51.09	9.76	54.01	10.43
<u>PST</u>	58.20	9.88	55.30	10.34	52.05	10.51	55.06	10.51

Note. All scores are T-scores (range 0-100, mean=50, standard deviation=10). SOM = Somatization; O-C = Obsessive-Compulsive; I-S = Interpersonal Sensitivity; DEP = Depression; ANX = Anxiety; HOS = Hostility; PHOB = Phobic Anxiety ; PAR = Paranoid Ideation; PSY = Psychoticism; GSI = Global Severity Index; PSDI = Positive Symptom Distress Index; PST = Positive Symptom Total.

Correlational Analyses

Pearson correlations were calculated for all continuous variables.

Table 4 describes the correlations of age, education, IHSL Subscale 2, IHSL Subscale 4, IHSL Total, DEP, ANX and GSI scores. These subscales were selected for presentation because they represent the variables of interest in the subsequent analysis of major hypotheses.

Table 4

Correlation Matrix for Interval Level Variables

	1	2	3	4	5	6	7	8	9
1. Age	~								
2. Income	.26***	~							
3. Education	.38***	.20**	~						
4. IHSL Two	.10	-.07	-.01	~					
5. IHSL Four	-.01	-.11	-.27***	.44***	~				
6. IHSL Tot.	.00	-.10	-.14*	.85***	.66***	~			
7. DEP	-.24***	-.30***	-.25***	.13	.07	.19**	~		
8. ANX	-.26***	-.20**	-.16*	.05	.10	.14*	.76***	~	
9. GSI	-.30***	-.31***	-.25***	.10	.11	.18**	.92***	.85***	~

Note. * = p.05; ** = p.01; *** = p.001. IHSL Two = Subscale 2; IHSL Four = IHSL Subscale 4; IHSL Tot. = IHSL Total; DEP = SCL-90-R Depression; ANX = SCL-90-R Anxiety; GSI = SCL-90-R Global Severity Index.

Significant correlations were expected and found between the IHSL subscales and IHSL Total score. In addition, the DEP, ANX, and GSI were significantly correlated.

A significant correlation also existed between the IHSL Total score and the SCL-90-R Global Severity Index. Therefore, Hypothesis 1 was supported. This finding indicated the correlation between general internalized homophobia and current level of psychological distress was significant. In addition, a significant correlation between the IHSL Total score and the SCL-90-R DEP Subscale indicated support for Hypothesis 2. This finding meant the relationship between general internalized homophobia and depression was significant. The correlation between IHSL Subscale 4 and the SCL-90-R DEP Subscale was not significant; therefore, Hypothesis 3 was rejected. This finding indicated internalized homophobia related to religious and moral attitudes toward lesbianism was not significantly correlated with depression. Finally, findings did not indicate a significant correlation between the IHSL Subscale 2 and SCL-90-R ANX Subscale; therefore, Hypothesis 4 was rejected. Internalized homophobia related to public identification as lesbian did not significantly correlate with generalized anxiety

Comparison of Demographic Variables

Prior to analysis of Hypotheses 5-7, the three age groups were compared across demographic variables using one-way ANOVAs to determine if they were equivalent on years of education and annual income. Significant differences were found (see Tables 5 and 6). Where significant differences were noted, analysis procedures for Hypotheses 5-7 were modified to ANCOVAs to allow for control of the relevant covariates.

Table 5

ANOVA Summary Table-Age Group x Education

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Age Group	174.55	2	87.27	12.61	0.000
Error	1362.86	197	6.91		

Table 6

ANOVA Summary Table-Age Group x Income

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Age Group	2.96	2	1.48	6.31	0.002
Error	4.62	197	2.34		

The results of these ANOVAs indicated that significant differences existed among the three age groups in both the number of years of

formal education and annual income. Therefore, years of education and income were used as covariates in the analysis of the formal Hypotheses 5-7.

Chi-square comparisons across age groups showed no significant differences on any of the categorical variables (ethnicity, religion, therapy status and medication status). Therefore, none of these variables were needed as covariates

ANCOVA Analyses for Hypotheses 5-7

Three hypotheses were tested using ANCOVA procedures.

Hypothesis 5 stated that lesbians in the youngest age group (18-29) would exhibit significantly higher internalized homophobia related to religious and moral attitudes toward lesbians than the other two age groups (30-39, 40+). This hypothesis was rejected. IHSL Subscale 4 scores showed no significant differences between the age groups ($F = .90$; $df\ 2, 195$; $p = .408$). The results of this ANCOVA are depicted in Table 7.

Table 7

ANCOVA Summary Table-IHSL Subscale 4 x Age Group

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Age Group	50.04	2	25.02	0.90	.408
Income	31.16	1	31.16	1.12	.291
Education	441.09	1	441.09	15.86	.000
Error	5423.06	195	27.81		

Hypothesis 6 stated that lesbians in the middle age group (30-39) would exhibit significantly less internalized homophobia as measured by the IHSL Total score than either of the other two age groups (18-29, 40+). This hypothesis was rejected. IHSL Total scores showed no significant differences between the age groups ($F = .08$; df 2, 195; $p = .918$). Results of this ANCOVA are depicted in Table 8.

Table 8

ANCOVA Summary Table-IHSL Total x Age Group

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Age Group	262.86	2	131.43	0.08	.918
Income	1449.77	1	1449.77	0.94	.332
Education	4126.37	1	4126.37	2.69	.103
Error	299067.96	195	1533.68		

Hypothesis 7 stated that lesbians in the oldest age group (40+) would exhibit significantly higher internalized homophobia related to public identification as lesbian when compared with the other two age groups (18-29, 30-39). This hypothesis was rejected. IHSL Subscale 2 scores showed no significant differences between the age groups ($F = .68$; $df\ 2, 195$; $p = .506$). Results of this ANCOVA are depicted in Table 9.

Table 9

ANCOVA Summary Table-IHSL Subscale 2 x Age Group

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Age Group	482.71	2	241.35	0.68	.506
Income	503.04	1	503.04	1.42	.234
Education	9.67	1	9.67	0.27	.869
Error	68755.19	195	352.59		

Multiple Regression Analysis of Hypothesis 8

An exploratory step-wise multiple regression analysis was conducted to determine what variables would best predict psychological distress as measured by the Global Severity Index (GSI) of the SCL-90-R. Results of the step-wise multiple regression are presented in Table 10.

Table 10

Exploratory Step-Wise Multiple Regression

<u>Effect</u>	<u>Coef</u>	<u>Standard</u> <u>Error</u>	<u>Standard</u> <u>Coef</u>	<u>Tolerance</u>	<u>Df</u>	<u>F</u>	<u>'p'</u>
<u>In</u>							
Constant					1		
IHSL Five	.24	.09	.16	.98	1	6.88	.009
Age	-.25	.06	-.25	.89	1	16.24	.000
Ethnicity	1.65	.72	.14	.96	1	5.28	.023
Income	-.00	.00	-.21	.91	1	11.02	.001
Meds	-7.45	1.57	-.29	.97	1	22.47	.000
<u>Out</u>							
	<u>Partial</u> <u>Coef.</u>						
IHSL One	.07	.	.	.75	1	.96	.327
IHSL Two	.06	.	.	.79	1	.87	.350
IHSL Three	.03	.	.	.75	1	.22	.633
IHSL Four	.02	.	.	.73	1	.07	.786
IHSL Total	.07	.	.	.52	1	1.12	.290
City	-.00	.	.	.94	1	.00	.962
Religion	.10	.	.	.96	1	2.10	.149
Education	-.54	.	.	.78	1	.55	.456
Therapy	.05	.	.	.88	1	.57	.449

Note. Coef. = Coefficient; Standard Coef. = Standard Coefficient;

Partial Coef. = Partial Coefficient.

This exploratory multiple regression shows that overall psychological distress was predicted by (in order of significance) age, medication usage, income, attitudes towards other lesbians and ethnicity. Younger age, medication usage, lower income, negative attitudes toward other lesbians and non-white ethnicity was associated with greater psychological distress.

Analysis by City

Also of concern in this project was the impact city size might have on the degree of internalized homophobia displayed by participants. An exploratory ANOVA was conducted to examine this question. The mean IHSL Totals by city were; Dallas = 111.06, Austin = 110.74, and San Angelo = 166.86. Results indicated highly significant mean differences ($F = 6.99$; $df\ 2, 195$; $p = .001$). Table 11 depicts the results of this ANOVA.

Table 11

ANOVA Summary Table-City x IHSL Total

<u>Source</u>	<u>SS</u>	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
City	20429.71	2	10214.85	6.99	.001
Age Group	140.04	1	140.69	0.09	.757
Income	1264.67	1	1264.89	0.86	.353
Error	284801.04	195	1460.51		

Results of this ANOVA indicated participants from the smallest city in the sample displayed significantly higher levels of internalized homophobia as measured by the IHSL Total scores when compared to participants from the other cities. Participants from the two larger cities displayed little difference in IHSL Total scores. However, results from this ANOVA should be interpreted cautiously due to the very small cell size ($n = 8$) for city three (the smallest, most rural city).

CHAPTER V

Discussion

In this chapter, the major hypotheses and the statistical findings that support or reject those hypotheses are discussed, as well as the suggested rationale for the results obtained. Exploratory analyses are also presented and discussed. In addition, the results of this study as they relate to the literature and their implications for theory, research and practice/training are examined. Limitations to the study are also presented.

Summary of Results

The most important findings of this study are the support of Hypotheses 1 and 2. Hypothesis 1, that IHSL Total scores would positively correlate with SCL-90-R Global Severity Index scores (GSI), was supported. The Global Severity Index combines information concerning the number of symptoms reported with the intensity of perceived distress and was noted by the author of the instrument as the best summary measure of overall distress provided by the SCL-90-R (Derogatis, 1994). This finding indicates that the relationship between general internalized homophobia and psychological distress in lesbians is significant.

Hypothesis 2, that IHSL Total scores would positively correlate with SCL-90-R Depression scores, was also supported. This finding indicates that the relationship between general internalized homophobia and depression is significant.

Two hypotheses addressed the relationship between specific aspects of internalized homophobia and specific negative affective states. Regarding Hypothesis 3, a significant correlation was not found between internalized homophobia related to religious and moral attitudes toward lesbianism and depression. In addition, Hypothesis 4, the correlation between internalized homophobia related to public identification as lesbian and generalized anxiety was not significant.

Three age-related hypotheses were examined (Hypotheses 5-7). While significant differences were expected by age group, none were noted. Lesbians aged 18-29 did not display significantly higher rates of internalized homophobia related to religious and moral attitudes toward lesbianism (Hypothesis 5). Lesbians aged 30-39 did not display significantly lower general internalized homophobia (Hypothesis 6). Finally, lesbians aged 40+ did not display significantly higher levels of homophobia related to public identification as lesbian (Hypothesis 7). These results suggest that differences in internalized homophobia may be impacted more by an individual's personal experiences and identity

development processes than by differences in age-cohort experiences.

The results of the exploratory step-wise multiple regression indicated overall psychological distress was associated with age, medication usage, income, attitudes towards other lesbians and ethnicity. The findings indicated that younger age, medication usage, lower income, negative attitudes toward other lesbians and non-white ethnicity were associated with greater psychological distress among participants in the sample. In addition, findings of an exploratory ANOVA indicated that lesbians from the smallest rural city in the sample displayed significantly higher levels of internalized homophobia than participants from the larger metropolitan cities. However, these results should be interpreted cautiously due to the very small cell size ($n = 8$) for the smallest city. The implications for theory, research and practice/training of the aforementioned findings are examined next.

Implications for Theory

Within the theoretical literature, internalized homophobia is held to be associated with psychological distress and as presenting a significant threat to healthy self-esteem and identity development in lesbians (Ross & Rosser, 1996; Sophie, 1987). Results of this study provide the first known empirical support for the theoretical literature and indicate that internalized homophobia is a significant contributor to

overall psychological distress as well as depression in lesbians.

Glaus (1988) maintained that internalized homophobia is tied closely to negative affective states. The results of this study support this connection empirically. Overall psychological distress as measured by the SCL-90-R GSI significantly correlated with general internalized homophobia in this study. This finding suggests that internalized homophobia may be connected to an array of negative affective states.

One negative affective state mentioned frequently in the theoretical literature as being associated with internalized homophobia is depression. Researchers who have held internalized homophobia to be closely related to depression in lesbians and gays include Cimini (1992), Herbert et al. (1994) and Malyon (1985). The findings of this study provide empirical evidence for an association between depression and internalized homophobia in lesbians and strengthen theories linking these two variables.

The results of the exploratory multiple regression indicate that ethnic minority membership significantly impacts the mental health of lesbians. These results support theoretical models such as Morales' (cited in Morales, 1990) who discussed identity development in ethnic minority lesbians. His approach was unique in its attempt to understand the interaction between minority identity development and sexual

identity development.

In his model, Morales (cited in Morales, 1990) argued that each dual identity development “state” has a corresponding affective response. Denial is the most commonly occurring response as individuals begins to integrate their dual identities. This response is followed by hopelessness and depression regarding the continuing identity conflicts as well as anxiety about betraying either of the communities to which an individual belongs. In the final two states, anger and a sense of isolation are common and result from experiences of racial discrimination within the lesbian and gay community.

The results of this study indicated ethnic minority lesbians displayed significantly higher rates of psychological distress. This finding empirically supports the notion that the additional stresses inherent in multiple minority status significantly and negatively impact ethnic minority lesbians.

Analysis and incorporation of the specific role that internalized homophobia plays in dual identity developmental models would add to the theoretical usefulness of those models. Further clarification of the interaction between the formation of ethnic and lesbian identities would contribute significantly to the identity development literature. Many ethnic minority lesbians are faced with an environment in which they are

not only rejected or ignored by members of their ethnic group because of their lesbianism, but also by the lesbian community due to their minority status. While the stages of development in many ethnic or lesbian identity development models are similar, the literature would benefit from further clarification of how these processes interact, and what effect they have on the transition from one identity development stage (either ethnic or lesbian) to another.

Results of the multiple regression analysis indicated psychological distress (as measured by the GSI) was associated with younger age, medication usage, lower income, negative attitudes toward other lesbians and non-white ethnicity. Both depression and anxiety appear to be prominent aspects of the psychological distress displayed by younger participants with highly significant negative correlations observed between age and both depression and anxiety (see Table 4). According to the DSM-IV (APA, 1994), average onset of depression is the mid-20s, although epidemiological data suggest age of onset is decreasing for those born more recently. Onset of anxiety disorders typically occurs in childhood or adolescence (although onset in the 20s is not uncommon). Based on the information provided in DSM-IV (APA), it is unclear at this point if these results reflect trends similar to those seen in the general population or if they are in some way unique to this sample of lesbians.

Medication was also associated with psychological distress in this sample. Participants were asked to indicate use of medications and to specify which medication(s) they were taking. Findings indicated that 26% of the sample used some type of psychotropic medication. Of those, 96% reported use of antidepressants, 23% reported use of antianxiety medication(s) and 3% reported use of antipsychotics. Clearly, the vast majority of drugs utilized are antidepressants, further supporting the prevalence of depression in this sample. It is not surprising that the use of psychotropic medication would be associated with psychological distress and therefore highly unlikely this finding is in some way unique to this sample.

Korchin (1980) reported that psychological disorders are more common and severe among those with the lowest socioeconomic status. This finding was supported by the research of Cockerham (1990). His large-scale study found that as income increased, psychological distress decreased. The results of the current study, therefore, do not appear unique with regard to the well-established link between income and psychological distress.

Negative attitudes toward other lesbians (as measured by IHSL Subscale 5) was also significantly associated with psychological distress. The nature of the relationship between psychological distress and

negative attitudes toward other lesbians is unclear as this specific relationship has yet to be examined in the literature. Based on other aspects of our theoretical and clinical knowledge base, however, a couple of hypotheses may be advanced in regard to this relationship. First, it is possible that holding significantly negative attitudes toward other lesbians is at least in part a response to feelings regarding one's own lesbian identity. Stated another way, holding negative feelings toward other lesbians may be a projective defense designed to protect oneself from the stigmatizing aspects associated with a lesbian identity. Second, negative attitudes toward other lesbians may be indicative of a more generalized worldview, having less to do with other lesbians per se than with a general pattern of negativity towards all other people and a resultant dynamic of social isolation or withdrawal.

Previous research (Cimini, 1992; Frock, 1997) supported Ross and Rosser's (1996) argument that religious or moral attitudes regarding lesbianism are a salient factor in internalized homophobia, particularly for younger lesbians. This theory was not supported by the current findings. Thus, the relationship between religiosity, internalized homophobia and identity development remains unclear. Identity development theory would benefit from a deeper exploration of the specific role that religious or moral convictions play in the level of

internalized homophobia expressed by individuals and how this interacts with transitions in the identity development process.

The current results also suggest that residing in a rural versus an urban area may significantly impact internalized homophobia. Participants from the smallest and most rural city in the study displayed significantly higher levels of internalized homophobia compared to those residing in the larger, more urban cities. While this finding should be interpreted cautiously due to the small sample size ($n = 8$), it is consistent with Cody and Welch's (1997) qualitative study examining the coping styles and life experiences of rural gay men. Their results indicated internalized homophobia was the second-most commonly occurring theme. The authors argued that the more restrictive attitudes regarding gender roles characteristic of many rural areas are likely to include strongly negative attitudes toward homosexuality. This attitude has the potential to create an environment in which negative messages regarding homosexuality are even more pervasive and stigmatizing than in urban areas. The results of the current study and those of Cody and Welch indicate that rural versus urban living may significantly impact sexual identity development and internalized homophobia. Therefore, identity development models and theories regarding internalized homophobia may benefit from a more

explicit exploration of the role environmental variables play in sexual identity development.

Implications for Research

As noted previously, internalized homophobia has been characterized as one of the greatest impediments to the mental health of lesbians (Gonsiorek, 1988). However, the literature to date is primarily theoretical and few studies exist attempting to establish empirical links between internalized homophobia and the psychological functioning of lesbians.

Among other factors, historical zeitgeists appear to have contributed to the dearth of empirical literature addressing the issue of internalized homophobia and mental health in lesbians. As discussed in the literature review, homosexuality was routinely pathologized within the scientific community as recently as the early 1970s. After the removal of homosexuality from the DSM-II (APA, 1973), a shift in focus slowly began to take place within the scientific community. This shift brought about attempts to establish affirmative identity models and to de-pathologize homosexuality within the literature. During that time, most researchers would have been ill-advised to conduct research which attempted to make any links between homosexuality and pathology.

It appears the time is now appropriate for researchers to actively

address the mental health needs of lesbians and gays by clarifying the links between a lesbian or gay identity and mental health. This is not an attempt to pathologize lesbians and gays. Rather, it is an attempt to reflect more deeply within the empirical literature the involvement of the larger culture in creating an oppressive, stigmatizing culture which impacts lesbians and gays significantly and negatively. Internalized homophobia is created and sustained in large measure by the non-lesbian and non-gay culture.

Research is needed which addresses the interaction of identity development and internalized homophobia in lesbians. Specifically, the literature base would be strengthened by research which attempts to clarify the relationship between identity development and internalized homophobia. It is unclear if a shift in identity development precedes, follows, or occurs in conjunction with a change in the level of internalized homophobia within an individual. In addition, empirical examination is needed to determine if a significant correlation exists between the level of internalized homophobia displayed by an individual and their current identity development level.

Levine (1997) explored the use of the Cass Homosexuality Identity Formation (HIF) model in measuring lesbian identity development. She found that a relationship existed between measured and self-reported

identity development stage and stated that her findings indicate support for the utility of the HIF model and its measurement. Empirical analysis of the relationship between sexual identity development and internalized homophobia could be accomplished using a method similar to that described by Levine.

Ethnicity and its impact on the sexual identity development process also requires additional research. Empirical research is needed to clarify the interaction of internalized homophobia and ethnic identity development and what role these variables play in the sexual identity development process.

The current empirical literature base is clearly inadequate in its coverage of internalized homophobia in both lesbians and gay men (although more research does exist regarding gay men and internalized homophobia). This situation highlights the critical need for reliable studies addressing various aspects of internalized homophobia and its impact on sexual identity development and mental health in lesbians. In particular, the results of this suggest further research is needed to clarify the impact of age, religiosity and internalized homophobia related to negative attitudes toward other lesbians on identity development and mental health in lesbians.

Results of the multiple regression indicate that psychological

distress is associated with younger age. However, the youngest age group (18-29) did not differ significantly from the other age groups in the level of internalized homophobia displayed. Research is needed to more clearly understand the relationship between age, psychological distress and internalized homophobia in lesbians.

Internalized homophobia related to religious and moral attitudes toward lesbianism did not significantly correlate with depression in this study. In addition, participants in the youngest age group (18-29) did not display significantly higher rates of internalized homophobia related to religious and moral attitudes toward lesbianism. These findings are inconsistent with those of Frock (1997) whose results indicated internalized homophobia related to religious and moral concerns was significantly higher for lesbians under 30 and Cimini (1992), who found religiosity to be a significant predictor of internalized homophobia for lesbians. This inconsistency may be related to sample differences, or to differences in variables studied. The sample in Frock's 1997 study was taken wholly from a large city in central Texas. In addition, the study examined the relationship between internalized homophobia and substance abuse as opposed to more general psychological distress. Differences in sampling and in variables studied may have impacted the findings with regard to religion in the current study. The findings

regarding the impact of religion on internalized homophobia appear mixed then, and merit additional research that attempts to clarify the connection between these two variables.

The finding that negative attitudes toward other lesbians was associated with psychological distress was unexpected. As noted previously, the nature of the relationship between psychological distress and negative attitudes toward other lesbians is unclear as this relationship has yet to be examined in the literature. Future research is needed which sheds light on the relationship between these variables.

This study was an effort to systematically examine the association between the variables of age, ethnicity, level of internalized homophobia, and psychological distress in lesbians. Determination of the role that internalized homophobia plays in psychological distress in lesbians opens new avenues in addressing the mental health needs of lesbians and may begin to fill some of the gaps in the clinical as well as theoretical literature regarding lesbian women and psychological distress.

Implications for Practice and Training

Diamond and Wilsnack (1978) stated research is necessary to effectively develop and implement treatment programs that are sensitive to the special needs of lesbians. When a lesbian presents in therapy with

psychological distress, it is vital that the therapist is equipped to explore issues of societal and internalized homophobia with her. The replacement of myths and stereotypes with accurate information within practice and training communities is of particular importance.

It is critical that practitioners and practitioners-in-training gain a clear understanding of the myriad manifestations and effects of internalized homophobia on lesbian identity and mental health.

Expressions of internalized homophobia vary greatly from person to person and are often subtle in their presentation. Because internalized homophobia appears to be an important determinant of psychological distress in lesbians, psychotherapy with this population should include careful assessment and treatment of internalized homophobia (Malyon, 1982; Shidlo, 1994).

Phillips and Fischer (1998) asserted that graduate training programs need to make a more consistent and concerted effort to integrate lesbian and gay issues into curricula in order to produce psychologists who competently able to work with lesbian and gay clients. In that vein, therapists working with lesbian clientele and those responsible for training future therapists should familiarize themselves with the concept of internalized homophobia and its relevance in achieving a stable and positive lesbian identity. Curricula and classroom

discussion designed to inform current and future practitioners regarding the mental health issues faced by lesbians and gays without recognition of and attention paid to internalized homophobia is incomplete. Including internalized homophobia and related issues in training curricula and the exploration of them in the classroom should assist practitioners in bringing them into the therapeutic process more explicitly and effectively

In working with ethnic minority lesbians, the additional stresses of multiple-minority membership must be considered in developing and implementing treatment plans. In particular, therapists working with ethnic minority lesbians are strongly advised to develop an awareness of the challenges faced by this population. Practitioners in training should also be familiarized with concepts relevant to working with ethnic minority lesbians as a part of their training. Morrow (1998) stated students should receive training in constructs common to many marginalized groups, including the consequences of marginalization and the implications of oppression for psychological functioning.

Morales (1990) noted management of the social tensions inherent in being both a visible and invisible minority is a consistent theme in the lives of ethnic minority lesbians and gays. Examination of the support systems and strategies for coping that have been successful in the past is

critical because the experience of being an ethnic minority can be applied toward understanding and coping with the sexual identity development process (Morales, 1990). Use of previously successful coping mechanisms, along with connection to resources within the lesbian and gay community, can be useful tools in developing an affirmative identity and receiving peer support.

Practitioners in training should be closely supervised with regard to working with lesbians and gays. Experience working with this population is essential in the development of the therapeutic skills necessary to effectively deal with the unique issues faced by lesbians and gays. Mobley (1998) noted that practitioners in training are not immune to the prejudice and discrimination of the larger society toward lesbians and gay men: therefore it is important to provide corrective learning experiences which serve to reduce stereotypes regarding lesbians and gay men. To that end, issues regarding internalized homophobia as well as personal homophobia should be addressed in supervision with practitioners in training. Therapists unwilling or unable to address their own homophobia successfully are ill-advised to work with a population that experiences the prejudice of others routinely.

Limitations of the Study

Limitations exist which need to be considered in interpreting the

results of this study. Limitations include those relating to the sample selection procedures and therefore the sample itself, and limitations imposed by the instruments used in the study.

Sampling Limitations

Research on a covert population is problematic and limitations are inherent in this work (Burns, 1996). Selection bias is likely to occur when attempts are made to reach individuals within a hidden population. Those who were most deeply “closeted” were also the most difficult to include in the current sample. Although attempts were made to reach individuals at all levels of “outness,” clearly those willing to be more visible were also more likely to have to be presented with an opportunity to participate. In addition, methods for locating participants and bias from refusals present further barriers to representativeness as individuals who choose to participate in research may differ significantly from those who do not (Ary, Jacobs, & Razaveih, 1990, as cited in Burns, 1996). Therefore, the current study may not represent the general population of lesbians, limiting the generalizability of the findings.

Generalizability is further limited by the demographic homogeneity of the sample. The sample was a predominantly Caucasian, well-educated group of women with moderately high incomes who reside in large metropolitan areas. Therefore, the sample cannot be said to

represent lesbians in Texas or in the United States in general.

Lesbians in more rural and smaller cities may be expected (as was the case in the small number of participants in this study) to respond to the measures differently. It is likely that lesbians living in large metropolitan areas can safely be more open about their sexuality and have more opportunities to interact with the lesbian and gay community at large.

While the results of the present study indicated that lesbians from the smaller, more rural city displayed significantly higher rates of internalized homophobia, the sample was quite small ($n = 8$). Attempts to draw more participation from this region were largely unsuccessful. It may be that the risks related to anonymity and confidentiality associated with participation in this type of research were presumed or feared to be greater than many individuals residing in this small city were willing to bear. A higher percentage of packets were returned from the small city (as compared to the other two) with the demographic data sheet either incomplete or not enclosed at all. This outcome would indicate that even some of the individuals who did choose to participate in some way feared for their anonymity and support the conclusion that many were simply not willing to risk participation. Future replication of the present study with a larger sample may or may not achieve the statistical significance of the current study in regards to city size.

Difficulty was also encountered in attempts to include significant numbers of 18-25 year-olds and ethnic minorities in the sample. Contact was made with several lesbian and gay student groups as well as groups serving lesbian young adults in both of the larger cities but resulted in few returned packets. In addition, while both groups were targeted at a large community gathering and on listserv postings, overall, few packets were received from these groups (relative to the rest of the sample). Several packets were received from younger and minority participants following the community gathering, suggesting this was a more successful sampling technique. In conducting future research of this kind, the researcher would recommend beginning the data collection period (rather than ending, as was the case with this study) by distributing several hundred packets at a similar event.

An additional limitation of the current sample concerns the lack of counterbalancing of the instruments. Each packet was assembled with the instruments in the same order. Therefore, it is possible that order-effects were encountered and not controlled for in the current sample.

Instrument Limitations

There are also limitations concerning the instruments selected for use in this study. The SCL-90-R is a sensitive measure of point-in-time psychological distress symptomatology. However, it was not designed for

use specifically with a lesbian population and at least one item contains a potential confound for this population. Item 21, "Feeling shy or uneasy with the opposite sex" which loads on the Interpersonal Sensitivity (I-S), was removed prior to scoring due to its potential heterosexist assumption. In addition, some items may confound with symptoms experienced by many women during menopause and this does not appear to have been accounted for while norming the instrument. Finally, no studies were found that used the SCL-90-R with a lesbian population. For these reasons, the results of this study should be interpreted with caution.

The IHSL was chosen because it is the only known measure specifically designed to measure internalized homophobia in lesbians. The authors stated their findings support the reliability and validity of the instrument for assessing internalized homophobia in lesbians (Szymanski & Chung, 1998). However, the measure is a recent addition to the literature, was not standardized and has not been used in the empirical literature to date. Therefore, some questions remain regarding its actual utility.

The IHSL no doubt represents a considerable advance in the measurement of internalized homophobia in lesbians. However, use of the instrument in this research raises issues meriting attention.

Specifically, some items may contain potential confounds.

Subscale 1 (Connection with the lesbian community) is intended to measure to the amount of interaction an individual has with other lesbians and the importance of having other lesbians as a social support network. Item 1, loads on this subscale and reads, “Most of my friends are lesbians.” This item is reverse scored (with affirmative responses indicating less internalized homophobia).

It is understandable that having lesbian friends as a part of one’s social support system would indicate a degree of comfort with one’s own lesbianism (and therefore less internalized homophobia). However, to assume having “mostly” lesbian friends is indicative of less internalized homophobia seems a precarious position to take. For example, it could reasonably be argued that those most comfortable with their sexual identity might also display comfort with a more diverse support system and network of friends. Conversely, those least comfortable with their sexual identity might avoid meaningful connection with heterosexuals. Finally, it seems reasonable to assume some lesbians may count similar numbers of lesbians and gay men among their social support system (particularly in more integrated communities). Based on these arguments, this item appears troublesome.

In addition, Subscale 4 (Moral and religious attitudes toward

lesbians) includes an item (42) stating, "Lesbian lifestyles are a viable and legitimate choice for women." The item is reverse scored. At issue with this item is the use of the word "choice." As noted in the literature review, the notion that homosexuality is freely chosen is often held by religious institutions as justification for labeling antidiscrimination statutes as "special rights" and continues to be used in an ongoing effort to delimit civil rights based on sexual orientation. Therefore, the word "choice" in this item may provoke a negative reaction (and response) from some individuals based on its history of oppressive use.

Finally, one third of the items on Subscale 1 (Connection with the lesbian community) refer to familiarity with lesbian movies, music and music festivals, books, magazines, conferences and community resources. For those living in rural areas, access to these items or information may be severely limited, particularly if one does not have access to the internet. For example, as recently as the early 90's the local outlet of a national chain of video stores in the smallest city in the sample did not carry lesbian or gay-themed movies. Such a strong emphasis on familiarity with various lesbian media and resources in Subscale 1 may confound internalized homophobia with availability of resources.

The IHSL appears to be a good measure of internalized

homophobia in lesbians and is a valuable contribution to the literature. The recent empirical literature has seen the emergence of internalized homophobia as a variable of interest and refinement of the IHSL could enhance the precision with which internalized homophobia is studied.

Conclusion

This study provided empirical evidence for the previously theorized link between internalized homophobia and general psychological distress, as well as depression, in lesbians. In doing so, this research demonstrated internalized homophobia is a salient variable and needs to be addressed when researching identity development and psychological functioning in lesbians. Additionally, this study points to the need for therapists who work with lesbians to have a clear understanding of internalized homophobia and skills in helping lesbians deal with this issue.

More research is needed to further clarify the relationship between internalized homophobia, identity development and psychological symptoms in lesbians. Research will benefit from further refinement of the instruments measuring internalized homophobia and stages of lesbian identity development.

It is hoped that work in all of the aforementioned areas of

internalized homophobia will be continued. As evidence mounts regarding the negative effects of societal oppression, perhaps stronger measures can be taken to eradicate these destructive attitudes and behaviors.

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TEXAS WOMAN'S UNIVERSITY
INFORMATION LETTER FOR PARTICIPANTS IN RESEARCH

Title: "The Relationship Between Internalization of Societal Homophobia and Psychological Distress"

Researcher: Sylva D. Frock
 (214) 941-9433

Research Supervisor: Sally D. Stabb, Ph.D
 (940) 898-2149

I understand that the return of my completed questionnaires constitutes my informed consent to act as a subject in this research.

The purpose of this study is to examine the relationship between psychological distress and the internalization of societal homophobia in lesbians. The questionnaires are anonymous and will take from 25 to 35 minutes to complete. Nothing else will be asked of you and your participation is entirely voluntary. There are no consequences for refusing to participate or for choosing not to continue at any point. The first questionnaire asks you about your experiences as a lesbian, and the second asks you about your experiences with problems that any person might have. The demographic data sheet asks questions regarding your age, sexual identity or orientation, ethnic background, income, years of formal education, religious affiliation, and history of psychological/therapeutic treatment.

This study, being conducted by a member of the lesbian community, will examine the effects of societal homophobia on lesbians, and how lesbians interpret these messages. The study attempts to examine the specific relationship between these messages and problems that people may experience to understand how homophobia affects the lives of lesbians. We will be asking about your age/ethnicity/religious affiliation/and therapy history as these factors have been shown to be important in understanding differences in how lesbians cope with their own and other's homophobia.

The potential risks or discomforts involved are those related to confidentiality or filling out the questionnaires. Every effort will be made to reduce any potential risk. Your confidentiality is protected by making the questionnaires anonymous. The data will be stored in a locking file cabinet at the home of the researcher. The data will be destroyed by deletion of computer files and shredding of packet materials within one year. Prior to shredding, only the researcher and research supervisor will have access to the data. Although the questionnaires are designed to minimize possible discomfort, there is a possibility that some of the questions may cause you to feel discomfort. If you experience any discomfort as a result of your participation, please feel free to contact me at the phone number listed. If you need to, you may discuss your feelings regarding participation with a counselor at the TWU Counseling Center provided you are a student at TWU (940) 898-3801. Other referrals include (these services are not free): Michal Anne Pepper, Dallas, TX (972) 233-1050; Waterloo Counseling Center, Austin, TX (512) 444-9922; and Carolyn Reed, San Angelo, TX, (915) 944-4677. I can also provide additional referrals if necessary.

There are some potential benefits to you as a result of your participation in this study. Participation may increase your awareness of the effects of societal homophobia in lesbians. Knowing that you have participated in a study regarding lesbians' welfare may result in feelings of unity or that you have helped the lesbian community. You may also

receive a summary of the study on request. To request a summary, please contact either the researcher or the research supervisor at the telephone numbers listed.

We will try to prevent any problems associated with this research. Please let us know at once if there is a problem and we will help you. You should understand, however, that TWU does not provide medical services or financial assistance for injuries that may occur as a result of participation in this research.

If you have any questions regarding this research study or about your rights as a subject, please ask us using the phone numbers provided at the top of this form. If you have questions later, or if you wish to report a problem, please call us or the Office of Research & Grants Administration at (940) 898-3375.

Your participation in this study is voluntary and you may withdraw from the study at any time. Refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled.

Appendix B: Demographic Data Sheet

DEMOGRAPHIC DATA SHEET

Do you self-identify as lesbian? Yes No

Age: _____

Ethnicity: African-American _____ Caucasian _____
 Asian-American _____ Hispanic _____
 Pacific Islander _____ Other (Multiple) _____
 Please list: _____

Religious Affiliation: Catholic _____ Jewish _____
 Muslim _____ None _____
 Protestant _____ Please specify: _____
 Other _____ Please specify: _____

Years of Education: _____

(e.g: High school diploma=12 yrs; 4-year college degree=16 years, etc.)

Annual Income (all sources combined): _____

Within the past year, have you received any type of counseling, psychotherapy or other mental health services?

Yes

No

If yes, please describe briefly:

(e.g: inpatient hospitalization, outpatient psychiatric services; individual, group or couples therapy)

Within the past year have you taken any prescription medications for the treatment of psychological distress (e.g. depression, anxiety) or mental illness?

Yes

No

If yes, please list:

Appendix C: Symptom Checklist 90-Revised (SCL-90-R).

Note: This instrument is copyrighted and may be obtained by writing to National Computer Services, INC. at 5605 Green Circle Drive, Minneapolis, MN 55343 or by calling 1-800-627-7271.

Appendix D: Internalized Homophobia Scale for Lesbians (IHSL)

Strongly Disagree	Moderately Disagree	Slightly Disagree	Neutral	Slightly Agree	Moderately Agree	Strongly Agree
1	2	3	4	5	6	7

- ____ 19. I feel comfortable talking to my heterosexual friends about my everyday home life with my lesbian partner/lover or my everyday activities with my lesbian friends.
- ____ 20. Having lesbian friends is important to me.
- ____ 21. I am familiar with lesbian books and/or magazines.
- ____ 22. Being a part of the lesbian community is important to me.
- ____ 23. As a lesbian, I am loveable and deserving of respect.
- ____ 24. It is important for me to conceal the fact that I am a lesbian from my family.
- ____ 25. I feel comfortable talking about homosexuality in public.
- ____ 26. I live in fear that someone will find out I am lesbian.
- ____ 27. If I could change my sexual orientation and become heterosexual, I would.
- ____ 28. I do not feel the need to be on guard, lie, or hide my lesbianism to others.
- ____ 29. I feel comfortable joining a lesbian social group, lesbian sports team, or lesbian organization.
- ____ 30. When speaking of my lesbian lover/partner to a straight person I change pronouns so that others will think I'm involved with a man rather than a woman.
- ____ 31. Being a lesbian makes my future look bleak and hopeless.
- ____ 32. Children should be taught that being gay is a normal and healthy way for people to be.
- ____ 33. My feelings toward other lesbians are often negative.
- ____ 34. If my peers knew of my lesbianism, I am afraid that many of would not want to be friends with me.
- ____ 35. I feel comfortable being a lesbian.
- ____ 36. Social situations with other lesbians make me uncomfortable.
- ____ 37. I wish some lesbians wouldn't "flaunt" their lesbianism. They only do it for shock value and it doesn't accomplish anything.
- ____ 38. I don't feel disappointment in myself for being lesbian.

Strongly Disagree	Moderately Disagree	Slightly Disagree	Neutral	Slightly Agree	Moderately Agree	Strongly Agree
1	2	3	4	5	6	7

- ____ 39. I am familiar with lesbian movies and/or music.
- ____ 40. I am aware of the history concerning the development of lesbian communities and/or the lesbian/gay rights movement.
- ____ 41. I act as if my lesbian lovers are merely friends.
- ____ 42. Lesbian lifestyles are a viable and legitimate choice for women.
- ____ 43. I feel comfortable discussing my lesbianism with my family.
- ____ 44. I don't like to be seen in public with lesbians who look "too butch" or are "too out" because others will then think I am a lesbian.
- ____ 45. I could **not** confront a straight friend or acquaintance if she or he made a homophobic or heterosexist statement to me.
- ____ 46. I am familiar with lesbian music festivals and conferences.
- ____ 47. When speaking of my lesbian lover/partner to a straight person, I often use neutral pronouns so the sex of the person is vague.
- ____ 48. Lesbian couples should be allowed to adopt children the same as heterosexual couples.
- ____ 49. Lesbians are too aggressive.
- ____ 50. I frequently make negative comments about other lesbians.
- ____ 51. Growing up in a lesbian family is detrimental for children.
- ____ 52. I am familiar with community resources for lesbians (i.e., bookstores, support groups, bars, etc.).