
CRITICAL REVIEW

Internalized homophobia and health issues affecting lesbians and gay men

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Abstract

This paper investigates the concept of internalized homophobia in both theory and research relating to lesbian and gay health. It offers a contemporary and critical review of research in this area, and discusses a range of recent findings relating to a range of health issues including HIV and AIDS. Whilst the concept has a resonance for gay men and lesbians, and is widely used in 'lesbian and gay-affirmative' interventions, the paper demonstrates that research findings have been equivocal and the term is often used without full consideration of its sociopolitical consequences. The paper concludes that the concept does have a valuable role to play in health promotion work with lesbians and gay men but invites further discussion and examination of the construct.

Introductory remarks

This paper aims to present both an overview and critical evaluation of the usefulness of the concept of internalized homophobia¹ in explaining health difficulties affecting lesbians and gay men. It has been argued by a variety of lesbian and gay social scientists that internalized homophobia has a central role as a predisposing and perpetuating

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factor in various aspects of ill-health, and may affect both the progression of illness and health-related decision-making processes with significant effect on the prevention of illnesses such as HIV infection. However, a number of theorists have argued that internalized homophobia is both frequently used uncritically with regard to its conceptualization and operationalization, and without due concern for its sociopolitical consequences (i.e. to repathologize the 'sick' lesbian or gay individual and focus attention away from the more salient issues of cultural and institutionalized heterosexism). My aim is to provide a synthesis which examines research suggesting an important relationship between health and internalized homophobia whilst deconstructing the concept and offering a discussion of the potential effects on gay and lesbian communities in contemporary British society.

Defining anti-gay and lesbian prejudice and its internalization

There has been considerable discussion within lesbian and gay academic circles about how best to conceptualize the nature of anti-gay and lesbian prejudice. Whilst the term 'homophobia'² is most widely used within British society, there appears to be a consensus amongst queer³ academics that the term is in many ways unhelpful and inaccurate for a variety of reasons. These include the emphasis on the affective (fear) component of prejudice at the expense of anti-gay and lesbian cognitions,

and the contextualization of prejudice within the individual rather than in society and its structures.⁴

Alternatives that have been suggested include 'homonegativism' (Hudson and Ricketts, 1980), which is a multidimensional construct that focuses more clearly on the belief and value systems of prejudiced individuals, and 'heterosexism', which now features widely in gay and lesbian literature, and refers to an underlying belief that heterosexuality is the natural/normal/acceptable or superior form of sexuality.

In common with research into other forms of prejudice,⁵ many individuals within lesbian and gay communities may internalize significant aspects of the prejudice experienced within a heterosexist society. This process is consistent with Allport's (Allport, 1954) theory of 'traits due to victimization'. He argues that stigmatized individuals engage in defensive reactions as a result of the prejudice they experience. These mechanisms may be extroverted, including exaggerated and obsessive concern with the stigmatizing characteristic, and/or introverted, which include self-denigration and identification with the aggressor. The second of these mechanisms equates more readily with contemporary understandings of internalized homophobia. Many writers believe that this is a normative or inevitable consequence because all children are exposed to heterosexist norms, and research suggests that most gay men and lesbians adopt negative attitudes towards (their) homosexuality early in their developmental histories (Isay, 1989; Davies, 1996). Despite the wide-scale ambivalence of academics and gay-affirmative psychotherapists regarding the term 'homophobia', the concept of 'internalized homophobia' is widely cited in most writings on the subject—perhaps because this is more easily understood by clients within the therapeutic milieu.⁶ A number of definitions of internalized homophobia have been suggested. Meyer and Dean [(Meyer and Dean, 1998), p. 161] offer 'the gay person's direction of negative social attitudes toward the self, leading to a devaluation of the self and resultant internal conflicts and poor self-regard'. Whilst Locke [(Locke, 1998),

p. 202] suggests 'the self-hatred that occurs as a result of being a socially stigmatized person'.

Plumer [(Plumer, 1996), p. 89] also highlights the impact of stigma upon an evolving identity: 'The awareness of stigma that surrounds homosexuality leads the experience to become an extremely negative one; shame and secrecy, silence and self-awareness, a strong sense of differentness—and of peculiarity—pervades the consciousness'.

The term has become widely used within lesbian and gay studies, especially within gay-affirmative psychotherapeutic models which understandably typically place the concept at the centre of explanations and interventions around mental health issues faced by lesbians and gay men. As a concept the idea of internalized homophobia strikes a chord within almost all gay men and lesbians, and a number of contemporary pieces of qualitative research provide evidence of consistent and coherent narratives of the phenomenon (Stokes and Peterson, 1998). Participants in Cody and Welch's ethnographic study of rural gay men frequently talked of having experienced intense feelings of shame and guilt. One participant had believed 'I was the embodiment of all those nasty things that have been said about gay people' [(Cody and Welch, 1997), p. 60]. However, internalized homophobia has not proven to be such an easy concept to validate and operationalize as an acceptable theoretical and research-orientated concept, particularly for larger scale quantitatively oriented investigations. Wagner *et al.* [(Wagner *et al.*, 1994), pp. 91–92] also discuss the lack of precision and reliability which has often accompanied research in this area. 'Internalized homophobia as a psychological phenomenon has attracted little systematic research despite its destructive impact on the mental health of the gay community... As a result little is known about what predicts or precludes internalised homophobia.'

Validating and measuring internalized homophobia

As Shidlo argues in his seminal article on conceptual and empirical issues in measuring internalized

homophobia [(Shildo, 1994), p.176], 'the construct...can serve as a central organizing concept for a gay and lesbian affirmative psychology'. He suggests a number of major reasons for the significance of the construct which include the role played by internalized homophobia in psychological distress in lesbians and gay men, and the internalization of anti-gay and lesbian prejudice as a developmental event which is essential to understanding models of developing lesbian and gay identities. Internalized homophobia, he argues [(Shildo, 1994), p. 177], 'can be a heuristic construct that organizes factors unique to lesbians and gay men in the areas of development, psychopathology, psychotherapy, and prevention'. Shidlo also argues that the generation of psychometrically efficient scales to measure levels of internalized homophobia are of use in examining the extent (and domains) of internalized prejudice, and therefore potentially assessing risk to the individual and evaluating the success of therapeutic or preventive interventions.

Few lesbian and gay academics, therapists or health professionals would dispute the importance of internalized homophobia. Indeed a number of valuable and sophisticated models exist which coherently outline the mechanisms and potential consequences of the internalization of anti-lesbian and gay oppression [e.g. (Bremner and Hillin, 1993)]. However, if approached from a more hard-nosed, empirical-based perspective, the conceptualization and operationalization of internalized homonegativity is less satisfactory. Traditionally, internalized homophobia was equated with an ego-dystonic⁷ form of being lesbian or gay and research typically included only one or two items allowing participants to express their degree of satisfaction regarding their sexuality. A number of more sophisticated models have been produced during the last 25 years. The two most widely cited in research are those by Martin and Dean (Martin and Dean, 1987) who developed a nine-item scale for gay male participants based on the criteria for ego-dystonic homosexuality when it was last included in the APA's DSM-III (American Psychiatric Asso-

ciation, 1980) and Nungesser's (Nungesser, 1983) scale.

The Nungesser Homosexuality Attitudes Instrument (NHAI) is lengthier, and comprises three subscales which are attitudes towards one own's sexuality, attitudes towards homosexuality *per se* and a disclosure scale which measures degree of comfort with others knowing one's gay or lesbian sexuality. Shidlo (Shildo, 1994) has revised the NHAI, removing or changing the least valid or most ambiguous items and adding a number of new items to one of the existing scales. He also suggests an optional extra 15-item subscale which measures internalized homonegativity in relation to issues around HIV and AIDS. Wagner *et al.* (Wagner *et al.*, 1994) also combined nine items from the NHAI with 11 new ones to form their Internalized Homophobia Scale.

The NHAI has been shown to demonstrate convergent validity with Martin and Dean's scale (0.59, $N = 159$, $P < 0.01$) in a study by Sbordone (Sbordone, 1993) using a sample of gay fathers. Furthermore, research by Shidlo (Shidlo, 1987) using a sample of 59 found significant relationships with measures of a range of related concepts including self-esteem (-0.59 , $P < 0.01$), depression (0.37, $P < 0.01$), stability of self (-0.35 , $P < 0.01$) and loneliness (0.62, $P < 0.001$).⁸ However, recent research using Shidlo's modified version of the NHAI and Rosenberg's widely used Self-Esteem Scale (Rosenberg, 1965) with a community sample of British gay men found no relationship between the two sets of scores (-0.05 , $N = 127$, $P = \text{non-significant}$) (Williamson, 1999). This study also found mixed results for the internal reliability of the three subscales of the test. Attitudes towards one's own sexuality and disclosure subscales produced significant Cronbach α values of 0.68 and 0.76, respectively, but the measure of attitudes towards homosexuality generated an α score of only 0.07. Further analysis of responses to items on this subscale may identify certain 'rogue' items which could be removed although such inconsistencies may to an extent accurately represent some of the ambivalence and inconsistencies experienced by some lesbian and gay indi-

viduals, perhaps particularly as they 'work through' their internalized homophobia.

A more recent scale to measure internalized homophobia amongst gay men has been developed by Ross and Rosser (Ross and Rosser, 1996), and suggests four dimensions to the construct: public identification as being gay, perception of stigma associated with being gay, degree of 'social comfort' with other gay men and beliefs regarding the religious or moral acceptability of homosexuality. Ross and Rosser (Ross and Rosser, 1996) report a series of significant associations for male participants between scores on the scale and a variety of other measures potentially relating to a healthy adjustment to a gay identity. These include affiliation to gay community groups, relationship satisfaction and duration, and disclosure in personal and work lives. The predictive validity of the public identification and social comfort subscales appears to be considerably stronger than for the other two. Overall this scale looks promising, but clearly needs further rigorous testing with regard to demonstrating psychometric credibility more fully.

Perhaps partly because research with lesbians has more typically adopted a feminist/qualitative paradigm, there appears to be no scales which have been developed for and widely used with female participants. Generally, scales have been validated on and typically include items which are directed towards the experience of urbanized, White gay men and may not adequately reflect heterogeneous experiences of being gay or lesbian.

Furthermore, establishing such measures and operationalizing internalized homophobia has proved difficult because of the considerable overlap with other relevant concepts (e.g. other aspects of self-esteem), and traditionally a lack of clear differentiation between internalized homophobia itself and certain intrapsychic or behavioural consequences (e.g. intimacy difficulties, depression, etc.). There is no clear consensus over the most salient aspects of homophobia and there may also be problems with scales which suggest that discomfort regarding disclosure is a valid measure of internalized homophobia. Whilst 'coming out' is arguably the most salient and powerful process

of developing a well integrated lesbian or gay identity,⁹ and a valid indicator of reduced internalized homophobia, considerable literature documents the hostile environment within which many individuals disclose, and the continued prevalence of anti-lesbian and gay violence and victimization. (Herek and Berrill, 1992). In such circumstances choosing not to come out may to an extent represent an adaptive process. This is especially true for those in isolated areas where there is little or no lesbian and gay-affirmative social infrastructure and for those within highly homophobic families and communities.

It would therefore appear that whilst these scales are clearly of potential interest and value to health and clinical psychologists, it remains highly questionable to what extent any of the scales can be considered sufficiently psychometrically robust and universally applicable for unqualified endorsement.

Nonetheless, the development of such scales allows for the measurement of internalized homophobia, and it becomes possible for social scientists to carry out quantitative analysis to add to the qualitative dimensions of assessing its role in explaining and preventing health difficulties.

Internalized homophobia as 'minority stress'

A recent development in this area has been to conceptualize internalized homophobia as a component of minority stress. Following from the work of Brooks (Brooks, 1981) which conceptualizes minority stress as a psychosocial stress that is derived from membership of a low status minority group, studies by Meyer (Meyer, 1995) with gay men and DiPlacido (DiPlacido, 1998) with lesbians have found this to be a useful paradigm for the study of internalized homophobia and its relation to aspects of ill-health. In a detailed and articulate account, Meyer (Meyer, 1995) develops the conceptualization of minority stress within a social stress discourse, and drawing on aspects of conflict and societal reaction theories and social comparison and symbolic interactionist processes. He argues, 'minority stress arises not only from nega-

tive events but from the totality of the minority person's experience in dominant society. At the centre of this experience is the incongruence between the minority person's culture, needs, and experience, and societal structures' [(Meyer, 1995), p. 35]. In Meyer's model, internalized homophobia represents one (although the 'most insidious') of three aspects of minority stress and was operationalized through use of the Martin and Dean scale described above. The other dimensions of minority stress are perceived stigma and the experience of what he calls 'prejudice events'. Meyer argues that each of these three aspects significantly impact upon psychological adjustment, but there is also an interaction which compounds what he calls the 'psychologically-injurious effects'. Meyer provides evidence for his theory with a large-scale study of 741 gay men in New York recruited through a combination of network and snowball sampling techniques.¹⁰ Using multiple regression analysis and controlling for potential confounding variables, Meyer found a significant relationship between internalized homophobia and five measures of psychological distress. These were demoralization, guilt, sex difficulties, suicide (ideation and/or behaviour) and AIDS-related traumatic stress response. The later includes measures of a range of symptoms of distress relating to effects of the impact of AIDS on the gay community, and includes items on daily functioning, preoccupation and nightmares. Meyer found that whilst both stigma and experience of prejudice events were also significantly related to most of the measures of distress, internalized homophobia was reliably the most powerful predictor.

DiPlacido's research on minority stress also emphasizes the role of internalized homophobia but her ongoing research is in many ways rather different to that of Meyer.¹¹ The study involves a smaller sample of lesbians with a significant number (41%) describing themselves as 'at least halfway or more in the closet'. Again, a significant relationship is reported between internalized homophobia (measured using the NHAI) and salient aspects of psychological functioning, e.g. positive correlations were found with negative affect and

alcohol consumption. Depression also significantly correlated with the disclosure subscale of the NHAI. It will only be possible to provide a detailed analysis when the survey results are completed. (DiPlacido aims to provide data from a more heterogeneous sample of 500 lesbians within the New York area.) From a minority stress perspective, lesbians are seen to experience a dual (or multiple for lesbians from minority ethnic groups) stigmatization (i.e. as women and as homosexuals) with potentially greater effects of internalized oppression. It is also important to consider the significant role of HIV and AIDS with regard to contemporary discourse around gay sexuality, and how this may have served to reinforce lesbian invisibility and trivialize lesbian health issues.¹² With regard to internalized homophobia, most recent research has investigated its potential role at various stages of gay men's health experiences and behaviours, particularly those relating to HIV and AIDS.

Internalized homophobia and HIV

Considerable amounts of research have investigated the role of internalized homophobia within HIV processes. These can largely be reduced into three areas—HIV prevention and safer sex decision-making processes, coping strategies of seropositive gay men, and whether internalized homophobia has any effect upon viral progression.

A relationship between internalized homophobia and riskier sexual acts seems logical for a number of reasons. Homonegative gay men are likely to be less affiliated with the gay community and may therefore have less access to safer sex information and resources. Furthermore, homonegativity correlates with lower self-esteem which may undermine the individual's desire to keep themselves safe. Finally, some studies have suggested that greater levels of homonegativity may be related to greater substance use and alcohol consumption (e.g. Finnegan and Cook, 1984, Glaus, 1988; Meyer and Dean, 1995) which may impair decision-making processes.

Despite widespread knowledge about the risks of

HIV transmission, especially through unprotected receptive anal intercourse with multiple partners, rates of anal sex without condoms remain surprisingly high. Davies *et al.* (Davies *et al.*, 1993) asked participants who enjoyed receptive anal sex to explain why. A small group of respondents explained that it helped reaffirm their gay identity. It is possible that this may apply to a greater extent to homonegative gay men whose sexual identity may be more fragile. In another qualitative study, Gold *et al.* (Gold *et al.*, 1994) found that escapism is another motivating factor for engaging in (unprotected) anal intercourse. It may be that homonegative gay men feel a greater need for escapism than ego-syntonic¹³ gay men.

Interestingly, despite a range of potential theoretical explanations for a relationship between internalized homophobia and reduced condom usage, correlations in studies have typically been weak or inconsistent (Sandfort, 1995). Kippax *et al.* (Kippax *et al.*, 1993) in their study of 535 Australian gay men found that two measures of gay community attachment (social engagement with other gay men and gay community involvement) were predictors of engaging in safer sex practices. Shidlo (Shidlo, 1994) found no relationship between internalized homophobia and engaging in anal sex without condoms, whilst Meyer and Dean (Meyer and Dean, 1995) found a small subgroup of gay men (6%) who appeared to be qualitatively different from their rest of the sample and who reported very high levels of internalized homophobia, substance use and participation in high-risk acts. A relationship between the two variables may not affect all gay men equally, but caution should be exercised before it is concluded that no relationship exists between homonegativity and high-risk sex. As Meyer and Dean (Meyer and Dean, 1998) suggest, other variables such as sexual difficulties and intimacy issues may interact with these processes. Furthermore, sampling techniques used in studies like these are likely to use gay-affirmative networks, commercial venues and community centres, and are most unlikely to recruit reasonable numbers of more closeted gay men who feel alienated from organized gay communities.

Other research has looked into seropositive men and how internalized homophobia might impact upon the selection and success of coping strategies.

Nicholson and Long (Nicholson and Long, 1990) in a study of 89 seropositive gay men correlated scores on the NHAI and a modified version of Folkman *et al.*'s Ways of Coping Scale (Folkman *et al.*, 1986). High homonegativity was significantly related to avoidant coping strategies such as resignation or denial, whilst low negativity predicted proactive or active-behavioural coping strategies such as problem solving and resource seeking. As part of a longitudinal study in New York State, Wagner *et al.* (Wagner *et al.*, 1996) asked a sample of gay men to fill in a battery of instruments including a modified version of NHAI, Lazarus and Folkman's (Lazarus and Folkman, 1984) version of the Ways of Coping scale and a number of measures of psychological distress. Participants¹⁴ completed these scales twice at the beginning and end of a 2-year period with a baseline sample of 142 and a follow-up sample of 97.¹⁵ Internalized homophobia significantly correlated with all measures of self-reported distress (including anxiety, depression and demoralization) at both baseline and follow-up. However, more detailed analyses demonstrated that a significant correlation between baseline internalized homophobia and follow-up distress was only found amongst asymptomatic seropositive participants. Results regarding homophobia and coping style were not as clear as anticipated. 'Correlations were weak and inconsistent and internalized homophobia did not predict either avoidant or proactive coping in regression analyses' [(Wagner *et al.*, 1996), p. 103]. Wagner *et al.*'s study also tested whether there was a relationship between internalized homophobia and illness stage and progression. A number of theorists have suggested that notification of seropositive status or AIDS diagnosis may trigger a re-emergence of feelings of residual homonegativity, especially in gay men who are AIDS-phobic or demonstrate ego-dystonic gay sexuality (Ross and Rosser, 1996). Equally, it might be anticipated that internalized homophobia and related feelings of distress could impact upon

physiological measures of immunosuppression such as CD4 cell count. Neither of these hypotheses could be supported although it was noted that the sample used was significantly skewed with participants typically demonstrating high levels of resilience and low levels of homonegativity. This again draws attention to the difficulty of recruiting truly representative samples for health-related research with gay men (and lesbians) (Harry, 1986; Sell and Petruccio, 1996).

Research involving HIV and AIDS represents the largest body of knowledge for testing the relationship between conceptualizations and measures of internalized homophobia and illness. The research produced has had rather mixed results, suggesting that the concept may have some empirical value and predictive validity, but the relatively poor levels of reliability and replicability in studies, even allowing for difficulties with sampling strategies, should advise caution in those employing the construct in their research.

Internalized homophobia and other health issues

Some of the potential effects of internalized homophobia upon affect and psychological adjustment generally have been presented above. A number of other studies have also suggested that internalized homophobia may be a valid antecedent of a range of psychological problems. One area that has attracted particular interest is that of self-injurious behaviours including substance abuse, eating disorders, self mutilation and suicidality. A number of studies have shown the increased vulnerability of young lesbians and gay men to suicide generally (Remafedi *et al.*, 1991), and research by Rofes (Rofes, 1983) amongst others suggests that internalized homonegativity may explain differences within lesbian and gay communities. Hammelman (Hammelman, 1993) found that young lesbians and gay men were at greater risk of attempted suicide if they discovered their same sex preference early in adolescence, experienced negative 'coming out' reactions from significant others, experienced sexuality-orientated victimization, and used drugs

and alcohol to cope with problems relating to their lesbian or gay identity. All of these findings are consistent with an internalized homophobia hypothesis. Teenagers who discover and disclose their sexuality earlier may be more isolated, cognitively embedded within heterosexist norms and values, and have less access to gay-affirmative organizations (e.g. at college, etc.) and individuals. Gonsiorek and Rudolph (Gonsiorek and Rudolph, 1991) refer to a narcissistic injury which is the significant blow to self-esteem that occurs when the individual is rejected through disclosing significant, personal information such as disclosing a lesbian or gay identity. Younger adolescents may be particularly vulnerable because they have less developed coping strategies and fewer coping resources—particularly given the overtly heterosexist culture of most secondary schools.¹⁶ It may also be that significant others (particularly parents, teachers) are more likely to trivialize or dismiss younger adolescents same-sex attractions. In Hammelman's study most of the participants problematized their sexuality and related behaviours. For example, 59% of those who disclosed a substance abuse problem directly attributed it to coping with their sexuality. Research strongly indicates that alcohol and other substance abuse is another predictor of youth suicide, and there may be a powerful interaction which makes a proportion of lesbian and gay youth particularly vulnerable to suicide ideation and behaviours.

Research also suggests that internalized homophobia may also be associated with more chronic forms of self-harm. Studies on alcoholism and substance abuse have already been mentioned. Research on gay men has indicated a strong relationship between measures of ego-dystonic gay sexuality and the NHAI with a number of measures of eating disturbance including the Eating Attitudes Test (Garner and Garfinkel, 1979) and Garner's (Garner, 1991) Eating Disorders Inventory #2 (Williamson and Hartley, 1998; Williamson, 1999). The relationship appears to be strongest with measures of bulimia and this may be consistent with a desire to punish the body for its same-sex urges. In America, work by Brown (Brown,

1987) has pointed to similar correlations amongst lesbian women.

Internalized homophobia may also affect health indirectly—especially when operating below consciousness. Work by Margolies *et al.* (Margolies *et al.*, 1987) and Malyon (Malyon, 1982) suggest that internalized homophobia may affect intrapsychic functioning by generating various defence mechanisms. These may project themselves through difficulties with intimacy, commitment or other aspects of relationships. For example, a study by Rosser *et al.* (Rosser *et al.*, 1997) reports significantly lower levels of sexual satisfaction in high scoring homonegative gay participants compared to low scorers. Equally, homonegativity may lead to the development of self-defeating personality traits which reflect internal representations of the stereotypical dysfunctional homosexual. These ‘secondary and tertiary adaptations’ as Malyon labels them may have a profound impact upon the mental health of the individual and any interventions would need to be within a gay-affirmative therapeutic paradigm.

Internalized homophobia—balancing the ‘personal’ and the ‘political’

Despite the widespread acceptance of internalized homophobia as a valid concept within lesbian and gay health and social scientific arenas, there are a number of concerns around an indiscriminating acceptance of the term as a research-orientated and theoretical paradigm. In addition to the conceptual and methodological difficulties raised earlier in this paper, there are also significant implications for lesbian and gay communities if we choose to explain and conceptualize health difficulties in this way. Kitzinger (Kitzinger, 1996, 1997) raises a number of objections to the concept of internalized homophobia. These include its emphasis on individual pathology rather than on institutional oppression. The danger of using terms like internalized homophobia or homonegativity is that being gay or lesbian is implicitly represented in pathological terms. ‘Instead of going to heterosexual therapists to be cured of our homosexuality, now

lesbians and gay men are supposed to seek out lesbian and gay therapists to be cured of internalized homophobia’ [(Kitzinger, 1997), p. 211]. The concept suggests weakness rather than the resilience demonstrated by lesbians and gay men, and keeps the focus away from the structures of inequality and oppression.¹⁷ In addressing internalized homophobia rather than institutionalized and cultural heterosexism, lesbian and gay academics are in many ways ‘buying into’ the individualistic and positivist-empiricist biases of mainstream psychology which continues to denigrate and pathologize the voices, identities and experiences of lesbians and gay men. However, it must be noted that many lesbians and gay men do benefit from the gay-affirmative therapeutic interventions of lesbian and gay therapists which typically explicitly address internalized homophobia, and there is a considerable body of evidence linking homonegativity and pathology. It may well be that as queer academics we are persuaded by the dangers of current conceptualizations of internalized homophobia in a socio-political sense, but also recognize a need to address the problems of lesbians and gay men in a health milieu. This must involve addressing issues as clients see them and using language that they can identify with. There is a need to achieve a balance between the personal and political, and it is incumbent on lesbian and gay social scientists to be especially sensitive to and critical of the concepts we use and their consequences, particularly where there is potential for reinforcing oppressive, heterosexist structures.

Furthermore there is a clear need to balance interventions on an individual basis with more collective social action. There is clearly a need in most countries for specific legislation which addresses the civil rights of lesbian and gay peoples, and which addresses ‘hate crimes’ specifically. In Britain, the repeal of Section 28 of the 1988 Local Government Act, which prohibits the ‘intentional promotion of homosexuality’ in Local Education Authority run schools, is essential for teachers and school counsellors to feel free to fully support lesbian and gay students without fear of sanction.

Whilst cultural and institutional heterosexism remain largely unchallenged, it is difficult to provide nurturing and supportive environments for all lesbian and gay people, and particularly those who are particularly anxious, distressed or confused about their sexual identities.

Fortunately, there does appear to be an increase in the social/support infrastructure available to (particularly younger) lesbians and gay men in many areas. Cody and Welch's study (Cody and Welch, 1997) demonstrated the importance of social and community groups in working through issues around internalized homophobia and constructing 'families of choice'. One participant in the study states; 'The support group helped me to feel better about being gay...being happy and gay is not an oxymoron. You can have both' [(Cody and Welch, 1997), p. 62]. Interestingly a sense of community was achieved by men in this study through groups, friendship networks and particular partners rather than through participation in the commercial gay 'scene' in neighbouring towns and cities. This may be particularly valid for women for whom there is often a dearth of commercial venues which are not (gay) male dominated. Such groups appear to often play a vital role in providing accurate information, discussing salient issues and working on skills (e.g. assertiveness, negotiating safer sex, etc.) and strategies both formally and informally within a safe and explicitly gay-affirmative environment.

Concluding remarks

This paper has aimed to provide a wide-ranging discussion of the role of internalized homophobia with health-related problems amongst lesbians and gay men. I have provided evidence that suggests that homonegativity merits consideration as a predisposing and perpetuating factor in many aspects of ill-health. As a concept, it may help to identify particularly vulnerable and at risk individuals, and should be considered in health education and disease prevention models. Internalized homophobia may relate to coping strategies and a willingness to access certain coping resources. There is as yet

no clear evidence that homophobia impacts directly on the progression of illnesses, although it may interact with other factors (e.g. coping strategies) to produce important health-related consequences. I hope that the paper has re-emphasized the need for gay-affirmative models of health care and intervention. Whilst there is a valid explanatory role for internalized homophobia, there remains a number of integral inadequacies and inconsistencies in how the concept is defined and operationalized, and there is a significant need to refine the concept and improve the way that it is assessed, both qualitatively and quantitatively. Furthermore, there is also a need to be aware of the potentially harmful role of using the concept imprudently in terms of feeding into heterosexist pathological models and in underestimating both the heterogeneity and resilience of lesbian and gay communities. At worst, internalized homophobia represents a catch-all pseudo-explanation which colludes with anti-gay and lesbian models of ill-health. As social scientists and health professionals, we need to ensure that this does not happen but rather that the concept is used judiciously and helps to further develop models which validate the experiences of lesbians and gay men and provide adequate interventions to health problems.

Notes

1. The term 'internalized homophobia' had been used throughout this article to represent the negative and distressing thoughts and feelings experienced by lesbians and gay men about their sexuality, and which are attributed to experiences of cultural heterosexism and victimization. For reasons discussed in the text, the author believes the term 'homophobia' to be highly problematic; however, for the purposes of continuity and consistency with the majority of other publications on this issue, the term has been replicated here rather than using more accurate but obscure terminology.
2. Defined by Sprecher and McKinney (Sprecher and McKinney, 1993) as 'negative and/or fearful attitudes about homosexuals or homosexuality'.
3. Used here as an inclusive term to include all social scientists working from an explicitly lesbian, gay, transgender or bisexual perspective.
4. See Logan (Logan, 1996) for a fuller discussion.
5. For example, Clark and Clark's (Clark and Clark, 1958) study into young Black children's internalization of racial prejudice.

6. Shidlo (Shidlo, 1994) argues that the terms 'internalized homonegativity' and 'internalized homonegativism' are preferable to 'internalized homophobia', but that these are conceptually similar enough to use interchangeably. The former of these has been used on occasion in this article.
7. Ego-dystonic homosexuality refers to an individual's persistent and profound distress with their lesbian or gay sexuality and is often associated with a desire to modify sexual orientation. The term has become particularly controversial after the inclusion of the term as a diagnostic classification within DSM-III (American Psychiatric Association, 1980). See Cabaj and Stein [(Cabaj and Stein, 1996), pp. 25–26] for more information. Bohan [(Bohan, 1996), p. 19] also offers a brief, lucid discussion of 'ego-dystonia'.
8. Shidlo (Shidlo, 1994) offers a detailed overview of a number of studies which have evaluated the NHAJ.
9. See Davies (Davies, 1992), Sophie (Sophie, 1987) or Plummer (Plummer, 1995) for a fuller discussion
10. It is worth noting that the majority of the sample (85%) were strongly affiliated to the 'gay community' and open about their sexuality. As is a frequent problem with studies involving gay men, the sample here, although large and recruited through a number of sampling strategies, is most unlikely to be a good representation of the overall gay community.
11. This research is still being carried out. Discussion of the study is based upon the pilot study data published in 1998.
12. There is markedly less literature on the issue of homophobia, and its impact upon lesbian identity and health issues generally. Two valuable references, however, are Sophie (Sophie, 1987) and O'Hanlan (O'Hanlan, 1996).
13. Ego-syntonic—where the individual is accepting of lesbian or gay sexual identity. Being gay or lesbian represents a potential source of pride.
14. Participants were heterogeneous in relation to HIV status, and included significant numbers of seronegative men, symptomatic and asymptomatic HIV-positive men, and a small number with an AIDS diagnosis.
15. Attrition rate of the sample was due to drop-out ($N = 25$) or death ($N = 20$). No participants had seroconverted during the two testing periods.
16. For a full discussion, see Williamson (Williamson, 2000) or Walters and Hayes (Walters and Hayes, 1998).
17. Kitzinger goes on to argue that distress in the face of oppression is perfectly reasonable and that to see such 'forms of unhappiness' as internalized homophobia (i.e. an example of individual pathology) is inaccurate. Because 'homophobia' strongly suggests pathology, homonegativity again appears to be a preferable alternative.

References

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- Allport, G. (1954) *The Nature of Prejudice*. Addison-Wesley, Reading, MA.
- American Psychiatric Association (1980) *Diagnostic and Statistical Manual of Mental Disorders*, 3rd edn. APA, Washington.
- Bohan, J. (1996) *Psychology and Sexual Orientation*. Routledge, New York.
- Bremner, J. and Hillin, A. (1993) *Sexuality, Young People and Care: Creating a Positive Context for Training, Policy and Development*. Central Council for Education and Training in Social Work, London and South East Region, London.
- Brooks, V. (1981) *Minority Stress and Lesbian Women*. Lexington Press, Lexington, KY.
- Brown, L. (1987) Lesbians, weight and eating: new analyses and perspectives. In Boston Lesbian Psychologies Collective (eds), *Lesbian Psychologies: Explorations and Challenges*. University of Illinois, Urbana, IL, pp. 294–309.
- Cabaj, R. and Stein, T. (eds) (1996) *Textbook of Homosexuality and Mental Health*. American Psychiatric Press, Washington, DC.
- Clark, K. and Clark, M. (1958) Racial identification and preference in Negro children. In Maccoby, E., Newcomb, T. and Hartley, E. (eds), *Readings In Social Psychology*, 3rd edn. Holt, Rinehart & Winston, New York, pp. 602–609.
- Cody, P and Welch, R. (1997) Rural gay men in northern New England. *Journal of Homosexuality*, **33**, 51–67
- Davies, P. (1992) The role of disclosure in coming out. In Plummer, K. (ed.), *Modern Homosexualities*. Routledge, London, pp. 75–83.
- Davies, D. (1996) Homophobia and heterosexism. In Davies, D. and Neal, C. (eds), *Pink Therapy*. Open University Press, Buckingham, pp. 41–65.
- Davies, P., Hickson, F., Weatherburn, P. and Hunt, A. (1993) *Sex, Gay Men and AIDS*. The Falmer Press, London.
- DiPlacido, J. (1998) Minority stress among lesbians, gay men and bisexuals: a consequence of heterosexism, homophobia and stigmatization. In Herek, G. (ed.), *Stigma and Sexual Orientation*. Sage, Thousand Oaks, CA, pp. 138–159.
- Finnegan, D. and Cook D. (1984) Special issues affecting the treatment of gay male and lesbian alcoholics. *Alcoholism Treatment Quarterly*, **1**, 85–98.
- Folkman, S., Lazarus, R., Dunkel-Schetter, C., DeLongis, A. and Gruen, R. (1986) Dynamics of a stressful encounter: cognitive appraisal, coping and encounter outcomes. *Journal of Personality and Social Psychology*, **50**, 992–1003.
- Garner, D. (1991) *The Eating Disorders Inventory Version Two*. Psychological Assessment Resources, Odessa, WA.
- Garner, D. and Garfinkel, P. (1979) The Eating Attitudes Test: an index of the symptoms of anorexia nervosa. *Psychological Medicine*, **9**, 273–279.
- Glaus, O. (1988) Alcoholism, chemical dependency and the lesbian client. *Women and Therapy*, **8**, 121–144.
- Gold, R., Skinner, M. and Ross, M. (1994) Unprotected anal intercourse in HIV-infected and non-HIV-infected gay men. *The Journal of Sex Research*, **31**, 59–77.
- Gonsiorek, J. and Rudolph, J. (1981) Homosexual identity: coming out and other developmental events. In Gonsiorek, J. and Weinrich, J. (eds), *Homosexuality*. Sage, Thousand Oaks, CA, pp. 161–176.
- Hammelman, T. (1993) Gay and lesbian youth: contributing factors to serious attempts or considerations of suicide. *Journal of Gay and Lesbian Psychotherapy*, **2**, 77–89
- Harry, J. (1986) Sampling gay men. *The Journal of Sex Research*, **22**, 21–34.
- Herek, G. and Berrill, K. (eds) (1982) *Hate Crimes: Confronting Violence against Lesbians and Gay Men*. Sage, Thousand Oaks, CA.
- Hudson, W. and Ricketts, W. (1980) A strategy for the measure of homophobia. *Journal of Homosexuality*, **5**, 357–372.

- Isay, R. (1989) *Being Homosexual: Gay Men and Their Development*. Farrar, Straus and Giroux, London.
- Kippax, S., Connell, R., Dowsett, G., and Crawford, J. (1993) *Sustaining Safe Sex: Gay Communities respond to AIDS*. The Falmer Press, London.
- Kitzinger, C. (1996) Speaking of oppression: psychology, politics and the language of power. In Rothblum, E. and Bond, L. (eds), *Preventing Heterosexism and Homophobia*. Sage, Thousand Oaks, CA, pp. 3–19.
- Kitzinger, C. (1997) Lesbian and gay psychology. In Fox, D. and Prilleltensky, I. (eds), *Critical Psychology*. Sage, London, pp. 202–216.
- Lazarus, R. and Folkman, S. (1984) *Stress, Appraisal and Coping*. Springer, New York.
- Locke, J. (1998) Treatment of homophobia in a gay male adolescent. *American Journal of Psychotherapy*, **52**, 202–214.
- Logan, C. (1996) Homophobia? No, homophobia. *Journal of Homosexuality*, **31**, 31–53.
- Malyon, A. (1982) Psychotherapeutic implications of internalised homophobia in gay men. *Journal of Homosexuality*, **7**, 59–70.
- Margolies, L., Becker, M. and Jackson-Brewer, K. (1987) Internalised homophobia: identifying and treating the oppressor within. In Boston Lesbian Psychologies Collective (ed.) *Lesbian Psychologies: Explorations and Challenges*. University of Illinois, Urbana, IL, pp. 229–241.
- Martin, J. and Dean, L. (1987) *Ego-Dystonic Homosexuality Scale*. School of Public Health, Columbia University.
- Meyer, I. (1995) Minority stress and mental health in gay men. *The Journal of Health and Social Behaviour*, **36**, 38–56.
- Meyer, I. and Dean, L. (1998) Internalized homophobia, intimacy and sexual behaviour among gay and bisexual men. In Herek, G. (ed.), *Stigma and Sexual Orientation*. Sage, Thousand Oaks, CA, pp. 160–186.
- Nicholson, W. and Long, B. (1990) Self-esteem, social support, internalised homophobia, and coping strategies of HIV+ gay men. *Journal of Consulting and Clinical Psychology*, **58**, 873–876.
- Nungesser, L. (1983) *Homosexual Acts, Actors and Identities*. Praeger, New York.
- O'Hanlan, K. (1996) Homophobia and the health psychology of lesbians. In Kato, P. and Mann, T. (eds), *Handbook of Diversity Issues in Health Psychology*. Plenum Press, New York, pp. 261–284.
- Plummer, K. (1995) *Telling Sexual Stories*. Routledge, London.
- Remafedi, G., Farrow, J. and Deisher, R. (1991) Risk factors for attempted suicide in gay and bisexual youth. *Paediatrics*, **87**, 869–875.
- Rofes, E. (1983) *I Thought People Like That Killed Themselves: Lesbians, Gay Men and Suicide*. Grey Fox, San Francisco.
- Ross, M. and Rosser, B. (1996) Measurement and correlates of internalised homophobia: a factor analytic study. *Journal of Clinical Psychology*, **52**, 15–21.
- Rosser, B., Metz, M., Bocking, W. and Buroker, T. (1997) Sexual difficulties, concerns and satisfaction in homosexual men: an empirical study with implications for HIV prevention. *The Journal of Sex and Marital Therapy*, **23**, 61–73.
- Sandfort, T. (1995) HIV/AIDS prevention and the impact of attitudes toward homosexuality and bisexuality. In Herek, G. and Greene, B. (eds), *AIDS, Identity and Community: The HIV Epidemic and Lesbians and Gay Men*. Sage, Thousand Oaks, CA, pp. 112–125.
- Sell, R. and Petruccio, C. (1996) Sampling homosexuals, bisexuals, gays and lesbians for public health research: a review of the literature from 1990 to 1992. *Journal of Homosexuality*, **30**, 31–48.
- Shidlo, A. (1994) Internalized homophobia: conceptual and empirical issues in measurement. In Greene, B. and Herek, G. (eds), *Lesbian and Gay Psychology: Theory, Research and Clinical Applications*. Sage, Thousand Oaks, CA, pp. 176–205.
- Sophie, J. (1987) Internalised homophobia and lesbian identity. *Journal of Homosexuality*, **14**, 53–66.
- Stokes, J. and Peterson, J. (1998) Homophobia, self-esteem and risk for HIV among African American men who have sex with men. *AIDS Education and Prevention*, **10**, 278–292.
- Sprecher, S. and McKinney, K. (1993) *Sexuality*. Sage, Thousand Oaks, CA.
- Wagner, G., Brondolo, E. and Rabkin, J. (1996) Internalised homophobia in a sample of HIV+ gay men, and its relationship to psychological distress, coping and illness progression. *Journal of Homosexuality*, **32**, 91–106.
- Walters, A. and Hayes, D. (1998) Homophobia within schools: challenging the culturally sanctioned dismissal of gay students and colleagues. *Journal of Homosexuality*, **35**, 1–21.
- Williamson, I. (1999) Towards an understanding of eating disturbance and body dissatisfaction amongst gay men. Paper presented at the *British Psychological Society Annual Conference*, Belfast.
- Williamson, I. (2000) *Sexuality*. In Hill, D. and Cole, M. (eds), *Schooling and Equality: Empirical and Conceptual Issues*. Tufnell Press, London, in press.
- Williamson, I. and Hartley, P. (1998) British research into the increased vulnerability of young gay men to eating disturbance and body dissatisfaction. *European Eating Disorders Review*, **6**, 60–70.

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