Young, Gay and Suicidal: Who Cares?

The Attitudes of Australian Heterosexual and Homosexual Men and Women Towards the Suicide of Gay Male and Lesbian Adolescents

by

Mari Molloy

B. A. (Psych), Post Grad Dip. (Psych)

A research thesis submitted in partial fulfillment of the requirements for the degree of

Doctor of Psychology (Clinical)

School of Behavioural and Social Sciences and Humanities

University of Ballarat

PO Box 663

Gear Avenue, Mt Helen

Ballarat, Victoria, 3350

Australia

June 2004

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

Appendix

Statement of Authorship

Except where explicit reference is made in the text of this document, this body of work contains no material published elsewhere or extracted in whole or part from a thesis by which I have qualified for or been awarded another degree or diploma. No other person's work has been relied upon or used without due acknowledgement in the main text or reference list of this thesis.

Signature: _____

Date: _____

ACKNOWLEDGEMENTS

There are many people who contributed either directly or indirectly in the preparation and completion of this thesis, and to whom I would like to express my thanks:

♥ To my wonderful partner, Susan Hannah for all your support, patience and encouragement over the decade of my life as a student. For the quiet and unspoken way you took care of our boys and myself and the running of our household when I was too consumed by my studies to do so. All the hours you worked alongside me as an unofficial yet very valuable and supportive research assistant did not go unnoticed. You have been my rock throughout this time and I know I could not have made it through without you there to share my joys, comfort my fears, and celebrate my successes.

♥ To my boys, Michael, Chris, and Benn. You have lived through ten long years of having a student for a Mum. In all that time, you have encouraged and supported me in my goals, despite the cost to you all at times when my studies meant I seemed to always be attached to my computer or buried within the depths of a textbook. Thank-you for still being there as I reach the end of my time as a student. I promise I will cook more often now.

♥ To my supervisor Dr Suzanne McLaren, words can never convey the significance you have had on my life. You entered my life at a time when I was still unsure of were I was going. You encouraged me from the beginning to believe that I could do anything if I wanted it badly enough, and throughout the past 4 years, you have supported and nurtured me towards reaching goals that I never thought were possible. Your acceptance of me as an individual and passion for the work we have done together have been an inspiration to me. You are a skilled and caring teacher and I have so valued working and learning alongside you. As this stage of my life nears completion, I feel sad that my time as your student is ending, but look forward to having you as a friend for very many years to come.

♥ To my associate supervisor, Dr Angus McLachlan, what can I say but thank-you. The term critical difference will always have a special meaning for me, and will bring back fond memories of your unfailing patience throughout the analysis phase of this project. Your input in to this research, and assistance in the forming of the final document was very much appreciated. Now, I promise never to knock at your door again, except to say hello and how are you going.

♥ To Sue Taylor for all your help and assistance in getting the vast number of articles and books I needed to complete this thesis. Your help in this aspect of this project did not go unnoticed, or unappreciated. Nothing was ever too much trouble for you, and I was always welcomed into your office with a smile. You really are one in a million.

♥ To the University of Ballarat for their wholehearted support of my research into gay and lesbian issues despite initial negative reactions from some sections of the university community. Your willingness to support and defend the importance of valuing and accepting diversity is greatly appreciated and highly valued.

♥ To the heterosexual and homosexual men and women who participated in this research, for your willingness to share openly and honestly of yourselves in this study. Your support in investigating such a sensitive and emotive area was wonderful.

Abstract

Despite gay male and lesbian adolescents being at significant risk for suicide, few studies have been undertaken to examine attitudes towards gay male and lesbian adolescent suicide. The present study sought to examine the attitudes of heterosexual and homosexual men and women towards gay male and lesbian adolescent suicide. Approximately 1200 Australians completed a series of questionnaires, including the Suicide Attitude Vignette Experience. Results indicate that the suicide of a gay male or lesbian adolescent was rated as more justified, acceptable, necessary and psychologically healthy than the suicide of a heterosexual male or female adolescent. However this attitude was shown to vary according to both the gender and sexual orientation of the participant and the suicide victim. The level of empathy for the victim was also shown to vary across the participants, with homosexual participants reporting greater empathy for the gay male and lesbian suicide victims than the heterosexual male and female victims. Heterosexual males reported greater empathy for heterosexual male and female victims, whereas heterosexual female participants showed greater empathy for the gay male suicide victims. Predictors of attitudes towards gay male and lesbian adolescent suicide were also examined. Findings indicated that the strongest predictors within heterosexual participants were age and gender, with younger participants and male participants reporting the most tolerant attitudes to gay male and lesbian adolescent suicide. For homosexual participants the strongest predictor was age. Again, younger participants held the most tolerant attitudes to gay male and lesbian adolescent suicide. Finally the effect of frequency and type of contact with gay males and lesbians on heterosexual participants' level of homophobia was examined. Homophobia was greatest for those participants who had no contact or infrequent non-social types of contact with homosexuals. These

findings suggest that there is a belief within the Australian heterosexuals and homosexuals that suicide is one of the recognised and tolerated choices open to a young person who becomes aware of their homosexuality. However, the meaning of this tolerance could not be identified within the current study. Interventions, which enhance awareness about homosexuality and the needs of gay male and lesbian adolescents, particularly within the younger members of the Australian community, should be the focus of interventions.

Chapter 1: Introduction

There is increasing concern about the rising incidence of suicide in Australia. The latest figures available show that in 1999, 2,683 suicides were recorded (Australian Bureau of Statistics, 2000). Of significant importance within these statistics is the high rate of suicide among young Australians. In 1999, 446 suicides occurred among young people aged 15-24 (364 males and 82 females). The Australian Bureau of Statistics reports that between 1978 and 1999 the age specific death rate for suicide among young people aged 15 to 24 has risen from 11 to 17 deaths per 100,000. This places suicide as the second most common cause of death among Australian adolescents, accounting for 25% of all deaths within this age group, and preceded only by death due to motor vehicle accidents (Australian Bureau of Statistics, 2000).

As a consequence of this high suicide rate, extensive research has been undertaken to gain insight and understanding into the development of suicidal behaviour among young people. The findings of this research have proven effective in identifying many of the indicators for suicidality among adolescents. Researchers have investigated some of the important underlying vulnerabilities that may impact on the development of suicidal behaviour in adolescence (Bagley & Tremblay, 1997; Bull, 1994; Crespi, 1990; Deluty, 1988/89a; Emslie, 1996; Hassan, 1995; Ingram & Ellis, 1995; Kalafat, 1990; Kandel, Ravis, & Davies, 1991; Marks, 1989; Popenhagen & Qualley, 1998; Remafedi, 1994; Rubinstein, Heeren, Housman, Rubin, & Stechler, 1989; Silbert & Berry, 1993; Wagner, Cole, & Schwartzman, 1995; Williams & Pollock, 1993). Described as risk factors, these elements reflect the relative difficulties and vulnerabilities that can exist among various sub-populations of adolescents. Research into these ‘risk factors’ has helped researchers identify a need not only for prevention strategies that address the immediate causes but also the effects of these various underlying risk factors as they apply across the various sub-populations of adolescents (Commonwealth Department of

Health & Family Services, 1997; Emslie, 1996; Erwin, 1993; Herschberger & Pilkington, 1997; Proctor & Groze, 1994; Remafedi, 1994; Williams & Pollock, 1993).

1.1 Risk Factors Associated with Adolescent Suicide

Every suicide attempt is an individual event, affected by the interaction of a multiplicity of different factors of causation and mediation. Examination of life histories has shown, however, that there are underlying 'risk factors' that are common to many attempters. These risk factors fall into three main categories – predisposing factors, precipitating factors, and perpetuating factors (Taylor, 1994). Taylor states that some of the factors that have been proposed as predisposing factors for suicide attempts are a history of suicide attempts by family or friends, a history of sexual abuse and mental illness, particularly clinical depression.

A significant amount of research has focused on the immediate circumstances surrounding suicide deaths or attempts in an effort to determine common precipitating factors. These are traumatic life events that can act as catalysts to a suicide attempt, and include relationship break-ups, a diagnosis of a terminal illness, the loss of a job, the experience of violence, the death of a loved one, or rejection by one's family (Crespi, 1990; Deluty, 1988/89a; Hassan, 1995; Ingram & Ellis, 1995; Kalafat, 1990; Popenhagen & Qualley, 1998; Silbert & Berry, 1993; Wagner et al., 1995; Williams & Pollock, 1993).

It is important to note that the risk factors outlined are not expected to act as accurate predictors of suicide attempts. Some attempters will exhibit few or none of the indicators mentioned. Alternatively, there are numerous individuals who demonstrate many of the recognised risk factors who will never attempt suicide. As such, the complex interaction of the multiplicity of recognised factors may never be completely understood (Bettes & Walker, 1986; Kalafat, 1990).

Remafedi (1994) suggests that the risk factors associated with adolescent suicide can be conceptualised into three categories of related issues: childhood adversity, social disadvantage and psychiatric morbidity, with each independently contributing to the increased risk of suicidal behaviour and suicide. As such, factors that have been shown to be associated with an increased risk of suicidality and identified high-risk groups within the adolescent population include living with mental illnesses, psychiatric illnesses, and/or depressive illnesses (Commonwealth Department of Health & Family Services, 1997; Emslie, 1996), living in a rural and/or remote areas (Dudley & Waters, 1991; Dudley, Waters, Kelk, & Howard, 1992; Erwin, 1993; Herschberger & Pilkington, 1997; Lawerence & Williams, 1990; Medland, 1991; Proctor & Groze, 1994; Quittner, 2000; Remafedi, 1994; Williams & Pollock, 1993; Woodard, 1997), unemployment, family and interpersonal problems (Herschberger & Pilkington, 1997; Kournay, 1987; Rubenstein et al., 1989; Savin-Williams, 1989), physical and/or sexual abuse (Crespi, 1990; Silbert & Berry, 1993), homelessness, drug or alcohol use (Bukstein et al., 1993; Crespi, 1990; Kalafat, 1990; Kandel et al., 1991), depression (Kandel et al., 1991; McDermott et al., 1990) and a homosexual sexual orientation (D'Augelli & Herschberger, 1993; Hammelman, 1993; Herdt & Boxer, 1993; Herschberger & D'Augelli, 1995; Herschberger, Pilkington, & D'Augelli, 1996; Hunter, 1990; Martin & Hetrick, 1988; Remafedi, 1987a, 1987c, 1990; Remafedi, Farrow & Deisher, 1991; Rotheram-Borus, Hunter & Rosario, 1994; Schneider, 1991; Schneider, Fareberow, & Kruks, 1989). Further, research has identified gay male and lesbian adolescents as a particularly high-risk sub-group of adolescents who often exhibit many of these risk factors simultaneously. This is of significant concern in Australia given that current estimates suggest 10% of the Australian population has experienced some level of same-sex attraction and suggests that approximately one in every five families in this country has a gay male or lesbian child (Dahlheimer & Feigal, 1991).

1.2 Gay Male and Lesbian Adolescent Suicide

Research investigating the impact of sexuality on the rates of suicide and suicidality among adolescents within Australian research has been scant at best (Emslie, 1996; Mason, 1989; Morgan, 1996; Sibley, 1995). The outcomes reported in the few studies that have been undertaken have viewed homosexual adolescents as an alienated, marginalised and disaffected group of young people who require mental health support (Emslie, 1996; MacDonald & Cooper, 1998; Nicholas & Howard, 1998). It is also important to note that an emphasis only upon the mental health problems associated with suicide and suicidality among gay male and lesbian adolescents may not be sufficient (Emslie, 1996). Prominent US researcher into gay male and lesbian adolescent suicide, Remafedi (1994) believed that a mental health discourse alone only serves to further marginalise gay male and lesbian adolescents and does nothing to eradicate the heterosexism and homophobia, which he argued, is at the centre of their experience. He believed that such views as this fail to recognise that social factors might be relatively more important than intrapsychic variables in explaining suicide among gay male and lesbian adolescents. Remafedi concluded that adolescence in and of itself is a difficult developmental stage, fraught with change and turmoil, and it is made even more complicated when one is homosexual.

The proposition that gay male and lesbian adolescents are more vulnerable to suicide has undergone considerable investigation by researchers, mostly within the United States of America. Investigations within gay male and lesbian adolescent populations in the US have explored questions about suicide risk in relation to gay male and lesbian sexual orientation and found that there seems to be an unusual prevalence of suicide attempts and ideation among gay male and lesbian adolescents (D'Augelli & Herschberger, 1993; Freidman & Downey, 1994; Hammelman, 1993; Herdt & Boxer, 1993; Herschberger & D'Augelli, 1995; Herscberger et al., 1996; Hunter, 1990; Martin

& Hetrick, 1988; Remafedi, 1987b, 1990; Remafedi et al., 1991; Rotheram-Borus et al., 1994; Schneider, 1991; Schneider et al., 1989).

The statistics on suicide ideation, attempted and completed suicides among gay male and lesbian adolescents, however, are widely variable, with the percentages of completed and attempted suicide by gay male and lesbian adolescents comprising anywhere from 2.5% to 30% of those of adolescents in general (Bagley & Tremblay 1997; Bull, 1994; Dempsey, 1994; Gibson, 1989; Hammelman, 1993; Herdt & Boxer, 1993; Pilkington & D'Augelli, 1997; Remafedi et al., 1991; Remafedi, French, Story, Resnick, & Blum, 1998). The risk among gay male and lesbian adolescents is anywhere from slightly less (Herschberger et al., 1996) to 13 times greater (Bagley & Tremblay, 1997) than that of heterosexual adolescents. Research has shown however, that as many as 60% of gay males and lesbians have reported serious suicidal ideation (Herschberger et al., 1996; Schneider et al., 1989) and that somewhere between 20% and 42% of gay male and lesbian adolescents attempt suicide (Bagley & Tremblay, 1997; Bull, 1994; Dempsey, 1994; Gibson, 1989; Hammelman, 1993; Herdt & Boxer, 1993; Herschberger et al., 1996; Pilkington & D'Augelli, 1997; Remafedi et al., 1991; Remafedi et al., 1998). Researchers also note that the suicidal behaviours or attempts undertaken by gay male and lesbian adolescents are more serious and more often fatal than those of their heterosexual counterparts (Kournay, 1987; Remafedi et al., 1998).

The extremely wide range of statistics on the correlation between a gay male and/or lesbian sexual orientation and suicide stems from a number of factors, including difficulties in determining the sexual orientation of the suicide victim (Bagley & Tremblay, 1997; Herschberger et al., 1996; Remafedi et al., 1998), the 'type' of homosexual population studied, for example, runaways, gay and lesbian support group members, crisis centre clients, university students, internet respondents, and school-based adolescents (DuRant, Krowchuk, & Sinal, 1998; Faulkner & Cranston, 1998;

Garaofalo, Wolf, Kessel, Palfrey, & DuRant, 1998; Lebson, 2002; Remafedi et al., 1998; Savin-Williams, 1994), the definition of what the study is investigating (i.e., suicidal behaviour versus suicidal ideation) (Lebson, 2002), rural versus urban locations (Buhrich & Loke,1988) and differing cultural and religious societies (Buhrich & Locke, 1988; Herschberger et al., 1996). Despite these issues, however, empirical evidence continues to support the assertion that gay male and lesbian adolescents are at a greater risk for suicidal behaviour and suicide than their heterosexual counterparts (Bagley & Tremblay, 1997; Faulkner & Cranston, 1998; Fergusson, Horwood, & Beautris, 1999; Garofalo et al., 1998; Remafedi et al., 1998; Waldo, Hesson-McInnis, & D'Augelli, 1998).

As noted above, it is not possible to comment upon the exact relationship between gay and lesbian adolescent suicidal behaviour and suicide in Australia, as neither gay male and lesbian adolescents nor the issues of sexual orientation and sexual identity, in relation to suicide and suicidal behaviour have been the subjects of any systematic research. The occurrence of gay male and lesbian suicide and suicidal behaviour within the Australian adolescent population has, however, been identified by researchers and official reports (Commonwealth Department of Human Services and Health 1995a, 1995b; Commonwealth Department of Health and Family Services, 1997; Costigan, 1996; Emslie, 1996; Leary, 1992; MacDonald & Cooper, 1998; Mason, 1989; Nicholas & Howard, 1998; Taylor, 1994, 1995).

Comparison of the incidence of gay male and lesbian adolescent suicide and suicidal behaviour in Australia with US figures, however, is limited. A report conducted for the Young Lesbian Support Group investigated suicide attempts and ideation in 200 Australian lesbians aged 14–25 years (Barbeler, 1991) with 47.5% reporting having made a suicide attempt at some time in their life, and 31% of

attempters indicating it was because of their sexuality. Similarly, prior suicidal ideation was common, but attributed to sexuality in less than 50%.

Nicholas and Howard (1998), using a matched sample of 57 gay and 54 heterosexual males, found that gay males were 3.7 times more likely to attempt suicide than heterosexual males. The study involved 57 gay-identified and 54 straight-identified participants recruited from the greater Sydney area. Participants were recruited through personal referral, universities, gay-identified support services and welfare agencies. They also found correlates of the factors surrounding suicide attempts within their gay sub-sample to include sexual assault, experiences of violence, low levels of parental support and precocious sexual identity development. Similarly, MacDonald and Cooper (1998), in a study of young gay men in Perth, found that the prevalence of homophobic attitudes and lack of support for young gay men may be important factors in the high suicide rate among young gay males in Australia. These results, while limited, are consistent with those reported within the US studies.

In summary, while the rate of adolescent suicide in Australia has continued to rise in recent years, the impact of differing sexual orientations on the suicidality within this population has largely been ignored. The current view of gay male and lesbian adolescents within Australia appears to be one that sees them as being in need of mental health support and intervention. The evidence presented from overseas research has shown that gay male and lesbian adolescent's vulnerability towards suicide is due to factors other than that of mental health problems. This suggests that the perpetuation of a solely mental health focus for gay male and lesbian adolescents, without a thorough investigation of society's attitudes and responses towards homosexuality and gay male and lesbian adolescents, fails to consider the possible role these elements may play in the development of mental health issues, suicidal behaviour and suicide among gay male and lesbian adolescents.

1. 3 Risk Factors for Gay Male and Lesbian Adolescent Suicide

Research evidence has shown that homosexual adolescents are vulnerable to the same risk factors for suicidal behaviour that affect heterosexual adolescents. These include low self-esteem, isolation, guilt, depression, poor problem solving skills, and stress (Capuzzi, 1994; Hunter, 1990; Proctor & Groze, 1994; Remafedi et al., 1991; Rofes 1989). However, gay male and lesbian adolescents often experience a higher incidence of some of these factors (Bagley & Tremblay, 1997; Coleman & Remafedi, 1989; D'Augelli & Herschberger, 1993; Emslie, 1996; Gibson, 1989; Hammelman, 1993).

Further, these factors, when applied to homosexual adolescents, can become amplified due to the unique developmental processes homosexual adolescents experience and the oppression and stigma to which they are exposed (Emslie, 1996; Herschberger & Pilkington, 1997; Proctor & Groze, 1994; Remafedi, 1987c; Remafedi et al., 1991; Troiden, 1989; Vare & Norton, 1998). Some perpetuating factors that research has suggested to be involved in a significant number of suicides by gay male and lesbian adolescents are non-reconciliation of one's sexuality with religious beliefs, ongoing homophobic harassment, ongoing internalisation of negative views about homosexuality, non-conformity with gay male and lesbian stereotypes, and a lack of social support networks; homophobia, coming out as a gay male or lesbian at a young age, and for males, having feminine gender characteristics (Bagley & Tremblay, 1997; Coleman & Remafedi, 1989; Commonwealth Department of Human Services and Health, 1995a; Costigan, 1996; D'Augelli & Herschberger, 1993; Dempsey, 1994; Emslie, 1996; Gibson, 1989; Hammelman, 1993; Herek, 1987a, 1991; Herschberger & D'Augelli, 1995; Herschberger & Pilkington, 1997; Lock & Kleis, 1998; MacDonald &

Cooper, 1998; Martin, 1989; McFarland, 1998; McMillen, 1991; Nicholas & Howard, 1998; Proctor & Groze, 1994; Remafedi, 1987a; Remafedi et al., 1991).

The impact of the difficulties that these issues produce for emerging gay male and lesbian adolescents have been identified as an additional 12 risk factors for the development of suicide behaviour in homosexual adolescents (Gibson, 1989; Popenhagen & Qualley, 1998; Proctor & Groze, 1994; Remafedi, 1987a; Remafedi et al., 1991). Each of these factors relate to the negative and hostile attitudes of society towards homosexuality; a lack of self-esteem due to an internalisation of this societal negative image of homosexuality as something that is bad, wrong or worthless and the influence of the myths and stereotypes that exist within society. The 12 additional factors therefore are as follows: the threat of verbal and/or physical abuse from family members and others within the wider society that often arises following disclosure of their sexuality; conflict between their sexuality and the religious beliefs of both the gay male or lesbian adolescent or that of their family; the absence of support for and education about homosexuality within schools and universities; social isolation due to rejection by their non-gay peers and little or no contact with other gay male or lesbian adolescents or adults to help them develop a balanced view of homosexuality and reduce the feelings of isolation; the absence of positive role models to provide them with an awareness of the diversity of the gay male and lesbian population (to assist in normalising their own experience of being homosexual); the possibility of substance abuse as a means of coping with the emotional distress and negative reactions they experience; a lack of understanding and support among health professionals of the issues and problems surrounding the development of a healthy homosexual identity (with many still viewing homosexuality as a mental illness or developmental phase); the failure of communities to provide social and recreational programs that support gay male and lesbian adolescents; failure in early sexual relationships which can compound

negative self-evaluations and serve to reinforce stereotypical beliefs regarding homosexuals; the pressures of self-sufficiency due to homelessness resulting from disclosure and rejection and lack of support by families; lack of education resulting from harassment and discrimination within unsupportive school environments; and finally, a fear of contracting HIV/AIDS.

Research indicates that gay male and lesbian adolescents experience considerable difficulty in adjusting to a socially stigmatised role (Cass, 1984; Coleman, 1982; Troiden, 1988). Research investigating the effects of verbal and physical abuse on gay male and lesbian adolescents from peers and family as well as the wider community (D'Augelli, 1992; Hunter & Schaecher, 1990; Remafedi, 1987a; Savin-Williams & Lenhart, 1990) suggests such abuse represents a source of great stress and turmoil to gay male and lesbian adolescents, which in turn can result in a detrimental effect on their mental health.

Gay male and lesbian adolescents are more likely to feel isolated and reserved in their social contacts, with contributing factors including fear of disclosure, feelings of being the only gay male or lesbian adolescent, or actual discrimination by homophobic peers (Wells, 1999). These adolescents may believe themselves to be completely alone and unable to talk to anyone about their sexual identity. They may withdraw from family and friends for fear of rejection and lack of support (Savin-Williams, 1994). Peer rejection or lack of support can precipitate the emergence of additional risk factors that further increase the risk of suicide (Brown 2002; Dean et al., 2000; Walker, 2001). The belief that they are alone contradicts their desire to belong and fit in. Further, gay male and lesbian adolescents who defy social norms in connection to societal beliefs, attitudes, ideologies and practices about appropriate male and female roles or outwardly express their gay male or lesbian sexual orientation may be even more susceptible to social isolation (Wells, 1999). Conversely, having the support of their peers is a

significant protective factor for reducing the risk of suicide (Brown, 2002; Coyle, 1993; Dean et al., 2000; Green, 1996; Lienert, 1999; Travers & Schneider, 1997; Walker, 2001).

Cognitive isolation is directly related to a lack of access to accurate information regarding homosexuality, including a lack of appropriate role models (Hetrick & Martin, 1987). Many gay male and lesbian adolescents demonstrate ignorance of what it means to be homosexual, often relying on stereotypes about gay males and lesbians (Hetrick & Martin, 1987). Further to this, Dempsey (1994) noted that the lack of positive role models within society for gay male and lesbian adolescents leaves them with only the societal stereotypes of homosexuality such as; homosexuals cannot form loving relationships; are sexually promiscuous; are unhappy; and prey on young children to assess their new identity. This further hinders the development of a healthy homosexual identity, thereby intensifying the stress which results from continued identity confusion.

Research has also shown that gay male and lesbian adolescents are seen to differ from other minority groups in a unique way because they become a member of a minority group during adolescence rather than at the time of their birth (Hetrick & Martin, 1987; Martin & Hetrick, 1988; Tellojohann & Price, 1993). As such, their membership is vastly different from that of other racial or ethnic minorities due to a lack of information about their new status; a lack of preparation for management of their new social identity; and often a lack of support and understanding within their family of origin as normally applies to other minority groups. Morrow (1993) explained this is so because most parents of gay male and lesbian adolescents are heterosexual, and as such, they cannot teach their adolescent gay son or lesbian daughter what it is like to be a gay male or lesbian; and they are unable to be role models of a positive homosexual identity for their child. This lack of access to accurate information again compounds the gay

male or lesbian adolescent's distress and sense of isolation, thereby increasing their experience of cognitive dissonance.

Furthermore, these young people have often been reared with negative stereotypes about homosexuality. These standards and expectations regarding homosexuality, which the homosexual adolescent has therefore incorporated from both his or her family and society at large, have therefore equipped him or her to be cognisant of what others see as his or her failings, inevitably causing him or her to fall short of what they really ought to be. The outcome of such dissonance can result in feelings of shame, with the individual's perception of these attributes as being repulsive. Further, Hunter and Schaecher (1987) noted that family recognition and acceptance are central to healthy adolescent maturation and is directly related to the development of a positive self-image. When this fails to occur, Scheff (1990) stated that in their isolation, and in the face of a homophobic societal atmosphere, along with their own internalisation of these homophobic views, many gay male and lesbian adolescents may come to feel there is no one else like them and/or that no one could possibly love and/or accept them because being homosexual is wrong and sick. At this point many may come to feel it may be better to die than live their life as a homosexual person. Schneider et al. (1989) supported this view, stating that for gay male and lesbian adolescents, being a member of a stigmatised minority within a majority may significantly contribute to the development of suicidality.

In summary, while gay male and lesbian adolescents are open to the same risks for suicide as heterosexual male and female adolescents, their status as members of a stigmatised minority group and the unique process of identity development that they must negotiate within a hostile and unsupportive environment may elevate their risk of suicide. Research has shown them to become confronted with the effects of stigmatisation at an intrapsychic level. Without support, assistance and understanding

of the difficulties which they must negotiate, particularly within their families of origin, they are likely to experience emotional, social, and cognitive isolation, family difficulties, and violence well beyond that experienced by other racial or ethnic minorities or their heterosexual peers. As such, for many gay male and lesbian adolescents, suicide becomes a very real and enticing option for alleviating the distress they are subjected to by these additional risks that appear largely to result as a consequence of a negative and unsupportive societal view of homosexuality and the fact that they think they should be able to change, but can't. The proposition that these negative views of homosexuality may also contribute towards societal views of gay male and lesbian adolescent suicide is yet to be empirically tested. In seeking to understand why these factors have a greater impact for gay male and lesbian adolescents, it is necessary to examine the unique developmental processes through which a gay male or lesbian adolescent must travel.

1. 4 Sexual Identity Development

For the young same-sex attracted person, the process of homosexual identity development begins with an emerging awareness of their 'differentness' from their peers regarding their sexual feelings (Cass, 1979, 1984; Corbett, 1998; Faderman, 1984; Lewis, 1984; McFarland & McMahon, 1999; Sophie, 1986; Troiden, 1979, 1989). From this point the same-sex attracted adolescent enters a period where they are challenged to give up their initial identity as a heterosexual and then negotiate themselves through the process of developing a healthy homosexual identity (Cass, 1979, 1984; Costigan, 1996; D'Augelli & Herschberger, 1993; Hammelman, 1993; Herek & Capitanio, 1996; Hetrick & Martin, 1987; Hunter & Schaecher, 1990; Troiden, 1979, 1988, 1989). This development often occurs within a homophobic and homo-hostile environment (Britton, 1990; Cass, 1979, 1984; Costigan, 1996; Dadisman, 1991;

D'Augelli & Herschberger, 1993; Edwards, 1996; Emslie, 1996; Ficarrotto, 1990; Haddock, Zanna, & Esses, 1993; Hansen, 1982b; Herdt & Boxer, 1993; Herek, 1984b, 1988, 1991, 1994; Herschberger & Pilkington, 1997; Hunter, 1990; Kurdek, 1988; McFarland, 1998).

Gay male and lesbian adolescents share the same physical, cognitive, psychological, and social tasks of development as heterosexual male and female adolescents, many of which are unaffected by issues of any type of sexual orientation. However, since one of the major psychological tasks of adolescence is that of identity formation and consolidation, the gay male or lesbian adolescent faces a myriad of challenges that the heterosexual male or female adolescent does not (Cass, 1979; Faderman, 1984; Lewis, 1984; Sophie, 1986; Troiden, 1979, 1989).

The various components of any individual's identity include the sense of which one is as a sexual being (i.e., a sexual identity; Cass, 1979; Faderman, 1984; Lewis, 1984; Sophie, 1986; Troiden, 1979, 1989). Several processes by which an adolescent clarifies and consolidates this particular sense of self are cohort comparisons, societal confirmation, and peer affirmation. Environmental systems such as school, family, neighbourhood, and work setting assist in this process. For the adolescent struggling with a sense of undefined 'differentness' regarding the focus of their sexual attractions, these typical avenues and resources for sexual identity clarification and healthy formation are frequently unavailable at best (Bukstein et al., 1993; Crespi, 1990; Remafedi, 1994; Rofes, 1989; Troiden, 1989; Vare & Norton, 1998). More likely, however, they present a negative and stigmatising backdrop against which the adolescent must explore their feelings and thoughts about this highly personal and integral aspect of their personal identity.

In schools, it is commonplace for students to routinely apply the words 'faggot,' 'gay,' 'dyke,' or 'queer' to anyone they dislike for any reason, highlighting the

devaluing of anything associated with being homosexual (Fontaine, 1998; Rhoads, 1995; Rowe, 1992; Telljohan & Price, 1995). Support cannot be assumed to come from family and friends, since it is likely that they will have expressed some antagonistic attitudes towards homosexuality at some point in the past (Remafedi, 1994; Rofes, 1989). The cost of this stigmatisation becomes all too apparent in the statistics that report a disproportional frequency of psychological disturbance among gay male and lesbian adolescents. Leaving home at an early age, substance abuse, depression, anxiety, suicide, and prostitution have all been evidenced among gay male and lesbian adolescents in higher proportions than for heterosexual male and female adolescents (Popenhagen & Qualley, 1998; Procter & Groze, 1994; Remafedi, 1987a, 1987b; Rotheram-Borus et al., 1994; Savin-Williams, 1989; Schneider, 1991; Silbert & Berry, 1993; Vare & Norton, 1998). Gibson (1989), in a project funded by the US Department of Mental and Human Services, reported that 30% of all completed adolescent suicides were committed by adolescents dealing with sexual identity issues.

Gay men and lesbians do not suddenly 'appear' in adulthood. Many more adolescents will question their sexual identity than will actually come to define themselves as gay, lesbian, or bisexual (Coleman & Remafedi, 1989; Feinstein & Looney, 1982). As such, the task of differentiating and providing meaning to sexual feelings and experiences in adolescence becomes a confusing one. Compared to the 'development' of a heterosexual identity, a norm requiring little conscious thought or effort, the attempt to develop a healthy and viable homosexual identity is a draining, secretive, anxiety producing, and lonely task for adolescents (Cass, 1979, 1984; Costigan, 1996; D'Augelli & Herschberger, 1993; Hammelman, 1993; Herek & Capitanio, 1996; Hunter & Schaecher, 1990; Troiden, 1979, 1988, 1989). Hetrick and Martin (1987) noted that the primary presenting problem for gay male and lesbian adolescents was one of both social and emotional isolation and loneliness, which, at

times, initiated sexual involvement with same sex adults simply from a need for some type of social contact.

Troiden (1989) suggested that it is highly likely that the process of claiming a gay male or lesbian identity may not be completed during adolescence. He further believes that this process also may not be attached to any demonstrative homosexual behaviour for many adolescents. At the same time, due to a lack of a supportive discernment process, many gay male and lesbian adolescents believe they have to directly experience a same-sex encounter to prove to him or her self that they are homosexual. Such beliefs, he feels, put gay male and lesbian adolescents at considerable risk for inappropriate sexual contact.

The process of self-identification and the acquisition of a homosexual identity occur over a long period, and is often characterised by extreme emotional turmoil. There are several models of this process of sexual identity formation, which seek to explain the sequence of this self-labelling, or 'coming-out' process (Cass, 1979; Coleman, 1982; Faderman, 1984; Lewis, 1984; Sophie, 1986; Troiden, 1979, 1989). All share the commonality that each stage moves towards an increasing level of acceptance of a homosexual identity. A progression from confusion, through exploration, to synthesis or integration is outlined in all.

Cass (1979) was among the first to put forward a model of homosexual identity. She developed a categorical theory, which described fixed classifications of homosexual, heterosexual, and bisexual. According to this theory, every individual fits into one of these categories, which are fixed and unchangeable, and external factors may influence the expression of certain sexualities within a particular society or subculture. Similarly, Troiden (1989) proposed that an individual goes through four stages in their acquisition of a homosexual identity, namely, sensitisation, identity confusion, identity assumption, and commitment. Contrary to Cass however, Troiden

specified that these categories related to certain age groups, for example, he suggested that the first stage began before puberty. Yet another stage theory has been proposed by Coleman (1982). In this theory, Coleman describes five developmental stages: pre-coming out, coming out, exploration, first relationships, and identity integration. This latest theory differs from previous stage theories, in that during the stages, the homosexual individual must develop interpersonal skills for meeting those with a similar sexuality; they need to develop a sense of personal attractiveness; and they must learn that sexual activity does not in and of itself establish healthy self-esteem (Coleman, 1982).

A common element to all of the stage theories is that by the final stage, the homosexual individual has been able to bring together the public and private parts of themselves to create an integrated homosexual identity. In support of stage theories, research has investigated how individuals have thought, felt, and behaved in relation to their sexual identity, using self-report measures and identified six stages which have been reliably differentiated (Cass, 1984). In contrast, Weinberg (1984) has argued that stage models of development are constricting because of the assumption of the linearity of stages. According to this argument, stage approaches result in the consideration of only one path to identity, from the same starting point, rather than the possibility of multiple paths to multiple identities. Further, any deviation from this path is viewed as immature or fixated (Weinberg, 1984). The empirical evidence is not always consistent with such a linear developmental sequence (Cox & Gallois, 1996). Further, Gonsiorek and Rudolph (1991) suggested that the process of development is different for gay males and lesbians.

While categorical perspectives have been useful, their scope is limited by the focus on the individual factors to the exclusion of larger social factors (Cox & Gallois, 1996). In contrast, a social psychological perspective examines the effects of the wider

society on individual development in terms of social groups and membership of those groups (Tajfel, 1982; Tajfel & Turner, 1979). Social identity theory (Hogg & Abrams, 1988; Tajfel, 1982; Tajfel &Turner, 1979), unlike stage models, focuses on the social or group-based aspects of identity and how these interact with social structure. Further, the theory is concerned with social influences in the development of the self-concept and the derivation of positive self-esteem contingent upon it (Hogg & Abrams, 1988; Tajfel, 1982; Tajfel & Turner, 1979).

According to social identity theory, there are two major processes of homosexual identity state that the first process is that of self-categorisation as a gay male or lesbian and the incorporation of this into a social identity, which may be based on characteristics such as sexual behaviour, erotic orientation, emotional attachment, and friendship choice. The second process concerns the evaluations made of social categories and that once an individual socially self-categorises as gay male or lesbian, they are motivated to perceive the homosexual in-group in a positive light (Cox & Gallios, 1996; Tajfel, 1982; Tajfel & Turner, 1979).

In this way, social identity theory overcomes some of the criticism that has been shown towards the existing sequential stage approaches to homosexual identity development (Hogg & Abrams, 1988; Tajfel & Turner, 1979). Social identity theory is primarily concerned with the process issues of identity rather than the specific content of identity, which is the focus of most stage models (Cox & Gallios, 1996). As such, evidence suggests that there is wide variation within the developmental path/s of a homosexual identity for which stage theories cannot account (Cox & Gallois, 1996).

Therefore, while stage theories have provided insight into important developmental milestones regarding gay male and lesbian identities, it is important to also explore how this development occurs. In addition to this, there is also the belief that individuals are born into exclusive heterosexuality, and that any other form of

sexual expression seen as a deviance chosen by the individual (Fordham, 1998). Research undertaken by Kinsey (1948) and supported by the American Psychiatric Association, refutes this theory and regards a gay male or lesbian sexual orientation as unchangeable. In line with Kinsey's research, the more popular theory is that all types of sexual orientation appear to be established prior to adolescence and is not subject to change (Savin-Williams, 1990). The discovery of same-sex attraction can occur in early childhood, while realisation of a homosexual identity may develop during middle school years (Cook & Powlowski, 1991). Evidence supports both gender and age differences in how males and females come to know they are homosexual (Bell, Weinberg, & Hammersmith, 1981; Gonsiorek, 1988; Remafedi, 1987b). Research indicates that on average, gay males become aware of same-sex attraction at around age 13 and act on these feelings at around age 15 (McFarland, 1993; Remafedi, 1987c). Further, Savin-Williams (1990) reported the mean age for coming out to self as 13 years for males and 15 years for females. Savin-Williams also noted that this gender difference may increase the risk of suicide among gay male adolescents, as they are more likely to feel isolated at an earlier age.

In summary, stage theories state that the process of developing a healthy homosexual identity requires the adolescent to negotiate a series of 'stages' that will lead them through an initial sense of identity confusion, comparison, and tolerance to eventual acceptance, pride, and synthesis of their identity as a homosexual. Social identity theory suggests this involves a process of self-categorisation and incorporation of positive feelings towards homosexuality, which culminates in the emergence of a positive social identity as a gay male or lesbian. While it is true to say that the development of a healthy sense of one's identity is a journey that all adolescents travel throughout their teenage years, the course of developing a healthy homosexual identity

appears to be an isolating experience, which is often made more difficult due to society's negative views about homosexuality.

1. 5 Societal Impact on Homosexual Identity Development

Rofes (1989) states that placing a gay male or lesbian identity into an appropriate perspective, as a part of an overall total identity, is made particularly difficult for several reasons. Society's focus on the sexual component of a gay male or lesbian sexual orientation, excluding feelings of attraction, love, companionship, and sub-cultural mores, encourages the perpetuation of inaccurate sexual myths and stereotypes. For example, the myths that anonymous sexual liaisons are the only resource for gay males, or that gay males are a danger to children, derive from exclusionary focus on the sexual behaviour component of homosexual orientation. Adolescence in general is a time of natural heightened interest in sexuality for both heterosexual and homosexual adolescents. The adolescent can easily be overwhelmed with an amplified version of sex as the primary component in a gay male or lesbian's life, versus one of the many aspects of identity.

Due to the current stigma that surrounds homosexuality, it is unlikely that the majority of affected adolescents will present themselves for help with issues related to their sexual identity. Coleman and Remafedi (1989) believe that most adolescents, even those seriously questioning their sexual identity, will identify as heterosexual until there is compelling evidence to the contrary. One study found that 40% of gay male adolescents interviewed had sought prior psychiatric treatment, but did not necessarily disclose their sexual orientation at the time (Remafedi, 1987c). To maintain their 'secret', gay male and lesbian adolescents will present as heterosexual adolescents seeking treatment for more traditional psychological problems (e.g., school phobia, depression, suicide attempts). It is only with an awareness of gay male or lesbian sexual

orientation as a possible precipitator of unacceptable or apparently pathological behaviour that service providers can begin to identify these issues. Hetrick and Martin (1987), in one of the few studies on the types of problems presented by self-identified gay male and lesbian adolescents, found the major reason for seeking help was a sense of extensive isolation from family, social networks, and peers. They also noted that this isolation was magnified by the lack of access to accurate information about homosexuality.

Family problems were the second most frequent area of concern cited by Hetrick and Martin (1987). Difficulties ranged from parental rejection to violence and expulsion from the home. Coming out to parents is perhaps one of the most serious issues in the coming out process. Drug use was evidenced in 5% of Hetrick and Martin's sample, psychological problems such as depression and anxiety in approximately 19%, and suicide attempts in 20% of those seeking help. It is interesting to note that suicide completions and attempts by adolescents decrease with age (Bell & Weinberg, 1978; Hetrick & Martin, 1987; Saghir & Robins, 1973). This decrease is thought to be related to the increased freedom of movement and a diminished sense of isolation that occurs for older homosexuals.

For the adolescent coming to terms with the fact that he or she might be homosexual, the process of accepting oneself is intertwined with the decision to inform others. There seem to be few young people for whom the decision to 'come out' is not a major life disruption (Coleman, 1989; Costigan, 1996; Edwards, 1996; Fontaine & Hammond, 1997). As a group, gay male and lesbian adolescents comprise an invisible sexual minority, often not disclosing their sexual orientation to others. They are the silent adolescents who struggle in isolation and fear of discovery (to self or others), yet survive using socially acceptable methods. Their price is high, however, as the consequent emotional isolation inhibits the timely and successful progression of

adolescent developmental tasks which are put 'on hold' until a safer time. In this regard, adolescents are denied the opportunity to develop social and sexual experiences appropriate to their developmental stage.

Schneider et al. (1989) explored the relationship between homosexual identity and suicidal behaviour, concluding that attempters, as compared to non-attempters, struggled with their homosexual identity earlier in adolescence. At the time of their first attempt, most were aware of their sexuality, but had not yet progressed to the development of a positive homosexual identity. Most attempters felt confused, depressed, or fearful, and hid their homosexuality. Those who had come out were often rejected by the significant others in their lives. Lacking resources to cope with this rejection, suicide was chosen as a way to cope.

It is evident, therefore, that within this process of identity development, the homosexual adolescent must also learn to deal with issues such as the management of a social stigmatisation, or what Goffman (1963) referred to as a spoiled identity and the cognitive dissonance (Festigner, 1957) which occurs as the homosexual adolescent comes to recognise him or her self as now being a member of a largely hated and despised minority group; and the possible self-hatred that develops from their own internalised attitudes and homophobia. These issues most often result from the homosexual adolescent not having had any opportunities to develop an alternative perception of homosexuality to counter the degradation of the conventional stereotypes that exist within society about homosexuals (Edwards, 1996). In seeking to understand this, it is important to undertake a review of societal attitudes towards homosexuality and homosexual individuals.

1. 6 The Formation of Attitudes Towards Homosexuality

In examining attitudes towards homosexuality, it is important to understand the theories surrounding attitude formation. Haddock et al. (1993) defined an attitude as an overall categorisation of an attitude object along an evaluative dimension (e.g., favourable-unfavourable, positive-negative). Eagly and Chaiken (1993) and Zanna and Rempel (1988) perceived such evaluations as having multiple antecedents. According to this perspective, the attitude concept is viewed as being based on three general sources of information: (a) cognitive information (e.g., beliefs about the attitude object), (b) affective information (e.g., feelings or emotions associated with the attitude object), and (c) information concerning past behaviours or behavioural intentions towards the attitude object.

The multicomponent formulation of the attitude concept can be seen in attitudes towards homosexuals. In terms of the role of cognition in intergroup attitudes, Haddock et al. (1993) postulated that two separate types of beliefs are relevant to the cognitive component of prejudice. One type of cognitive information is stereotypic beliefs, that is, the characteristics attributed to typical members of a target group (e.g., the belief that typical members of a group are friendly, unintelligent, or both). This is the most popular conception of the cognitive component of prejudice (Ashmore & Del Boca, 1981), with a long history in social psychology (Katz & Braly, 1933). Traditionally, the evaluative implications of stereotypes have been taken as the cognitive component of intergroup attitudes (Fishbein, 1963; Harding, Proshansky, Kutner, & Chein, 1996), with the suggestion that such implications account for individual differences in intergroup attitudes.

Cognitions about social groups, however, may not be derived entirely from stereotypic beliefs. For instance, Rokeach (1968) discovered that perceived similarity in values serves as an important determinant of platonic interpersonal attraction. In

addition, research on the importance of values in the expression of symbolic racism (McConahay, 1986; Sears, 1988) has led to the belief that other general, more abstract beliefs are also relevant to the cognitive component of intergroup attitudes. Haddock et al. (1993) referred to these as symbolic beliefs. Symbolic beliefs are beliefs that social groups violate or promote the attainment of cherished values, customs, and traditions. These beliefs, however, are different from the concept of symbolic racism in that the later concept focuses on affect and values, whereas symbolic beliefs focus solely on the importance of the values in relation to intergroup attitudes.

In contrast, the affective component of intergroup attitudes focuses on the evaluative implications of the emotions that are elicited by members of different social groups (e.g., typical group members may evoke feelings of fear, admiration, or both) (Allport, 1954). Although not entirely independent of the cognitive component of prejudice, assessing the affective component of prejudice of intergroup attitudes provides information that is not captured by simply assessing individual's beliefs. For example, Dijker (1987) and Stangor, Sullivan, and Ford (1991) found that emotional responses towards social groups make a significant contribution to the prediction of intergroup attitudes. The conceptualisation of attitude as an overall evaluation based upon multiple sources of information is an important development, in that it extends previous models (e.g., the theory of reasoned action; Fishbein & Ajzen, 1975) that conceptualise attitudes as being based entirely on the evaluative implications of beliefs associated with the attitude object.

In summary, attitudes provide an overall categorisation of an object based upon beliefs about, feeling towards, and past behaviours or intentions towards an attitude object. When assessed in relation to attitudes towards gay males and lesbians, two different belief types emerge, these being stereotypic beliefs, which relate to the characteristics, attributed to the attitude object, and symbolic beliefs, which relate to the

perceived violations of values, customs, and traditions attributed to have occurred by the attitude object. Attitudes have also been shown to be influenced by the emotional response of an individual towards the attitude object. This suggests that an examination of the multiple sources of such information in seeking to understand all the possible factors involved in the formation of attitudes towards gay males and lesbians is warranted.

1. 6. 1 Sex-Role Rigidity

Sex-role rigidity within a society has an effect on attitudes toward homosexuality (Krulewitz & Nash, 1980; Lieblich & Friedman, 1985; Ross, 1983). That is, the stronger the boundaries between what is masculine and feminine within a given society, the greater the fear and rejection of homosexuality (i.e., homophobia) that exists. Krulewitz and Nash (1980), in a study using male heterosexual students, found that sex-role attitudes have a significant impact on the response or reaction to homosexual individuals. Results suggested that those who hold relatively liberal sex-role attitudes show greater acceptance of gay males and lesbians than do persons who endorse more traditional sex-role beliefs. Those with more traditional sex-role attitudes rejected gay males and lesbians on measures of interpersonal attraction and indicated an unwillingness to approach a homosexual individual.

Similarly, Ross (1983) undertook a comparison study between Sweden and Australia on societal relationships and gender roles in male homosexuals (gender role in his study was equivalent to that of sex-role). Results indicated that the more rigid the sex-roles in a society, the greater the tendency for a feminine gender role to be adopted by homosexual men. That is, in a society with rigid sex-roles, gay men will adopt a more feminine gender role. In this study, Australian society sex-roles were found to be more rigid than those of the Swedish society, and gay men in Australia were found to be

significantly more feminine than Swedish gay men. Ross, therefore, concluded that the issues relating to the gender identity of gay men is a function of society seeing a differentiation in male-female sex-roles, and devaluing homosexual relationships to the point where gay men feel that they must either mimic heterosexual roles, or, because they identify sexually with members of their own sex, see themselves, or are seen as identifying themselves, as female.

In a comparison study of sex-role polarisation in Israel and the US found that the level of sex-role polarisation was significantly higher in Israel than the US (Lieblich & Friedman, 1985). In terms of sex-role rigidity, the Israeli culture was found to be more conservative, having a stronger division between the masculine and feminine roles. They determined that masculine and feminine roles are very well defined and rigidly held within this culture. The Israelis were also found to be significantly more homophobic with regard to gay males. Across the Israeli and US participants, individuals who displayed strong divisions between what is masculine and feminine were more homophobic. Thus, sex-role rigidity on societal and individual levels results in a greater fear and rejection of homosexuality.

The results of these studies appear to indicate that there is a high level of social learning in the development of opposite-sex identity. In societies that have rigid sex-roles, such as Australia, there will be an increased adoption of the feminine gender role among gay males. If the sex-role rigidity is internalised, then the process of internalisation may lead to an internalisation of the view that because a male relates emotionally and sexually to another male, he must to some degree adopt a feminine role. This is not the case in societies that do not have a strong sex-role polarisation, such as in Sweden.

There is evidence to suggest that some gay males and lesbians respond to the pressure of society to maintain the heterosexual ideal of sex-roles by having a

heterosexual relationship. Ross (1978) conducted a study on the relationship of social hostility, conformity and psychological adjustment in gay males. He found that those who feel that the perceived reaction of society will be anti-homosexual conform to the pressures to be heterosexual by marrying and remaining married. The more the individuals perceive the reaction of society to be negative and/or hostile, the more likely they are to maintain the heterosexual façade. The relationship of these findings to gay male and lesbian adolescents is the creation and perpetuation of unrealistic and often times inaccurate representations of homosexuality, both male and female, commonly referred to as stereotypes.

1. 6. 2 Stereotypes

Stereotypes and prejudice are a part of everyday life. Individuals attribute stable traits and enduring dispositions to other people in an attempt to understand other people's actions and predict their behaviour (Wright, Aron, McLaughlin-Volpe, & Ropp, 1997). Moreover, individuals may use these beliefs to guide their behavioural interactions with other people (Snyder & Uranowitz, 1978).

Many social psychologists (Carroll & Payne, 1976; Hamilton, 1976; Snyder, 1981) view stereotypes as cognitive categorisations of people that are a natural by-product of categorisation processes that normally serve people well. Categorisation reduces a world of infinite stimuli into a cognitively manageable number of categories (Rosch, Mervis, Gray, Johnson, & Boyes-Braem, 1976). Other social psychologists (Tajfel, 1981; Tajfel & Turner, 1979) have noted that negative stereotypes of outgroups (groups to which a person does not belong) may also serve ego-enhancing needs: putting down outgroups serves to bolster self-esteem by making people feel superior to others.

Although classifying others simplifies a person's world and may bolster self-esteem, it may also provide an overly simplistic picture of a complex reality. Indeed, research indicates that people tend to overestimate the similarities of individuals within one group and to overestimate the differences between groups (Myers, 1987). Because group stereotypes are often inaccurate when it comes to individual members of groups, treating individuals on the basis of their group membership is problematic. Equally disturbing is the self-sustaining nature of these often-inaccurate stereotypes of outgroups. Snyder (1981) suggested that when people place faith in their stereotypes, they may treat others in ways that actually elicits behaviour that supports their stereotypes. Further, if they were to develop doubts about their stereotypes, they might test these by selectively gathering evidence that appears to confirm them. In conclusion he states that such may be the power of social stereotypes, that even when they are wrong, they can create and sustain their own social reality.

Stereotypes are prevalent throughout every society, but various outgroups are often the focus of negative perceptions. Gay males and lesbians, for example, have long been considered to be deviants. Simmons (1965) reported gay males and lesbians amongst his findings of discernable stereotypes for several kinds of deviants in the United States. This list also included adulterers, beatniks, political radicals and marijuana smokers. Further to this, in the 1960s, gay males and lesbians were rated as the third most dangerous group of individuals in the US in a public opinion survey, outranked only by communists and atheists (Aguero, Bloch, & Byrne, 1984). Some of the labels given to gay males and lesbians in Simmons' (1965) study included sexually abnormal, perverted, mentally ill, maladjusted, and oversexed. Even within the discipline of psychology, gay males and lesbians have been perceived negatively. Jones (2000) noted, in his investigation of the attitudes towards gay men and lesbians among Australian psychologists and psychologists in training, that despite mental health policy

changes in the mid-1970's (American Psychiatric Association, 1975) psychology's attitudes towards homosexuality have been in a state of flux, with internally contradictory attitudes arising from a collision between affirmative professional policy and negative cultural influences (Gelso & Fastinger, 1990; Gelso, Fassinger, Gomex & Latts, 1995). Indeed, research points to the persistence of professional ignorance, ambivalence, and hostility towards gay men and lesbians and a lack of affirmative attitudes towards diversity in sexual orientation (Buhrke, Ben-Ezra, Hurley & Ruprecht, 1992; Betz & Fitzgerald, 1993).

There are several kinds of stereotypes surrounding homosexuality and gay males and lesbians that can affect an individual's attitudes towards homosexuality. First, sex-role stereotypes have an effect on attitudes. These stereotypes tend to be cross-gendered for both male and female homosexuals. That is, gay men are described in feminine terms (Bowman, 1979; Herek, 1984a; Page & Yee, 1985; Taylor, 1983) and lesbians are described in masculine terms (Bowman, 1979; Steffensmeier & Steffensmeier, 1974; Taylor, 1983).

Snyder and Uranowitz (1978) found that lesbian stereotypes include the views that lesbians have abusive fathers, have never had a steady boyfriend, never date men, and are rather unattractive. In Staats (1978) study on social distance and traits given to gay males and lesbians, it was found that increased social distance from gay males and lesbians was correlated with using the following traits to describe gay males and lesbians: cowardly, sly, suspicious, shrewd, stupid, impulsive, and ignorant. However, people who were less socially distant from gay males and lesbians used these traits to describe them: individualistic, intelligent, honest, imaginative, and neat.

Bowman (1979), in an investigation of attitudes toward gay males and lesbians among New Zealand heterosexual adults, found that gay males were perceived as being effeminate in attitudes, posture, and dress and as being more emotional and sensitive.

He also found that lesbian women were viewed as tough, aggressive, butch, and masculine in temperament and behaviour. Taylor (1983) found that gay men were rated as more feminine than lesbian women and that lesbian women were rated more masculine than gay men. Gay men and lesbian women were also seen as significantly different from heterosexual men and women on sex-role items, with gay men perceived in feminine terms and lesbian women perceived in masculine terms. Lesbian women were stereotypically described as not needful of others' approval, controlling, unhelpful, and unable to express tender feelings. Taylor states that these cross-gendered stereotypes help to order reality, but are limited, often narrow minded, and inaccurate. If the gay man is perceived as feminine and the lesbian woman as masculine, then the heterosexual ideal is not completely destroyed. For many heterosexuals, seeing gay men as feminine explains why they are attracted to men. The same is true of lesbian women. They are viewed as masculine and because it is because of their masculinity that they are attracted to women. Page and Yee (1985), using a sample of university undergraduates, reported that gay males were seen as more concerned with feminine traits such as talkativeness, tact, gentleness, concern for appearance, reticence, need for security, and liking for art and literature than heterosexual males. These findings are very similar to those found by Taylor (1983).

Kite and Deaux (1987) explored the content of stereotypes towards gay males and lesbians in reference to the inversion theory of sexuality (i.e., the assumption that gay males and lesbians are perceived as similar to opposite-sex heterosexuals). Consistent with their predictions, gay males were perceived as being 'positive towards males', 'feminine', and possessing a 'high-pitched voice'. Lesbians were perceived as being 'positive towards females', 'masculine', and having 'short hair' (see also Jackson & Sullivan, 1990; Page & Yee, 1985). Despite the research into the content of stereotypes, the extent to which these beliefs are related to attitudes remains unclear. Although

Herek (1991) pointed out that strongly correlated with negative attitudes towards gay males and lesbians is acceptance of negative stereotypes, the magnitude of this association is unknown.

A second common stereotype of both gay men and lesbians found in several studies is that of personal maladjustment (Davison & Friedman, 1981; Krulewitz & Nash, 1980; Page & Yee, 1985; Price, 1982; Steffensmeier & Steffensmeier, 1974). The college students in Steffensmeier and Steffensmeier's (1974) research described both gay men and lesbian women as psychologically disturbed. Krulewitz and Nash (1980) found that gay men were described as less intelligent, more immoral, and less well adjusted than heterosexuals. The findings of the study undertaken by Davison and Friedman (1981) further supported this view, adding that when homosexuality is a part of an individual's history, this will be considered as part of the person's psychological difficulties. Thus, gay men and lesbian women are seen as pathological, abnormal, immoral, and unnatural.

A third stereotype that emerges repeatedly in the research is that of the dangerousness of homosexuality (Laner & Laner, 1980; Steffensmeier & Steffensmeier, 1974; Winberger & Millham, 1979) and, as a result, the need for distance from homosexuals (Krulewitz & Nash, 1980; Staats, 1978). According to Steffensmeier and Steffensmeier's (1974) findings, homosexuals are stereotypically characterised as dangerous people. Laner and Laner (1980) found that lesbians received significantly more attributions of dangerousness than non-lesbian targets. Winberger and Millham (1979) undertook a factor analysis of the belief and attitudes towards homosexuality. They described one as a homophobic factor. This homophobic factor was made up of the belief that gay males and lesbians are dangerous and that personal anxiety rises when around them. Krulewitz and Nash (1980) reported that the participants in their

research liked gay men and lesbians less and avoided them more than heterosexual males and females.

In summary, stereotypes result from the attribution of stable and enduring dispositions to other people or groups. However, these often provide an overly simplistic picture of reality that leads to both overestimation and underestimation of the differences between groups of individuals and results in-group members being treated solely on the basis of their group membership. These stereotyped beliefs are seen to be extremely resistant to change, even in the face of evidence that proves them to be false. Examination of the types of stereotypical beliefs that exist about gay men and lesbians showed that society generally tends to view them negatively. Research demonstrated that heterosexual individuals typically perceive gay men and lesbians in terms of cross-gendered sex roles, that is that gay men are perceived as feminine and lesbians as masculine. Further gay men and lesbians are typically perceived as pathological, abnormal, immoral, dangerous, and unnatural. Further, whether these assumptions apply equally to the development of attitudes towards gay men and lesbians must also be examined. However, it is also noted, that there has been a paucity of more recent research into the influence of sex-role rigidity and stereotypes on attitudes towards gay males and lesbians and therefore it is unclear as to whether the findings presented here are still as influential in the formation of attitudes towards gay males and lesbians today.

1. 7 Attitudes Towards Gay Males and Lesbians

In reviewing the existing research on attitudes towards gay men and lesbians, a progressive liberalisation of attitudes towards homosexuality was shown to emerge in the late 1960s (Vaughan & Hogg, 1995). By 1975 the American Psychological Association had acknowledged that homosexuality was neither a mental illness nor a personality trait (Johnson, Brems, & Alford-Keating, 1997). However, the move

towards a more tolerant attitude was not a universal occurrence. Within Australia, for example, as late as the mid 1980s one state (Queensland) still legally sanctioned sexual prejudice by passing legislation that prohibited the serving of alcohol in hotel bars to 'perverts and deviants'. This legislation was seen as applicable to gay males and lesbians, who were seen as deviants at that time. When the Labor Party came into power in 1989 the legislation was repealed, however this amendment was unpopular and caused controversy and much negative public reaction, particularly among religious groups (Vaughan & Hogg, 1995). Strong public reaction towards gay males and lesbians was also observed in Australia in 1994 when the Australian Broadcasting Commission (ABC) made the decision to televise the Sydney Gay and Lesbian Mardi Gras Parade for the first time in accordance with its charter of cultural diversity. Distinctly polarised views emerged in the public debate that followed this decision as to the suitability of presenting a prime time telecast of what was perceived as the typical gay male and lesbian persona (Lane, 1994; Tanner, 1994). Although the telecast went ahead as scheduled, no further telecasts of this annual event have been screened on the ABC. Conversely, the Sydney Mardi Gras is still shown annually on Australian Commercial Television stations, with the support of viewers sufficient to warrant sponsorship from advertisers. However, its representation of gay men and lesbians could still be argued to be as "freaks" and "oddballs"

Recent research in the Australian Monitor (Kelley, 2001) on the Australian public's attitudes towards gay males and lesbians indicates this negative view of homosexuality is still strong. Data were derived from the International Social Science Survey/Australia 1999/2000 (IsssA) and the International Social Survey Program (ISSP). Australian opinions derived from this source appear particularly polarised with little room for ambiguity (Kelley, 2001). Simply put, 48% of Australians believe homosexual behaviour is 'Always wrong' whereas only, 28% regard homosexual

behaviour as ‘Not wrong at all’. A decrease in negative attitudes towards homosexual behaviour was observed over the past 15 years. In the mid 1980s, 64% of Australians believed homosexual behaviour was ‘Always wrong’. Kelley (2001) suggested the decrease in negative attitudes from 1980 to the present day is perplexing. An explanation proposed by Kelley to account for this position is the development of compassion within our society. Another explanation suggests sympathetic media exposure in the form of television, newspapers, magazines and books may well have contributed to the lessening of negative attitudes (Pratte, 1993).

A further aspect of the ISSP study compared Australian attitudes with those of the other 28 countries involved (Kelley, 2001). This broad investigation revealed that with varying degrees, each of the 28 nations demonstrated a degree of intolerance towards homosexual activity. Countries such as the Philippines and Chile were the least tolerant, with the Netherlands being the most tolerant. By comparison, many countries such as Spain, Sweden, Germany, Norway, Czech Republic, Austria and France were more tolerant than Britain, Australia, and New Zealand. Other nations including Italy and the US were even less tolerant, with the majority of opinion in the region of ‘Almost always wrong’.

In summary, attempting to account for the negativity towards gay males and lesbians within society is problematic. Attitudinal change observed from the 1980s to the 1990s in Australia and the US may reflect that society in general is becoming more compassionate. However, what remains apparent is that most nations, to varying degrees, are still intolerant towards homosexuals and harbour a degree of homophobia.

1. 7. 1 Differences in Attitudes Toward Gay Men and Lesbians

Considerable research has been carried out to investigate attitudes when the sex-roles and sexual orientations are varied within the target being studied (Black &

Stevenson, 1984; Goodyear, Abadie, & Barquest, 1981; Kite, 1984; Kite & Whitely, 1996; Laner & Laner, 1979, 1980; Larsen, Reed, & Hoffman, 1980; Lieblich & Friedman, 1985; MacDonald & Games, 1974; Maret, 1984; Minnigerode, 1976; Page & Yee, 1985; Price, 1982; Steffensmeier & Steffensmeier, 1974; Storms, 1978; Young & Whertvine, 1982). Many studies have reported that heterosexual males have more negative attitudes, and greater homophobia towards homosexuality than heterosexual females (Aberson, Swan, & Emerson, 1999; Finlay & Walther, 2003; Hansen, 1982a; Herek, 2002; Herek & Capitanio, 1999; Herek & Glunt, 1993; Kerns & Fine, 1994; Kite & Whitely, 1996; LaMar & Kite, 1998; Lieblich & Friedman, 1985; Lottes & Kuriloff, 1992; Louderback & Whitely, 1997; Marsiglio, 1993; Oliver & Hyde, 1995; Pagtolun-An & Clair, 1986; Sakalli, 2002; Wills & Crawford, 2000). Conversely, other research has shown both male and female heterosexuals to hold more negative attitudes towards gay males than lesbians (Herek, 2002; Lieblich & Friedman, 1985).

Storms' (1978) study investigated attitudes towards homosexuality and femininity in men. College students were given a short description of a man. There were four types of description, each varying the sex-role and sexual orientation: masculine /heterosexual, feminine/heterosexual, masculine/homosexual, feminine/homosexual. The results indicated that attitudes against homosexuality were more evident than attitudes against femininity. The participants clearly disliked homosexuality in the male target, but did not significantly dislike femininity in the target. He also found that the masculine heterosexual man was liked more than the feminine heterosexual man and the feminine homosexual man was liked more than the masculine homosexual man.

Storms' (1978) findings were supported in a study on why gay men are disliked conducted by Laner and Laner (1979). In this study sex-roles were divided into hypermasculine (effeminate), masculine, and hypomasculine (butch-macho). Their findings indicated that more men than women are negative towards effeminate and

'undetectably' masculine gay men. Hypermasculine gay men were disliked by the majority of respondents, and considerably fewer men or women found the leather and chains type of gay male as likable as his heterosexual counterpart.

Laner and Laner (1980) followed up this study on gay men with a study on lesbians. Again, their results indicated that non-lesbians were viewed more positively than lesbians. Also, departures toward either end of the femininity/masculinity continuum of gender styles were either moderately or greatly disliked. Gravitation to either pole on the sex-role continuum by heterosexuals was viewed as acceptable. However, if the woman was a lesbian, movement towards the masculine pole or the feminine pole of the continuum resulted in a negative response. Thus it would appear that heterosexual women are allowed more freedom in sex-role variance than lesbians.

Related to the dislike of heterosexual men and women toward gay men and lesbians for deviance on the sex-role continuum, Laner and Laner (1979, 1980) developed a hierarchy of likeableness for males and females which they varied by sexual preference and gender style in order to portray the following sex-roles: hypermasculine, masculine, hypomasculine, hyperfeminine, feminine, and hypofeminine. It was found that heterosexual males and females liked those at the top of the hierarchy the most. The hierarchy for women is a follows: (1) heterosexual feminine, (2) heterosexual hyperfeminine, (3) homosexual feminine, (4) heterosexual hypofeminine, (5) homosexual hyperfeminine, and (6) homosexual hypofeminine. The hierarchy for the men was similar: (1) heterosexual masculine, (2) heterosexual hypomasculine, (3) homosexual masculine, (4) homosexual hypomasculine, (5) heterosexual hypomasculine, and (6) homosexual hypermasculine. While variations of these hierarchies have been used in other studies, they remain very similar overall. Results from two studies (Goodyear et al., 1981; MacDonald & Games, 1974), noted that heterosexual women were the most liked, then heterosexual men, followed by gay

men and lastly lesbian women. MacDonald and Games found that lesbian women rated second in potency only to heterosexual men and yet they were liked the least. This appears to be supported by the findings of Laner and Laner (1980), in that departure towards the masculine pole on the sex-role continuum by lesbian women is disliked.

Steffensmeier and Steffensmeier (1974) found evidence on sex status that suggests lesbians are less likely to be defined as a social problem, less likely to be negatively stereotyped, and less likely to be rejected than gay males. Page and Yee (1985) found similar results when they had participants differentiate between a heterosexual adult, a lesbian, and a gay man. They found that the gay man was consistently differentiated and viewed unfavourably from the heterosexual adult. Lesbians, however, were rated more favourably than gay man. These findings are contrary to the findings of other studies (Goodyear et al., 1981; Laner & Laner, 1979, 1980; MacDonald & Games, 1974). However, regardless of these slight discrepancies, research indicates gay men and lesbian women are consistently disliked and viewed unfavourably by heterosexual men and women, while those gay men and lesbian women who present with a cross-gendered sex-roles are disliked only slightly less than those gay men and lesbian women who do not.

Black and Stevenson (1984) sought to investigate the relationship of the self-reported sex-role characteristics of participants and their attitudes towards homosexuality. The participants comprised heterosexual male and female undergraduates. They found that the females who exhibited cross-sex traits, that is, those classified as masculine, were more accepting of homosexuality while males who exhibited feminine traits were less accepting of homosexuality. Black and Stevenson explained these results by stating that ‘females who were high in stereotypical masculine traits have demonstrated their willingness to go against societal norms; perhaps then, they are more able to accept the behaviour of others that are not

normative' (p. 92). However, this explanation does not apply to males, since those who are stereotypically deviant are more rejecting. One might suggest that these males have become sensitive to any suggestions that they are not masculine and that their negative reaction to homosexuality is therefore a defensive one. It seems that feminine heterosexual males are homophobic and, as result, display negative attitudes towards homosexuality.

Further to this, Kite and Whitely (1996) suggested that gender role beliefs contribute to the differences in attitudes towards homosexuality of heterosexual males and females by way of its defining of the appropriate behaviours for men and women. Because gender-associated norms are more rigidly defined within the structure of what constitutes the appropriate gender-roles for men than they are for women (Herek, 1986, 2002; Hort, Fagot, & Leinbach, 1990), society tends to have a more negative reaction towards men who have more feminine traits than to women who have more masculine traits (Herek, 2002; Page & Yee, 1985). Therefore, the perception of a male breaking out of this traditional male gender role is judged as having committed a far more serious sex-role violation than a female who violates the traditional female gender role. Society at large has an expectation that men must avoid female traits and activities, and because homosexual males are often perceived to possess inappropriate sex-roles (Herek, 2002; Kite & Deaux, 1987), men may feel considerable societal pressure to hold negative feelings towards homosexuality, and towards gay males in particular. Kite and Whitely (1996) also argued that because women typically feel less societal pressure to validate their femininity, they may be less motivated to make such differential ratings of gay males and lesbians. However, several studies dispute this, reporting that the heterosexual females within their studies also rated gay males more negatively than lesbians (D'Augelli & Rose, 1990; Herek & Glunt, 1993; Kite & Whitely, 1996; Kurdek, 1988; Stark, 1991). This suggests that females may also succumb to the

societal pressures regarding traditional male gender roles and therefore view transgressions of this more seriously than those committed by females.

In summary, the investigation of societal attitudes towards homosexuality has focused on three different factors. First, in societies with rigid sex-roles, such as Australia, gay men and lesbian women are disliked and rejected more than in societies with more liberal sex-roles. Findings also indicate that gay men and lesbian women in societies with rigid sex-roles are found to more frequently adopt cross gender sex-roles. Second, research findings indicate that society's stereotypes of gay men and lesbian women are also cross gender in nature. Gay men are perceived as having feminine traits and lesbian women are perceived as having masculine traits. Other stereotypes of gay men and lesbian women include personal maladjustment and dangerousness. Finally, research findings indicate that heterosexual men and women consistently dislike gay men and lesbian women.

These negative responses of society towards homosexuality might displace the gay male or lesbian adolescent from mainstream society. The resulting anxiety, shame and sense of loss, together with the adolescents' own internalised negative evaluation of their homosexual identity due to the impact of negative societal attitudes regarding homosexuality, all contribute to the development of suicidal behaviour among gay male and lesbian adolescents.

1. 8 The Emergence of Homophobia and Sexual Prejudice

In 1972, George Weinberg officially coined the term 'homophobia' to describe these negative societal attitudes and reactions towards homosexuality (Britton, 1990). In doing so, he also provided a definition of homophobia as an unreasoning fear of, or antipathy towards, gay males and lesbians and homosexuality (Herek, 1994; Luchetta, 1999). Since that time, homophobia as a concept has been absorbed into contemporary

society (Sears & Williams, 1997). In response to the controversy surrounding the usage of the term homophobia, alternative terminology has been suggested. Homonegativity (Hudson & Ricketts, 1980), heterosexism and homoprejudice (Herek, 1984b), and sexual prejudice (Herek, 2000), have all been put forward as more appropriate to describe this attitude. Most displays of anti-homosexual behaviour fall into the category of prejudice and not a phobia, as the term would suggest.

Prejudice can be described as an extreme and intolerant attitude toward a group or individual belonging to that group (Allport, 1954). This aversion is grounded in hate and based on an inflexible generalisation of what the group or individual represents, usually a deviation from what is considered the norm (Allport, 1954). Further to this, sexual prejudice, or homophobia, can be seen to operate on two levels, internally and externally and an individual may experience one level exclusively or both levels simultaneously.

1. 8. 1 External Homophobia

External homophobia is defined as the overt expression of those biases, and the expression of these can range from social avoidance of gay males and lesbians to legal and religious proscription and even violence against gay males and lesbians on a personal and societal level (O'Hanlon & Robertson, 1996). Examples of external homophobia include the exclusion of same-sex rights to gay male and lesbian couples by governments, the refusal of religious rights such as the taking of communion to gay males and lesbians, and violent verbal and/or physical assaults on individual gay males or lesbians or of gay male or lesbian groups.

Weinberg's (1972) definition of homophobia has been revised to also include the fear, disgust, anger, discomfort, and aversion that individuals may experience in dealing with gay males and lesbians (Hudson & Ricketts, 1980), and a dread of being in close

quarters with gay males and lesbians (Weinberg, 1972). As such, the term has come to be more broadly defined as any belief system which supports negative myths and stereotypes about gay males and lesbians (Morin & Garfinkle, 1978) and any of the varieties of negative attitudes which arise from fear or dislike of homosexuality (Martin, 1982).

Numerous researchers have attempted to explain the origins of homophobic attitudes. Churchill (1967) proposed a sexual conservatism theory of homophobia. He claimed negative attitudes towards homosexuality are the end product of a sex-negative culture, which he defined as one in which the human sex drive is viewed as a threat to social organisation. Alternatively, Ficarrotto (1990) viewed homophobia within the context of intergroup prejudice and assumes homophobia is similar to other forms of social prejudice directed at other minority groups.

Similarly, Allport's (1954) model of intergroup prejudice offers another explanation for the development of homophobia. This model consists of three components: cognitive, affective, and conative. Cognitive relates to a set of beliefs about the attitude object. Affective relates to the strong feelings (usually negative) about the object and the qualities it is believed to possess. Conative relates to a set of intentions to behave in certain ways towards the attitude object. When viewed in the context of intergroup prejudice this relates to the unfavorable attitudes which the members of one social group can be seen to hold for the members of another social group, with the resulting intergroup behaviour regulated by the individual's awareness of and identification with different social groups.

In an investigation into these three differing theories, Ficarrotto (1990), using a population sample of university undergraduates, concluded all three were found to be independent and equal predictors of anti-homosexual attitudes. He suggests that among homophobic people, distinct etiological differences may operate in producing the same

phenotypic behaviour. For some, homophobia may be rooted within a rigid set of beliefs and deep-seated negative feelings about human sexuality, whereas for others, a personality trend focused towards prejudice might best explain the emergence of homophobic attitudes.

Yet another view of the development of homophobic attitudes is that of Herek (1984b), who presents a functional approach towards the development of attitudes towards gay males and lesbians, which appears to both support and add further explanation to Ficarrotto's (1990) findings. Herek argued that the same attitude, which may be expressed by two uniquely different people towards the same object, may in fact be serving completely distinct psychological functions for each, contingent upon their individual differences in psychological need. Herek's research has suggested that attitudes towards gay males and lesbians, both good and bad, appear to be rooted within three different kinds of motivations (Dadisman, 1991). The first of these are 'evaluative attitudes', based upon concrete happenings and result in easily understood reactions. That is, good or positive experiences result in favorable attitudes, and bad or negative experiences result in unfavorable attitudes. Herek noted that typically 30% of people have who reported homophobic attitudes towards homosexuals have not knowingly had any personal experience with gay males and/or lesbians. It is more likely that such people will have based their attitudes on the second motivation, that of 'expressive attitudes'. Within this context, gay males and lesbians become a symbol for good or evil and, as such, are often seen as a moral or political issue, which is used as an opportunity to express one's own sense of self. In this instance, homosexuality is seen as more of a symbol than anything else. The third motivation in attitudes towards homosexuality is that of concern by the individual for his or her own sexual identity. In this context, for some, homosexuality raises concerns about one's own sense of what is masculine and what is feminine; their own sense of one's self as a man or woman. For

those for whom there is some uncertainty about their own sense of self and their sexuality within that context, their resulting attitudes towards gay males and lesbians can be very negative because they symbolise unacceptable aspects of themselves. From his investigations into each of these three attitude elements, Herek concluded that the most powerful and prevalent motivations appear to be those based upon one's values, be they political, moral or religious in origin. As such, investigation into the factors related to the development of homophobia is necessary.

1. 8. 2 Internalised Homophobia

Internalised homophobia is defined as the prejudices and stereotypes that individuals incorporate into their belief systems as they grow up in societies biased against homosexuals. Weinberg (1972) noted that it was entirely possible for gay males and lesbians themselves to experience internalised homophobia resulting from their own internal incorporation of these stereotypes.

Given that almost all gay males and lesbians are raised within an exclusively heterosexual environment prior to their realisation of their own sexuality, they too are subject to acquiring and absorbing these same stereotypes into their belief systems. This can also be another source of immense distress and conflict for the newly emerging gay male or lesbian adolescent who struggles to understand his or her own experience of homosexuality with that of his or her internalised beliefs about homosexuality. Internalised homophobia has been seen as the most important barrier to the adjustment of a positive homosexual identity (Brown, 1996; Cass, 1979; Taylor & Robertson, 1994; Troiden, 1989; Wagner & Brondolo, 1996). Carrion and Locke (1997) argued that the mental health and social problems associated with being gay are related to internalised homophobia. Internalised homophobia, as mentioned above, can represent a gay male or lesbian individual's internalisation of the negative attitudes and assumptions

concerning homosexuality (Fordham, 1998; Shidlo, 1994; Sophie, 1987). Internalised homophobia is an important construct to study because it is suggested to be a developmental occurrence that all gay males and lesbians experience to varying degrees as a result of living in a heterosexist and homophobic society, and it is a suggested cause of psychological distress in many gay men and lesbians (Shidlo, 1994). The effects of the internalisation of such negative attitudes on the development of a healthy homosexual identity have far reaching outcomes. O'Hanlon and Robertson (1996) suggested the developmental steps that gay males and lesbians must negotiate helps to explain the psychological injury to which they are vulnerable from the effects of internalised homophobia. These include recognising and accepting their homosexual sexual orientation despite pervasive familial and societal condemnation; developing a new identity as a gay male or lesbian person, a process labelled 'coming out'; and confronting ubiquitous homophobia.

Cognitive dissonance of this magnitude can be a critical issue for a gay male or lesbian individual. Many become in a sense separate from themselves; a member of, but still separate from, their primary group. For example, devout Catholic or Orthodox Jewish adolescents have a personal identity closely intertwined with their social/religious identities as Catholics or Jews. Recognition of a homosexual sexual orientation leads not only to conflict between what they are feeling and what they have been taught about sexual morality, but to a questioning of their sense of self as Catholic or Jewish (Hetrick & Martin, 1987). Thus, to belong, they must condemn and attempt to repress their developing sexuality; to accept their sexuality, they must cease to belong (Troiden, 1979).

Denial of group membership, such as religious affiliation, is intimately intertwined with identification with the dominant group and, thus, with self-hatred. If one believes that heterosexuality is better than homosexuality, then one may try to become

heterosexual. The resulting failure can cause one to hate the homosexual desires that prevent complete identification with the dominant group (Hetrick & Martin, 1984).

In summary, research suggests that the gay male or lesbian individual must often contend not only with the social stigmatisation, victimisation and cognitive dissonance that occurs as a result of membership to a despised minority group, but also the self-hatred that develops from internalised homophobia (Cass, 1979; Hetrick & Martin, 1987; Troiden, 1989).

1. 9 Predictors of Attitudes Towards Gay Males and Lesbians

The diversity of what actually determines an attitude towards gay men and lesbians is complex and wide-ranging. Research from the US indicates that being male, being older, being less well educated, and living in rural areas is associated with more negative attitudes towards gay males and lesbians (Herek, 1984a; Herek & Glunt, 1993). Religious beliefs, reflected in regularity of attendance at religious services, endorsement of orthodox beliefs, and conservative political preferences are also associated with higher levels of prejudice towards gay males and lesbians (Herek, 1984b; Herek & Glunt, 1993).

1. 9. 1 Gender

Homophobic attitudes have been shown to be influenced by both the gender of the individual expressing the attitudes and the gender of the homosexual target (Evans, 1996; Herek, 1984b; Herek & Glunt, 1993; Johnson et al., 1997; Kelley, 2001; Kite, 1984, 1992, 1994; Kite & Whitley, 1996; LaMar & Kite, 1998; Lock & Kleis, 1998; Logan, 1996; O'Hare, Williams, & Ezoviski, 1996; Oliver & Hyde, 1993; Royse & Birge, 1987; Royse, Dhooper, & Hatch, 1987; Wisniewski & Toomey, 1987). Research indicates that heterosexual male's attitudes towards gay males and lesbians are more

negative than female heterosexuals (Evans, 1996; Herek, 1988; Herek & Capitanio, 1995, 1999; Herek & Glunt, 1993; Johnson et al., 1997; Kelley, 2001; Kite & Deaux, 1986; Kite & Whitley, 1996; LaMar & Kite, 1998; Logan, 1996; Louderback & Whitely, 1997). Results have also shown that within US society, this negativity is seen as socially acceptable, whether it is among college samples (Herek, 1984a, 1986; Kite, 1994) or community samples (Herek, 1991; Herek & Capitanio, 1996; Herek & Glunt, 1993).

Herek's (1984b) theory of sexual prejudice suggests that heterosexual men react more negatively than females due to an intrinsic response to the social and psychological aspects of both their role as men, and, their identity as people. Put simply, heterosexual males reaffirm their male identity by rejecting gay males. It appears that gender role violation is viewed more seriously when the violator is a male. As such, men's greater gender role rigidity leads them to be especially condemning of males who violate the male gender role (Herek, 1984b, 1986).

Women, however, are seen to be permitted far greater gender role flexibility. As such, they hold more tolerant attitudes towards those who are seen to violate the gender roles, regardless of the gender of the violator (LaMar & Kite, 1998).

Another explanation for gender differences in attitudes suggests that heterosexual males may consider lesbianism in erotic terms (LaMar & Kite, 1998; Louderback & Whitely, 1997). They suggest that the erotic value attached to lesbianism for many heterosexual males may serve to counter the general stigma associated with the concept of homosexuality. As such, the attitude held towards lesbians is less negative than the attitude for gay males (LaMar & Kite, 1998; Louderback & Whitely, 1997). From the female perspective it has been noted that heterosexual women do not sexualize male homosexuality. The result may account for the observed imbalance between

heterosexual male and female attitudes towards gay males and lesbians (Louderback & Whitely, 1997).

1. 9. 2 Age

Research on age as a predictor of attitudes towards gay males and lesbians tends to be inconsistent. Several studies have indicated that young adults express positive and more tolerant attitudes towards homosexuality compared to older adults (Britton, 1990; Van de Ven, 1994; Whitely, 1987; Whitely & Kite 1995). The conservatism of older age was clearly observed in the IssA study, not only within the Australian population, but also across the 28 nations investigated (Kelley, 2001). Individuals in their 20s demonstrated the most tolerant attitude, with those in their 40s showing less tolerance. Individuals in their 60s were seen as even less tolerant, whilst those in their 80s were the most intolerant. These results suggest a move towards greater tolerance within society in the late twentieth century in Australia, Britain and North America (Kelley, 2001).

Conversely, other studies indicate that it is the older adult who expresses a more positive and tolerant attitude towards gay males and lesbians (Johnson et al., 1997; Pratte, 1993; Seltzer, 1992). This particular trend was observed in a study examining age and its relationship to homophobia on three personality variables: empathy, religiosity, and coping styles (Johnson et al., 1997). The study consisted of 714 heterosexual students aged from 18 to 53 years. Results showed that, regardless of gender, older participants where less homophobic than younger participants. Of note here however, is the use of a convenience sample of students with the oldest individual being 53 years of age. If compared to the aforementioned study of Kelley (2001), the oldest participant would not qualify for either of the two older aged groupings within that study. A further aspect however, must be considered in reviewing the research on

age and attitudes with respect to the use of student samples. That is, that there could be something about the desire to return to study that suggests older students may have a more open mind, and therefore report more positive attitudes towards gay males and lesbians

Another aspect to consider when examining age is that research has found that an individual's attitudes may change overtime (Pratte, 1993). This was established in a longitudinal study of college students' attitudes towards homosexuality in 1986 and 1991 (Pratte, 1993). It was found that negative attitudes remained stable in the under 25 age group, with the greatest attitude change being observed in the 25 to 39 age group. Further to this, a significant decrease in anti-homosexual attitudes for the 40+ age group during the five-year time frame. Although the reason for this trend remains unclear, it has been suggested that a change in an individual's level of homophobia occurs over the life span, or alternatively, a decrease in prejudice against gay males and lesbians is becoming apparent within society (Johnson et al., 1997; Pratte, 1993).

Another aspect to consider when examining the effect of age on attitudes towards gay males and lesbians is that several studies have shown that younger people are more likely to view homosexuality as a lifestyle choice and therefore open to change, rather than having a genetic basis (Baumrind, 1995; Johnson et al., 1997; Matchinsky & Iverson, 1996; Patterson, 1995). The attribution of a choice/no choice gay male or lesbian sexual orientation results in either negative or positive attitudes (Baumrind, 1995). In a study of 108 female students in a Northern US university, those students who believed homosexuality was psychologically caused held more negative attitudes than those who believed in biological causes (Matchinsky & Iverson, 1996). Therefore, greater tolerance was shown for those who are 'born that way'.

Finally, Herek and Capitanio (1999) suggested that the effect of age is moderated by two factors: level of education and type of sample under investigation (university

students versus a community sample). Support for this view is found in a study by Whitely (1987), who demonstrated that older college students were less homophobic towards gay males and lesbians than younger students. However, it must be noted that typically most of the research in this area has relied heavily upon the use of university students for their sample selection and as such, the results reported must be viewed with caution (Britton, 1990).

1. 9. 3 Level of Education

Research has shown that increased levels of education tend to be predictive of positive attitudes towards homosexuality (Britton, 1990; Herek, 2000; Herek & Capitanio, 1999; Kelley, 2001; Pratte, 1993; Schellenberg, Hirt, & Sears, 1999; Seltzer, 1992; Yoder & Preston, 1997). The IssA study (Kelley, 2001) separates out the various educational levels as they relate to Australians. Kelley reports that individuals with only eight or nine years education are particularly intolerant in their attitudes towards gay males and lesbians, whereas those with ten or more years of education are more tolerant. Individuals who progress further into higher levels of education show even greater tolerance towards homosexuality. This positive correlation between level of education and attitudes is also evident in North America, Scandinavia, and New Zealand (Kelley, 2001).

The correlation between education and attitudes was evident in a study examining US students' attitudes (Schellenberg et al., 1999). This study demonstrated that attitudes towards gay males and lesbians appear to change positively as a by-product of higher education and related life experience. The important factor here however may be 'related life experience' and possible exposure from personal contact (Allport, 1954) with gay males and lesbians. In this context, education may not necessarily be defined as formal schooling. Research has shown that individuals who had extended their

knowledge through reading about homosexuality or who had undergone various educational courses or workshops also became more tolerant of homosexuality (Stevenson, 1988).

Quinley and Glock (1979) proposed several reasons for why education appears to reduce prejudice. First, students are taught to cognitively appraise prejudicial beliefs and to distinguish between inference and evidence. Further, they have contact with minority groups and the customs of these groups and have developed the ability to think independently and critically about societal norms and practices.

One Australian study however, reported a similar conclusion in relation to an individual's life experience (Van de Ven, 1994). This study examined homophobic reactions in university undergraduates, high school students, and young criminal offenders. Results showed that neither age nor levels of education were consistently related to levels of homophobia. Van de Ven concluded that males and females of all ages and levels of education may hold homophobic attitudes, and it is the individual's quality of life and their learning experiences in life that may mediate a more tolerant attitude towards gay males and lesbians.

In summary, it appears that higher levels of education may facilitate more positive attitudes towards gay males and lesbians, with the degree of tolerance increasing in line with the level of education. Others have suggested that increased tolerance is associated with the knowledge that comes from informal education, such as reading about homosexuality, self-development through educative short courses or workshops, or through positive life experiences in general.

1. 9. 4 Religion

According to most major religions, homosexuality is presented as sinful, dirty, and deviant and many families rely on religious doctrines for an understanding of

homosexuality. Consequently, these negative views espoused by religion may be internalised by families, particularly religious families. In other words, religion may facilitate the spread of negative attitudes towards gay males and lesbians by its teachings and beliefs. Consequently, the principal reason parents often extricate their gay son or lesbian daughter from the home, is due to their religious beliefs (Gibson, 1989). Homosexuality is often incongruous with religious teachings, and thus a family's way of life, bringing rise to the young gay male or lesbian experiencing feelings of isolation, condemnation, and of being cut-off from their family system.

The association between attitudes to homosexuality and religiosity is however, complex. Previous studies have found that people who are more religious, have more conservative religious beliefs, and attend church frequently hold more negative attitudes towards gay males and lesbians (Britton, 1990; Finlay & Walther, 2003; Herek, 1987a, 2000; Herek & Capitanio, 1996; Herek & Glunt, 1993; Johnson et al., 1997; Maney & Cain, 1997; Marsiglio, 1993; Matchinsky & Iverson, 1996; Seltzer, 1992; Yoder & Preston, 1997). Allport and Ross (1967) made a distinction between extrinsic and intrinsic orientations to religion. An extrinsic orientation reflects a conventional, instrumental approach, whereas an intrinsic orientation reflects an internal, meaning-based approach. They found that an extrinsic orientation tends to be positively associated with prejudice, whereas an intrinsic orientation stresses love, tolerance, and an acceptance of differences. Conversely, Herek (1987a) explored the association between religion and attitudes towards gay men and lesbians and found no significant correlation between intrinsic versus extrinsic orientation and homophobia. Instead, he found that the degree to which an individual's religious beliefs were valued and incorporated into and openly practiced in their day-to-day living predicted his or her levels of homophobia.

The degree of an individual's religiosity may also be determined by their belief in a personal God or the individual's church attendance (Evans, 1996; Kelley, 2001). Kelley stated that believers in a personal God were less tolerant towards gay males and lesbians than individuals who reject the idea of a personal God. Belief in a personal God was shown to be the greatest predictor of negative attitudes towards gay males and lesbians in the IssA study. Kelley reported that the large effects observed were found to be independent of the attitudes and values the individual associated with their fellow parishioners or clergy. Overall, those who attended church regularly were shown to be less tolerant towards gay males and lesbians than non-church goers (Kelley, 2001).

These trends were also observed in most of the 28 other countries that took part in the IssA study, although they varied in terms of which variables were more important (religious belief alone, both belief and church attendance, or church attendance alone) (Kelley, 2001). Kelley concluded that Australian opinions were unremarkable and fell around the middle point when compared with the other 28 nations. However, Australians were shown to be less tolerant than many other mainly secular countries, for example, the Netherlands, but not as intolerant as more religious nations, such as Chile and the Philippines.

In summary, research suggests that an individual's religious beliefs do influence their tolerance to homosexuality. Negative attitudes towards gay males and lesbians can generally be predicted for those who attend church regularly, endorse conservative beliefs, hold an extrinsic approach to the faith, and believe in a personal God.

1. 9. 5 Place of Residence

Attitudes towards gay males and lesbians have been shown to vary according to where an individual resides, with those who live in less populated areas displaying more negative attitudes towards gay males and lesbians than those living in more populated

areas (Britton, 1990; Fordham, 1998; Green, 1996; Herek, 1994, 2000; Marsiglio, 1993; Pratte, 1993). One difficulty however, in researching the effect of place of residence, is that no one singular definition of rurality exists across the spectrum of residence types (Castaneda, 2000), making comparisons between Australia and other countries extremely problematic. For example, rurality may be defined as a geographical distance from major metropolitan centres; the level of restricted accessibility to goods and services, or the level of restricted opportunities for social interaction (Castaneda, 2000). Each of these various definitions produce distinctly different concepts of what constitutes rural living.

Within Australia, rural areas are particularly low in terms of population density and are typically large distances from urban centres (Wyn, Stokes, & Stafford, 1997). This is a major distinction from what would be considered rural regions in other countries, such as Europe or North America (Wyn et al., 1997). This said, however, similarities are seen within these countries with rural communities tending to be more traditional and conservative than their urban counterparts. The most salient characteristics observed among rural residents are a valuing of quality friendships, familiarity with other in their community, a sense of belonging to their community, continuity across generations and a narrow concept of what constitutes masculinity and femininity (Wyn et al., 1997).

Researchers have examined rural young peoples' attitudes to gender roles (Smith & Borthwick, 1991). This study involved interviews with 300 individuals from a variety of rural regions from isolated settlements to large country towns from Central Queensland to Tasmania. Results showed that, in relation to gender roles, young people themselves upheld a traditional belief system, which as noted earlier, is a common characteristic of rural communities. Respondents in this study reported that gay male and lesbian peers within their communities were generally ostracised with the overall

consensus being that a gay male or lesbian was incompatible with living in a rural community.

Green (1996) suggested that in both Australia and North America, homophobia among rural residents, plus a sense of isolation and the feelings of rejection experienced by gay males and lesbians, appear to be linked to a generalised rural intolerance towards homosexuality. As discussed previously, homophobia, isolation, rejection, and other precipitating factors contribute to the risk of suicide among gay male and lesbian adolescents, however, these characteristics are further exaggerated in rural and remote settings.

Rural communities are seen to be more traditional and conservative than urban communities and are generally less informed and display less tolerance to diverse groups (Britton, 1990; Fordham, 1998; Herek, 1994; Marsiglio, 1993; Pratte, 1993; Seltzer, 1992; Yoder & Preston, 1997). Pratte (1993) examined attitude change towards homosexuality among college students and rural residents in southwest Missouri from 1986 to 1991. Results showed that the rural respondents expressed more negative attitudes towards gay males and lesbians than their urban counterparts.

In summary, rural communities have been shown to have a distinct culture, marked by certain behaviours and that these are often resistant to change. Although not representative of all rural residents, there is an identified trend linking less populated areas with more anti-gay attitudes. Further, the opportunity for contact and acquaintance with gay males and lesbians is not as readily accessible as exists within urban regions where attitudes are shown to be more tolerant.

1. 9. 6 Contact with Gay Men and Lesbians

For over 40 years the ‘contact hypothesis’ (Allport, 1954, Amir, 1969; Cook, 1985; Williams, 1947) has proposed that intergroup contact under certain prerequisite

conditions promotes the development of more harmonious intergroup relations (Gaertner & Rust, 1994). This hypothesis proposes that under a given set of circumstances, contact between members of different groups reduces existing negative intergroup attitudes. As such, the intergroup contact hypothesis has been among one of the most enduring theoretical perspectives in the study of intergroup relations (Brewer & Miller, 1984; Pettigrew, 1986, 1998; Stephan, 1987; Taylor & Moghaddam, 1994). Early formulations (Allport, 1954; Williams, 1947) focused on the potential for contact between members of different groups to reduce existing negative intergroup attitudes. Even in these early statements of the hypothesis it was realised that contact in and of itself was not adequate, and that societal, situational, and even personal variables could undermine or enhance the positive impact of contact. As evidence of the potential negative effects of contact (i.e., confirmation and strengthening of negative outgroup attitudes) grew, the list of provisions and qualifications for successful contact grew.

In looking to investigate the effects of the intergroup contact hypothesis on individual's attitudes towards gay males and lesbians, studies have shown that homophobic attitudes are highest among people who have never knowingly met a gay male and/or lesbian and that is easy to hate a population when you have no personal attachment or risk involved (Anderson, 1994). Several studies have reported that interaction with and/or exposure to a gay male and/or lesbian decreases homophobia and increases positive attitudes towards homosexuality (Allport, 1954; Britton, 1990; Herek, 2000; Herek & Capitanio, 1996; Herek & Glunt, 1993; Lance, 1987; O'Hare et al., 1996).

However, a resurgence of interest in the contact hypothesis has sparked a number of advancements and raised new controversies (Brewer & Miller, 1984; Brown, 1995; Hewstone & Brown, 1986; Mackie & Hamilton, 1993). Three of these recent additions warrant close examination. The first is the special importance of cross-group

friendships. Several recent theoretical discussions of contact effects have focused on the role of interpersonal intimacy (Cook, 1984; Herek & Capitanio, 1996; Pettigrew, 1997). In support of the importance of intimacy, Pettigrew (1997), using data from a large international European sample, demonstrated that having an outgroup friend predicts lower levels of both subtle and blatant prejudice, greater support for pro-outgroup policies, and even generalised positive attitudes toward outgroups other than that of the friend. Similar effects were not found when the individual had an outgroup co-worker or neighbour (but not a friend). Recent research suggests that the effect may be most clearly associated with the specific contact of a friendship relationship (Wright et al., 1997). This extended contact hypothesis proposes that knowledge that an in-group member has a close relationship with an out-group member can lead to positive intergroup attitudes. Further, the hypothesis proposes that knowledge that an in-group member has a close relationship with an out-group member can lead to positive intergroup attitudes.

The second recent addition involves a theoretical perspective on contact that emerges from the social identity approach (Hewstone & Brown, 1986). Pettigrew (1986) however, questioned how the positive effects of contact with an individual outgroup member could generalise to attitudes about the out-group as a whole. Turner, Hogg, Oakes, Reicher, and Wetherell (1987) also question this, stating that because the interactions at the interpersonal and intergroup levels are considered to involve unique psychological processes, these interpersonal interactions (i.e., between individuals interacting as individuals) would have little impact on an individual's attitudes and actions towards the out-group as a whole (Hewstone & Brown, 1986). Although some research has shown that personalised contact can result in positive generalisations to the out-group (Marcus-Newhall, Miller, Holtz, & Brewer, 1993) there has as yet been no

investigation of the effects of such contact of heterosexual male and females with gay males and/or lesbians and heterosexual male and female attitudes towards homosexuals.

The third issue arises out of work that suggests that interactions with outgroup members, especially when group memberships are highly salient, can be fraught with anxiety, discomfort, fears of appearing prejudiced or intolerant, and other negative emotions. These negative emotions in turn increase the likelihood of self-censorship, misattribution, and stereotype confirmation (Bodenhausen, 1993; Stephan & Stephan, 1985; Wilder, 1993). The way in which all of these factors combine to contribute towards attitudes towards homosexuality and gay males and lesbians is important to the investigation of attitudes towards gay male and lesbian adolescent suicide.

In reviewing the influence of contact with gay males and lesbians and attitudes, several studies have suggested that interaction with or exposure to gay males and/or lesbians will promote a more positive attitude towards gay males and lesbians. However, more recent studies have indicated that the type of contact and/or interaction is important to facilitate improved attitudes towards gay males and lesbians. This research suggests that when the type of contact is in the nature of a close social relationship, more positive attitudes result than when the type of contact is of a more impersonal and less social relationship, such as that of the gay male or lesbian being a neighbour or co-worker.

In summary, it has been shown that homophobia is comprised of two aspects, an internal and/or an external expression of an unreasoning fear of or antipathy towards gay males and lesbians and homosexuality. The negative attitudes of homophobia are seen to extend beyond those outlined in the theory of intergroup prejudice (Allport, 1954) and may have distinct etiological differences operating. Research has demonstrated a difference in the levels of homophobia between heterosexual males and females with males displaying more negative attitudes than females while both genders

record greater negativity towards gay males than lesbians. An individual's age, gender, educational level, religion, and place of residence were also identified as factors related to the development of negative attitudes towards gay males and lesbians.

1. 10 Societal Attitudes Towards Suicide

Historically, most Western societies disapprove of suicide among its members. Stillion and Stillion (1998-99) note that prior to the early Christian era, suicide in the form of martyrdom was embraced. In order to discourage suicide, the Christian church declared suicide to be a sin and undertook steps to ensure those who took their lives were punished, by excommunication and denial of funeral rites (Alvarez, 1970). By 1670, civil legislation was passed making suicide a crime (Fareberow, 1975). This was the period in which punishment became common both for the deceased and his or her family.

By the nineteenth century, questions began to be raised about the nature of the act of suicide and the repercussions to the deceased and his/her family. With the rise of existentialism in the late nineteenth and early twentieth centuries, philosophers such as Kierkegaard and Neitzche, followed by Heidegger, Satre, and Camus introduced the idea that individual freedom to act and responsibility for one's acts are fundamental characteristics of the human condition (Stillion & Stillion, 1998-99).

The nineteenth century closed with the publication of Emile Durkheim's '*Suicide*' (1897/1951). It remains an influential work to this day for two reasons. First, it made a case for using sociological methods to understand an individual phenomenon and, second, it introduced a system for classifying suicides and, in that way, set the model that has generated classification systems throughout the past century (Stillion & Stillion, 1998-99).

The twentieth century was witness to major changes in attitudes towards suicide as more emphasis has been placed on mental health. Freud postulated that there are intrapsychic reasons for suicide in *Mourning and Melancholia* (1917/1961), suggesting that suicide results when anger, harbored by the id toward some outside force, is turned inward upon the ego.

At the same time, the influence of the scientific method was also spreading. Beginning mid-century, suicide centres were established in major cities in order to prevent suicide and to study its causes and consequences. Further, studies were conducted into possible biological bases for and correlates of depression (e.g., Asberg, Nordstrom, & Traskman-Bendz, 1986; Asberg & Traskman, 1981; Asberg, Traskman, & Thoren, 1976).

Stillion and Stillion (1998-99) noted that all the forces mentioned have influenced the attitudes of modern society toward suicide. Some still speak of suicide as a sin while other people view it as a crime against society. Some regard suicide as an indication of mental illness and others view it as a rational, individual choice, perhaps even a right. Because it is viewed in so many contradictory ways, sometimes by the same individual, it is difficult to capture a given society's attitude toward suicide. However, in the past two decades, researchers have attempted to do just that. Examination of the findings of this research is therefore important.

1. 10. 1 Gender and Attitudes Towards Suicide

One of the major factors consistently linked to attitudes towards suicide is gender. Males have been shown to be less sympathetic towards individuals who suicide, whereas females are found to be more sympathetic (Deluty, 1988/89a; Domino & Groth, 1997; Marks, 1989; Stillion, McDowell, & May, 1984; Stillion, McDowell, & Shamblin, 1984; Stillion, McDowell, Smith, & McCoy, 1986; Wellman & Wellman,

1986; White & Stillion, 1988). Similarly, females have been shown to exhibit higher levels of empathy for suicide than males and are more likely to provide assistance to a suicidal individual (Trobst, Collins, & Embree, 1994; Wellman & Wellman, 1986). This suggests that the level of empathy may be a significant contributor to previously reported gender differences (Mueller & Waas, 2002). Further, studies have also shown that the participants' gender identity can affect their reactions towards suicidal persons. For example, one study showed that androgynous individuals were more likely than gender-undifferentiated persons to view the suicidal person as emotionally maladjusted (Dahlen & Canetto, 1996).

1. 10. 2 Age and Education and Attitudes Towards Suicide

Age and educational level have also been shown to influence attitudes towards suicide (Ingram & Ellis, 1995; Stillion & Stillion, 1998-1999). In the United States, non-fatal suicidal behaviour tends to be perceived as feminine, youthful behaviour (Canetto, 1997). Kalish, Reynolds, and Farberow (1974) found older men rated impairment in mental or physical health a major factor influencing suicide, while younger men placed love and psychological stress as primary factors. Further, a Canadian study of community attitudes towards suicide found young people more accepting of suicide than older people (Bagley & Ramsey, 1989). Those who had achieved a higher level of education were less accepting of suicide than those with a low level of education. In a study of undergraduate college students and their parents, Boldt (1982) found evidence of generational differences in attitudes towards suicide, with younger generations shown to be consistently less judgmental and stigmatising of suicide than older generations.

1. 10. 3 Attitudes Towards Suicidal Behaviour

There is a fundamental dilemma in relating attitudes concerning suicide to suicidal behaviour, as this is part of the wider problem that attitudes are not always directly related to behaviour. However, researchers have shown that more positive attitudes towards suicidal behaviour are shown among individuals with high suicidal ideation (Ingram & Ellis, 2001; McAuliffe, Corcoran, Keeley, & Perry 2003; O'Carroll, Berman, Maris, Moscicki, Tanney, & Silverman, 1996). Suicidal ideation is defined as plans or wishes to commit suicide and as self-reported thoughts of engaging in suicide-related behaviour (Beck, Kovacs, & Weissman, 1979).

Research has shown that suicidal ideation can impact on an individual's attitude towards suicidal behaviour. Several studies have identified that participants who have engaged in suicidal ideation held more positive attitudes towards suicidal behaviour and saw suicidal behaviour as normal and that people have a right to die. Further, they did not believe that suicidal behaviour was not associated with mental illness (Ingram & Ellis, 2001; McAuliffe, Corcoran, Keeley, & Perry 2003).

1. 10. 4 Gender of the Suicide Victim and Attitudes Towards Suicide

Attitudes to suicide can vary according to the gender of the suicidal person (Dahlen & Canetto, 2001). However, the evidence on whether male and female suicide victims are evaluated differently is mixed.

Studies of non-fatal suicidal behaviour have reported that the gender and age of the suicidal person does affect evaluations of non-fatal suicidal behaviour. For example, in the US, non-fatal suicidal behaviour is perceived as a feminine, youthful behaviour (Canetto, 1997), while at the same time there tends to be greater agreement with the suicidal choice of an older person (Parker, Cantrell, & Demi, 1997) and that attempted suicide by troubled males may be viewed by other males as a violation of the

gender-role messages of decisiveness, success, and inexpressiveness (Miller, 1994). Yet another common attitude is that killing oneself is a masculine act (Lineham, 1973).

Other researchers, however, have been unable to demonstrate that the gender of the suicide victim has impacted on participants' judgments about the suicide (Dahlen & Canetto, 1996; Van Winkle, Calhoun, Cann, & Tedeschi, 1998). One study that did, noted that young female suicide victims were shown more sympathy than older female or male suicide victims of any age (Stillion, White, Edwards, & McDowall, 1989). Further, Deluty (1988/89a) examined the acceptability of suicide as a function of gender of the victim, and found suicide by females rated more negatively and with less acceptance than suicide by males, while another study found males and females showed greater respect for a suicide death from a member of their own gender (Sorjonen, 2002-2003).

One largely understudied aspect of gender in relation to attitudes towards suicidal behaviour however, is that of gender identity. Gender identity is defined as the internalised scripts of femininity and masculinity that exist within a culture or society. Canetto (1997) stated that within the United States, for example, non-fatal suicidal behaviour is more socially acceptable and common in females, while killing oneself is seen as more appropriate for, and occurs more frequently in males, and suggests that cultural scripts of femininity and masculinity may also affect how suicidal behaviour is interpreted.

One study that examined attitudes towards suicide that included a measure of gender identity, however, failed to find a significant effect for gender identity on sympathy, agreement, and acceptability of suicidal behaviour. It did however note a trend for individuals with a conventionally feminine identity to show higher levels of sympathy for the suicidal behaviour than conventionally masculine persons (Stillion et al., 1986).

Following on from this study, Dahlen and Canetto (2002) sought to examine factors that affect young adults' attitudes towards non-fatal suicidal behaviour. Attitudes were evaluated on how participants' sex and gender identity, the reason for the suicidal act, and the gender of the suicidal person influenced reactions to the suicidal decision. Results showed that gender appears to play a role in the acceptability of suicidal behaviour, with males seen to be more likely to agree with and accept the suicidal decision than females. Further, androgynous persons were seen to view the decision to suicide as foolish, independent of the reason for the suicidal act. They were also shown to report less agreement, acceptance and sympathy for such a decision.

1. 10. 5 Context of the Suicide and Attitudes Towards Suicide

Attitudes have also been found to differ according to the reasons for or situation surrounding the suicide. Several studies have shown people respond differently to hypothetical cases of suicide, depending on the conditions that provoked the act (Ingram & Ellis, 1995). Individuals are judged less negatively when the suicidal behaviour is in response to a serious physical illness (Dahlen & Canetto, 1996; Deluty, 1988-89a, 1988-89b; Droogas, Siiter, & O'Connell, 1982-83; Ellis & Hirsch, 1995; Hammond & Deluty, 1992; Ingram & Ellis, 1995; Lester, Guerriero, & Wacther, 1991; Lo Presto, Sherman, & DiCarlo, 1994-95; Range & Martin, 1990; Singh, Williams, & Ryther, 1986) compared with other situations such as relationship breakdown or academic failure (Dahlen & Canetto, 2002). Further, medical problems are viewed as more acceptable reasons for suicide than psychological reasons (Range & Martin, 1990).

In summary, research suggests that the age, gender, educational level of the individual, along with the gender of the suicidal victim, do affect an individual's attitude towards suicide in general. As yet, however, there has been a paucity of

research into whether or not these factors also play a role in an individual's attitudes towards gay male and lesbian suicide.

1. 11 Societal Attitudes Towards Gay Male and Lesbian Suicide

In seeking to understand the development of an individual's attitudes towards gay male and lesbian adolescent suicide, it is necessary to first re-examine the impact of society on attitudes towards suicide in general. As noted earlier, one of the most important studies into the societal view of suicide was that of Emil Durkheim (1897/1951). His comparative study of suicide rates within and across the social groups of several European countries led him to propose a theory of anomic suicide. The concept of 'anomie' referred to people who feel they do not belong to society or who have been marginalised or stigmatised. Durkheim suggested acts of suicide are socially defined and conditioned and represented a barometer of the health of a society, while suicide rates represented an index of the forces of social disruption or disintegration or the factors that reduce social regulatory pressures on the individual. It is these forces that he believes cast vulnerable individuals adrift, disconnecting them from their sense of social place.

In applying this to the issue of gay male and lesbian adolescent suicide, Saunders and Valente (1987), while supportive of Durkheim's theory, emphasised that the body of empirical evidence, identified risk factors and Durkheim's theory all support the proposition that homosexuals are at a higher risk of suicide. Martin (1988) explained that often enough, gay male and lesbian adolescents feel hated and rejected by almost everyone, including their peers, teachers, parents, religious leaders, and even their god. He goes on to state that the truth concerning gay male and lesbian adolescents is that they are not like other adolescents. Their difference stems from their membership to one of the most hated and despised minority groups in society. Wagner et al. (1995)

suggested gay male and lesbian adolescents have been socially conditioned to hate themselves, thus producing what could be called an internal anomie. When combined with Durkheim's 'anomie', high levels of distress, attempted and completed suicides can be expected.

Adding to this, attitudes towards gay male and lesbian suicide are also linked to the myth and misconception that surrounds homosexuality. These originated with the pathologising of homosexuality in the early twentieth century (Rofes, 1983). Karl Heinrich Ulrichs pioneered the view of homosexuality as an inborn and incurable condition in the early 1860s (Carpenter, 1908). Richard Von Krafft-Ebing authored a landmark volume of research into sexuality and created categories for gay males and lesbians that defined homosexuality as an innate morbid phenomenon. Once homosexuality became categorised as an 'illness' the medical profession spent considerable time and energy investigating and analysing its 'causes' and searching for a 'cure'. Rofes stated these assertions presented a view of homosexuality as an inherently self-destructive illness for which no effective cure could be found. Such reasoning, he asserts, provided the seed for the development of the 'homosexuality is a sickness myth', which was then infused into public attitudes through popular literature, plays, novels, films and magazines. This myth dictates that gay males and lesbians not only commit suicide at a rate considerably higher than society-at-large, but that somehow a person's homosexuality is in itself the source of this self-destructiveness and therefore to be expected.

Researchers assert there is nothing inherent in homosexuality that would make a person self-destructive (Rofes, 1983). However, despite the depathologising of homosexuality by the American Psychiatric Association in 1973, the view of homosexuality as pathology is still very much in existence today (Eidenberg, 1998). This view is highlighted in the studies of attitudes towards gay males and lesbians

among health care professionals, which have shown that many still view homosexuality as an illness, based within a pathologising of homosexuality in general, and suggests such a view may also apply to the suicide of gay males and lesbians specifically (McMillen, 1991; Remafedi, 1985; Rofes, 1983; Rubinstein, 1995). This proposition, however, has yet to be empirically tested. It is important to note that if such thinking still exists within the health professions who are at the forefront of scientific knowledge, and who are held in high regard as the 'authorities' in the field of suicide and its causes, then one can assume that this view will also exist within the attitudes of average community members.

1. 12 Attitudes Towards Gay Male and Lesbian Adolescent Suicide.

Although there is a wealth of research into the incidence of and risk factors associated with gay male and lesbian adolescent suicide, there is a paucity of research into the assessment of attitudes towards gay male and lesbian suicide. Only recently have researchers begun to examine this aspect of gay male and lesbian suicide.

One US study sought to investigate the reactions of young adults to gay male and lesbian peers who became suicidal following coming out to their parents (Cato & Canetto, 2003). Attitudes towards gay male and lesbian suicidal behaviour in response to this particular stressor were compared with attitudes towards persons who became suicidal in response to other stressors. Participants in this study were university students who earned course credit for their participation as well as students associated with the university Gay/Lesbian/Bisexual/Transgender Student Services Office. Attitudes were evaluated using a modified form of the Suicide Attitude Vignette Experience (SAVE, Stillion et al., 1984). A series of eight vignettes depicted adolescents engaging in non-fatal suicidal behaviour as a result of incurable physical illness, relationship loss, academic failure or after 'coming out' to their parents and

being rejected. Results showed that gay males and lesbians who engaged in suicidal behaviour following coming out were not viewed in particularly forgiving or empathic ways. Further, it was found that both the participants' gender and gender identity influenced the evaluations of the suicidal person. Female participants perceived the gay male or lesbian suicidal person less negatively than male participants. However female participants rated the suicidal person as more maladjusted than male participants. Both male and female participants perceived all suicidal persons as relatively feminine, although suicidal males were rated as more masculine if they engaged in suicidal behaviour because of academic failure or physical illness, while suicidal females were only viewed as masculine if their suicidal behaviour followed academic failure.

Australian researchers recently investigated attitudes towards gay male and lesbian adolescent suicide. Molloy and McLaren (in press) assessed the attitudes towards gay male and lesbian adolescent suicide among heterosexual Australian university students as a function of the participants' gender, age, and level of homophobia. It was hypothesised that gay male and lesbian adolescent suicide would be viewed with greater approval than that of heterosexual adolescent suicide and that greater this effect would be strongest among the younger participants in the study. It was further hypothesised that the participants' level of homophobia would be a greater predictor of attitudes towards gay male and lesbian adolescent than either the gender or age of the participant. Participants were provided with a vignette, depicting a relationship breakdown, which concludes with the adolescent depicted committing suicide. This vignette was manipulated to depict a heterosexual male, heterosexual female, gay male, or lesbian suicide victim. Participants were then asked to rate how acceptable, necessary, justified, and psychologically healthy they felt the suicide was. They were also asked to rate the level of empathy that they felt for the suicidal victim. Results showed that the suicide of a gay male or lesbian adolescent, was viewed as significantly more acceptable,

necessary, justified, and psychologically healthy than that of the heterosexual male or female adolescent. Further, the levels of empathy reported for the gay male and lesbian suicide victims were significantly less than that reported for the heterosexual male and heterosexual female victims. These results were consistent for all participants regardless of their age or gender. It was also noted that the participants' level of homophobia was shown to be the greatest predictor of attitudes towards gay male and lesbian adolescent suicide, with higher levels of homophobia positively correlated with greater approval for gay male and lesbian adolescent suicide.

In summary, it would appear that numerous myths and misconceptions exist in relation to homosexuality and suicide. Historically, homosexuality has been seen as an incurable and ultimately self-destructive disease. Research evidence suggests that despite the depathologising of homosexuality, such attitudes are still very much in existence today, even within the attitudes of highly educated mental health professionals, despite vigorous lobbying by humanitarian agencies to promote a more realistic portrayal of gay males and lesbians.

Similarly, the findings of the study by Molloy and McLaren (in press) suggest that such views may indeed still permeate Australian society, however, one must use caution in this assumption, as their use of a university population does limit the generalisability of the findings. It is also of particular interest that no investigation of attitudes of gay males and lesbians towards gay male and lesbian adolescent suicide has yet been undertaken. Given the evidence of the effects of internalised homophobia among homosexuals, such an investigation may prove vital in facilitating a greater understanding of attitudes towards gay male and lesbian adolescent suicide in terms of how this population themselves perceive the alarming incidence of suicide among members of its own community.

1. 13 Present Study

Based upon the above review of the incidence of gay male and lesbian adolescent suicide, along with the thorough review of the research evidence surrounding the various factors that appear to contribute towards the formation of attitudes towards gay males and lesbians and gay male and lesbian adolescent suicide, together with the recent findings of the study by Molloy and McLaren (in press), this study investigated the attitudes of Australian heterosexual male and female and gay male and lesbian adults towards gay male and lesbian adolescent suicide. There were three main aims to the current study.

1. 13. 1 Aim 1: The Attitudes of Heterosexual Males and Females and Gay Males and Lesbians Towards Gay Male and Lesbian Adolescent Suicide

Attitudes towards gay male and lesbian adolescent suicide were investigated using heterosexual male and female and gay male and lesbian participants' evaluations of a vignette depicting either a heterosexual male, heterosexual female, gay male or lesbian adolescent suiciding as a result of a relationship breakdown.

1. 13. 1. 1 Hypothesis One

It was predicted that both the heterosexual male and female and the gay male and lesbian participants would rate the suicide of a gay male or lesbian adolescent more positively than the suicide of a heterosexual male or female adolescent. This was done through examination of the same variables found to contribute to the formation of attitudes towards gay male and lesbian adolescent suicide used in the researchers previous study. That is, how justified, acceptable, necessary, was the suicide and how psychologically healthy was the suicide victim. Greater endorsement on each of these variables was be indicative a more positive attitude.

1. 13. 1. 2 Hypothesis Two

It was also predicted that the heterosexual male and female participants would report higher levels of empathy for the heterosexual male and female adolescent suicide victims than for the gay male and lesbian adolescent suicide victims, and that the gay male and lesbian participants' would report higher levels of empathy for the gay male and lesbian suicide victims than the heterosexual male and female suicide victims. This was done through examination of the same variable found to contribute to the formation of attitudes towards gay male and lesbian adolescent suicide used in the researchers previous study. That's is, how much empathy did you feel for the suicide victim? Greater endorsement on this variable was seen as indicative of greater empathy.

1. 13. 2 Aim 2: Predictors of Attitudes Towards Gay Male and Lesbian Adolescent Suicide in the Heterosexual Male and Female and Gay Male and Lesbian Participants.

Predictors of attitudes towards gay male and lesbian adolescent suicide in both heterosexual male and female and gay male and lesbian participants were investigated through examination of the same factors found to contribute to the formation of general attitudes towards gay males and lesbians in previous research.

1. 13. 2. 1 Hypothesis Three

It was hypothesised that the heterosexual male and female participants' level of homophobia and gay male and lesbians participants' level of internalised homophobia would act as greater predictors of attitudes towards gay male and lesbian adolescent suicide than the gender of the suicide victim, level of contact with gay males and lesbians or the age, gender, place of residence, religious affiliation or importance of religion, or level of education of the participant.

1. 13. 3 Aim 3: The Effect of Contact with Gay Males and Lesbians on Heterosexual Male and Female Participants Levels of Homophobia Towards Gay Males and Lesbians

Finally, the researcher aimed to investigate the effect of frequency and type of contact with gay men and lesbians on levels of homophobia reported by heterosexual male and female participants.

1. 13. 3. 1 Hypothesis Four

It was predicted that the heterosexual male and female participants' frequency and type of contact with gay males and lesbians would be directly related to their level of homophobia, with those reporting frequent social contact displaying lower levels of homophobia than those who have frequent non-social contact, infrequent social or non-social contact, or no contact with gay males and lesbians.

Chapter 2: Method

2. 1 Participants

Participants were self-reported heterosexual male and female, gay male and lesbian volunteers over the age of 18 years recruited Australia wide, but predominately from Victoria and New South Wales. An internet website with an online version of the questionnaire package was established within the University of Ballarat, Victoria, in order to reach volunteers who may have otherwise been inaccessible to this research. This was particularly so for some gay male and lesbian participants who were living a closeted existence and could not have been accessed through other means, such as gay male and lesbian groups or events. Further, a total of 2000 printed questionnaires were also distributed with a return rate of 25%. In all, the total number of questionnaires returned were comprised of 41.1% (n = 499) printed questionnaires and 60% (n = 814) online questionnaires.

The initial data pool totaled 1343, with 44% (n = 591) males and 56% (n = 749) females. This was reduced to a final sample of 1213 participants due to the removal of 93 participants who had recorded they were either bisexual, trans-sexual or unsure of their sexuality. A further 37 participants were eliminated from the study due to incomplete demographic and psychometric information.

The mean age of the participants was 34.46 years (SD = 11.15), with ages ranging from 18 to 73. The final sample consisted of 42.5% (n = 515) heterosexual participants, comprised of 32.6% males (n = 168) and 67% females (n = 347), and 57.5 % homosexual participants (n = 698), comprised of 54.7% gay males (n = 382) and 45.3% lesbians (n = 316).

Participants come from across Australia, with 61.3% from Victoria (n = 744), 18.8% from New South Wales (n = 228), 7.7% from Queensland (n = 94), 4.8% from

Western Australia (*n* = 58), 4.2% from Tasmania (*n* = 51), 2.2% from South Australia (*n* = 27), and 1.0% from the Northern Territory (*n* = 11).

Inspection of the relationship status of participants revealed that 44.7% were single/separated/divorced/widowed (*n* = 542) and 55.3% were in a married/defacto/same-sex relationship (*n* = 671). The majority (71.6%) of participants did not have children (*n* = 896).

Inspection of participants' level of education revealed that 26.1% had completed secondary school education (*n* = 317), 17.1% had achieved a TAFE or trade certificate (*n* = 207), 32% had an undergraduate university degree (*n* = 388) and 24.8% had a post graduate university degree (*n* = 301).

Inspection of the religious affiliations of participants showed 36.3% were affiliated with a Christian religion (*n* = 440), 16.6% to other religious groups, for example Buddism, Muslim, Hindu, Wiccan, Spiritualists, New Age, and Pagan (*n* = 201), while 47.2% had no religious affiliation (*n* = 572). Inspection of ratings of the importance of religion in the participants' life showed that the majority (68.2%) did not see religion as important in their life (*n* = 827). Finally, 52.2% of participants resided in an urban location (*n* = 633) while 47.8% resided in a rural location (*n* = 580).

Finally, inspection of participants' frequency of contact with gay males and lesbians showed that 57% of heterosexual participants (*n* = 294) and 81% of homosexual participants (*n* = 682) had frequent contact with homosexuals. Further, inspection of participants' type of contact with homosexuals showed that 63% of heterosexual participants (*n* = 328) and 92% of homosexual participants (*n* = 645) had social types of contact with gay males and lesbians.

2. 2 Materials

2. 2. 1 Plain Language Statement

The Plain Language Statement (see Appendix A) provided a brief explanation of the purpose of the research, and addressed the issue of providing anonymity for the participant, clearly stating that there was no obligation to participate, and that returning the questionnaire indicated informed consent to participate in the study.

Participants were advised that the student researcher and principal supervisor would be available for consultation if any questions and/or concerns arose as a consequence of their participation. Further to this, a list of various agencies, for example, Lifeline and the Gay and Lesbian Switchboard, were also provided should the respondent experience distress arising from their involvement in the study. Finally, participants were informed that the results of the study would be available to them by contacting the researchers or, alternatively, logging onto the University of Ballarat web site.

All participants were asked to retain a copy of the plain language statement for their own records, with those taking part in the online questionnaire asked to print a copy from the web site.

2. 2. 2 Demographic Section

A series of demographic questions (Appendix A) were used to elicit each participant's gender, age, relationship status, and number of children, level of education achieved, occupation, religious affiliation, importance of religion, place of residence, sexual orientation, and contact with gay males/lesbians.

One of the major issues associated with research within homosexual populations is the lack of a standard operating definition of sexual orientation (Fordham, 1998). Classifying participants with regard to their sexual orientation for the purpose of

research is a difficult task and previous research has relied on the use of sexual identity or self-labelling of the participants for identification of sexual orientation (Brown, 1996; Herschberger & D'Augelli, 1995; Proctor & Groze, 1994; Remafedi et al., 1991). Given that self-identified gay men and lesbians are only a small proportion of the individuals who experience same-sex attractions, and some individuals engage in homosexual behaviour but do not identify themselves as a gay male or a lesbian (Hillier, Warr, & Haste, 1996), when conducting a broad based study of individuals sexual preferences, it is more useful to ask questions about sexual attractions, sexual acts, and lifestyle. In line with this research, the demographic component of the current study asked questions regarding sexual attraction, sexual behaviour, lifestyle, and sexuality.

To assess contact with homosexuals, an overall score was created for each participant. For the five questions asking if the person knew a gay male or lesbian, they were awarded one point, and if they knew both a gay male and a lesbian they received two points. Similarly, if they had a gay male or lesbian relative, they received one point, if they had both a gay male and a lesbian relative, they received two points. For having contact with a gay male or lesbian, they received one point, for having contact with both a gay male and a lesbian, they received two points. For frequency of contact with homosexuals, participants received one point for '*infrequen*t', two points for '*fortnightly*', three points for '*weekly*', and 4 points for '*daily*' contact. Higher scores were indicative of greater frequency of contact. For type of contact with homosexuals, participants received one point for '*work-related*', two points for '*social*' and three points for '*social and work-related*'. Higher scores were indicative of social contact.

2. 2. 3 The Suicide Attitude Vignette Experience

Attitudes towards suicide were measured using the Suicide Attitude Vignette Experience (SAVE; Stillion et al., 1984; see Appendix A). The SAVE consisted of

eight vignettes; each describing a different hypothetical situation that results in the adolescent depicted committing suicide. For the purposes of this research one vignette of the SAVE (Vignette Six) was modified. This vignette depicted a relationship break-up. The sexual orientation of the adolescent who suicided was experimentally manipulated to produce four versions which depicted either a gay male, lesbian and heterosexual male and heterosexual female adolescent. A total of eight vignettes were presented to each participant in order to hide the target vignette. The seven other vignettes also presented variations of the gender and sexual orientation of the suicide victim.

Participants were asked to report their attitudes, in terms of how acceptable, justified, necessary they saw the suicide, along with their view of the psychological health of the suicide victim and the degree of empathy they felt for the suicide victim, to the suicides depicted in each of the eight vignettes using a four-point Likert-type scale. Justified, acceptable, necessary, were rated as, for example, 1 = *completely justified*, 2 = *somewhat justified*, 3 = *somewhat unjustified*, and 4 = *completely unjustifi*ed. Psychologically health was rated as 1 = *completely unhealthy*, 2 = *somewhat unhealthy*, 3 = *somewhat healthy*, and 4 = *completely healthy*. Empathy was rated as 1 = *no empathy*, 2 = *little empathy*, 3 = *some empathy*, and 4 = *a lot of empathy*.

Participants' responses to vignette six were the only responses analysed. Possible scores for each of the five variables ranged from one to four. Total scores for the vignette were calculated by adding together each of the five response scores. Possible scores for this ranged from four to 20. Low scores indicated a low level of tolerance towards suicidal behaviour whereas high scores indicated a high level of tolerance towards suicidal behaviour.

The SAVE has been shown to retain adequate reliability and validity, even when

the content of the vignettes are manipulated. Stillion et al. (1984) report the SAVE obtained significant levels of test-retest reliability of r = .65, concurrent validity of r = .46, and adequate convergent-discriminant validity for the original scale items.

2. 2. 4 Attitudes Towards Gay Men and Lesbian Scales

Homophobia was assessed, within heterosexual participants only, using the Attitudes Toward Lesbians and Gay Men Scales (ATLG; Herek, 1984b; see Appendix A). This scale presents statements that tap heterosexuals' affective responses to homosexuality and lesbians and gay men. The scale comprises two identical sets of 20 statements, with one set describing lesbians and the other, gay men. Participants were asked to respond to each on a five-point Likert-type scale, where 1 = *strongly disagree* and 5 = *strongly agree*. Scoring was accomplished by summing the numerical values across items for each subscale. Reverse scoring was used for those items that present positive statements (i.e., items 2,4,7,11,15, 17). Total scores can range between 20 (extremely positive attitudes) and 100 (extremely negative attitudes).

The ATLG has consistently shown high levels of internal consistency and reliability. Among non-student adults completing a self-administered questionnaire, alpha values typically exceed .80 (Herek, 1994; Herek & Glunt, 1991). Test-retest reliability correlations were found to be r = .90 (Davis, Yarber, Bauserman, Schreer, & Davis, 1998). The ATLG has also been consistently correlated with other theoretically relevant constructs. Higher scores (more negative attitudes) correlate significantly with high religiosity, lack of contact with lesbians and gay men, adherence to traditional sex role attitudes, belief in traditional family ideology, and high levels of dogmatism (Herek, 1987a, 1987b, 1988, 1994; Herek & Capitanio 1995, 1996; Herek & Glunt, 1993). The ATLG's discriminant validity has also been established. Members of lesbian and gay organisation scored at the extreme positive end of the range (Herek, 1988), and non-student adults who publicly supported a local gay rights initiative scored

significantly lower on the ATLG than did community residents who publicly opposed the initiative (Herek, 1994). Both the Lesbian and the Gay Male subscales of the ATLG Scale were presented to each heterosexual male and female participant.

2. 2. 5 Internalised Homophobia Scale

Internalised Homophobia was assessed, within homosexual participants only, using the Internalised Homophobia Scale (IHS; Wagner, 1994; see Appendix A). This scale measures the extent to which negative attitudes and beliefs about homosexuality have been internalised and integrated into homosexuals' self-image and identity as a lesbian or gay man. The IHS consisted of 20 items (10 positive statements and 10 negative statements), each scored on a five-point Likert-type scale where 1 = *strongly disagree* and 5 = *strongly agree*. Scoring is accomplished by summing the numerical values across each item. The range for the total score is 20 to 100, with higher scores representing greater levels of internalised homophobia.

Testing for the internal consistency and reliability of the IHS yielded an alpha of .92 for the total score (Wagner, Serafini, Rabkin, Remein, & Williams, 1994). Research into the validity of the IHS revealed the construct to be positively correlated with mental health measures including demoralisation (r = .49), global psychological distress (r = .37), depression (r = .36), degree of integration into the gay community (r = -.54), self-acceptance of being homosexual (r = .46), and distress over time (r = .61) (Wagner et al., 1994). The IHS was presented to each gay male or lesbian participant.

2. 2. 6 Social Desirability Scale

In order to examine each participant's level of social desirability as a response tendency, the short form of the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960), as developed by Reynolds (1982), was used (see Appendix A).

This scale consists of 13 items and is a psychometrically sound alternative to the longer 33-item scale developed by Crowne and Marlowe (1960). Participants rated each of the 13 statements as 'true' or 'false' as it applied to them. This scale has been used extensively in research as an adjunct measure to assess the impact of social desirability on self-report measures (Reynolds, 1982). Scale statements were defined by two major attributes, they are 'good' culturally sanctioned statements, and they are probably untrue of most people (Crowne & Marlowe, 1964). Scoring the scale involves the summing of each participant's score. High scores are indicative of individuals who conform to social stereotypes in order to achieve the approval of others. Furthermore, high scorers tend to hold the expectancy that approval is gained by engaging behaviours, or endorsing attitudes that are culturally acceptable. The approval construct accounts well for many test-taking behaviours and is also reflected in a wide range of social behaviours or situations (Crowne & Marlowe, 1964). The social desirability scores obtained were entered as a covariate in the analyses.

2. 2. 7 Suicide Ideation Sub-Scale from the General Health Questionnaire

The Suicide Subscale of the General Health Questionnaire (Goldberg & Hillier, 1979; see Appendix A) was used for the purpose of examining the participants' current level of suicidal ideation. This scale consists of seven questions that test the extent to which an individual has thought about or behaved in a suicidal manner over the past few weeks. Participants rated their level of suicidal thoughts and feelings for the past few weeks from one (not at all) to four (much more than usual). Possible scores ranged from seven (has not had a thought or behaved in a suicidal manner), to 49 (has thought or behaved in a suicidal manner much more than usual).

Correlation coefficients between the Suicide Subscale of the scaled General Health Questionnaire and independent clinical measures range from *r* =. 21 to *r* =. 56. However correlations for the total scaled General Health Questionnaire are stronger, peaking at *r* = .76. Scores in this range indicate concurrent validity (Goldberg & Hillier, 1979). This scale was used to access each participant's current level of suicidal ideation as research has shown that individuals who report a high level of suicidal ideation are more inclined to report a greater level of acceptability to suicide (Goldberg & Hillier, 1979). Consequently, suicidal ideation scores were entered as a covariate in the analyses.

2. 3 Procedure

All questionnaires (both printed and online) were counterbalanced through the application of a Latin Square to minimise possible order effects (Shaughnessy & Zechmeister, 1994).

Participants were recruited in a wide variety of ways over a 12-month period. Initially, individuals were approached via the friendship groups of the researcher. Many of these individuals also took questionnaires to pass along to family members, work colleagues, and friends. In order to maximise participation by heterosexuals in the study, the researcher also made contact with many community groups such as Rotary, Lion's Club, Apex, YMCA, School Councils, Sporting Clubs, Health and Welfare Agencies, Youth Groups, Church Social Clubs, Social Groups, and Support Groups. For many of these contacts, the researcher went along to meetings to present the research being conducted, answer questions, and invite participation. The researcher also undertook setting up stands in shopping centres to distribute questionnaires at Bay City Plaza, Geelong; Bunnings Warehouse, Corio; Bellarine Village, Newcomb; and Kmart, Belmont. Further to this, email invitations, for recruitment of heterosexual and

gay males and lesbians were sent out to social groups and clubs, community organisations, and health and welfare agencies obtained from the public domain listings on the Internet.

In regards to email invitations, the researcher sent an email inviting participation (Appendix B) to the secretary of the organisation being contacted. This invitation provided a brief overview of the purpose of the study, and asked that, if appropriate, and with the approval of the organisation, this invitation could be forwarded to their membership. The invitation also provided the website address for online participation along with the passwords required to access the online questionnaire package, or alternatively individuals could request a printed copy to be sent to them. Details of the contact numbers for the student researcher and principal supervisor at the University of Ballarat were also supplied. The invitation also informed the recipient that their participation in the study was voluntary and would remain anonymous, as all email addresses would be automatically removed from completed questionnaires when the submit button was selected. By asking the organisation to distribute the invitation to their membership, a further level of anonymity was provided because at no time did the researcher have a list of the membership of these organisations. Finally, the recipient was invited to forward this invitation onto anyone they might know who would be interested in taking part in this study to facilitate a snowballing effect. In all, a total of 450 email invitations where distributed.

Recruitment of the gay male and lesbian participants also occurred in a variety of ways. The researcher made contact with the various gay and lesbian groups of which she was a member and obtained permission to distribute to the membership of these groups. Of most prominence was the Community Mental Health Team of the University of Ballarat marching in the Gay Pride March in St Kilda, Melbourne, in January 2002. This involved marching in front of thousands of people under the

University banner and handing out flyers to promote the research and the web site for online participation in the study (Appendix C). In addition to this event, the Team also had tents at 'Carnival Day' during Melbourne's Gay and Lesbian Midsummer Festival in February 2002, and the Gay and Lesbian 'Chill Out' Festival in Daylesford, Victoria, in March 2002 where flyers and printed questionnaires were distributed. These events were very prominent on the gay and lesbian social calendar and attracted thousands of people from gay and lesbian communities both local and interstate. The researcher also attended both the Gay Games and the Health in Difference 4 conference (where preliminary results of this study were presented) in Sydney in September 2002. Flyers and questionnaires were distributed to people she met during these events.

The researcher also took part in a number of media events, undertaking radio interviews promoting the study, these being the 'In ya face' program on Melbourne community radio station 3CR, Joy FM in Melbourne, and Rainbow Radio in Bendigo. In each instance flyers and questionnaires where left at the stations for distribution. The Ballarat Courier newspaper ran a one-page article highlighting the study (Appendix D) and provided contact details for those interested in taking part in November 2002. In addition, advertisements were taken out in two prominent gay magazines for one month, these being 'B News' and the 'Melbourne Star'. Once again, these contained information about the research, the website details and contact numbers for the research team.

Several community groups also assisted in promoting the research and obtaining participants by providing links to the research website on their own websites. These groups included: The Also Foundation, the Victorian AIDS Council, the Country AIDS Network, Pflag Australia, the Country Women's Association, the Australian Psychological Society and internet groups including the Pink Lounge, Youth Gas, Reach Out and Lifeline Australia. Further to this, the researcher travelled to many rural

locations across Victoria to meet with health workers, social workers, counsellors, university student associations, outreach workers, and gay male and lesbian groups to facilitate awareness of the study in rural areas and provide questionnaires and flyers for distribution. The researcher also spent several weeks door knocking across country towns, coastal towns and rural farmhouses to distribute questionnaires in an endeavour to gain greater representation from rural communities.

Chapter 3: Results

Data obtained from completed questionnaires were entered into and analysed using the Statistical Package for the Social Sciences (SPSS) for Windows (SPSS, Inc, 1999). An alpha level of .05 was used for statistical significance. Results are presented, following the initial screening and analysis process, in the order of the hypotheses proposed in the Introduction.

3. 1 Initial Analysis

3. 1. 1 Demographic Data

The main demographic variables were gender, sexual orientation, residential location, relationship status, number of children, importance of religion, and employment status. The variable sexual orientation was categorised into 1 = *heterosexual* and 2 = *homosexual*. The variable gender was categorised into 1 = *male*, and 2 = *female*. As stated previously in the method section, those men and women who had self-identified as queer were classified as gay male or lesbian according to their gender. Out of a total sample size of 1343 participants, 1213 participants were identified as heterosexual/male, heterosexual/female, homosexual/male or homosexual/female. Of the 130 participants removed from the sample, 37 were removed due to missing data, or overseas residency (as sample was based on an Australian population). The remaining 93 participants removed from the sample had identified as either bisexual, trans-sexual, or were unsure of their sexual orientation. Due to the low numbers in this group, and given that many bisexual individuals do not want to be associated with the gay male and lesbian community (The Australian Bisexual Men's Association, 2000), these cases were suspended from the analysis. Ideally, with greater numbers this group could have been analysed as a separate category.

For the remaining 1213 participants, residential location was categorised as 1 = *urban* and 2 = *rural*. Residential location was classified using Australia Post classifications. Participants were classified as living in an urban location if their postcode fell within Australia Post's listing for a capital city and associated suburbs. All other postcodes were considered to be rural.

Participants relationship status was categorised as 1 = *single, separated, divorced or widowed,* and 2 = *married, defacto or same-sex relatio*nship. Number of children was categorised as 1 = *no children* and 2 = *has children*. Importance of religion was categorised as 1 = *important* and 2 = *not important*. Finally, employment status was categorised as 1 = *employed, full-time or part-time,* and 2 = *volunteer, unemployed, workcover, or retired*.

Chi-square tests were used to test for differences between the four groups (heterosexual males, heterosexual female, gay males, lesbians) on categorical demographic variables. Significant group differences are reported in Table 1.

As can be seen from Table 1, heterosexual men and women were more likely to be in a relationship and to have children compared with gay men and lesbians. Gay men and lesbians were shown to be significantly more educated than heterosexual men and women. Heterosexual men and women reported religion as 'important' more frequently than gay men or lesbians. Heterosexual men and women were more likely to live in a rural location than gay men or lesbians. Finally, no significant difference was identified in employment status between heterosexual men and women, gay men or lesbians.

Given that heterosexual males and females and gay males and lesbians demonstrated significant differences with regard to residential location, relationship status, number of children, and importance of religion, these variables were entered as covariates in the examination of attitudes towards gay males and lesbians.

Table 1

Descriptive Statistics and Chi-square Values for Participant Demographic Variables

	Hetro Male		Hetro Female		Gay Male		Lesbian			
Demographics[a]	*N*	%	*N*	%	*N*	%	*N*	%	χ^2	*df*
Relationship Status										
Single/ divorced/ separated/widowed	59	35	132	38	207	54	144	45	26.83 *	3
Married/de facto/ Same-sex r/ship	109	65	215	62	174	46	173	55		
Children										
No Children	89	53	168	48	356	93	256	81	223.01 *	3
Has Children	79	47	179	52	25	7	61	19		
Education Level										
Secondary	39	23	113	33	77	20	88	28	37.78 *	9
TAFE/Trade Cert	44	26	50	15	58	16	55	17		
Undergraduate	56	33	104	30	146	38	82	26		
Postgraduate	29	18	80	23	100	26	92	29		
Employment Status										
Employed	137	81	293	84	323	85	246	77	7.58	3
Unemployed/ Retired	31	39	54	16	58	15	71	23		
Importance of Religion										
Important	61	36	142	41	97	26	86	27	25.13 *	3
Not Important	107	64	205	59	284	74	231	73		
Residential Location										
Urban	51	30	97	28	282	74	203	64	204.35 *	3
Rural	117	70	250	72	99	26	114	36		

[a] $n = 1213$.

*$p < .001$.

3. 1. 2 Age Differences

A one-way analysis of variance (ANOVA) was conducted to assess age differences between the four groups of participants (heterosexual males, heterosexual female, gay males, lesbians). Results indicated no significant difference between the four groups F (3,1186) = 2.02, $p > .05$. Given this finding, age was not controlled for in the subsequent analyses.

3. 2 Assumption Testing

All data were screened to test assumptions of normality, skewness and kurtosis, as suggested by Coakes and Steed (1999), Francis (1999) and Tabachnick and Fidell (2000). Examination of the Marlowe-Crowne Social Desirability Scale revealed a normal distribution (M = 19.15, SD = 1.97). The Suicidal Ideation Scale, taken from the General Health Questionnaire, was found to have a mild positive skew (M = 9.16, SD = 3.44). Given that the skew identified was mild and the nature of this scale tends to produce skewed distributions as few participants report moderate to high levels of suicidal thoughts (Ferguson, 1981), transformation of this variable was not performed. Both the Social Desirability and Suicide Ideation Scale scores were entered as covariates in the analyses performed.

The application of particular data transformations on the dependent variables to correct for skewness was required to achieve both univariate and multivariate normality (Tabachnick & Fidell, 2000). Each of the five individual Suicide Attitude Vignette Experience (SAVE) variables was observed to be skewed. As such, reciprocal transformations were performed on the '*justified*', '*acceptable*', and '*necessary*' variables, a logarithmic transformation was performed on the '*psychological health*' variable, and a square root transformation was performed on the '*empathy*' variable. The transformations undertaken reduced skew to acceptable levels for analysis. Further,

the Attitudes Toward Gay Men Scale total and Attitudes Toward Lesbian Scale total were both found to be skewed, requiring a logarithmic transformation to be performed on the Attitudes Towards Lesbian Scale and a reciprocal transformation to be performed on the Attitudes Towards Gay Men Scale. These newly transformed variables were used for all subsequent analyses. It is noted that the use of transformed data for the analyses undertaken has in no way impacted upon the interpretability of the findings presented due to the arbitrary nature of the data. Osbourne (2002) notes that the action of altering the relative distances between arbitrary data points through transformations in order to improve normality, allows all data points to remain in the same relative order as prior to the transformation, and therefore allows the interpretation in terms of increasing scores.

3. 3 Correlations

Pearson's correlation coefficients were generated to examine the strength of the relationships between the five variables of the SAVE. The results are presented in Table 2.

Table 2
Correlations between the five factors of the Suicide Attitude Vignette Experience (SAVE)

SAVE Variable	Justified	Acceptable	Empathy	Necessary	Psych Health
Justified	–	.64*	.24*	.55*	.21*
Acceptable		–	.17*	.62*	.23*
Empathy			–	.14*	.14*
Necessary				–	.22*
Psych Health					–

*$p < .01$

Results indicated all five SAVE variables were significantly correlated with each other. The strongest correlations were between the three variables '*justified*', '*acceptable*', and '*necessary*'. These three variables had weaker relationships with the variables of '*empathy*' and '*psychological health*'.

3. 4 Hypothesis Testing – The Relationship Between the Gender and Sexual Orientation of the Participant on Attitudes Towards Gay Male and Lesbian Adolescent Suicide

A two (sexual orientation of the suicide victim) by two (gender of the suicide victim) by two (sexual orientation of participant) by two (gender of participant) MANCOVA was conducted to test for differences in attitudes towards adolescent suicide based on the five SAVE variables. Variables entered as covariates in the analysis were: Social Desirability and Suicidal Ideation, participants' number of children, level of education, relationship status, importance of religion, and residential location. Follow-up ANCOVAS were then performed for significant findings obtained from the MANCOVA analysis. Significant interactions identified from the ANCOVA analyses were identified through examination of the adjusted transformed means against critical values (*CD*) obtained through Tukey's HSD test to determine significance and to provide control of Type 1 error. In reporting the findings from this examination, the untransformed and unadjusted means have been presented in the tables and graphs for the purposes of clarity however, this does result in occasional apparent discrepancies between the graphs of unadjusted means and those used in the statistical analyses. In addition, only the significant highest order interactions are reported in detail to facilitate clarity in the presentation of the findings observed. In reporting lower order effects and interactions, comparisons of the adjusted means were used to provide brief descriptions of the patterns of results. The means and standard deviations for the five SAVE variables used in the MANCOVA analysis are presented in Table 3.

3. 4. 1 Examination of Covariates

MANCOVA results for the covariates indicated that social desirability, *Wilks Λ* = .98, $F(5, 1186) = 4.40$, $p < .05$, *partial* $\eta^2 = .02$; suicidal ideation, *Wilks Λ* = .99, $F(5, 1186) = 3.30$, $p < .05$, *partial* $\eta^2 = .01$; participants' children, *Wilks Λ* = .98, $F(5, 1186) = 4.31$, $p < .05$, *partial* $\eta^2 = .02$; participants' level of education, *Wilks Λ* = .96, $F(5, 1186) = 10.41$, $p < .05$, *partial* $\eta^2 = .04$; and participants' residential location, *Wilks Λ* = .99, $F(5, 1186) = 3.42$, $p < .05$, *partial* $\eta^2 = .01$, were significant. Participants' relationship status, *Wilks Λ* = .99, $F(5, 1186) = 1.49$, $p > .05$, *partial* $\eta^2 = .04$, and importance of religion, *Wilks Λ* = .99, $F(5, 1186) = 0.75$, $p > .05$, *partial* $\eta^2 = .00$, were shown not to be significant.

3. 4. 2 MANCOVA Results

MANCOVA results indicated a significant four-way interaction between the participants' gender and sexual orientation and the gender and sexual orientation of the suicide victim, *Wilks Λ* = .99, $F(5, 1186) = 2.62$, $\underline{p} < .05$, *partial* $\eta^2 = .01$.

Significant three-way interactions were identified between participants' sexual orientation and the gender and sexual orientation of the suicide victim, *Wilks Λ* = .98, $F(5, 1186) = 5.35$, $\underline{p} < .05$, *partial* $\eta^2 = .02$, participants' gender and sexual orientation and the suicide victims' sexual orientation, *Wilks Λ* = .99, $F(5, 1186) = 2.90$, $p < .05$, *partial* $\eta^2 = .02$, and participants' gender and sexual orientation and the gender of the suicide victim, *Wilks Λ* = .99, $F(5, 1186) = 2.72$, $p < .05$, *partial* $\eta^2 = .01$.

Significant two-way interactions were identified between the participants' gender and the gender of the suicide victim, *Wilks Λ* = .99, $F(5, 1186) = 2.49$, $p < .05$, *partial* $\eta^2 = .01$, participants' sexual orientation and the gender of the suicide victim, *Wilks Λ* = .98, $F(5, 1186) = 4.18$, $p < .05$, *partial* $\eta^2 = .02$, participants' sexual orientation and the sexual orientation of the suicide victim, *Wilks Λ* = .99, $F(5, 1186) = 3.54$, $p < .05$,

partial η^2 = .02, and the gender and sexual orientation of the suicide victim, *Wilks* Λ = .99, $F(5, 1186) = 2.22$, $p < .05$, *partial* η^2 = .01.

Finally, significant main effects were identified for participants' gender, *Wilks* Λ = .99, $F(5, 1186) = 3.49$, $p < .05$, *partial* η^2 = .01, gender of the suicide victim, *Wilks* Λ = .98, $F(5, 1186) = 4.09$, $p < .05$, *partial* η^2 = .02, and sexual orientation of the suicide victim, *Wilks* Λ = .95, $F(5, 1186) = 13.69$, $p < .05$, *partial* η^2 = .06.

3. 5 Hypothesis 1: How Acceptable, Justified, and Necessary was the Suicide and How Psychologically Healthy was the Suicide Victim?

3. 5. 1 How Acceptable was the Suicide?

Univariate analysis indicated a significant interaction between the sexual orientation of the participant and the sexual orientation and gender of the suicide victim, $\underline{F}(1, 1190) = 18.77$, $\underline{p} < .05$. The interaction is shown in Figure 1.

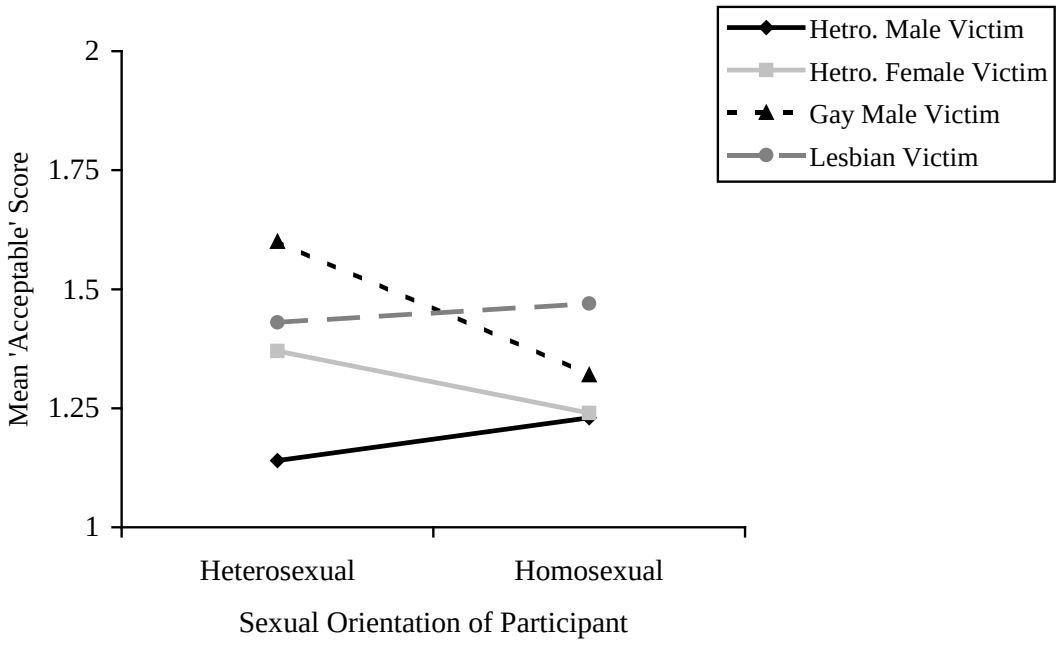

Figure 1. *Interaction between the sexual orientation of the participant and the sexual orientation and gender of the suicide victim for how acceptable was the suicide.*

Tukey's HSD (*CD* = 0.0818 for the transformed and adjusted means) revealed that heterosexual participants rated the suicide of a gay male adolescent as more acceptable

than homosexual participants rated the suicide of a gay male or both heterosexual suicide victims. Heterosexual participants rated the suicide of a heterosexual male adolescent less acceptable than that of a gay male, lesbian or heterosexual female and less acceptable than homosexual participants rated the suicides of a gay male or a lesbian. Homosexual participants rated the suicide of a lesbian adolescent as more acceptable than the suicide of a gay male or both heterosexual victims.

Univariate analysis also indicated a significant main effect for the gender of the suicide victim on acceptability of the suicide, $F(1, 1190) = 6.20$, $p < .05$. Examination of the adjusted means suggested female adolescent suicide was seen as more acceptable than male adolescent suicide. Further, a significant main effect was also observed for the sexual orientation of the suicide victim on acceptability of the suicide, $F(1, 1190) = 37.41$, $p < .05$. Examination of the adjusted means suggested homosexual adolescent suicide was seen as more acceptable than heterosexual adolescent suicide.

3. 5. 2 How Justified was the Suicide?

Univariate analysis indicated a significant interaction between the sexual orientation of the participant and the sexual orientation and gender of the suicide victim, $F(1, 1190) = 7.06$, $p < .05$. The interaction is shown in Figure 2.

Tukey's HSD ($CD = 0.0913$) revealed that heterosexual participants rated the suicide of a gay male adolescent as more justified than the suicide of a heterosexual male and female and more justified than homosexual participants rated the suicide of a gay male and heterosexual male and female suicide. Homosexual participants also rated the suicide of a lesbian adolescent as more justified than both homosexual and heterosexual participants rated the suicide of a heterosexual female adolescent.

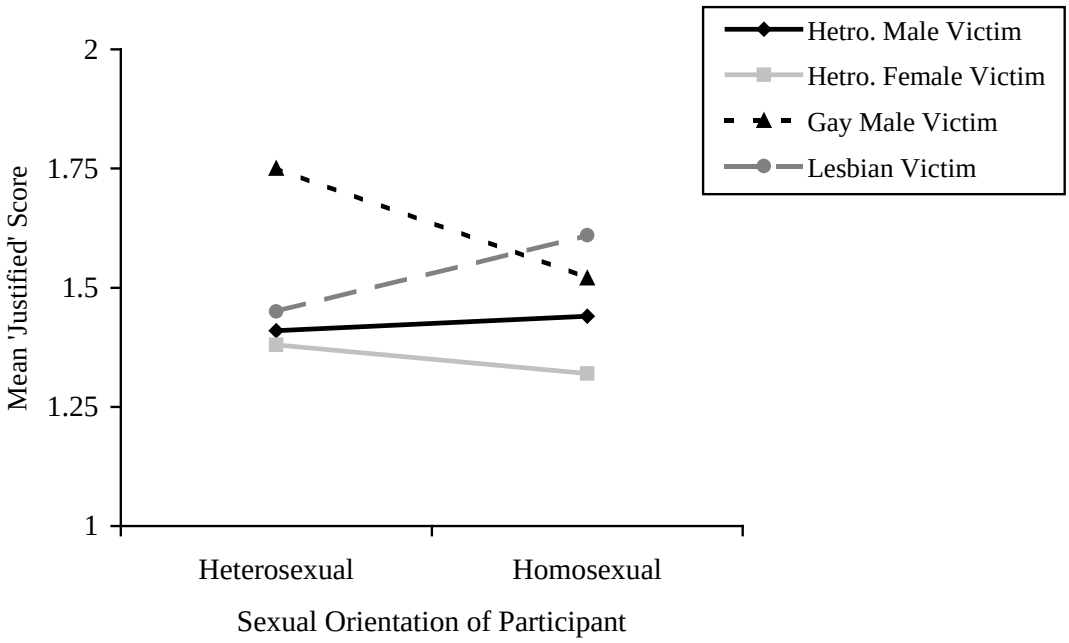

Figure 2. *Interaction between the sexual orientation of the participant and the sexual orientation and gender of the suicide victim for how justified was the suicide.*

Univariate analysis also indicated a significant two way interaction involving participants' sexuality and the gender of the victim, $F(1, 1190) = 5.93$, $p < .05$. This arose from the heterosexual participants rating the suicide of male victims as more justified than female victims but homosexual participants rating female suicides as more justified than male suicides. There was also a main effect for sexual orientation of the suicide victim on the ratings of justification, $F(1, 1190) = 18.74$, $p < .05$. Examination of the adjusted means indicated that homosexual adolescent suicide was seen as more justified than heterosexual adolescent suicide.

3. 5. 3 How Necessary was the Suicide?

Univariate analysis indicated a significant interaction between the sexual orientation of the participant and the sexual orientation and gender of the suicide victim, $F(1, 1190) = 18.15$, $p < .05$. The interaction is shown in Figure 3.

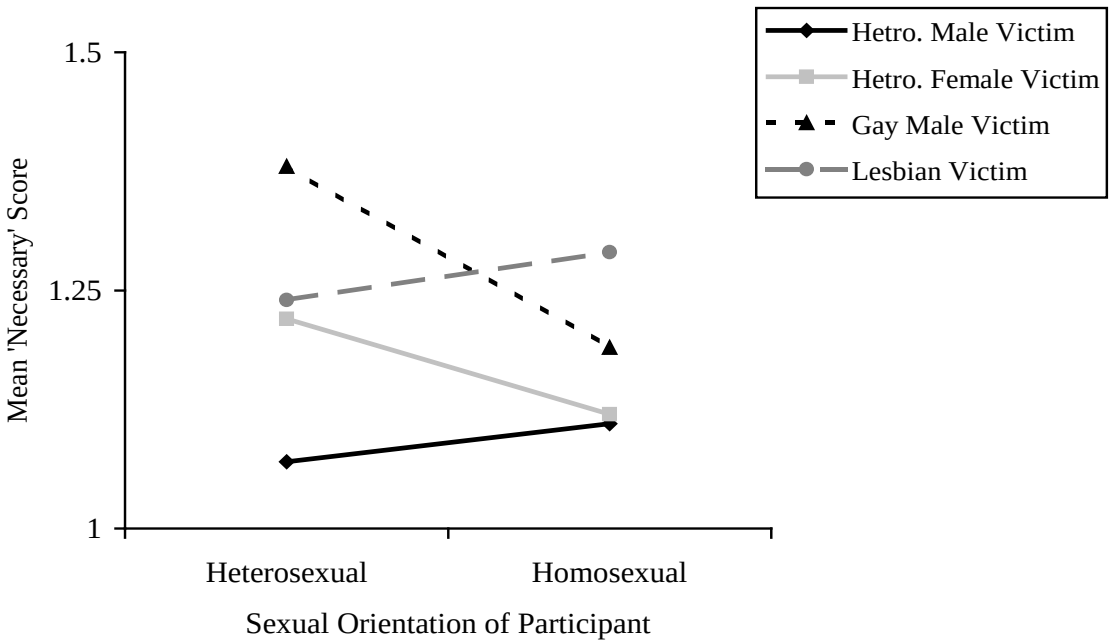

Figure 3. *Interaction between the sexual orientation of the participant and the sexual orientation and gender of the suicide victim for how necessary was the suicide.*

Tukey's HSD (*CD* = 0.0675) revealed that heterosexual participants rated the suicide of a gay male adolescent as more necessary than the suicide of a female and male heterosexual adolescent and more necessary than homosexual participants rated gay male suicide and the suicide of heterosexuals of both genders. Both heterosexual and homosexual participants rated the suicide of a lesbian adolescent as more necessary than homosexual participants rated male and female heterosexual victims and more necessary than heterosexual participants rated the necessity of a male heterosexual suicide. Finally heterosexual participants rated the suicide of a heterosexual male as less necessary than the suicide of female heterosexual and lesbian victims and less than homosexual participants rated the suicide of a lesbian adolescent.

Univariate analysis also indicated a significant interaction between the gender and sexual orientation of the participant and the sexual orientation of the suicide victim, $F(1, 1190) = 5.35$, $p < .05$. The interaction is shown in Figure 4.

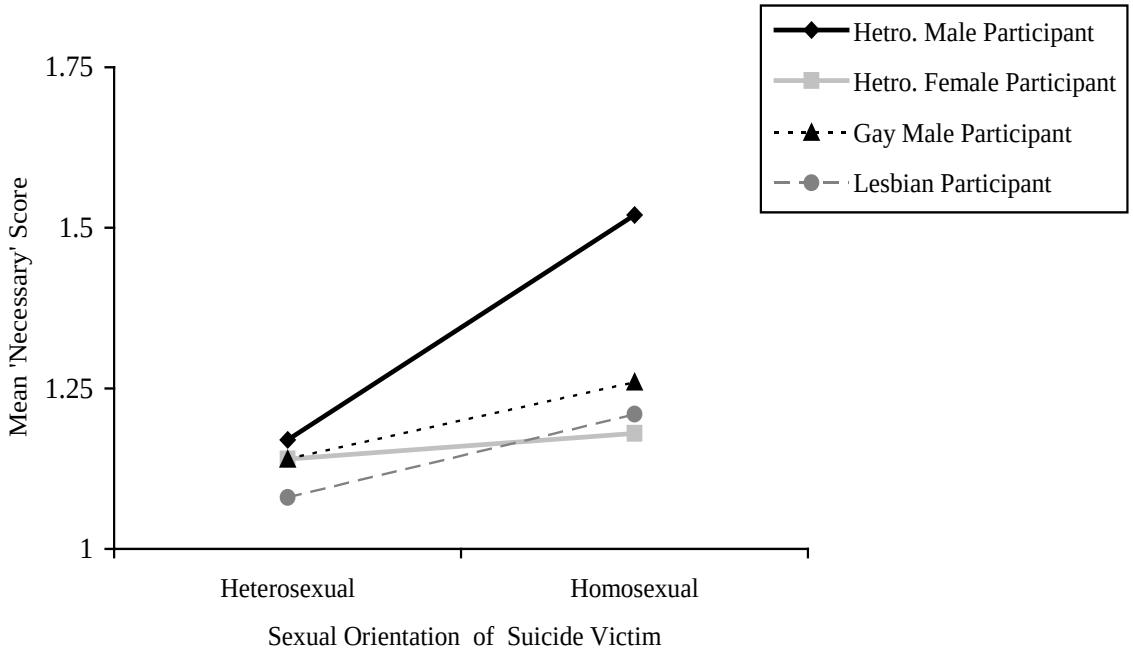

Figure 4. *Interaction between the gender and sexual orientation of the participant and the sexual orientation of the suicide victim for how necessary was the suicide.*

Tukey's HSD (*CD* = 0.0675) revealed that heterosexual male participants rated the suicide of a homosexual adolescent as more necessary than any other group of participants rated either heterosexual or homosexual victims. Lesbian participants rated the suicide of a heterosexual victim as less necessary than gay and heterosexual male participants rated the homosexual suicide victim.

Univariate analysis also indicated a significant main effect for the gender of the participant on the ratings of the necessity of the suicide, $F(1, 1190) = 6.36$, $p < .05$. Examination of the means showed that male participants rated the various suicides as more necessary than the female participants. Further, a significant main effect was also observed for the sexual orientation of the suicide victim on the necessity of the suicide, $F(1, 1190) = 37.46$, $p < .05$, with homosexual adolescent suicide seen as more necessary than heterosexual adolescent suicide.

3. 5. 4 How Psychologically Healthy was the Suicide Victim?

Univariate analysis indicated a significant interaction between the gender and sexual orientation of the participant and the sexual orientation of the suicide victim, $F(1, 1190) = 5.75$, $p < .05$. The interaction is shown in Figure 5.

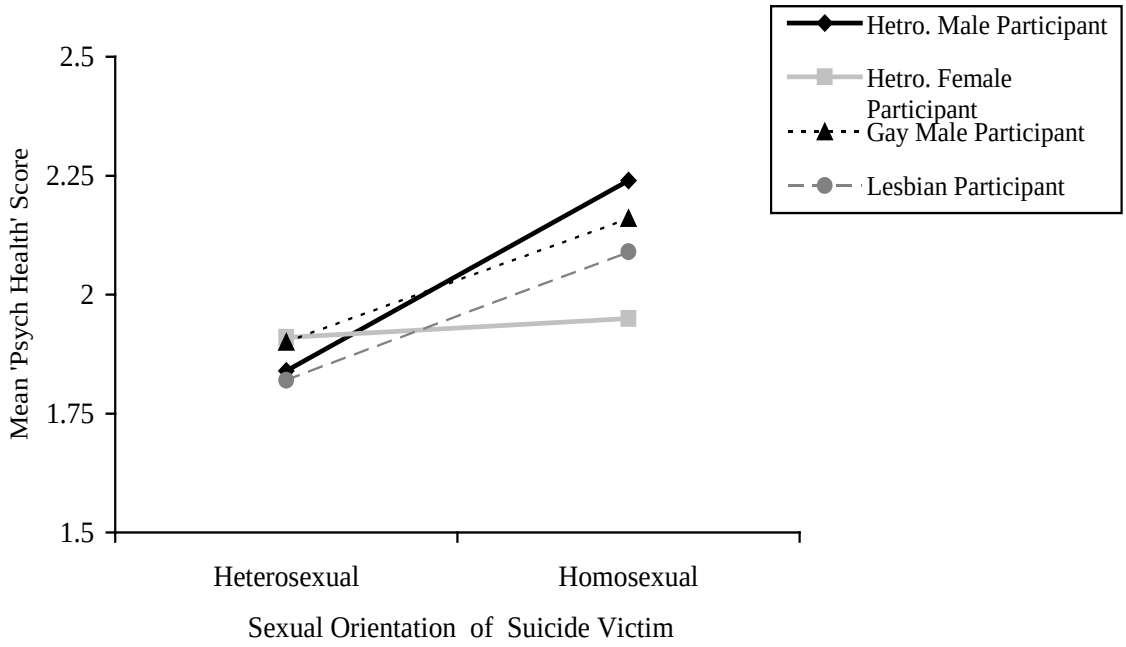

Figure 5. *Interaction between the gender and sexual orientation of the participant and the sexual orientation of the suicide victim on the psychological health of the suicide victim.*

Tukey's HSD (*CD* = 0.0583) revealed that heterosexual male participants rated homosexual adolescent suicide victims as psychologically healthier than heterosexual male and female and lesbian participants rated the heterosexual adolescent suicide victims. Heterosexual male, gay male and lesbian participants also rated homosexual adolescent suicide victims as psychologically healthier than heterosexual male and lesbian participants rated the heterosexual suicide victims.

Univariate analysis also indicated a significant interaction between gender and sexual orientation of the participant and the gender of the suicide victim, $F(1, 1190) = 5.57$, $p < .05$. The interaction is shown in Figure 6.

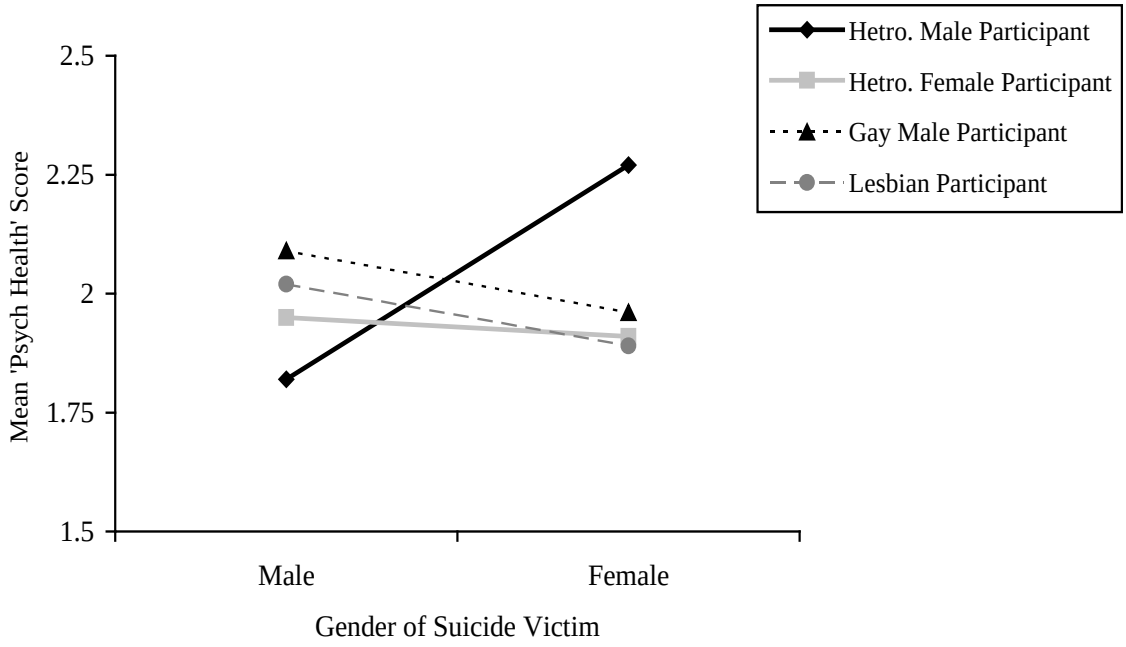

Figure 6. *Interaction between the gender and sexual orientation of the participant and the gender of the suicide victim on the psychological health of the suicide victim.*

Tukey's HSD (*CD* = 0.0583) revealed that heterosexual male participants rated female adolescent suicide victims as psychologically healthier than did heterosexual female or lesbian participants. They also rated female adolescent suicide victims as psychologically healthier than male adolescent suicide victims. Gay male participants rated male adolescent suicide victims as psychologically healthier than did heterosexual male participants.

Univariate analysis of ratings of the psychological health of the victim also indicated a third significant three-way interaction involving sexual orientation of the participant and the gender and sexual orientation of the suicide victim, $F(1, 1190) = 7.78$, $p < .05$. The interaction is shown in Figure 7.

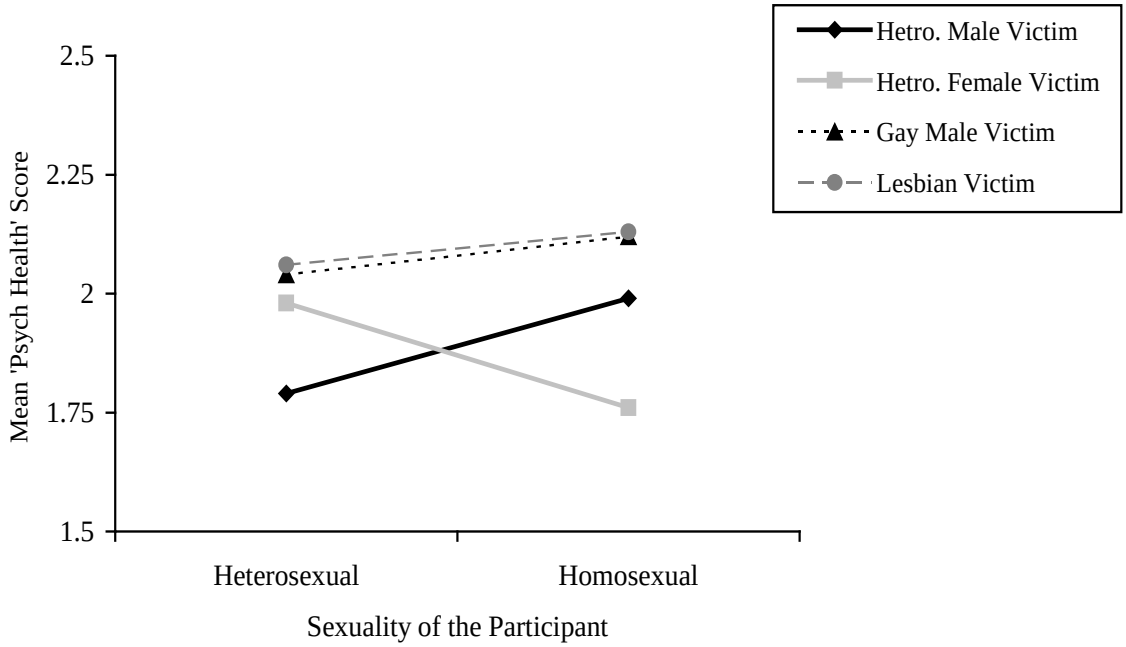

Figure 7. *Interaction between the sexual orientation of the participant and the gender and sexual orientation of the suicide victim on the psychological health of the suicide victim.*

Tukey's HSD (*CD* = 0.0583) revealed that all homosexual victims, irrespective of their gender and by whom they were rated, were seen as healthier than the female heterosexual victim as rated by the homosexual participants and the male heterosexual victim as rated by the heterosexual participants. The male heterosexual victim rated by the heterosexual participants was rated as less healthy than all other victims rated by both heterosexual and homosexual participants except for the female heterosexual victim rated by the homosexual participants.

Univariate analysis also indicated a significant two-way interaction for the gender of the participant and gender of the suicide victim on the psychological health of the suicide victim, $F(1, 1190) = 8.60$, $p < .05$. Examination of the means revealed that male participants saw female adolescent suicide victims as psychologically healthier than male adolescent suicide victims, while female participants saw male adolescent suicide victims as psychologically healthier than female adolescent suicide victims.

A further significant interaction was identified between the sexual orientation of the participant and the gender of the suicide victim, $F(1, 1190) = 9.52$, $p < .05$. Examination of the means showed heterosexual participants saw female adolescent suicide victims as psychologically healthier than male adolescent suicide victims, while homosexual participants saw male adolescent suicide victims as psychologically healthier than female adolescent suicide victims.

Finally, univariate analysis also indicated a significant main effect for the sexual orientation of the suicide victim, $F(1, 1190) = 27.35$, $p < .05$. Homosexual adolescent suicide victims were seen as psychologically healthier than heterosexual adolescent suicide victims.

3. 6 Hypothesis 2: Level of Empathy for the Suicide Victim

Univariate analysis indicated a significant interaction involving all four factors: gender and sexual orientation of the participant and the gender and sexual orientation of the suicide victim, $F(1, 1190) = 7.13$, $p < .05$. The interaction is shown in Figure 8.

Tukey's HSD ($CD = 0.1746$) revealed that lesbian participants reported greater empathy for the lesbian adolescent suicide victims than they did for the heterosexual female adolescent suicide victims. Lesbian participants also reported significantly more empathy for the lesbian victim than male heterosexuals reported for both female heterosexual and gay male victims, female heterosexuals for male heterosexual victims and gay males for both male and female heterosexual victims. Gay male participants reported significantly more empathy for the lesbian adolescent suicide victims than they did for male heterosexual victims.

Univariate analysis also indicated a significant interaction between the sexual orientation of the participant and sexual orientation of the suicide victim on the empathy shown to the suicide victim, $F(1, 1190) = 13.44$, $p < .05$. Examination of the means suggested that homosexual participants reported much greater empathy for homosexual adolescent suicide victims than for heterosexual adolescent suicide victims but heterosexual participants showed only marginally more empathy with homosexual victims compared to heterosexual victims.

Further, univariate analysis also indicated a significant main effect for the gender of the participant on empathy shown to the suicide victim, $F(1, 1190) = 4.06$, $p < .05$, with female participants reporting greater empathy towards the adolescent suicide victims than male participants.

Finally, a significant main effect was also observed for the sexual orientation of the suicide victim on empathy shown to the suicide victim, $F(1, 1190) = 16.10$, $p < .05$. Homosexual adolescent suicide victims were rated with greater empathy than heterosexual suicide victims.

3. 7 Hypothesis 3: Predictors of Heterosexual and Homosexual Participants' Attitudes Towards Gay Male and Lesbian Adolescent Suicide

3. 7. 1 Predictors of Heterosexual Participants' Attitudes Towards Gay Male and Lesbian Adolescent Suicide

A Hierarchical Multiple Regression Analysis (HMRA) was conducted to examine the predictors of heterosexual participants' attitudes towards the suicide of a gay male or lesbian adolescent. Heterosexual participants who received the vignette depicting a heterosexual adolescent suicide were deleted, leaving a final sample of 253 participants. A total score for participants' attitude towards gay male and lesbian adolescent suicide was compiled by adding together the scores for each of the five SAVE variables.

The predictors, entered singly or in pairs, consisted of the gender of the suicide victim, the participants' gender, age, level of education, residential location, religious affiliation and importance of religion, level of homophobia towards gay males and lesbians, and level of contact with homosexuals. The final model is presented in Table 4, with the full model displayed in Appendix E.

Table 4
Summary of Final Model of the Hierarchical Regression Analysis for Predictors of Heterosexual Participants' Attitudes Towards Gay Male and Lesbian Adolescent Suicide

Variable	*B*	*SE B*	β	sr^2
Step 8				
Gender of Suicide Victim[a]	-0.17	0.11	-.10	-.09
Gender[a]	-0.23	0.11	-.13*	-.12
Age	-0.02	0.00	-.37**	-.35
Level of Education	0.02	0.05	.03	.03
Place of Residence[b]	0.10	0.13	.05	.04
Religious Affiliation[c]	0.09	0.07	.09	.08
Importance of Religion[d]	0.02	0.13	-.02	-.01
Homophobia Towards Gay Males	-4.49	14.59	-.05	-.02
Homophobia Towards Lesbians	0.56	0.86	.11	.04
Level of Homosexual Contact	-0.02	0.02	-.00	-.00

Note. *B* = unstandardised slope parameter, *SE B* = standard error of Beta, β = standardised slope parameter, sr^2 = semi-partial correlations squared R^2 = .02 for Step 1; R^2 = .02 for Step 2; R^2 = .13 for Step 3; R^2 = .00 for Step 4; R^2 = .01 for Step 5; R^2 = .01 for Step 6; R^2 = .00 for Step 7; R^2 = .00 for Step 8.
[a]1 = *Male*, 2 = *Female*. [b]1 = *Urban*, 2 = *Rural*. [c]1 = *Religion*, 2 = No *religion*. [d]1 = *important*, 2 = *not important*.
*p < .05. **p < .001.

At Step 1 of the HMRA, the suicide victim's gender was entered. This was found to be significant at this stage, ΔR^2 = .02, *adjusted* R^2 = -.02, *Fchange* (1, 252) = 4.95, p < .05, and Beta-values confirmed that gender of the suicide victim contributed to the

predictive power of the model, $t(253) = -2.22$, $p < .05$, with participants reporting greater endorsement towards the suicide of gay males than lesbians.

At Step 2, the addition of the participants' gender produced a significant improvement in the model's predictive ability, explaining nearly 4% of the variance in attitudes, $\Delta R^2 = .02$, *adjusted* $R^2 = .03$, *Fchange* $(1, 251) = 5.68$, $p < .05$. Examination of the Beta-values revealed that both the gender of the suicide victim, $t(253) = -2.26$, $p < .05$, and the participants' gender, $t(253) = -2.38$, $p < .05$, contributed to the predictive power of the model. Male participants reported greater endorsement of gay male and lesbian suicide than female participants.

At Step 3, the addition of the participants' age also produced a significant improvement in the model's predictive power, explaining an additional 13% of the variance, $\Delta R^2 = .13$, *adjusted* $R^2 = .16$, *Fchange* $(1, 250) = 39.31$, $\underline{p} < .05$. Examination of the Beta-values revealed that the gender, $\underline{t}(253) = -1.36$, $\underline{p} < .05$, and age of the participant contributed to the predictive power of the model, $\underline{t}(253) = -2.23$, $\underline{p} < .05$, indicating younger participants reported greater endorsement of gay male and lesbian suicide than older participants.

At Step 4, the addition of the participants' level of education failed to produce any significant improvement in the model's predictive power, $\Delta R^2 = .00$, *adjusted* $R^2 = .16$, *Fchange* $(1, 249) = 0.37$, $p > .05$. Examination of the Beta-values revealed that the gender, $t(253) = -2.21$, $p < .05$, and age of the participant contributed to the predictive power of the model, $t(253) = -6.26$, $p < .05$.

At Step 5, the addition of the participants' residential location also failed to produce a significant improvement in the model's predictive power, $\Delta R^2 = .01$, *adjusted* $R^2 = .16$, *Fchange* $(1, 248) = 1.85$, $p > .05$. Examination of the Beta-values revealed that the gender, $t(253) = -2.32$, $p < .05$, and age of the participant still contributed to the predictive power of the model, $t(253) = -6.41$, $p < .05$.

At Step 6, the addition of both participants' religious affiliation and the importance of religion failed to produce any significant improvement in the model's predictive power, $\Delta R^2 = .01$, *adjusted* $R^2 = .16$, $Fchange(2, 246) = 1.09$, $p > .05$. There was no change in the significant predictors: gender, $t(253) = -2.31$, $p < .05$, and age of the participant, $t(253) = -6.15$, $p < .05$.

At Step 7, the addition of the participants' level of homophobia towards both gay males and lesbians also failed to add to the predictive power of the model, $\Delta R^2 = .00$, *adjusted* $R^2 = .16$, $Fchange(2, 244) = 0.51$, $p > .05$. Again there was no change in the significant predictors: gender, $t(253) = -2.13$, $p < .05$, and age of the participant, $t(253) = -6.03$, $p < .05$.

Finally, in Step 8, the addition of the participants' level of contact with homosexuals also failed to increase the predictive power of the model, $\Delta R^2 = .00$, *adjusted* $R^2 = .16$, $Fchange(1, 243) = 0.00$, $p > .05$. Examination of the Beta-values revealed that the gender, $t(253) = -2.13$, $p < .05$, and age of the participant, $t(253) = -6.02$, $p < .05$, remained the only significant predictors.

In the final model, the two significant predictors of heterosexual attitudes towards gay male and lesbian adolescent suicide were age of the participant, with younger participants reporting a stronger endorsement of gay male and lesbian adolescent suicide compared with older participants, and gender of the participant, with males reporting greater endorsement of gay male and lesbian adolescent suicide than females.

3. 7. 2 Predictors of Homosexual Participants' Attitudes Towards Gay Male and Lesbian Adolescent Suicide

A Hierarchical Multiple Regression Analysis (HMRA) was conducted to examine the predictors of homosexual participants' attitudes towards homosexual adolescent suicide. Homosexual participants who received the vignette depicting heterosexual

adolescent suicide were deleted, leaving a final sample of 337 participants. A total score for participant's attitude towards gay male and lesbian adolescent suicide was compiled by adding together the scores for each of the five SAVE variables. The predictors, entered singly or in pairs, consisted of the gender of the suicide victim, the participants' gender, age, level of education, residential location, religious affiliation and importance of religion, level of internalised homophobia, and level of contact with homosexuals. The final model is presented in Table 5, with the full model displayed in Appendix F.

Table 5
Summary of Final Model of the Hierarchical Regression Analysis for Predictors of Homosexual Participants' Attitudes Towards Gay Male and Lesbian Adolescent Suicide

Variable	*B*	*SE B*	β	sr^2
Step 8				
Gender of Suicide Victim[a]	-0.14	0.09	.08	.04
Gender[a]	-0.08	0.10	-.05	.02
Age	-0.01	0.01	-.14*	.14
Level of Education	-0.04	0.04	-.06	.01
Place of Residence[b]	0.11	0.10	.06	-.10
Religious Affiliation[c]	0.09	0.06	-.09	.06
Importance of Religion[d]	0.16	0.09	.11	.03
Internalised Homophobia	-0.09	0.01	-.05	-.04
Level of Homosexual Contact	0.03	0.02	.07	.70

Note. *B* = unstandardised slope parameter, *SE B* = standard error of Beta, β = standardised slope parameter, sr^2 = R^2 = .01 for Step 1; R^2 = .00 for Step 2; R^2 = .02 for Step 3; R^2 = .00 for Step 4; R^2 = .00 for Step 5; R^2 = .01 for Step 6; R^2 = .00 for Step 7; R^2 = .01 for Step 8.
[a]1 = *Male*, 2 = *Female*. [b]1 = *Urban*, 2 = *Rural*. [c]1 = *Religion*, 2 = N*o religion*. [d]1 = *important*, 2 = *not important*.
*p < .05.

At Step 1 of the HMRA, the gender of the homosexual suicide victim was entered. This was found to be significant, ΔR^2 = .01, *adjusted* R^2 = -.01, $F_{change}(1, 336) = 4.77$, p < .05. Gender of the suicide victim contributed to the predictive power of the model,

$t(337) = 2.18$, $p < .05$, indicating that participants reported greater endorsement for the suicide of a lesbian than a gay male.

At Step 2, the addition of participants' gender failed to produce a significant improvement in the predictive power of the model, $\Delta R^2 = .00$, *adjusted* $R^2 = .01$, $F_{change}(1, 335) = 0.17$, $p > .05$. Examination of the Beta-values revealed that gender of the suicide victim still contributed to the predictive power of the model, $t(337) = 2.19$, $p < .05$.

At Step 3, the participants' age produced a significant improvement in the predictive power of the model, explaining 2% of the variance, $\Delta R^2 = .02$, *adjusted* $R^2 = .03$, $F_{change}(1, 334) = 6.74$, $p < .05$. Examination of the Beta-values revealed that only the age of the participant contributed to the predictive power of the model, $t(337) = -2.60$, $p < .05$. Younger participants reported a stronger endorsement towards the suicide of a gay male or lesbian adolescent than older participants.

At Step 4, participants' level of education was added, again providing no significant change in the model's predictive power, $\Delta R^2 = .00$, *adjusted* $R^2 = .03$, $F_{change}(1, 333) = 1.21$, $p > .05$. Examination of the Beta-values revealed that none of the variables entered added significantly to the predictive power of the model.

At Step 5, the addition of the participants' residential location also failed to produce a significant improvement in the predictive power of the model, $\Delta R^2 = .00$, *adjusted* $R^2 = .03$, $F_{change}(1, 332) = 0.85$, $p > .05$. Examination of the Beta-values revealed that the age of the participant still contributed to the predictive power of the model, $t(337) = -1.96$, $p < .05$.

At Step 6, the addition of participants' religious affiliation and importance of religion failed to produce any significant improvement in the predictive power of the model, $\Delta R^2 = .01$, *adjusted* $R^2 = .03$, $F_{change}(2, 330) = 1.83$, $p > .05$. Examination of the

Beta-values revealed that the age of the participant was maintained as a predictor, $t(337) = -2.03$, $p < .05$.

At Step 7, the addition of the participants' level of internalised homophobia also failed to produce any significant improvement in the predictive power of the model, $\Delta R^2 = .00$, *adjusted* $R^2 = .03$, $F_{change}(1, 329) = 0.75$, $p > .05$. Age of the participant remained a significant predictor in the model, $t(337) = -2.14$, $p < .05$.

Finally, at Step 8, the addition of the participants' level of contact with homosexuals failed to increase the predictive power of the model, $\Delta R^2 = .01$, *adjusted* $R^2 = .03$, $F_{change}(1, 328) = 1.57$, $p < .05$.

In the final model, only one significant predictor of homosexual attitudes towards gay male and lesbian adolescent suicide was identified. This was age of the participant, with younger participants reporting a stronger endorsement of gay male and lesbian adolescent suicide.

3. 8 Hypothesis 4: The Effect of Frequency and Type of Contact with Homosexuals on Heterosexual Male and Female Participants' Levels of Homophobia Towards Gay Males and Lesbians

For the purposes of this analysis, gay male and lesbian participants were removed from the data set leaving a final sample of 515 heterosexual male and female participants. A series of MANCOVA analyses were then conducted. Social Desirability was entered as covariate, along with the following demographic variables identified by previous research as influential in an individual's level of homophobia: participants' level of education, importance of religion and residential location. Significant MANCOVA analyses were followed with univariate analyses. Significant univariate results were then subjected to an examination of the transformed and adjusted means using critical values (*CD*) obtained through Tukey's HSD test to determine

significance and to provide control of Type 1 error. In reporting the findings from this examination, the untransformed and unadjusted means have been presented for the purposes of clarity. In addition, only the significant highest order results for each analysis are reported in detail, to facilitate clarity in the presentation of the findings observed. In reporting lower order results, comparisons of the adjusted means were used to provide a brief description of the patterns of results.

3. 8. 1 The Effect of Frequency of Contact with Homosexuals on Heterosexual Male and Female Participants' Level of Homophobia Towards Gay Males and Lesbians

A five (levels of contact with homosexuals) by two (gender of participant) MANCOVA was conducted to test for differences in heterosexual participants reported levels of homophobia towards lesbians and gay males. MANCOVA results indicated that participants' residential location was a significant covariate, *Wilks* $\Lambda = 0.94$, $\underline{F}(2, 500) = 16.24$, $p < .05$, *partial* $\eta^2 = .06$ but not social desirability, *Wilks* $\Lambda = 1.00$, $\underline{F}(2, 500) = 0.05$, $p > .05$, *partial* $\eta^2 = .00$, participants' level of education, *Wilks* $\Lambda = 1.00$, $\underline{F}(2, 500) = 1.17$, $p > .05$, *partial* $\eta^2 = .01$, or importance of religion, *Wilks* $\Lambda = 1.00$, $\underline{F}(2, 500) = 0.38$, $p > .05$, *partial* $\eta^2 = .00$. The means and standard deviations for this analysis are presented in Table 6.

MANCOVA results indicated a significant two-way interaction between the participants' frequency of contact with homosexuals and the gender of the participant, *Wilks* $\Lambda = 0.97$, $\underline{F}(8, 1000) = 2.02$, $p < .05$, *partial* $\eta^2 = 0.02$.

Table 6
Means and Standard Deviations of Heterosexual Participants' Level of Homophobia Towards Gay Males and Lesbians by Frequency of Contact with Homosexuals

		Level of Homophobia			
		Male Participants[a]		Female Participants[b]	
Frequency of Contact		Gay Scale	Lesbian Scale	Gay Scale	Lesbian Scale
None	*M*	58.92	54.81	39.35	42.02
	SD	21.36	20.24	15.01	16.87
Monthly	*M*	43.34	41.32	41.42	44.62
	SD	21.09	16.80	17.51	21.52
Fortnightly	*M*	40.33	38.00	39.96	40.70
	SD	22.50	20.81	16.92	19.60
Weekly	*M*	42.87	39.82	36.00	36.88
	SD	18.10	15.45	14.56	14.66
Daily	*M*	41.02	39.96	37.20	39.12
	SD	16.35	17.67	13.83	16.00

[a]n = 168. [b]n = 347.

Inspection of the univariate analysis found a significant interaction between frequency of contact with homosexuals and participants' level of homophobia towards gay males $F(4, 515) = 3.67$, $p < .05$. The interaction can be seen in Figure 9.

Tukey's HSD (CD = 0.0052 for the adjusted transformed means) revealed that male participants who have no contact with homosexuals reported higher levels of homophobia towards gay males than female participants who had no contact with homosexuals. Further, male participants who had no contact with homosexuals reported significantly higher levels of homophobia towards gay males than males who had infrequent, fortnightly, weekly or daily contact. No significant difference was found

between any of the levels of contact for female participants and their level of homophobia towards gay males.

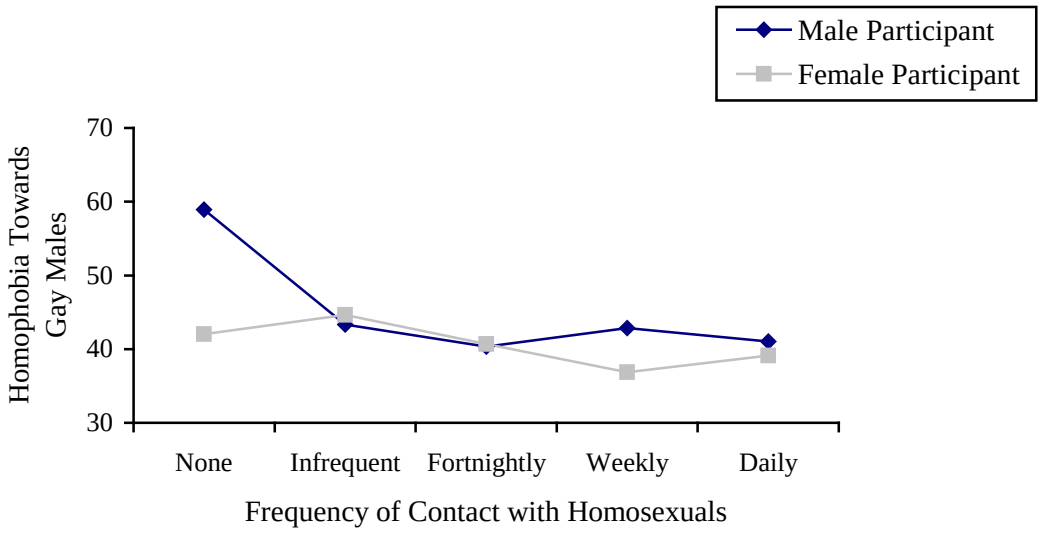

Figure 9. *Interaction between heterosexual participants' gender and frequency of contact with homosexuals with respect to their level of homophobia towards gay males.*

Univariate analysis also indicated a significant interaction between frequency of contact with homosexuals and participants' gender $F(4, 515) = 2.73$, $p < .05$. The interaction can be seen in Figure 10.

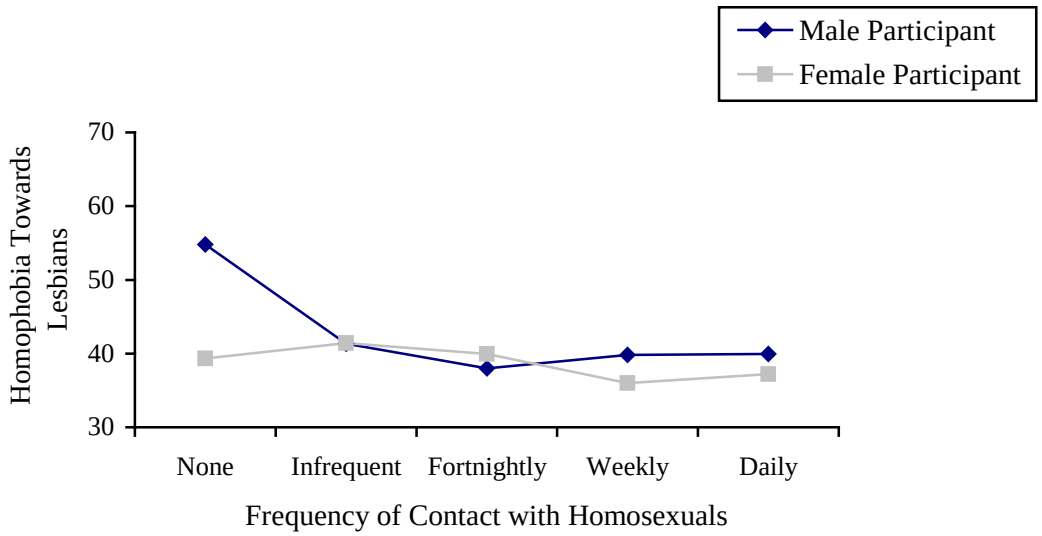

Figure 10. *Interaction of heterosexual participants' gender and the frequency of their contact with homosexuals on the level of homophobia towards lesbians.*

Tukey's HSD (*CD* = 0.0855) revealed that male participants who have no contact with homosexuals reported higher levels of homophobia towards lesbians than female participants who had no contact with homosexuals. Male participants who had no contact with homosexuals also reported significantly higher levels of homophobia towards lesbians than males who had infrequent, fortnightly, weekly or daily contact. No significant difference was found between any of the levels of contact for female participants with respect to their level of homophobia towards lesbians.

3. 8. 2 The Effect of Type of Contact with Homosexuals on Heterosexual Male and Female Participants' Level of Homophobia Towards Gay Males and Lesbians

A four (types of contact with homosexuals) by two (gender of participant) MANCOVA was conducted to test for differences in heterosexual participants' levels of homophobia towards lesbians and gay males.

MANCOVA results indicated that participants' residential location was a significant covariate, *Wilks* $\Lambda = 0.94$, $F(2, 502) = 17.72$, $p < .05$, *partial* $\eta^2 = .07$ with participants in urban locations shown to have lower levels of homophobia than rural participants. Social desirability, *Wilks* $\Lambda = 1.00$, $F(2, 502) = 0.41$, $p > .05$, *partial* $\eta^2 = .00$, participants' level of education, *Wilks* $\Lambda = 1.00$, $F(2, 502) = 1.35$, $p > .05$, *partial* $\eta^2 = .01$, and importance of religion, *Wilks* $\Lambda = 1.00$, $F(2, 502) = 1.01$, $p > .05$, *partial* $\eta^2 = .00$, were found to be not significant. The means and standard deviations for this analysis are presented in Table 7.

Table 7
Means and Standard Deviations of Participants' Level of Homophobia Towards Gay Males and Lesbians by Type of Contact with Homosexuals

		Level of Homophobia			
		Male Participants[a]		Female Participants[b]	
Type of Contact		Gay Scale	Lesbian Scale	Gay Scale	Lesbian Scale
None	*M*	59.83	55.26	41.32	38.80
	SD	21.74	20.58	16.38	14.61
Work	*M*	44.32	43.20	40.53	40.09
	SD	20.07	18.95	15.95	14.95
Social	*M*	37.54	34.54	41.29	38.81
	SD	18.50	12.92	18.03	15.54
Work & Social	*M*	43.98	41.70	38.69	36.80
	SD	16.54	15.58	17.98	15.51

[a]$n = 168$. [b]$n = 347$.

MANCOVA results revealed a significant two-way interaction between the participants' type of contact with gay males and lesbians and the gender of the participant, *Wilks* $\Lambda = 0.96$, $F(6, 1004) = 3.51$, $p < .05$, *partial* $\eta^2 = 0.02$.

Significant main effects were also identified for participant gender, *Wilks* $\Lambda = 0.98$, $F(2, 502) = 4.98$, $p < .05$, *partial* $\eta^2 = 0.02$, and type of contact with gay males and lesbians, *Wilks* $\Lambda = 0.96$, $F(6, 1004) = 3.06$, $p < .05$, *partial* $\eta^2 = 0.02$.

Univariate analysis indicated a significant interaction between type of contact with gay males and lesbians and participants' gender $F(3, 515) = 6.02$, $p < .05$. The interaction can be seen in Figure 11.

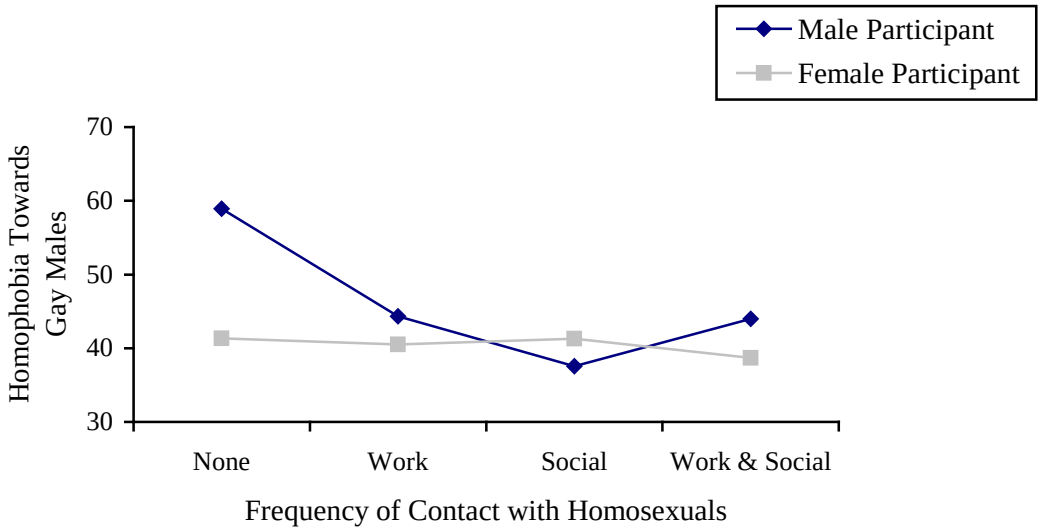

Figure 11. *Interaction between heterosexual participants' gender and type of contact with homosexuals on level of homophobia towards gay males.*

Tukey's HSD (*CD* = 0.0049) revealed that male participants who have no contact with homosexuals reported higher levels of homophobia towards gay males than female participants who had no contact with homosexuals. Male participants who had no contact with gay males and lesbians also reported significantly higher levels of homophobia towards gay males than males who had work or social types of contact. No significant difference was found between any of the types of contact for female participants and their level of homophobia towards gay males.

Univariate analysis also indicated a significant interaction between type of contact with homosexuals and participants' gender with respect to their level of homophobia towards lesbians $F(3, 515) = 6.17$, $p < .05$. The interaction can be seen in Figure 12.

Tukey's HSD (*CD* = 0.0812) revealed that male participants who have no contact with gay males and lesbians reported higher levels of homophobia towards lesbians than female participants who had no contact with gay males and lesbians. Male participants who had no contact with gay males and lesbians also reported significantly higher levels of homophobia towards lesbians than males who had work, social, or social and work types of contact with gay males and lesbians. Furthermore, male participants who had

work type contact with gay males and lesbians reported significantly higher levels of homophobia than male participants who had social type contact with gay males and lesbians. No significant differences were found between any of the types of contact for female participants and their level of homophobia towards gay males and lesbians.

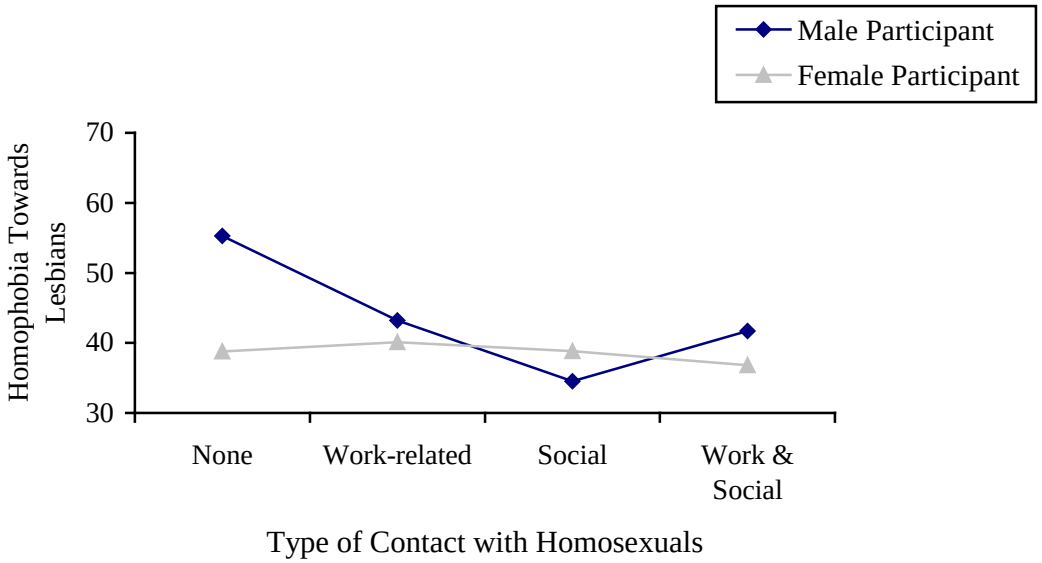

Figure 12. *Interaction between heterosexual participants' gender and type of contact with homosexuals on level of homophobia towards lesbians.*

Univariate analysis also indicated a significant main effect for gender of the participant on the level of homophobia towards gay males $F(1, 515) = 8.65$, $p < .05$, and lesbians $F(1, 515) = 9.97$, $p < .05$, with males reporting higher levels of homophobia than females. There was also a significant main effect for the type of contact with homosexuals on participants' level of homophobia towards gay males, $F(3, 515) = 3.53$, $p < .05$, and lesbians, $F(3, 515) = 3.67$, $p < .05$ with participants who has no contact with gay males and lesbians reporting higher levels of homophobia than participants who had work, social or social and work types of contact with gay males and lesbians. Both effects are heavily circumscribed by the interactions reported above.

Chapter 4: Discussion

4. 1 Overview of Results

The current study investigated the attitudes of Australian heterosexual and gay and lesbian men and women towards gay male and lesbian adolescent suicide. The study had three distinct aims. Firstly, the study examined attitudes towards gay and lesbian adolescent suicide among heterosexual and homosexual men and women. Secondly, the study investigated the predictors of attitudes towards gay and lesbian adolescent suicide. Finally, the study sought to investigate the effect of contact with homosexuals on the level of homophobia reported by heterosexual men and women.

In broad terms, this study sought to expand the findings of previous research that has investigated attitudes towards gay and lesbian adolescent suicide among university students (Cato & Canetto, 2003; Molloy & McLaren, in press). The research was based on an extensive Australian community sample of heterosexual and homosexual men and women from urban and rural areas. The self-report outcome measures employed are used extensively in the literature, and therefore the data set from this study can be regarded as a reliable one. Discussion of the results is presented on the basis of individual hypotheses, before consideration of the implications and limitations of the study and recommendations for future research.

4. 2. Aim 1: Heterosexual and Homosexual Men and Women's Attitudes Towards Gay Male and Lesbian Adolescent Suicide

4. 2. 1 Hypothesis One

Hypothesis One proposed that the heterosexual and homosexual male and female participants would rate the suicide of a gay male and lesbian adolescent as significantly more acceptable, justified, and necessary than the suicide of a heterosexual male or heterosexual female adolescent and that gay male and lesbian adolescent suicide victims

would be seen as psychologically healthier than heterosexual male or heterosexual female adolescent suicide victims.

Results indicated that the heterosexual participants viewed the suicide of a gay male adolescent as significantly more acceptable, justified, and necessary than the suicide of both heterosexual male and heterosexual female victims, with heterosexual males tending to report the strongest attitudes. Heterosexual male and female participants did not view the suicide of a lesbian adolescent as any more acceptable, justified or necessary than the suicide of a heterosexual male or heterosexual female adolescent. Further, both gay male and lesbian suicide victims were seen as psychologically healthier than the heterosexual victims but only the differences between the homosexual victims and the male heterosexual victim reached significance.

Gay male and lesbian participants, however, did not match the attitudes of their heterosexual counterparts exactly. Gay male and lesbian participants were shown to rate the suicide of a lesbian adolescent as significantly more necessary and acceptable than the suicide of either a heterosexual male and heterosexual female adolescent, and more justified and healthier than the suicide of a heterosexual female adolescent. Gay male and lesbian participants also viewed the suicide of a gay male adolescent as more acceptable, justified, necessary and healthier than the suicide of a heterosexual male and heterosexual female adolescent.

Broadly, then, while both homosexual and heterosexual participants saw the suicide of the gay male and lesbian adolescents in more positive terms than the suicide of a heterosexual male or female adolescents, heterosexual participants were observed to report this most strongly towards the gay male suicide victims, while the gay male and lesbian participants reported this most strongly towards the lesbian suicide victims.

In addition to these findings it was observed that, with respect to ratings of necessity, male heterosexual participants viewed the suicide of homosexual victims

more positively than did female heterosexual, gay male and lesbian participants. In a similar vein, male heterosexual participants saw the suicide of homosexual victims as psychologically more healthy than both male and female heterosexual and lesbian participants viewed heterosexual suicide victims. There was a suggestion, therefore, that male heterosexual participants tended towards more extreme views with respect to homosexual suicide victims than the other groups of participants.

These findings demonstrate partial support for Hypothesis One. While gay and lesbian adolescent suicides were shown to elicit stronger attitudes, indicating greater tolerance towards the suicide death of a gay or lesbian adolescent, this behaviour varied somewhat depending on the sexual orientation of the participants and the gender of the suicide victim. Heterosexual participants' greater approval towards the suicide of a gay male adolescent and homosexual participants' approval of lesbian suicide clearly illustrated that victim gender, as well as participant sexual orientation, played a role in the attitudes measured in this study.

The finding that gay male and lesbian adolescent suicides are viewed with greater tolerance supports previous research (Molloy & McLaren, in press). One explanation of this trend is proposed by Herek (1991) who states that negative sex-role stereotypes are strongly correlated with negative attitudes towards gay men and lesbians. As such, the finding that heterosexual participants viewed gay male and lesbian adolescent suicide as more acceptable, justified, and necessary may be the result of their holding more traditional and rigid gender-role attitudes. This rigid application of gender roles would lead to an antipathy towards those who breach these roles and a resultant tolerance of gay male or lesbian adolescent suicides.

The finding that heterosexual males judged gay male and lesbian adolescent suicide victims to be psychologically more healthy than heterosexual male or heterosexual female adolescent suicide victims, and that this group tended to be extreme

in their views generally, concurs with the findings of previous research undertaken by the researcher (Molloy & McLaren, in press) and is in line with the view that the tolerance of gay male and lesbian suicide reflects negative stereotypes of the homosexual community. Heterosexual males have more investment in their dominant role and may be particularly harsh on those who breach the conventions (Herek, 2002; Kite & Deaux, 1987).

A corollary of this view is that participants perceive that homosexuality, in and of itself, is an inherently self-destructive identity which dictates that gay males and lesbians will not only commit suicide, but at a rate that is considerably higher than society-at-large, and must therefore be expected (Rofes, 1983). Such a view may account for the lack of consideration that the gay male and lesbian adolescents depicted in the suicide vignettes were experiencing psychological ill health in favour of a perceived characteristic of homosexual culture.

For this type of explanation to hold it is necessary to account for the surprising finding that gay male and lesbian participants also reported a more positive attitude towards the suicide of a homosexual adolescent than that of a heterosexual adolescent. One possibility is that the strength of the negative stereotypes for gay males and lesbians is such that the gay and lesbian community share them to an extent and this therefore prompts this community to see the suicide of those who share their sexual orientation with a more positive attitude as is true for internalised homophobia.

An alternative explanation for the tolerance of gay and lesbian suicide shown by all participants could be that their judgments reflect an awareness of the difficulties experienced in belonging to a minority group. Such an explanation would suggest that suicide by a gay male or lesbian adolescent may therefore be judged as an acceptable, justified and, perhaps, necessary solution to these difficulties. This explanation would account for the approval of gay and lesbian adolescent suicide by both heterosexual and

homosexual participants. In effect all groups step back and view society, objectively, as predominantly heterosexual and thus antithetic towards those who do not share this orientation. The suicides are therefore the inevitable outcome of the intolerable situation in which gay males and lesbians find themselves.

It can be argued that such a "sympathetic" response is little different from the "punitive" attitude that might underlie the view that the suicides of gay males and lesbians are a "good thing". Both the "sympathetic" and the "punitive" views are condoning the deaths of adolescents. However, it is hard to see how the two positions can be merged when the bulk of the gay and lesbian participants in this study were more tolerant of the gay and lesbian suicides than they were of the heterosexual suicides.

While there are a number of arguments that can explain the tolerance shown towards gay and lesbian adolescent suicide, it must be noted that the degree of tolerance shown towards gay male or lesbian adolescent suicide differed according to the sexual orientation and, to some extent, the gender of the respondent. Furthermore, this finding is comparable to that found in previous research into heterosexual men and women's general attitudes towards gay men and lesbians (Herek, 2002; Lieblich & Friedman, 1985). Additionally, the finding that heterosexual males hold more extreme attitudes towards homosexual suicide than other groups is also comparable with previous research on general attitudes towards gay men and lesbians (Aberson et al., 1999; Finlay & Walther, 2003; Herek, 2002; Herek & Capitano, 1999; Herek & Glunt, 1993; Kerns & Fine, 1994; Kite & Whitely, 1996; LaMar & Kite, 1998; Lottes & Kuriloff, 1992; Louderback & Whitely, 1997; Marsiglio, 1993; Sakalli, 2002; Wills & Crawford, 2000).

One possible explanation for the heterosexual participants' greater tolerance of gay male suicide compared to lesbian adolescent suicide may be the influence of gender-role rigidity and a reliance on stereotypes in the participants' decision-making process. Gender-role rigidity has been shown to affect attitudes towards homosexuality

(Krulewitz & Nash, 1980; Lieblich & Friedman, 1985; Ross, 1983) and relates to the boundaries of what is perceived as masculine and feminine within society. Because gender-roles are typically more rigidly defined for men than they are for women (Herek, 1986, 2002; Hort et al., 1990), and society tends to have a more negative reaction towards men who have more feminine traits (Herek, 2002; Page & Yee, 1985), a male breaking out of this traditional male gender role is often judged as having committed a far more serious sex-role violation than a female who violates the traditional female gender role (Herek, 2002; Kite & Deaux, 1987). Therefore, lesbians are less likely to be defined as a social problem, less likely to be negatively stereotyped, and less likely to be rejected than gay males among the heterosexual community (Steffensmeier & Steffensmeier, 1974). Again it is unclear whether the greater tolerance of gay male suicide is a function of a more punitive response to the males who have committed a more serious breach of convention or whether it is a more sympathetic response in recognition of the greater difficulties faced by gay males.

Gender-role rigidity is also linked to the use of sex-role stereotypes and this may also account for the ratings of homosexual participants. For gay males and lesbians, these stereotypes tend to be cross-gendered, with gay men described in feminine terms (Bowman, 1979; Herek, 1984; Page & Yee, 1985; Taylor, 1983) and lesbians described in masculine terms (Bowman, 1979; Taylor, 1983; Steffensmeier & Steffensmeier, 1974). Perhaps within the homosexual community it is the "feminine" gay male that is the norm and the "masculine" lesbian that is the exception. Therefore, within the gay and lesbian community, the level of awareness about the relative difficulties experienced by gay male and lesbian adolescents may be more acute than among the heterosexual community, leading this group of participants to regard the suicide of the lesbian adolescent in a more tolerant light as it is recognised that the lesbian adolescent who is committing the more serious violation and is thus more at risk. Thus, if one

accepts that the gender stereotypes are reversed within the homosexual community, then it would follow that the same psychological processes with respect to role violations and resulting tolerance that were at work in the heterosexual community are at work in the homosexual community but with gender roles reversed.

Finally, within homosexual participants, gay male participants were seen to view male suicide victims as psychologically healthier than heterosexual male participants and suggests perhaps a bias towards one's own gender in relation to psychological ill health. Of interest is the fact that homosexual participants did not report good psychological health for the gay male and lesbian suicide victims, which may again reflect an awareness of the impact of the difficulties encountered as a gay male or lesbian in a heterosexual society. However, unlike the heterosexual participants, homosexual participants' evaluations may have been made from personal experience of the psychological impact experienced as a member of a minority group, rather than from the perhaps more objective stance of heterosexual participants.

In conclusion the study has shown that there is complex amalgam of factors that contributed to both the heterosexual and homosexual participants' judgments in relation to the acceptability, justification, necessity of the suicide and the psychological health of the suicide victim. More research will be needed to clarify these factors and their inter-relationships.

4. 2. 2 Hypothesis Two

Hypothesis Two proposed heterosexual participants would report higher levels of empathy towards the heterosexual suicide victims than the homosexual suicide victims and homosexual participants would report higher levels of empathy towards homosexual suicide victims than for heterosexual suicide victims. The findings of this study show partial support for Hypothesis Two.

Heterosexual male participants reported greater empathy for heterosexual male adolescent suicide victims than for gay male adolescent suicide victims. Heterosexual female participants reported greater empathy for gay male suicide victims than for heterosexual male adolescent suicide victims. Gay male participants reported greater empathy for gay male and lesbian adolescent suicide victims than for heterosexual male or heterosexual female suicide victims. Lesbian participants reported greater empathy for lesbian adolescent suicide victims than for heterosexual female adolescent suicide victims.

These findings do not support the findings of previous researchers, who reported heterosexuals as having significantly less empathy for homosexual adolescent suicide victims than for heterosexual adolescent suicide victims (Cato & Canetto, 2003; Molloy & McLaren, in press). Further, it does not support the findings of previous research into attitudes towards suicide in which researchers found males were less empathic towards individuals who commit suicide than females (Deluty, 1989; Marks, 1989; Trobst et al., 1994; Wellman & Wellman, 1986).

In reviewing these findings, two factors appear to be involved in the level of empathy expressed towards the adolescent suicide victims by participants. The first concerns the gender of the suicide victim, while the second relates to the sexual orientation of the victim. For heterosexual male and lesbian participants, the empathic responses appear to be influenced by both the gender of the suicide victim and his or her sexual orientation but not in a straightforward manner. Heterosexual males are seen to report greatest empathy towards suicide victims of their own gender and sexual orientation and least towards adolescent suicide victims of their own gender but opposite sexual orientation. Lesbian participants' reaction to the gender of the victim matches that of the heterosexual male participants with them reporting greatest empathy towards adolescent suicide victims of their own gender and sexual orientation and least

empathy to their own gender but opposite sexual orientation. Further, both heterosexual male and lesbian participants were shown to report relatively less empathy towards suicide victims who shared their sexuality but were of opposite gender and relatively more empathy to victims who did not share their sexuality but were the opposite gender.

There is a nice symmetry to these results if we were to accept that lesbian participants occupied a "masculine" role relative to the gay participants but clearly empathised more with victims who shared their sexuality. Both groups appear to be saying that it is difficult to occupy the roles that that they do with respect to gender and sexual orientation. Both groups empathise with those in this position who commit suicide. On the other hand, both groups appear to take a more punitive stance in relation to those who share their gender but who "cop out" of the sexual orientation. Both male heterosexual and lesbian participants have difficulty empathising with the suicide victims from this group.

The heterosexual female participants' empathic responses show elements of both male heterosexual and lesbian participants' responding. They match lesbian participants in showing more empathy for homosexual victims but unlike the lesbian group they show relatively more empathy for gay male victims than for lesbian victims. They also show relatively less sympathy for male heterosexual victims than female heterosexual victims. Thus they match the lesbian participants in terms of showing empathy with homosexual victims but show the same gender preferences with respect to sexuality as do male heterosexual participants – empathising relatively more with heterosexual victims of their own gender and relatively more with homosexual victims of the opposite gender. Interestingly female heterosexual participants are unique in not showing the highest level of empathy for those who share their gender and sexuality.

For the gay male participants, it seems that the sexual orientation of the adolescent suicide victim was influential in the level of empathy expressed towards the adolescent

suicide victims. Gay male participants were shown to report greater empathy for homosexual adolescent suicide victims, irrespective of their gender, and less empathy for heterosexual suicide victims, again irrespective of gender. Looking at it in another way, gay male participants responses matched those of the heterosexual female participants, in that both demonstrated greater tolerance for gay male victims. On the other hand they were quite different to female heterosexual participants but similar to lesbian participants in showing more empathy for lesbian victims and much less to female heterosexual victims

In conclusion, the results for empathy demonstrated an intriguing pattern of results with each group of participants sharing some behaviour with some groups but in no simple way. The shortest summary sees male heterosexual participants and lesbians sharing a gender and sexual orientation perspective but requires a major assumption that lesbians have assumed a "masculine" role within the homosexual community. Female heterosexual participants have adopted a similar gender perspective to the male heterosexual participants and the "masculine" lesbians but allied this to a cross-sexuality perspective. Gay male participants show greater empathy for homosexual victims, along with lesbian and female heterosexual participants, but have little regard for gender. Therefore, it would appear that these patterns might be explicable in terms of gender and sexuality roles and inversions but in no straightforward manner.

4. 3 Aim 2: Predictors of Attitudes Towards Gay Male and Lesbian Adolescent Suicide in Heterosexual and Homosexual Participants

4. 3. 1 Hypothesis Three

Hypothesis Three proposed that the heterosexual participants' level of homophobia towards gay males and lesbians and the homosexual participants' level of internalised homophobia would act as greater predictors of attitudes towards gay and

lesbian adolescent suicide than age, gender, level of education, place or residence, religious status, or contact with homosexuals. The findings of this study did not support the hypothesis.

For the heterosexual participants, age and gender were found to be significant predictors of attitudes towards gay and lesbian adolescent suicide with younger participants held the strongest attitudes, indicative of greater tolerance towards the suicide death of gay and lesbian adolescents. Males were also more likely to hold the stronger attitudes compared to females. For the homosexual participants, age was identified as the only significant predictor of attitudes towards gay and lesbian adolescent suicide, with younger participants holding stronger attitudes, indicative of greater tolerance towards the suicide death of gay male and lesbian adolescents. This finding replicates that found in previous research (Dalhen & Canetto, 2003; Molloy & McLaren, in press) which found that younger people hold a more tolerant attitude towards the suicide of gay male and lesbian adolescents. However this does not support the findings of other researchers, who have shown that older people display a more tolerant attitude towards homosexuals (Johnson et al., 1997; Kurdek, 1998. Further, the conservatism of older age Australians attitudes towards homosexuality as demonstrated in the IssA study (Kelley, 2001) was not supported.

By way of explanation, this outcome might be indicative of a reluctance to move towards greater tolerance of homosexuality within Australian society. This is illustrated in these results, which show that the younger members of society are more tolerant of gay and lesbian adolescent suicide, whereas, the older members appear to be less tolerant and less conservative in their attitudes.

Another important aspect to this view is that younger people are more likely to view homosexuality as a lifestyle choice, rather than having a genetic basis that is beyond the control of the individual, and that the attribution of choice or no choice in

sexual orientation results in either negative or positive attitudes towards homosexuals (Baumrind, 1995; Johnson et al., 1997; Matchinsky & Iverson, 1996; Patterson, 1995). As such, a view of homosexuality as a chosen lifestyle may result in the expression of an attitude that suggests suicide is a fate deserved, while those who hold a view of homosexuality as having genetic origin may express an attitude that suggests suicide is less deserved and therefore less acceptable.

Another aspect to the finding that age (i.e. being younger) was a significant predictor of tolerant attitudes toward gay male and lesbian adolescent suicide is to understand what is meant by tolerance. For example, the tolerance shown towards gay male and lesbian adolescent suicide may be an indication of an understanding among young people of the difficulties faced by gay male and lesbian adolescents. In this way, tolerance may mean that rather than young people do not have concern for or care about gay male and lesbian adolescent suicide, it is an expression of tolerance indicative of an acceptance that the difficulties experienced by gay male and lesbian adolescents may lead them to chose suicide as a way of resolving these difficulties.

In relation to gender as a predictor of attitudes towards gay male and lesbian adolescent suicide in heterosexual participants, this finding supports that of previous research which found males to be more likely to agree with and accept suicide than females (Dahlen & Canetto, 2002).

Further, the finding that homophobia, for both the heterosexual and the homosexual participants, did not contribute significantly as a predictor suggests that there may be different factors involved in the formation of attitudes towards gay male and lesbian adolescent suicide which were not identified among the demographic variables examined. These measures were included in this study, based upon the existing research into attitudes towards gay males and lesbians, with an expectation that such would also be identified within the attitudes to suicide examined within the current

study. In seeking to understand this finding, it is proposed that the possible effects of gender roles the attitudes expressed may have negated these variables. Determination of such could be obtained in future research through a qualitative exploration of the meaning that participants place in the items being used to measure homophobia in order to better understand the factors influencing their responses.

Finally, perhaps there is a developmental issue, namely that of the search for identity, including both sexual and gender-role identity, should be considered when examining age-related attitudes about homosexuality. Traditionally, younger people, particularly males, may feel more threat to their heterosexual masculine identity during the adolescent developmental stage and thus exhibit greater negative attitudes relating to homosexuals than would older persons (Oliver & Hyde, 1995). Once again, however, the exact meaning of the attitudes reported cannot be determined from the findings of this study.

4. 4 Aim 3: The Effect of Contact with Homosexuals on Homophobia in Heterosexual Male and Female Participants

4. 4. 1 Hypothesis Four

Hypothesis Four proposed that heterosexual participants' frequency and type of contact with gay males and lesbians would be directly related to their level of homophobia, with homophobia highest in participants who had no or infrequent non-social contact and lowest for those participants who had frequent social contact.

The results of this study provided partial support for Hypothesis Four. Males who had work type contact were observed to report higher levels of homophobia towards lesbians than males who had social type contact with gay males and lesbians. Further, male participants who had no contact with gay males and lesbians reported higher levels of homophobia towards gay males and lesbians than female participants

who had no contact with gay males and lesbians for both frequency of and type of contact with gay males and lesbians.

Several possibilities may account for why contact with gay males and lesbians did not significantly reduce heterosexual participants level of homophobia towards gay men and lesbians. One important feature relates to the fact that certain geographic areas are conducive to homosexual populations. Gay male and lesbian populations tend to be concentrated in, but are not limited to, certain the inner-city areas of each Australian Capital City as well as the Hepburn/Daylesford region in Victoria (Birrell & Rapson, 2002). If indeed this is the case, and gay males and lesbians choose to reside where tolerance and acceptance exists, thereby enabling them to publicly visible or 'out', it may be assumed that the average Australian who resides elsewhere will have less opportunity to interact with gay males and lesbians who are publicly visible or 'out' even though they may unknowingly have interactions with gay males and lesbians who remain 'closeted'.

While the majority of the participants in the current study reported having frequent contact with homosexuals, it is possible that many of them may not have lived in geographic locations with significant homosexual populations. Further to this, participants were not asked to report how many homosexuals they had contact with. Contact with only one or two homosexuals, even if frequent and social, may have been less effective in reducing levels of homophobia, for example, than contact with greater numbers of homosexuals.

A further consideration relates to particular conditions under which contact can begin to ameliorate negative attitudes. These include equal status, mutually shared goals, cooperation to achieve goals, and friendship encompassing intimacy and disclosure (Allport, 1954; Pettigrew, 1998). Contact under these conditions tends to be predictive of more positive attitudes (Britton, 1990; Herek, 1988, 2000; Herek & Glunt,

1993; Schellenberg et. al., 1999). However, it may be that the participants in this study did not meet all the above criteria, even though they may have been in contact with gay men and lesbians. This then reduces the opportunity for heterosexuals to reformulate their attitudes based on actual experience without relying on stereotypes

4. 5 Summary of Results

While not universal in their assessment, Australian heterosexual and homosexual communities have indicated that they expressed some empathy for the suicide of a gay or lesbian adolescent, and reported greater tolerance towards their suicide than that of their heterosexual peers. Further, gay male and lesbian adolescent suicide victims were seen as psychologically healthier than their heterosexual peers. These findings were discussed in terms of the possible meanings attributed to the attitudes assessed. Possible explanations for these findings included a view that suggests that the suicide of gay male and lesbian adolescents is tolerated due to enduring negative attitudes towards homosexuality. An alternative view was that tolerance arises out of an awareness and appreciation of the difficulties faced by gay male and lesbian adolescents living in a heterosexual society. However, an exact understanding of the meanings of these attitudes was unable to be identified within the current study. Exploration of the decision-making processes undertaken by the individual that facilitate such attitudes would enable greater insight into their meaning.

When the predictors of these attitudes were examined, age and gender of the participant were found to be indicative of such attitudes within the heterosexual participants, while age alone was indicative of such an attitude among the homosexual participants. The significance of younger aged individuals predicting more tolerant attitudes towards the suicide of gay male and lesbian adolescent suicide was explored. One possible view was that younger people saw homosexuality as a life style choice and

suicide as a fate deserved, while an alternative view suggested an awareness and understanding of the difficulties faced by young gay males and lesbians that develops a tolerance which understands why a young gay male or lesbian might chose to suicide. Further, the finding that males held more tolerant attitudes towards gay male and lesbian adolescent suicide was supportive of previous research which identified that males are more likely to agree with and accept suicide than females (Dahlen & Canetto, 2002).

Finally, it is not to say that the remaining demographic variables of education, residential location, religiosity and contact with gay males and lesbians did not provide some contribution as predictors. However, for each of these variables, they were not significant in explaining the additional variance.

Research has shown each of these factors to be related to attitudes towards homosexuals. For example, living in rural areas (Britton, 1990; Green, 1996; Herek, 1994, 2000; Marsiglio, 1993; Pratte, 1993), lower levels of education (Britton, 1990; Herek, 2000, Herek & Capitanio, 1999a; Kelley, 2001; Pratte, 1993; Schellenberg et al., 1999; Seltzer, 1992; Stevenson, 1998; Yoder & Preston, 1997), and religion (Britton, 1990; Herek, 1987b, 2000; Herek & Capitanio, 1996; Johnson et al., 1997; Maney & Cain, 1997; Marsiglio, 1993; Matchinsky & Iverson, 1996; Seltzer, 1992; Yoder & Preston, 1997) are all indicative of negative attitudes towards homosexuals. The current study clearly showed that once the variance in attitudes towards gay and lesbian suicide explained by the age, or age and gender, the participant was removed; these variables did not add anymore explanatory power. Thus these variables are not useful in accounting for attitudes towards suicide other than simply knowing an individual's attitude towards homosexuals. The limitations in the interpretation of the findings due to the lack of a clear understanding of the attitudes expressed were also examined.

Further, significantly lower levels of homophobia towards lesbians were identified in heterosexual males who had social type contact rather than work type contact with

homosexuals. However, frequency of contact with homosexuals was not significant in reducing in levels of homophobia towards gay men and lesbians in heterosexual participants beyond that reported by heterosexual males and females who had no contact with homosexuals.

4. 6 Limitations

Certain limitations in the present study need to be acknowledged. Quantitative data, although informative, failed to allow certain conclusions to be drawn. For example, the finding that the suicide of a lesbian adolescent was seen as more acceptable, justified and necessary than that of a gay male among the homosexual participants is an unexpected finding that can only be speculated upon. Another important finding relates to heterosexual males' view of homosexual suicide victims being psychologically healthier than heterosexual suicide victims, while gay male participants viewed male suicide victims as psychologically healthier than heterosexual males. One can only speculate on the psychological processes that may have been involved in the formation of participants' attitudes towards gay and lesbian adolescent suicide. This study was unable to identify how factors such as reliance upon stereotypes, traditional gender-roles, or personal knowledge about experience with homosexuals, or prior exposure to suicide may have contributed to the attitudes reported. Therefore, it remains unknown as to how participants arrived at their responses.

A further limitation involves the geographical location of the respondents. It must be noted that although participants were recruited from all states of Australia, the majority of the respondents resided in Victoria. This was largely unavoidable with the researcher living in Victoria and having greater access to this State's population. As such, future research should seek to address attitudes more uniformly across the nation.

Future research also needs to address attitudes in remote areas. Although the researcher attempted to address this issue in the current study through the use of the Internet, success was limited in terms of gaining access to individuals living in remote areas.

A final limitation involves establishing the representativeness of the current sample. The current sample was over represented by individuals who did not have children, had attained a university degree, had no religious affiliation and did not see religion as an important aspect of their lives. Further, heterosexual females were over represented within the heterosexual participant sample. With the use of a convenience sample for data collection the researcher had little control over who returned the completed questionnaires, however, these imbalances are noted. There may be a bias in the population samples in that less well educated, and subsequently, perhaps lower income earners, were not adequately represented (Hewitt, 1995). Survey methods create a response bias in that participants tend to represent those who can read and write and understand how to respond to questions. This precludes those who are not well educated or have some disability.

This sample bias may also have had an effect on the return rate of the surveys. While a return rate of 25% for the written questionnaire appears low, a response of 1 in 4 is acceptable given the large amount of questionnaires distributed to varying types of respondents. Access to computers to complete Internet versions may also create a bias in that a respondent needs to be educated and able to afford a computer or have access to one in order to respond. It is not known what the response rate was for the Internet versions. There was no collection of data to indicate if people had logged on but had not completed or decided not participate in the study. The decision to combine both sources of information gathering was to counteract the fact that the written versions were predominantly handed out at social events, whilst the Internet version gave those

who were not socially 'out' or who had limited access to social events due to rural residency, to still be able to participate in the research.

The majority of rural participants came from large rural centres rather than farms and isolated communities. Consequently, farmers and those living in isolated communities were underrepresented in this sample. Generalisation of these results to the wider population of both heterosexuals and homosexuals should be conducted with care. Future research could improve on this study by increasing the participation of individuals from more rural and isolated locations across Australia.

Finally, one aspect not considered within this study was participants' prior exposure to suicide and suicidal behaviour on a personal or interpersonal level. Prior experience or exposure to suicide may have been influential in the formation of attitudes towards suicide. As discussed, suicide among gay and lesbian adolescents has been shown to occur at a greater rate than that within the heterosexual community (D'Augelli & Herschberger, 1993; Freidman & Downey, 1994; Hammelman, 1993; Herdt & Boxer, 1993; Herschberger & D'Augelli, 1995; Herschberger et al., 1996; Hunter, 1990; Kournay, 1987; Martin & Hetrick, 1988; Remafedi, 1987a, 1987b, 1990; Remafedi et al., 1991; Rotheram-Borus, Hunter, & Rosario, 1994; Schneider, 1991; Schneider et al., 1989). Therefore it is conceivable that many of the gay and lesbian respondents in this study may themselves have had experiences of, or exposure to suicide or suicidal behaviour. Similarly, suicide within heterosexual adolescents is also high (Bagley & Tremblay, 1997; Bettes & Walker, 1986; Boldt, 1982; Bull, 1994; Crespi, 1990; Deluty, 1989; Emslie, 1996; Hassan, 1995; Harlow, Newcomb, & Bentler, 1986; Ingram & Ellis, 1995; Kalafat, 1990; Kandel, Ravis, & Davies, 1991; Marks, 1989; Neiger & Hopkins, 1988; Popenhagen & Qualley, 1998; Remafedi, 1994; Rubinstein et al., 1989; Silbert & Berry, 1993; Wagner & Schwartzman, 1995; Wellman & Wellman, 1986; Williams & Pollock, 1993) suggesting many of the heterosexual respondents may also

have had such experience or exposure to suicide and suicidal behaviour. Therefore, future research should seek to examine attitudes between participants with and without prior exposure to suicide or suicidal behaviour in order to establish whether such exposure is influential on the formation of attitudes towards gay male and lesbian adolescent suicide.

4. 7 Implications of Current Research

It is evident from the current study that Australian heterosexual and homosexual people view the suicide of a gay male or lesbian adolescent with greater tolerance than the suicide of a heterosexual male and heterosexual female adolescent. The reasons as to why this attitude was not found to be universal within either group of participants, nor was this attitude expressed towards gay males and lesbians in the same way within each community, needs to be addressed. The differences observed between the heterosexual and homosexual communities may be as a result of the same attitude, when expressed by different people toward the same object, serving distinctly different psychological functions for each individual contingent upon his or her own psychological needs (Herek, 1984). Therefore, investigation into the process of attitude formation towards gay male and lesbian adolescent suicide is critical in gaining an understanding of the meanings ascribed to the attitudes expressed so that appropriate intervention and support strategies can be developed to enhance those currently available for gay male and lesbian adolescents.

Another issue arising from the findings of the current study is that the younger participants showed greater towards tolerance of gay male and lesbian adolescent suicide than older participants, regardless of their sexual orientation. This result occurred despite the fact that the majority of the respondents in this study were found to be more highly educated. Research has indicated that increased levels of education tend

to be predictive of positive attitudes towards homosexuality (Britton, 1990; Herek, 2000; Herek & Capitano, 1999a; Kelley, 2001; Pratte, 1993; Schellenberg et al., 1999; Seltzer, 1992; Stevenson, 1988; Yoder & Preston, 1997). The IssA study (Kelley, 2001) separates out the various educational levels as they relate to Australians. Kelley reports that individuals with a minimum of eight years education are particularly negative in their attitudes towards homosexual people, whereas those with ten years of education are more positive. Individuals who progress further into higher levels of education show even greater improvements in positive attitudes towards homosexuality. However, Australian researcher Van de Ven (1994) stated that males and females of all ages and educational attainment may hold negative views towards homosexuals, and that it is the person's quality of life and learning experiences that may mediate a more positive attitude towards homosexual people. He suggested that people who had experienced positive interactions with gay males and lesbians, and those who were more open-minded and inclusive in their attitudes typically held more positive attitudes towards gay males and lesbians.

Given that younger people represent the peer group for gay male and lesbian adolescents, and rejection or a lack of support by their peer group is one of the identified risk factors for suicide for gay male and lesbian adolescents (Brown, 2002; Dean et al., 2000; Walker, 2001), this finding that younger people hold a more tolerant view towards the suicide of gay male and lesbian adolescents is a major concern. Peer rejection or lack of support can precipitate the emergence of additional risk factors that further increase the risk of suicide. Social isolation can compound the effects of other stresses, such as rejection from family, verbal or physical violence, and a lack of support within schools (D'Augelli, 1998; Faulkner & Cranston, 1998; Garafalo et al., 1998; Pilkington & D'Augelli, 1995). Gay male and lesbian adolescents are also often alone as they seek a healthy sense of their identity (Emslie, 1996; Herschberger et al.,

1996; Vare & Norton, 1996). Conversely, having the support of their peers is a significant protective factor for reducing the risk of suicide (Brown, 2002; Coyle, 1993; Dean et al., 2000; Green, 1996; Lienert, 1999; Travers & Schneider, 1997; Walker, 2001). As such, suicide prevention efforts must address the existence of the unique problems of gay male and lesbian adolescents, particularly within educational settings where gay male and lesbian adolescents spend significant time with their peers.

Despite research findings that show around 10% of young people aged 14 to 18 in Australia are same-sex attracted (Hillier et al., 1998), this group of adolescents continues to remain ignored or denied by the education system. As such, there are a number of areas in which educational institutions could implement changes in order to inform and educate both students and staff about homosexuality in order to create greater awareness and understanding of the needs of gay male and lesbian adolescents and to assist in the development of more positive attitudes and the provision of a more supportive environment for gay male and lesbian adolescents. Firstly, educational strategies should focus on the formal areas of curriculum to determine where information about sexual orientation can be inserted into each particular subject (Baker, 2002; Bass & Kaufman, 1996; Kirby, 2001; Lipkin, 1994; Murray, 2001). For example, time in relevant classes could be devoted to examining the contributions of sexual minority authors, artists, scientists, and musicians. Additionally, there must be strong administrative support for the integration of this material, given that student or parental reactions may be negative (Lipkin, 1994; Murray, 2001). Teachers should also attend training programs designed to educate them about homosexuality, sexual identity development in gay males and lesbians, homophobia, and the risk factors for gay and lesbian adolescent suicide (Baker, 2002; Bass & Kaufman, 1996; Kirby, 2001; Lipkin, 1994).

Secondly, intervention strategies should seek to focus on visual and verbal methods for challenging negative attitudes to homosexuality within the school environment, and explore opportunities for a more welcoming and visible gay and lesbian presence. This could involve promoting support groups for gay male and lesbian students, articles in school magazines and newsletters, and rainbow stickers on teachers' offices (Murray, 2001; Walter, 1994).

Further, school counsellors and welfare officers need to be aware that a lack of peer support and a strong sense of isolation among some gay male and lesbian adolescents can increase their risk for suicide and suicidal behaviour (Black & Underwood, 1998; Henquinet, Phibbs, & Skoglund, 2000; McFarland, 1998;). Counselors should seek to develop and promote peer support programs and social outlets for gay male and lesbian adolescents (Muller & Hartman, 1998). Counselor education programs should seek to address issues such as isolation and suicidality among sexual minority youth and how counselors can enhance life-sustaining supports (Robinson, 1994; Treadway & Yoakham, 1992).

As noted earlier, it is critical that educational interventions take into consideration the various psychological functions that negative attitudes towards gay male and lesbian adolescent suicide serve. Therefore, providing information is not enough. Sears (1997) suggested that most current educational strategies fail to target thought, feeling, and action in their content and, as such, fail to move the individual from the psychology of the other to the phenomenology of self to affect significant change in attitude. Several studies have demonstrated that these elements can be tapped through role-playing, psychodrama, and journal writing (Miller, 1994; Phifer, 1994; Regan, 1993). Mager and Sulek (1997), for example, provided evidence for the effectiveness of incorporating these elements in their account of the use of role-play within a unit addressing homophobia, institutional policy, and social justice. Students were asked to take part in

a role-play depicting the exclusion of a gay student from a university campus. This exercise involved the entire class over four sessions, with each assuming roles in the 'play' (i.e., football players, member of the gay and lesbian support group, room mates, Christian Club members, gay students, and University Officials). Students worked through this issue according to their assigned role. Afterward students acknowledged they had learned much about a previously unknown group and, more importantly, about themselves as perpetrators of homophobia and victims of rigid norms and heterosexist stereotypes. Similarly, Russell (1997) used music that portrayed the experiences of gay males and lesbians as part of a homophobia reduction-training program as a medium for imparting content-based information and to enable participants to access their emotional reactions. It is evident from this US research that a range of intervention strategies integrating thought, feeling, and action can reduce homophobia and change attitudes.

In Australia, gay male and lesbian adolescents remain largely ignored by the education system. In view of the findings of the current study, there is a clear need for a range of programs in schools and universities to enhance the development of supportive attitudes towards gay male and lesbian adolescents. While the use of an integrative approach, as outlined above, is more likely to reduce negative attitudes towards gay males and lesbians, there has been limited empirical testing of this approach in Australian educational settings. One study of a six-week program designed to help Australian Year 10 students explore their attitudes towards gay males and lesbians was shown to produce positive attitudinal changes (Higgins, King, & Witthaus, 2001). However, the limited use of such integrative programs currently restricts evaluation of their effectiveness in Australian society.

4. 8 Directions for Future Research

The current study has implications for undertaking future research. One important aspect relates to positive contact between heterosexual and homosexual people as a way of ameliorating negative attitudes (Herek, 1988, 2000; Herek & Glunt, 1993; Schellenberg et al., 1999). For various reasons the present study failed to establish interpersonal contact as a predictor of more positive attitudes. For the majority of respondents, contact with homosexuals was minimal, if at all, and features such as personal disclosure of sexual orientation and degree of intimacy regarding the friendship were not directly assessed. Future research could address these shortcomings. Further, the examination of the characteristics from within tolerant and accepting communities where gay male and lesbian people are known to reside may help establish what type of interpersonal contact reduces sexual prejudice.

Future research should undertake an investigation of attitudes in relation to the effect of gender roles, which could assist inn identifying the possible influence of this on attitudes towards gay males and lesbians. This was a limitation of the current study, which failed to include any measure of gender roles in its investigation. The inclusion of such a measure may have provided a greater understanding of how the attitudes expressed by the participants in this study were formed.

In relation to methodology, future research may consider combining quantitative methodology and qualitative methodology, in the form of open-ended questions, to gain a better understanding of the participant's thought processes behind the participants' responses. By identifying specific reasons as to why certain conclusions were drawn, appropriate interventions could then target inaccuracies in community thinking. In the current study, for example, it would be advantageous to identify why respondents with different sexual orientations singled out either a gay male or lesbian and not both in their assessments as to how acceptable, justified and necessary they viewed the suicide.

Such methods could also seek to identify why gay male and lesbian adolescent suicide victims are seen as psychologically healthier than their heterosexual counterparts in order to determine whether such attitudes result from an internalised negative view of homosexuality and therefore of gay male and lesbian adolescents, or from an empathic understanding of the difficulties faced by gay and lesbian adolescents living in a homophobic and unsupportive society.

4. 9 Conclusion

In conclusion, this study has demonstrated that the sexual orientation of the suicide victim plays a significant role in the way in which an adolescent suicide is viewed. Further, it appears that gay and lesbian adolescents may not have the vital support of their peers to help them negotiate the development of a healthy identity and a sense of belonging in the heterosexual society in which they live, and to protect them from the risk factors associated with suicide. Although this study has been able to identify the existence of a more tolerant attitude towards the suicide death of gay male and lesbian adolescents within the participants of this study, there is still much more that needs to be examined in order to better understand the origins of these attitudes. Greater understanding of the decision making process that precedes the formation and expression of attitudes in relation to the acceptability, justification and necessity of gay male and lesbian adolescent suicide, along with an understanding of the meanings of expressions of empathy and psychological health for the gay male and lesbian adolescent suicide victims. Such insight will extend current understanding and assist the development of education and training resources designed to enhance community awareness and encourage the development of a more positive attitude towards homosexuals and homosexual suicide within, not only the heterosexual and homosexual communities of Australia, but also perhaps the wider global community

References

Aberson, C. L., Swan, J., & Emerson, E. P. (1999). Covert discrimination against gay men by U.S. college students. *Journal of Social Psychology, 139* , 323-334.

Aguero, J. E., Bloch, L., & Byrne, D. (1984). The relationships among sexual beliefs, attitudes, experience, and homophobia. Journal of *Homosexuality, 10,* 95-107.

Allport, G. (1954). *The nature of prejudice.* Reading, MA: Addison-Wesley.

Allport, G. W., & Ross, J. M. (1967). Religious orientation and prejudice. *Journal of Personality & Social Psychology, 5,* 432-443.

Alvarez, A. (1970). The savage god: A study of suicide. New York: Random House.

American Psychiatric Association (1975). *Diagnostic and statistical manual of mental disorders (3rd ed.).* Washington, DC: Author.

Amir, Y. (1969). Contact hypothesis in ethnic relations. *Psychological Bulletin, 71,* 319-342.

Anderson, J. D. (1994). School climate for gay and lesbian students and staff members. *Phi Delta Kappan, 75* (2), 151-154.

Asberg, M., Nordstrom, P., & Traskman-Bendz, L. (1986). Cerebrospinal fluid studies in suicide. *Annals of the New York Academy of Sciences, 487*, 243-255.

Asberg, M., & Traskman, L. (1981). Studies of CSF 5-HIAA in depression and suicidal behaviour. *Experiments in Medical Biology, 133,* 739-752.

Asberg, M., Traskman, L., & Thoren, P. (1976). 5-HIAA in the cerebrospinal fluid: A biochemical suicide predictor. *Archives of General Psychiatry, 33,* 1193-1197.

Ashmore, R. D., & Del Boca, F. K. (1981). Conceptual approaches to stereotypes and stereotyping. In D. L. Hamilton (Ed.), *Cognitive processes in stereotyping and intergroup behaviour* (pp. 1-36). Hillsdale, NJ: Erlbaum.

Australian Bureau of Statistics. (2000). *Suicides: Australia: 1921-1998.* Canberra, Australia: Australian Government Publishing Service.

Baker, J. M. (2002). What happens to gay children at school? In J. M. Baker (Ed.), How homophobia hurts children (pp. 85-100). Binghamton, NY: Harrington Park Press.

Bagley, C., & Ramsay, R. F. (1989). Attitudes toward suicide, religious values and suicidal behavior: Evidence from a community survey. In R. F. W. Diekstra & R. Maris (Eds.), *Suicide and its prevention: The role of attitude and imitation* (pp. 78-90). Leiden, Netherlands: E. J. Brill.

Bagley, C., & Tremblay, P. (1997). Suicidality problems of gay and bisexual males: Evidence from a random community survey of 750 men aged 18 to 27. *Suicidal behaviours in adolescents and adults: Taxonomy, understanding and prevention.* Brookfield, VT: Avebury.

Barbeler, V. (1991). *The young lesbian report: a study of the attitudes and behaviours of adolescent lesbians today.* Sydney, Australia: Young Lesbian Support Group.

Bass, E., & Kaufman, K. (1996). *Free your mind: The book for gay, lesbian, and questioning youth and their allies.* New York: Harper Perennial.

Baumrind, D. (1995). Commentary on sexual orientation: Research and social policy implication. *Developmental Psychology, 31*, 130-136.

Beck, A. T., Kovacs, M., & Weissman, A. (1979). An assessment of suicidal intention: The scale for suicidal ideation. *Journal of Consulting and Clinical Psychology, 47*, 343-352.

Bell, A., & Weinberg, M. (1978). *Homosexualities: A study of diversity among men and women.* New York: Simon & Schuster.

Bell, A. P., Weinberg, M. S., & Hammersmith, S. (1981). *Sexual preference: Its development in men and women.* Bloomington, IN: Indiana University Press.

Bettes, B. A., & Walker, E. (1986). Symptoms associated with suicidal behaviour in childhood and adolescence. *Journal of Abnormal Child Psychology, 14*, 591-604.

Betz, E., & Fitzgerald, L (1993). Individuality and diversity: Theory and research in counselling psychology. *Annual Review of Psychology, 44,* 343-381.

Birrell, B., & Rapson, V. (2002). How gay is Australia? *People and Place, 10 (4),* 59-66.

Black, J., & Underwood, J. (1998). Young, female and gay: Lesbian students and the environment. *Professional School Counseling, 1 (3),* 15-20.

Black, K. N., & Stevenson, M. R. (1984). The relationship of self-reported sex-role characteristics and attitudes towards homosexuality. *Journal of Homosexuality, 10,* 83-93.

Bodenhausen, G. V. (1993). Emotions, arousal and stereotypic judgements: A heuristic model of affect and stereotyping. In D. M. Mackie & D. L. Hamilton (Eds.), *Affect, cognition and stereotyping: Interactive processes in group perception* (pp. 13-37). San Diego, C.A.: Academic Press.

Boldt, M. (1982). Normative evaluations of suicide and death: A cross generational study. *Omega: Journal of Death & Dying 13 (2),* 145-157.

Bowman, R. (1979). Public Attitudes towards homosexuality in New Zealand. *International Review of Modern Sociology, 9 (2),* 229-238.

Brewer, M. B., & Miller, N. (1984). Beyond the contact hypothesis: Theoretical perspectives on desegregation. In N. Miller & M. Brewer (Eds.), *Groups in Contact: The psychology of desegregation* (pp. 281-302). New York: Academic Press.

Britton, D. M. (1990). Homophobia and homosociality: An analysis of boundary maintenance. *Sociological Quarterly, 31 (3),* 432-440.

Brown, G. (1996). *An invisible youth.* Paper presented at the First National Lesbian, Gay, Transgender and Bisexual Health Conference, Sydney, Australia.

Brown, L. S. (1995). Lesbian identities: Concepts and issues. In A. R. D'Augelli & C. J. Patterson (Eds.), *Lesbian, gay and bisexual identities over the lifespan: Psychological perspectives* (pp. 3-23). New York: Oxford University Press.

Brown, R. (2002). Self harm and suicide risk for same-sex attracted young people: A family perspective. *Australian e-Journal for the Advancement of Mental Health, 1 (1), 1-11.*

Buhrich, N., & Loke, C. (1988). *Homosexuality, suicide, and parasuicide in Australia. Journal of Homosexuality, 15*, 113-129.

Buhrke, R. A., Ben-Ezra, L. A., Hurley, M. E., & Ruprecht, L. J. (1992). Content analysis and methodological critique of articles concerning lesbian and gay male issues in counselling journals. *Journal of Counseling Psychology, 39* (1*)*, 91-99.

Bukstein, O. G., Brent, D. A., Perper, J. A., Moritz, G., Baugher, M., Schweers, J., Roth, C., & Balach, L. (1993). Risk factors for completed suicide among adolescents with a lifetime history of substance abuse: A case controlled study. *Acta Psyhciatrica Scandinavia, 88 (6),* 403-408.

Bull, C. (1994). Suicidal tendencies. *The Advocate, 4,* 36-37.

Canetto, S. S. (1997). Gender and suicidal beahvior: Theories and evidence. In R. W. Maris, S. S. Canetto, & M. M. Silverman (Eds.), *Review of Suicidology* (pp. 3-8). New York: Springer.

Capuzzi, D. (1994). *Suicide prevention in schools: Guidelines for middle and high school settings.* Alexandria, VA: American Counseling Association.

Carpenter, E. (1908). *The intermediate sex.* London: Allen & Unwin.

Carrion, V., & Lock, J. (1997). The coming out process: Developmental stages for sexual minority youth. *Clinical Child Psychology and Psychiatry, 2* (3), 369-377.

Carroll, J. S., & Payne, J. W. (1976). *Cognition and Social Behaviour*. Hillsdale, NJ: Erlbaum.

Cass, V. C. (1979). Homosexual identity formation: A theoretical model. *Journal of Homosexuality, 4 (3),* 219-235.

Cass, V. C. (1984). Homosexual identity formation: Testing a theoretical model. *The Journal of Sex Research, 20 (2),* 143-167.

Castaneda, D. (2000). HIV/AIDS related services for women and the rural community context. *AIDS Care, 12 (5),* 549-566.

Cato, J. E., & Canetto, S. S. (2003). Young adults' reactions to gay and lesbian peers who become suicidal following "coming out" to their parents. *Suicide and Life-Threatening Behaviour, 33 (2),* 201-210

Churchill, W. (1967). *Homosexual behaviour among males: A cross-cultural and cross-species investigation.* New York: Hawthorne.

Coakes, S. J., & Steed, L. G. (1999). *SPSS Analysis without anguish: Versions 7.0, 7.5, 8.0 for Windows.* Brisbane, Australia: John Wiley & Sons.

Coleman, E. (1982). Developmental stages of the coming out process. *Journal of Homosexuality, 7,* 31-43.

Coleman, E. (1989). The development of male prostitution activity among gay and bisexual adolescents. *Journal of Homosexuality, 17,* 131-149.

Coleman, E., & Remafedi, G. (1989). Gay, lesbian, and bisexual adolescents: A critical challenge to counsellors. *Journal of Counselling and Development, 68 (1),* 36-40.

Commonwealth Department of Human Services and Health (1995a). *Here for life: A national plan for youth distress.* Canberra, Australia: Australian Government Publishing Service.

Commonwealth Department of Human Services and Health (1995b). *Youth Suicide in Australia: A background monograph.* Canberra, Australia: Australian Government Publishing Service.

Commonwealth Department of Health and Family Services. (1997). *Youth suicide in Australia: A background monograph (2nd edition)*. Canberra, Australia: Australian Government Publishing Service.

Cook, A. T., & Powlowski, W. (1991). *Youth and homosexuality (Issue Paper No. 3).* Washington, DC: Federation of Parents and Friends of Lesbians and Gays.

Cook, E. P. (1985). *Psychological androgyny.* New York: Pergamon Press.

Cook, S. W. (1984). Cooperative interaction in multi ethnic contexts. In N. Miller, & M. Brewer (Eds.), *Groups in Contact: The Psychology of desegregation* (pp. 155-185). New York: Academic Press.

Corbett, K. (1998). Cross-gendered identifications and homosexual boyhood: Toward a more complex theory of gender. *American Journal of Orthopsychiatry, 68*, 352-360.

Costigan, G. (1996). The cost of coming out. *The Big Issue, 3,* 11-14.

Cox, S., & Gallois, C. (1996). Gay and lesbian identity development: A social identity perspective. *Journal of Homosexuality, 30,* 1-30.

Coyle, A. (1993). A study of psychological well-being among gay men using the GHQ-30. *British Journal of Clinical Psychology, 32 (2),* 218-220.

Crespi, T. D. (1990). Approaching adolescent suicide: Queries and signposts. *The School Counselor, 37 (4),* 256-260.

Crowne, D. P., & Marlowe, D. (1960). A new scale of social desirability independent of psychopathology. *Journal of Consulting Psychology, 24,* 349-354.

Crowne, D. P., & Marlowe, D. (1964). *The approval motive*. New York: John Wiley.

Dadisman, M. A. (1991). Roots of hate: Homophobia at its source. *Human Rights: Journal of the Section of Individual Rights and Responsibilities, 18* (1), 24-26.

Dahlen, E. R., & Canetto, S. S. (1996). *The role of gender and context in attitudes toward nonfatal suicidal behaviour*. Paper presented at the 29th Annual Conference of the American Association of Suicidology, St Louis, MO.

Dahlen, E. R., & Canetto, S. S. (2002). The role of gender and suicide precipitant in attitudes toward nonfatal suicidal behaviour. *Death Studies, 26 (2),* 99-116.

Dahlheimer, D., & Feigal, J. (1991). Gays and lesbians in therapy: Bridging the gap. *The Family Therapy Networker, 15 (1),* 44-53.

D'Augelli, A. R. (1992). Lesbian and gay male undergraduates experiences of harassment and fear on campus. *Journal of Interpersonal Violence, 7 (3),* 383-395.

D'Augelli, A. (1998). Developmental implications of victimization of lesbian, gay, and bisexual youths. In G. Herek (Ed.), *Stigma and sexual orientation: Understanding prejudice against lesbians, gay men, and bisexuals* (pp. 187-210). Thousand Oaks, CA: Sage.

D'Augelli, A. R., & Herschberger, S. L. (1993). Lesbian, gay, and bisexual youth in community settings: Personal challenges and mental health problems. *American Journal of Community Psychology, 21,* 1-28.

D'Augelli, A. R., & Rose, M. L. (1990). Homophobia in a university community: Attitudes and experiences of heterosexual freshman. *Journal of College Student Development, 32 (6),* 484-491.

Davis, C. M., Yarber, W. L., Bauserman, R., Schreer, G., & Davis, S. L. (1998). *Handbook of sexuality-related measures.* Thousand Oaks, CA: Sage.

Davison, G. C., & Friedman, S. (1981). Sexual orientation stereotypy in the distortion of clinical judgment. *Journal of Homosexuality, 6,* 37-44.

Dean, L., Meyer, I., Robinson, K., Sell, R., Sember, R., Silenzo, V., et al. (2000). Lesbian, gay, bisexual, and transgender health: Findings and concerns. *Journal of the Gay and Lesbian Medical Association, 4,* 116-120.

Deluty, R. H. (1988-89a). Factors affecting the acceptability of suicide. *Omega: Journal of Death and Dying, 19 (4),* 315-326.

Deluty, R. H. (1988-89b). Physical illness, psychiatric illness, and the acceptability of suicide. *Omega: Journal of Death and Dying, 19 (1),* 79-91.

Dempsey, C. (1994). Health and social issues of gay, lesbian, and bisexual adolescents: Families in society. *Journal of Contemporary Human Services, 75 (3),* 160-167.

Dijker, A. J. M. (1987). Emotional reactions to ethnic minorities. *European Journal of Social Psychology, 17,* 305-325.

Domino, G., & Groth, M. (1997). Attitudes toward suicide: German and U.S. nationals. *Omega: Journal of Death and Dying, 35 (3),* 309-319.

Droogas, A., Siiter, R., & O'Connell, A. N. (1982-83). Effects of personal and situational factors of attitudes towards suicide. *Omega: Journal of Death and Dying, 13 (2),* 127-144.

Dudley, M., & Waters, B. (1991). Adolescent suicide and Suicide Behaviour. *Modern Medicine of Australia, September,* 90-95.

Dudley, M., Waters, B., Kelk, N., & Howard, J. (1992). Youth suicide in New South Wales: Urban-rural trends. *The Medical Journal of Australia, 156,* 83-88.

DuRant, R. H., Krowchuk, D. P., & Sinal, S. H. (1998). Victimization, use of violence, and drug use at school among male adolescents who engage in same-sex sexual behavior. *Journal of Pediatrics, 132,* 113-118.

Durkheim, E. (1951). *Suicide: A study in sociology.* New York: Free Press. (Original work published 1897).

Eagly A. H., & Chaiken, S. (1993). *The psychology of attitudes.* Fort Worth, TX: Harcourt Brace Jovanovich.

Edwards, W. J. (1996). A sociological analysis of an invisible minority. *Youth and Society, 27 (3),* 334-356.

Eidenberg, D. (1998). It's all in your head. *Advocate, 760,* 49-52.

Ellis, J. B., & Hirsch, J. K. (1995). Attitudes of traditional and non-traditional college students towards suicide. *College Student Journal, 29 (4),* 445-447.

Emslie, M. (1996). Ignored to death. *Youth Studies Australia, 15*, 38-42.

Erwin, K. (1993). Interpreting the evidence: Competing paradigms and the emergence of lesbian and gay suicide as a social fact. *International Journal of Health Services, 23*, 53-64.

Evans, M. D. R. (1996). How much tolerance for homosexuals? *WwA: Worldwide Attitudes, 1996.07.29,* 1-8.

Faderman, L. (1984). The new gay lesbians. *Journal of Homosexuality, 10*, 85-95.

Fareberow, N. L. (Ed.). (1975). *Suicide in different cultures*. Baltimore, MD: University Park Press.

Faulkner, A., & Cranston, K. (1998). Correlates of same-sex sexual behaviour in a random sample of Massachusetts high school students. *American Journal of Public Health, 88 (2),* 262-266.

Feinstein, S., & Looney, J (Eds.). (1982). *Adolescent Psychiatry: Volume X*. Chicago: University of Chicago Press.

Fergusson, D., Horwood, J., & Beautrais, A. (1999). Is sexual orientation related to mental health problems and suicidality in young people? *Archives of General Psychiatry, 55 (10),* 876-880.

Festinger, L. (1957). *A theory of cognitive dissonance.* Evanston, IL: Row, Peterson

Ficarrotto, T. J. (1990). Racism, sexism, and erotophobia: Attitudes of heterosexuals towards homosexuals. *Journal of Homosexuality, 19*, 111-116.

Finlay, B., & Walther, C. S. (2003). The relation of religious affiliation, service attendance, and other factors to homophobic attitudes among university students. *Review of Religious Research, 44 (4),* 370-393.

Fishbein, M. (1963). An investigation of the relationships between beliefs about an object and the attitude toward the object. *Human Relations, 16,* 233-259.

Fishbein, M., & Ajzen, I. (1975). *Belief, attitude, intention, and behaviour: An introduction to theory and research.* Reading, MA: Addison-Wesley.

Fontaine, J. H. (1998). Evidencing a need: School counsellor's experiences with gay and lesbian students. *Professional School Counselling, 1 (3),* 8-15.

Fontaine, J. H., & Hammond, N. L. (1997). Counseling issues with gay and lesbian adolescents. *Adolescence, 31 (124),* 817-831.

Fordham, K. (1998). *Sexuality and suicide: An investigation of health compromising and suicidal behaviours among gay and bisexual male youth in Tasmania.* University of Tasmania: (unpublished manuscript).

Francis, G. (1999). *Introduction to SPSS for Windows (2nd ed.).* Sydney, Australia: Prentice Hall.

Freidman, R., & Downey, J. (1994). Homosexuality. *New England Journal of Medicine, 331,* 932-930.

Freud, S. (1961). Mourning and melancholia. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 14, pp 243-258). London: Hogarth Press. (Original work published in 1917).

Gaertner, S. L., & Rust, M. C. (1994). The contact hypothesis. *Small Group Research, 25 (2),* 224-250.

Garofalo, R., Wolf, R., Kessel, S., Palfrey, J., & Durant, R. (1998). The association between health risk behaviours and sexual orientation among a school-based sample of adolescents. *Pediatrics, 101 (5),* 895-902.

Garofalo, R., Wolf, R. C., Wissow, L. S., Woods, E. R., & Goodman, E. (1999). Sexual orientation and risk of suicide attempts among a representative sample of youth. *Archives of Pediatric Adolescent Medicine, 153,* 487-493.

Gibson, P. (1989). Gay male and lesbian suicide: prevention and intervention in youth suicide. *Report to the US Secretary's Task Force on Youth Suicide, Vol. 3: Preventions and Interventions in Youth Suicide* (pp 110-142). (DHHS Publication No. ADM 89-1623). Washington, DC: U.S. Government Printing Office.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity.* Engelwood Cliffs, NJ: Prentice-Hall.

Goldberg, D. P., & Hillier, V. F. (1979). A scaled version of the General Health Questionnaire. *Psychological Medicine, 9 (1),* 139-145.

Gonsiorek, J. C. (1988). Mental health issues of gay and lesbian adolescents. *Journal of Adolescent Health Care, 9,* 114-122.

Gonsiorek, J. C., & Rudolph, J. R. (1991). Homosexual identity: Coming out and other developmental events. In J. C. Gonsiorek & J. D. Weinrich (Eds.), *Homosexuality: Research implications for public policy* (pp. 161-176). Newbury Park, CA: Sage.

Goodyear, R. K., Abadie, P. D., & Barquest, K. A. (1981). Ascription of negative traits based on sex-role and sexual orientation. *Psychological Reports, 49 (1),* 194.

Green, E. (1996). Rural youth suicide: The issue of male homosexuality. In G. Lawrence, K. Lyons, & S. Momtaz (Eds.), *Social change in Australia* (pp. 35-48). Rockhampton, Australia: Rural Social and Economics Research Centre, Central Queensland University.

Haddock, G., Zanna, M. P., & Esses, V. M. (1993). Assessing the structure of prejudicial attitudes: The case of attitudes towards homosexuals. *Journal of Personality and Social Psychology, 65 (6),* 1105-1118.

Hamilton, D. L (1976). Cognitive biases in the perception of social groups. In J. S. Carroll & J. W. Payne (Eds.), *Cognition and social behaviour* (pp. 81-93). Hillsdale, NJ: Erlbaum.

Hammelman, T. (1993). Gay and lesbian youth: contributing factors to serious attempts or considerations of suicide. *Journal of Gay and Lesbian Psychotherapy, 2 (1),* 77-89.

Hammond, L. K., & Deluty, R. H. (1992). Attitudes of clinical psychologists, psychiatrists, and oncologists towards suicide. *Social Behavior and Personality, 20,* 289-294.

Hansen, G. L. (1982a). Androgyny, sex-role orientation, and homosexism. *Journal of Psychology, 112*, 39-45.

Hansen, G. L. (1982b). Measuring prejudice against homosexuality (homosexism) among college students: A new scale. *Journal of Social Psychology, 117 (2),* 233-236.

Harding, J., Proshansky, H., Kutner, B., & Chein, I. (1996). Prejudice and ethnic relations. In G. Lindzey (Ed.), *Handbook of social psychology* (Vol. 5, pp. 1-76). Reading, MA: Addison-Wesley.

Hassan, R. (1995). *Suicide explained: The Australian experience*. Melbourne, Australia: Melbourne University Press.

Henquinet, J., Phibbs, A., & Skoglund, B. (2000). Supporting our gay, lesbian, bisexual and transgender students. *About Campus, Nov/Dec,* 24-26.

Herdt, G., & Boxer, A. (1993). *Children on the horizon: How gay and lesbian teens are leading a new way out of the closet.* Boston: Beacon Press.

Herek, G. M. (1984a). Attitudes toward lesbians and gay men: A factor analytic study. *Journal of Homosexuality, 10,* 39-51.

Herek, G. M. (1984b). Beyond homophobia: A social psychological perspective on attitudes toward lesbians and gay men. *Journal of Homosexuality, 10,* 1-21.

Herek, G. M. (1986). On heterosexual masculinity: Some psychical consequences of the social construction of gender and sexuality. *American Behavioural Scientist, 29 (5),* 563-577.

Herek, G. M. (1987a). Can functions be measured? A new perspective on the functional approach to attitudes. *Social Psychology Quarterly, 50 (4),* 285-303.

Herek, G. M. (1987b). Religion and prejudice: A comparison of racial and sexual attitudes. *Personality and Social Psychology Bulletin, 13,* 56-65.

Herek, G. M. (1988). Heterosexuals' attitudes towards lesbians and gay men: Correlates and gender differences. *The Journal of Sex Research, 25 (4),* 451-477.

Herek, G. M. (1991). Stigma, prejudice, and violence against lesbians and gay men. In J. C. Gonsiorek & J. D. Weinrich (Eds.), *Homosexuality: Research implications for public policy* (pp. 60-80). Newbury Park, CA: Sage.

Herek, G. M. (1994). Assessing heterosexuals' attitudes towards lesbian and gay men. In B. Greene & G. M. Herek (Eds.), *Psychological perspectives on lesbian and gay issues, Vol 1: Lesbian and gay psychology: theory, research and clinical applications* (pp. 206-228). Thousand Oaks, CA: Sage.

Herek, G. M. (2000). The psychology of sexual prejudice. *Current Directions in Psychological Science, 9 (1),* 19-22.

Herek, G. M. (2002). Gender gaps in public opinion about lesbians and gay men. *Public Opinion Quarterly, 66 (1),* 40-66.

Herek, G. M., & Capitanio, J. P. (1995). Black heterosexuals' attitudes toward lesbians and gay men in the United States. *Journal of Sex Research, 32,* 95-105.

Herek, G. M., & Capitanio, J. P. (1996). Some of my best friends: Intergroup contact, concealable stigma, and heterosexuals' attitudes towards gay men and lesbians. *Personality and Social Psychology Bulletin, 22 (4),* 412-424.

Herek, G. M., & Capitanio, J. P. (1999). Sex differences in how heterosexuals think about lesbians and gay men: Evidence from survey context effects. *Journal of Sex Research, 36 (4),* 348-361.

Herek, G. M., & Glunt, E. K. (1991). AIDS-related attitudes in the United States: A preliminary conceptualisation. *The Journal of Sex Research, 28 (1),* 99-123.

Herek, G. M., & Glunt, E. K. (1993). Interpersonal contact and heterosexuals' attitudes toward gay men: Results from a national survey. *The Journal of Sex Research, 30 (3),* 239-244.

Herschberger, S. L., & D'Augelli, N. W. (1995). The impact of victimization on the mental health and suicidality of lesbian, gay, and bisexual youths. *Developmental Psychology, 31 (1),* 65-74

Herschberger, S. L., & Pilkington, N. W. (1997). Predictors of suicide attempts among gay, lesbian, and bisexual youth. *Journal of Adolescent Research, 12 (4),* 477-498.

Herschberger, S. L., Pilkington, N. W., & D'Augelli, A. R. (1996). Categorization of lesbian, gay and bisexual suicide attempters. In C. J. Alexander (Ed.), *Gay and lesbian mental health: A sourcebook for practitioners* (pp. 39-59). New York: Harrington Park Press.

Hetrick, E. S., & Martin, A. D. (1984). Ego-dystonic homosexuality: A developmental view. In E. Hetrick & T. Stein (Eds.), *Innovations in psychotherapy with homosexuals* (pp. 52-65). Washington, DC: American Psychiatric Press.

Hetrick, E. S., & Martin, A. D. (1987). Developmental issues and their resolution for gay and lesbian adolescents. *Journal of Homosexuality, 14,* 25-43.

Hewitt, C. (1995). The socio-economic position of gay men: A review of the evidence. *The American Journal of Economics and Sociology, 54 (4),* 461-480.

Hewstone, M., & Brown, R. (1986). Contact is not enough: A inter-group perspective on the contact hypothesis. In M. Hewstone & R. Brown (Eds.), *Contact and conflict in inter-group encounters* (pp. 1-44). Cambridge, MA: Basil Blackwell.

Higgins, D., King, R., & Witthaus, D. (2001). Pride and prejudice: Facilitating change in the attitudes of students toward gay men and lesbians. *Health Promotion Journal of Australia, 12,* 238-241.

Hillier, L., Warr, D., Haste, B. (1996). *The rural mural: Sexuality and diversity in rural youth.* Carlton, Australia: Centre for The Study of Sexually Transmitted Diseases, National Centre in HIV Social Research, LaTrobe University.

Hogg, M. A., & Abrams, D. (1988). *Social identifications.* London: Routledge.

Hort, B. E., Fagot, B. I., & Leinbach, M. D. (1990). Are people's notions of maleness more stereotypically framed than their notions of femaleness? *Sex Roles, 23 (3-4),* 197-212.

Hudson, W. W., & Ricketts, W. A. (1980). A strategy for the measurement of homophobia. *Journal of Homosexuality, 5,* 357-372.

Hunter, J. (1990). Violence against lesbian and gay male youths. *Journal of Interpersonal Violence, 5,* 295-300.

Hunter, J., & Schaecher, R. (1987). Stresses on lesbian and gay adolescents in schools. *Social Work in Education, 9 (3),* 180-189.

Hunter, J., & Schaecher, R. (1990). Lesbian and gay youth. In M. J. Rotheram-Borus, J. Bradley, & N. Obolensky (Eds.), *Planning to live: Evaluating and treating suicidal teens in community settings* (pp. 297-316), Tulsa, Ok: University of Oklahoma Press.

Ingram, E., & Ellis, J. B. (1995). Situational analysis of attitudes toward suicide behaviour. *Death Studies, 19 (3),* 269-275.

Jackson, L. A., & Sullivan, L. A. (1990). Cognition and affect in evaluations of stereotyped group members. *Journal of Social Psychology, 129 (5),* 659-672.

Johnson, M. E., Brems, C., & Alford-Keating, P. (1997). Personality correlates of homophobia. *Journal of Homosexuality, 34,* 57-69.

Jones, L. S. (2000). Attitudes of Psychologists and Psychologists-in-Training to Homosexual Women and Men: An Australian study. *Journal of Homosexuality, 39,* 113-133.

Kalafat, J. (1990). Adolescent suicide and the implications for school response programs. *The School Counselor, 37 (5),* 359-369.

Kalish, R. A., Reynolds, D. K., & Farberow, N. L. (1974). Community attitudes towards suicide. *Community Mental Health Journal, 10 (3),* 301-308.

Kandel, D. B., Ravis, V. H., & Davies, M. (1991). Suicidal ideation in adolescence: Depression, substance use, and other risk factors. Special issue: The emergence of depressive symptoms during adolescence. *Journal of Youth and Adolescence, 20 (2),* 289-309.

Katz, D., & Braly, K. (1933). Racial stereotypes of 100 college students. *Journal of Abnormal & Social Psychology, 28,* 280-290.

Kelley, J. (2001). Attitudes toward homosexuality in 29 nations. *Australian Social Monitor, 4 (1),* 15-22.

Kerns, J. G., & Fine, M. A. (1994). The relation between gender and negative attitudes towards gay men and lesbians: Do gender attitudes mediate this relation? *Sex Roles, 31 (5-6),* 297-307.

Kinsey, A. C. (1948). *Sexual behaviour in the human male.* Philadelphia: W. B. Saunders.

Kirby, K. M. (2001). Issues of difference: Gender, sexuality, and the elementary school child. In D. S. Sandhu (Ed.), *Elementary school counseling in the new millennium* (pp. 239-258). Alexandria, VA: American Counseling Association.

Kite, M. E. (1984). Sex differences in attitudes towards homosexuals: A meta-analytic review. *Journal of Homosexuality, 10,* 69-81.

Kite, M. (1992). Individual differences in males' reactions to gay males and lesbians. *Journal of Applied Social Psychology, 22 (15),* 1222-1239.

Kite, M. (1994). When perceptions meet reality: Individual differences in relation to lesbians and gay men. In B. Greene & G. M. Herek (Eds.), *Psychological perspectives on lesbian and gay issues: Vol 1: Lesbian and gay psychology: Theory, research, and clinical applications* (pp. 25-53). Thousand Oaks, CA: Sage.

Kite, M. E., & Deaux, K. (1986). Attitudes toward homosexuality: Assessment and behavioural consequences. *Basic and Applied Psychology, 7* (2), 137-162.

Kite, M. E., & Deaux, D. (1987). Gender belief systems: Homosexuality and the implicit inversion theory. *Psychology of Women Quarterly, 11* (1), 83-96.

Kite, M. E., & Whitely, B. E., Jr. (1996). Sex differences in attitudes towards homosexual persons, behaviour, and civil rights: A meta-analysis. *Personality and Social Psychology Bulletin, 22 (4),* 336-353.

Kournay, R. F. (1987). Suicide among homosexual adolescents. *Journal of Homosexuality, 13,* 111-117.

Krulewitz, J., & Nash, J. (1980). Effects of sexual attitudes and similarity on men's reactions to homosexuals. *Journal of Personality and Social Psychology, 38,* 76-84.

Kurdek, L. A. (1988). Correlates of negative attitudes towards homosexuals in heterosexual college students. *Sex Roles, 18 (11-12),* 727-738.

LaMar, L., & Kite, M. (1998). Sex differences in attitudes toward gay men and lesbians: A multidimensional perspective. *Journal of Sex Research, 35 (2),* 189-197.

Lance, L. M. (1987). The effects of interaction with gay persons on attitudes towards homosexuality. *Human Relations, 40 (6),* 329-336.

Lane, T. (1994, March 6). How about prime time for hetero Mardi Gras? *The Sunday Age,* Melbourne, Australia, p. 14.

Laner, M. R., & Laner, R. H. (1979). Personal style or sexual preference: Why gay men are disliked. *International Review of Modern Sociology, 9 (2),* 215-228.

Laner, M. R., & Laner, R. H. (1980). Sexual preference or personal style: Why lesbians are disliked. *Journal of Homosexuality, 5, 339-356.*

Larsen, K. S., Reed, M., & Hoffman, S. (1980). Attitudes of heterosexuals towards homosexuality: A Likert-type scale and construct validity. *Journal of Sex Research, 16 (3),* 245-257.

Lawrence, G., & Williams, C. (1990). The dynamics of decline: Implications for social welfare delivery in rural Australia. In T. Cullen, P. Dunn, & G. Lawrence (Eds.), *Rural health and welfare in Australia* (pp. 38-60). Riverina, Australia: Charles Sturt University.

Leary, D. (1992). Fast cars don't kill me: Marginalized young people, HIV and suicide. *Preventing youth suicide.* Canberra, Australia: Australian Institute of Criminology.

Lebson, M. (2002). Suicide among homosexual youth. *Journal of Homosexuality, 42,* 107-118.

Lester, D., Guerriero, J. M., & Wachter, S. M. (1991). The suicide attitude vignette experience (SAVE): A search for sexual stereotypes in the perception of suicidal behavior. *Death Studies, 15 (5),* 435-441.

Lewis, L. A. (1984). The coming out process for lesbians: Integrating a stable identity. *Journal of the National Association of Social Workers, 29 (5),* 464-469.

Lieblich, A., & Friedman, G. (1985). Attitudes towards male and female homosexuality and sex-role stereotypes in Israeli and American students. *Sex Roles, 12 (5-6),* 561-570.

Lienert, T. (1999). *Lesbians and mental health: Importance of friendship.* Paper presented at Health In Difference 3 Conference, Adelaide, Australia.

Linehan, M. M. (1973). Suicide and attempted suicide: Study of perceived sex differences. *Perceptual and Motor Skills, 37,* 31-34.

Lipkin, A. (1994). The case for a gay and lesbian curriculum. *The High School Journal, 77 (1-2),* 95-107.

Lock, J. & Kleis, B. (1998). Origins of homophobia in males. *American Journal of Psychotherapy, 52 (4),* 425-437.

Logan, C. R. (1996). Homophobia? No homoprejudice. *Journal of Homosexuality, 31,* 31-53.

Lo Presto, C. T., Sherman, M. F., & DiCarlo, M. A. (1994-95). Factors affecting the unacceptability of suicide and the effects of evaluator depression and religiosity. *Omega: Journal of Death and Dying, 30 (3),* 205-221.

Lottes, I. L. & Kuriloff, P. J. (1992). The effects of gender, race, religion and political orientation on the sex role attitudes of college freshmen. *Adolescence, 27 (107),* 675-688.

Louderback, L. A., & Whitley, B. E. (1997). Perceived erotic value of homosexuality and sex-role attitudes as mediators of sex differences in heterosexual college students' attitudes towards lesbians and gay men. *Journal of Sex Research, 34 (2),* 175-182.

Luchetta, T. (1999). Relationships between homophobia, HIV/AIDS stigma, and HIV/AIDS knowledge. In L. Pardie & T. Luchetta (Eds.), *The Construction of*

Attitudes Toward Lesbians and Gay Men (pp. 1-18). New York: Harrington Park Press.

MacDonald, A. P., Jr., & Games, R. G. (1974). Some characteristics of those who hold positive and negative attitudes towards homosexuals. *Journal of Homosexuality, 1,* 9-27.

MacDonald, R., & Cooper, T. (1998). Young gay men and suicide. *Youth Studies Australia, 17,* 23-27.

Mackie, D. M., & Hamilton, D. L. (Eds.) (1993). *Affect, cognition and stereotyping: Interactive processes in group perception.* San Diego, C.A.: Academic Press.

Mager, D., & Sulek, R. (1997). Teaching about homophobia at a historically black university: A role-play for undergraduate students. In J. Sears & W. Williams (Eds.), *Overcoming heterosexism and homophobia: Strategies that work* (pp. 182-208). New York: Columbia University Press.

Maney, D. W., & Cain, R. E. (1997). Preservice elementary teachers' attitudes toward gay and lesbian parenting. *Journal of School Health, 67 (6),* 236-242.

Marcus-Newall, A., Miller, N., Holtz, R., & Brewer, M. B. (1993). Cross-cutting category membership with role assignment: A means of reducing inter-group bias. *British Journal of Social Psychology, 32,* 125-146.

Maret, S. M. (1984). Attitudes of fundamentalists towards homosexuality. *Psychological Reports, 55 (1),* 205-206.

Marks, A. (1989). Structural parameters of sex, race, age, and education and their influence on attitudes towards suicide. *Omega: Journal of Death & Dying, 19 (4),* 327-336.

Marsiglio, W. (1993). Attitudes towards homosexual activity and gays as friends: A national survey of heterosexual 15 to 19 year old males. *Journal of Sex Research, 30 (1),* 12-17.

Martin, A. (1982). Learning to hide: The socialization of the gay adolescent. *Adolescent Psychiatry, 10,* 52-65.

Martin, A. D. (1988). Young, gay and afraid. *New York Times,* A33.

Martin, A. D. (1989). The stigmatization of the gay or lesbian adolescent. In M. S. Schneider (Ed.), *Often invisible: Counseling gay and lesbian youth* (p. 56-70) Toronto, Canada: Central Toronto Youth Services.

Martin, D. A., & Hetrick, E. S. (1988). The stigmatization of the gay and lesbian adolescent. *Journal of Homosexuality, 15,* 163-184.

Mason, G. (1989). *Youth suicide in Australia: Prevention strategies.* Canberra, Australia: Australian Government Publishing Service.

Matchinsky, D. J., & Iverson, T. G. (1996). Homophobia in heterosexual female undergraduates. *Journal of Homosexuality, 31,* 123-128.

McAuliffe, C., Corcoran, P., Keeley, H. S., & Perry, I. J. (2003). Risk of suicidal ideation associated with problem-solving ability and attitudes toward suicidal behaviour in university students. *Crisis, 24,* 160-167.

McConahay, J. B. (1986). Modern racism, ambivalence, and the modern racism scale. In J. F. Dovidio & S. L. Gaertner (Eds.), *Prejudice, discrimination, and racism* (pp. 84-105). New York: Academic Press.

McDermott, R. J., Hawkins, W. E., Marty, P. J., Littlefield, E. A., Murray, S., & Williams, T. K. (1990). Health behaviour correlates of depression in a sample of high school students. *Journal of School Health, 60,* 414-417.

McFarland, W. P. (1993). A developmental approach to gay and lesbian youth. *Journal of Humanistic Education and Development, 32,* 17-29.

McFarland, W. P. (1998). Gay, lesbian, and bisexual student suicide. *Professional School Counseling, 1 (3),* 26-30.

McFarland, W. P. & McMahon, T. R. (1999). Male archetypes as resources for homosexual identity development in gay men. *Journal of Humanistic Counseling, Education & Development, 38 (1),* 47-61.

McMillen, J. C. (1991). Sexual identity issues related to homosexuality in the residential treatment of adolescents. *Residential Treatment for Children and Youth, 9*, 5-21.

Medland, J. (1991). *Adolescence in rural Australia in the 1990s: Lifestyle risks and counselling needs.* Paper presented at the National Rural Health Conference, Toowoomba, New South Wales, Australia.

Miller, R. (1994). Fault lines in the contact zone. *College English, 56(4), 389-408.*

Millham, J., San Miguel, C. L., & Kellogg, R. (1976). A factor-analytic concepualization of attitudes towards male and female homosexuals. *Journal of Homosexuality, 2,* 3-10.

Minnigerode, F. A. (1976). Attitudes towards homosexuality: Feminist attitudes and sexual conservatism. *Sex Roles, 2 (4),* 347-352.

Molloy, M., & McLaren S. (in press). Suicide: The right decision? *Journal of Gay and Lesbian Issues in Education.*

Morgan, W. (1996). Still in the closet: The heterosexism of equal opportunity law. *Critical in Queeries, 1 (2)* 35-39.

Morin, S. F., & Garfinkle, E. M. (1978). Male homophobia. *Journal of Social Issues, 34 (1),* 29-47.

Morrow, D. F. (1993). Social work with gay and lesbian adolescents. *Social Work, 38 (6),* 655-660.

Muller, L. E., & Hartman, J. (1998). Group counseling for sexual minority youth. *Professional School Counseling, 1*, 38-41.

Mueller, M. A., & Waas, G. A. (2002). College students' perceptions of suicide: The role of empathy on attitudes, evaluation, and responsiveness. *Death Studies, 26 (4),* 325-341.

Murray, D. (2001). Out with homophobia. *Youth Studies Australia, 20, (1),* 32-37.

Myers, A., & Hansen, C. (1997). *Experimental Psychology (4th ed.).* Los Angeles, CA: Brooks Cole.

Myers, D. G. (1987). *Social Psychology (2nd ed.).* New York: McGraw-Hill.

Nicholas, J., & Howard, J. (1998). Better dead than gay: Depression, suicide ideation and attempt among a sample of gay and straight-identified males aged 18 to 24. *Youth Studies Australia, 17* (4), 28-33.

O'Carroll, P. W., Berman, A. L., Maris, R. W., Moscicki, E. K., Tanney, B. L., & Silverman, M. M. (1996). Beyond the tower of Babel: A nomenclature for suicidology. *Suicide and Life-Threatening Behavior, 26,* 237-252.

O'Hanlon, K. A., & Robertson, P. (1996). Homophobia is a health hazard. *USA Today Magazine, 125 (2618),* 26-30.

O'Hare, T., Williams, C., & Ezoviski, A. (1996). Fear of AIDS and homophobia: Implications for direct practice and advocacy. *Social Work, 41 (1),* 51-58.

Oliver, M. B., & Hyde, J. S. (1993). Gender differences in sexuality: A meta-analysis. *Psychological Bulletin, 114 (1),* 29-51.

Oliver, M., B., & Hyde, J. S. (1995). Gender differences in attitudes towards homosexuality: A reply to Whitley and Kite. *Psychological Bulletin, 117 (1),* 115-158.

Page, S., & Yee, M. (1985). Conception of male and female heterosexual stereotypes among university undergraduates. *Journal of Homosexuality, 12,* 109-118.

Pagtolun-An, I. G., & Clair, J. M. (1986). An experimental study of attitudes towards homosexuals. *Deviant Behaviour, 7 (2),* 121-135.

Patterson, C. J. (1995). Sexual orientation and human development: An overview. *Developmental Psychology, 31 (1),* 3-11.

Pettigrew, T. F. (1986). The intergroup contact hypothesis reconsidered. In M. Hewstone & R. Brown (Eds.), *Contact and conflict in intergroup encounters* (pp. 169-195). Cambridge, MA: Basil Blackwell.

Pettigrew, T. F. (1997). Generalized intergroup contact effects on prejudice. *Personality & Social Psychology Bulletin, 23 (2),* 173-185.

Pettigrew, T. F. (1998). Intergroup Contact Theory. *Annual Review of Psychology, 49 (1),* 65-85.

Phifer, N. (1994). Homophobia: The theme of the Novel *Jack. ALAN Review, 21 (2),* 10-11.

Pilkington, N. W., & D'Augelli, A. R. (1995). Victimization of lesbian, gay, and bisexual youth in community settings. *Journal of Community Psychology, 23 (1),* 34-57.

Popenhagen, M. P., & Qualley, R. M. (1998). Adolescent suicide: Detection, intervention, and prevention. *Professional School Counseling, 1,* 30-36.

Pratte, T. (1993). A comparative study of attitudes towards homosexuality. *Journal of Homosexuality, 26,* 77-82.

Price, J.H. (1982) High school students attitudes towards homosexuality. *The Journal of School Health, 52 (8),* 469-474.

Proctor, C. D., & Groze, V. K. (1994). Risk factors for suicide among gay, lesbian, and bisexual youths', *Social Work, 39 (5),* 504-512.

Quinley, H. E., & Glock, C. Y. (1979). *Anti-semitism in America*. New York: The Free Press.

Quittner, J. (2000). To live and die in Grant Town. *Advocate,* August, 21-23.

Range, L. M., & Martin, S. K. (1990). How knowledge of extenuating circumstances influences community reactions toward suicide victims and their bereaved families. *Omega: Journal of Death and Dying, 21 (3),* 191-198.

Regan, A. (1993). "Type normal like the rest of us": Writing, power, and homophobia in the Networked Composition Classroom. *Computers and Composition, 10,* 11-23.

Remafedi, G. (1985). Adolescent homosexuality: Issues for pediatricians. *Clinical Pediatrics, 24 (9),* 481-485.

Remafedi, G. (1987a). Adolescent homosexuality: Psychosocial and medical implications. *Pediatrics, 79 (3),* 331-337.

Remafedi, G. (1987b). Homosexual youth: A challenge to contemporary society. *Journal of the American Medical Association, 258,* 222-225.

Remafedi, G. (1987c). Male homosexuality: The adolescent's perspective. *Pediatrics, 79 (3),* 326-330.

Remafedi, G. (1990). Fundamental issues in the care of homosexual youth. *Medical Clinics in North America, 74,* 1169-1179.

Remafedi, G. (Ed.). (1994). *Death by denial.* Boston: Alyston Publications.

Remafedi, G., Farrow, J., & Deisher, R. (1991). Risk factors for attempted suicide in gay and bisexual youth. *Pediatrics, 87 (6),* 869-875.

Remafedi, G., French, S., Story, M., Resnick, M., & Blum, R. (1998). The relationship between suicide risk and sexual orientation: Results of a population-based study. *American Journal of Public Health, 88 (1),* 57-60.

Reynolds, W. M. (1982). Development of reliable and valid short forms of the Marlowe-Crowne Sociable Desirability Scale. *Journal of Clinical Psychology, 38 (1),* 119-125.

Rhoads, R. A. (1995). The college campus climate for gay students. *Education Digest, 61 (1),* 57-61.

Robinson, K. E. (1994). Addressing the needs of gay and lesbian students: The school counselor's role. *The School Counselor, 41 (5),* 326-332.

Rofes, E. E. (1983). *I thought people like that kill themselves.* San Francisco: Grey Fox Press.

Rofes, E. E. (1989). Opening up the closet: Responding to the educational needs of gay and lesbian youth. *Harvard Educational Review, 59* (4), 444-453.

Rokeach, M. (1968). *Beliefs, attitudes, and values: A theory of organisation and change.* San Francisco: Jossey-Bass.

Rosch, E., Mervis, C. B., Gray, W. D., Johnson, D., & Boyes-Braem, P. (1976). Basic objects in natural categories. *Cognitive Psychology, 8 (3),* 382-439.

Ross, M. W. (1978). The relationship of perceived societal hostility, conformity, and psychological adjustment in homosexual males. *Journal of Homosexuality, 4,* 157-168.

Ross, M. W. (1983). Societal relationships and gender role in homosexuals: A cross-cultural comparison. *The Journal of Sex Research, 19 (3),* 273-288.

Rotheram-Borus, M. J., Hunter, J., & Rosario, M. (1994). Suicidal behaviour and gay related stress among gay and bisexual adolescents. *Journal of Adolescent Research, 9 (4),* 498-508.

Rowe, R. N. (1992). Are we educators who are homosexual recruiting youth? *Education, 112 (4),* 609-612.

Royse, D., & Birge, B. (1987). Homophobia and attitudes towards AIDS patients among medical, nursing, and paramedical students. *Psychological Reports, 61 (3),* 868-870.

Royse, D., Dhopper, S. S., & Hatch, L. R. (1987). Undergraduate and graduate students' attitudes towards AIDS. *Psychological Reports, 60 (3),* 1185-1186.

Rubinstein, G. (1995). The decision to remove homosexuality from the DSM: Twenty years later. *American Journal of Psychotherapy, 49 (3),* 416-428.

Rubinstein, J. L., Heeren, T., Housman, D., Rubin, C., & Stechler, G. (1989). Suicidal behaviour in 'normal' adolescents: Risk and protective factors. *American Journal of Orthopsychiatry, 59 (1),* 59-71.

Russell, G. (1997). Using music to reduce homophobia and heterosexism. In J. Sears & W. Williams (Eds.), *Overcoming heterosexism and homophobia: Strategies that work (*pp. 156-166). New York: Columbia University Press.

Saghir, M. T., & Robins, E. (1973). *Male and female homosexuality: A comprehensive investigation.* Baltimore, MD: Williams & Wilkins.

Sakalli, N. (2002). Application of the attribution model of prejudice to homosexuality. *Journal of Social Psychology, 142 (2),* 264-272.

Saunders, J. M., & Valente, S. M. (1987). Suicide risk among gay men and lesbians: A review. *Death Studies, 11 (1),* 1-23.

Savin-Williams, R. C. (1989). Parental influences on the self-esteem of gay and lesbian youths: A reflected appraisals model. *Journal of Homosexuality, 17,* 93-109.

Savin-Williams, R. C. (1990). *Gay and lesbian youth: Expressions of identity.* New York: Hemisphere.

Savin-Williams, R. C. (1994). Verbal and physical abuse as stressors in the lives of lesbian, gay male, and bisexual youths: Associations with school problems, running away, substance abuse, prostitution, and suicide. *Journal of Consulting and Clinical Psychology, 62 (2),* 261-269.

Savin-Williams, R.C., & Lenhart, R.E. (1990). AIDS prevention among gay and lesbian youth: Psychosocial stress and health care intervention guidelines. In D. G.

Ostrow (Ed.), *Behavioural aspects of AIDS and other sexually transmitted diseases* (pp. 75-99). Newbury Park, CA: Sage.

Scheff, T. J. (1990). *Microsociology: Discourse, emotion and social structure.* Chicago: University of Chicago Press.

Schellenberg, E., Hirt, J., & Sears, A. (1999). Attitudes toward homosexuals among students at a Canadian University. *Sex Roles, 40 (1-2),* 139-154.

Schneider, S. G. (1991). Developing services for lesbian and gay adolescents. *Canadian Journal of Community Mental Health, 10 (1),* 133-151.

Schneider, S. G., Fareberow, N. L., & Kruks, G. N. (1989). Suicidal behaviour in adolescent and young adult gay men. *Suicide and Life-Threatening Behaviour, 19 (4),* 381-394.

Sears, D. O. (1988). Symbolic racism. In P. A. Katz & D. A. Taylor (Eds.), *Eliminating racism* (pp. 53-84). New York: Plenum Press.

Sears, J. (1997). Thinking critically/intervening effectively about heterosexism and homophobia: A twenty-five-year research retrospective. In J. Sears & W. Williams (Eds.), *Overcoming heterosexism and homophobia: Strategies that work* (pp. 13-48). New York: Columbia University Press.

Sears, J. T., & Williams, W. L. (Eds.). (1997). *Overcoming heterosexism and homophobia: Strategies that work.* New York: Columbia University Press.

Seltzer, R. (1992). The social location of those holding anti-homosexual attitudes. *Sex Roles, 26 (9-10),* 639-650.

Shaughnessy, J. J., & Zechmeister, E. B. (1994). *Research methods in psychology (3rd ed.).* Singapore: McGraw-Hill.

Shidlo, A. (1994). Internalised homophobia: Conceptual and empirical issues in measurement. In B. Greene & G. M. Herek (Eds.), *Lesbian and gay psychology:*

Theory, research and clinical application (pp. 176-205). Thousand Oaks, CA: Sage.

Sibley, J. (1995*). Geographies of exclusion.* London: Routledge.

Silbert, K. L., & Berry, G. L. (1993). The suicidal adolescent and special service providers: Guidelines for early intervention. *Special Services in Schools, 7 (1),* 65-77.

Simmons, J. L. (1965). Public stereotypes of deviants. *Social Problems, 1 (3),* 223-232.

Singh, B. K., Williams, J. S., & Ryther, B. J. (1986). Public approval of suicide: A situational analysis. *Suicide and Life-Threatening Behavior, 16 (4),* 409-418.

Smith, V. & Borthwick, P. (1991). That's how it is: Gender and sexuality in rural Australia. *On the Level, 1 (1),* 8-11.

Snyder, M. (1981). On the self-perpetuating nature of social stereotypes. In D. L. Hamilton (Ed.*), Cognitive processes in stereotyping and ingroup behaviour* (pp. 183-212). Hillsdale, NJ: Erlbaum.

Snyder, M., & Uranowitz, S.W. (1978). Reconstructing the past: Some cognitive consequences of person perception. *Journal of Personality and Social Psychology, 36 (9),* 941-950.

Sophie, J. (1986). A critical examination of stage theories of lesbian identity development. *Journal of Homosexuality, 12,* 39-51.

Sophie, J. (1987). Internalised homophobia and lesbian identity. *Journal of Homosexuality, 14,* 53-65.

Sorjonen, K. (2002-2003). For whom is suicide accepted: The dependency effect. *Omega: Journal of Death and Dying, 46 (2),* 137-140.

Staats, G. R. (1978). Stereotype content and social distance: Changing views of homosexuality. *Journal of Homosexuality, 4,* 15-27.

Stangor, C., Sullivan, L. A., & Ford, T. E. (1991). Affective and cognitive determinants of prejudice. *Social Cognition, 9 (4),* 359-391.

Stark, L. P. (1991). Traditional gender role beliefs and individual outcomes: An exploratory analysis. *Sex Roles, 24 (9-10),* 639-650.

Steffensmeier, D., & Steffensmeier, R. (1974). Sex differences in reactions to homosexuals: Research continuities and further developments. *The Journal of Sex Research, 10,* 52-67.

Stephan, W. G. (1987). The contact hypothesis in intergroup relations. In C. Hendrick (Ed), *Group processes in intergroup relations: Review of personality and social psychology* (Vol. 9, pp. 13-40). Newbury Park, CA: Sage.

Stephan, W. G., & Stephan, C. W. (1985). Intergroup anxiety. *Journal of Social Issues, 41*, 157-175.

Stevenson, M. R. (1988). Promoting tolerance for homosexuality: An evaluation of intervention strategies. *The Journal of Sex Research, 25 (4),* 500-511.

Stillion, J. M., McDowell, E. E., & May, J. H. (1984). Developmental trends and sex differences in adolescent attitudes towards suicide. *Death Education, 8,* 81-90.

Stillion, J. M., McDowell, E. E, & Shamblin, J. B. (1984). The suicide attitude vignette experience: A method for measuring adolescent attitudes toward suicide. *Death Education, 8 (Suppl.),* 65-79.

Stillion, J. M., McDowell, E. E., Smith, R. T., & McCoy, P. A. (1986). Relationships between suicide attitudes and indicators of mental health among adolescents. *Death Studies, 10 (3),* 289-296.

Stillion, J. S., & Stillion, B. D. (1998-99). Attitudes toward suicide: Past, present and future. *Omega: Journal of Death and Dying 38,* 77-97.

Stillion, J. M., White, H., Edwards, P. J., & McDowell, E. E. (1989). Ageism and sexism in suicide attitudes. *Death Studies, 13,* 247-261.

Storms, M. D. (1978). Attitudes towards homosexuality and femininity in men. *Journal of Homosexuality, 3,* 257-263.

Tabachnick, B. G., & Fidell, L. S. (2000). *Using multivariate statistics (4th ed.).* New York: HarperCollins.

Tajfel, H. (1981). *Human groups and social categorisation.* Cambridge, England: Cambridge University Press.

Tajfel, H. (Ed.). (1982). *Social identity and intergroup relations.* Cambridge, NY: Cambridge University Press.

Tajfel, H., & Turner, J.C. (1979). An integrative theory of social conflict. In W. Austin & S. Worschel (Eds.), *The social psychology of intergroup relations* (pp. 33-47). Monterey, CA: Brooks-Cole.

Tanner, L. (1994, March 12). Gay and harmless affair. *The Herald Sun*, Melbourne, Australia, p. 19.

Taylor, A. (1983). Conceptions of masculinity and femininity as a basis for stereotypes of male and female homosexuals. *Journal of Homosexuality, 9,* 37-53.

Taylor, B. (1994). *The prevention of youth suicide and self harm: Promoting intersectoral action.* Melbourne, Australia: Victorian Health Promotion Foundation.

Taylor, B. (1995). From a distance: HIV and its impact on young people in Australia. *National AIDS Bulletin, 9,* 27-33.

Taylor, D. M., & Moghaddam, F. M. (1994*). Theories of intergroup relations: International social psychological perspectives (2nd ed.).* Westport, C.T.: Praeger Publishers.

Taylor, I., & Robertson, A. (1994). The health needs of gay men: A discussion of the literature and implications for nursing. *Journal of Advanced Nursing, 20 (3),* 560-566.

Tellojohann, S. K., & Price, J. H. (1993). A qualitative examination of adolescent homosexuals' life experiences: Ramifications for secondary school personnel. *Journal of Homosexuality, 26,* 41-56.

Tellojohann, S. K., & Price, J. H. (1995). Teaching about sexual orientation by secondary health teachers. *Journal of School Health, 65 (1),* 18-23.

The Australian Bisexual Men's Association (2000). *Submission on scope and priorities for the Victorian Ministerial Advisory Committee on gay and lesbian health.* Melbourne, Australia: Author.

Travers, R., & Schneider, M. (1997). A multi-faceted approach to reduce risk factors for lesbian, gay, and bisexual youth. In M. Schneider (Ed.), *Pride and prejudice: Working with lesbian, gay, and bisexual youth* (pp. 125-149). Toronto, Canada: Central Toronto Youth Services.

Treadway, L., & Yoakham, J. (1992). Creating a safer school environment for lesbian and gay students. *Journal of School Health, 62,* 352-357.

Trobst, K. K., Collins, R. L., & Embree, J. M. (1994). The role of emotion in social support provision: Gender, empathy and expressions of distress. *Journal of Social and Personal Relationships, 11 (1),* 45-62.

Troiden, R. R. (1979). Becoming homosexual: A model of gay identity acquisition. *Psychiatry, 42 (4),* 362-373.

Troiden, R. R. (1988). Homosexuality identity development. *Journal of Adolescent Health Care, 9,* 105-113.

Troiden, R. R. (1989). The formation of homosexual identities. In G. Herdt (Ed.*), Gay and lesbian youth* (pp 43-73). London: Haworth Press.

Turner, J. C., Hogg, M. A., Oakes, P. J., Reicher, S. D., & Wetherell, M. S. (1987). *Rediscovering the social group: A self-categorization theory*. Cambridge, MA: Basil Blackwell.

Van De Ven, P. (1994). Comparisons among homophobic reactions of undergraduates, high school students, and young offenders. *Journal of Sex Research, 31,* 117- 124.

Van winkle, D., Calhoun, L. G., Cann, A., & Tedeschi, R. (1998). Social reactions to attempted suicide: The effects of gender and physical attractiveness. *Omega: Journal of Death and Dying, 37,* 89-100.

Vare, J. W., & Norton, T. L. (1998). Understanding gay and lesbian youth: Sticks, stones, and silence. *Clearing house, 71 (6),* 327-332.

Vaughan, G., & Hogg, M. (1995). *Social psychology*. Australia; Prentice Hall.

Wagner, G. J. (1998). Internalized homophobia scale (HIS). In C. M. Davis, W. L. Yarber. R. Bauserman, G. Schreer, & S. L. Davis (Eds.), *Handbook of sexuality-related measures.* (pp. 371-372) Thousand Oaks, CA: Sage Publishers.

Wagner, B. M., Cole, R. E., & Schwartzman, P. (1995). Psychosocial correlates of suicide attempts among junior and senior high school youth. *Suicide and Life-Threatening Behaviour, 35 (3),* 358-372.

Wagner, G., & Brondolo, E. (1996). Internalized homophobia in a sample of HIV+ gay men and its relationship to psychological distress, coping, and illness progression. *Journal of Homosexuality, 32,* 91-107

Wagner, G., Serafini, J., Rabkin, J., Remein, R., & Williams, J. (1994). Integration of one's religion and homosexuality: A weapon against internalised homophobia? *Journal of Homosexuality, 26,* 91 –111.

Waldo, C. R., Hesson-McInnis, M. S., & D'Augelli, A. R. (1998). Antecedents and Consequences of victimization of lesbian, gay, and bisexual young people: A structural model comparing rural university and urban samples. *American Journal of Community Psychology, 26 (2),* 307-334.

Walker, P. (2001). Sexual identity, psychological well-being and suicide risk among lesbian and gay young people. *Educational and Child Psychology, 18 (1),* 47-61.

Walters, A., S., (1994). Using visual media to reduce homophobia: A classroom demonstration. *Journal of Sex Education and Therapy, 20,* 92-100.

Weinberg, G. (1972). *Society and the healthy homosexual.* New York: St. Martins Press.

Weinberg, T. S. (1984). Biology, ideology, and the reification of developmental stages in the study of homosexual identities. *Journal of Homosexuality, 10,* 77-84.

Wellman, M. M., & Wellman, R. J. (1986). Sex differences in peer responsiveness to suicide ideation. *Suicide and Life Threatening Behaviour, 16 (3),* 360 –377.

Wells, S. (1999). The health beliefs, values and practices of gay adolescents. *Clinical Nurse Specialists, 13,* 69-73.

White, H., & Stillion, J. M. (1988). Sex differences in attitudes toward suicide: Do males stigmatise males? *Psychology of Women Quarterly, 12 (3),* 357-366.

Whitely, B. E., Jr. (1987). The relationship of sex-role orientation to heterosexuals' attitudes towards homosexuals. *Sex Roles, 17,* 103-113.

Whitely, B. E., Jr., & Kite, M. E. (1995). Sex differences in attitudes toward homosexuality: A comment on Oliver and Hyde (1993). *Psychological Bulletin, 117 (1),* 146-154.

Wilder, D.A. (1993). The role of anxiety in facilitating stereotypic judgments of outgroup behavior. In D. M. Mackie & D. L. Hamilton (Eds.), *Affect, cognition and stereotyping: Interactive processes in group perception* (pp. 87-109). San Diego, C.A.: Academic Press.

Williams, J. M. G., & Pollock, L. R. (1993). Factors mediating suicidal behaviour: Their utility in primary and secondary prevention. *Journal of Mental Health, 2 (1),* 3-27.

Williams, R. M. (1947). The reduction of intergroup tensions: A survey on problems of ethnic, racial and religious group relations. *Social Science Research Council Bulletin, 57,* 153-166.

Wills, G, & Crawford, R. (2000). Attitudes towards homosexuality in Shreveport-Bossier City, Louisiana. *Journal of Homosexuality, 38,* 97-116.

Winberger, L. L., & Millham, J. (1979). Attitudinal homophobia and support of traditional sex-roles. *Journal of Homosexuality, 4,* 236-246.

Wisniewski, J., & Toomey, B. G. (1987). Are social workers homophobic? *Social Work, 32 (5),* 454-455.

Woodard, J. (1997). In search or the rural gay. *Alberta Report, 24,* 33-34.

Wright, S.C., Aron, A., McLaughlin-Volpe, T., & Ropp, S.A. (1997). The extended contact effect: Knowledge of cross-group friendships and prejudice. *Journal of Personality and Social Psychology, 73 (1),* 73-90.

Wyn, J., Stokes, H., & Stafford, J. (1997). *Challenges and resilience factors for young people living in rural Australia in the 1990's.* Paper presented at the National Rural Public Health Forum, Adelaide, South Australia.

Yoder, R. E. & Preston, D. B. (1997). Rural school nurses' attitudes about aids and homosexuality. *Journal of School Health, 67 (8),* 341-348.

Young, M., & Whertvine, J. (1982). Attitudes of heterosexual students towards homosexual behavior. *Psychological Reports, 51 (2),* 673-674.

Zanna, M. P., & Rempel, J. K. (1988). Attitudes: A new look at an old concept. In D. Bar-Tal & A.W. Kruglanski (Eds.), *The social psychology of knowledge* (pp. 315-334). Cambridge, England: Cambridge University Press.

Appendix A

Cover Letter and Questionnaire Package

Invitation to Participate in Research:
Attitudes Towards Homosexual Youth Suicide Among
Heterosexual and Homosexual Communities: A Urban/Rural Perspective

Dear Resident,
This is an invitation to participate in research being conducted by Ms. Mari Molloy under the supervision of Dr. Suzanne McLaren at the University of Ballarat, Mt Helen campus. This study will investigate perceptions of youth suicide and the degree to which these perceptions may vary across different communities. Conducting this research will result in a specialised knowledge base pertinent to Australians.

Your street and house number has been selected at random in an attempt to access a wide range of opinions. No record of your address has been recorded or retained. If you volunteer to participate in this research, you will be asked to complete several questionnaires. You will also be asked to provide some demographic information about yourself, including your age, gender, marital status, sexual orientation, education, place of residence, and religious affiliation.

In the first questionnaire you will be asked to read a series of short stories, each containing a young person experiencing a different life situation which results in suicide. Each of these stories will be followed by a series of questions that will ask you to assess the suicide that has occurred. These questions will cover such areas as how necessary do you think the suicide was?, how much empathy did you feel for the suicidal person?, how important was the situation to the suicide and so on. You will be asked to score each of these questions on a numbered scale from 1 to 4. You will not be required to give lengthy written responses. Four additional questionnaires are included assessing social attitudes (“I am always courteous, even to people who are disagreeable.”) social attitudes in relation to homosexual persons (“ Female homosexuality in itself is no problem unless society makes it a problem.”), and social attitudes in relation to suicide (“Felt that life wasn’t worth living.”). Again this will require you to rate these items on a numbered scale.

The researchers understand the sensitive nature of such questions, hence participation is fully voluntary. Your name is not required on the questionnaire; thereby assuring your anonymity will be protected. None of the information you supply for this study can in anyway be linked back to you. If completed and returned, your anonymous questionnaire will form part of a larger database, from which only group data will be reported. Further, only the two researchers (Ms. Mari Molloy & Dr. Suzanne McLaren) will have access to this data.

The questionnaire will take approximately 30 minutes to complete, and it is important that each question is answered as honestly as possible for the research to be of significant value.

If you are feeling distressed at any time following completion of this study and wish to preserve your anonymity, 24-hour support is available by contacting Lifeline on freecall 1300 651 251 or for the cost of a local call on 131114. Other alternative forms of support that people may feel more comfortable with include contacting your personal physician, making contact with the Gay & Lesbian Switchboard on 9510 5488 or 1800 631 493 for the cost of a local call, or with the researchers whose number is listed at the bottom of this letter.

Please understand that we care for your welfare. As the questionnaire is fully voluntary and anonymous, we will not have a record of your contact details. Since we will be unable to contact you, we have supplied our telephone numbers in the belief that, should you need to, you will contact us.

If for any reason you do not wish to complete the questionnaire you may withdraw at this point without repercussion. Please understand that once you have posted the completed questionnaire, it will be unidentifiable amongst the larger pool, hence withdrawal at this stage will not be possible. Returning the questionnaire indicates that you understand the nature of the research and freely consent to participate in this study.

Should you decide to participate, please complete the enclosed questionnaire and return it in the provided reply paid envelope (note that a stamp is not necessary). To facilitate the timely completion of the study, we ask that that you return the questionnaire to us **within two weeks.**

If you have **any** concerns during or after completing the questionnaire, you are encouraged to discuss these with the researchers, Dr. Suzanne McLaren or Ms. Mari Molloy. Should you live outside what is considered a local telephone call charge, you are welcome to reverse the call charges. If your concerns are of a personal nature we encourage you to contact your doctor, or if you prefer to retain your anonymity, Lifeline is available 24-hours-a-day (13 11 14 or 1300 651 251), or alternatively, you may prefer to discuss certain issues with the Gay and Lesbian Switchboard (95105488 or 1800 631 493).

A summary of results will be available in mid 2003. Participants interested in receiving this information are invited to contact the researchers. Additionally, it is anticipated that summaries of the research will appear in the media. Thank you for considering participating in this study.

Dr. Suzanne McLaren & Ms. Mari Molloy
Ph.: 03 5327 9628 E-mail: s.mclaren@ballarat.edu.au

Note that this page is to be retained by you. Please return only the questionnaire.

Note. Should you have any soncerns about the conduct of this research project, please contact the Executive Officer, Human Research Ethics Committee, Scholarship and Educational Development services Branch, University of Ballarat, PO Box 663, Mt Helen VIC 3353: (03) 5327 9765.

DEMOGRAPHIC INFORMATION

This section concerns demographic information.

1. **Your Gender** Male ☐ Female ☐

2. **Your Age** _____

3. **Your current relationship status?**

Married	☐	Defacto	☐
Single	☐	Divorced	☐
Separated	☐	Widowed	☐

4. **Postcode of residential address:** ☐☐☐☐

5. **How many years/months have you lived at that postcode?** _____

6. **Number of children** ____

7. **Highest educational level achieved:**

☐	Primary	☐	Secondary School - Years 7, 8, or 9
☐	Secondary School - Years 10 or 11	☐	Secondary School - Year 12/HSC/VCE /TAFE
☐	Trade Certificate	☐	University - Undergraduate degree
☐	University - Postgraduate degree	☐	Other (please specify)_____

8. **What is your current employment status?**

☐	Employed (Full Time) (please specify your job)_____	☐	Employed (Part-time/casual) (please specify your job)_____
☐	Volunteer (Full Time) (please specify your job)_____	☐	Volunteer (Part Time) (please specify your job)_____
☐	Workcover	☐	Unemployed
☐	Student	☐	Unemployed

9. How would you describe your religious affiliation?

Christian ☐
None ☐
Other _____

11. Which of the following is the most representative of you?

- ☐ I am largely attracted to males
- ☐ I am largely attracted to females
- ☐ I am largely attracted to both males and females

12. Who do you have sex with?

- ☐ Men
- ☐ Women
- ☐ Both Men and Women

13. What sort of lifestyle do you lead?

- ☐ Gay
- ☐ Straight
- ☐ Lesbian
- ☐ Both Gay/Lesbian and Straight

14. What do you consider to be your sexuality?

- ☐ Heterosexual
- ☐ Gay
- ☐ Lesbian
- ☐ Bisexual
- ☐ Don't know/unsure
- ☐ Other (Please specify)_____

15. Do you know a person who is a: ☐ Gay Male ☐ Lesbian

16. Do you have a relative who is a: ☐ Gay Male ☐ Lesbian

17. In your everyday life, do you have contact with: ☐ Gay Male ☐ Lesbian

18. If you have contact with a gay/lesbian person, how often does this occur?

- ☐ Daily
- ☐ Weekly
- ☐ Fortnightly
- ☐ Infrequently
- ☐ Other (please specify)_____

19. If you have contact with a gay/lesbian person, is this contact:

- ☐ Social
- ☐ Work-related
- ☐ Social & Work related
- ☐ Other (please specify)_____

PLEASE COMPLETE THIS PAGE **ONLY** IF YOU IDENTIFIED YOUR SEXUAL ORIENTATION AS GAY OR LESBIAN.

DO NOT COMPLETE THIS PAGE IF YOU ARE HETEROSEXUAL

INSTRUCTIONS: The following are statements that individuals can make about being gay or lesbian. Please read each one carefully, decide the extent to which you agree with the statement, then circle the number which best reflects how much you agree or disagree with the statement.

1	2	3	4	5
Strongly Agree	**Agree**	**Neither Agree or Disagree**	**Disagree**	**Strongly Disagree**

1. Homosexuality (male and/or female) is a natural expression of sexuality in human beings.	**1**	**2**	**3**	**4**	**5**
2. I wish I were heterosexual.	**1**	**2**	**3**	**4**	**5**
3. When I am sexually attracted to someone of the same sex, I don't mind if someone else knows how I feel.	**1**	**2**	**3**	**4**	**5**
4. Most problems that homosexuals have comes from their status as an oppressed minority, not from their homosexuality per se.	**1**	**2**	**3**	**4**	**5**
5. Life as a homosexual is not as fulfilling as life as a heterosexual.	**1**	**2**	**3**	**4**	**5**
6. I am glad to be homosexual.	**1**	**2**	**3**	**4**	**5**
7. Whenever I think a lot about being homosexual, I feel critical about myself.	**1**	**2**	**3**	**4**	**5**
8. I am confident that my homosexuality does not make me inferior.	**1**	**2**	**3**	**4**	**5**
9. Whenever I think a lot about being homosexual, I feel depressed.	**1**	**2**	**3**	**4**	**5**
10. If it were possible, I would accept the opportunity to be completely heterosexual.	**1**	**2**	**3**	**4**	**5**
11. I wish I could become more sexually attracted to the opposite sex.	**1**	**2**	**3**	**4**	**5**
12. If there were a pill that could change my sexual orientation, I would take it.	**1**	**2**	**3**	**4**	**5**
13. I would not give up being homosexual even if I could.	**1**	**2**	**3**	**4**	**5**
14. Homosexuality is deviant.	**1**	**2**	**3**	**4**	**5**
15. It would not bother me if I had children who were homosexual.	**1**	**2**	**3**	**4**	**5**
16. Being homosexual is a satisfactory and acceptable way of life for me.	**1**	**2**	**3**	**4**	**5**
17. If I were heterosexual, I would probably be happier.	**1**	**2**	**3**	**4**	**5**
18. Most homosexual people end up lonely and isolated.	**1**	**2**	**3**	**4**	**5**
19. For the most part, I do not care who knows I am homosexual.	**1**	**2**	**3**	**4**	**5**
20. I have no regrets about being homosexual.	**1**	**2**	**3**	**4**	**5**

PLEASE COMPLETE THIS PAGE **ONLY** IF YOU IDENTIFIED YOUR SEXUAL ORIENTATION AS HETEROSEXUAL.DO NOT COMPLETE THIS PAGE IF YOU ARE GAY OR LESBIAN

INSTRUCTIONS: The following are statements that individuals can make about gay men. Please read each one carefully, decide the extent to which you agree with the statement, then circle the number which best reflects how much you agree or disagree with the statement.

1	2	3	4	5
Strongly Disagree	**Disagree**	**Neither Agree or Disagree**	**Agree**	**Strongly Agree**

1. Gay men just can't fit into our society	**1**	**2**	**3**	**4**	**5**
2. A male's homosexuality should not be a cause for job discrimination in any situation.	**1**	**2**	**3**	**4**	**5**
3. Male homosexuality is bad for society because it breaks down the natural divisions between the sexes.	**1**	**2**	**3**	**4**	**5**
4. Any laws against private sexual behaviour between consenting adult men should be abolished.	**1**	**2**	**3**	**4**	**5**
5. Male homosexuality is a sin.	**1**	**2**	**3**	**4**	**5**
6. The growing number of male homosexuals indicates a decline in Australian morals.	**1**	**2**	**3**	**4**	**5**
7. Male homosexuality in itself is no problem unless society makes it a problem.	**1**	**2**	**3**	**4**	**5**
8. Male homosexuality is a threat to many of our basic institutions.	**1**	**2**	**3**	**4**	**5**
9. Male homosexuality is an inferior form of sexuality.	**1**	**2**	**3**	**4**	**5**
10. Male homosexuals are sick.	**1**	**2**	**3**	**4**	**5**
11. Male homosexual couples should be allowed to adopt children the same as heterosexual couples.	**1**	**2**	**3**	**4**	**5**
12. I think male homosexuals are disgusting.	**1**	**2**	**3**	**4**	**5**
13. Male homosexuals should not be allowed to teach in schools.	**1**	**2**	**3**	**4**	**5**
14. Male homosexuality is a perversion.	**1**	**2**	**3**	**4**	**5**
15. Male homosexuality is a natural expression of sexuality in men.	**1**	**2**	**3**	**4**	**5**
16. If a man has homosexual feelings, he should do everything to overcome them.	**1**	**2**	**3**	**4**	**5**
17. I would not be too upset if I learned my son was a homosexual.	**1**	**2**	**3**	**4**	**5**
18. Sex between two men is just plain wrong.	**1**	**2**	**3**	**4**	**5**
19. The idea of male homosexual marriages seems ridiculous to me.	**1**	**2**	**3**	**4**	**5**
20. Male homosexuality is merely a different kind of lifestyle that should not be condemned	**1**	**2**	**3**	**4**	**5**

This questionnaire asks you to read each of the following statements and answer each true or false as they apply to you. Please answer each as accurately as you can.

	True	False
1. It is sometimes hard for me to go on with my work if I am not encouraged	☐	☐
2. I sometimes feel resentful when I don't get my way.	☐	☐
3. On a few occasions, I have given up doing something because I thought too little of my ability.	☐	☐
4. There have been times when I felt like rebelling against people in authority even though I knew they were right.	☐	☐
5. No matter who I am talking to, I am always a good listener.	☐	☐
6. There have been occasions when I took advantage of someone.	☐	☐
7. I'm always willing to admit it when I make a mistake.	☐	☐
8. I sometimes try to get even rather than forgive and forget.	☐	☐
9. I'm always courteous, even to people who are disagreeable.	☐	☐
10. I have never been irked when people expressed ideas very different from my own.	☐	☐
11. There have been times when I was quite jealous of the good fortune of others.	☐	☐
12. I am sometimes irritated by people who ask favours of me.	☐	☐
13. I have never deliberately said something that hurt someone's feelings.	☐	☐

This questionnaire consists of seven items. Please read each item carefully, then circle the one answer for each question which you think most applies to you, using the following scale:

1	2	3	4
not at all	**no more than usual**	**somewhat more than usual**	**much more than usual**

Over the past few weeks, have you:

1. Been thinking of yourself as a worthless person?	**1**	**2**	**3**	**4**
2. Felt that life is entirely hopeless?	**1**	**2**	**3**	**4**
3. Felt that life isn't worth living?	**1**	**2**	**3**	**4**
4. Thought of the possibility that you might kill yourself?	**1**	**2**	**3**	**4**
5. Found that at times you couldn't do anything because your nerves were too bad?	**1**	**2**	**3**	**4**
6. Found yourself wishing you were dead and away from it all?	**1**	**2**	**3**	**4**
7. Found that the idea of taking your own life kept coming into your mind?	**1**	**2**	**3**	**4**

Note: We take this opportunity to remind you of the support options available to you. Should you be experiencing any distress (at any time now or after completing the questionnaire) you are encouraged to contact one of the resources listed on your Plain Language Statement. If you wish to preserve your anonymity we would encourage you to contact Lifeline on 13 1114 or 1300 651 251.

This questionnaire consists of 8 separate vignettes, each one describing a young person experiencing a different life situation. Read each vignette thoroughly and indicate your responses on the scales provided.

1. Stephen is an 18-year-old male, living with his lover, Amy at University. His parents know nothing about him living with a girl or about his lover Amy. One day, unexpectedly, his parents arrive for a visit and upon entering his room using a spare key; they find him in bed with his girlfriend. His parents are shocked and angry and leave saying that unless he ceases his relationship with Amy immediately he is no longer their son and they will want nothing more to do with him. Distraught and upset by these events, Stephen commits suicide.

A. How justified was the decision to commit suicide?

1	2	3	4
completely unjustified	somewhat unjustified	somewhat justified	completely justified

B. How acceptable was the suicide?

1	2	3	4
completely unacceptable	somewhat unacceptable	somewhat acceptable	completely acceptable

C. How much empathy do you feel for the suicidal person?

1	2	3	4
no empathy at all	very little empathy	some empathy	a lot of empathy

D. How necessary was the suicide?

1	2	3	4
completely unnecessary	somewhat unnecessary	somewhat necessary	completely necessary

E. How psychologically healthy do you feel the suicidal person was?

1	2	3	4
completely unhealthy	somewhat unhealthy	somewhat healthy	completely healthy

F. How important was the victim's gender to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

G. How important was the victim's age to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

H. How important was the victim's sexual orientation to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

I. How important was the victim's situation to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

2. Stephen is 16 years old. Eight months ago he confessed to his best friend Wayne that he was gay. Wayne then told all the other boys in his class at school. In no time at all the whole school knew. Since then Stephen has been teased constantly about being a 'girl' and a 'faggot'. On several occasions he has been pushed and punched by groups of students in the hallways and on his way home from school. His locker has been constantly vandalised and sprayed with derogatory comments. None of friends are willing to spend time with him anymore during class breaks. School becomes unbearable and Stephen commits suicide.

A. How justified was the decision to commit suicide?

1	2	3	4
completely unjustified	somewhat unjustified	somewhat justified	completely justified

B. How acceptable was the suicide?

1	2	3	4
completely unacceptable	somewhat unacceptable	somewhat acceptable	completely acceptable

C. How much empathy do you feel for the suicidal person?

1	2	3	4
no empathy at all	very little empathy	some empathy	a lot of empathy

D. How necessary was the suicide?

1	2	3	4
completely unnecessary	somewhat unnecessary	somewhat necessary	completely necessary

E. How psychologically healthy do you feel the suicidal person was?

1	2	3	4
completely unhealthy	somewhat unhealthy	somewhat healthy	completely healthy

F. How important was the victim's gender to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

G. How important was the victim's age to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

H. How important was the victim's sexual orientation to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

I. How important was the victim's situation to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

3. Carol has had leukaemia since she was 13. She is now 17. She has always maintained a positive approach to her illness throughout this time. She had been in remission for a considerable period but this ended several months ago and she has been informed recently that the disease will most likely kill her. This has seen her plans to move out of the family home and live independently dashed and has resulted in her losing her job as a shop assistant due to her frequent hospitalisations. Lately the pain Carol is experiencing has increased to the point where the drugs no longer control it. Her family have been very supportive throughout her illness and try to do all they can to assist her. Despite this Carol feels unable to cope anymore and commits suicide.

A. How justified was the decision to commit suicide?

1	2	3	4
completely unjustified	somewhat unjustified	somewhat justified	completely justified

B. How acceptable was the suicide?

1	2	3	4
completely unacceptable	somewhat unacceptable	somewhat acceptable	completely acceptable

C. How much empathy do you feel for the suicidal person?

1	2	3	4
no empathy at all	very little empathy	some empathy	a lot of empathy

D. How necessary was the suicide?

1	2	3	4
completely unnecessary	somewhat unnecessary	somewhat necessary	completely necessary

E. How psychologically healthy do you feel the suicidal person was?

1	2	3	4
completely unhealthy	somewhat unhealthy	somewhat healthy	completely healthy

F. How important was the victim's gender to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

G. How important was the victim's age to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

H. How important was the victim's sexual orientation to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

I. How important was the victim's situation to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

4. Seventeen-year-old Jane has always been a child whose parents were very proud of her. She is obedient and respectful and never gives them any trouble. She is a committed student who consistently achieves good grades and she is well liked by her peers and has a close group of friends. Over the past few months she has become close to a new girl at school named Julie. Last month Jane told her parents that she is a lesbian and that she was in love Julie. Her parents were outraged about this and constantly refuse to discuss her feelings about this saying it's just a phase And she will outgrow it. They have forbidden her to have any further contact with Julie and have arranged for her to receive counselling. Jane commits suicide.

A. How justified was the decision to commit suicide?

1	2	3	4
completely unjustified	somewhat unjustified	somewhat justified	completely justified

B. How acceptable was the suicide?

1	2	3	4
completely unacceptable	somewhat unacceptable	somewhat acceptable	completely acceptable

C. How much empathy do you feel for the suicidal person?

1	2	3	4
no empathy at all	very little empathy	some empathy	a lot of empathy

D. How necessary was the suicide?

1	2	3	4
completely unnecessary	somewhat unnecessary	somewhat necessary	completely necessary

E. How psychologically healthy do you feel the suicidal person was?

1	2	3	4
completely unhealthy	somewhat unhealthy	somewhat healthy	completely healthy

F. How important was the victim's gender to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

G. How important was the victim's age to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

H. How important was the victim's sexual orientation to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

I. How important was the victim's situation to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

5. Nineteen-year-old Michael is an apprentice mechanic and comes from a very religious family. For the past two years he has known that he is gay but has kept it secret from everyone he knows. He feels ashamed and disgusted with what he is because the priests have always told him that homosexuality is a mortal sin. During this time Michael has tried to ignore his feelings and be 'straight' by having several girlfriends and 'hanging out' with his mate Paul from work. Over the past few months he has become increasingly attracted to Paul and is afraid that someone will discover this. Unable to resolve his feelings, Michael commits suicide.

A. How justified was the decision to commit suicide?

1	2	3	4
completely unjustified	somewhat unjustified	somewhat justified	completely justified

B. How acceptable was the suicide?

1	2	3	4
completely unacceptable	somewhat unacceptable	somewhat acceptable	completely acceptable

C. How much empathy do you feel for the suicidal person?

1	2	3	4
no empathy at all	very little empathy	some empathy	a lot of empathy

D. How necessary was the suicide?

1	2	3	4
completely unnecessary	somewhat unnecessary	somewhat necessary	completely necessary

E. How psychologically healthy do you feel the suicidal person was?

1	2	3	4
completely unhealthy	somewhat unhealthy	somewhat healthy	completely healthy

F. How important was the victim's gender to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

G. How important was the victim's age to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

H. How important was the victim's sexual orientation to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

I. How important was the victim's situation to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

6. Pauline has been going out with Bryan for three years. They are in Year 12 and have been planning to live together after their graduation. Pauline has been offered a junior position in a large marketing firm in their hometown and Bryan has applied to attend the local University to study Accounting. For the past six months they have been busy working to save the funds they will need to set up their new home. One month ago, Bryan received an offer of a full scholarship from another University several hundred kilometres away. Pauline refuses to consider moving or giving up her job to enable Bryan to accept this offer and Bryan feels the offer is too good to refuse. This has resulted in them arguing more frequently than ever before. The day before their graduation, following yet another argument, Bryan ends their relationship. Bryan subsequently accepts the offer and moves away. Devastated, Pauline commits suicide.

A. How justified was the decision to commit suicide?

1	2	3	4
completely unjustified	somewhat unjustified	somewhat justified	completely justified

B. How acceptable was the suicide?

1	2	3	4
completely unacceptable	somewhat unacceptable	somewhat acceptable	completely acceptable

C. How much empathy do you feel for the suicidal person?

1	2	3	4
no empathy at all	very little empathy	some empathy	a lot of empathy

D. How necessary was the suicide?

1	2	3	4
completely unnecessary	somewhat unnecessary	somewhat necessary	completely necessary

E. How psychologically healthy do you feel the suicidal person was?

1	2	3	4
completely unhealthy	somewhat unhealthy	somewhat healthy	completely healthy

F. How important was the victim's gender to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

G. How important was the victim's age to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

H. How important was the victim's sexual orientation to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

I. How important was the victim's situation to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

7. Anne is 21-years-old and has always thought of herself as an intelligent and responsible person. Two years ago she had her first sexual experience. Since then she has had numerous male sex partners. Anne has never practiced safe sex with any of her partners, as she believed she was careful and so could not contract AIDS. Lately, however, she noticed that she is losing weight and becoming extremely tired. When she noticed dark spots forming on her body she went to the local medical clinic, where they advised her to have an AIDS test. The results showed that she had tested HIV positive. Her doctor has advised her to begin a course of medications to assist her in living with the virus and provided her with contact numbers for support. Devastated by this news, Anne commits suicide.

A. How justified was the decision to commit suicide?

1	2	3	4
completely unjustified	somewhat unjustified	somewhat justified	completely justified

B. How acceptable was the suicide?

1	2	3	4
completely unacceptable	somewhat unacceptable	somewhat acceptable	completely acceptable

C. How much empathy do you feel for the suicidal person?

1	2	3	4
no empathy at all	very little empathy	some empathy	a lot of empathy

D. How necessary was the suicide?

1	2	3	4
completely unnecessary	somewhat unnecessary	somewhat necessary	completely necessary

E. How psychologically healthy do you feel the suicidal person was?

1	2	3	4
completely unhealthy	somewhat unhealthy	somewhat healthy	completely healthy

F. How important was the victim's gender to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

G. How important was the victim's age to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

H. How important was the victim's sexual orientation to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

I. How important was the victim's situation to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

8. Fifteen-year-old James had been an ordinary sort of kid. For the past six months however he has been of considerable concern to his family. He has been involved in a number of fights at school and has been suspended on two occasions for his aggression towards other children. He often sneaks out at night and his mother has found marijuana in his room. When she confronted him, he admitted to smoking it regularly. His father has threatened to throw him out of the family home if he can't 'get his act together'. James refuses to talk to his parents, saying only that 'no-one would understand' and spends most of his time at home, alone in his room listening to loud music. Last week, after sneaking out at night, they where woken by the police who had bought James home in a drunken state after collecting him from a local bar for fighting. His parents are told there will be charges filed. The next day, James commits suicide.

A. How justified was the decision to commit suicide?

1	2	3	4
completely unjustified	somewhat unjustified	somewhat justified	completely justified

B. How acceptable was the suicide?

1	2	3	4
completely unacceptable	somewhat unacceptable	somewhat acceptable	completely acceptable

C. How much empathy do you feel for the suicidal person?

1	2	3	4
no empathy at all	very little empathy	some empathy	a lot of empathy

D. How necessary was the suicide?

1	2	3	4
completely unnecessary	somewhat unnecessary	somewhat necessary	completely necessary

E. How psychologically healthy do you feel the suicidal person was?

1	2	3	4
completely unhealthy	somewhat unhealthy	somewhat healthy	completely healthy

F. How important was the victim's gender to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

G. How important was the victim's age to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

H. How important was the victim's sexual orientation to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

I. How important was the victim's situation to the suicide?

1	2	3	4
not important at all	somewhat important	important	very important

Appendix B

E-mail Invitation Promoting the Research and Website Details

School of Behavioural & Social Sciences & Humanities

Community Health Research Team

Please allow me to introduce myself to you. My name is Mari Molloy. I am a registered probationary psychologist and am currently a student of the University of Ballarat in my second year of a Professional Doctorate Degree in Psychology.

As part of my studies I am conducting research that is seeking to investigate

Attitudes Towards Youth Suicide within Australian Heterosexual and Homosexual Communities.

To date, there have been no Australian studies on attitudes in this area, as such, the information I will obtain from this study will, for the first time, provide an insight into this issue within an Australian context.

This is my purpose in writing to you today. I need lots of people to complete the survey, which I have developed to obtain this information. This survey is available online or if you would prefer I can mail out printed copies for people to complete and return via reply paid post. What I would like to ask you is if you could please post this information on your website and/or pass this information along to the other members of your group (via email or verbally). Below I have set out the website access details along with an invitation for people to enable them to easily pass this information along to any friends, family etc they know and feel may be interested in taking part in the study. If you are happy to assist me in this way, I suggest you could simply copy and paste the information below onto your website, into an email, or print it out to hand along to others.

I thank you for the time you have given to me in reading this request. Please feel free to contact me at any time with any questions or concerns you may have. I would value it if you would reply to this request to let me know whether or not you and your group are willing to assist me in this way. I will be travelling to a number of towns and cities around Victoria (alas I don't have funds to travel beyond my home state) over the coming months and would be only too willing to meet with you and/or your group if I should be in your town during my travels. Alternatively, if you would like to have me speak at your group, you could contact to arrange this.

I felt that using the Internet was one way to allow an opportunity for a large representation of people from both heterosexual and homosexual communities across Australia to take part. The results of this study will be made available in the early part of 2004. If you would like to receive this, please send me an email indicating you interest and I will enure these are forwarded to you when they become available.

Thank-you for considering being a part of this study.

Ms. Mari Molloy email: m.molloy@ballarat.edu.au

University of Ballarat

School of Behavioural & Social Sciences & Humanities

Community Health Research Team

THIS INVITATION COULD BE USED FOR INFORMING YOUR GROUP, FAMILY, FRIENDS ETC OF THE STUDY. IT COULD ALSO BE POSTED ON YOUR WEBSITE (IF DESIRED) OR FORWARDED ON VIA EMAIL OR PRINTED OUT FOR DISTRIBUTION

This is an invitation for you to participate in important research currently being conducted by the University of Ballarat. This research is seeking to investigate attitudes towards gay and lesbian youth suicide within both the homosexual and heterosexual communities. Your participation would require you to complete an online questionnaire that will take approximately 15-20mins. Your participation in this study is entirely voluntary and your contribution will remain completely anonymous (your email address will be removed from your survey at the time you select the submit button). You may choose to withdraw from participation at any stage during prior to submission of your completed questionnaire. However, withdrawal will not be possible following submission of your completed questionnaire due to the removal of all identifying information. To begin the questionnaire, simply click on the web address below.

http://www.ballarat.edu.au/bssh/research/Community_Health/chrtpro.shtml

Once there select the Attitudes to Youth Suicide Project

You will then be asked for both a user name and password word. These are

User name: subject Password : agrees

There you will then be asked to read through and agree with a plain language statement, which will outline the purpose of the study prior to accessing the questionnaire package.

Please feel free to pass this message along to anyone whom you feel may be interested in this study.

My heartfelt thanks for your interest in this important work.

Mari Molloy Email: m.molloy@ballarat.edu.au

Dr. Suzanne McLaren Email: s.mclaren@ballarat.edu.au

Appendix C

Flyer Promoting the Research and Website Details

University of Ballarat

School of Behavioural & Social Sciences & Humanities

Community Health Research Team

We are a research team investigating mental health in Australians. The research team is composed of fourth year and research higher degree students researching aspects of clinical and health psychology under the supervision of Dr Suzanne McLaren. Currently, the Community Mental Health Research Team is focusing on (1) comparisons between rural, regional and urban Australians, and (2) sexual orientation and mental health.

You are invited to participate in any or all of our research projects. Questionnaires can be completed on-line at the following address:

http://www.ballarat.edu.au/bssh/research/Community_Health/chrtpro.shtml
User Name: subject Password: agrees

Alternatively, you may contact Dr Suzanne McLaren on 5327 9628 or s.mclaren@ballarat.edu.au, and questionnaires will be posted or e-mailed to you.

Current Projects include:

- Sense of Belonging and Mental Health in Australian Women as a Function of Sexual Orientation and Place of Residence
- Sense of Belonging and Mental Health in Australian Men as a Function of Sexual Orientation and Place of Residence
- An Investigation of Homosexual and Heterosexual Community Members' Attitudes Towards Youth Suicide
- Sense of Belonging, Self-esteem and Body Satisfaction in Gays, Lesbians, and Bisexuals

Appendix D

Newspaper Article from Ballarat Courier Newspaper

Appendix E

Full Model for the Hierarchical Regression Analysis for Predictors of Heterosexual Participants' Attitudes Towards Gay Male and Lesbian Adolescent Suicide

Table E1

Full Model for the Hierarchical Regression Analysis for Predictors of Heterosexual Male and Female Participants' Attitudes Towards Gay and Lesbian Adolescent Suicide

Variable	*B*	*SE B*	β	sr^2
Step 1				
Gender of Suicide Victim[a]	-0.25	0.11	-.14 *	-.14
Step 2				
Gender of Suicide Victim[a]	-.025	0.11	-.14 *	-.14
Gender[b]	0.26	0.12	-.15 *	-.15
Step 3				
Gender of Suicide Victim[a]	-0.14	0.11	-.08	-.08
Gender[b]	-0.24	0.11	-.13 *	-.13
Age	-0.03	0.00	-.37**	-.36
Step 4				
Gender of Suicide Victim[a]	-0.14	0.11	-.08	-.08
Gender[b]	-0.24	0.11	-.13 *	-.13
Age	-0.03	0.00	-.37**	-.36
Level of Education	0.03	0.05	.04	.04
Step 5				
Gender of Suicide Victim[a]	-.015	0.11	-.09	-.08
Gender[b]	-0.25	0.11	-.13 *	-.13
Age	-0.03	0.00	-.38**	-.37
Level of Education	0.04	0.05	.05	.05
Place of Residence[c]	0.16	0.12	.08	.09
Step 6				
Gender of Suicide Victim[a]	-0.16	0.11	-.09	-.09
Gender[b]	-0.25	0.11	-.13 *	-.13
Age	-0.03	0.00	-.37**	-.35
Level of Education	0.02	0.05	.03	.03
Place of Residence[c]	0.14	0.12	.07	.06
Religious Affiliation[d]	0.09	0.07	.09	.08
Importance of Religion[e]	-0.02	0.13	-.01	-.01

Table E7 continued

Step 7				
Gender of Suicide Victim[a]	-0.17	0.11	-.10	-.09
Gender[b]	-0.23	0.11	-.13 *	-.13
Age	-0.03	0.00	-.37**	-.35
Level of Education	0.02	0.05	.03	.03
Place of Residence[c]	0.10	0.13	.05	.04
Religious Affiliation[d]	0.09	0.07	.09	.08
Importance of Religion[e]	-0.03	0.13	-.02	-.01
Homophobia Towards Gay Males	-4.47	14.51	-.05	-.02
Homophobia Towards Lesbians	0.56	0.86	.11	.04
Step 8				
Gender of Suicide Victim[a]	-0.17	0.11	-.10	-.09
Gender[a]	-0.23	0.11	-.13 *	-.12
Age	-0.02	0.00	-.37**	-.35
Level of Education	0.02	0.05	.03	.03
Place of Residence[b]	0.10	0.13	.05	.04
Religious Affiliation[c]	0.09	0.07	.09	.08
Importance of Religion[d]	0.02	0.13	-.02	-.01
Homophobia Towards Gay Males	-4.49	14.59	-.05	-.02
Homophobia Towards Lesbians	0.56	0.86	.11	.04
Level of Homosexual Contact	-0.02	0.02	-.00	-.00

Note. B = unstandardised slope parameter, *SE B* = standard error of Beta, β = standardized slope parameter, sr^2= semi-partial correlations squared. R^2 = .02 for Step 1, R^2 = .02 for Step 2, R^2 = .13 for Step 3, R^2 = .00 for Step 4, R^2 = .01 for Step 5, R^2 = .01 for Step 6, R^2 = .00 for Step 7, R^2 = .00 for Step 8. [a]1 = *Male*, 2 = *Female*, [b]1 = *Male*, 2 = *Female*, [c]1 = *Urban*, 2 = *Rural*. [d]1 = *Religion*, 2 = *No religion*. [e]1 = *important*, 2 = *not important*.
*p < .05. **p < .001.

Appendix F

Full Model for the Hierarchical Regression Analysis for Predictors of Homosexual Participants' Attitudes Towards Gay and Lesbian Adolescent Suicide

Table F1

Full Model for the Hierarchical Regression Analysis for Predictors of Gay Male and Lesbian Participants' Attitudes Towards Gay and Lesbian Adolescent Suicide

Variable	*B*	*SE B*	*β*	sr^2
Step 1				
Gender of Suicide Victim[a]	0.19	0.09	.12 *	.10
Step 2				
Gender of Suicide Victim[a]	0.20	0.09	.12 *	.11
Gender[b]	-0.04	0.09	-.02	-.03
Step 3				
Gender of Suicide Victim[a]	0.17	0.09	.10	.12
Gender[b]	-0.05	0.09	-.03	-.02
Age	-0.01	0.00	-.14**	.15
Step 4				
Gender of Suicide Victim[a]	0.16	0.09	.10	.13
Gender[b]	-0.05	0.09	-0.03	-.02
Age	-0.08	0.01	-.11	.08
Level of Education	-0.04	0.04	-.07	.12
Step 5				
Gender of Suicide Victim[a]	0.17	0.09	.11	.11
Gender[b]	-0.06	0.09	-.04	.01
Age	-0.09	0.01	-.12 *	.11
Level of Education	-0.04	0.04	-.06	.10
Place of Residence[c]	0.09	0.10	.05	-.17
Step 6				
Gender of Suicide Victim[a]	0.16	0.09	.09	.10
Gender[b]	-0.05	0.09	-.03	.01
Age	-0.09	0.01	-.12 *	.11
Level of Education	-0.04	0.04	-.05	.09
Place of Residence[c]	0.09	0.09	.05	-.17
Religious Affiliation[d]	0.09	0.06	-.09	-.08
Importance of Religion[e]	0.16	0.09	.11	-.02

Table E8 continued

Step 7				
Gender of Suicide Victim[a]	0.15	0.09	.09	.10
Gender[b]	-0.08	0.10	-.05	.01
Age	-0.10	0.01	-.13 *	.11
Level of Education	-0.04	0.04	-.90	.09
Place of Residence[c]	-0.08	0.10	.05	-.17
Religious Affiliation[d]	-.10	0.06	-.09	.08
Importance of Religion[e]	0.16	0.09	.11	-.02
Internalised Homophobia	-0.09	0.01	-.05	.01
Step 8				
Gender of Suicide Victim[a]	-0.14	0.09	.08	.04
Gender[b]	-0.08	0.10	-.05	.02
Age	-0.01	0.01	-.14 *	.14
Level of Education	-0.04	0.04	-.06	.01
Place of Residence[c]	0.11	0.10	.06	-.01
Religious Affiliation[d]	0.09	0.06	-.09	.06
Importance of Religion[e]	0.16	0.09	.11	.03
Internalised Homophobia	-0.09	0.01	-.05	-.04
Level of Homosexual Contact	0.03	0.02	.07	.70

Note. B = unstandardised slope parameter, *SE B* = standard error of Beta, β = standardized slope , parameter, sr^2= semi-partial correlations squared. R^2 = .01 for Step 1, R^2 = .00 for Step 2, R^2 = .02 for Step 3, R^2 = .00 for Step 4, R^2 = .00 for Step 5, R^2 = .01 for Step 6, R^2 = .00 for Step 7, R^2 = .01 for Step 8..

[a]1 = *Male*, 2 = *Female*, [b]1 = *Male*, 2 = *Female*, [c]1 = *Urban*, 2 = *Rural*. [d]1 = *Religion*, 2 = *No religion*. [e]1 = *important*, 2 = *not important*.

*p < .05. **p < .001.