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The Interrelations Between Internalized Homophobia, Depressive Symptoms, and Suicidal Ideation Among Australian Gay Men, Lesbians, and Bisexual Women

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Abstract

Internalized homophobia has been linked to depression among gay men, lesbians and bisexuals. Relatively little research has investigated the link between internalized homophobia and suicidal thoughts and behaviors. The current research investigated the interrelations among internalized homophobia, depressive symptoms, and suicidal ideation by testing additive, mediation, and moderation models. Self-identified Australian gay men (n = 360), lesbians (n = 444), and bisexual women (n = 114) completed the Internalized Homophobia Scale, the Center for Epidemiological Studies Depression Scale, and the suicide subscale of the General Health Questionnaire. Results supported the additive and partial mediation models for gay men and the mediation and moderation models for lesbians. None of the models were supported for bisexual women. The findings imply that clinicians should focus on reducing internalized homophobia and depressive symptoms among gay men and lesbians, and depressive symptoms among bisexual women, in order to reduce suicidal ideation.

Key words: Internalized Homophobia; Depressive Symptoms; Suicidal Ideation

The Interrelations Between Internalized Homophobia, Depressive Symptoms, and Suicidal Ideation Among Australian Gay Men, Lesbians, and Bisexual Women

Sexual orientation has been identified as a key risk factor for mental health problems. A systematic review indicated that gay, lesbian, and bisexual (GLB) adults are twice as likely to have attempted suicide or to have experienced depression in the previous 12 months as heterosexual adults (King et al., 2008). Internalized homophobia has been identified as a key risk factor for poor mental health among GLB adults (Igartua, Gill, & Montoro 2003). Internalized homophobia refers to "a set of negative attitudes and affects toward homosexuality in other persons and toward homosexual features in oneself" (Shidlo, 1994, p. 178), and is a direct result of living in a heterosexist society. Dimensions of internalized homophobia include negative global attitudes towards homosexuality, discomfort with disclosure of sexual orientation to others, disconnectedness from other gay individuals, and discomfort with same-sex sexual activity (Meyer & Dean, 1998). It is argued that internalized homophobia is experienced to varying degrees by almost all GLB individuals raised in a homophobic society (Gonsiorek, 1988; Sophie, 1988; Szymanski, Chung, & Balsam, 2001).

Internalized homophobia has been directly related to depression among GLB adults (e.g., Frost & Meyer, 2009; Gold, Marx, & Lexington, 2007; Goldberg & Smith, 2011; Igartua et al., 2003; Szymanski et al., 2001; see Newcomb & Mustanski, 2010, for a review). For example, Igartua et al. found that attitudes towards one's own sexual orientation, attitudes towards other gay men and lesbians, and attitudes towards self-disclosure of one's sexual orientation were each related to depression in a sample of gay men and lesbians.

Fewer studies have examined the relationship between internalized homophobia and suicide among GLB adults. Igartua et al. (2003) found a significant relationship between internalized homophobia and suicidal thoughts and behaviours in their sample of gay men

and lesbians. When internalized homophobia and depression were entered simultaneously in a regression analysis to predict suicidal thoughts and behaviours, only depression predicted suicidal ideation. These results do not support an additive model, which proposes that both variables explain unique variance in an outcome measure. The results suggest that depression mediates the relation between internalized homophobia and suicidal ideation among gay men and lesbians. Formal testing of a mediation model for GLB adults has not been conducted.

In addition to a mediation model, it is possible that depression moderates the relationship between internalized homophobia and suicidal ideation among GLB adults. It is likely that the strength of the relationship between internalized homophobia and suicidal ideation would be stronger for GLB adults who have high levels of depression. To the best of my knowledge, a moderation model has not been tested.

The aim of the current study was to investigate whether additive, mediation, and moderation models explain the interrelationships between internalized homophobia, depressive symptoms, and suicidal ideation among GLB adults. Understanding how internalized homophobia and depressive symptoms are related to suicidal ideation has implications for the development of interventions aimed at reducing suicidal ideation among GLB adults. It was hypothesized that internalized homophobia and depressive symptoms would independently predict suicidal ideation (additive model). Consistent with a mediation model, it was hypothesized that higher levels of internalized homophobia would be related to higher levels of depressive symptoms, and higher levels of depressive symptoms in turn would be associated with higher levels of suicidal ideation. It was also hypothesized that depressive symptoms would moderate the internalized homophobia-suicidal ideation relation, such that the relation would be stronger for GLB adults with higher levels of depressive symptoms.

Method

Participants

Participants were recruited primarily at prominent gay, lesbian and bisexual social events, such as community festivals, in the states of Victoria and Queensland, Australia during 2013. Snowball methods were used to try to include people who did not attend such events. A total of 1200 questionnaires were distributed, with 931 being returned (78% response rate).

Self-identified gay men (n = 360), lesbians (n = 444), and bisexual women (n = 114) volunteered to complete the questionnaire. Only two men who identified as bisexual participated in the study. Their data was not included in the analyses. Characteristics of each sample can be seen in Table 1. The gay men ranged in age from 18 to 82 years (M = 35.39, SD = 12.35). The majority of men was in a same-sex relationship, had at least one university degree, and worked full time. Nearly a quarter of the men earned over AUS$70,000 before tax per year.

The lesbians ranged in age from 18 to 68 years (M = 33.73, SD = 11.64). The majority of the sample was in a same-sex relationship, and worked full time. Half of the women had at least one university degree.

The bisexual women ranged in age from 18 to 56 years (M = 26.85, SD = 9.72). Half of the sample was single. Over a third of the women had completed a university degree, and most were employed. One third earned less than AUS$10,000 per year before tax.

Materials

A cover letter outlined the purpose of the study and the requirements of participation in this study. It also contained contact numbers of the researcher and a telephone counselling service specifically for gay men, lesbians, and bisexuals.

The demographic section of the questionnaire asked participants to report their gender, age, relationship status, highest education level achieved, current employment status, and

income per year before tax. Participants answered the question "Would you consider yourself to be predominately: heterosexual, lesbian, gay, bisexual, or unsure?". Participants who answered heterosexual (n = 6) or unsure (n = 5) were excluded, as inclusion was based on self-identification as gay, lesbian, or bisexual.

The Center for Epidemiological Studies–Depressive Scale (Radloff, 1977) was used to assess the level of depressive symptoms experienced by the participants in the past week. Participants responded to the 20 items (e.g., *I thought my life had been a failure*) using a 4-point scale, from 0 = *Rarely or None of the time (less than 1 day)* to 3 = *Most or All of the time (5-7 days)*. Higher scores indicate higher levels of depressive symptoms (Radloff, 1977). The Scale has previously shown strong internal consistency for a sample of gay men (α = .93) and lesbians (α = .94; McLaren, Gibbs, & Watts, 2013). Internal consistency was high for the current samples (gay men α = .92, lesbians α = .91, bisexual women α = .91).

The Internalized Homophobia Scale (Wagner, 1998) measures how much an individual's self-image and identity have been influenced by the internalization of anti-homosexual attitudes and beliefs (e.g., *I wish I were heterosexual*). Participants indicated how much they agreed with each of the 20 items by using a 5 point scale, from 1 = *strongly disagree* to 5 = *strongly agree*. Higher scores indicated higher levels of internalized homophobia. Studies have found that scores on the Internalized Homophobia Scale are positively correlated with demoralisation (r = .49), global psychological distress (r = .37) and depression (r = .36; Wagner, Serafini, Rabkin, Remien, & Williams, 1994). Adequate internal reliability has been shown for a sample of 142 gay men (Cronbach's alpha = .92; Wagner et al., 1994). Internal consistency was high for the current samples (gay men α = .91, lesbians α = .88, bisexual women α = .91).

The 4-item suicide subscale of the General Health Questionnaire (Goldberg & Hillier, 1979) assessed suicidal thoughts over the past few weeks. The participants answered two

items, “Felt that life isn’t worth living”, and “Found yourself wishing you were away from it all”, using the options 0 = *Not at all,* 1 = *No more than usual,* 2 = *Rather more than usual,* and 3 = *Much more than usual,* and two items, “Thought of the possibility that you might do away with yourself”, and “Found the idea of taking your own life kept coming into your mind”, using the options, 0 = *Definitely not, 1 = I don’t think so, 2 = Has crossed my mind,* and *3 = Definitely has*. Higher scores reflected increasing intensity of suicidal ideation (Goldney, Winefield, Tiggemann, Winefield, & Smith, 1989; Hamilton & Schweitzer, 2000). Scores on the suicide subscale correlated with hopelessness, a significant predictor of suicidal ideation (Goldney et al., 1989). The internal consistency of the suicide subscale (e.g., α = .89, Hamilton & Schweitzer, 2000; α =.79, McLaren & Challis, 2009) is acceptable in other samples. Internal consistency was high for the current samples (gay men α = .91, lesbians α = .94, bisexual women α = .93).

Procedure

Ethics approval was obtained from Federation University’s Human Research Ethics Committee. Participation was voluntary and this was explained to potential participants in the cover letter and during the course of speaking with them. Nearly all participants completed the questionnaire at the place of recruitment, and upon returning the completed questionnaires, received a bag of lollies (AUS$2.00). Some participants took additional questionnaires for distribution to people who did not attend social gatherings. These questionnaires were returned to the researcher via a reply paid envelop.

Data Analysis

Models were calculated separately for each group. The additive and moderation effects were examined using hierarchical regression analysis. Internalized homophobia and depressive symptoms were entered at Step 1. At Step 2, the interaction term (internalized homophobia x depressive symptoms) was entered. Prior to calculating interaction terms for

the hierarchical regressions, the internalized homophobia and depressive symptoms terms were centred using the mean-deviation method (Tabachnick & Fidell, 1996). These new centred scores were then multiplied together to create the new interaction term. Centering scores minimizes inflating standard errors of the regression coefficients (Jaccard, Turrisi, & Wan, 1990) and addresses the issue of multicollinearity (Cronbach, 1987).

The mediation model was tested using three regression equations. In equation one, the criterion (suicidal ideation) was regressed on the predictor (internalized homophobia). In equation two, the mediator (depressive symptoms) was regressed on the predictor. In equation three, the criterion was regressed on the predictor and the mediator simultaneously. As recommended by Baron and Kenny (1986), mediation was inferred if the predictor had an effect on the criterion (equation 1) and mediator (equation 2), and if equation 3 indicated that first, the mediator had an effect on the criterion, and second, the effect of the predictor on criterion was either significant but less than that found for this relation in equation 1 (partial mediation), or less and not significant (full mediation). The Sobel Test (Sobel, 1982) was used to verify full or partial mediation.

Results

Means and standard deviations for each variable, and correlations between variables, for each sample can be seen in Table 2.

Gay Men

From Table 2, it can be seen that higher levels of internalized homophobia were related to higher levels of depressive symptoms and suicidal ideation, and higher levels of depressive symptoms were related to higher levels of suicidal ideation. The results for the additive and moderation models can be seen in Table 3. At Step 1, internalized homophobia and depressive symptoms accounted for 46% of the variance in suicidal ideation scores. Results supported the additive model, with both internalized homophobia and depressive symptoms

predicting suicidal ideation. The addition of the interaction term at Step 2 failed to explain additional variance in suicidal ideation scores. The moderation model was therefore not supported.

The results for the mediation model can be seen in Table 4. Results indicated that the predictor variable (internalized homophobia) had an effect on the criterion (suicidal ideation) and the mediator (depressive symptoms). Further, the results from equation 3 indicate that the mediator and the predictor had an effect on the criterion. The beta value for the internalized homophobia was lower in equation 3 than in equation 1, suggesting a partial mediation model. The Sobel test indicated that the decrease in variance explained by internalized homophobia from equation 1 to equation 3 was significant ($z = 7.42$, $p < .001$). Results indicate a partial mediating effect of depressive symptoms on the relation of internalized homophobia to suicidal ideation.

Lesbians

From Table 2, it can be seen that higher levels of internalized homophobia were related to higher levels of depressive symptoms and suicidal ideation, and higher levels of depressive symptoms were related to higher levels of suicidal ideation. The results for the additive and moderation models can be seen in Table 3. At Step 1, internalized homophobia and depressive symptoms accounted for 45% of the variance in suicidal ideation scores. Only depressive symptoms predicted suicidal ideation, therefore the additive model was not supported. The addition of the interaction term at Step 2 explained an additional 1% of the variance in suicidal ideation. The moderation model was supported.

Figure 1 shows the internalized homophobia x depressive symptoms interaction effect. For the graph, the effects of internalized homophobia and depressive symptoms on suicidal ideation were plotted at three points: high, average and low. High, average and low values for both these measures were +1 *SD*, 0 *SD*, and -1 *SD* of their centred mean of zero.

The beta values were significant for high, $b = 0.03$, t (440) = 2.19, $p = .03$, and average, $b = 0.004$, t (444) = 17.09, $p < .001$, but not low, $b = -0.02$, t (440) = -1.31, $p > .05$, depressive symptoms. Higher levels of internalized homophobia were associated with higher levels of suicidal ideation for lesbians with high and average levels of depressive symptoms. In contrast, at low levels of depressive symptoms, there was no association between internalized homophobia and suicidal ideation.

From Table 4, it can be seen that internalized homophobia had an effect on suicidal ideation and depressive symptoms. Further, the results from equation 3 indicate that the mediator, depressive symptoms, had an effect on suicidal ideation, but that the predictor, internalized homophobia, was no longer significant. These results suggest support for full mediation, which was confirmed by the Sobel Test ($z = 5.94$, $p < .001$).

Bisexual Women

From Table 2, it can be seen that levels of internalized homophobia were unrelated to levels of depressive symptoms and suicidal ideation. Higher levels of depressive symptoms were related to higher levels of suicidal ideation. The results for the additive and moderation models can be seen in Table 3. At Step 1, internalized homophobia and depressive symptoms accounted for 34% of the variance in suicidal ideation scores. Results did not support the additive model, with only depressive symptoms predicting suicidal ideation. The addition of the interaction term at Step 2 failed to explain additional variance in suicidal ideation scores. The moderation model was therefore not supported.

From Table 4, it can be seen that internalized homophobia was not a significant predictor of suicidal ideation, therefore results do not support the mediation model.

Discussion

The study aimed to investigate the relationships between internalized homophobia, depressive symptoms, and suicidal ideation among GLB adults by testing three models.

Support for each model varied according to the gender and sexual orientation of the participants. For gay men, results supported the additive model and partial mediation model. For lesbians, results supported a full mediation model and the moderation model. In contrast, none of the models were supported for the bisexual women.

For gay men, the additive and mediation models helped explain how internalized homophobia and depressive symptoms are related to suicidal ideation. The additive model suggests that internalized homophobia and depressive symptoms are both independently related to suicidal ideation among gay men. This result is in contrast to Igartua et al. (2003), who found only depression to predict suicidal thoughts and behaviours in their sample of gay and lesbian adults. Analysing the data of gay men and lesbians together in one analysis may explain the different findings. Support for the partial mediation model implies that internalized homophobia is directly and indirectly related to suicidal ideation, via depressive symptoms, among gay men. Higher levels of internalized homophobia were related to higher levels of depressive symptoms, and, in turn, higher levels of depressive symptoms were related to higher levels of suicidal ideation.

For lesbians, the mediation and moderation models explained how internalized homophobia and depressive symptoms are related to suicidal ideation. Whereas a partial model was supported for gay men, a full mediation model was supported for lesbians. This means that the direct relationship between internalized homophobia and suicidal ideation was not significant, when depressive symptoms were taken in to account. This result is consistent with Igartua et al.'s (2003) finding. The support for the full mediation model indicated that higher levels of internalized homophobia were related to higher levels of depressive symptoms, and, in turn, higher levels of depressive symptoms were related to higher levels of suicidal ideation.

Support for the moderation model indicated that high and average levels of depressive symptoms strengthened the association between internalized homophobia and suicidal ideation among lesbians. Indeed, when lesbians reported low levels of depressive symptoms, the association between internalized homophobia and suicidal ideation was not significant. In other words, the relationship between internalized homophobia and suicidal ideation only existed for lesbians with high and average levels of depressive symptoms.

None of the models were supported for the sample of bisexual women. Indeed, for the bisexual women, internalized homophobia was not significantly related to depressive symptoms or suicidal ideation. The lack of support for any of the models may be explained by the possibility that the internalized homophobia scale may not have been relevant or appropriate for bisexual women. Further research investigating the relationships between internalized homophobia, depressive symptoms, and suicidal ideation among bisexual women is clearly warranted.

The results have implications for clinical practice. For gay men, there should be a focus on decreasing levels of internalized homophobia. Results imply that decreasing internalized homophobia should have a direct and independent effect on suicidal ideation, as well as an indirect effect via lower levels of depressive symptoms. For lesbians, there should be a focus on decreasing internalized homophobia, which should be related to reducing depressive symptoms. This goal of reducing depressive symptoms is significant, given that there was not a significant relationship between internalized homophobia and suicidal ideation among lesbians with low levels of depressive symptoms. Among bisexual women, this research suggests that lowering depressive symptoms would be directly associated with lower levels of suicidal ideation.

Kashubeck-West, Szymanski, and Meyer (2008) outline a number of interventions aimed at reducing internalized homophobia. For example, clinicians can work with individual

clients to assist them to understand the relationship between their internalized homophobia and living in a heterosexist society to reduce victim blame, and to encourage clients to join GLB community groups. Acceptance and Commitment Therapy has also been associated with a decrease in internalized homophobia and depression among a small sample of gay men and lesbians (Yadavaia & Hayes, 2012).

The results and implications of this study need to be considered in light of several limitations. A key limitation was the inability to attract enough bisexual men to participate in the study. It is unclear whether bisexual men attended the events at which recruitment took place, or whether they attended, but did not volunteer to participate in the research. It is clear that alternative methods of recruitment are needed if sufficient numbers of bisexual men are to be recruited to enable statistical analyses to be conducted. The sole use of self-report measures and the non-random selection of participants are other methodological issues of concern. The place of recruitment is also a limitation. It is likely that GLB adults who attend prominent GLB social events, such as community festivals, experience lower levels of internalized homophobia, depressive symptoms, and suicidal ideation. The results therefore can not be generalized to GLB adults who do not participate in GLB events. The cross sectional design of the study limits the conclusions that can be drawn from the results. In particular, causality can not be determined.

In summary, the interrelations among internalized homophobia, depressive symptoms, and suicidal ideation vary according to gender and sexual orientation. The study highlights the importance of testing models separately, as well as the difficulties in obtaining a sample of bisexual men sufficient to test models. Based on the results of this study, clinicians should focus on reducing internalized homophobia and depressive symptoms among gay men and lesbians, and depressive symptoms among bisexual women, in order to reduce suicidal ideation.

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Table 1

Demographic Data for Each Sample

	Gay Men		Lesbians		Bisexual Women	
	N	%	*N*	%	*N*	%
Relationship Status						
Partnered	185	51.4	284	64.0	51	44.7
Single	159	44.2	131	29.5	56	49.1
Married	2	0.6	17	3.8	0	0
Separated/Divorced	13	3.6	10	2.3	29	25.4
Widowed	1	0.3	2	0.5	42	36.8
Highest Level of Education						
Primary School	0	0	4	0.9	3	2.6
Secondary School	87	24.2	102	23.0	42	36.8
Trade Certificate	66	18.3	118	22.0	25	21.9
University Degree	207	57.5	220	49.5	44	38.6
Employment Status						
Full time	216	60.0	237	53.4	45	39.5
Part time	70	19.4	141	31.8	43	37.7
Unemployed	39	10.8	44	9.9	21	18.4
Retired	10	2.8	4	0.9	1	0.9
Other	25	6.9	18	4.1	4	3.5
Gross Income						
< $10,000	40	11.1	60	13.5	36	31.6

$10,000-$19,999	42	11.7	39	8.8	11	9.6
$20,000-$29,999	18	5.0	43	9.7	12	10.5
$30,000-$39,999	49	13.6	62	14.0	16	14.0
$40,000-$49,999	49	13.6	62	14.0	16	14.0
$50,000-$59,999	45	12.5	70	15.8	8	7.0
$60,000-$69,999	32	8.9	38	8.6	7	6.1
> $70,000	85	23.6	70	15.8	8	7.0

Table 2

Relationships Between Internalized Homophobia, Depressive Symptoms, and Suicidal Ideation, and Mean Scores and Standard Deviations for the Three Samples

Variable	1	2	3	*M*	*SD*
Gay Men					
1. Internalized Homophobia	-	.41***	.36***	38.56	13.38
2. Depressive Symptoms		-	.67***	14.96	11.15
3. Suicidal ideation			-	1.76	2.71
Lesbians					
1. Internalized Homophobia	-	.38***	.29***	34.59	11.60
2. Depressive Symptoms		-	.68***	14.96	11.84
3. Suicidal ideation			-	1.74	3.07
Bisexual Women					
1. Internalized Homophobia	-	.12	.18	40.11	12.59
2. Depressive Symptoms		-	.60***	19.11	11.91
3. Suicidal ideation			-	2.69	3.53

*$p < .05$. **$p < .01$. ***$p < .001$.

Table 3

Results of the Hierarchal Regression Analyses Testing the Additive and Moderation Models

	Gay Men		Lesbians		Bisexual Women	
Variable	ΔR^2	β	ΔR^2	β	ΔR^2	β
Step 1	.46***		.46***		.37***	
IH		.11*		.04		.10
Depression		.63***		.66***		.58***
Step 2	.00		.01**		.00	
IH x Depression		.06		.10**		-.03

Note. IH = Internalized homophobia.

*p < .05. **p < .01. ***p < .001.

Table 4

Results of Regression Analyses Testing the Mediation Model

		Gay Men	Lesbians	Bisexual Women
		B	*B*	*B*
Equation 1: SI on	IH	0.07***	0.08***	0.05
R^2		.36	.08	.03
F		54.71***	40.03***	3.55
Equation 2: Dep on	IH	0.34***	0.39***	0.12
R^2		.17	.14	.02
F		71.23***	74.52***	1.70
Equation 3: SI on	IH	0.02*	0.01	0.03
	Dep	0.15***	0.17***	0.17***
R^2		.46	.46	.37
F		151.60***	185.44***	32.08

Note. SI = Suicidal Ideation. IH = Internalized Homophobia. Dep = Depressive Symptoms.

*$p < .05$. **$p < .01$. ***$p < .001$.

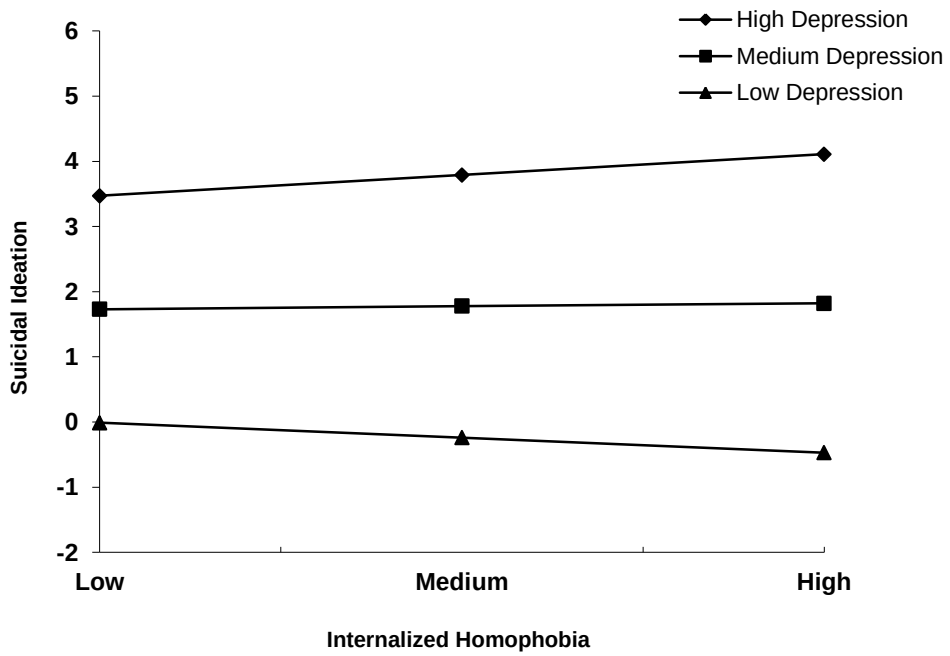

Figure 1. The interaction effect of internalized homophobia x depressive symptoms on suicidal ideation among lesbians.