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Does internalized homonegativity cause depression in lesbian, gay, and bisexual individuals?

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DOES INTERNALIZED HOMONEGATIVITY CAUSE DEPRESSION IN LESBIAN, GAY, AND BISEXUAL INDIVIDUALS?

A Project

Presented to the

Faculty of

California State University,

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In Partial Fulfillment

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Master of Social Work

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ABSTRACT

This paper investigates the effects of internalized homonegativity on the mental health of lesbian, gay, and bisexual (LGB) people. Specifically, does internalized homonegativity cause depression? Past research indicates a higher risk of mental health issues amongst LGB individuals when compared to the heterosexual individuals. This paper discusses the bio-psycho-social factors that may lead to internalized homonegativity and how internalized homonegativity is formed. Using a quantitative methodology and a convenience sample of 20 males, 257 females, and 2 gender non-conformant participants (ages 18 and older) who attend California State University San Bernardino and or have a Facebook account, participants completed an electronic survey that measured levels of internalized homonegativity and depression. The results indicated medium to high levels of internalized homonegativity and low levels of depression thus no correlation between internalized homonegativity and depression was found. Implications for preventions and interventions at the macro, mezzo, and micro level are discussed.

ACKNOWLEDGMENTS

I would like to thank God for blessing me with a wonderful circle of support. If it wasn't for my family, my partner and friends I do not think I could have made it through this long educational career. I dedicate this thesis to both those who have devoted their lives towards achieving equality for all and to those who have been victims of discrimination and or oppression.

It is with great pride that I honorably wear my last name "Garfias" and self-identify as lesbian. I owe everything I have, and have accomplished (Masters in Social Work) to my family, friends, and my beautiful LGBT community, for they have been my driving force.

Credo: "I can't for the life of me imagine that God will say, 'I will punish you because you are black, you should have been white; I will punish you because you are a woman, you should have been a man; I will punish you because you are homosexual, you ought to have been heterosexual.' I can't for the life of me believe that is how God sees things." -Archbishop Desmond Tutu

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CHAPTER ONE

INTRODUCTION

This paper focuses on the impact that internalized homonegativity has on the mental health of lesbian, gay, and bisexual (LGB) individuals. To be specific, this paper seeks to investigate if internalized homonegativity is correlated to depression. This paper discusses the bio-psycho-social factors that may lead to internalized homonegativity and how internalized homonegativity is formed. Implications for preventions and interventions at the macro, mezzo, and micro level are discussed.

Definitions

LGBT people are those who self-identify as lesbian, gay, bisexuals and or transgendered. LGBT people report same-sex attractions, desires, and or engage in same-sex behavior (Russell, & McGuire, 2006, p. 647). *Transgender* is an umbrella term that is broadly used to describe people with gender identities, expressions or behaviors that differ from their biological sex (Haas, Eliason, Mays, Mathy, Cochran, et al., 2011). It is important to note that lesbian, gay, and bisexual (LGB) individuals are the focus of this paper. Throughout this paper many

articles use the acronym of LGBT; that is because the research included transgendered participants. There is not enough research on transgendered people as it relates to internalized homonegativity; for that reason transgendered people were not sampled in this study. Although, this paper discusses lesbian, gay, bisexual, and transgendered (LGBT) issues, it is important to keep in mind that the study only involves lesbian, gay, and bisexual (LGB) participants. The acronym LGB and LGBT may be used interchangeably throughout this paper.

Homonegativism is defined as "a multidimensional construct that focuses more clearly on the belief and value systems of prejudiced individuals and heterosexism" (Roderick, McCammon, Long, & Allred, 1998, p. 80). The terms "*internalized homonegativity*" will be used instead of the word "internalized homophobia" because internalized homonegativism indicates that there is an underlying belief that heterosexuality is the normal and natural way to be; while internalized homophobia emphasizes the affect of fear and disgust towards same-sex attraction (Williamson, 2000). *Internalized homonegativity* is formed when an LGBT individual internalize society's negative views of homosexuality

towards the self; this devaluation of the self, results in internal conflicts and poor self-regard. Internalized homonegativity is self-prejudice guided from societal views (Frost, & Meyer, 2009). *Heterosexism* is the cultural ideology that perpetuates stigma from values that are derived from the belief that heterosexual orientation is superior, while at the same time denies, and or denigrates, any non-heterosexual form of behavior, identity, relationship, or community (Meyer, 2003, p. 667).

Problem Statement

Past studies indicate that LGBT people are at an elevated risk of physical, psychological and mental health issues (Allen, 2001:Anetzberger, Ishler, Mostade, & Blair, 2004:Cass, 1979:Ciliberto, & Ferrari, 2009: Igartua, Gill, & Montoro, 2003: Frost, & Meyer, 2009:Greenwood, & Gruskin, 2007:Marszalek, Cashwell, Dunn, & Heard, 2004:Meyer, 2003: Meyer, & Dean, 1998: Moradi, Van den Berg,& Epting, 2009: Roderick, McCammon, Long, & Allred, 1998: Russell, & McGuire, 2006: Rutter, 2008: Spinardi-Pirozzi, 2009: Stall, & Wiley,1988: Szymanski, & Carr, 2008: Williamson, 2000). It is

hypothesized that internalized homonegativity is the main contributor of the elevated risk of mental health issues found in some LGBT youth (Meyer, & Dean, 1998). Most of those who self-identify as LGBT have internalized homonegativity to some degree, and those who successfully overcome it lead much healthier lives and have a stronger sense of self-concept (Frost, & Meyer, 2009).

Internalized Homonegativity

Internalized homonegativity is known to be the single greatest obstacle for an LGBT individual to develop a positive identity (Allen, 2001). Those who suffer from internalized homonegativity are known to have elevated levels of isolation, hopelessness, poor coping strategies, and negative self-evaluation (Allen, 2001: Hershberger, & D'Augelli, 1995:Igartua, Gill, & Montoro, 2003: Rutter, 2008: Szymanski, & Carr, 2008: Williamson, 2000). This is caused by the feeling of alienation, and lack of support an LGBT feels, once they acknowledge that their views do not match those of the dominant culture (Moon, Fornili, & O'Briant, 2007). In extreme cases such internalized homonegativity can lead to a denial of one's

sexual orientation, which can lead to high levels of psychopathology (Frost, & Meyer, 2009).

Social Injustice

While North America has advanced in the attempt to grant LGBT people the same basic human rights that heterosexual individuals have, oppression continues to be personified through politics. Homonegativism is personified by physical displays of discrimination that are enacted by our society as impacts on civil and legal rights. Those civil and legal rights discriminate against LGBT individuals by banning gay marriages, criminalizing same-sex activity, prohibiting of gay adoption, and the denying of partnership benefits (Anetzberger, Ishler, Mostade, & Blair, 2004; Harper, & Schneider,2003). Not only do these laws criminalize same-sex partners and add to the internalization of homonegativity, but they also make it easier to discriminate against LGB individuals by conveying the message that it is okay to deny LGBT of "heterosexual privileges" such as employment, housing, etc. (Harper, & Schneider, 2003).

Current civil and legal rights are not set in concrete; they are subject to change. Social workers are

bound by the code of ethics to take an active stand against social and legal oppression, especially as it relates to vulnerable populations such as LGBT persons. The code of ethics for social workers states

> Social workers should engage in social and political action that seeks to ensure that all people have equal access to the resources, employment, services, and opportunities they require to meet their basic human needs and to develop fully. Social workers should be aware of the impact of the political arena on practice and should advocate for changes in policy and legislation to improve social conditions in order to meet basic human needs and promote social justice. (Workers, 2008)

Thus it is important that social workers advocate for a change in laws, legislation, and or policies; and doing so may reduce the psychological stress felt by LGBT individuals. Mental health practitioners should use their training as advocates and researchers to effectively intervene at the macro, mezzo, and micro level (Rostosky, & Riggle, 2011).

Furthermore, according to a recent demographic study, there are approximately four million LGBT

Americans in the United States (Black, Gates, Sanders, & Taylor, 2000). Four million is a significant number and a hard population to ignore. Anyone who is concerned with social justice and delivery of services with commitment to diversity would be concerned about this issue. Such people are: social workers, health practitioners, human service agencies, special interest groups, and or anyone else who is interested in disparities and or oppression.

Current Lesbian, Gay, and Bisexual Literature

Although research on the LGBT population exists, most research is focused on HIV/AIDS (Van Voorhis & Wagner, 2002). More specifically, according to Van Voorhis and Wagner (2002), who studied article reviews, about 2/3 of literature that was published by four major social work journals focused on HIV/AIDS and most of the other research was written with a problem-orientated view. The authors stated that little research is focused on the concept of homonegativism and or interventions. In addition, among all of those articles, none discussed mental health practice as it related to the LGBT elderly population. The author strongly believes that more

research is needed in the areas of community strengths and social justice (Van Voorhis, & Wagner, 2002).

As illustrated above, mental health professions should advocate on behalf of the LGBT population's civil and legal rights. Mental health researchers should focus on internalized homonegativity and its consequences so that this could lead to better preventions and interventions. Unfortunately, not many mental health professionals are advocating and or are researching on behalf of the LGBT population; all of these short comings then affect the way mental health services are provided. If mental health professionals are not aware of the injustice that civil and legal laws are causing their LGBT clients, and if they are not aware of the impact oppression has on internalized homonegativity, and or of preventative and or effective interventions, how could adequate services be provided to the LGBT population?

Need for Cultural Competence

Consequently, some existing research focuses on the mental health professionals' lack of knowledge as it relates to LGBT development, past psychological "cures" and how that relates to sensitivity needs, internalized

homonegativity, preventions and or interventions (Long & Serovich, 2003; Russell et al, 2006; Willging, Salvador, & Kano, 2006; Williamson, 2000). Reviewing literature stemming from different mental health disciplines, such as psychology, social work, and marriage and family therapist, it is found that many professionals are not adequately equipped to effectively provide services to the LGBT population (Long & Serovich, 2003; Russell et al, 2006; Willging, Salvador, & Kano, 2006).

Among those articles, one article that specifically examines Marriage Family Therapist's (MFT) preparedness to serve the LGBT population found that most MFTs are more willing than they are capable to serve LGBT individuals. More specifically, this article stated that clinical issues can even arise from knowledgeable therapists. The issues arise when the therapist tries to apply theories and previous knowledge to an LGBT individual without having understood in depth their situation and all the factors that come into play for a member of the LGBT community such as the environmental factors and or LGBT developmental factors (Long & Serovich, 2003). The authors of this article stated that even though the Commission of Accreditation of Marriage

Family Therapist Education (COAMFTE) called for integration of LGBT content into MFT curriculum programs, many researcher question MFT's preparedness to serve the LGBT population (Long & Serovich, 2003).

Among the researchers that believe mental health practitioners lack the knowledge it takes to adequately serve LGBT clients, are researchers that focus on cultural relevance and sensitivity needs. Authors Willging, Salvador, and Kano (2006) interviewed 20 clinicians from a rural clinical setting and found that clinicians believed that there is no difference between their LGBT clients and their non-LGBT clients. Clinicians who were interviewed well-intentionally said that "everyone deserves and can receive the same quality of services" (Willging, Salvador, & Kano, 2006, p. 867). The authors suggest that this kind of therapeutic neutrality projects detrimental consequences onto the LGBT clients. Therapeutic neutrality also interferes with the clinician's ability to deliver culturally relevant services to their LGBT clients. The author found that although the clinicians claimed to accept their LGBT clients they lacked education about LGBT mental health

issues, they offered their clients homophobic influenced services, and even denied services to LGBT clients.

Further analysis of this article revealed that the some of the clinicians assumed heterosexual orientation for all their clients. The author goes into further detail by stating that one of the clinicians laughed in disbelief when his client disclosed his sexual orientation as gay. Another LGBT client stated she felt as if the clinician blamed her for "deciding" to be in an interracial relationship with another woman. The client then stated that his comment made her feel depressed and discouraged to seek care. Although mental health professions and disciplines value cultural competence and condemn anti-gay statements and or reparative therapy, one of the 20 clinicians stated that many of his colleagues made anti-gay statements to their LGBT clients such as "if you'd get over that, things would fall into place" (Willging, Salvador, & Kano, 2006). The interview's summary was full of other alarming maltreatments of LGBT clients. In conclusion, the authors of this article blame the lack of explicit policy, the lack of LGBT education and the lack of heterosexist awareness for the inadequate services that were provided

to the LGBT clients of this study (Willging, Salvador, & Kano, 2006).

Furthermore, some researchers have expressed concern over the lack of sufficient research on the concept of internalized homonegativity. "Internalized homophobia as a psychological phenomenon has little systematic research despite its destructive impact on the mental health of the gay community" (Williamson, 2000, p. 104). While there is need for more research on internalized homonegativity there is also a need for more systematic preventions and interventions. Thus it is important to emphasize the problem, raise awareness, and advocate on behalf of the oppressed, LGBT population. The more research and attention this matter receives, the greater the likelihood that this population will receive appropriate mental health care such as effective measures to prevention and interventions. It is worth noting that although more research is needed regarding the negative consequences of internalized homonegativity, new mental health studies suggest that looking at the LGBT community's resiliency and coping mechanisms is as important (Harper, & Schneider, 2003).

Purpose of the Study

This paper seeks to investigate the effects of internalized homonegativity on the mental health of LGB individuals. Past research has indicated that LGB individuals suffer from an array of mental health issues due to the prolonged and increased psychological stressors faced compared to their heterosexual counterparts (Safren, & Heimberg, 1999). Such mental health issues consist of substance abuse, schizophrenia, bi-polar, suicidal ideation, self-mutilation, etc. (Frost, & Meyer, 2009; Marszalek, Cashwell, Dunn, & Heard, 2004; Meyer, 2003; Meyer, & Dean, 1998; Moradi, Van den Berg,& Epting, 2009; Roderick, McCammon, Long, & Allred, 1998; Russell, & McGuire, 2006; Rutter, 2008; Spinardi-Pirozzi, 2009; Szymanski, & Carr, 2008).

This paper will specifically focus on mental health in terms of depression. This study will seek to answer whether or not internalized homonegativity is correlated with depression. LGB individuals are considered a vulnerable population in the field of mental health. They are considered vulnerable because they have suffered oppression for many years. Health disparities are also seen in this population and such disparities are also

seen as a cause of oppression. Oppression has not only caused health and mental health risks for the LGB population, but it has also created civil and legal laws that rob the population of important human rights.

Thus this study aims to establish the severity of these issues so that awareness is increased and better preventions and interventions can be generated at the micro, mezzo, and macro level. This study provides the reader with information regarding LGB individual's developmental processes, the impact of heterosexism on the LGB individual's identity formation, and Allport's theory of traits due to victimization. This study attempts to explain how LGB individuals internalize homonegativity.

Because this study is interested in measuring how much, if any, levels of internalized homonegativity and depression exist in many LGB individuals, the study conducted uses a quantitative methodology. The data needed to test this hypothesis can be measured by asking narrow and specific questions thus a quantitative study seems appropriate. An electronic survey was given to a convenience sample of students who attend California State University of San Bernardino. The study was also

advertised on Facebook.com, a well-known social networking site (Facebook, 2011).

Significance of the Project for Social Work

Clearly, the oppression of the LGB population affects LGB individuals on macro, mezzo, and micro levels. As stated in the previous paragraphs LGB individuals face civil and legal oppression, they are underrepresented in terms of prevention and intervention research, and they are being neglected and or given substandard services. It is imperative that social workers use their training and education to advocate and or intervene for this vulnerable population.

Social workers can advocate for LGB individuals on a macro level by promoting change on a societal and or global level. Macro change can be achieved by voting, protest campaigns, and or lobbying on behalf of LGB individuals. Changes on the mezzo level can be accomplished by advocating for change at the community, agency, and work place. Mezzo level advocacy can be done by a social worker by adding to the body of LGB research. An example of community advocacy is participation in and supporting LGBT events. An example of agency advocacy

would be something such as promoting the implementation of gender neutral language. An example of advocacy in the work place would be something simple such as displaying an "equality" logo or sticker in the lunch area.

Micro level advocacy can be done by any mental health practitioner, assuming that they are open to learning about heterosexual biases and LGB education. As research has indicated most mental health professionals assume that they are effective in servicing the LGB population but in fact are not (Long & Serovich, 2003; Russell et al., 2006; Willging, Salvador, & Kano, 2006; Williamson, 2000). Research shows that higher levels of LGB-related education lead to more effective cultural competence practice (Russell et al., 2006). Thus mental health practitioners who are understand the specific needs of LGB individuals can help restore justice by advocating on behalf their behave.

Some research states that Masters in Social Work (MSW) schools are not effectively doing their part to teach their students enough about LGB education and or cultural competence (Van Den Berg & Crisp, 2004). More so, research has indicated the need for a more comprehensive education in social work programs. More

specifically, there is research that focuses on the fact that the Council on Social Work Education (CSWE) fails to define the application of cultural competence with LGBT people (Van Den Berg & Crisp, 2004). If the CSWE is not mandating specific guidelines as to what schools must teach upcoming social workers, it is more than feasible that social workers are not receiving the appropriate education when it comes to serving the LGB population.

It is imperative that social workers are educated in LGBT issues because they may sooner or later have to encounter a person and or client who self-identifies as a member of the LGBT community. By knowing the consequences of homonegativism and internalized homonegativity, social workers will become more culturally competent. Studies regarding internalized homonegativity, like this one, can help bring attention to the unattended problems LGBT people face.

In summary, this paper strives to highlight the social work areas that need attention so that the social work profession as a whole can be more effective in fighting for social justice and for their LGB clients' well-being. This paper aims to inform the assessing phase found in the generalist model of social work. The

objective of this paper is to assess if internalized homonegativity causes depression in LGB adults and to briefly discuss prevention and intervention strategies for the macro, mezzo, and micro level.

CHAPTER TWO

LITERATURE REVIEW

Introduction

To fully understand how homonegativism is developed it is helpful to first understand the context of heterosexism. It is helpful to recognize that most people's perception of right and wrong comes from what they perceive as "normal and not normal". Everyone, in the North American culture, are raised in a heterosexist world, thus it is "wrong" to be different (LGBT). Since childhood, they are sent messages, via advertisement, media, and role modeling that heterosexuality is the "right sexuality" (Butler, 2009). The beliefs that homosexuality is unnatural and immoral are reinforced by societal norms and religious believes, but homosexuality is found in most species (Bagemihl, 1999). Thus the notion of homonegativism seems to be socially constructed, however political and historical events can reinforce this belief.

Historically, homosexuality was believed to be a mental illness and it was categorized as such in the *Diagnostic and Statistical Manual*. Although it was later

removed as a mental disorder in 1973, the stigma still haunts the LGBT community (Butler, 2009). Many researchers believe that internalizing homonegativity is inevitable since children are exposed to heterosexism very early on (Williamson, 2000). The following paragraphs will discuss how heterosexism, gender roles, and homonegativism can lead to internalized homonegativity. In addition, previous literature regarding internalized homonegativity and mental health is discussed.

Gender Roles

Equally as important, one must understand the importance of gender roles in order to fully grasp the concept of heterosexism and homonegativism. Gender roles guide men and women's' behavior. Gender roles set gender expectations in today's society. Gender roles must be followed in order to be considered normal. Since heterosexism is considered to be the legitimate sexual orientation, traditional gender norms are gender norms guided by heterosexism (Ciliberto & Ferrari, 2009). Research indicates that the expectation that everyone must follow traditional gender roles can cause negative

consequences to LGB individuals' mental health (Szymanski & Carr, 2008). Mental health consequences experienced by LGB individuals come from both the external and internal oppression LGB individuals face when they do not conform to traditional gender roles.

To be more specific, an article found psychological distress in both gay and bisexual men. According to this article, psychological distress was defined as depression, anxiety, intrapersonal sensitivity, and or obsessive compulsive disorder (Szymanski & Carr, 2008). Psychological distress occurs when gay or bisexual men internalize the rigidity of gender roles, which tell them "how a man should act". That internalization then results in personal restriction, and or devaluation of the self and or others (Szymanski & Carr, 2008).

In addition, this article indicates findings that suggest that those who have conflicting gender roles have negative self-esteem; those who have negative self-esteem are shown to use avoidant coping strategies. The use of avoidant coping strategies can result in poorer mental health (Szymanski & Carr, 2008). Gender roles have a lot to do with the way people view themselves. When an LGB individuals gender roles conflict with traditional gender

roles their risks of depression are elevated (Szymanski & Carr, 2008).

Theories Guiding Conceptualization

Taking into consideration the concept of heterosexism and society's emphasis on gender roles, it is also important to discuss homosexual development and Theory of Traits due to Victimization in order to fully understand the concept of internalized homonegativity and its consequences. According to Cass, there are six different stages required for an LGB individual to develop a healthy sense of self. The stages are as follows, in sequential order; identity confusion, identity comparison, identity tolerance, identity acceptance, identity pride, and identity synthesis. The following is a short example of the stages using a made-up character named "Mario" to demonstrate these stages.

Theory of Homosexual Development

Identify confusion: Mario believes he may be attracted to men, but society tell him that homosexuality is wrong thus Mario does not know what to make of his feelings towards men. Identity comparison: Mario grows

more and more aware of his feelings for men. There is no doubt that he is attracted to men, yet he keeps comparing how he feels to how he "should feel". Identity tolerance: Mario stops questioning himself, stops comparing himself and begins to tolerate the fact that he is attracted to men. Identity acceptance: at this stage, Mario is able to accept the fact that he is gay and is able to disclose it, if he wishes to. Identity pride: Mario no longer feels shameful for being gay; he feels proud. Identity synthesis: Mario is able to accept that being gay is a part of his life and not his entire life. He can describe himself to anyone by naming others aspects of his life such as "college graduate, son, and baseball player" amongst being gay.

Cass acknowledges that not all LGB individuals go through all phases due to varying differences in their environment. In addition, Cass states that an LGB individual identity may not reach synthesis, healthy identity, due to identity foreclosure. If identity foreclosure happens early on and does not reach identity tolerance, personal conflict may arise. Personal conflict is known to cause psychological distress (Marszalek, Cashwell, Dunn, & Heard, 2004).

It is important to remember that developmental courses interact with each stage. If an LGB individual faces strong cognitive conflict such as negative feelings, thoughts and emotions about being gay, that individual may find the experience overwhelming and his or identity may come to a foreclosure causing negative self-regard (Marszalek, Cashwell, Dunn, & Heard, 2004). As mentioned earlier negative feelings, thoughts and emotions about being gay are generated by heterosexism and homonegativism (Butler, 2009) Negative self-regard is known to lead internalized homonegativity (Frost, & Meyer, 2009).

Theory of Traits Due to Victimization

Consequently, Gordon Allport's theory of "Traits due to Victimization" is used to explain how homonegativism is internalized by members of the LGB population. Allport is known for his work *The Nature of Prejudice* published in 1954. Allport studied the dynamics of what drives prejudice and victimization. According to Allport's theory of traits due to victimization, stigmatized individuals, such as LGBT members, respond to the conflict in a flight or fight fashion. In order to cope

with the prejudice being experienced LGBT people engage in one of the two defense reactions. LGBT people will either use their extroverted defense mechanism or their introverted defense mechanism. An individual who uses their extroverted defense mechanism will show exaggerated or obsessive concern with the stigmatizing characteristic. The introverted mechanisms are more closely related to what we now know as internalized homonegativism (Williamson, 2000). An individual who uses their introverted defense mechanism will suffer from self-denigration and will identify with the aggressor. Identification with the aggressor may look like the following statement "they are right, I am what they say I am, I am worthless and perverted".

Internalize Homonegativity and Mental Health Issues

Depression

All the information presented above explains how heterosexism and homonegativism can cause an LGBT individual to internalize homonegativity. Most LGBT literature that exists and relates to mental health, indicates that the LGBT population has a higher prevalence of mental health issues, including depression,

when compared to heterosexuals, however it is important to distinguish that from the actual classification of LGBT as a mental disorder. Most of the literature found blames the elevated risk on heterosexism, internalized homonegativism and or minority stress. According to Meyer, LGBT people are more prone mental health issues, including depression, due to the stressful environment they have to live in. This environment is made stressful because of all of the discrimination, alienation, stigma, and prejudice towards minority populations such as the LGBT population (Meyer, 2003).

Suicide Ideation

Past research has shown that internalized homonegativity can lead to low self-esteem, depression, and or suicide ideation. When depression becomes severe some individuals start to have suicidal ideation. LGBT individuals have elevated risks of suicide when compared to their heterosexual counterparts. In a study conducted by Moon, Fornili, and O'Briant (2007) researchers found LGB people to have a suicide rate of 28% males and 21% females compared to the 15% females and 4% males in the heterosexual community (Moon, Fornili, & O'Briant, 2007). Some researchers have even said that internalized

homonegativity is the most insidious stress an LGBT individual can experience (Moradi, Van den Berg, & Epting, 2009, p. 121).

Anxiety

Society's views about the LGB individuals may cause the LGB individuals to manifest these thoughts into identity self-fragmentation and self-hatred which may lead to an elevated risk in the mental health of LGB individuals. Research by Igartua, Gill, and Montoro (2003) studied a sample of 220 participants in order to try and find out if internalize homonegativity can predict depressive, and or anxious symptomology. The results indicated that internalized homonegativity accounted for 18% of depressive symptoms and 13% of anxious symptoms. Those findings do not sound pervasive; however the authors discussed several limitations that might have caused a lower prevalence than expected.

Furthermore, results from a different study indicate that environmental factors are to blame for LGBT individual's elevated psychological distress (Safren & Heimberg, 1999). Safren and Heimberg (1999) conducted a study with both LGB and heterosexual participants. Researchers wanted to account for the reasons why there

is such a huge discrepancy in the mental health, depression and hopelessness, of LGB individuals and heterosexual individuals. Results indicated that when psychosocial variables were accounted for, the discrepancy of mental health issues between homosexuals and heterosexuals significantly lowered. In conclusion, these researchers suggest that the discrepancy between LGB individuals and heterosexual individuals stems largely from environmental factors and stigma, and it suggests that preventative factors be considered (Safren & Heimberg, 1999).

Substance Abuse

Nonetheless, some researchers have focused their research on the LGBT population and substance abuse. Internalized homonegativity has been shown to cause or increase LGB individuals' substance abuse problems. According to an article where researchers conducted a college study researchers it was that on average LGB college students drank significantly more than their heterosexual peers (Spinardi-Pirozzi, 2009).

A different researcher, who has an interest in health disparities, stated that it made sense that the LGBT community had an elevated use of tobacco and alcohol

compared to the heterosexual population because LGBT people are exposed to more stigmas through their life time and because most LGBT-friendly places are bars and clubs (Greenwood, & Gruskin, 2007). It is widely known that LGBT people can visit "gay clubs" to feel a sense of belonging and acceptance (Greenwood & Gruskin, 2007). Thus the author suggested that LGBT individuals learned to socially drink and inevitably use alcohol as a coping mechanism (Greenwood & Gruskin, 2007). Some LGBT individuals attempt to cope with stigma and or depression by using substances (Greenwood & Gruskin, 2007).

The author also stated that co-morbidity rates, substance abuse, and depression, among the LGBT population are higher when compared to the heterosexual population. In addition, this article stated that tobacco and alcohol companies advertise their acceptance of the LGBT population and target the LGBT population frequently in their advertisements. While a study by Stall and Wiley, (1988) concluded that gay and bisexual men did not drink more frequently than heterosexual men, they did however drink more heavily. All in all, most articles that found that LGBT individuals had a substance abuse problem concluded that such addictions may be stemming

from the attempt to cope with stigma, low self-esteem, and or depression (Greenwood & Gruskin, 2007; Spinardi-Pirozzi, 2009; Stall & Wiley, 1988).

Summary

In summary, heterosexism, homonegativism, social oppression, civil and legal laws are causing LGBT individuals to internalize homonegativism. Internalized homonegativity may be causing elevated mental health risk for LGBT individuals. Many mental health practitioners are not equipped to adequately provide services to LGBT individuals. Furthermore some MSW programs are failing to adequately train MSW students. All of these short-comings lead to a recipe for disaster and serve to maintain physical and mental health disparities. There is an apparent need for preventions and interventions at the macro, mezzo, and micro level.

CHAPTER THREE

METHODS

The purpose of this study is to investigate the effects of internalized homonegativity on the mental health of lesbian, gay, and bisexual (LGB) people. As previously stated, past research indicates a higher risk of mental health issues amongst LGB individuals when compared to heterosexual individuals. This study specifically focused on mental health in terms of depression. This study sought to answer whether or not internalized homonegativity is correlated with depression.

This study used a quantitative method to try and understand how internalized homonegativity affects the mental health of an LGB individual. The data needed to test this hypothesis can be measured by asking narrow and specific questions, thus a quantitative study seemed appropriate and was used. A convenience sample of those who attend California State University San Bernardino and individual who use Facebook was used.

Participants were asked to complete an electronic survey posted on SurveyMokey.com (2012) that measured

their levels, if any, of internalized homonegativity, and depression (appendix A). Surveys were administered to participants via an electronic survey because an electronic survey could facilitate the process for those who are "closeted" to take the survey. Those who are "closeted" are people who identify as LGBT, but have chosen to disclose their identity to a select few or no one at all (Frost & Meyer, 2009). Quantitative methods are known to be useful in keeping data anonymous; since members of the LGB community are known to be stigmatized for identifying as a member, thus it was important to offer the participants the most anonymity as possible. By making the survey electronic versus administering the survey in a school setting, the participants got to access the survey more readily.

Some limitations to having the survey in electronic format are that the survey must be kept short in order to ensure full completion. Some research suggests that many who take electronic surveys expect incentives. Last, although many prefer internet based surveys because they are easier to access, some do not have internet access thus limiting the sample size and affecting the sample's representative efficacy. Furthermore, limitations for

using a quantitative method are that surveys have the limited ability to probe answers, and that one participant's answer may not represent the sample as a whole thus making the data seem biased.

Clearly then, this study aimed to answer the question "is internalized homonegativity correlated with depression?" It is hypothesized that higher levels of internalized homonegativity will lead to higher levels of depressive symptoms.

Sampling

A convenience sample of lesbian, gay, and bisexual (LGB) individuals who attended California State University San Bernardino (CSUSB) and of those who use Facebook was recruited to participate in this study. Currently CSUSB has a student body composed of 17,500 or more students. CSUSB is known for its ethnically diverse population. There is no majority ethnic group on campus because of the vast diversity (California State University, San Bernardino, 2011). Having a large number of students and a diverse representation makes the sample study more representative of the general population.

CSUSB has many programs and clubs for people who identify as lesbian, gay, bisexual and transgendered (LGBT) individuals, such as the Pride Center, the Gay Straight Alliance, and counseling services specifically design for LGB individuals; thus it was assumed that obtaining a representative sample was feasible. Because this study measures internalized homonegativity (a phenomenon identified with LGB individuals), participants were eligible to take the survey based on their identification as a lesbian, gay, and or bisexual individual.

Recent Facebook demographic studies indicate that approximately 19,041,160 Californians use Facebook, the social network (Facebook, 2011). Furthermore, poll studies indicate that LGB individuals use social networking sites more frequently than heterosexual individuals (Soto, 2006). Lesbians and gays reported nearly 32% weekly usage of social networking sites; that's nearly double the amount of heterosexuals reported use of 18% (Soto, 2006). The majority of members of Facebook are male (51.2%) and minority is female (48.8%). According to Facebook, the largest age groups of people who use Facebook fall under the ages of 26-34 (26.1 %),

the second largest age group being those who are 18-25 (25.8%). No demographic information regarding sexual orientation was found (Facebook, 2011). A total of 279 participants were surveyed. Participants were eighteen years of age or older.

Data Collection and Instruments

This study used a combination of two scales to measure the correlation between the independent variable and the dependent variables. The independent variable in this study is internalized homonegativity. The dependent variable is depression. Using a mixture of Beck's Depression Inventory Scale (Stulz & Crits-Christoph, 2010) and The Lesbian Health Survey (Weibley, 2009), an instrument was created for this study. Many scales that measure internalized homonegativity have been created and each varies from one another. There are many common constructs found in these scales. Most researchers have included the following constructs in their scale: visibility, morality, affirmations, connectedness, self-acceptance, judgment, disclosure, view of other LGB individuals, and or religion (Currie, Cunningham, &

Findlay, 2004; Mayfield, 2001; Meyer, 2003; Remafedi, Farrow, & Deisher, 1991).

The scale used to measure depression was the Beck's Depression Inventory Scale which asks the participants to rate their agreement to statements using a Likert-type scale. Depression levels are measured based on their total scores. If participants score in the range of 1-10, the symptoms are considered normal. If participants score in the range of 11-16, the symptoms are considered a mild disturbance. If participants score in the range of 21-31, the participants are considered moderately depressed. If participants score in the range of 31-40, the participants are considered severely depressed. And lastly, if participants score in the range of 40 and above, the participants are considered extremely depressed.

The scale used to measure internalized homonegativity in this study is The Lesbian Health Survey. Originally constructed by Weibley (2009), this scale asked 70 questions using four constructs: self-acceptance, judgment, visibility, and connectedness (Weibley, 2009). Each construct was assigned a group of questions that measures internalized homonegativity. For

example, in the construct of "visibility", participants were asked to rank their agreement with a question such as "I am comfortable discussing my same-sex partner in a public setting" (Weibley, 2009). Participants were asked to rank whether they highly agreed, agreed, disagreed or highly disagree to each statement on a four point Likert-type scale ranging from one for strongly agree to four for strongly disagree (Weibley, 2009). Responses that fall in the range of (1.0) are considered as low levels internalized homonegativity, responses under the range (1.1) to (1.9) are considered mild levels of internalized homonegativity, responses that fall in the range of (2.0) to (2.9) are considered medium levels of internalized homonegativity and lastly responses that fall in the category of (3.0) to (4.0) are considered high levels of internalized homonegativity (Weibley, 2009).

Procedures

Participants were recruited via advertisement on college bulletin boards. Participants were also recruited by soliciting participation via Facebook/internet announcements. Participants who visited the survey site were greeted with a short introduction, the survey's

purpose, information regarding voluntary participation, and expected time of completion. In addition, when participants entered the survey they were given an informed consent and they were informed of confidentiality and anonymity. No identifying information was collected from the participants. Participants were asked to take a 70-question survey that would take approximately 20 to 25 minutes to complete. Participants then completed the online survey. When participants finished their surveys they were presented with the debriefing form and resource list.

Although the researcher does not foresee any harm by asking the participants to take this survey, a resource list was given in the debriefing form after the completion of this survey just in case the information in the survey caused participants to experience painful memories and or emotions. This resource list listed the telephone numbers to agencies and peer support who can help participants get or seek professional help.

Protection of Human Subjects

The LGB population is considered a vulnerable population by the National Association of Social Work

thus it is important that participants' well-being be kept in mind at all times (Workers, 2008). This study design is one in which it is impossible to trace data or information back to the participant because no identifying information was asked of the participants. Furthermore, the data gathered from the participants will be kept secured in a locked file cabinet to which only the researcher will have access. The participants in this study were advised of anonymity and confidentially in the consent form. However, keeping in mind that this study might elicit painful memories and or emotions, the participants were debriefed and given a list of resources they could call if they felt they needed professional help or someone with who to talk.

Data Analysis

This study was primarily interested in figuring out if internalized homonegativity is correlated with depression. As previously stated homonegativism is a social construct phenomenon that posits that homosexuality is wrong and or immoral. Such perceptions can be internalized by LGB individuals and thus cause internalized homonegativity. As research has shown there

are many constructs that can be taken into account when considering the measurement of internalized homonegativity. This study chose to measure four constructs: self-acceptance, judgment, visibility, and connectedness (Weibley, 2009).

In order for a participant to be considered eligible to take this study, the participants had to fit the sexual orientation variable. However other variables such as gender, ethnicity, and or income were not considered criteria for eligibility. Since the instrument, The Lesbian Health Survey was primarily used on female participants; the researcher refined the language so that it could address both male and females. A *t* test, analysis of variance (ANOVA), and a Pearson correlation test a will determine significant findings. All in all, the data collected will further enhance knowledge related to the mental health of LGB individuals.

Summary

In summary, this study seeks to discover the association between internalized homonegativity and depression. This study samples an ethnically diverse population. This study keeps in mind the participants'

vulnerability and ensures participants well-being by keeping the study anonymous and giving participants a resource list if they need to contact professional help and or peer support.

CHAPTER FOUR

RESULTS

Introduction

The following will elaborate on the details and findings of this study; i.e. study details, sample characteristics, self-reported health measures, and findings related to internalized homonegativity and depression.

The survey was posted electronically from approximately 2/7/12 until approximately 3/7/12 during which 279 participants chose to participate. Originally, only lesbian, gay, and or bisexual individuals were recruited, but because of the amount of people who chose not to label themselves under any category the author took into account the category of label non-conformant. Thus this analysis is limited to men and woman who are or desire to be in a relationship with individuals of their same-sex.

Sample Characteristics

A total of 20 males, 257 females, and 2 gender non-conformant participants completed the study. Most of the participants of this study self-identified as lesbians

(73.3%), some identified as gay (7.9%), some identified as bisexual (15.7%) and others identified as label-non-conformant (2.9%). Most participants (62.4%) in the sample reported being in the age group of 21-29 years old. As for ethnicity, 4.3 % were African American, 3.6% were Asian, 66.8% were Hispanic, 1.1% were Native American, 16.1% were European American, 7.9% were of mixed race and the other 1% did not answer this question. As for education, 6.1% had less than a high school degree, 22.9% had a high school degree or equivalent, 39.3 % had some college, but no degree, 11.1% had an associate's degree, 12.2% had a bachelor's degree, 5.4% had a graduate school degree, 2.9% indicated "other schooling" as their level of education, and the other 1% did not answer this question.

Self-Reported Health Measures

Previous studies have found that lesbian, gay, and bisexual individuals have increased levels of anxiety, alcohol abuse, and depression when compared to their heterosexual counterparts (Frost, & Meyer, 2009; Marszalek, Cashwell, Dunn, & Heard, 2004; Meyer, 2003; Meyer, & Dean, 1998; Moradi, Van den Berg,& Epting, 2009; Roderick, McCammon, Long, & Allred, 1998; Russell, &

McGuire, 2006; Rutter, 2008; Spinardi-Pirozzi, 2009; Szymanski, & Carr, 2008).

Participants self-reported previously experiencing anxiety at a comparatively high rate, 33.9 %, when compared to those of the general population, 18.1% (National Institute of Mental Health, 2011). Although still higher than the general population, when asked about current symptoms of anxiety, the participants' anxiety levels lowered (19.6%).

Moreover, nearly twice the national average (16.8% versus 8.46) of the sampled population reported past alcohol abuse problems (The National Institute on Alcohol Abuse and Alcoholism, 2011). When asked about current alcohol abuse problems 4.3% reported having issues with alcohol abuse.

Furthermore, participants of this study self-reported an abnormally high rate of previously experienced depression 71.33% (SD = .453) when compared to the average prevalence of Americans (6.7%), (National Institute of Mental Health, 2011). Although still higher than the general population, when asked about current symptoms of depression, the participants' depression levels lowered 31.8% (SD = .466).

Even more troubling, 28.9% of participants self-reported that they have had suicidal ideation in the past, 4.6% self-reported current suicide ideation and 0.07% participants indicated that they "would kill themselves if they had the chance". These findings are consistent with past LGB research in that the levels of suicide ideation seemed to be alarmingly higher than those to the general population. According to the National Institute of Mental Health (2011), 3.7% of adults eighteen an older had had suicide ideation. Both past and current suicide ideology rates of participants of this study are higher than the average rates of the general population.

Internalized Homonegativity and Depression Findings

This study looked at the way various variables interacted with one another and found significance in some relationships. Greater importance was given to the following variables and relationships: internalized homonegativity, demographics, depression, connectedness and readiness to connect with the community.

Amongst the different variables, there were no significant differences between the responses of males and females on the Lesbian Health Survey (internalized

homonegativity scale) and Becks Depression Scale. There were no significant differences between males and females as it relates to anxiety depression, and alcohol abuse.

Furthermore, Participants that have had some college education experience have higher levels of connectedness when compared to participants who did not finish high school $f\ (6,227) = 2.305,\ p < .05)$. There were no other significant findings related to education and internalized homonegativity and or depression. There was no significant difference between age and internalized homonegativity and depression.

More than half of the population (68.9%) reported that they are connected to the community. This was measured by the amount of times participants attend Lesbian Gay and or Bisexual (LGB) functions. There were no significant differences between men and women as it relates to degree of community connectedness.

The average age in which participants came out to themselves was 14 years old (SD = 5.26), 16 years old when they came out to friends (SD = 4.84), and 18 years old when they came out to their family (SD = 4.23).

As previously mentioned, The Lesbian Health Survey is composed of four constructs, those constructs are as

follows: visibility, connectedness, self-acceptance, and judgment, of which the authors of the scale gave the most importance to "self-acceptance". Participants of this study on average scored a mean of 19 (SD = 2.34) on the sub-scale of visibility, meaning participants scored a medium level of internalized homonegativity on this sub scale. On average participants scored a mean of 24 (SD = 2.20) on the sub-scale of connectedness, meaning participants scored a medium level of internalized homonegativity on this sub scale. On average participants scored a mean of 22 (SD = 3.14) on the sub-scale of self-acceptance, meaning participants scored a high level of internalized homonegativity on this sub scale. Lastly, on average participants scored a mean of 45 (SD = 4.52) meaning participants scored a high level of internalized homonegativity on this subscale. Collectively, participants of this study scored medium to high levels of internalized homonegativity. Moreover, on average participants of this study scored a mean of 9 (SD = 10.1) meaning that the sample tested relatively normal, with little-to-no symptoms of depression. However, 4.8% of the participants scored moderate levels of depression, 1.2% scored severe levels of depression and 0.08 scored extreme

levels of depression. Those who scored extreme depression also indicated suicidal ideation.

A Pearson's correlation analysis indicated that there were no significant correlations between visibility, connectedness, judgment, and depression. However there was a significant correlation between self-acceptance and depression. Self-acceptance was negatively correlated with depression ($r = -.24$, $p < .001$). The more self-acceptance one has, the less likely they will experience depression.

Findings regarding the relationship between LGB self-reported (past and current) symptoms of anxiety, depression, and problems with alcohol abuse are consistent with earlier studies regarding LGB and their mental health.

In summary, a large percentage of the participants self-identified as Hispanic, lesbian, women. Past and current self-reported health measures indicate elevated rates of mental health issues when compared to the heterosexual population. Levels of internalized homophobia were not significantly correlated to levels of depression. Interpretations of findings are discussed in further detail below.

CHAPTER FIVE

DISCUSSION

The following section will seek to analyze and interpret the findings of the study. This study contributes to the underdeveloped field of research regarding internalized homonegativity and mental health (Weibley, 2009, p. 48). This study advances our understanding of mental health disparities, internalized homonegativity, levels of education, age, and connectedness along with its impact on lesbian, gay, and bisexual individuals. This discussion will first review and examine the significant findings of the present study.

The results of this study did not indicate a correlation between internalized homonegativity and depression. Levels of internalized homonegativity were on average medium to high and levels of depression were little-to-none. However, participants self-reported high levels of experiencing (past and current) symptoms of anxiety, alcohol abuse, depression and suicide ideology compared to their heterosexual counterparts. Thus these findings reinforce the notion that (LGB) individual have

elevated risks for mental health issues. While this may be due to matters of social justice, such as: reduced income, reluctance or distrust of health care providers, lack of resources, discrimination, and or institutionalized discrimination; this study hypothesized that mental health disparities were greatly influenced by internalized homonegativity.

More specifically, the question of interest in this study was: are symptoms of depression correlated with internalized homonegativity? This is what was found; self-acceptance was negatively correlated with depression. Meaning, the more an individual accepts themselves the less likely it is that they will experience symptoms of depression. This finding is consistent with the theory of homosexual identity development (Marszalek, Cashwell, Dunn, & Heard, 2004). According to Cass, there are six different stages required for an LGB individual to develop a healthy sense of self. The stages are as follows, in sequential order; identity confusion, identity comparison, identity tolerance, identity acceptance, identity pride, and identity synthesis. Cass stated that an LGB individual identity may not reach synthesis, healthy identity, due

to identity foreclosure. If identity foreclosure happens early on and does not reach identity tolerance, personal conflict may arise. Personal conflict is known to cause psychological distress (Marszalek, Cashwell, Dunn, & Heard, 2004). Thus explaining the importance of self-acceptance and how that relates to mental health issues, in this case depression.

Furthermore, results indicated that the higher education one has, the less likely it is that they will experience symptoms of depression. While this phenomenon can be accounted for by a variety of different factors, studies show that it may be due to protective factors, gender roles, and or coping mechanism (Levecque, Van Rossem, De Boyser, et al., 2011; Nicholson, & Long, 1990; Ross, & Mirowsky, 2006).

Past research indicates that higher levels of education may serve as a protective factor against depression (Ross & Mirowsky, 2006). Specifically, there are a number of studies that argue that this phenomenon is more prevalent amongst women. That is to say, higher levels of education act as protective factors for women (Levecque, Van Rossem, De Boyser, et al., 2011; Ross & Mirowsky, 2006). That phenomenon can be explained by The

Resource Substitution Theory which compares men and women and hypothesizes that education improves well-being more for women, because socioeconomic disadvantage makes them depend more on education to achieve well-being (Ross & irowsky, 2006, p. 1400). This theory places a great emphasis on a woman's social economic disadvantage, thus when considering an LGB individuals' equally distressing minority status one can hypothesize that a lesbian woman's double minority effect may heighten the protective factor that is explained by this theory. A double minority identity is an identity that encompasses more than one minority status identity (Chan, 1989).

This study's sample size was composed of 91.8% women thus it is likely that their education level (and or minority status) acted as a protective factor against symptoms of depression. Furthermore, it is likely that with more education comes more experiences (connectedness) with other diverse (similar) populations, information regarding heterosexism, homonegativity, and a sense of control (Ross & Mirowsky, 2006) all of which can serve as a protective factor against symptoms of depression. More research regarding education as a

protective factor is needed in the field of LGB and internalized homonegativity.

Limitations

There were a number of different limitations to this study. The following discussion will focus on the following limitations: sample comparisons, the majority ethnicity of the sample size, the scale used to measure internalized homonegativity, past and current depression, the length of the scale, and the use of internet as a procedure.

It is important to note that the sample in this study is significantly smaller than the sample used to compare national levels of mental health diagnoses. While this is a great limitation, these numbers help put disparities into perspective (National Institute of Mental Health, 2011).

Moving forward, the survey sample consisted of a high number of Hispanic women (67.0%) when compared to the Hispanic population in the United States (16%), (U.S. Census, 2011). This reduces the ability to make accurate conclusions about other groups of women. Thus future

research is needed among other majority groups, European Caucasian and African American.

One major limitation to this study was the use of The Lesbian Health Survey (Weibley, 2009) to measure levels of internalized homonegativity. Although Weibley stated that this scale was tested for internal reliability and validity and that it yielded favorable reliability and validity scores (Weibley, 2009, p. 48) three out of her four constructs did not measure significance. The three constructs that did not measure any significance were "Judgment, connectedness, and visibility". This can be due to the lack of significance of these three constructs found in this certain sample and lack of scale reliability or validity.

Furthermore, the scale used to measure internalized homonegativity was created to measure internalized homonegativity in lesbian or bisexual women. Thus generalizing this scale to men may not yield reliable or valid results. Although only 7.1% of participants identified as male, the findings cannot be generalized to the gay male population due to sample size and questionable reliability.

Additionally, the length of this study summed up to roughly ten pages including informed consent and debriefing. Electronically-based survey must be kept short in order to ensure completion. A total of 293 participants initiated the survey but only 279 completed the survey. Thus, a total of 14 participants did not finish the survey; this may be due to the length of the survey. The researcher combined two scales to measure both internalized homonegativity and depression. The finalized scaled was comprised of 70 questions total. Data collection indicated that most participants opted out of the survey after the first set of questions (The Lesbian Health Scale) and chose not to continue to the second set of questions (Becks Depression Scale). Thus future electronically-based surveys should be kept short in order to get the maximum response rate. Moreover, when measuring past symptoms of depression, the author asked the participants to choose between "yes" or "no", thus limiting the findings. Instead, participants should have been given a scale, such as a likert-scale, in which they could more accurately rate their past levels of depression.

Lastly, the use of an electronically-based survey may have excluded participants who have limited access and knowledge of computers. For example: individuals such as those with lower economics status, elderly individuals, and or non-English readers with monolingual proficiency. Thus researchers should consider using several different vehicles to contact hard to reach groups of the LGB population.

Recommendations for Social Work Practice, Policy and Research

This study provides insight regarding the relationship between internalized homonegativity and mental health issues. It is clear that LGB individuals experience higher rates of mental health issues related to their minority status and internalized homonegativity. The data gathered in this study is valuable in that it surveyed a hard-to-reach population and reached a high number of lesbian, Hispanic, women, 259 to be exact. Results from this data set could produce numerous opportunities for researchers to develop and analyze internalized homonegativity and mental health issues as it relates to lesbian, Hispanic, women.

Social Work Practice

Traditionally, the focus has been on how to create a more accepting society, although such focus is vital to the aid of LGB individuals; the results from this study put into perspective the need for micro level interventions. Mental health professionals should ask themselves what they could do in order to reduce the impact of homonegativity and internalized homonegativity on the LGB population. Thus mental health professionals should always consider how LGB individuals are internalizing societal messages regarding their sexuality in order to help LGB individuals recover from mental health issues.

Policy Implications

As mentioned earlier, institutionalized homonegativity (marriage bans, housing discrimination, adoption bans etc.) derives from societal homonegativity. The denial of fundamental rights such as marriage equality devalues the relationships of same-sex couples and sends out a message of inferiority which is then internalized and creates psychological harm (Riggle & Rostosky, 2005). Thus policy implications such as the legalization of same-sex marriage or adoption rights

would send out a message of equality and thus may help combat internalized homonegativity and its detrimental consequences on the mental health of LGB individuals. Not to mention, policy changes can facilitate a safer environment in which LGB individuals can live.

Social Work Research

Furthermore, the social work field can benefit from more research on the following areas: internalized homonegativity, mental health professionals' confidence in treating LGB individuals suffering from internalized homonegativity and effective treatment modalities. Additionally, the social work field can also benefit from knowing more about LGB individual resiliency and protective factors, and risk factors, such as education, age, religion etc. Lastly, mental health professionals can be of better service to their LGB clients if they had an accurate screening tool that incorporates internalized homonegativity in their assessment of mental health diagnosis. Accurately assessing for internalized homonegativity can facilitate the recovery of LGB individuals. Thus research is needed in order create an accurate internalized homonegativity screening tool.

Conclusion

In conclusion, pervasive homophobic cultural norms and beliefs have a profound impact on the mental health of LGB individuals. Ignoring the fact that LGB individuals face such hardships, discrimination, and internalization is unethical and only leaves room for cultural incompetence and fosters and environment for inadequate social work practice. It is imperative that mental health providers acknowledge the concept of internalized homonegativity and their effects on the mental health of LGB individuals. In doing so, mental health practitioners may be compelled to intervene more effectively at a micro, mezzo, and macro level.

APPENDIX A

QUESTIONNAIRE

QUESTIONNAIRE

Lesbian, Gay, or Bisexual (LGB) Survey
To be qualified to take this survey, you must self-identify as lesbian, gay or bisexual (LGB) and be 18 years or older.

1. Do you identify as
   - ☐ Lesbian
   - ☐ Gay
   - ☐ Bisexual
   - ☐ Other? _____

2. What is your age?

3. What is your race/ethnicity?
   1. African American
   2. Asian/ Pacific Islander
   3. Hispanic
   4. Native-American
   5. White
   6. Other (please specify)

4. What city and state do you live in? _____

5 What is your education level?
   - ☐ Less than high school
   - ☐ High school/GED
   - ☐ 2-year college degree (Associates)
   - ☐ 4-year college degree (BA, BS)
   - ☐ Masters
   - ☐ PhD, MD, JD or equivalent
   - ☐ Vocational degree

6. Have you ever experienced any of the following (Please check all that apply)?
   - ❑ Depression: Symptoms of depression usually consist of feelings of sadness, guilt, or unworthiness; crying spells; disturbance in appetite and weight changes; and disturbance in sleep.
   - ❑ Chronic anxiety: At least 6 months of "excessive anxiety and worry" about a variety of events and situations. Generally, "excessive" can be interpreted as more than would be expected for a particular situation or event.
   - ❑ Alcohol abuse: Have you continued to use alcohol despite meeting one or more of the following? Please indicate which if any apply to you:
   - ❑ A. Continued use despite social or interpersonal problems.
   - ❑ B. Repeated use resulting in failure to fulfill obligations at work, school, or home.
   - ❑ C. Repeated use resulting in physically hazardous situations.
   - ❑ D. Use resulting in legal problems.
   - ❑ Suicidal thoughts: Having thoughts about taking one's own life.
   - ❑ I have never experienced any of the symptoms that were mentioned above.

7. Are you currently experiencing any of the following (Please check all that apply)?
   - ❑ Depression: Symptoms of depression usually consist of feelings of sadness, guilt, or unworthiness; crying spells; disturbance in appetite and weight changes; and disturbance in sleep.
   - ❑ Chronic anxiety: At least 6 months of "excessive anxiety and worry" about a variety of events and situations. Generally, "excessive" can be interpreted as more than would be expected for a particular situation or event.
   - ❑ Alcohol abuse: Have you continued to use alcohol despite meeting one or more of the following? Please indicate which if any apply to you:
   - ❑ A Continued use despite social or interpersonal problems.
   - ❑ B. Repeated use resulting in failure to fulfill obligations at work, school, or home.
   - ❑ C. Repeated use resulting in physically hazardous situations.
   - ❑ D. Use resulting in legal problems.
   - ❑ Suicidal thoughts: Having thoughts about taking one's own life.
   - ❑ No

8. At what age did you come out to your family? (If you have not done so, please enter "never.")

9. At what age did you come out to your friends? (If you have not done so, please enter "never.")

10. At what age did you come out to yourself?

11. How often do you attend LGB (lesbian/ gay/ bisexual) events or social functions?
    Never
    _____Times per week
    _____ Times per month
    or
    _____Times per year

Please assess the following:

12. Being LGB (lesbian/ gay/ bisexual) is against my religious beliefs or morals.
    Strongly Agree Agree Disagree Strongly Disagree

13. Being LGB (lesbian/ gay/ bisexual) is alright when you are young, but I worry about how people will perceive me as an older LGB (lesbian/ gay/ bisexual) individual.
    Strongly Agree Agree Disagree Strongly Disagree

14. Children should be taught that being LGB (lesbian/ gay/ bisexual) is normal.
    Strongly Agree Agree Disagree Strongly Disagree

15. Everyone in my life does not need to accept the fact that I am LGB (lesbian/ gay/ bisexual)
    Strongly Agree Agree Disagree Strongly Disagree

16. I am comfortable being "out."
    Strongly Agree Agree Disagree Strongly Disagree

17. I am comfortable being a LGB (lesbian/ gay/ bisexual) individual
    Strongly Agree Agree Disagree Strongly Disagree

18. I am out to my boss/employer.
    Strongly Agree Agree Disagree Strongly Disagree

19. I am out to my co-workers.
    Strongly Agree Agree Disagree Strongly Disagree

20. I am out to my parents or family
    Strongly Agree Agree Disagree Strongly Disagree

21. I feel comfortable about the idea of a same-sex person making an advance toward me.
    Strongly Agree Agree Disagree Strongly Disagree

22. I feel comfortable at gay centered events or places.
Strongly Agree Agree Disagree Strongly Disagree

23. I feel comfortable discussing homosexuality in a public setting.
Strongly Agree Agree Disagree Strongly Disagree

24. I feel comfortable in social situations with LGB (lesbian/ gay/ bisexual) individuals.
Strongly Agree Agree Disagree Strongly Disagree

25. I feel comfortable thinking about my homosexuality.
Strongly Agree Agree Disagree Strongly Disagree

26. I find myself making negative comments about other LGB (lesbian/ gay/ bisexual) individuals.
Strongly Agree Agree Disagree Strongly Disagree

27. I have felt shameful after having a sexually/physically intimate relationship with a same-sex person.
Strongly Agree Agree Disagree Strongly Disagree

28. I have stopped myself from coming out because no heterosexuals are truly accepting.
Strongly Agree Agree Disagree Strongly Disagree

29. I have very little in common with other LGB (lesbian/ gay/ bisexual) people.
Strongly Agree Agree Disagree Strongly Disagree

30. I sometimes feel disappointed in myself for being a LGB (lesbian/ gay/ bisexual) individual.
Strongly Agree Agree Disagree Strongly Disagree

31. I sometimes feel embarrassed to be a LGB (lesbian/ gay/ bisexual) individual.
Strongly Agree Agree Disagree Strongly Disagree

32. I sometimes think heterosexual people's negative judgments of LGB (lesbian/ gay/ bisexual) are at least, in part, justified.
Strongly Agree Agree Disagree Strongly Disagree

33. I think of LGB (lesbian/ gay/ bisexual) individuals as sexually predatory.
Strongly Agree Agree Disagree Strongly Disagree

34. I wish other LGBs (lesbians/ gays/ bisexuals) would not flaunt their "gay-ness"
Strongly Agree Agree Disagree Strongly Disagree

35. I would be offended if an anti- gay joke is told in my presence
Strongly Agree Agree Disagree Strongly Disagree

36. I would prefer to be heterosexual.
Strongly Agree Agree Disagree Strongly Disagree

37. It is important for me to be part of the LGB (lesbian/ gay/ bisexual) community.
Strongly Agree Agree Disagree Strongly Disagree

38. It is important to have people in my life who know I am LGB (lesbian/ gay/ bisexual).
Strongly Agree Agree Disagree Strongly Disagree

39. It is understandable that people judge LGB (lesbian/ gay/ bisexual) who do not dress or act "straight."
Strongly Agree Agree Disagree Strongly Disagree

40. It is understandable that some people believe that LGB (lesbian/ gay/ bisexual) are not worthy of the same treatment as other individuals.
Strongly Agree Agree Disagree Strongly Disagree

41. LGB (lesbian/ gay/ bisexual) couples should be able to adopt children with the same rights as heterosexual couples.
Strongly Agree Agree Disagree Strongly Disagree

42. LGB (lesbian/ gay/ bisexual) should try to look as non-offensive as possible.
Strongly Agree Agree Disagree Strongly Disagree

43. Lesbians who have a very masculine appearance make me uncomfortable.
Strongly Agree Agree Disagree Strongly Disagree

44. Men who have a very feminine appearance make me uncomfortable.
Strongly Agree Agree Disagree Strongly Disagree

45. Most LGBs (lesbians/ gays/ bisexuals) grow out of their lifestyles
Strongly Agree Agree Disagree Strongly Disagree

46. My sexuality does not need to be public.
Strongly Agree Agree Disagree Strongly Disagree

47. Stable romantic relationships are important.
Strongly Agree Agree Disagree Strongly Disagree

48. When discussing your partner it is alright to use gender neutral pronouns to make heterosexual people more comfortable.
Strongly Agree Agree Disagree Strongly Disagree

49. When/if I am in a relationship, I feel comfortable talking about my same-sex partner.
Strongly Agree Agree Disagree Strongly Disagree

Please indicate the option that best corresponds to each letter.

A. I do not feel sad.
0. I feel sad
1. I am sad all the time and I can't snap out of it.
2. I am so sad and unhappy that I can't stand it.

B.
0. I am not particularly discouraged about the future.
1. I feel discouraged about the future.
2. I feel I have nothing to look forward to.
3. I feel the future is hopeless and that things cannot improve.

C.
0. I do not feel like a failure.
1. I feel I have failed more than the average person.
2. As I look back on my life, all I can see is a lot of failures.
3. I feel I am a complete failure as a person.

D. 0. I get as much satisfaction out of things as I used to.
1. I don't enjoy things the way I used to.
2. I don't get real satisfaction out of anything anymore.
3. I am dissatisfied or bored with everything.

E. 0. I don't feel particularly guilty
1. I feel guilty a good part of the time.
2. I feel quite guilty most of the time.
3. I feel guilty all of the time.

F. 0. I don't feel I am being punished.
1. I feel I may be punished.
2. I expect to be punished.
3. I feel I am being punished.

G. 0. I don't feel disappointed in myself.
1. I am disappointed in myself.
2. I am disgusted with myself.
3. I hate myself.

H. 0. I don't feel I am any worse than anybody else.
1. I am critical of myself for my weaknesses or mistakes.
2. I blame myself all the time for my faults.
3. I blame myself for everything bad that happens.

I. 0. I don't have any thoughts of killing myself.
1. I have thoughts of killing myself, but I would not carry them out.
2. I would like to kill myself.
3. I would kill myself if I had the chance.

J. 0. I don't cry any more than usual.
1. I cry more now than I used to.
2. I cry all the time now.
3. I used to be able to cry, but now I can't cry even though I want to.

K. 0. I am no more irritated by things than I ever was.
1. I am slightly more irritated now than usual.
2. I am quite annoyed or irritated a good deal of the time.
3. I feel irritated all the time.

L. 0. I have not lost interest in other people.
1. I am less interested in other people than I used to be.
2. I have lost most of my interest in other people.
3. I have lost all of my interest in other people.

M. 0. I make decisions about as well as I ever could.
1. I put off making decisions more than I used to.
2. I have greater difficulty in making decisions more than I used to.
3. I can't make decisions at all anymore.

N. 0. I don't feel that I look any worse than I used to.
1. I am worried that I am looking old or unattractive.
2. I feel there are permanent changes in my appearance that make me look unattractive
3. I believe that I look ugly.

O. 0. I can work about as well as before.
1. It takes an extra effort to get started at doing something.
2. I have to push myself very hard to do anything.
3. I can't do any work at all.

P. 0. I can sleep as well as usual.
1. I don't sleep as well as I used to.
2. I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3. I wake up several hours earlier than I used to and cannot get back to sleep.

Q. 0. I don't get more tired than usual.
1. I get tired more easily than I used to.
2. I get tired from doing almost anything.
3. I am too tired to do anything.

R. 0. My appetite is no worse than usual.
1. My appetite is not as good as it used to be.
2. My appetite is much worse now.
3. I have no appetite at all anymore.

S. 0. I haven't lost much weight, if any, lately.
1. I have lost more than five pounds.
2. I have lost more than ten pounds.
3. I have lost more than fifteen pounds.

T. 0. I am no more worried about my health than usual.
1. I am worried about physical problems like aches, pains, upset stomach, or constipation.
2. I am very worried about physical problems and it's hard to think of much else.
3. I am so worried about my physical problems that I cannot think of anything else.

U. 0. I have not noticed any recent change in my interest in sex.
1. I am less interested in sex than I used to be.
2. I have almost no interest in sex.
3. I have lost interest in sex completely.

*Scale was adapted from The Lesbian Health Survey
Weibley, M. S. (2009). *Creating a scale to measure internalized homophobia among self-identified lesbians*, Thesis/dissertation, Manuscript Vita. (UMI No. AAT3381665.) Retrieved August 20, 2011, from Dissertations and Theses database Hopkins University, 2011.
and
Becks Depression Scale
Stulz, N., & Crits-Christoph, P. (2010). Distinguishing anxiety and depression in self-report: Purification of the beck anxiety inventory and beck depression inventory-ii. *Journal of Clinical Psychology, 66*(9), 927.

APPENDIX B

INFORMED CONSENT

INFORMED CONSENT

The study in which you are being asked to participate is designed to investigate the effects of internalized homonegativity on the mental health of lesbian, gay, and or bisexual (LGB) adults. *Internalized homonegativity* is self-prejudice guided from societal views. This study is being conducted by Guadalupe Garfias under the supervision of Danny Perez, MSW at California State University, San Bernardino. This study has been approved by the School of Social Work's Institutional Review Board, California State University, San Bernardino.

PURPOSE: This study investigates the effects of internalized homonegativity on the mental health of LGB individuals. Past research indicates a higher risk of mental health issues among LGB individuals when compared to heterosexual individuals. This study specifically focuses on mental health in terms of depression. This study seeks to answer whether or not internalized homonegativity causes depression.

DESCRIPTION: As a participant you will be asked to fill out a 70-question survey that will take approximately 20-25 minutes. On completion, you will be debriefed. You may discontinue participation at any time without penalty or loss of benefits before submitting your results. You do not have to complete this survey in order to receive the resource list. If you are completing this survey online, you can access the resource list by clicking the link found at the bottom of each web page.

PARTICIPATION: Participation is voluntary. Refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. Regarding the survey, you may discontinue participation at any time without penalty or loss of benefits before submitting your results. If you want to withdraw from the study, stop answering survey questions and close your Internet browser.

CONFIDENTIALITY OR ANONYMITY: The information that you give in the online survey will be handled with total anonymity. No identifying information will be asked. The data gathered from the surveys will be maintained confidentially. The researcher will be the only individual with access to the files. Once the data has been collected, the online survey will be deactivated. All paper data will be kept in a locked drawer.

RISKS: Although we do not foresee and harm by asking you to take this survey, a resource list will be offered in case that the information in the survey causes you to experience painful memories and or emotions. This resource list indicates telephone numbers to agencies and peer-support who can help you get or seek professional help.

BENEFITS: The benefits resulting from this research study will be used to expand knowledge of how internalized homonegativity affects the mental health of LGB individuals. These findings may influence the profession of social work to become more aware of its impact on the LGBT community. In addition this information can lead to prevention and or interventions.

CONTACT: If you have any questions or concerns regarding answers to pertinent questions about the research and research subjects' rights, please feel free to contact Prof. Rosemary McCaslin at rmccasli@csusb.edu

RESULTS: Results from this study will be available on the third floor in Pfau Library at the California State University San Bernardino campus after September 2012.

SIGNATURE: Thank you for considering participation in this study. If you agree to participate please click on the "continue" option. By clicking the "continue" option you are acknowledging that you have been informed of the purpose of this study, that you are participating freely, and that you are at least 18 years of age or older.

APPENDIX C

STUDY OF INTERNALIZED HOMONEGATIVITY

Study of Internalized Homonegativity
Debriefing Statement

The study you have just completed was designed to investigate if there is a correlation between internalized homonegativity and depression. In this study two constructs were measured. These were: internalized homonegativity and depression. We are particularly interested in finding out if internalized homonegativity causes depression in lesbian, gay, or bisexual individuals. Although we do not foresee any harm by having asked you to take this survey, a resource list can be found at the bottom of this page just in case the information in the survey caused you to experience painful memories and or emotions. As a reminder, you may discontinue participation at any time without penalty or loss of benefits before submitting your results. If you are completing this survey online, you can access this resource list by clicking the link found at the bottom of each web page. The resource list indicates the telephone numbers to agencies and peer-support who can help you get or seek professional help.

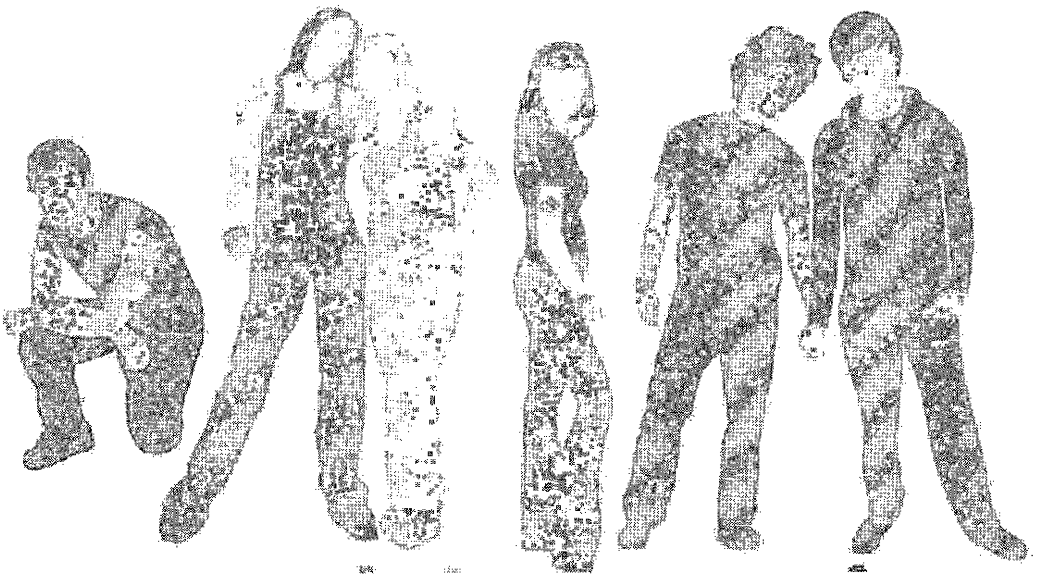
Psychology Counseling Center at CSUSB 909-357-5040	**Pride Center at CSUSB** (909) 537-5963	**RPYA** http://www.rpya.org/	**The Center** 562-434-4455	**The Trevor Project** THE TREVOR LIFELINE 1-866-488-7386
California State San Bernardino's psychology Counseling Center facilitates a self-help and mutual aid group every Monday. This group is free for student members. The LGBTQQI Group purpose is to provide a safe, positive, empowering, and confidential space for lesbian, gay, bisexual, transgender, queer, questioning, and intersex students to discuss identity, coming out, family and relationship issues.	Welcoming and friendly environment with amenities Knowledgeable staff sensitive to LGBTQQIA needs Opportunity to create lifelong bonds and friendships Resource information for community based programs Resource Library with LGBTQQIA literature, reference material and films.	RPYA is the only non-profit organization in San Bernardino and western Riverside counties dedicated to addressing the needs of these youth. RPYA is a support organization for Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and questioning youth (ages 13-20 years old), their families and their friends. RPYA's groups are facilitated every Mondays, Wednesdays, and Fridays.	The Center in Long Beach assist people to enhance their relationships, improve healthy communication, decrease violence, address substance abuse, improve self-esteem and provide for a greater sense of safety and well-being in their lives by providing a number of support groups for the LGBT community.	The Trevor Project is the leading national organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender, and questioning youth IF YOU ARE IN CRISIS OR THINKING ABOUT SUICIDE YOU DESERVE IMMEDIATE SUPPORT PLEASE CALL THE TREVOR LIFELINE 1-866-488-7386

Thank you for your participation. If you have any questions about the study, please feel free to contact Guadalupe Garfias or my advisor Daniel Perez at Dnlprz744@gmail.com if you would like to obtain a copy of the results of this study, they will be available in the Pfau library as of September 2012.

APPENDIX D

FLYER

Do you want to improve the understanding others have of the Lesbian, Gay, and Bisexual (LGB) Community?



If you are 18 years or older and you self-identify as lesbian, gay, or bisexual, you are invited to participate in an online survey.

WHY SHOULD YOU PARTICIPATE? This study seeks to answer whether or not *Internalized Homonegativity* causes depression. Its findings may help shape how mental health professionals interact with LGB individuals/ and LGB issues.

WHAT YOU CAN EXPECT: As a participant, you will be asked to fill out an online survey that will take approximately 20-25 minutes.

IT IS CONFIDENTIAL: The information you provide in the online survey will be handled with total anonymity. No identifying information will be asked. The data gathered from the surveys will be maintained strictly confidential.

TO PARTICIPATE:
https://www.surveymonkey.com/s/LGBCommunitySurvey

APPENDIX E

DEMOGRAPHIC SUMMARY

Demographic Summary (N = 279)

Variable	Frequency	Percent
Gender		
Male	20	7.1%
Female	257	91.8%
Gender Queer	2	.7%
No response/Missing	1	.4%
Sexual Orientation		
Lesbian	205	73.2%
Gay	22	7.9%
Bisexual	44	15.7%
Label Non-Conformant	8	2.9%
No response/Missing	1	.4%
Age Groups		
0-17	1	.4%
18-20	60	21.4%
21-29	174	62.1%
30-39	32	11.4%
40-49	5	1.4%
50-59	3	1.1%
60+	4	1.4%
No response/Missing	1	.4%
Ethnicity		
African American	12	4.3%
Asian	10	3.6%
Hispanic	187	67.0%
Native American	3	1.1%
White	45	61.7%
Other	22	7.9 %
No response/Missing	1	.4%
Education		
Less than high school degree	17	6.1%
High school or equivalent	64	22.9%
Some college but no degree	110	39.3%
Associates degree	31	11.1%
Bachelor's degree	34	12.1%
Graduate school degree	15	5.4%
Other	8	2.9
No response/Missing	1	.4%

APPENDIX F

TABLES

Table 1.

Mean Comparisons of Mental Health: LGB individuals and General Population (with Standard Deviations in Parentheses)

	Self-Reports of Past Symptoms versus Statistical Data (NIMH)		
Population	Anxiety	Depression	Alcohol Abuse
LGB Sample	34% (0.47)	71.33 (0.45)	16.8% (0.37)
General Population	18.1%	6.7%	8.4%

Note. $N = 279$.

Table 2.

Mean Comparisons of Mental Health: LGB individuals and General Population (with Standard Deviations in Parentheses)

	Self-Reports of Current Symptoms versus Statistical Data (NIMH)		
Population	Anxiety	Depression	Alcohol Abuse
LGB Sample	19% (0.39)	31% (0.46)	4.3% (0.20)
General Population	18.1%	6.7%	8.4%

Note. $N = 279$.

Table 3.

Mean Comparisons of Suicide Ideology: LGB individuals and General Population

(with Standard Deviations in Parentheses)

	Self-Reports of Suicide Ideation versus Statistical Data (NIMH)	
Population	Has had Thought of Suicide	Currently has Thoughts of Suicide
LGB Sample	28% (0.45)	4.6% (0.21)
General Population	3.7%	3.7%

Note. $N = 279$.

REFERENCES

Allen, D. J. (2001). The role of personality and defense mechanisms in the adjustment to a homosexual identity. *Journal of Homosexuality, 42*(2), 45-62. Retrieved from EBSCO*host*.

Anetzberger, G. J., Ishler, K. J., Mostade, J., & Blair, M. (2004). Gray and gay: A community dialogue on the issues and concerns of older gays and lesbians. *Journal of Gay & Lesbian Social Services: Issues in Practice, Policy & Research, 17*(1), 23-45. doi:10.1300/J041v17n01_03

Bagemihl, B. (1999). *Biological exuberance: Animal homosexuality and natural diversity*. NY: St. Martin's Press

Black, D., Gates, G., Sanders, S., & Taylor, L. (2000). Demographics of the gay and lesbian population in the United States: Evidence from available systematic data sources. *Demography, 37*(2), 139-139-154. Retrieved from http://search.proquest .com/docview/60094656?accountid=10359

Butler, C. (2009). Sexual and gender minority therapy and systemic practice. *Journal of Family Therapy, 31*(4), 338-358. doi:10.1111/j.1467-6427.2009.00472.x

California State University, San Bernardino. (2011). Dec. 05, 2011, Retrieved from http://csusb.edu

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

Chan, C. (1989). Issues of identity development among asian-american lesbians and gay men. *Journal of Counseling & Development, 68*(1), 16.

Ciliberto, J., & Ferrari, F. (2009). Interiorized homophobia, identity dynamics and gender typization. Hypothesizing a third gender role in Italian LGB individuals. *Journal of Homosexuality, 56*(5), 610-622. doi:10.1080/00918360903005279.

Council on Social Work Education (CSWE). (2011). Dec. 05 2011., Retrieved from <http://www.cswe.org/>.

Currie, M. R., Cunningham, E. G., & Findlay, B. M. (2004). The short internalized homonegativity scale: Examination of the factorial structure of a new measure of internalized homophobia. *Educational And Psychological Measurement, 64*(6), 1053-1067. doi:10.1177/0013164404264845

Facebook. (2011). *About Statistics*. Retrieved from http://www.facebook.com/http://www.facebook.com/facebookdiversity#!/photo.php?fbid=243456702417506&set=a.196865713743272.42938.105225179573993&type=1&theater

Frost, D., & Meyer, I. (2009). Internalized homophobia and relationship quality among lesbians, gay men, and bisexuals. *Journal of Counseling Psychology, 56*(1), 97-109. doi:10.1037/a0012844.

Greenwood, G. L., & Gruskin, E. P. (2007). LGBT tobacco and alcohol disparities. In I. H. Meyer, M. E. Northridge, I. H. Meyer, M. E. Northridge (Eds.) , *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual, and transgender populations* (pp. 566-583). New York, NY US: Springer Science + Business Media. Retrieved from EBSCO*host*.

Harper, G. W., & Schneider, M. (2003). Oppression and discrimination among lesbian, gay, bisexual, and transgendered people and communities: A challenge for community psychology. *American Journal of Community Psychology, 31*(3-4), 243-252. doi:10.1023/A:1023906620085

Haas, A. P., Eliason, M., Mays, V. M., Mathy, R. M., Cochran, S. D., D'Augelli, A. R., & ... Clayton, P. J. (2011). Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: Review and recommendations. *Journal Of Homosexuality, 58*(1), 10-51. doi:10.1080/00918369.2011.534038

Herek, G. M. (2004). Beyond 'homophobia': Thinking about sexual prejudice and stigma in the twenty-first century. *Sexuality Research & Social Policy: A Journal of the NSRC, 1*(2), 6-24. doi:10.1525/srsp.2004.1.2.6

Hershberger, S. L., & D'Augelli, A. R. (1995). The impact of victimization on the mental health and suicidality of lesbian, gay, and bisexual youths. *Developmental Psychology, 31*(1), 65-74. doi:10.1037/0012-1649.31.1.65

Igartua, K. J., Gill, K., & Montoro, R. (2003). Internalized homophobia: A factor in depression, anxiety, and suicide in the gay and lesbian population. *Canadian Journal of Community Mental Health, 22*(2), 15-30. Retrieved from EBSCO*host*.

Levecque, K., Van Rossem, R., De Boyser, K., Van de Velde, S., & Bracke, P. (2011). Economic hardship and depression across the life course: The impact of welfare state regimes. *Journal of Health and Social Behavior, 52*(2), 262-276.

Long, J. K., & Serovich, J. M. (2003). Incorporating sexual orientation into MFT training programs: Infusion and inclusion. *Journal of Marital and Family Therapy, 29*(1), 59-67. doi:10.1111/j.1752-0606.2003.tb00383.x

Marszalek III, J. F., Cashwell, C. S., Dunn, M. S., & Heard, K. (2004). Comparing gay identity development theory to cognitive development: An empirical study. *Journal of Homosexuality, 48*, 103-123. DOI: 10.1300/J082v48n01_05

Mayfield, W. (2001). The development of an internalized homonegativity inventory for gay men. *Journal Of Homosexuality, 41*(2), 53-76. doi:10.1300/J082v41n03_05

Mayer, K., Bradford, J., Makadon, H., Stall, R., Goldhammer, H., & Landers, S. (2008). Sexual and gender minority health: what we know and what needs to be done. *American Journal of Public Health, 98*(6), 989-995. Retrieved from EBSCO*host*.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674-697. doi:10.1037/0033-2909.129.5.674

Meyer, I. H., & Dean, L. (1998). Internalized homophobia, intimacy, and sexual behavior among gay and bisexual men. In G. M. Herek, & G. M. Herek (Eds.), *Stigma and sexual orientation: Understanding prejudice against lesbians, gay men, and bisexuals* (pp. 160-186). Thousand Oaks, CA US: Sage Publications, Inc. Retrieved from EBSCO*host*.

Moon, M., Fornili, K., & O'Briant, A. (2007). Risk comparison among youth who report sex with same-sex versus both-sex partners. *Youth & Society, 38*(3), 267-284. doi:10.1177/0044118X06287689.

Moradi, B., van den Berg, J., & Epting, F. (2009). Threat and guilt aspects of internalized antilesbian and gay prejudice: An application of personal construct theory. *Journal of Counseling Psychology, 56*(1), 119-131. doi:10.1037/a0014571

National Institute on Alcohol Abuse and Alcoholism, a component of the National Institutes of Health. (2011). Retrieved from National Institute on Alcohol Abuse and Alcoholism: http://www.niaaa.nih.gov/NewsEvents/NewsReleases/Pages/NESARCNews.aspx#chart

National Institute of Mental Health. (2011). *Anxiety disorders* (NIH Publication No. 09-3879). Retrieved from National Institute of Mental Health website: http://www.nimh.nih.gov/statistics/1ANYANX_ADULT.shtml

National Institute of Mental Health. (2011). *Mood disorders* (NIH Publication No. 09-3878). Retrieved from National Institute of Mental Health website: http://www.nimh.nih.gov/statistics/1MDD_ADULT.shtml

National Institute of Mental Health. (2011). *Mood disorders/suicide* (NIH Publication No. 09-3878). Retrieved from National Institute of Mental Health website: http://www.nimh.nih.gov/statistics/3TSMSP.shtml

Nicholson, W., & Long, B. (1990). Self-esteem, social support, internalized homophobia, and coping strategies of HIV+ gay men. *Journal of Consulting and Clinical Psychology, 58*(6), 873-876.

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

Riggle, E. D. B, & Rostosky, S. S (2005). The well-being consequences of marriage policy. In C. Rimmerman, & C. Wilcix (Eds.). *The polictics of same-sex marriage*. Chicago: university of Chicago.

Roderick, T., McCammon, S. L., Long, T. E., & Allred, L. J. (1998). Behavioral aspects of homonegativity. *Journal of Homosexuality, 36*(1), 79-88. doi:10.1300/J082v36n01_05

Ross, C., & Mirowsky, J. (2006). Sex differences in the effect of education on depression: Resource multiplication or resource substitution?. *Social Science & Medicine, 63*(5), 1400.

Ross, M. W., & Simon Rosser, B. R. (1996). Measurement and correlates of internalized homophobia. *Journal Of Clinical Psychology, 52*(1), 15-21.

Rostosky, S., & Riggle, E. (2011). Marriage equality for same-sex couples: Counseling psychologist as social change agents. *The Counseling Psychologist 39*(7) 956-972. *doi:10.1177/0011000011398398*

Russell, S. T., & McGuire, J. K. (2006). Critical mental health issues for sexual minority adolescents. In F. A. Villarruel, T. Luster, F. A. Villarruel, & T. Luster (Eds.), *The crisis in youth mental health: Critical issues and effective programs, Vol. 2: Disorders in adolescence* (pp. 213-238). Westport, CT US: Praeger Publishers/Greenwood Publishing Group. Retrieved from EBSCO*host*.

Rutter, P. (2008). Suicide protective and risk factors for sexual minority youth: Applying the Cumulative Factor Model. *Journal of LGBT Issues in Counseling*, *2*(1), 81-92. doi:10.1080/15538600802077681.

Safren, S. A., & Heimberg, R. G. (1999). Depression, hopelessness, suicidality, and related factors in sexual minority and heterosexual adolescents. *Journal of Consulting and Clinical Psychology*, 67(6), 859-866. doi:10.1037/0022-006X.67.6.859

Spinardi-Pirozzi, J. (2009). A comparison of drinking behavior between heterosexual and gay, lesbian and bisexual college students: An examination of prevalence and contributing factors. *Dissertation Abstracts International*, 69, Retrieved from PsycINFO database.

Soto, M. (2006). *Gays, lesbians, and bixeuslas lead the useage of online social networks*. Retrived January 21, 2009 from http//www.harrisinteractive.com/news/allnewsbydate.asp?newsID=1136

Stall, R., & Wiley, J. (1988). A comparison of alcohol and drug use patterns of homosexual and heterosexual men: The San Francisco Men's Health Study. *Drug and Alcohol Dependence*, 22(1-2), 63-73. doi:10.1016/0376-8716(88)90038-5

Stulz, N., & Crits-Christoph, P. (2010). Distinguishing anxiety and depression in self-report: Purification of the beck anxiety inventory and beck depression inventory-ii. *Journal of Clinical Psychology, 66*(9), 927.

SurveyMonkey.com. (2012). *LGB community survey*. Retrieved April 1, 2012 from https://www.surveymonkey.com/s/LGBCommunitySurvey

Szymanski, D. M., & Carr, E. R. (2008). The roles of gender role conflict and internalized heterosexism in gay and bisexual men's psychological distress: Testing two mediation models. *Psychology of Men & Masculinity, 9*(1), 40-54. doi:10.1037/1524-9220.9.1.40

Weibley, M. S. (2009). *Creating a scale to measure internalized homophobia among self-identified lesbians*, Thesis/dissertation, Manuscript Vita. (UMI No. AAT3381665.) Retrieved August 20, 2011, from Dissertations and Theses database Hopkins University, 2011.

Willging, C. E., Salvador, M., & Kano, M. (2006). Unequal treatment: Mental health care for sexual and gender minority groups in a rural state. *Psychiatric Services, 57*(6), 867-870. doi:10.1176/appi.ps.57.6.867

Williamson, I. R. (2000). Internalized homophobia and health issues affecting lesbians and gay men. *Health Education Research, 15*(1), 97-107. doi:10.1093/her/15.1.97

Workers, N. A. (2008). *NASW code of ethics* (Guide to the Everyday Professional Conduct of Social Workers). Washington, DC: NASW.

Van Den Berg, N., & Crisp, C. (2004). Defining culturally competent practice with sexual minorities: Implications for social work education and practice. *Journal of Social Work Education, 40*(2), 221-238. Retrieved from EBSCO*host*.

Van Voorhis, R., & Wagner, M. (2002). Among the missing: content on lesbian and gay people in social work journals. *Social Work, 47*(4), 345-354. Retrieved from EBSCO*host*.

United States Census Bureau. (2010). Retrieved May 1, 2012, from http://www.census.gov.Census statistics/ 2010census/data