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Internalized Heterosexism

Measurement, Psychosocial Correlates, and Research Directions

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This article provides an integrated critical review of the literature on internalized heterosexism/internalized homophobia (IH), its measurement, and its psychosocial correlates. It describes the psychometric properties of six published measures used to operationalize the construct of IH. It also critically reviews empirical studies on correlates of IH in the areas of sexual identity formation and the coming-out process; mental, psychosocial, and physical health; substance use; sexual risk-taking behavior; intimate relationships; parenting and family issues; gender roles and feminism; race and ethnicity; religion; career issues; and counselor–client interactions and treatment interventions. Last, it discusses limitations of the body of research and provides suggestions for future research throughout the review.

Internalized heterosexism (IH)—or the internalization of negative messages about homosexuality by lesbian, gay, and bisexual (LGB) people—has been a core concept in LGB psychology since 1972 when George Weinberg first described the construct. Following his lead, early clinicians (e.g., Malyon, 1982; Sophie, 1987), feminist theorists (e.g., Brown, 1988, 1994, 1995), and minority stress theorists (e.g., Brooks, 1981; Meyer, 1995) have postulated that IH is related to delays in sexual identity development and various psychosocial difficulties in LGB individuals. During the past decade, an explosion of research examining these assertions has been conducted. The major purpose of this article is to provide a critical

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review of the literature on the psychosocial correlates of IH. Another purpose, addressed first, is to discuss the psychometric quality of measures of IH. Such a discussion provides an important context for evaluating the psychosocial correlate literature that follows.

Measurement of IH

Studies examining correlates of IH have used a range of methods to assess it, from unpublished measures with limited and unknown psychometric support, to measures that were designed to assess heterosexual's attitudes toward lesbian and gay persons, to published IH scales with clear evidence of psychometric quality. Because it is important for researchers to use instruments that were designed to assess IH in LGB persons and to use scales that have good reliability and validity support, in this section we describe and critique published measures that have been used to operationalize the construct of IH.

Nungesser Homosexuality Attitudes Inventory

The most popular and widely used scale to assess IH in gay men is the Nungesser Homosexuality Attitudes Inventory (NHAI; Nungesser, 1983). Nungesser (1983) conceived of IH as consisting of attitudes toward one's own homosexuality (self), attitudes toward homosexuality in general and toward other gay persons (other), and reaction toward others' knowing about one's homosexuality (disclosure). His scale consists of 34 items assessing these three dimensions. Example items include "I wish I were heterosexual" and "If it were made public that I am homosexual, I would be extremely unhappy." Each statement is rated on a 5-point Likert-type scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Higher scores indicate more IH.

Internal reliability (coefficient alpha) for subscale scores ranged from .68 to .93, and the alpha for full scale scores was .94. Validity of scores on the NHAI was supported by positive correlations with two different IH measures, frequency of passing as a heterosexual, degree to which one is in the closet, and negative reactions by others to disclosure of sexual orientation and by negative correlations with number of persons to whom one is out as a gay person and proportion of gay social support (Alexander, 1986; Nungesser, 1983; Sbordone, 1993). Shidlo (1994) revised the NHAI by omitting items that confounded IH with other variables; adding more extreme items, such as suicidal items to improve content validity; and rephrasing unclear and grammatically awkward items. Shidlo reported an alpha coefficient of .90 for scores on this revised 36-item full scale. Validity

of scores on the NHAI-Revised was supported by correlating it with various psychosocial variables, such as psychological distress, self-esteem, and social support (Shidlo, 1994). Although this scale was designed to assess IH in gay men, it has been modified for use with lesbians (cf. McGuire, 1995; Radonsky & Borders, 1995). However, no validity support exists for scores on the modified version with a lesbian sample.

Martin and Dean's Internalized Homophobia Scale

Martin and Dean (1987) developed the Internalized Homophobia Scale (IHP), a nine-item scale for gay males based on the criteria for ego-dystonic homosexuality in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1980). Example items include "I wish I weren't gay/bisexual" and "If someone offered me the chance to be completely heterosexual, I would accept the chance." Each statement is rated on a 5-point Likert-type scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Higher scores reflect greater amounts of IH.

The internal consistency (alpha) for scores on the IHP was .85 for a gay male sample (Herek & Glunt, 1995). Validity of IHP scores was supported by demonstrating that higher scores on the IHP were significantly correlated with lower collective self-esteem, lower community consciousness, less importance attached to community involvements, less disclosure or outness to heterosexual friends, higher dissatisfaction with the local gay and bisexual community, less importance attached to political symbols, and a greater tendency to attribute personal setbacks to antigay prejudice. In addition, men with more IH were less likely to have the beliefs and attitudes that foster HIV risk reduction (Herek & Glunt, 1995). A later study by Herek, Cogan, Gillis, and Glunt (1998) modified the IHP for use with a sexual minority female and male sample. The reported alpha for scores on the nine-item IHP with a lesbian and bisexual female sample in this study was .71, and the alpha with the gay and bisexual male sample was .83. Finally, Herek, Cogan, and Gillis (2000) developed a five-item short form of the IHP, which had acceptable validity support, as evidenced by correlations with the nine-item IHP and with measures of how open a person was about his or her sexual orientation, self-esteem, connection with and feelings toward the LGB community, perceived stigma related to one's sexual orientation, and depression. Reliability for scores on the five-item IHP was not reported. Shidlo (1994) critiqued the IHP's narrow conceptualization of IH and suggested that it may not be sufficiently sensitive to detect low or moderate levels of IH.

Wagner et al.'s Internalized Homophobia Scale

The Internalized Homophobia Scale of Wagner and colleagues (IHS; Wagner, Brondolo, & Rabkin, 1996; Wagner, Serafini, Rabkin, Remien, & Williams, 1994) was developed to assess IH in gay men. It consists of 20 items: 9 items borrowed from Nungesser's NHAI (1983) and 11 items developed by the HIV Center for Clinical and Behavioral Studies at the New York State Psychiatric Institute. Example items include "Male homosexuality is a natural expression of sexuality in human males" (reverse scored) and "Life as a homosexual is not as fulfilling a life as a heterosexual." Each statement is rated on a 5-point Likert-type scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). The IHS includes reverse-scored items to reduce the effect of response sets. Higher scores indicate more IH.

Internal reliability (coefficient alpha) was .92 for scores on the IHS (Wagner et al., 1994). Validity of IHS scores was supported by exploratory factor analysis and by demonstrating that the items on the IHS were conceptually distinct from items on depression and demoralization scales. In addition, validity was supported by positive correlations with psychological distress, depression, demoralization, and age at which one first accepted being gay and by negative correlations with degree of integration into the gay community (Wagner et al., 1994; Wagner et al., 1996).

Ross and Rosser's Internalized Homophobia Scale

Ross and Rosser (1996) developed the 26-item Internalized Homophobia Scale to assess IH in gay men. Their exploratory factor analysis revealed four dimensions of IH: public identification as a gay man, perception of stigma associated with being homosexual, social comfort with gay men, and the moral and religious acceptability of being gay. Example items include "I would prefer to be more heterosexual" and "It is important to me to control who knows about my homosexuality." No information about how items were generated or how they are rated was provided. The scale scores of these four dimensions had internal reliabilities (coefficient alpha) of .85, .69, .64, and .62 and contained 10, 6, 6, and 4 items, respectively. Ross and Rosser did not report a reliability coefficient for scores on the full scale.

Several of the scale items are problematic because they confound IH with realistic perceptions of societal obstacles in a heterosexist society (e.g., "Discrimination against gay people is still common," "Society still punishes people for being gay, " and "It would not be easier in life to be heterosexual"). In addition, the reliabilities for three of the four scales are

low (although somewhat lower reliabilities are to be expected with short scales). Validity was supported via exploratory factor analysis and by demonstrating that public identification as gay and social comfort with gay men (higher scores indicate less public identification as gay and less social comfort with gay men) were negatively related to extent of attraction to men, relationship satisfaction, openness about being gay or bisexual in personal life and at work, number of people known with HIV/AIDS, and membership in a gay or bisexual group and were positively related to extent of attraction to women and proportion of social time with gays. In addition, public identification as gay was negatively associated with duration of longest same-sex relationship. Validity for the perception of stigma associated with being gay and the moral and religious acceptability of being gay was weak, with the former being associated with only one of the nine validity measures and the latter with only five of the nine validity measures.

Internalized Homonegativity Inventory

Mayfield (2001) developed the Internalized Homonegativity Inventory (IHNI) to assess IH in gay men. The IHNI consists of 23 items reflecting three dimensions: personal homonegativity, gay affirmation, and morality of homosexuality. Example items include "I feel ashamed of my homosexuality" and "I believe it is morally wrong for men to be attracted to each other." Each item is rated on a 6-point Likert-type scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*). Scores on each item are summed, with higher scores representing greater IH.

The scores on the three subscales had internal reliabilities (coefficient alpha) of .93, .80, and .66 and contained 11, 7, and 5 items, respectively. The interscale correlations based on Mayfield's data ranged from .41 to .55. The alpha for the scores on the IHNI full scale was .91. Validity of scores on the IHNI was supported by exploratory factor analysis, strong positive correlations with Nungesser's NHAI (1983), and negative correlations with gay identity development and percentage of LGB friends and by demonstrating that the IHNI was conceptually distinct from neuroticism, extroversion, and social desirability (Mayfield, 2001).

Lesbian Internalized Homophobia Scale

All of the aforementioned measures were developed for use with gay men, and several of the items on these scales reflect aspects of gay male culture. Accordingly, Szymanski and Chung (2001b) developed the Lesbian

Internalized Homophobia Scale (LIHS) using a rational and theoretical approach to test construction. The LIHS consists of 52 items derived from the clinical and theoretical literature on lesbian IH, and it has five subscales: Connection With the Lesbian Community, Public Identification as a Lesbian, Personal Feelings About Being a Lesbian, Moral and Religious Attitudes Toward Lesbianism, and Attitudes Toward Other Lesbians. Example items include "I hate myself for being attracted to other women" and "I live in fear that someone will find out I am a lesbian." Each statement is rated on a 7-point Likert-type scale from 1 (*strongly disagree*) to 7 (*strongly agree*). The LIHS includes reverse-scored items to reduce the effect of response sets. Average total and subscale scores are used, with higher scores indicating more IH.

According to Szymanski and Chung (2001b), the scores on the five subscales had internal reliabilities (coefficient alpha) of .87, .92, .79, .74, and .77 and contained 13, 16, 8, 7, and 8 items, respectively. The interscale correlations ranged from .37 to .57, and the alpha for the scores on the LIHS total scale was .94. Correlations between the total and subscale scores ranged from .60 to .87. Test–retest correlations across a 2-week period for scores on the LIHS total scale and subscales were .93, .91, .93, .88, .75, and .87, respectively (Szymanski & Chung, 2001a). Content validity was supported by an extensive review of the literature and by five expert raters (Szymanski & Chung, 2001b). Construct validity of the scores was supported by significant correlations between the LIHS and measures of self-esteem, loneliness, depression, social support, passing for straight, membership in a LGB group, and conflict concerning sexual orientation (Szymanski & Chung, 2001b; Szymanski, Chung, & Balsam, 2001). The LIHS has been translated into Italian and normed on a lesbian sample from Italy (Montano, 2000). Although this scale was designed to assess IH in lesbians, it has been modified for use with bisexual women (cf. Balsam & Szymanski, 2005; Rowan, 2004).

Piggot (2004) created a 39-item short form of Szymanski and Chung's LIHS (2001b), which consists of five subscales: Personal Feelings About Being a Lesbian, Connection With the Lesbian Community–Interaction, Connection With the Lesbian Community–Knowledge of Resources, Public Identification as a Lesbian, and Attitudes Toward Other Lesbians. Reported alphas for the subscale scores were .76, .80, .87, .92, and .72, respectively, and the alpha for scores on the full scale was .93. Piggot validated the LIHS short form by using a cross-cultural sample of 803 sexual minority women from 20 countries. Validity was supported by exploratory factor analysis and by correlating the scale with measures of depression, self-esteem, and psychosexual adjustment.

Summary, Limitations, and Future Directions

All the scores on the measures described above, except for Ross and Rosser's Internalized Homophobia Scale (1996), appear to have adequate reliability and validity support, at least with primarily European American samples. Thus, counseling psychologists have at least five good measures from which to choose when providing clinical services and/or conducting research with European American individuals. For working with such clients in therapy or conducting research on them, we suggest using Shidlo's revised version of the NHAI (1994), Wagner et al.'s IHS (Wagner et al., 1994; Wagner et al., 1996), Mayfield's IHNI (2001), and Szymanski and Chung's LIHS (2001b) because these instruments are more likely to detect low and moderate levels of IH, and they seem to be stronger predictors of psychosocial problems than the IHP. In addition, these instruments offer not only broader conceptualizations of IH but also more items that may allow for ways to encourage exploration and discussion of how IH manifests in clients' lives. For clinical and research settings where a short measure of IH is needed (i.e., screening a large group of people, a large research study where survey length is an issue), we suggest using Martin and Dean's IHP (1987) because of its brevity.

It is important to note the potential problems of using IH instruments designed for sexual minority men with sexual minority female samples and vice versa. Several theorists (cf., Mayfield, 2001; Szymanski & Chung, 2001b) have suggested that differences in gender socialization between men and women and the experiences of sexism and feminism in lesbian and bisexual women's lives may lead to differences in patterns of sexual identity development and differences in the ways that IH is experienced for sexual minority men and women. In addition, Herek et al. (1998) pointed out how items developed to assess IH in gay men may not be appropriate for lesbians and vice versa. For example, they asserted that Martin and Dean's IHP (1987) includes several items that express the desire to develop heterosexual attractions or to stop being gay. Given sexual minority women's experience of greater fluidity in their sexual orientation when compared to that of men, Herek et al. suggested that items like these may be more applicable to men's experiences than women's. A similar argument can be made for the potential problems in the use of IH measures designed for gay men and lesbians with bisexual persons because the unique experiences of bisexuals may lead to differences in the ways that IH is experienced between the former and the latter.

Thus, it is important that researchers continue to identify manifestations of IH that are unique to sexual minority women and to bisexual persons.

Additionally, future research might examine whether scores on measures of IH are more reliable or more predictive for men than for women or for gay men and lesbians than for bisexual persons and if differences occur when using measures that were derived from theoretical reports on lesbians versus those derived from theoretical reports on gay men (Szymanski & Chung, 2003). Finally, because the samples used to support reliability and validity of scores on the aforementioned IH measures have been primarily White, well educated, and middle to upper class, future research is needed to establish the psychometric properties of these IH measures with racial and ethnic minority LGB individuals and with LGB individuals of lower educational and socioeconomic statuses.

Empirical Studies on the Correlates of IH

In this section, we offer a critical review of the empirical studies on the correlates of IH using the following broad categories: sexual identity formation and the coming-out process; mental, psychosocial, and physical health; substance use; sexual risk-taking behavior in gay and bisexual men; intimate relationships; parenting and family issues; gender roles and feminism; race and ethnicity; religion; career issues; and counselor–client interactions and treatment interventions. For each category, we discuss limitations and/or future research ideas specific to each domain. We chose these categories because they captured the majority of the research on psychosocial correlates of IH. Where available, we present statistical results and information about the size of effects found in the studies. We used Pearson's *r* as the effect size and interpreted it using Cohen and Cohen's guidelines (1983) regarding effect sizes—namely, .10 for small, .30 for medium, and .50 for large. Because most of the weaknesses in IH research are the same across these broad categories, we include toward the end of this article a separate section summarizing these thematic limitations.

Sexual Identity Formation and the Coming-Out Process

Sexual identity formation models implicate IH as a core construct in a LGB person's journey to become aware of and positively accept her or his sexual orientation. Several researchers have empirically examined the theorized relationships between IH and sexual identity formation and various aspects of the coming-out process—particularly, disclosure of sexual orientation to others.

Sexual identity formation. Five studies examined the relationship between IH and sexual identity formation among sexual minority women. The three studies that used measures designed to assess Cass's sexual identity development model (1979, 1984) revealed conflicting results. Kahn (1991) found that levels of IH among lesbians did not differ across Cass's stages of sexual identity development (i.e., identity confusion, identity comparison, identity tolerance, identity acceptance, identity pride, and identity synthesis). However, these nonsignificant results may be due to the use of an author-developed IH measure with limited psychometric support and a small sample size. In contrast, Piggot (2004) found that sexual minority women in the later stages of identity development (i.e., identity pride and identity synthesis) reported significantly lower levels of IH than did participants in the early stages of identity formation (i.e., identity confusion, identity comparison, identity tolerance, and identity acceptance). Relatedly, T. L. Peterson and Gerrity (2006) found that sexual minority women's IH correlated negatively with Cass's gay identity stages ($r = -.47$).

Using a measure to assess the McCarn and Fassinger model (1996) of lesbian identity development, Mildner (2001) found that lesbians' IH was negatively correlated with phase of individual sexual identity development (i.e., the process involving the recognition and acceptance of same-sex attraction and lifestyle preferences, $r = -.44$) and phase of group membership identity development (a process involving the acceptance of one's status as a member of an oppressed group and the confrontation of oppression, $r = -.42$). Relatedly, Fingerhut, Peplau, and Ghavami (2005) found that IH was negatively related to lesbian identity ($r = -.42$) and marginally related to mainstream/heterosexual identity ($r = -.16$, $p = .10$). This finding suggests that lower levels of IH are associated with higher identification with lesbian communities and mainstream/heterosexual communities. The unexpected relationship between IH and heterosexual communities may be due to connections that lesbians form with open-minded individuals in mainstream society.

Three quantitative studies examined the relationship between IH and sexual identity development among gay men. Using measures designed to assess Cass's gay identity development stages (1979, 1984), Mayfield (2001) and Rowen and Malcolm (2002) demonstrated a large and negative relationship between IH and gay identity stages ($r = -.68$ and $r = -.52$, respectively), suggesting that high levels of IH may lead to delays in sexual identity development. Using a measure to assess models of sexual identity development by Fassinger and Miller (1996) and McCarn and Fassinger (1996), Welch (1998) found that participants who had lower levels of IH were more

likely to have higher individual and group sexual identity development. As well, individuals who had higher IH were less likely to resolve the later stages of ego identity development.

Supplementing these findings, Cody and Welch (1997) used qualitative methodology to examine the experiences of 20 White gay men living in rural New England. Eighty-five percent of participants ($n = 17$) indicated that they had experienced IH in their developmental history, and most reported that they were deeply affected by the negative messages concerning homosexuality that they had heard and internalized from parents, peers, teachers, and religious leaders. Seven of these participants indicated that they had experienced intense feelings of guilt and shame for being gay. Some of the participants also reflected various stages of unlearning their IH.

In sum, using a variety of assessment measures and models of sexual identity development, higher IH has been shown to be related to lower levels of sexual identity development for lesbians and gay men in eight of the nine studies reviewed above. These findings suggest that IH is more pronounced early in the coming-out process, consistent with the tenets of sexual identity development models. Only two studies (T. L. Peterson & Gerrity, 2006; Piggot, 2004) included bisexual persons in the sample; so, it is uncertain if these results generalize to bisexual women and men. In addition, current lesbian and gay male sexual identity development models do not attend to the unique issues and identity development of bisexual women and men and may thus have limited validity and applicability for use with these populations.

Disclosure of sexual orientation to others. In addition to examining sexual identity development, researchers have examined the relationship between IH and various aspects of the coming-out process, including disclosure of sexual orientation to others. Self-disclosure to others has been assessed in numerous ways from number of individuals or groups to whom a person has come out to, to measures of openness and total disclosure to others, to disclosure to specific groups of people (e.g., friends, family, parents, heterosexual friends, acquaintances, coworkers, and other LGB persons), to comfort with disclosing one's sexual orientation to others. Fourteen studies (Alford-Keating, 1991; Herek et al., 1998; House, 2004b; Kahn, 1991; Lewis, Derlega, Griffin, & Krowinski, 2003; McDermott, Tyndall, & Lichtenberg, 1989; McGregor et al., 2001; Nungesser, 1983; Radonsky & Borders, 1995; Ross & Rosser, 1996; Rostosky & Riggle, 2002; Voisard, 1995; Welch, 1998; Zuckerman, 1998) examining the link between IH and various aspects of self-disclosure of one's sexual orientation have largely supported the notion that more IH is related to less disclosure of sexual orientation to

others among sexual minority women and men. Across these 14 studies, 29 significant correlations between IH and disclosure were identified that ranged from –.23 to –.64, with an average medium effect size of –.41. However, it is important to note that a few of these studies also found nonsignificant findings between IH and certain aspects of disclosure.

IH was not found to be related to the order in which an LGB person came out to others (Radonsky & Borders, 1995). Mixed findings were found for the relationship between IH and disclosure to family members, with two studies (Welch, 1998; Zuckerman, 1998) finding significant negative correlations and one reporting nonsignificant findings (Kahn, 1991). Mostly supportive findings were found for the relationship between IH and workplace disclosure, with five studies (House, 2004b; Ross & Rosser, 1996; Rostosky & Riggle, 2002; Voisard, 1995; Welch, 1998) reporting significant negative correlations and one (Zuckerman, 1998) reporting nonsignificant findings. In addition, two studies examined IH along with contextual issues in the workplace as predictors of self-disclosure. Rostosky and Riggle (2002) found that IH (accounting for 23.5% of the variance) and workplace nondiscrimination policies (accounting for 10.7% of the variance) were significant predictors of workplace disclosure for lesbians and gay men. That is, an individual was more likely to disclose sexual orientation at work if nondiscriminatory policies were in place and if IH was low. Consistent with these results, House (2004b) found that direct ($\beta = -.30$) and indirect ($\beta = -.43$) discrimination in the workplace and organizational tolerance of heterosexism ($\beta = -.28$), and IH ($\beta = -.25$) were significant predictors of self-disclosure among lesbians.

In addition to research on disclosure of sexual orientation to others, several studies have provided support for the link between IH and other aspects of the coming-out process. IH is related to more conflict concerning sexual orientation (Szymanski et al., 2001), more passing as a heterosexual (Nungesser, 1983; Szymanski et al., 2001), greater degree to which one is in the closet (Nungesser, 1983), lack of membership in a LGB group (Ross & Rosser, 1996; Szymanski et al., 2001), less percentage of LGB friends (Mayfield, 2001), and less social time spent with LGB persons (Ross & Rosser, 1996).

Taken together, the studies examining the links between IH and the coming-out process largely support the notion that more IH is related to less sexual identity development, less self-disclosure of sexual orientation to others, and more difficulties with various aspects of the coming-out process. Future research should employ longitudinal methodology to examine if IH remains stable in some people while varying over time in others and to investigate the developmental relationships between IH, sexual identity

formation, and the development of psychosocial difficulties in LGB persons (Shidlo, 1994). Investigations are also needed to identify what factors lead to higher levels of IH (e.g., exposure to anti-LGB messages in religious institutions, heterosexist attitudes, and rejection by family and friends) and more difficulty with the coming-out process. Research is needed that examines the relationships between IH, sexual identity development, and other minority identity development processes (e.g., feminist identity, racial/ethnic identity) for LGB persons with multiple minority statuses. Finally, future studies are needed to investigate potential mediators and moderators of the relationship between IH and sexual identity formation, such as social support, supportive family relations, positive counseling experiences, and coping strategies.

Mental, Psychosocial, and Physical Health

Perhaps the largest area of research on IH has examined its relation to a variety of psychological, social, and physical health variables. In this section, we review the research examining the relationship between IH and self-esteem, social support, depression and psychological distress, psychosocial distress, body dissatisfaction, and physical health.

Self-esteem. Seven studies examined the relationship between IH and self-esteem among sexual minority women. Five of these studies (Burns, 1995; Burris, 1996; T. L. Peterson & Gerrity, 2006; Piggot, 2004; Szymanski & Chung, 2001b) found significant negative correlations between IH and self-esteem (*r*s ranged from –.17 to –.35, $M = -.28$), suggesting that more IH is related to lower self-esteem. Significant correlations between IH and self-esteem held true for sexual minority women in five countries, namely, Australia, Canada, England, Finland, and the United States (Piggot, 2004). In addition, Piggot (2004) found that after controlling for social desirability responding, IH and internalized sexism were significant predictors of self-esteem (accounting for 11% of the variance), indicating that more internalized oppressions were related to poorer self-esteem. One study (McGregor et al., 2001) found that the relationship between IH and self-esteem approached significance ($r = -.21$, $p = .06$). The use of a small homogenous sample of 57 lesbians treated for early-stage breast cancer in this study may have attenuated the relationship between IH and self-esteem. Another study (Herek et al., 1998) found that IH was not significantly correlated with self-esteem for sexual minority women.

Eight studies examined the relationship between IH and self-esteem among sexual minority men. All these studies (Alexander, 1986; Allen &

Oleson, 1999; Frederick, 1995; Herek et al., 1998; Lima, Lo Presto, Sherman, & Sobelman, 1993; Linde, 2002; Rowen & Malcolm, 2002; Shidlo, 1994) found significant negative correlations between IH and self-esteem (*r*s ranged from –.20 to –.59, $M = –.39$), suggesting that more IH is related to lower self-esteem in sexual minority men.

Stokes and Peterson (1998) qualitatively examined IH and its relationships to self-esteem in African American males. Several participants perceived that negative attitudes toward homosexuality were greater in the African American community than in the White community. The participants reported that they had internalized many of these negative attitudes, and many believed that homosexuality was a sin. In addition, a number of participants thought that there was a connection between IH and low self-esteem and other forms of psychological suffering. Finally, White men were perceived to have less IH than that of African American men. Taken together, the 15 studies examining the relationship between IH and self-esteem largely support the notion that more IH is related to less self-esteem in sexual minority women and men.

Social support. For sexual minority women and men, IH has been fairly consistently found to be significantly related to fewer social supports. IH has been found to be related to less overall social support (*r*s ranged from = –.28 to –.46, $M = –.34$), less lesbian and gay social support ($r = –.36$), and less satisfaction with social support ($r = –.25$) among sexual minority women (McGregor et al., 2001; Szymanski et al., 2001; Walsh, 1995). Among sexual minority men, Nungesser (1983) and Shidlo (1994) reported that IH was negatively related to overall social support ($r = –.41$ and $r = –.25$, respectively) and to proportion of gay social support ($r = –.42$ and $r = –.50$, respectively). Shidlo also reported a medium and negative relationship between IH and satisfaction with social support ($r = –.33$). One conflicting study by Wolcott, Namir, Fawzy, Gottlieb, and Mitsuyasu (1986) found that IH was not related to social support satisfaction among 50 gay men who had been recently diagnosed with AIDS. Similar to the findings concerning IH and self-esteem, the findings from these studies support the notion that more IH is related to less social support.

Depression and psychological distress. Numerous studies have examined the relationship between IH and depression and psychological distress. Four studies examined the relationship between IH and depression using sexual minority female samples. Three of these studies (Frock, 1999; Piggot, 2004; Szymanski et al., 2001) found significant positive correlations between IH

and depression (*r*s ranged from .19 to .33, *M* = .28). Significant correlations between IH and depression held true for sexual minority women in Australia, Canada, Finland, and the United States but not in England (Piggot, 2004). In addition, Piggot found that after controlling for social desirability responding, IH and internalized sexism were significant predictors of depression and accounted for 9% of the variance. Herek et al. (1998) compared the minority of participants who scored extremely high on the IHP with other respondents. The findings revealed that sexual minority women with the highest IHP scores reported significantly more depression.

The five studies (Alexander, 1986; Herek et al., 1998; Shidlo, 1994; Wagner et al., 1996; Zuckerman, 1998) that examined the relationship between IH and depression among sexual minority men all found significant positive correlations between IH and depression (*r*s ranged from .27 to .41, *M* = .35). One study by Lewis et al. (2003) used a combined sample of sexual minority men and women and found that IH correlated positively with depression (*r* = .14). Taken together, the findings from the 10 studies examining the relationship between IH and depression largely support the notion that more IH is related to higher levels of depression among sexual minority women and men.

Given these results related to IH and depression, one would expect links between IH and suicidal ideation. In a study of LGB individuals aged 60 and older, D'Augelli, Grossman, Hershberger, and O'Connell (2001) found that personal IH was significantly related to current mental health (*r* = –.30), deterioration of mental health in the past 5 years (*r* = .11), lifetime suicidal ideation (*r* = .26), lifetime suicidal ideation related to sexual orientation (*r* = .31), suicidal ideation in past year (*r* = .19), and suicidal ideation related to sexual orientation in past year (*r* = .24). Suicide-related IH (i.e., suicidal actions and thoughts linked to dissatisfaction about sexual orientation) was significantly related to current mental health (*r* = –.16), lifetime suicidal ideation (*r* = .33), lifetime suicidal ideation related to sexual orientation (*r* = .50), suicidal ideation in past year (*r* = .14), and suicidal ideation related to sexual orientation in past year (*r* = .36). Suicide-related IH was not significantly correlated with deterioration of mental health in the past 5 years.

Turning to psychological distress, three studies (Frock, 1999; McGregor et al., 2001; Szymanski, 2005) examined the relationship between IH and psychological distress in sexual minority women. All of them found significant positive correlations (*r*s ranged from .18 to .38, *M* = .29), indicating that more IH is related to higher levels of psychological distress. Szymanski (2005) also found that recent sexist events, recent sexual orientation-based hate crime victimization, IH, and the interaction of recent sexist events and

recent sexual orientation–based hate crime victimization were significant predictors of psychological distress, accounting for 31% of the variance.

Szymanski (2006) examined the potential moderating role of IH in the link between external heterosexism and psychological distress in sexual minority women. Szymanski found that recent perceived heterosexist harassment, rejection, and discrimination correlated positively with psychological distress ($r = .35$). However, she found no support for the moderating role of IH in the link between general heterosexist events and lesbian and bisexual women's psychological distress.

McGregor et al. (2001) investigated self-esteem and social support as potential mediators in the relationship between IH and psychological distress among 57 lesbians treated for early stage breast cancer. They found that theory-driven path analysis models, controlling for age, were consistent with the notion that IH leads to psychological distress through less perceived availability of social support and lower self-esteem. However, they also found that the data were consistent with an alternative path analysis model in which low-self esteem leads to IH through greater psychological distress. Finally, no moderating effects of self-esteem and social support were found.

Two studies (Shidlo, 1994; Wolcott et al., 1986) examined the relationship between IH and psychological distress among sexual minority men. Both studies found significant positive correlations and medium effect sizes ($r = .43$ and $r = .40$, respectively) between IH and psychological distress, indicating that more IH is related to higher levels of psychological distress. Relatedly, Allen (2001) found that gay men with higher IH scored more extreme than did a lower IH group on a variety of personality-type disturbances and clinical syndromes.

A longitudinal study by Wagner et al. (1996) examined the relationships between IH and psychological distress, coping, and HIV illness progression in sexual minority men At baseline and 2-year follow-up, results indicated that IH was positively correlated with self-report measures of psychological distress and produced small to medium effect sizes ($r = .37$ and $r = .30$ for baseline and 2-year follow-up, respectively), depression ($r = .36$ and $r = .30$), anxiety ($r = .32$ and $r = .32$), and demoralization ($r = .40$ and $r = .23$) and negatively correlated with proactive coping ($r = –.22$ and $r = –.26$). Also, IH was significantly related to avoidant coping at baseline ($r = .18$) and to a clinician-rated measure of depression at 2-year follow-up ($r = .32$).

Consistent with feminist and minority stress theorists' assertions that IH is related to poorer mental health, research has fairly consistently demonstrated a positive relationship between IH and depression and psychological distress in sexual minority women and men. In addition, research has just begun to

examine moderators and mediators of this relationship and the relation of multiple oppressions to depression and psychological distress. The longitudinal work by Wagner et al. (1996) is important in demonstrating a causal relationship between IH and psychological distress. More work of this type in a variety of populations is needed.

Psychosocial distress. In addition to depression and psychological distress, researchers have examined the relationship between IH and other psychosocial variables among samples of sexual minority females and sexual minority males. Among sexual minority women, participants who had higher levels of IH were more likely to report a history of engaging in self-harming behaviors (e.g., cutting, banging, burning, and skin picking among lesbians and bisexual women living in Central Scotland) and to feel more demoralized than were those with low IH levels (Bennett & O'Connor, 2002; Herek et al., 1998). In addition, IH has been found to be related to loneliness ($r = .41$; Szymanski & Chung, 2001b) and emotional intelligence ($r = –.27$; Rowan, 2004). Finally, IH was largely unrelated to somatic complaints and stability of self-concept among sexual minority women (Szymanski et al., 2001).

Among sexual minority men, IH has been found to be related to demoralization ($r = .40$; Herek et al., 1998) and shame ($r = .30$; Allen & Oleson, 1999). In addition, Shidlo (1994) found that IH was positively related to somatic symptoms ($r = .49$), distrust ($r = .62$), loneliness ($r = .62$), and AIDS-related IH ($r = .68$) and negatively related to stability of self ($r = –.35$) and self-confidence ($r = –.42$). Rowen and Malcolm (2002) found that IH was related to physical appearance self-concept ($r = –.38$), emotional stability ($r = –.36$), sex guilt ($r = .18$), and perceptions of societal, familial, and religious repression specific to homosexuality during childhood ($r = .53$) and the present ($r = .69$). Further analyses by Rowen and Malcolm supported the hypothesis that IH mediated the relationship between current perceptions of societal, familial, and religious repression specific to homosexuality and sex guilt. Among HIV-positive gay men, IH was positively associated with fatigue ($r = .29$), state anxiety ($r = .47$), confusion ($r = .34$), and avoidant cognitions ($r = .37$) but not with tension, anger, vigor, or intrusive thoughts (Zuckerman, 1998). Nicholson and Long (1990) found that among HIV-positive sexual minority men living in Canada, IH was associated with more avoidant coping ($r = .42$), more mood disturbance ($r = .44$), and less proactive coping ($r = –.24$).

Meyer (1995) found that IH was significantly correlated with demoralization ($r = .25$), guilt ($r = .31$), suicidal ideation and behavior ($r = .15$), psychological distress symptoms related to the effects of the AIDS epidemic

($r = .24$), and sex problems ($r = .12$) in gay men who did not have a diagnosis of AIDS. Meyer also found that IH did not moderate the effect of perceived stigma on any of the distress measures. The interaction of IH with actual experiences of discrimination and violence was significant, with individual interactions predicting demoralization and guilt but not predicting suicidal ideation and behavior, psychological distress related to the effects of the AIDS epidemic, and sex problems. Meyer's findings suggest that high IH, along with high heterosexist experiences, can have a more negative effect on some aspects of mental health than that of low IH and high heterosexist events among gay men. These findings should be interpreted with caution, however, because of the use of a two-item measure assessing experiences of discrimination and violence and the cross-sectional correlational nature of the study. Taken together, the findings in this section indicate that IH is related to many, but not all, indices of psychosocial distress, such as demoralization, coping strategies, loneliness, and guilt.

Body dissatisfaction. Pitman (1999) examined the relationship between lesbians' IH and body dissatisfaction using mixed-methods methodology. Controlling for body weight and other demographic variables, she found that the variance accounted for by IH in predicting various aspects of body dissatisfaction was small (less than 4%), which suggests that other factors, such as internalized sexism and sexual objectification, may be at work. Using qualitative methodology with eight lesbians representing a range of responses on the body image and IH scales, Pitman found that all these lesbians believed that they had IH to some degree, that there was a connection between IH and body dissatisfaction, and that this link was related to relationship and intimacy difficulties with other women.

Consistent with Pitman's findings (1999), those of Kimmel and Mahalik (2005) revealed that minority stressors (i.e., IH, expectations that others will stigmatize them because of their sexual orientation, and experience of an antigay physical attack) were associated with body dissatisfaction and masculine ideal body distress in gay men, accounting for 5% and 13% of the variance, respectively. Gay men's conformity to masculine norms uniquely explained an additional 3% of variance in masculine body ideal distress but not body image dissatisfaction. Overall, then, the findings from Pitman (1999) and from Kimmel and Mahalik suggest that IH in sexual minority men and women is a relatively minor factor in understanding how they feel about their bodies. However, this conclusion is tentative, given that we found only two studies in this area.

Physical health. Two studies have examined the relationship between IH and physical health among lesbians. The first study (Pitman, 1999) found that IH (accounting for 3.7% of the variance) was a significant predictor of health orientation, indicating that more IH is related to a lesser degree of investment in one's physical health. IH did not predict perceived fitness level or involvement in personal fitness activities. In a study of lesbians with breast cancer, McGregor et al. (2001) found that more IH was related to less frequent Pap smears ($r = –.25$), fewer gynecological visits before cancer diagnosis ($r = –.34$), and fewer breast examinations by medical professionals ($r = –.33$). No significant relationships were found between IH and breast self-examination.

Sexual minority men with AIDS had higher levels of IH as compared to those not having AIDS (Linde, 2002; Wolcott et al., 1986). Among sexual minority men with HIV or AIDS, greater IH was related to more illness concerns ($r = .33$), lower levels of current physical performance capacity ($r = –.48$), and less natural killer cell percentages ($r = –.32$) but not with other immune function indicators, illness stage, illness progression, nor subjective health status (Linde, 2002; Wagner et al., 1996; Wolcott et al., 1986; Zuckerman, 1998). Although there are few studies in the area of IH and physical health, the studies reviewed above suggest that the connection between IH and physical health merits further investigation.

Summary, limitations, and future directions. In sum, IH has been associated with poorer mental health and a variety of psychosocial difficulties among LGB persons. Most of this research has examined direct links between IH and psychosocial health. Only a handful of studies have examined potential mediators and moderators in these links. For example, McGregor et al.'s work (2001) is the only study that examined potential mediators (i.e., self-esteem and social support) of the relationship between IH and psychological distress. However, this study is limited by its focus on lesbians who were treated for early-stage breast cancer and by a small sample size. Future research is needed to explore these relations with larger and more diverse samples. In addition, other potential mediators of the relationship between IH and psychological distress—such as degree of outness, connection with the LGB community, avoidant coping, and family support—need to be examined.

Several studies have examined potential moderators of the link between IH and psychosocial health. For example, Szymanski (2005) examined whether internalized sexism moderated the link between IH and psychological distress. However, her research was limited by the use of assessment measures that have been critiqued for having limited utility for use with lesbian and

bisexual female samples. Thus, research is needed to more fully explore the influence of IH and internalized sexism on sexual minority women's lives, as well as the interactions of IH and other internalized oppressions (e.g., racism, classism, anti-Semitism) to the psychosocial health of diverse groups of LGB persons. In addition, examinations of other potential moderators of the link between IH and psychosocial and physical health are encouraged. Research examining potential moderators of the link between IH and psychosocial and physical health might identify subgroups of LGB persons for whom this link may be more pronounced and could thus ultimately inform interventions by counseling psychologists targeted to these subgroups.

The two studies (Meyer, 1995; Szymanski, 2006) examining IH as a moderator of the link between heterosexist events and psychological distress revealed conflicting results, in that IH was a moderator for gay men in predicting demoralization and guilt but not in predicting suicidal ideation and behavior, psychological distress related to the effects of the AIDS epidemic, and sex problems. In addition, IH was not found to be a moderator among lesbians. Because these two studies did not directly compare the experiences of sexual minority women and men and because they used different measures to assess IH, heterosexist events, and psychological distress, it is unclear whether the findings are the result of gender differences or differences between measures assessing these three constructs (Szymanski, 2006). Clearly, further research using a variety of assessment measures among sexual minority women and men is needed to more fully investigate the potential moderating role of IH in the link between heterosexist events and psychosocial distress. In addition, investigations are needed to address how various aspects of heterosexism are related to LGB persons' experience of IH. For example, does IH mediate and/or moderate the relationship between different forms of cultural, political, institutional, religious, and familial heterosexism and psychosocial health?

In contrast to the large body of research examining the relations between IH and psychosocial health, only a few studies have investigated the relationship between IH and physical health variables. Future research is also needed to more fully examine how IH might be related to physical health variables such as stress-related physical diseases, health behaviors, cigarette smoking, exercise, and interactions with health care providers. For example, are men with high IH more likely to exercise to appear more masculine? In addition, investigations are needed to explore the relationships between IH and other psychosocial variables, such as class attendance and academic success in high school and college.

Substance Use

There are many reports examining substance use among LGB individuals as compared to heterosexual individuals. Overall, these studies show that LGB people report higher levels of alcohol consumption, alcohol-related problems, drug use, and drug-related problems than do people who identify as heterosexual (e.g., Cabaj, 1996; Cochran & Mays, 2000; McKirnan & Peterson, 1989; Skinner & Otis, 1996). Many theorists (e.g., Cabaj, 1996; Kowszun & Malley, 1996; Kus, 1988) suggest that these substance abuse issues are related to the minority stress experienced by LGB persons and to the internalized oppression that results from exposure to heterosexism. The empirical studies in this area are somewhat contradictory.

A number of studies have reported positive links between IH and substance use and/or substance use–related problems. Burris (1996) found that in a large sample of lesbians, IH was a good predictor of alcohol dependence ($r = .20$) but not of drug abuse. Cherry (1996) studied IH and substance use in gay and bisexual men and found that IH correlated with alcohol consumption (Kendall's tau-$b = .17$) and with number of alcohol-related problems ($r = .25$). Cherry reported that although IH was unrelated to frequency of drug use, it was correlated with drug-related problems ($r = .30$). Finally, Cherry reported that IH was not related to alcohol use during sex but that it was related to drug use during sex ($r = .36$).

In 1998, DiPlacido reported results from a pilot study examining internal stressors and health behaviors in a small sample of 17 lesbian and bisexual women. DiPlacido found that the amount of alcohol consumed by the women in the study was correlated positively with IH ($r = .54$), indicating that as IH went up, so did alcohol use. Nicely (2001) found that among gay and bisexual males, those who identified as alcoholic had significantly higher scores on overall IH than did those who did not identify as alcoholic. In addition, IH scores were positively correlated with scores on an alcohol use measure ($r = .26$). Finally, Farnsworth (2002) studied gay and bisexual men and found that IH produced small effect sizes when correlated with tobacco use ($r = .20$), methamphetamine use ($r = .23$), ecstasy use ($r = .18$), and psilocybin use ($r = .19$).

In contrast to the studies described above that found a positive link between IH and substance use variables, the following studies reported finding mostly no relationship between IH and substance use. Allen (2001) examined the relationship between IH and alcohol and drug abuse in gay men. Results indicated that IH was not related to either alcohol abuse or drug abuse. Similar findings were reported by D'Augelli et al. (2001) in their sample of

older LGB adults; that is, neither personal IH nor suicide-related IH were correlated with alcohol or drug abuse. Ross et al. (2001) studied the relations among IH and drug use in men who have sex with men and showed that IH was primarily unrelated to alcohol and drug use. Only one IH dimension, lack of social comfort with gay men, was positively related to increased levels of hard drug use (crack, cocaine, heroin, crank, amphetamines, barbiturates, and other illegal drugs).

One study reported results in the direction opposite than expected. Amadio and Chung (2004) investigated relations between IH and substance use in a sample of attendees at a gay pride festival in Atlanta, Georgia. For the women in the study, IH was significantly correlated with frequency of lifetime alcohol use ($r = –.36$), lifetime and monthly use of marijuana ($r = –.30$ and $r = –.26$, respectively), and lifetime cigarette use ($r = –.32$). Thus, lower levels of IH were associated with greater lifetime use of alcohol, marijuana, and cigarettes and greater monthly use of marijuana in women. There were no significant relations between IH in women and monthly or daily alcohol use, monthly cigarette use, alcohol problems, or substance problems. Regarding the males in the study, none of the correlations between IH and substance use or substance use problems were significant.

As noted at the beginning of this section, the results of the studies described above are conflicting: Five studies showed a relationship between IH and substance use that is in the expected direction of higher IH associated with greater substance use or with more substance use–related problems. One study showed results in the opposite direction for lesbians and no relationship between IH and substance abuse for gay men. Three more studies found no relationship between IH and substance use. An additional finding is that studies that examined subscales of IH (Cherry, 1996; Nicely, 2001) revealed that IH directed toward the self and IH directed toward other LGB people were more important (in terms of relations with alcohol abuse) than IH conceptualized as attitudes toward disclosure of one's sexual orientation to others.

The variety of methods used to assess substance use and abuse in the aforementioned studies is a limitation in this area of research. Investigators need to use measures of substance abuse that have demonstrated good psychometric properties and that provide the information needed to test hypotheses. A second area for research is that of method of recruitment, since one of the potential confounds in the research above has to do with the varying methods used to solicit participants into the sample. Third, it is possible that the conflicting findings reported above are reflective of a lack of a true relationship between IH and substance use behavior. Future research

with improved research methodology is needed to ascertain this possibility. An example of research that would shed light in this area is longitudinal research that follows LGB individuals from the beginning of their coming-out process over a significant length of time. Fourth, the presence of conflicting findings indicates that potential moderators (e.g., genetic risk for alcohol dependence) of the relationship between IH and substance use may exist. Similarly, perhaps the relationship between IH and substance use is mediated by other variables, such as social support, resilience, and coping strategies. Future research is needed to identify mediators and moderators of the relationship between IH and substance use.

Sexual Risk-Taking Behavior in Gay and Bisexual Men

HIV/AIDS changed the landscape of sexual behavior for men who have sex with men, increasing the risks associated with sex, from the potential for a number of sexually transmitted diseases that could be treated effectively with antibiotics to a matter of life and death. Once knowledge of how this new disease was transmitted became available, much effort was put into decreasing the incidence of sexual behaviors that are deemed to be high risk for the transmission of the virus. Although it is clear that many men who have sex with men have dramatically changed their behavior—given the decrease in rates of HIV infections in gay and bisexual men in the United States over the past two decades—rates of infection continue to be higher than would be predicted if knowledge were all that was necessary to stop the spread of the disease. Unfortunately, studies have clearly indicated that knowledge about the transmission of HIV is not enough to eliminate engagement in risky sexual behavior by many individuals (Kalichman, Tannenbaum, & Nachimson, 1998). Much attention has been given to identifying correlates of risky sexual behavior in men who have sex with men. Included in this body of literature is research on the relationship of IH to risky sexual behavior. Interestingly, the results of these studies provide conflicting information.

Four studies were found that support a relationship between IH and risky sexual behavior. A study by Meyer and Dean (1995) employed young gay men from New York City as participants. Risky sexual behavior was defined as engaging in receptive anal intercourse, whereas very high-risk sexual behavior was defined as unprotected receptive anal intercourse with multiple partners. The results indicated that men who engaged in very high-risk behavior had higher IH scores ($M = 16.5$, $SD = 3.6$) when compared to men in the no or low-risk group ($M = 12.9$, $SD = 4.3$). Put another way, men who were above the sample mean on IH, as compared to men who

were below the mean on IH, had an 8.75 odds ratio estimate of engaging in very high-risk behavior. In contrast, IH did not predict receptive anal intercourse if such sexual behavior was limited to one partner. Meyer and Dean suggested that minority stress (difficulties in accepting one's sexual identity) was at the center of high risk taking in these young gay men.

Several other studies support the relationship between IH and risky sexual behavior. For example, Stokes and Peterson (1998) gathered qualitative data from African American men who had had sex with men in the previous 6 months. Several links between IH and risky sexual behavior (defined as unprotected sex) were revealed by participants: Less self-acceptance leads to decreased self-esteem, which leads to increased risk behaviors for HIV because of a lack of motivation; fear of being perceived as gay or bisexual leads to avoidance of HIV/AIDS issues and condom use; men who are high in IH will not enter into steady relationships with other men, thereby putting themselves at risk by engaging in more transient types of sexual encounters; men with high IH and low self-esteem use sex to affirm their attractiveness and worth and to fill a void; and because of anxiety about same-sex sexual behavior (IH), men will deny relevance of HIV to their lives. In a similar vein, J. L. Peterson et al. (1992) reported that African American men who felt discomfort with publicly revealing their same-sex behavior and identity were more likely to have practiced unprotected anal intercourse in the past 6 months (adjusted odds ratio = 1.15, 95% confidence interval = 1.02–1.29, $p < .02$). A caution in interpreting these results is that the internal consistency for the discomfort with disclosure measure was just .54.

A study by Ratti, Bakeman, and Peterson (2000) investigated correlates of high-risk sexual behavior in a sample of South Asian and European Canadian men from Canada. IH accounted for 7% of the variance in high-risk oral sex and 5% of the variance in high-risk anal sex ($p < .08$). Interestingly, although the South Asian men in the sample had higher rates of IH, they did not report higher rates of high-risk sexual behaviors, thereby suggesting a more complicated relationship between IH and risky sexual behavior than a simple direct path.

In contrast to the studies above, several studies reported no significant links or only indirect links between IH and risky sexual behavior in men who have sex with men. Vincke, Bolton, Mak, and Blank (1993) found that IH was unrelated to anal intercourse (with or without a condom) in a sample of Flemish (Belgian) gay men. Herek and Glunt (1995) reported that IH was not related directly to risky sexual behavior in two studies of gay and bisexual men from Sacramento, California. However, individuals who scored high on IH were more likely to report a sense of low self-efficacy for safe sex

behavior and more likely to see barriers to practicing safer sex. Herek and Glunt suggested that IH (among other identity variables, such as being closeted) is related to a lower sense of personal power and an expectation that sexual partners will not cooperate in safe sex practices. In a similar vein, Parsons, Bimbi, Koken, and Halkitis (2005) reported an indirect relationship between IH and risky sexual behavior through the variable of childhood sexual abuse; however, they did not assess the direct link between IH and sexual risk behavior. Likewise, Dew and Chaney (2005) investigated relations among IH, sexual compulsivity, and risky sexual behavior in gay and bisexual men who used Internet chat rooms. Dew and Chaney reported that higher levels of IH were associated with greater sexual compulsivity ($R^2 = .14$, $\beta = .23$, $p < .001$), which was in turn associated with high-risk sexual behavior, such as unprotected oral and anal receptive intercourse.

Farnsworth (2002) examined IH and self-destructive acts such as having unprotected anal sex in a sample of gay and bisexual men. Results indicated no relationship between IH and the number of high-risk sexual behaviors that participants reported. Shidlo (1994) reported that IH was not a predictor of self-reported condom use in gay men who reported anal or vaginal intercourse over the past year. Similarly, Dudley, Rostosky, Korfliage, and Zimmerman (2004) examined the correlates of high-risk sexual behavior in a sample of young men who have sex with men. Results indicated that IH was not related to the reported frequency of unprotected anal sex during the previous 3 months.

Several studies examining IH and sexual risk-taking behavior reported findings in the opposite direction than expected. For example, an early study conducted by Joseph, Adib, Joseph, and Tal (1991) found that a more positive attitude toward one's gay identity was predictive of greater risky sexual behavior, although the overall percentage of variance accounted for was small (less than 2%). However, among men with a more positive attitude toward their own gay identity, social participation with other gay men was related significantly to less risky sexual behavior ($r = –.31$). In the study reported above, Shidlo (1994) unexpectedly found lower levels of IH in gay men who reported oral sex without condoms over the past year when compared to those men who reported not engaging in oral sex over the past year.

In a study of ethnic differences in sexual behavior in African American and White men who have sex with men, Stokes, Vanable, and McKirnan (1996) reported mixed results. None of the correlations between self-acceptance (of having sex with men, a one-item scale) and risky sexual behavior were significant for White gay men. For Black men (both bisexual and gay), increased self-acceptance correlated with more receptive oral sex and more receptive anal sex, over the past 6 months ($r = .28$ and $r = .16$, respectively) and over

the lifetime (r = .23 and r = .17, respectively). For White bisexual men, increased self-acceptance was associated with more receptive oral sex over the past 6 months (r = .24), with more insertive anal sex over the lifetime (r = .34) and over the past 6 months (r = .29), and with more receptive anal sex over the past 6 months (r = .19) and over the lifetime (r = .19). Effect sizes for these findings were mostly small.

The studies reviewed above reveal conflicting findings regarding the relationship between IH and risky sexual behavior. Some studies support the existence of a relationship between increased IH and more sexual behavior that puts one at risk for contracting the HIV/AIDS virus; some studies did not find evidence of such a relationship; some studies found a relationship but in the opposite direction than expected; and a few studies suggested indirect relationships between IH and risky sexual behavior.

Several possibilities might explain the conflicting results. First, studies defined risky sexual behavior differently, with some studies considering oral sex risky, some considering any anal sex risky, and others' defining receptive anal intercourse without condoms as risky behavior. Consistency across definitions of sexual risk behaviors would eliminate one source of noise in the findings and perhaps clarify the nature of the relationship, if any, between IH and risky sexual behavior. Second, the measures of IH used across the studies varied in what was known about their psychometric quality. More of the studies that did not find a relationship used measures of IH that had unknown psychometric properties with these samples.

A third explanation for the different findings in this body of research has to do with sampling issues. Many of the studies used samples primarily comprising well-educated gay White men with low or very low levels of IH. Interestingly, there was more racial and ethnic diversity in the samples where a relationship between IH and risky sexual behavior was found, suggesting that race and ethnicity may act as moderating variables; future research investigating this possibility is needed. Finally, it may be that the inconsistent results reported in the literature is due to there being no true relationship between IH and risky sexual behavior

As noted by Ratti et al. (2000), if the finding of a relationship between IH and participation in high-risk sexual activities is true, it would thereby suggest an important component for interventions designed to promote safer sex activities among men who have sex with men. Clearly, future research needs to investigate this relationship more closely. Additionally, a meta-analysis of the literature in this area might identify study characteristics associated with differences in findings. Importantly, research that includes attention to the contextual and systemic factors related to IH and sexual behavior is

needed, especially when attempting to understand these relationships in racial and ethnic minority men who have sex with men. Such research, when conducted in a sample followed over time, would be quite illuminating.

Intimate Relationships

Contrary to the myths that many individuals hold, lesbian and gay male couples both desire and maintain long-lasting romantic relationships (Blumstein & Schwartz, 1983; Haas & Stafford, 1998; Kurdek, 2005; Peplau, 1991). Indeed, same-sex and heterosexual couples often deal with similar issues, including decisions about money, division of labor, and career versus relationship (Ossana, 2000). However, numerous authors (cf. Brown, 1995; Ossana, 2000) have noted the deleterious effects of societal heterosexism on the intimate relationships of LGB individuals. For example, same-sex couples may lack social validation of their relationships, fear rejection from family and friends, experience discrimination and violence, and face an absence of legal protections that places them at risk in cases of child custody, medical decision making, and survivor benefits. In spite of the additional stressors faced by lesbian and gay couples, their relationships appear to be as satisfying as those experienced by heterosexual couples (cf. Kurdek, 2005). Interestingly, only a few studies have examined how the internalization of societal heterosexism might affect the quality of intimate relationships of LGB individuals.

One area of interest has been the relationship between IH and intimacy. Frederick (1995) hypothesized that gay men who reported higher levels of IH also reported greater fears of intimacy (after controlling for self-esteem). His results supported his hypothesis, suggesting that IH in gay men is associated with a fear of intimacy ($\beta = .26$). Similarly, in a study of relationship satisfaction, McGuire (1995) examined IH and intimacy in lesbian couples. McGuire found significant negative correlations between intimacy (emotional and intellectual) and IH, thus suggesting that lesbians who are high in IH report less emotional intimacy ($r = -.32$) and intellectual intimacy ($r = -.37$) with their partners. IH was unrelated to three other types of intimacy. Thus, the results of these two studies indicate that IH is related to some aspects of relationship intimacy in gay men and lesbians.

Several studies have investigated how IH might be related to relationship functioning in same-sex couples. For example, Melamed (1992) reported that IH was related to dyadic adjustment ($r = -.31$), commitment ($r = -.18$), and investment ($r = -.15$) in the relationship, in a large sample of lesbian couples. Melamed also found that partner discrepancies on IH predicted

investment in the relationship ($r = –.14$) and dyadic adjustment ($r = –.12$). Studies by Henderson (2001) and Gaines et al. (2005) examined whether IH predicted destructive and constructive responses to relationship conflicts in women and men who were involved in same-sex relationships. Identical findings in both studies indicated that IH predicted destructive responses to conflict (r's from .12 to .21) but not constructive responses. In a similar vein, Balsam and Szymanski (2005) reported that IH was negatively related to relationship quality ($r = –.26$) and positively related to perpetration and receipt of domestic violence in the relationship in the past year ($r = .19$ for both) in a sample of lesbian couples. Path analyses revealed that relationship quality fully mediated the relationship between IH and recent domestic violence (perpetration and victimization).

Research attention has also been focused on how IH might affect sexual functioning within same-sex relationships. For example, in an early study of IH and sexual satisfaction in single gay men who reported practicing safer sex, Goldberg (1988) found that participants who had higher levels of IH were less sexually satisfied ($r = –.30$). Similarly, Rosser, Metz, Bockting, and Buroker (1997) reported that in a large sample of gay and bisexual men, greater sexual satisfaction was correlated with lower levels of IH ($r = –.36$) and greater comfort with one's sexual attraction to other men ($r = .28$). Shires and Miller (1998) conducted semistructured interviews with gay and heterosexual men and concluded that gay men with erectile dysfunction were affected by cognitions related to IH, HIV anxiety, and intimacy issues. Other studies (cf. Dupras, 1994; Meyer & Dean, 1998) have found an inverse relationship between IH and sexual satisfaction. One study focused solely on sexual minority women: Piggot (2004) found that IH was significantly correlated with sexual self-esteem ($r = –.27$), sexual anxiety ($r = .31$), sexual depression ($r = .29$), fear of sexual relationships ($r = .33$), and sexual satisfaction ($r = –.33$) in women from several different countries. For the most part, these findings produced medium effect sizes. In contrast to these consistent results, those reported by Biss and Horne (2005) revealed no relationships between IH and sexual satisfaction in gay men or lesbians. Biss and Horne speculated that the lack of significant results may be due to the low levels of IH in their sample.

Thus, consistent with feminist and minority stress theories (e.g., Brown, 1995; Meyer, 2003), the data in the studies reviewed above suggests that internalized oppression in the form of IH is associated with poorer relationship quality. IH was related to fear of intimacy, dyadic adjustment, commitment, investment, destructive responses to conflict, and overall relationship quality. Research also shows that greater levels of IH are associated with lower levels

of relationship satisfaction in gay and bisexual men (Ross & Rosser, 1996) but not in lesbians (McGuire, 1995); however, the sample size in McGuire's study (1995) was quite small. The poorer relationship quality associated with IH extends to the realm of sexual satisfaction for lesbians and gay men.

Clearly, an individual's level of IH has important connections to the quality of relationships that the person has. Not only do individuals in a relationship have to cope with their own issues related to IH, but the amount of discrepancy in IH between partners is also related to relationship satisfaction. More partner discrepancy in IH is related to less relationship satisfaction and quality (McGuire, 1995; Melamed, 1992). Given the external barriers to equality, the lack of support for their relationship that many couples experience, and the influences of IH on relationships, it is apparent that the relationships of LGB individuals can suffer a fair amount of stress. The fact that so many LGB individuals are in successful, high-quality relationships would seem to be a testament to the strength and importance of these relationships.

Although research has begun to examine the negative effects of external heterosexism and IH on LGB persons' same-sex relationships, no research has examined the concurrent and interactive nature of multiple oppressions (e.g. heterosexism, sexism, racism, classism) and their impact on relationships. Future research is encouraged to examine the impact of multiple external and internalized oppressions on same-sex relationships. In addition, longitudinal studies of the developmental changes, strengths, and weaknesses of same-sex relationships over time would add to the overall knowledge about intimate relationships in general and same-sex relationships in particular. Finally, because many of the measures used to assess relationship quality in these studies were developed with heterosexual couples in mind, it is important that future research evaluate the reliability and validity of scores on these measures using samples of LGB individuals.

Parenting and Family Issues

Little information can be gathered about IH and issues of parenting and family for sexual minority individuals. Only five empirical studies have been conducted on this topic, three within the last few years. Researchers are beginning to take a close look at the correlates of parenthood, family dynamics, and IH. The topic of IH and parenting has taken on increased importance, given the rising number of lesbian and gay male couples who are parenting children. A couple of decades ago, children in these types of families were typically the product of heterosexual marriages that had

ended. Currently, many lesbian couples—and to a lesser extent, gay male couples—are creating intentional families through adoption, artificial insemination, and surrogacy. Understanding the role that IH may play in these families is important for counseling psychologists.

Two studies examined IH as it relates to being a parent. Sbordone (1993) found that fathers displayed significantly lower levels of IH than nonfathers did. Similar results were achieved in comparisons of fathers and nonfathers who reported wanting to raise a child. These results suggest that lower levels of IH in the parent group may be the result of fatherhood itself. In contrast, Burns (1995) examined the relationship between lesbians' IH and parenting choices. No significant differences in IH were found among the three parenting groups—namely, those considering parenting, those currently parenting, and those not parenting.

Bos, van Balen, van den Boom, and Sandfort (2004) explored the issue of minority stress among two-mother families with at least one child aged 4–8 years. Regression analyses indicated that IH directed to the self ($\beta = .15$), experiences of rejection ($\beta = .17$), and perceived attitudes of others toward homosexuality ($\beta = .17$) were significant predictors of parental justification. Thus, mothers who had greater IH (and who perceived negative attitudes and rejection from others) more often believed that they had to defend their position as a mother. There was no support for the hypothesis that IH would be related to parental stress or adjustment issues for children.

Three studies have examined the relationship between IH and family-of-origin relations. Kahn (1991) found that lower IH among lesbians was related to less intergenerational family conflict ($r = .38$) and to more personal authority, defined as interactional patterns of behavior that reflect the ability to converse with one's parents in an intimate manner while maintaining an individuated stance ($r = –.40$). Relatedly, Pedretti (2004) found that gay men who disclosed their sexual orientation to their parents reported less IH than did undisclosed sons. Furthermore, IH was negatively correlated with time since disclosure to mother ($r = –.24$) and father ($r = –.20$), suggesting that sons who have been out to their parents for longer periods report lower levels of IH. For all sons, increased IH was associated with more negative parental attitudes toward homosexuality ($r = .30$ for mother's attitudes and $r = .35$ for father's attitudes). Furthermore, greater IH was associated with less closeness and caregiving ($r = –.20$), more intrusiveness ($r = .17$), and less open communication ($r = –.21$) with mothers and more intrusiveness with fathers ($r = .27$). IH was not related to closeness and caregiving or communication with fathers.

In a sample of LGB youth who lived with parents who raised them, D'Augelli, Grossman, and Starks (2005) examined factors that differentiated

youth whose parents knew of their sexual orientation from youth whose parents did not know. Regression analysis revealed that less IH ($\beta = -.68$), more LGB self-identification, greater childhood gender atypicality, more family support, less fear of parental harassment or rejection, and more past verbal sexual orientation victimization by parents were significant predictors of parental awareness and thus accounted for over half of the variance.

In sum, for lesbian parents, IH is not related to the choice to be parents, parental stress, or adjustment issues for children, but it is related to a greater need to justify or explain the quality of parenting decisions. Also, IH is lower in gay male parents than in nonparents. In terms of family-of-origin issues, less IH is related to parental awareness of LGB youth's sexual orientation, less negative parental attitudes toward homosexuality, less intergenerational family conflict, more individuation, and less distant, rejecting, and intrusive parental behaviors.

One clear limitation in this body of research is its dearth of studies. In terms of future research directions, there is much work to be done. Research is needed to identify gender, class, and race/ethnicity differences in the relations of IH to decisions to parent and to openness about one's alternative family status. Other potential areas of research include how IH may relate to decisions about becoming a parent, feelings about raising boys or girls, attitudes toward gender roles in children, issues faced by children and parents when interacting with day care providers and schools, and the effect of children on relationship quality. Longitudinal work in this area is critical. For example, does raising children change one's level of IH over time? Longitudinal studies are needed using direct observation of parents' attitudes and behaviors as they relate to the development of IH in LGB youth. Another important area of research would be the examination of how multiple oppressions interact with IH to affect parenting and family-of-origin issues. For example, recent data (Cianciotto, 2005) show that lesbian and gay male couples in which both partners are Hispanic are raising children at twice the rate (66% for lesbian couples, 58% for gay male couples) when compared to White lesbian couples (32%) and gay male couples (19%).

Gender Roles and Feminism

Feminist theorists have highlighted the importance of social constructions of gender in U.S. culture and the negative impact that adherence to traditional gender roles can have on women and men (Enns, 2004; Worell & Remer, 2003). They have also asserted that heterosexism acts as a weapon of sexism by enforcing compulsory heterosexuality and rigid gender roles (Pharr, 1988).

In addition, several authors have theorized that feminism may provide some sexual minority persons with self-identification, pro-female and/or pro-LGB attitudes, tools to critique the institutions of patriarchy and heterosexuality, strategies for confronting and dealing with oppressive heterosexist environments, and bridges to communities that counteract or lessen IH (cf. McCarn & Fassinger, 1996; Rich, 1980; Szymanski, 2004; Szymanski & Chung, 2003). Building on this theoretical literature, several researchers have examined the link between IH and gender roles and various dimensions of feminism.

Alexander (1986) found that gay men's IH correlated negatively with support for equality for women and men (r = –.34). Consistent with Alexander's findings, Kahn's work (1991) revealed that more IH was related to more traditional gender role attitudes (r = .69) among sexual minority women. Frederick (1995) conducted ANOVAs to examine the relationships between gay men's IH and masculine, feminine, androgynous, and undifferentiated gender roles. Results revealed that gay men who reported androgynous gender roles were significantly lower in IH when compared to gay men of all other gender role types. In contrast, Cimini (1992) found that gender role type (i.e., feminine, masculine, androgynous, undifferentiated) was not related to IH for gay men or lesbians.

Sanchez (2005) and Ervin (2004) examined relations between IH and gender role conflict in gay men. Their results indicated that the greater the IH, the more conflict that men reported with expressing emotions (r = .39), being affectionate with other men (r = .56), being concerned with power and dominance (r = .25), and balancing school/work and home life (r = .18). Additionally, Sanchez reported that IH fully mediated the relationship between outness and gender role conflict.

Kimmel (2004) examined the relationship between IH and sexual minority men's enactment of stereotypical masculine norms. Her results indicated that IH was correlated positively with masculine norms of power (r = .24), dominance (r = .14), self-reliance (r = .29), emotional control (r = .22), winning (r = .23), pursuit of status (r = .12), and disdain for sexual minority persons (r = .59). Regression analysis with IH, stigma, and experience of prejudice as predictors of masculine norms was also significant, accounting for 13% of the variance. IH (β = .36) was the only significant predictor in this analysis, indicating that sexual minority men with higher levels of IH were more likely to conform to stereotypical masculine norms. Thus, IH seems to be related to the internalization of traditional gender role ideology in gay men.

Piggot (2004) investigated the relations between IH and internalized sexism in a cross-cultural sample of sexual minority women. She found that

IH was significantly correlated with internalized sexism (r = .46) for the total sample and for participants from Australia, Canada, Finland, and the United States. IH was not related to internalized sexism for the participants from England. Piggot's findings illustrate the importance of considering multiple sources of oppression based on identity.

Szymanski and Chung (2003) examined the relations between IH and feminism and between IH and coping resources in sexual minority women. Results indicated that IH correlated negatively with self-identification as a feminist (r = –.42), attitudes toward feminism (r = –.47), involvement in feminist activities (r = –.42), and coping resources (r = –.21). Controlling for income and age, regression analysis identified attitudes toward feminism, involvement in feminist activities, and coping resources as unique predictors of IH, accounting for 31% of the variance. However, this study was limited by the use of single-item measures to assess self-identification as a feminist and involvement in feminist activities.

Szymanski (2004) expanded on Szymanski and Chung's study (2003) in her investigation of the relationship between IH and feminism in 227 lesbian and bisexual women. Results indicated that IH was significantly correlated with self-identification as a feminist (r = –.36), attitudes toward feminism (r = –.35), involvement in feminist activities (r = –.30), conservative/nonfeminist ideology, (r = .36), most of the feminist theories assessed in the study (r values –.19 to –.26), and most of the feminist identity development dimensions (small to medium effect sizes). A multiple regression analysis conducted with all feminist variables as predictors of IH was significant and accounted for 34% of the variance.

In sum, IH is related to traditional gender role attitudes, internalized sexism, and various dimensions of feminism in sexual minority women. For sexual minority men, more IH is related to less support for equality of women and men, more gender role conflict, and more enactment of stereotypical masculine norms. Mixed findings were found for the relationship between sexual minority men's IH and gender roles.

Future research is needed to examine if adherence to stereotypical masculine norms moderates and/or mediates the relationship between IH and psychosocial health, substance use, and risky sexual behavior among men who have sex with men (Kimmel, 2004). Future investigations might also examine if IH is related to adherence to stereotypical female norms for sexual minority women. Given the relationships among traditional gender role enforcement, sexism, and heterosexism, future research might examine if IH is related to various aspects of feminism among sexual minority men. Investigations are also needed to examine whether various aspects of feminism

(e.g., self-identification as a feminist, exposure to feminism, involvement in feminist activities) mediate the relationship between external heterosexism and IH and sexism and psychological distress among sexual minority women.

Race and Ethnicity

Studies examining correlates of IH have used predominately White samples. However, sexual minority women and men come from diverse cultural groups with diverse racial and ethnic identities. Writings on IH among sexual minority women and men of color have been largely theoretical. Counseling psychologists are just beginning to empirically examine the tasks involved in combining two or more marginalized identities and the impact of multiple forms of external and internalized oppression on LGB persons' experience of IH and psychosocial health. In this section, we review the scant research on race/ethnicity and IH.

Dube and Savin-Williams (1999) examined whether differences existed in IH among diverse youth, namely, Asian and Pacific Islander, African American, Latino/Latina, and White. Results indicated no significant differences in IH across the four racial/ethnic groups. A large relationship between IH and disclosure was found for Latino/Latina youth ($r = –.53$) and Asian youth ($r = –.60$), indicating that as IH increases, disclosure concerning sexual orientation decreases for these two groups. No significant relations were found for White and African American youth. Regression analysis was conducted to determine if ethnicity and sexual identity integration predicted IH. The model was not significant, suggesting that the integration of these identities may be independent of the traditional coming-out process. However, findings are limited by the use of only one item, with no reliability or validity support to assess integration of ethnic and sexual identities.

Rosario, Schrimshaw, and Hunter (2004) conducted a longitudinal study examining racial/ethnic differences in the coming-out experiences of Black, Latino/Latina, and White LGB youth. Results indicated that Black youth, when compared to White youth, had more IH and were not as comfortable with others' knowing their sexual identity. Latino/Latina youth were more comfortable with others knowing their sexual identity than were Black youth. The results also indicated that over time, Black youth had greater increases in positive attitudes toward homosexuality than did White youth. This finding suggests that Black youth became more comfortable with their sexual identity, suggesting the ability to overcome IH over time and to be more certain about their identity. No other significant differences were

found among racial/ethnic groups. The findings suggest that cultural factors may influence some aspects of IH.

Two studies examined the relationship between IH and ethnic identity. From (2000) found that Black lesbian and gay men's IH correlated negatively with ethnic identity attitudes ($r = –.36$) and sexual identity development ($r = –.42$), indicating that those with higher IH held less positive ethnic and sexual identity attitudes. Building on a theoretical model proposed by Chung and Katayama (1998), Chung and Szymanski (2006) hypothesized that Asian gay men's IH would differ among marginalists (those holding negative attitudes toward one's own ethnic group and toward the dominant cultural group), separationists (those possessing positive attitudes toward their own ethnic group but negative attitudes toward the dominant cultural group), assimilationists (those holding positive attitudes toward the dominant cultural group but negative attitudes toward their own ethnic group), and integrationists (those possessing positive attitudes toward one's own ethnic group and toward the dominant cultural group). Consistent with theoretical propositions, their findings revealed that assimilationists had the most IH, followed by marginalists and separationists, with integrationists having the least IH. Additional analysis of qualitative interviews with a smaller subset of these men ($n = 10$) indicated that many of these Asian gay men described a developmental journey from IH to acceptance and pride.

In sum, the limited research on LGB persons suggests that culture may affect African American, Latina/Latino, and Asian American sexual minority persons' experience of IH. In addition, some evidence exists demonstrating a relationship between IH and ethnic identity attitudes among Black and Asian American sexual minority persons. No research was identified that used Native American samples. However, the research on race/ethnicity and IH is scant, and most studies are limited by small sample sizes and by use of measures whose psychometric characteristics with LGB people of color have not been established. Clearly, more research examining how culture influences the experience of IH among Black, Asian, Hispanic/Latino/a, and Native American men or women is needed. In addition, studies investigating correlates of IH among racial and ethnic minority groups are needed to see if findings are similar to those using predominately White samples.

Given the evidence that racial groups are not genetically discrete, lack conceptual and scientific meaning, do not meet the criteria to be an independent variable, and contribute to racial stereotyping, researchers are encouraged to move away from examining differences among IH by racial category to examining how IH is related to racial categorization constructs, such as racial and ethnic identity attitudes, level of external and internalized

racism, and stereotype threat (Helms, Jernigan, & Mascher, 2005). In addition, studies are needed, especially longitudinal studies, examining the impact of external and internalized racism and heterosexism on the biopsychosocial health of gay and bisexual men of color, as well as the impact of external and internalized sexism, racism, and heterosexism on lesbian and bisexual women's mental health.

Religion

Religion and spirituality are important in the lives of many LGB individuals, in spite of the heterosexism manifested in many religious organizations. Davidson (2000) noted that full inclusion and celebration of LGB individuals in monotheistic religions such as Christianity, Islam, and Judaism form the exception rather than the rule. Nonetheless, different movements, denominations, and sects vary in their degrees of tolerance, and LGB individuals have formed support groups in every Christian denomination as well as established their own denomination (Universalist Fellowship of Metropolitan Community Church) and federation of synagogues (World Congress of Gay and Lesbian Jewish Organization; Davidson, 2000). In addition, other LGB individuals have turned from mainstream religion to alternatives such as paganism, Buddhism, Native American traditions, Wiccan, and New Age movements. However, concerns remain about the impact of the institutionalized oppression found in many religious traditions on the psychological well-being of LGB individuals.

Several facets related to religion and IH have been studied. One area of examination is that of religious orientation, a concept put forth by Allport and Ross (1967). The experience of religion as threaded throughout life in a deep and personal manner is considered an intrinsic orientation to religion; the experience of religion as a means to an end (e.g., community, acceptance) is defined as an extrinsic religious orientation; and a flexible approach that involves an ongoing exploration of religious beliefs is called a quest orientation. Several authors have predicted that religious orientation should be related to IH; however, the findings have been mixed. For example, Noffsinger-Frazier (2003) reported that neither intrinsic nor extrinsic religious orientation was related to IH, although experiencing high levels of religious conflict when coming out predicted higher current levels of IH. However, Tozer and Hayes (2004) indicated that an intrinsic religious orientation was positively related to the propensity to seek conversion therapy ($r = .30$) and to IH ($r = .27$) and that a quest orientation was negatively related to the propensity to seek conversion therapy ($r = –.29$) and to IH ($r = –.31$). In addition, IH was strongly related to the propensity to seek conversion therapy ($r = .87$),

suggesting that LGB persons with more IH are more likely to seek conversion therapy and/or that the propensity to seek conversion therapy encompasses aspects of IH. Regression analyses indicated that IH fully mediated the relationships between religious orientation (intrinsic and quest) and the propensity to seek conversion therapy. These results suggest that religious orientation in and of itself is not important in understanding the tendency to seek conversion therapy; instead, IH is a critical factor in the likelihood of making a decision to pursue conversion therapy. Supporting these findings, qualitative research examining LGB persons' experiences with conversion therapy indicates that IH is an important precursor to seeking this type of treatment, as well as a harmful outcome of engaging in reparative therapy (Beckstead & Morrow, 2004; Shidlo & Schroeder, 2002).

Several studies have looked at membership in religious organizations as it relates to IH. For example, Rowen and Malcolm (2002) found that participants who reported belonging to a religious institution had significantly higher levels of IH than did those not belonging to a religious institution. In contrast, Wagner et al. (1994) found no differences in IH between nonpracticing Catholic gay men and men who belonged to Dignity, a Catholic organization for LGB individuals. However, Loon (2003) conducted a qualitative study with gay men who had experience with fundamentalist Christianity and indicated that all the participants believed that their Christianity had a negative impact on their feelings about their sexual orientation and that they had experienced isolation, ostracism, and guilt.

One factor that seems important in understanding the relationship between membership in a religious organization and IH is the level of heterosexism or LGB affirmation offered by the religious organization. Cimini (1992) found that higher levels of religiosity (defined as adherence to orthodox religious tenets) were associated with higher levels of IH in lesbians but were unrelated to IH in gay men. Farnsworth (2002) found that IH was associated with membership in a traditional (nonaffirming) religion ($r = .17$). Lease, Horne, and Noffsinger-Frazier (2005) reported that affirming faith experiences were related to less endorsement of IH ($\beta = -.33$). Thus, the results of these three studies suggest that belonging to religious organizations that are not affirming of LGB individuals is associated with greater IH, whereas belonging to LGB-affirming religious organizations is related to less IH.

Another method of dealing with heterosexist religious tenets and organizations may involve the degree of scriptural literalism (i.e., interpreting Biblical scripture with comparatively little attention to historical context) that one engages in versus one's level of postconventional religious reasoning (i.e., making religious decisions independently rather than in deference to

other authorities). Harris, Cook, and Kashubeck-West (in press) reported that contrary to expectations, scriptural literalism was not related to IH in a sample of lesbians and gay men. However, higher levels of postconventional religious ($\beta = -.35$) reasoning predicted less IH, accounting for 8% of the variance.

Unlike a number of the sections above, this section has few conflicting findings. In general, the results indicate that there is a relationship between IH and religious orientation. Specifically, the results suggest that adherence to orthodox or traditional (presumably heterosexist) religious beliefs is associated with greater IH and that membership in LGB-supportive faith organizations and independent religious decision making are associated with less IH. The data with regard to religious orientation (the role that religion plays in one's life) are more conflicting: Noffsinger-Frazier (2003) reported no relationship between religious orientation and IH, whereas Tozer and Hayes (2004) found that intrinsic religiosity was correlated positively with IH. However, Tozer and Hayes also found that IH fully mediated the relationship between religious orientation and propensity to seek conversion therapy, suggesting that IH was the critical variable in this study, rather than religious orientation.

A limitation in this area of research has to do with a lack of high-quality measures of religiosity and spirituality; use of measures with more limited psychometric support interferes with accurately reporting LGB people's experiences with religion and spirituality. In addition, most of the research has considered religiosity as a univariate construct or has focused on only one dimension of religious experience, ignoring the complexity and multidimensionality of religious experience (Harris et al., in press). Another weakness in this literature is that much of it examines individuals who have religious affiliations that are supportive of LGB lives. The failure to study individuals who are struggling with how to integrate their sexual orientation with their nonaffirming religious identity means that counseling psychologists remain in the dark about how to best assist these individuals.

An area for future research involves more study of individuals who were raised in nonaffirming religions and of those who still belong to such organizations. One question of interest is whether religious orientation is more relevant for individuals who belong to nonaffirming religions. Noffsinger-Frazier suggested that for members of an affirming faith community, intrinsic religious orientation may not be as much of a risk factor for IH as it might be for LGB individuals in faith communities that are not affirming. More research also needs to be conducted on spirituality in LGB individuals, given that most of the research in this area has concentrated on experiences

with traditional religious organizations and has not explored the meaning of spirituality separate from religion. Longitudinal studies would contribute a great deal toward the understanding of IH and religion/spirituality in LGB individuals' lives. In many ways, research on religion and spirituality in the lives of LGB individuals is in its infancy.

Career Issues

Although career issues are important to LGB individuals, only two such empirical articles related to IH were found. The first, a qualitative study by Boatwright, Gilbert, Forrest, and Ketzenberger (1996), found that in addition to external heterosexism, IH was an important factor impacting lesbians' career trajectory. Analyses on the impact of IH generated two themes: first, negative effects on self-confidence and self-esteem, described as a fear of whom to come out to and low self-confidence about the ability to compete for promotions; second, increased isolation because of a need to protect identity, feared identification as a lesbian, and feelings of shame. Findings also revealed that lesbians who chose to keep their sexual identity a secret were aware of their IH and went to great lengths to conceal their homosexuality, thereby consuming great amounts of energy in the workplace. Many positive benefits were cited once a lesbian sexual identity was revealed, such as belonging to a community, receiving support, and expressing self-confidence. A related qualitative study by House (2004a) revealed that heterosexist discrimination and IH were perceived as career barriers among lesbians.

Clearly, the research examining the relationship between IH and career issues is scant. Future research is needed to examine the relationship between IH and the potential limiting effect that it may have on career exploration, career choices, and career development. For example, individuals with high levels of IH may choose careers that are considered safe, such as stereotypically masculine professions (for gay men) or stereotypically feminine professions (for lesbians). In addition, LGB individuals high in IH may avoid careers that could put them at risk, such as careers in the military or child care (Morrow, 1997). Investigations are also needed to examine how IH is related to career self-efficacy (i.e., what one believes he or she can become).

Counselor–Client Interactions and Treatment Interventions

Although research indicates that LGB persons use counseling at higher rates than heterosexuals and that LGB clients are present in most counselors' caseloads (cf., Hughes, Haas, Razzano, Cassidy, & Matthews, 2000;

Murphy, Rawlings, & Howe, 2002), only four studies have been conducted on the correlates of IH and the counseling process from the perspectives of either client or counselor. McDermott et al. (1989) found that comfort with counseling concerns central to sexual identity was inversely correlated with IH in clients for the overall sample ($r = –.31$) and for gay men ($r = –.37$) but not for lesbians. No relationship existed between IH and counseling concerns that were peripheral to sexual identity (e.g., career choice and roommate problems). Relatedly, Lease, Cogdal, and Smith (1995) found that LGB clients with lower levels of IH reported higher expectations for levels of their own personal commitment (openness, motivation, and responsibility) to the counseling process. Counselor sexual orientation and the interaction between IH and counselor sexual orientation were not significantly related to counseling expectations. This study is limited by the use of a measure of IH that was designed to assess heterosexuals' attitudes toward lesbian and gay persons.

In a qualitative study of clinicians and LGB individuals with substance use problems, Barbara (2002) found that most of her participants believed that IH was related to clients' presenting problems of depression, substance use, and poor self-esteem issues and that resolving IH was an important component of treatment. Finally, Edwards (1996) found that therapists who were responding to vignettes of gay male clients had little sensitivity to IH, given that 30% demonstrated no sensitivity at all and less than 18% were coded as sensitive. Furthermore, therapists who were LGB were significantly more sensitive to IH than heterosexual therapists were.

In sum, IH is an important treatment issue and is related to comfort in discussing various concerns central to sexual identity and expectations for level of personal commitment to the counseling process. In addition, research suggests that LGB therapists are more sensitive to IH than heterosexual therapists are, but sensitivity to IH within therapists on the whole is low.

Research is needed to explore the efficacy of counseling and prevention interventions aimed at reducing IH in LGB clients. Future research is needed to examine the relationship of sexual minority counselors' IH to exploration of LGB issues in counseling sessions, contextualization of client issues within a heterosexist context, client satisfaction with the counseling process, and therapeutic change with LGB and questioning clients. Research is also needed to explore the impact of multiple external and internalized oppressions on LGB clients' willingness to seek help, counselor–client interactions, and client satisfaction with counseling. The literature on psychotherapeutic interventions with LGB clients is still new, and much empirical work in this area has yet to be done.

Thematic Limitations of Research on IH

Most of the studies examining correlates of IH are limited by use of convenience samples that are predominately White, highly educated, financially privileged, adult, open about their sexual orientation, and largely gay and lesbian. In addition, a few studies are limited by small and/or homogeneous samples (e.g., Bennett & O'Connor, 2002; Lima et al., 1993; McGregor et al., 2001; Nungesser, 1983; Shidlo, 1994; Wolcott et al., 1986). Research using large diverse samples is warranted. In addition, studies that examine samples primarily composed of racial and ethnic minorities and bisexuals are sorely needed. Alternative sampling methods, such as recruiting participants from the general population rather than through their association with the LGB community, recruiting via racial/ethnic minority community groups, and offering financial incentives, might reach more diverse groups of LGB persons.

Another limitation in this area of research is that the measures of IH used across the studies varied in what was known about their psychometric properties. To assess IH, several studies used measures designed to assess heterosexuals' attitudes toward LGB persons (e.g., Lease et al., 1995; Lima et al., 1993), unpublished measures with limited and unknown psychometric support (e.g. Burns, 1995; Kahn, 1991; Linde, 2002; Walsh, 1995; Welch, 1998; Zuckerman, 1998), and instruments developed for gay men but used with female samples (e.g., D'Augelli et al., 2001; Herek et al., 1998; Lewis et al., 2003). Researchers are encouraged to use IH measures that have been found to show good psychometric properties. In addition, a few studies (e.g., Allen, 2001; D'Augelli et al., 2001; Piggot, 2004; Zuckerman, 1998) are limited by the large number of analyses that were conducted without attention to the threat of Type I error. Finally, it is crucial to recognize that IH research has almost totally been correlational and cross-sectional in nature, rendering causal statements impossible to make. Longitudinal studies are critical in teasing out potential cause–effect relationships between IH and various aspects of LGB individual lives.

Summary

The research reviewed in this article largely, but not totally, supports feminist and minority stress theorists' assertions that IH is related to many aspects of LGB individuals' lives. Specifically, the empirical literature

shows relations between levels of IH and sexual identity development, disclosure of sexual orientation to others, difficulties with the coming-out process, self-esteem, depression, psychological distress, social support, psychosocial distress, physical health, intimate and sexual relationship quality, adherence to traditional gender role and feminist attitudes, traditional religious beliefs, and perceived career barriers (among lesbians). Mixed findings were also reported, especially with regard to substance use in LGB individuals and risky sexual behavior in men who have sex with men. Notably, many of the significant relationships were small, and their importance should not be overstated.

Based on this review, a number of suggestions for future research on the construct of IH is worth mentioning:

Research needs to be conducted establishing the psychometric quality of measures with samples of lesbians, bisexual individuals, and LGB people of color.

Further work is important on the construct of IH to ensure its distinction from related concepts, such as self-esteem and negative affect.

Relatedly, much of the empirical literature on the correlates of IH has been atheoretical; much attention needs to be directed toward strengthening the theory base behind the constuct of IH.

The field needs to move away from convenience samples that are primarily White, well educated, middle class, open about their sexuality, and low in IH.

Examination is critically needed of how culture influences the experience and manifestation of IH in LGB people of color.

Longitudinal research is necessary to establish that IH has deleterious consequences for LGB individuals. Important areas of study include the stability of IH over time; factors that increase or decrease IH; and the impact of varying levels of IH on sexual identity development, relationship functioning, career development, and psychological distress.

More complex correlational studies are needed that examine potential mediators and moderators of the relations between IH and psychosocial difficulties.

Researchers need to examine the impact of multiple sources of oppression, external and internalized, on the biopsychosocial health of LGB individuals.

Scant attention has been paid to bisexual issues separate from the issues faced by lesbian and gay individuals; future research in this area is clearly needed.

The field of counseling psychology can contribute a holistic perspective to the research literature on IH. For example, little research has been conducted in the areas of vocational development, religion and spirituality, parenting and family issues, psychological well-being, physical health, academic success, and coping strategies for managing IH.
Counseling psychologists can also contribute important research on psychotherapeutic methods to reduce IH in clients.

Clearly, this list is not exhaustive; our intent is to stimulate more research by counseling psychologists on the important concept of IH.

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