Internalised Homophobia: Correlations with Depression, Anxiety, Suicidal Ideation and Coming Out Age in the Gay, Lesbian, and Bisexual Community of Aotearoa New Zealand.

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1. Abstract

Internalised homophobia is defined as negative attitudes and feelings towards homosexuality that many lesbian, gay and bisexual (LGB) individuals hold within themselves. Studies have shown that internalised homophobia is linked to the development of mental health problems such as anxiety, depression and suicidal ideation. No studies have been conducted to investigate the relationship between internalised homophobia and psychological distress in the New Zealand LGB community. This study aimed to be the first of its kind to quantitatively investigate the relationship between internalised homophobia, anxiety, depression, and suicidal ideation symptoms in the New Zealand LGB community. The study also aimed to investigate how age and the age of *coming out* influenced feelings of internalised homophobia. A quantitative cross-sectional study of 359 LGB participants from the New Zealand general population was conducted. Participants completed an online survey containing measures of psychological distress, including SIDAS, DASS-21 and IHS. Multiple regression analyses were performed to assess relationships between internalised homophobia, psychological distress, age and *coming out* age. A total of 98% of participants reported feelings of internalised homophobia. The study found that internalised homophobia significantly contributed to anxiety and depression in gay men, lesbians and bisexual women and contributed to symptoms of depression in gay men and bisexual women. Internalised homophobia only predicted suicidal ideation in lesbians and bisexual women. LGB participants aged 16-19 years reported significantly higher levels of internalised homophobia compared to older age groups, but a significant negative correlation between age and internalised homophobia was only observed in gay men and bisexual women. The study results also found that *coming out* at a younger age did not reduce feelings of internalised homophobia. However, the number of years since disclosing sexual orientation did significantly correlate with lower levels of internalised homophobia in gay men. These results may prove to have clinical implications for developing interventions to reduce the levels of internalised homophobia in LGB individuals that could improve mental health outcomes.

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4. Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed: _____

Date: 19 Oct 2021

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The Auckland University of Technology Ethics Committee granted ethics approval for this research project on 16 Apr 2021 (reference number 21/98).

6. Introduction and Literature Review

Lesbian, gay and bisexual (LGB) individuals constantly report higher prevalence rates of psychological disorders compared to the heterosexual population, including depression, anxiety, substance use disorders, panic disorder and suicidality (Chard et al., 2015; Meyer, 2003). Global cross-sectional studies have also shown that sexual minority individuals are not only more likely to experience mental health issues at a higher rate, but are also more likely to experience several mental health comorbidities (King et al., 2010). Studies also show that LGB individuals, over the course of a year, are twice as likely to attempt suicide or experience anxiety and depression compared to heterosexual individuals (Sivasubramanian et al., 2011). In fact, suicidal ideation and attempt rates are two to three times higher among young LGB individuals, which is one of the primary factors driving mental health research in this at-risk minority population group (Hottes et al., 2016; King et al., 2010).

In New Zealand, the most robust links between sexuality and mental health have been made in the Christchurch and Dunedin health and developmental studies, which showed that the New Zealand LGB population is also at higher risk of mental health problems and suicide (Fergusson et al., 2005; Skegg et al., 2003). A more recent New Zealand based longitudinal study by Spittlehouse et al. (2020) confirmed these results and found that New Zealand's sexual minority groups, over the life course, experience significantly higher rates of depression, anxiety and suicidal ideation than heterosexual samples.

The study by Spittlehouse et al. (2020) also highlighted the importance of not aggregating sexual minorities into one group when researching mental health in this population, as significant variations were reported between gay, lesbian and bisexual groups. The study showed significantly higher anxiety rates in gay and lesbian participants than bisexual individuals, where bisexuals showed higher odds ratios for depression and suicidal ideation. These findings were supported by Ross et al. (2018a), who suggested that the disparities in the data between the different groups are due to

sexual orientation-specific societal discriminatory factors such as bisexual invisibility in the community. The factors contributing to the variations seen between the different sexual orientations within the LGB community are complex and not well understood, but recent research encourages the investigation of mental health in lesbians, gay men and bisexuals as separate groups (Bränström, 2017; Ross et al., 2018a).

In summary, when reviewing the literature, it is clear that LGB communities experience disproportionately higher rates of mental health disorders compared to heterosexual populations, both globally and within New Zealand. Research suggests that intergroup variation of mental health issues in the LGB community is significant and should be an important consideration when conducting research in sexual minority groups. These findings then lead to the question: what is causing these higher mental health issues in the LGB community?

6.1. Minority Stress

Over the last two decades, several studies endeavoured to identify potential risk factors that could explain the higher rates of mental illness in LGB communities (Fergusson et al., 2005; Skegg et al., 2013). Although sexual minorities are classified as a vulnerable group at higher risk of developing mental health concerns, sexual orientation, that is, homosexuality, is not considered the cause of mental health issues (Sahs, 1996).

Meyer and Frost (2013) proposed the minority stress model, which is today one of the most commonly used frameworks to explain the preponderance of mental illness in the LGB community. Minority stress is a form of chronic stress that sexual minorities experience, resulting from stigmatisation from living in a heterosexual or heteronormative society. A heteronormative society believes that heterosexuality is the default, preferred, or “normal” mode of sexual orientation and assumes that sexual and marital relations between people of the opposite sex are the norms and more acceptable (American Psychological Association, 2013).

Social theorist Michael Warner, who coined the term, states that heteronormativity is fundamentally embedded in and legitimised in social and legal institutions that devalue, marginalise, and discriminate against sexual minorities who deviate from its normative principle (Warner, 1991). This ideological assumption leads to heterosexism, which refers to a biased *system* of attitudes that denies, denigrates, and stigmatises any non-heterosexual form of behaviour, identity, relationship or community (Herek, 1990). For the purpose of standardisation, the current study will use *heterosexism* as an umbrella term that includes any form of stigmatisation, discrimination and prejudice towards or experienced by sexual minorities at any level.

Bränström (2017) explains that minority stress combined with general life stress can result in physical and mental health issues. Social studies found that LGB individuals experience higher exposure to social stressors than heterosexual individuals, including victimisation, employment discrimination, harassment in schools, and family rejection, which may account for the higher mental health issues in this community (Katz-Wise & Hyde, 2012). Numerous studies report ongoing stigmatisation faced by LGB individuals and show that the prevalence of victimisation is still widespread, ranging from physical, sexual, and verbal assaults, property crimes and threats of violence (Anderson et al., 2015). These chronic high levels of stress can cause biological and psychological stress responses, such as high blood pressure, increased cortisol levels and anxiety, that accrue over time, eventually leading to poor mental and physical health (Meyer, 2013).

According to Meyer (2003), minority stress manifests itself in four ways: (1) perceived stigma, which refers to expectations of discrimination, stigmatisation, and, or violence; (2) actual experiences of discriminatory and, or violent events, (3) concealment of sexual orientation and (4) internalised homophobia, which refers to the direction of negative societal attitudes towards oneself. Meyer and Frost (2013) state that not all LGB individuals may experience all four elements of minority stress, which are largely depended on several factors such as openness and acceptance of a society and more proximal factors of having social support and self-acceptance of sexual orientation (Chard et

al., 2015). However, researchers state that most LGB individuals experience some elements of minority stress that may increase the risk of mental health issues (Meyer & Frost, 2013).

The minority stress model led many studies to investigate the underlying mechanisms and links between the different manifestations of minority stress and mental health within LGB communities. The first area of focus was the hypothesis that external forms of heterosexism towards LGB individuals are the primary cause of mental distress. Indeed, several research studies have shown a correlation between heterosexism and mental health issues such as anxiety and depression (Guimarães Mongiovi et al., 2018). In fact, Ross et al. (2013) showed how heterosexism at different systemic levels, whether in healthcare or governmental policies, strongly correlates with adverse mental and physical health outcomes in gay men across 38 countries.

However, more recently, the focus has shifted towards investigating the relationship between internalised homophobia, the most proximal aspect of minority stress, and mental health in the LGB community, which is also the focus of the current study. Not all individuals that experience external forms of heterosexism develop mental health problems (Meyer & Frost, 2013). Research suggests that the internalisation of heterosexism (internalised homophobia) is a key risk factor for poor mental health in the LGB community and may be the intermediate variable explaining the link between heterosexism and poor mental health outcomes (McLaren, 2016).

6.2. Internalised Homophobia

6.2.1. Defining Internalised Homophobia

Some authors define internalised homophobia as a very narrow and specific psychological construct, while others apply a wider scope. In its most narrow conceptualisation, internalised homophobia is defined as negative feelings, attitudes, thoughts, and beliefs that LGB individuals harbour towards homosexuality in themselves and others (Frost & Meyer, 2009; Yolaç & Meriç, 2021). However, the definition not only includes an individual's discomfort and internal conflict due to their own homosexual feelings, but it may also include behaviours such as rejection or the exclusion of other LGB individuals while accepting their own homosexuality (Yolaç & Meriç, 2021).

Applying a wider lens, internalised homophobia also incorporates social dimensions that include attitudes towards disclosure of homosexuality, perception of stigma associated with being non-heterosexual, social comfort with other sexual minorities, and moral and religious acceptability of homosexuality (Ross & Rosser, 1996).

Meyer's minority stress model identified several dimensions of internalised homophobia, including negative global attitudes towards homosexuality, discomfort with disclosure of sexual orientation, disconnectedness from other LGB individuals, and discomfort with same-sex sexual activity (Meyer & Frost, 2013). Researchers argue that almost all LGB individuals raised in heteronormative societies experience some form of internalised homophobia, albeit at varying degrees (Berg et al., 2016; Szymanski et al., 2001).

Irrespective of how internalised homophobia is defined, it consists of negative feelings that LGB individuals have about homosexuality which impact their psychological wellbeing by causing low self-esteem and psychological distress (Igartua et al., 2009). Several studies have been conducted to understand the cause, development and underlying mechanisms leading to internalised homophobia and its links to mental health issues which will be discussed in the following sections.

6.2.2. Cause of Internalised Homophobia and Sexual Identity Development

Internalised homophobia is thought to be caused by the internalisation of social heterosexism, resulting in self-hatred, shame, fear, and other psychological distress (Igartua et al., 2009). Theoretically, in a heteronormative society, there is the general expectation that everyone is heterosexual until proven otherwise (Warner, 1991). This ideological stance directly and indirectly causes a variety of stressors uniquely experienced by sexual minorities that affect their mental health. One such example of stress experienced by some sexual minorities is the distress caused by concealment of sexual orientation in the workplace due to fear of bullying, stigmatisation, or adverse effects on career progression. This type of stressor is chronic and places immense psychological pressure on these individuals and their overall functioning.

In addition to social heterosexism, internalised homophobia also develops due to the disparity between what an LGB individual becomes and what their parents and society had expected and even demanded from them: being heterosexual (Igartua et al., 2009). It is thought that a major developmental task for sexual minority individuals is to integrate a positive homosexual identity by dispelling previous negative myths and stereotypes learned during childhood. This process of integrating a positive homosexual identity can significantly mitigate internalised homophobia. Bruce et al. (2015) state that once this developmental task has been achieved, individuals will continue to recognise the existence of heterosexism, but it will no longer resonate with them. These individuals will be able to discount it or give it minimal importance, and it will no longer threaten their self-esteem and reduce the possible adverse impact on their mental health.

Other authors proposed a stage model of homosexual identity formation whereby individuals go through a series of cognitive and behavioural shifts on their way to integrate a positive homosexual identity (Bruce et al., 2015). In summary, the researcher explains that homosexual identity formation starts with the awareness of same-sex attractions, followed by same-sex experiences, then self-labelling as homosexual, and finally the disclosure of their sexual orientation to others which ultimately results in a positive sexual identity. Internalised homophobia, however, disrupts, delays, and even prevents the LGB individual from moving through these stages, causing extreme psychological distress (Juster et al., 2016).

6.3. Correlations with Internalised Homophobia

6.3.1. Mental Health

Irrespective of how internalised homophobia is defined or even what is at the root cause, several studies have shown statistical links between internalised homophobia and the development of mental health issues, specifically anxiety, depression and suicide ideation, which are all highly prevalent in the LGB community (Newcomb & Mustanski, 2010; Russell & Fish, 2016).

However, upon closer investigation, a significant portion of the research investigating this correlation was conducted with gay male samples, and in many cases, human immunodeficiency

virus (HIV) positive gay men (Jaspal & Bayley, 2020; Livingston & Boyd, 2010; Ong et al., 2021). A meta-analysis of 201 studies spanning 23 years showed that almost 50% of these studies exclusively included gay men or men who have sex with men (Berg et al., 2016). In one such Turkish study by Yalçınoğlu and Önal (2014), they found significantly higher depression rates in gay men with internalised homophobia than those without. Another European study found even stronger positive correlations between internalised homophobia and depression (r = .71), as well as anxiety (r = .77) in gay men (Lorenzi et al., 2015). These male-focused studies suggest that internalised homophobia correlates to anxiety, depression, and suicidal ideation, although at varying degrees across different population samples and demographic groups.

It is also noteworthy to add that the level of internalised homophobia varied significantly between population groups in these studies. For example, Lorenzi et al. (2015) found that Italian gay men experience significantly lower levels of internalised homophobia than Belgian gay men, which affected the mental health outcomes of these groups. This study and others suggest that levels of internalised homophobia may also vary significantly between geographical locations, and the generalisation of findings across societies should be made with caution (McLaren, 2016a). In fact, a review of 18 studies specifically looking at the difference in internalised homophobia supported the notion that internalised homophobia levels may vary significantly between LGB groups across different countries (Berg et al., 2016).

Other studies, including more diverse sample groups of gay, lesbian and bisexual individuals, found similar correlations between internalised homophobia and mental health, again at varying degrees. A recent study by Yolaç and Meriç (2021) that included gay and lesbian individuals found a significant positive but weak relationship (r = .33) between the means of internalised homophobia and depression. The researchers reported that lower internalised homophobia rates were proportional to lower depression scores in their study. A meta-analysis of 101 studies by Newcomb and Mustanski (2010) reported a small to moderate overall correlation between internalised homophobia and depression and anxiety, although a stronger relationship was seen with depression

than anxiety. It is important to note that many of these studies grouped sexual minority individuals together, irrespective of sexual orientation, and reported correlations as global relationships across the entire LGB spectrum (Igartua et al., 2009; Newcomb & Mustanski, 2010).

A large review by Newcomb and Mustanski (2010) specifically looked at studies investigating associations of internalised homophobia and mental health. Results from this meta-analysis were mixed. A large portion of studies showed direct correlations, but others showed very small to no correlations between mental health and internalised homophobia. Skidmore et al. (2006) found no correlation (r = .04) between internalised homophobia, depression and anxiety in lesbians. Another study including male and female sexual minorities found an equally uninspiring correlation (r = .14) with depression. The author suggests that the differences seen in the published data may be due to unstandardised methodologies. However, they also propose that the variance in correlation data may be due to differences in levels of internalised homophobia experiences by LGB individuals in different populations, which may, in part, be related to varying levels of heterosexism in those societies.

Research has also shown that aggregating sexual minority samples together when investigating internalised homophobia and mental health may be a methodological limitation in these studies (Bränström, 2017). Research suggests that both internalised homophobia and rates of depression, anxiety and suicidality can vary significantly between gay, lesbian and bisexual groups. Spittlehouse et al. (2020) also highlighted the importance of not grouping sexual minorities into one uniform group when conducting research due to significant variations in the data of these groups. Their study showed that anxiety, depression, and suicidal ideation rates varied significantly between homosexual and bisexual participants, and differences were even reported between male and female bisexuals. Ross et al. (2018a) also found similar disparities in their data, suggesting that factors such as the availability of fewer bisexual affirmative services and other unique sexual orientation-specific societal discriminatory factors may explain these differences in rates. Other researchers echoed this

sentiment and encouraged the investigation of mental health in lesbians, gay men and bisexuals as separate groups (Bränström, 2017; Ross et al., 2018a).

Recent studies following this methodological approach of separating sexual minorities showed that internalised homophobia was an independent risk factor for depression, anxiety, and suicidal ideation in multiple regression models; again, significant differences were observed between sexual orientation groups (McLaren, 2016). Key aspects of this research showed that internalised homophobia combined with depression were strong predictors of suicidal ideation in gay men and lesbians, where depression, but not internalised homophobia, predicted suicidal ideation in bisexual women. This study showed that internalised homophobia was neither correlated with depression or suicidal ideation in bisexual women, where correlations were seen in lesbians and gay men. Baams et al. (2015) also found significant differences between bisexual women and other sexual minority groups. Bisexual women reported higher depression symptoms, but no differences in suicide ideation were reported in their study.

In summary, the literature shows an overall correlation between internalised homophobia and anxiety, depression and suicidal ideation, but these correlations vary significantly by population and sexual minority group. The research further suggests that internalised homophobia may vary significantly between gay, lesbian and bisexual groups and across different geographical societies, resulting in disparities in mental health rates and correlations with internalised homophobia.

Internalised homophobia research spanning 23 years has shown that 80% of internalised homophobia studies were conducted in North America, Europe, and Australia (Berg et al., 2016). Currently, a gap exists in the literature as no study has endeavoured to investigate the correlation between internalised homophobia and anxiety, depression, and suicidal ideation in a New Zealand LGB sample quantitatively, nor have studies been conducted to investigate internalised homophobia levels in this sample group.

6.3.2. Age

Key theorists stated that feelings of internalised homophobia are strongest when one is *coming out*, a process generally occurring during adolescent and young adult years, and decrease steadily over time as individuals develop a positive gay, lesbian or bisexual identity (Cass, 1984; Troiden, 1989). *Coming out* is a widely used metaphor to describe the process of LGB individuals' self-disclosure of their sexual orientation, and being *out* refers to an LGB person who has gone through the *coming-out* process and now lives their life without concealing their sexual orientation (Cohen, 1997). There are several proposed reasons for this heightened internalised homophobia when individuals consider disclosing their sexual identity. Some of these reasons include a lack of affirming social support, especially if sexual identity has not yet been shared with family and friends, low self-esteem, bullying, increased prejudicial attitudes and lack of internal coping strategies (Mulvey & Killen, 2015). Meyer (2003) further showed that exposure to heterosexist violence and discrimination is most acute at the beginning of the *coming-out* process adding to the minority stress experienced by these young individuals.

Many studies have supported this suggested correlation between internalised homophobia and age in that sexual minority individuals in lower age brackets show higher levels of internalised homophobia than older individuals (McLaren, 2015; Newcomb & Mustanski, 2010). A recent large meta-analysis by Dürrbaum and Sattler (2020) reported significantly higher levels of internalised homophobia in LGB individuals younger than 21 years and showed that internalised homophobia significantly decreased with age. In another study, McLaren (2015) showed that middle-aged and older individuals showed significantly lower internalised homophobia than younger aged groups. These authors suggest that older individuals are more likely to have developed positive sexual identities, accepted their sexualities, and have established supportive social networks that make them less prone to be influenced by minority stress (Meyer, 2003).

However, this association between age and internalised homophobia seems to vary between sexual minority groups and geographical locations. Several large global studies found strong

associations between age and internalised homophobia in gay and bisexual men in South Africa and several European countries, showing that those aged between 35 to 44 years experienced significantly lower internalised homophobia than younger groups. However, samples from Australia, Canada, United Kingdom and the United States showed no associations between age and internalised homophobia (Chard et al., 2015; Ross et al., 2013). Geographical variation in the association between age and internalised homophobia has also been observed in lesbians and bisexual women (McLaren, 2016a; Vale et al., 2019). Unfortunately, no study has included a New Zealand geographical sample that investigated possible correlations between age and internalised homophobia.

6.3.3. Coming Out Age

On average, today's LGB youth come out at the age of 14 years, which is lower than ever before, and public support for sexual minority issues has dramatically increased (Russell & Fish, 2016). In fact, studies have shown that there is a direct relationship between the decrease in age of *coming out* and the improvements in societal acceptance of LGB issues (Baams et al., 2015). Research showed that disclosing sexual orientation is one of the key aspects of developing a positive sexual identity which subsequently reduces internalised homophobia and the probability of developing mental health concerns (Meyer & Frost, 2013). The question could then be asked: why, if the age of disclosing sexual orientation is lower than ever, do young LGB individuals continue to be at higher risk of mental health concerns?

Several studies showed a possible association with the level of *outness* and internalised homophobia, in that the less an individual conceals their sexual identity, the lower their internalised homophobia tends to be (Vale et al., 2019). Other factors that may play a role in internalised homophobia are: the age at which an individual disclose their sexual orientation and the amount of time that an individual has been *out*. Limited research is available that have quantitatively investigated the possible relationships between the age of *coming out* and internalised homophobia.

Some authors have suggested that internalised homophobia levels may be higher in those who have not disclosed their sexual orientation and that internalised homophobia may even be a factor preventing individuals from disclosing their sexual orientation. In a recent study by Yolaç and Meriç (2021), the authors showed that individuals who have not disclosed their sexual orientation to their family or social circle had significantly higher internalised homophobia levels than those who have disclosed their sexual orientation. Other research suggests that the time since recognising same-sex attraction, not biological age, is a stronger predictor of internalised homophobia (Chard et al., 2015). In other words, the longer the time since an individual recognised their same-sex attraction, the lower their level of internalised homophobia might be. Herrick et al. (2013) showed similar results in that internalised homophobia levels tend to be significantly higher in those who have only recently recognised and accepted their same-sex attraction.

Unfortunately, the study by Herrick et al. (2013) did not investigate whether the age of *coming out* and the total number of years since disclosing sexual orientation correlated with internalised homophobia. The study did state that individuals who accepted their sexual orientation between the ages of 9 and 14 showed significantly lower levels of internalised homophobia than those accepting their sexual orientation later in life. However, the authors did not define what was meant by "accepting sexual orientation", this could refer to internally accepting one's sexual orientation, or it may include disclosing sexual orientation. Vale et al. (2019) also showed that age correlated positively with the level of *outness* and internalised homophobia in LGB individuals. Again, these authors did not consider that there could be a link between the number of years since an individual disclosed sexual orientation and their level of internalised homophobia. Hence, there seems to be a gap in our understanding of possible associations between the *coming out* age, the number of years being out and internalised homophobia.

6.4. Rationale and Aims of the Current Study

When reviewing the literature, it is reasonable to state that internalised homophobia experienced by LGB individuals is correlated with various measures of psychological distress, most

notably anxiety, depression, and suicidal ideation. The research further suggests that age, type of sexual minority orientation and geographical location may play a significant role in the level of internalised homophobia, which ultimately may affect mental health. However, on closer investigation of these global studies, it is evident that there are several gaps and limitations in the research that the current study aims to address.

Foremostly, a general research gap exists in that no published studies have quantitatively studied the correlation between internalised homophobia and anxiety, depression and suicidal ideation in the New Zealand LGB community. The only known research on internalised homophobia in Aotearoa, New Zealand, is an unpublished dissertation reviewing the use of psychotherapy in working with internalised homophobia (Colligan, 2006). Global studies have shown that the levels of internalised homophobia and its correlation with mental health concerns may vary significantly between geographical locations due to societal acceptance of sexual minorities and the level of heterosexism in those countries (Berg et al., 2016).

New Zealand has a unique and diverse population that is generally considered a liberal and accepting society with first world progressive legislation. However, empirical studies and media reports indicate that sexual minorities in New Zealand may be at a significantly higher risk of experiencing elevated internalised homophobia due to widespread heterosexism, leading to increased mental health concerns.

For example, New Zealand has the second-highest bullying rate in schools among the Organisation for Economic Co-operation and Development (OECD) countries: four out of ten LGB students report being hit or physically harmed in the last 12 months as a result of their sexual orientation or gender diversity (Franks, 2019; Lucassen et al., 2014). Denison et al. (2020) further report that 42% of New Zealand LGB athletes are regularly victims of homophobic bullying within their sports teams. The prevalence of New Zealand workplace bullying is equally high, showing that 38% of workers in some sectors experienced at least one negative act weekly or daily, often relating

to their sexual orientation. This bullying rate places New Zealand among the highest globally (Chambers et al., 2018).

Heterosexism seems to be rife in New Zealand, evidenced by the media regularly reporting brutal physical and social media attacks on members of the LGB community (Fraser, 2014; Hutt, 2021). In addition, New Zealand has only recently taken steps towards banning and criminalising gay conversion therapy (Pannett, 2021). These, and numerous other reports, indicate that heterosexism may still be deeply rooted and systemic within New Zealand society and suggest that LGB individuals living in New Zealand may be experiencing elevated levels of internalised homophobia and subsequent mental health issues.

In addition, New Zealand's suicide attempt rate is one of the highest in the developed world, and suicide rates in the LGB community are five times higher than the general population (Snowdon, 2020; Terruhn & Spoonley, 2018). This statistic supports the notion that sexual minorities in New Zealand may experience heightened minority stress compared to other countries. Potentially high levels of internalised homophobia may be a key risk factor in the poor mental health experienced by New Zealand's LGB community which warrant further research.

Other limitations identified in global research studies investigating correlations between internalised homophobia and mental health include a lack of sexual minority diversity in sampling. A large portion of studies includes only gay men or men who have sex with men and often in the context of HIV infection and acquired immunodeficiency syndrome (AIDS) (Shahar & Varda, 2020; Wagner & Brondolo, 1996). Notably, less research is available on lesbian and bisexual individuals.

Furthermore, research that included more diverse samples tended to group gay, lesbian, and bisexual individuals into one group, assuming that internalised homophobia and mental health issues are experienced at similar rates across LGB individuals. This is a significant limitation as a growing body of research suggest that groups based on sexual orientation should be studied separately (McLaren, 2016). Research has shown that psychological distress and mental health can vary

significantly between lesbian, gay and bisexual groups and grouping them may lead to skewed and unrepresentative results (Shearer et al., 2016).

The current study aimed to conduct a quantitative, survey-based, cross-sectional study in a sample of New Zealand lesbian, gay and bisexual individuals and be the first of its kind to quantitatively investigate the correlation between internalised homophobia and psychological distress of anxiety, depression and suicidal ideation symptoms in New Zealand. The study aimed to address the aforementioned research limitations by including a diverse New Zealand sexual minority sample, while analysing data from sexual minority groups separately. The results of this study may provide valuable data that could be applied to clinical practice when working with LGB clients in improving mental health by reducing internalised homophobia levels.

As an additional exploratory aim, the study also explored the possible correlation between the age of *coming out*, the number of years since disclosing sexual orientation and internalised homophobia. Limited research is available that investigated the association of both the age of *coming out* and the number of years since disclosing sexual orientation with internalised homophobia. Prior research largely focused on comparing internalised homophobia levels between those who shared their sexual orientation with others and those who have not. Investigating these possible correlations will provide some insight into whether *coming out* at an earlier age may be a mitigating factor in reducing internalised homophobia. The current study proposed the following research questions:

1. Is internalised homophobia correlated with symptoms of anxiety, depression and suicidal ideation in a New Zealand sample of gay, lesbian, and bisexual individuals?
2. What is the level of internalised homophobia experienced by New Zealand gay, lesbian and bisexual individuals, and does it significantly differ between these groups?

3. Is there a correlation between age and internalised homophobia, and does internalised homophobia levels significantly differ between age groups in a sample of New Zealand gay, lesbian, and bisexual individuals?

4. Does the *coming out* age and the duration of time since disclosing sexual orientation predict the level of internalised homophobia experienced by New Zealand gay, lesbian, and bisexual individuals?

7. Methods

7.1. Participants

A total of 359 New Zealand gay, lesbian and bisexual participants were voluntarily recruited by convenience and respondent-driven sampling through advertising on social media platforms, Facebook and Instagram. Direct peer-to-peer email invitations were also sent to the researcher's friends, family, and acquaintances to promote survey uptake. Participants could share the research invitation with as many individuals as they liked, creating a snowball effect. The research advertisement and email invitation contained a URL link and QR code to the anonymous online research questionnaire.

Participants living in New Zealand who were at least 16 years of age, cisgender and identified as gay, lesbian, or bisexual were included in the study. Participants not meeting these eligibility criteria were excluded from participation. Participants were provided with a participant information sheet and a consent statement once the online survey was accessed (Appendix C), at which point the participant could agree or decline participation. Only participants who affirmed willingness to participate and met the inclusion criteria were provided access to the survey questionnaire. Participation was entirely voluntary, and participants could withdraw from the study at any time by closing the survey without submitting it.

7.2. Survey Questionnaire

The online survey was designed using Qualtrics software and consisted of 4 sections that included: (1) Demographics; (2) Depression Anxiety Stress Scale (DASS-21); (3) Internalised Homophobia Scale (IHS), and (4) Suicide Ideation Attributes Scale (SIDAS) (Appendix B). The survey took 10-15 minutes to complete, but no time limit was set. The technical functionality of the survey was pre-tested prior to data collection, and data from the pre-tests were not included in the data analysis. All three psychometric measures included in the survey were open access self-report

questionnaires. Total scores of all measures were calculated and interpreted according to the specific questionnaire manuals.

7.2.1. Demographics

The demographics section of the survey requested participants to provide their country of residence, age, gender, sexual orientation, ethnicity, relationship status, highest level of education, gross annual income and status of disclosing sexual orientation. Ethnicity was categorised using Statistics New Zealand's level 1 ethnicity categories (Statistics New Zealand, 2018b). Age, sexual orientation and country of residence were used to assess eligibility. Data from participants who identified as non-cisgender (*n* = 18) or who were unsure about sexual orientation (*n* = 5) were excluded from data analysis. A total of 78 cisgender lesbians, 94 gay men, 124 bisexual women and 63 bisexual men completed the research questionnaire. Sexual orientation was classified based on the participants' self-identification of their sexual identity. This approach is similar to other studies investigating internalised homophobia (Kuperberg & Walker, 2018; McLaren, 2016b; Yolaç & Meriç, 2021).

Sociodemographic characteristics of each sample group can be seen in Table 1. The majority of participants across all groups were of European descent (74.7%), followed by Māori (6.1%) and the age range was 16 – 69 years (*M* = 27.7, *SD* ± 12.3). The age of gay men ranged between 16 and 67 years (*M* = 32.3, *SD* ± 14.2), and the majority were single, had a university degree and earned between $50,000 and $99,999 annually. Lesbians ranged in age from 16 to 68 years (*M* = 29.2, *SD* ± 14.0), and half were single and had a university degree, and most of the group earned less than $10,000. Bisexual men were aged between 16 and 46 years (*M* = 23.6, *SD* ± 8.2). Most bisexual men were educated to primary school level, were single and earned less than $10,000. Bisexual women range in age from 16 to 69 years (*M* = 25.5, *SD* ± 9.9). Half of these women were single, and the majority earned less than $10,000 and achieved the highest education level of secondary school.

Table 1

Demographic data (*N* = 395).

	Lesbians *n* = 78		Gay men *n* = 94		Bisexual women *n* = 124		Bisexual men *n* = 63	
Characteristic	***n***	**%**	***n***	**%**	***n***	**%**	***n***	**%**
Age group (years)								
16-19	19	24.4	20	21.3	44	35.5	29	46.0
20-29	34	43.6	30	31.9	50	40.3	22	34.9
30-39	15	19.2	18	19.1	20	16.1	7	11.1
≥ 40	10	12.8	26	27.7	11	8.9	5	7.9
Relationship status								
Partnered	23	29.5	27	28.7	47	37.9	18	28.6
Single	39	50	56	59.6	61	49.2	38	60.3
Married	14	17.9	10	10.6	13	10.5	6	9.5
Separated/Divorced	2	2.6	1	1.1	1	0.8	1	1.6
Widowed	0	0	0	0	2	1.6	0	0
Ethnicity								
European†	66	84.6	71	75.5	101	81.5	57	90.5
Māori	5	6.4	3	3.2	11	8.9	3	4.8
Asian	2	2.6	11	11.7	2	1.6	3	4.8
Pacific Peoples	0	0	1	1.1	2	1.6	0	0
Other‡	5	6.4	7	7.4	8	6.5	0	0
Level of Education								
Primary school	1	1.3	3	3.2	5	4.0	2	3.2
Secondary school	26	33.3	28	29.8	54	43.5	37	58.7
Technical College	10	12.8	11	11.7	10	8.1	6	9.5
Undergraduate	29	37.2	24	25.5	32	25.8	13	20.6
Postgraduate	12	15.4	28	29.8	23	18.5	6	9.5
Gross Income (annual)								
< $10,000	29	37.2	21	22.3	43	34.7	27	42.9
$10,000 - $49,999	18	23.1	17	18.1	23	18.5	14	22.2
$50,000 - $99,999	17	21.8	31	33.0	33	26.6	8	12.7
> $100,000	2	2.6	13	13.8	5	4.0	4	6.3

Note. †Inclusive of mainland Europe, New Zealand, Australian, South African and other European descendants; ‡Inclusive of diverse, Middle Eastern, Latin American and African ethnicities.

7.2.2. Depression Anxiety Stress Scale (DASS-21)

The self-report scale, DASS-21, developed by Lovibond and Lovibond (1995), assessed the level of anxiety and depression symptoms over the past week. The DASS-21 is the short form of the DASS-42 that quantitatively measures depression, anxiety and stress symptomology. The DASS-21 is a screening tool and not a categorical measure of clinical diagnoses. The current study only used the anxiety and depression subscales of the DAS-21 and not the stress subscale. The DASS-21 has been extensively normed and have internal consistency and concurrent validity in acceptable to excellent ranges (Henry & Crawford, 2005; Samani & Joukar, 2007).

Each subscale contains seven items that are similar in content. The depression subscale assesses dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest, involvement, anhedonia and inertia, whereas the anxiety subscale assesses autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious affect (Lovibond & Lovibond, 1995). The participants responded to the 14 items (for example, “I felt that I had nothing to look forward to ") using a 4-point scale. Scores of the depression and anxiety subscales were calculated by adding the relevant items’ scores. A point range of 0 to 21 was possible for each subscale. Scores for each subscale can be categorised into five symptom severity ranges: normal, mild, moderate, severe, and extremely severe. Higher scores indicate an increased severity rating.

7.2.3. Internalised Homophobia Scale (IHS)

Internalised homophobia was measured using the 20-item self-report IHS developed by Wagner and Brondolo (1996). The IHS is widely used in research to measure the extent to which negative attitudes and beliefs about homosexuality are internalised and integrated into one’s self-image and identity as gay, lesbian or bisexual (Kralovec et al., 2014; McLaren, 2016a). Examples of items include, “I wish I were heterosexual” and “If I were heterosexual, I would probably be happier”. Participants indicated how much they agreed to each item using a 5-point Likert-type scale (1 = *strongly disagree* to 5 = *strongly agree*). Ten of the scale items were positively keyed, and ten items

were negatively keyed. Total scores ranged between 20 and 100, where higher scores represent greater levels of internalised homophobia.

The IHS showed good internal consistency reliability in samples of sexual minorities, yielding a Cronbach alpha of .92, and the summed score of all 20 items is regarded as a homogeneous measure of internalised homophobia (Wagner et al., 1994). Scores on the IHS were also found to be positively correlated with demoralisation (*r* = .36), global psychological distress (*r* = .37) and depression (*r* = .36) (Wagner & Brondolo, 1996).

7.2.4. Suicide Ideation Attribution Scale (SIDAS)

The SIDAS was used to screen participants for the presence of suicidal thoughts and assess the severity of these thoughts over the past month (Van Spijker et al., 2014). The self-report scale consists of 5-items, each targeting an attribute of suicidal thoughts: frequency, controllability, closeness to attempt, level of distress associated with the thoughts and the impact on daily functioning. For example, “In the past month, how often have you had thoughts of suicide?” and “In the past month, how close have you come to making a suicide attempt?”. Responses were measured on a 10-point scale, and total SIDAS scores were calculated by adding scores of the five items, with the controllability item reversed scored. Total scores range from 0 (no suicidal ideation) to 50 (extreme or severe suicidal ideation). A cut-off score of 21 may be used to indicate high-risk suicidal behaviour (Van Spijker et al., 2014).

The SIDAS showed good psychometric properties with a high internal consistency (Cronbach alpha .91) and showed a sensitivity of 85.5% for suicide plans and 84.0% for suicide attempts. The SIDAS also showed good convergent validity with other similar scales, such as the Columbia-Suicide Severity Rating Scale (*r* = 61) (Van Spijker et al., 2014).

7.3. Data Collection

This cross-sectional study obtained ethical approval from the Auckland University of Technology Ethics Committee (AUTEC) on 16 April 2021. Data collection commenced on 20 April

2021 and concluded on 11 May 2021. Participants accessed the online survey through a URL link or QR code embedded in the social media and email invitations. No identifiable information was collected from the participants, and a random number was assigned to each survey response by the survey software. Participants were able to skip any survey question they did not want to answer. Data from partially completed surveys (n = 32) and 18 non-cisgender participants were not included in the data analysis.

7.4. Data Analysis

Statistical analysis was performed separately for each of the sexual orientation groups, which included gay, lesbian, bisexual men and bisexual women. The statistical software package IBM SPSS (version 27) was used for the data analysis. Descriptive statistics were analysed to ensure adequate data variability in terms of demographic characteristics, internalised homophobia and psychological measures of anxiety, depression and suicidal symptoms to inform acceptable statistical tests (i.e., parametric and non-parametric tests). Techniques used to assess data distribution included calculating skewness and kurtosis and reviewing histograms. Data distribution was further confirmed using the Shapiro-Wilk's test (p > .050), and homogeneity of variances was tested using the Levene's test where applicable. Data sets that were normally distributed and met specific statistical test assumptions were analysed using parametric tests, and those data sets not meeting these criteria were analysed using non-parametric tests.

Inferential statistical tests used to investigate intergroup mean differences included the Kruskal-Wallis test, and correlations between variables were tested using bivariate Pearson's correlations coefficient (r) and Spearman's rho correlation coefficient (ρ). Correlation coefficients ranged from -1 (perfect negative correlation), 0 (no correlation) to +1 (perfect positive correlation) (Koo & Li, 2016). Multiple linear regression analyses were also used to predict outcome variables by entering various predictors into the regression models as described in subsequent sections.

Statistical tests were two-tailed, and the level of statistical significance was set at a probability value of p < .050. All intergroup statistical differences were reported with epsilon square

(ε^2) effect size and interpreted using criteria outlined by Rea et al. (2014). The means (*M*) and standard deviations (*SD*) were reported for all parametric analyses and the medians (*Mdn*) for non-parametric analyses. The following sections provide a detailed description of the data analysis according to the four research questions.

7.4.1. Internalised Homophobia Correlation with Psychological Distress

Total scores of the IHS, DASS-21 and SIDAS were calculated for each participant. The total scores represented the level of internalised homophobia, anxiety and depression symptomology and suicidal ideation, respectively. This cross-sectional data was then examined by correlating the outcome measures of anxiety, depression and suicidal ideation with internalised homophobia using Pearson's correlation with a Bonferroni correction to control for multiple comparisons. Multiple linear regression was then performed on each outcome variable (anxiety, depression and suicidal ideation) to evaluate the impact of internalised homophobia on these variables. In other words, multiple linear regression was used to determine if and to what degree internalised homophobia predicts the development of anxiety, depression and suicidal ideation symptomology. Regression models were calculated separately for gay, lesbian, bisexual men and bisexual women groups.

For the first multiple regression analysis, internalised homophobia and age were entered as predictors into the regression model to predict depression symptomology (depression model). The regression analysis was then repeated for anxiety (anxiety model). Age was included as a predictor in all models, as it showed a correlation with the outcome variables. The multiple regression model for the prediction of suicidal ideation included internalised homophobia, anxiety, depression and age as predictors (suicidal ideation model). Since depression and anxiety are known risk factors for suicide, these were included in the suicidal ideation model with internalised homophobia (Raposo et al., 2014; Vandivort & Locke, 1979). Entering known strong contributors of suicidal ideation into the regression model with internalised homophobia allowed for a better assessment of whether internalised homophobia as a variable independently and statistically contributed to the prediction of suicidal ideation.

7.4.2. Differences in Internalised Homophobia Levels Between LGB Individuals

The level of internalised homophobia was calculated for each participant by adding the scores of all 20 items on the IHS questionnaire. A total score of between 20 and 100 was possible, where a score of 20 represented no internalised homophobia, and higher scores represented increasing levels of internalised homophobia. Intergroup comparison of the level of internalised homophobia was performed by grouping participants into four nominal groups based on their sexual orientation, which included gay, lesbian, bisexual men, and bisexual women. The Kruskal-Wallis test was performed as data sets were not normally distributed. A *post hoc* test was then performed to determine which groups varied significantly in their level of internalised homophobia. Significance values were adjusted by the Bonferroni correction for multiple tests and reported with the epsilon square effect size.

7.4.3. Internalised Homophobia Correlation with Age and Intergroup Differences

The relationship between internalised homophobia and age was tested using Spearman's ρ correlation coefficient as data were not normally distributed. The correlation analysis was performed separately for all sexual orientation groups. Intergroup mean differences were tested using the Kruskal-Wallis test followed by a *post hoc* test to determine significant differences in the level of internalised homophobia between age groups. Due to the small sample sizes in some age brackets when participants were grouped according to sexual orientation, it was not feasible to perform meaningful inferential statistics on groups separately. Hence, data analysis investigating internalised homophobia mean differences between age groups aggregated all participants into one group. Therefore, all participants, irrespective of their sexual orientation, were recoded to four nominal age groups that included 16-19 years, 20-29 years, 30-39 years and ≥ 40 years of age.

7.4.4. Coming Out Age Variables Predicting Internalised Homophobia

Multiple linear regression analysis was used to investigate whether *coming out* age and, or the duration of time since disclosing sexual orientation (i.e., *coming out*) predicts the level of internalised homophobia. Regression analysis was performed separately for each of the sexual orientation

groups. For the analysis, the *coming out* age and the number of years since disclosing sexual orientation were simultaneously entered as predictors into the regression model to predict the level of internalised homophobia. The *coming out* age was imported directly from the survey, while the number of years participants have been *out*, were calculated by subtracting *coming out* age from participants' current age as reported on the survey.

8. Results

The following sections present the results from the data analysis grouped according to the four research questions. All data and tables are reported as per the guidelines of the Publication Manual of the American Psychological Association, seventh edition (American Psychological Association, 2020).

8.1. Correlations Between Internalised Homophobia and Psychological Distress

Psychological distress scores in Table 2 show that gay men reported mild anxiety symptoms (M = 5.05, SD ± 4.3) while all other groups reported moderate symptoms (DASS-21 anxiety scores 6 - 7). Analysis of the intergroup differences in the level of anxiety showed that bisexual women reported significantly higher anxiety symptoms than gay men (p = .011), and no other differences were observed. All groups reported moderate levels of depression symptoms (DASS-21 depression scores 7 - 10). Again, bisexual women scored significantly higher depression symptoms than gay men (p = .007), and no other mean differences were observed.

Bisexual women reported the highest level of suicidal ideation (M = 11.81, SD ± 13.6); however, no statistically significant differences were found between the means of the group scores following adjustment by Bonferroni correction for multiple tests. The majority of the study sample (59%) reported suicidal ideation. It is worth noting that 20% (n = 71) of these participants scored ≥ 21 on the SIDAS, which indicate a high risk of suicidal behaviour. Bisexual women represented the majority (46%, n = 33) of this high-risk group, while the other sexual minorities had equal representation.

Table 2

Psychological distress scores from DASS-21 and SIDAS.

Group	**Anxiety**	**Depression**	**Suicidal ideation**
	M ± *SD*	*M* ± *SD*	*M* ± *SD*
Gay men	5.05 ± 4.3	6.51 ± 5.3	7.14 ± 10.5
Lesbians	6.30 ± 4.4	8.18 ± 5.9	8.45 ± 12.8
Bisexual men	5.97 ± 4.1	7.85 ± 13.7	9.89 ± 12.8
Bisexual women	7.05 ± 4.8	8.84 ± 5.5	11.81 ± 13.6

Note. Depression, anxiety and suicidal ideation refer to the symptom scores reported on the DASS-21 and SIDAS psychometric instruments.

The degree to which anxiety, depression and suicidal ideation scores are correlated with internalised homophobia is presented in Table 3. This analysis showed that internalised homophobia is significantly and positively correlated with anxiety (r = .252), depression (r = .241) and suicidal ideation (r = .291) scores.

Table 3

Internalised homophobia correlation with psychological distress scores.

Psychological distress	**IHS**	
	r	*p*-value
Anxiety	.252	< .001**
Depression	.241	< .001**
Suicidal ideation	.291	< .001**

Note. Statistical significance ** p < .010); IHS: Internalised homophobia scale score.

Multiple linear regression models were computed to determine the relationship between internalised homophobia and measures of anxiety, depression and suicidal ideation (Table 4). These results are summarised separately for each sexual orientation group below.

8.1.1. Gay Men

The results of the multiple linear regression predicting anxiety and depression, indicated that the models accounted for both 14% of the variance in anxiety (F(2, 90) = 7.17, p = .001, R^2 = .14) and depression (F(2, 90) = 7.38, p = .001, R^2 = .14) scores. Internalised homophobia significantly

contributed to the variance in anxiety (t = 2.75, p = .007) and depression (t = 3.05, p = .003) scores, while age did not. The suicidal ideation model indicated that 62% of the variance in suicidal ideation was explained by the predictors: anxiety, depression, internalised homophobia and age (F(4, 88) = 36.46, p < .001, R^2 = .62). However, examination of the individual predictors showed that only anxiety (t = -2.46, p = .016) and depression scores (t = 7.29, p < .001) significantly predicted suicidal ideation and not internalised homophobia (t = 0.48, p = .629) or age (t = .304, p = .762).

8.1.2. Lesbians

Regression models predicting anxiety and depression in lesbians showed that internalised homophobia did not contribute significantly to either anxiety (t = .91, p = .365) or depression scores (t = 1.37, p = .174). The model however, accounted for 19% of the variance in anxiety (F(2, 71) = 8.14, p = .001, R^2 = .19) and 13% in depression (F(2, 71) = 5.52, p = .006, R^2 = .13) scores due to the significant contribution of age in both models. The suicidal ideation model indicated that 58% of the variance in suicidal ideation was explained by the predictors (F(4, 69) = 23.46, p < .001, R^2 = .58). In this model, internalised homophobia did significantly contribute to the variance in suicidal ideation (t = 2.10, p = .040), although to a smaller degree than anxiety (t = 2.87, p = .005) and depression (t = 5.11, p < .001) scores. Age did not contribute significantly to suicidal ideation (t = .49, p = .626) in this model.

8.1.3. Bisexual Men

The anxiety regression model in bisexual men significantly predicted anxiety scores and accounted for 18% of the variance in anxiety scores (F(2, 57) = 6.10, p = .004, R^2 = .18). Both internalised homophobia (t = 3.08, p = .013) and age (t = -30, p = .016) contributed significantly to this variance. The depression regression model failed to significantly predict depression scores (F(2, 57) = 2.22, p = .118, R^2 = .07). The suicidal ideation model indicated that 67% of the variance in suicidal ideation was explained by the model predictors (F(4, 55) = 28.13, p < .001, R^2 = .67). However, only anxiety (t = 4.93, p < .001) and depression scores (t = 4.96, p < .001) significantly

contributed to the variance in suicidal ideation and not internalised homophobia (t = -.98, p = .332) or age (t = -.83, p = .408).

8.1.4. Bisexual Women

The results of the multiple linear regression models predicting anxiety and depression in bisexual women indicated that the models accounted for 22% of the variance in anxiety (F(2, 114) = 15.59, p < .001, R^2 = .22) and 18% in depression (F(2, 114) = 12.25, p < .001, R^2 = .18) scores. Internalised homophobia significantly predicted anxiety (t = 2.75, p = .007) and depression (t = 2.87, p = .005) scores in these models, as did age. The suicidal ideation model explained 67% of the variance in suicidal ideation scores (F(4, 112) = 57.10, p < .001, R^2 = .67). Internalised homophobia (t = .16, p = .006) and depression (t = .72, p < .001) were the only variables that significantly contributed to the prediction of suicidal ideation.

Table 4

Results of multiple regression analysis predicting anxiety, depression and suicidal ideation.

	Gay men		**Lesbians**		**Bisexual men**		**Bisexual women**	
Predictor variables	R^2	β	R^2	β	R^2	β	R^2	β
Anxiety model	.14**		.19*		.18*		.22**	
IH		.28**		.10		.31*		.24**
Age		-.16		-.41*		-.30*		-.36**
Depression model	.14**		.13**		.07		.18**	
IH		.31**		.15		.19		.23**
Age		-.13		-.32**		-.20		-.32**
Suicidal ideation model	.62**		.58**		.67**		.67**	
IH		.04		.17*		-.08		.16**
Age		.02		.04		-.07		.02
Anxiety		.21**		.30**		.48**		.07
Depression		.63**		.51**		.45**		.72**

Note. Statistical significance *p < .050), ** p < .010); IH: Internalised homophobia.

8.2. Differences in Internalised Homophobia Levels Between LGB Individuals

The median level of internalised homophobia for the entire study sample was 36.0, representing a mild to moderate severity level. A total of 9 participants reported no internalised

homophobia, while most participants (97.5%) reported some level of internalised homophobia. The intergroup differences of internalised homophobia levels between groups are presented in Table 5. Bisexual men showed the highest level of internalised homophobia (*Mdn* = 39.0) and lesbians the lowest (*Mdn* = 33.0). Male participants (gay and bisexual men) reported higher levels of internalised homophobia than female participants (lesbian and bisexual women). The Kruskal-Wallis test found a statistically significant difference in internalised homophobia levels between sexual orientation groups ($H(3) = 8.64$, $p = .034$) and the effect size was strong ($\varepsilon^2 = .02$), indicating that sexual orientation had a significantly strong effect on the level of internalised homophobia. *Post hoc* analysis indicated that only bisexual men reported significantly higher levels of internalised homophobia compared to lesbians ($p = .42$). No other significant differences were observed between the groups.

Table 5

Comparison of internalised homophobia levels between sexual orientation groups.

Characteristic	**Group size**	**IHS**	***H***	***p*-value**	**Effect size**
	n	*Mdn*			ε^2
Sexual Orientation			8.64	.034*	.02
Gay men	94	38.0			
Lesbians	77	33.0			
Bisexual men	63	39.0			
Bisexual women	124	36.0			

Note. *Statistical significance ($p < .050$); IHS: Internalised homophobia scale score.

8.3. Internalised Homophobia Correlation with Age

Data distributed by age for the entire sample (Table 6) indicated that the age group 16 - 19 years had the highest level of internalised homophobia (*Mdn* = 39.5), and the oldest age group (≥ 40 years of age) showed the lowest level of internalised homophobia (*Mdn* = 32.5). The Kruskal-Wallis test found a statistically significant difference in internalised homophobia levels between age groups, $H(3) = 9.28$, $p = .026$, and the effect size was strong ($\varepsilon^2 = .02$), indicating that age had a significantly strong effect on the level of internalised homophobia. *Post hoc* analyses, using Tukey's HSD test,

indicated that the youngest age group (16-19 years) had a significantly higher level of internalised homophobia compared to the oldest age group, ≥ 40 years (p = .015). No other significant differences were observed between the age groups. Furthermore, the analysis found a statistically significant negative correlation between internalised homophobia and age in only gay men (p = .004, ρ = -.29) and bisexual women (p = .025, ρ = -.20). In other words, the level of internalised homophobia declined with age in the gay men and bisexual women groups. There was no significant correlation observed between age and internalised homophobia in lesbians and bisexual men.

Table 6

Comparison of internalised homophobia between age groups and analysing the correlation with age.

Characteristic	**Group size**	**IHS**	***H***	***p*-value**	**ρ**	**Effect size**
	n	*Mdn*				ε^2
Age group (years)			9.28	.026*		.02
16-19	112	39.5				
20-29	136	36.0				
30-39	59	38.0				
≥ 40	52	32.5				
Age correlation						
Gay men				.004**	- .29	
Lesbians				.088	- .20	
Bisexual men				.980	.00	
Bisexual women				.025*	- .20	

Note. *Statistical significance *p < .050), ** p < .010); IHS: Internalised homophobia scale score.

8.4. Coming Out Age Variables Predicting Internalised Homophobia

Descriptive statistics in Table 7 show that 95.3% (n = 342) of the study sample had disclosed their sexual orientation, of which bisexual women (98.4%) and lesbians (97.4%) had the highest disclosure rate and bisexual men the lowest (90.5%). The mean *coming out* age across all sexual orientation groups was 18 years. The homosexual groups reported the highest number of years being *out* (that is, the number of years since disclosing sexual orientation), and the bisexual groups reported the lowest number of years.

Table 7

Coming out age data for the four sample groups.

Group	Disclosed sexual orientation	Coming out age	Number of years out
	n (%)	*M* ± *SD*	*M* ± *SD*
Gay men	88 (96.3)	18.0 ± 4.0	14.8 ± 12.9
Lesbians	75 (97.4)	17.6 ± 4.9	12.0 ± 13.1
Bisexual men	57 (90.5)	18.2 ± 5.3	5.7 ± 7.3
Bisexual women	122 (98.4)	18.3 ± 5.9	7.0 ± 7.7

Multiple linear regression was calculated for each group to predict internalised homophobia based on *coming out* age and number of years being *out*. Results from the regression analysis, presented in Table 8, show that for gay men, there was a significant collective effect between *coming out* age and the number of years *out* on internalised homophobia levels, $F(2, 85) = 5.18$, $p = .008$, $R^2 = .11$). Hence, the model indicated that 11% of the variance in the level of internalised homophobia was explained by *coming out* age and the number of years being *out*. However, examination of the individual predictors showed that only the number of years *out* ($t = -3.19$, $p = .002$) and not *coming out* age ($t = -.23$, $p = .825$) was a significant predictor of internalised homophobia in this model.

Regression analysis of the other groups found that the model was not significant for lesbians ($F(2, 72) = .84$, $p = .437$, $R^2 = .02$), bisexual men ($F(2, 54) = .91$, $p = .410$, $R^2 = .03$) and bisexual women ($F(2, 119) = 2.40$, $p = .095$, $R^2 = .04$). In other words, *coming out* age and the number of years being *out* did not significantly predict internalised homophobia in lesbian and bisexual individuals.

Table 8

Results of regression analysis testing coming out age variables prediction of internalised homophobia.

	Gay men		Lesbians		Bisexual men		Bisexual women	
Predictor variable	R^2	β	R^2	β	R^2	β	R^2	β
Model	.11**		.02		.03		.04	
Coming out age		.02		.06		.17		-.00
Number of years out		.33**	20	-.14		-.03		-.20

Note. Statistical significance ** $p < .010$).

9. Discussion

To date, no published studies have quantitatively investigated internalised homophobia and its relationship with anxiety, depression, suicidal ideation, age and *coming out* variables in the New Zealand LGB community. The overall purpose of the current study was to fill this research gap by conducting a cross-sectional study in a New Zealand population-based LGB sample. The most significant findings of this study included that internalised homophobia only correlated with some measures of psychological distress, and marked disparities in this relationship were observed between sexual minority groups. The study also showed significant differences in levels of internalised homophobia between sexual orientation groups. Age also showed a negative correlation with internalised homophobia but only in gay men and bisexual women. Results further indicated that *coming out* age did not predict the level of internalised homophobia in any sexual minority group. However, the number of years of being *out* seems to predict internalised homophobia levels in gay men. The following sections will discuss these findings in greater detail.

9.1. Internalised Homophobia Correlation with Psychological Distress

It is well documented that LGB individuals constantly report higher rates of psychological distress than their heterosexual counterparts (Chard et al., 2015). Hence, the high rates of anxiety, depression, and suicidal ideation symptoms observed in this New Zealand-based sample were not surprising. In fact, this non-clinical sample reported a mean moderate severity level of psychological distress across all three measures of anxiety, depression and suicidal ideation symptoms, which is higher than samples from the general population (Sadock et al., 2014). These cross-sectional results are consistent with the high rates of psychological distress observed in a recent New Zealand LGB longitudinal study by Spittlehouse et al. (2020).

The minority stress model proposes that these higher rates of mental health concerns are due to chronic stress experienced by LGB individuals living in a heteronormative society due to prejudice, stigmatisation, and victimisation (Meyer & Frost, 2013). These findings may suggest that

the New Zealand LGB population, similar to those in other countries, experiences higher exposure to social stressors than heterosexual individuals, such as victimization, employment discrimination, harassment in schools, and family rejection (Katz-Wise & Hyde, 2012). These unique social stressors create a fear of being identified as homosexual, anxiety about rejection, and a lack of self-confidence about one's ability to cope with stigma and prejudice, which are internalised and may ultimately lead to the development of mental health issues (Bränström, 2017; Szymanski & Ikizler, 2013).

The current study data also showed little differences between the psychological distress scores between sexual orientation groups, suggesting that gay men, lesbians and bisexual individuals may be at equal risk of developing psychological distress. The only significant difference observed was between bisexual women and gay men, where bisexual women reported significantly higher anxiety and depression symptoms. The study also reported a high rate of suicidal ideation in the sample, with 59% of participants reporting suicidal thoughts, of which 20% were considered at high risk of suicidal behaviour. These results were expected as rates of suicidal ideation and attempts have been reported as 2 to 3 times higher among young LGB adults than in the heterosexual population (Hottes et al., 2016). Again, bisexual women reported the highest suicidal ideation among all groups, although the result was not statistically significant.

There are several reasons why bisexual women may have reported higher anxiety, depression, and suicidal ideation symptoms, although these are only speculative. Firstly, bisexual women were overrepresented in the sample, with 32% of participants identifying as bisexual women, which may have skewed the data to some extent. Secondly, it is well known that women statistically report higher rates of anxiety and depression than men, which may have been a contributing factor (Sadock et al., 2014). However, if gender played a significant role in the study, it would be expected that lesbians also report equally higher scores of psychological distress, which was not the case. Baams et al. (2015) also found significantly higher rates of psychological distress in bisexual women compared to other sexual minority groups. Their study showed that perceived burdensomeness, in other words, feeling like a burden to people in their lives, may be an important mechanism in

explaining higher levels of depression and suicidal ideation in bisexual women. Finally, bisexual individuals have been shown to be at increased risk of depression and anxiety compared to monosexual individuals, as bisexuals are more likely to conceal their sexuality, a key factor associated with adverse mental health outcomes (Feinstein et al., 2020).

Reflecting on the key research question of whether a relationship exists between internalised homophobia and psychological distress in a sample of New Zealand LGB individuals, the current study showed a significant positive correlation between these variables. In other words, as internalised homophobia scores increased, so did symptom scores of anxiety, depression and suicidal ideation. These results were consistent with research conducted in other countries reporting a similar positive correlation between internalised homophobia and psychological distress (Lorenzi et al., 2015; Meyer & Frost, 2013; Xu et al., 2017; Yolaç & Meriç, 2021). Again, these results are not surprising and consistent with other global studies that showed that internalised homophobia was an independent risk factor for depression, anxiety, and suicidal ideation in multiple regression models (McLaren, 2016).

Clinically, it seems intuitive that when considering depression and suicidality, that a significant correlation is feasible with internalised homophobia due to its shared characteristics of a sense of worthlessness and low self-esteem (Yolaç & Meriç, 2021). More specifically, from the perspective of the minority stress model, elements of internalised homophobia that include: negative attitudes towards one’s own same-sex attraction, other sexual minorities and disclosure of sexual orientation were all shown to be related to depression in LGB individuals (Meyer & Frost, 2013). The link between anxiety and internalised homophobia, on the other hand, is not thought to be a result of the fear of being discovered as being LGB (Igartua et al., 2009). However, it seems that some LGB individuals' highly negative view about themselves creates anxiety irrespective of whether or not there is a threat of discovery. Some studies suggest that negative feelings about one's homosexuality are the most predictive factor in predicting psychological distress and that negative

feelings towards other sexual minorities or discomfort with disclosure of sexual orientation may be of limited importance (Yolaç & Meriç, 2021).

Internalised homophobia is a chronic stressor for many LGB individuals raised in Western cultures, and belonging to a minority group about which one feels negatively is bound to affect mental health (Yolaç & Meriç, 2021). Similar to other global research, the current study has indeed shown a significant link between internalised homophobia and psychological distress. These findings suggest that internalised homophobia is associated with anxiety, depression and suicidal ideation and may be an important risk factor for developing psychological distress in LGB individuals (Meyer, 2013).

However, under closer investigation, the results from the current study suggest that the correlation between internalised homophobia and psychological distress may be more complex than assuming that there is a positive correlation between these variables across all sexual minority groups. In fact, regression analysis showed that this positive correlation observed across the study sample is not a true reflection of this association for all sexual minorities. The current study found that the significant effect of internalised homophobia in predicting anxiety, depression and suicidal ideation differ significantly between sexual orientation groups and the type of psychological distress. These findings are consistent with recent studies following a similar methodological approach of separating sexual minorities during data analysis (McLaren, 2016). These studies also found significant variation in the relationship between internalised homophobia, as an independent risk factor, and depression, anxiety, and suicidal ideation among different sexual orientation groups

Regression analysis in the current study found that for gay men, internalised homophobia significantly predicted anxiety and depression symptoms but not suicidal ideation. These results may be explained by Igartua et al. (2009) that showed that once depression is added to the regression model, only depression and not internalised homophobia predict suicidal ideation. Therefore, internalised homophobia does not explain the unique variance in suicidal ideation. These results may

indicate that depression may mediate the association between internalised homophobia and suicidal ideation among New Zealand gay men.

In lesbians, internalised homophobia did not significantly contribute to either anxiety or depression but did predict suicidal ideation. This is an interesting finding and, in some sense, the opposite to the findings of gay men. It seems that although internalised homophobia does not independently contribute to, or predict anxiety and depression symptoms, both known predictors of suicidal ideation, it may be possible that depression and anxiety moderate the relationship between internalised homophobia and suicidal ideation among lesbians. It is surely possible that the strength of the relationship between internalised homophobia and suicidal ideation would be stronger for lesbians who have high levels of depression and, or anxiety. These results may imply that internalised homophobia is indirectly related to suicidal ideation via a moderation mechanism of depression and anxiety symptoms. In other words, the relationship between internalised homophobia and suicidal ideation may only exist for New Zealand lesbians with high levels of anxiety and depressive symptoms. Findings from McLaren (2016a) supported such a moderation model.

In bisexual women, internalised homophobia significantly contributed to all measures of psychological distress of anxiety, depression and suicidal ideation. These results suggest that in bisexual women, internalised homophobia is a strong predictor of anxiety, depression and suicidal ideation. These results also support findings by McLaren (2016a) suggesting an additive model where both internalised homophobia and depression independently contribute to suicidal ideation. Interestingly, when anxiety, depression and internalised homophobia were entered into the regression model, anxiety did not predict suicidal ideation as seen in the other sexual minority groups. This result suggests that for New Zealand bisexual women, internalised homophobia and depression are independent predictors of suicidal ideation and not anxiety.

For bisexual men, internalised homophobia only significantly predicted anxiety symptoms and not depression or suicidal ideation. In other words, in this group, internalised homophobia seems to independently contribute to the variance in anxiety symptoms and showed limited

influence on symptoms of depression and suicidal ideation. One possible explanation for this finding may relate to the concealment of sexual orientation being a salient stressor in bisexual men, which was found to cause significant anxiety in these men (Feinstein et al., 2020). Studies have shown that bisexual men's motivation to conceal sexuality is due to a fear of discrimination and victimisation, and many bisexual men conceal their same-sex attraction not just socially but in intimate relationships, especially for those men in heterosexual relationships with a partner unaware of their sexual orientation (van der Star et al., 2019).

These results show a marked difference in the relationship between internalised homophobia and psychological distress among New Zealand gay, lesbian and bisexual individuals. The possible reasons for the variation seen in the relationship between these variables may be complex and were not the focus of the current study. However, when reviewing the results, one might be tempted to suggest that gender may explain the variance seen between the groups. Indeed, this observation may be valid; however, numerous studies have shown that the experience of any level of homophobia may be associated with the development of internalised homophobia, which is associated with the development of internalised mental health problems. Consequently, gender was not found to significantly influence the strength of the internalised homophobia-psychological distress relationship (McLaren, 2015; Newcomb & Mustanski, 2010)

It is possible that sexual orientation-specific factors, such as differences in social acceptance of sexual minorities, where female sexual minorities are generally more accepted than non-heterosexual males, may play a role in the variance of the relationship seen between internalised homophobia and psychological distress (Bettinsoli et al., 2020). Other possible factors may include that some aspects of minority stress may be more prominently experienced by different sexual minorities, such as concealment of sexual orientation, which ultimately may influence internalised homophobia and development of mental health concerns (Meyer & Frost, 2013). Whatever the contributing factors, the results from the current study highlight that the relationship between internalised homophobia and psychological distress differs significantly between sexual minorities,

and a *one-size-fits-all* approach of studying mental health in the New Zealand LGB community would not produce representative results.

9.2. Differences in Internalised Homophobia Levels Between LGB Individuals

In this sample of 359 LGB participants, the median internalised homophobia score was 36.0, representing a mild to moderate severity level. The study showed that 97.5% of participants reported some level of internalised homophobia, and only nine participants reported no feelings of internalised homophobia. This finding is consistent with researchers that state that most LGB individuals raised in heteronormative societies experience some form of internalised homophobia, albeit at varying degrees (Berg et al., 2016; Meyer & Frost, 2013).

The findings in the current study are in contrast with the results from other recent studies by Yolaç and Meriç (2021) and Yalçınoğlu and Önal (2014), which reported much lower internalised homophobia rates of 22% of their samples. However, it is important to note that these studies grouped gay, lesbian, and bisexual individuals into one group during statistical analysis. A growing body of research shows that the rate and level of internalised homophobia may differ significantly between sexual minorities (Bränström, 2017). The current study followed the recommendation that sexual minority groups should be separated during data analysis to produce more accurate and representative results.

Another challenge in comparing the results from the current study with the studies that reported lower rates of internalised homophobia is that these studies included gender-diverse participants, such as transgender and other non-cisgender individuals. Gender diversity is a complex variable with numerous dimensions and constructs that may significantly influence levels of internalised homophobia (Rubin et al., 2020). Due to this reason, the current study only recruited cisgender participants in an effort to exclude additional variables, such as gender diversity, that may significantly affect the study results. Hence, comparing the results from the current study with studies including gender-diverse participants are challenging.

Internalised homophobia is strongly correlated with societal heterosexism, and the level of heterosexism is directly correlated with a society's acceptance of sexual minorities (Meyer, 2003; Warner, 1991). The high rate of internalised homophobia reported in this New Zealand LGB sample may suggest that LGB individuals experience high levels of heterosexism in New Zealand. This may indicate that parts of New Zealand's society may still have limited acceptance of sexual minorities, and heterosexism may still be deeply rooted and systemic within New Zealand. This notion is surely supported when considering New Zealand has the second-highest bullying rate in schools among the OECD countries, where 40% of bullied children report being physically harmed due to their sexual orientation or gender diversity (Franks, 2019; Lucassen et al., 2014). Homophobic bullying is also common in professional sports teams and workplaces, where almost 40% of sexual minority workers report daily or weekly homophobic acts against them (Chambers et al., 2018; Denison et al., 2020). News articles reporting physical attacks on sexual minorities are common and regular (Fraser, 2014; Hutt, 2021). Considering these factors, these high rates of internalised homophobia in this New Zealand LGB sample were not unexpected.

The current study also showed that internalised homophobia scores were higher in male participants compared to female participants, which was also reported by Yolaç and Meriç (2021). Although there is limited research investigating possible gender differences in internalised homophobia, research suggests that non-heterosexual men suffer more verbal and physical sexual-orientation-based victimisation than women, which may contribute to higher levels of internalised homophobia in men (McLaren, 2015). The increased heterosexism experiences by male sexual minorities may be due to societies being more accepting towards lesbians and bisexual women, which ultimately contribute to lower heterosexist acts against females and ultimately lower rates of internalised homophobia. Supporting this theory, Bettinsoli et al. (2020) surveyed the attitudes of the general populations of 23 Western and non-Western countries and found that non-heterosexual females were significantly more accepted than male non-heterosexuals. The study found a constant

relationship between gender norm endorsement and sexual prejudice across all these countries and showed that men are more likely to be both the targets and perpetrators of sexual prejudice.

Although findings from Yolaç and Meriç (2021) suggest that gender may play a role in internalised homophobia, the current study's results would argue that sexual orientation instead of gender may play a more significant role in internalised homophobia. Although the results show higher median internalised homophobia scores in males, statistical analysis showed that only bisexual men statistically reported higher levels of internalised homophobia compared to gay men, lesbians and bisexual women. This suggests that sexual orientation may be a key contributor to levels of internalised homophobia and not only gender, a notion supported by the strong effect size (ε^2 = .02) of sexual orientation reported in the current study. The higher levels of internalised homophobia in bisexual men were consistent with results from other studies that showed bisexual men constantly report higher internalised homophobia rates and are more likely to conceal their sexual orientation (Costa et al., 2013). The concealment of sexual orientation would explain the increased internalised homophobia rates reported in the study, as Meyer (2003) stated that concealment of sexual identity is one of the key contributors of internalised homophobia. This theory seems plausible when considering that bisexual men had the lowest *coming out* rate in this study compared with gay men, lesbians and bisexual women.

Some research suggests that the reason for this heightened level of internalised homophobia in bisexual men is that bisexual men's self-acceptance may be a more ambiguous situation compared to heterosexuals and homosexuals (Adebajo et al., 2012). Bisexual men tend to have less formed sexual identities, making them more vulnerable to internalising societal heterosexism. Bisexual individuals are often forced to live within heterosexual standards due to social or family pressure (Xu et al., 2017). Living as a heterosexual may lead to the exclusion of bisexual individuals, specifically bisexual men, from LGB social networks, limiting their social support that may otherwise reduce feelings of internalised homophobia (Wardecker et al., 2019).

A large cross-sectional study by Chard et al. (2015) found that bisexual men with a large gay and bisexual social network reported significantly lower feelings of internalised homophobia than bisexual men with social networks consisting of mostly heterosexual individuals. Ross et al. (2013) found an association between internalised homophobia, specifically concealment of sexual orientation, and the proportion of gay or bisexual men in a bisexual man's social network. Studies have also shown that community connectedness seems to surpass any cross-country cultural differences that may contribute to feelings of internalised homophobia (Chard et al., 2015). Social networks, no matter where, provide a support system and positive role models from other non-heterosexual men who experience the same stigmatisation and prejudice (Meyer, 2003). Meyer and Frost (2013) found this to be true for all male and female sexual minority individuals where internalised homophobia is significantly lower with greater community connectedness.

In summary, the current study reported high rates of internalised homophobia across all sexual minority groups in a New Zealand LGB population sample which may be due to elevated levels of heterosexism in the New Zealand society. The results also showed a strong influence of sexual orientation on levels of internalised homophobia, specifically in bisexual men, which may be due to higher sexual orientation concealment and limited sexual minority social support.

9.3. Internalised Homophobia Correlation with Age

The current study found significantly higher levels of internalised homophobia in the 16–19-year age bracket compared to the older age group (≥ 40 years of age). These results are consistent with a recent large meta-analysis that reported significantly higher levels of internalised homophobia in those younger than 21 years of age (Dürrbaum & Sattler, 2020). The current study results suggest that age may play a role in the level of internalised homophobia experienced by LGB individuals. This notion is supported by the strong effect size ($\varepsilon^2 = .02$) reported and indicates that the differences between the groups are likely due to age. Many studies have supported this suggested correlation between internalised homophobia and age in that sexual minority individuals in lower age brackets

show higher levels of internalised homophobia than older individuals (McLaren, 2015; Newcomb & Mustanski, 2010).

These findings are not surprising when considering that the adolescent and early adult years of many LGB individuals are dominated by the *coming out* process. These findings are consistent with theories stating that internalised homophobia is strongest when an individual is *coming out*, a process generally occurring during adolescent and young adult years and decline steadily over time as individuals develop a positive sexual identity (Cass, 1984; Troiden, 1989). The *coming out* process is often a period of heightened minority stress which would explain the higher internalised homophobia levels. There are several proposed reasons for this heightened internalised homophobia at this age where individuals consider disclosing their sexual identity. Some of these reasons include a lack of affirming social support, especially if sexual identity have not been shared with family and friends, low self-esteem, bullying, increased prejudicial attitudes and lack of internal coping strategies (Mulvey & Killen, 2015). Meyer (2003) further showed that exposure to heterosexist violence and discrimination is most acute at the beginning of the *coming out* process, adding to the minority stress experienced by these young individuals.

The current study also showed that individuals in the top age bracket (≥ 40 years) reported the lowest levels of internalised homophobia (*Mdn* = 32.5). Similar results were reported by McLaren (2015) that showed that middle-aged and older individuals showed significantly lower internalised homophobia than younger aged groups. Older individuals are more likely to have developed positive sexual identities, accepted their sexualities, and have established supportive social networks over the years that make them less prone to be affected by minority stress (Meyer & Frost, 2013). These findings are consistent with research by Dürrbaum and Sattler (2020), who showed that internalised homophobia significantly decreases with age across all sexual minority groups.

The significance of these findings goes beyond a simple statistical correlation between internalised homophobia and age. Research has shown that in sexual minorities, those in younger age brackets are more likely to have been diagnosed with depression and anxiety than individuals in

older age brackets (Newcomb & Mustanski, 2010). Similarly, suicide attempts in sexual minorities are significantly higher in those under the age of 30 years (Sivasubramanian et al., 2011). It is theorised that sexual minorities are most at risk of depression, anxiety and suicide due to the developmental tasks of questioning and developing their sexual identity and the subsequent *coming out* process (Meyer & Frost, 2013). Therefore, psychological distress and internalised homophobia are both prominent issues in younger sexual minority individuals suggesting age may moderate the internalised homophobia-psychological distress relationship (McLaren, 2015).

Interestingly, when correlation analysis was performed in this New Zealand LGB sample, age only significantly correlated negatively in gay men and bisexual women. In other words, internalised homophobia declined with age but only in gay men and bisexual women. These results were consistent with global studies that showed that the association between age and internalised homophobia varies between sexual minority groups and geographical locations (Chard et al., 2015; Ross et al., 2018b). These studies found strong associations between age and internalised homophobia in gay and bisexual men in South Africa and several European countries; however, samples from Australia, Canada, United Kingdom and the United States showed no associations between age and internalised homophobia. Geographical variation in the relationship between age and internalised homophobia has also been observed in lesbians and bisexual women (McLaren, 2016a; Vale et al., 2019).

Limited data is available to explain the variance in the relationship between age and internalised homophobia between sexual minority groups. One possible explanation may relate to differences in sexual identity development between these groups, especially regarding the processes of concealment and self-disclosure of sexual orientation. It is certainly possible that some sexual minorities, such as gay men, might engage in a swifter and, or complete process of sexual identity development that results in earlier disclosure of sexual orientation, compared to bisexual men, which would explain heightened levels of internalised homophobia during younger years that quickly decline with age. On the other hand, bisexual men may follow a different developmental path that

could be characterised by a more gradual and, or incomplete process where disclosure of sexual orientation happens later in life or, in some cases, never. Therefore, age may not play a significant role in the levels of internalised homophobia in bisexual men. Research has reported that concealment of sexual orientation is a prominent and persistent stressor, especially in bisexual men, due to fears of discrimination and victimisation (Feinstein et al., 2020). Indeed, the higher rate of concealment of sexual orientation reported by bisexual men in the current study supports this theory.

Another key factor that may explain the variance in the internalised homophobia-age relationship may also relate to differences in the availability of affirming services for the specific sexual minority groups and, most notably, social support throughout their journey of discovering sexual orientation. Again, bisexual men, as an example, might have limited social support from other LGB individuals due to ongoing concealing of their sexual orientation and possible rejection from other sexual minorities (Meyer & Frost, 2013). Social support has been identified as a significant independent mitigator of internalised homophobia across all sexual minority groups (Meyer, 2013). Bisexual men, over the life span, have reported higher levels of social isolation and loneliness, which might explain why internalised homophobia is not declining with age as with gay men or bisexual women (Power et al., 2021).

9.4. Coming Out Age Variables Predicting Internalised Homophobia

LGB youth *come out* at increasingly younger ages, which is primarily due to increasing societal support and acceptance of sexual minorities over the decades (Baams et al., 2015; Russell & Fish, 2016). Disclosing one's sexual orientation as an LGB individual is one of the key aspects of developing a positive sexual identity, which reduces internalised homophobia and promotes psychological wellbeing (Meyer & Frost, 2013). However, although disclosure of sexual orientation in LGB youth occurs at younger ages than ever before, proportionally higher levels of mental illness are still reported in this population group. This paradox led to this study investigating whether *coming*

out age and, or the duration of time since disclosing sexual orientation may predict the level of internalised homophobia experienced by New Zealand LGB individuals.

The average age of *coming out* across all sexual orientation groups in the current study was 18 years, which is higher than the average *coming out* age of 14, reported by Baams et al. (2015). For ethical reasons, the study only included participants 16 years of age and older, resulting in a higher sample mean age of 28 years, which is an older sample when considering *coming out* age. It is expected that older individuals would report a higher mean *coming out* age considering generational differences fueled by increased societal acceptance of sexual minorities over time. The study also showed that gay men and lesbians reported the highest mean number of years being *out*, 14.8 and 12.0 respectively, while for bisexual women, it was 7.0 years and bisexual men 5.7 years. As the average age of gay men and lesbians was higher than the other groups, the number of years since disclosing sexual orientation was expected to be higher for these groups. Bisexual men also reported a significantly lower rate of disclosing sexual orientation, which was consistent with results from a recent study that stated that bisexual men tend to conceal sexual orientation more frequently than other sexual minority groups (Feinstein et al., 2020).

Limited research is available that investigated the relationship between *coming out* age, the number of years since disclosing sexual orientation and internalised homophobia. The current study found that the age of *coming out* did not predict internalised homophobia in any of the sexual minority groups. These results suggest that in this New Zealand LGB sample, *coming out* at a younger age did not significantly affect the level of internalised homophobia. These results contradict researchers suggesting that *coming out* at a younger age would significantly benefit LGB individuals by reducing the likelihood of developing mental health concerns (Baams et al., 2015). The current study results are not suggesting that *coming out* at a younger age would have no psychological benefits. Indeed, disclosing one's sexual orientation at a young age may promote a positive sexual identity earlier in life by establishing a supportive family and social network, which subsequently may reduce internalised homophobia (Meyer, 2013). However, the results from this study suggest that

when considering the correlation between internalised homophobia and the development of mental health concerns, that the age of *coming out* had no statistically significant effect on the level of internalised homophobia in this New Zealand sample and may not be the key to unlocking our understanding of mental health in LGB individuals.

In contrast to these results, Herrick et al. (2013) found that individuals who accepted their sexual orientation between the ages of 9 and 14 years showed significantly lower levels of internalised homophobia than those accepting their sexual orientation later in life. However, these findings were challenging to interpret and compare, as the authors used the terminology "accepting sexual orientation" to describe their predictor variable. However, the authors did not define if this term refers to internally accepting one's sexual orientation or if it referred to actually disclosing one's sexual orientation, which was the variable used in the current study.

Using regression analysis, the current study showed that the total amount of time, measured in years, since disclosing sexual orientation significantly predicted internalised homophobia, but only in gay men. These results suggest that the time since recognising same-sex attraction and disclosing it to others is a strong predictor of internalised homophobia in gay men, which is consistent with the result from a study by Chard et al. (2015). In other words, the longer the time since when a gay man discloses their same-sex attraction, the lower their level of internalised homophobia tends to be. Herrick et al. (2013) showed similar results and found that internalised homophobia was significantly higher among gay and bisexual men who more recently disclosure their same-sex attraction. Meyer and Frost (2013) state that as the years accumulate since an LGB individual discloses their sexual orientation, the more likely it is that they have developed a positive sexual identity and have established supportive social networks, which decreases internalised homophobia over time (Herrick et al., 2013). However, the current study suggested that this theory may only apply to gay men.

The reason why a greater number of years *out* would correlate with lower levels of internalised homophobia in gay men but not other sexual minority groups is unknown. Possible reasons could include a stronger reluctance to disclose sexual orientation over the lifespan of

lesbians and bisexuals, even with increased age. Lesbians and bisexual individuals, especially bisexual men, may tend to conceal their sexual orientation out of shame and guilt or because they fear stigmatisation, prejudice and physical attacks and may choose to live a life less *out* than gay men (Yolaç & Meriç, 2021). Several other studies showed a possible association with the level of *outness* and internalised homophobia, in that the less an individual conceals their sexual identity, the lower their internalised homophobia tends to be (Vale et al., 2019). However, this study by Vale et al. (2019) did not distinguish between the different sexual orientation groups as did the current study. Additionally, the homosexual identity development model proposed by Bruce et al. (2015) states that LGB individuals move through a series of developmental milestones to achieve a positive sexual identity. It is possible that the developmental stages or the dynamics of sexual identity formation among LGB individuals may differ, which would be an interesting topic for future research.

9.5. Research Limitations

A pervasive methodological problem when conducting sexuality research is using cross-sectional study designs that only provide data from a snapshot in time which may produce results that are not fully representative. This limitation is particularly problematic in the view that sexuality is fluid, which means that a person may belong to, or identify as a different sexual orientation depending on the time the data was gathered (Diamond, 2016). This is especially true for females who report having more sexual fluidity than males (Baumeister, 2000).

This methodological limitation is further exacerbated when sexuality research includes mental health outcomes, as researchers have reported that sexually fluid females, but not males, experience worse mental health outcomes (Katz-Wise et al., 2017). This fact may have some merit when considering that lesbians and bisexual women reported the highest mean scores of anxiety and depression symptoms, and bisexual women reporting the highest suicidal ideation in this study. These findings may be coincidental and are not suggesting that a significant portion of female participants in this study were sexually fluid, however, this cannot be ruled out.

Several other limitations of the study may be attributed to the use of internet-based sampling. The use of convenience sampling through advertising on social media platforms may have introduced bias, and the results may not fully represent the New Zealand LGB community. The sampling may have resulted in an underrepresentation of LGB individuals who do not associate themselves with the LGB community, and who may not have responded to an advert calling on LGB participants. This fact may also be true for LGB individuals with extreme feelings of internalised homophobia who may also not respond to an LGB-themed research survey due to their negative feelings towards their sexual orientation. Again, this limiting factor may have merit evidenced by a low to moderate median level of internalised homophobia across the study sample, suggesting that fewer participants with extreme feelings of internalised homophobia participated. The lower average levels of internalised homophobia may have also been due to the fact that the majority (95.3%) of participants had disclosed their sexual orientation, which has been shown to reduce feelings of internalised homophobia (Baams et al., 2015).

Furthermore, as the survey questionnaire was primarily advertised on Facebook and Instagram, it excluded individuals who did not have these social media profiles. A lack of ethnic diversity was also observed in the sample as most participants were of European descent (74.6%), and only 6.1% of Māori participated, which is not representative of the New Zealand population (Statistics New Zealand, 2018a). Bisexual women were also overrepresented in the sample, which may have affected the data to some degree, although statistical analysis would have mitigated the potential skewing of data.

The scales used in the study have all demonstrated good psychometric properties across several population groups. However, the cultural validity of these scales is unclear, and items may have been interpreted differently by a New Zealand based sample which may have influenced the reported scores. Finally, because the modelling in this study was meant to be exploratory and due to the cross-sectional study design, causality could not be determined between covariates and outcome measures, and results should be interpreted as such.

9.6. Implications and Clinical Application

The results from this study may have implications for clinical practice. This study provided some insight into the relationship between internalised homophobia and psychological distress. These results suggest that exploring internalised homophobia as part of assessing psychological distress may be essential in understanding the cause and perpetuating factors of an LGB client's distress. The results also highlighted how internalised homophobia, depression and anxiety symptoms are related to suicidal ideation, which may prove valuable in working with sexual minorities at high risk of suicide. Understanding the relationship between these variables may have implications for developing interventions to reduce suicidal ideation among LGB individuals. Therefore, assessing internalised homophobia and its risk and mitigation factors within the scope of preventive mental health strategies, is important for risk management, early diagnosis, and treatment of possible mental disorders.

The study results showed that for gay men, clinicians should focus on decreasing levels of internalised homophobia which have a direct and independent effect on anxiety and depression symptoms. For lesbians, there should be a focus on decreasing internalised homophobia, depression and anxiety, which may all have a combined effect in reducing suicidal ideation. However, reducing internalised homophobia in these women may have no direct effect on reducing anxiety and depression. Among bisexual men, the results suggest that lowering internalised homophobia will reduce anxiety symptoms in these men and reducing internalised homophobia in bisexual women may reduce anxiety, depression and suicidal ideation.

Several interventions have been outlined specifically to reduce internalised homophobia in sexual minorities (Kashubeck-West et al., 2008). For example, clinicians can assist clients to understand the relationship between their internalised homophobia and living in a heterosexist society to reduce victim-blame while encouraging them to become part of LGB community groups to promote social support. Acceptance and commitment therapy (ACT) has also been associated with a decrease in internalised homophobia and depression in a small group of gay and lesbian individuals

(Yadavaia & Hayes, 2012). Clinicians working from a cognitive-behavioural perspective could treat internalised homophobia as dysfunctional cognition due to the unhelpful beliefs and assumptions underlying this cognitive distortion (Igartua et al., 2009). This study suggests that incorporating these therapeutic techniques that reduce internalised homophobia may improve mental health outcomes.

9.7. Recommendations for Future Research

Some individuals seem to work through their feelings of internalised homophobia relatively quickly and painlessly, while others develop psychological symptoms, and the reasons for this remain largely unknown (Bruce et al., 2015). This study suggests that disclosing sexual orientation may be one factor in this process, especially when considering the relationship seen between the number of years an individual has been *out* and lower levels of internalised homophobia. Research cited in this paper also suggests that the answer to this question lies in understanding how gender, sexual orientation, culture, religion, social networks and personal upbringing influence the underlying mechanism that causes psychological distress. Only once these mechanisms are well understood may specific and effective strategies be designed to reduce internalised homophobia and its adverse impact on mental health.

Research has shown that gender diversity may also play a significant role in internalised homophobia, evidenced by high internalised homophobia rates in the transgender community due to higher levels of discrimination and victimisation experienced by these individuals (Berg et al., 2016). Future research may include investigating the relationship between sexual fluidity, gender diversity and internalised homophobia, as many young sexual minorities identify as gender and sexually diverse (Rubin et al., 2020). Whether gender diversity, independent of sexual orientation, affects internalised homophobia would be an interesting avenue for future research. Future sexuality research may also want to reduce the inherent limitation of cross-sectional study designs and opt for longitudinal studies, which may be more appropriate to investigate these topics.

9.8. Conclusion

The current study highlighted that the New Zealand LGB community might be experiencing high levels of internalised homophobia, similar to other countries in the world. The results were not surprising considering New Zealand's high sexual orientation-related bullying in schools and workplaces. The study also supported findings from other countries that showed internalised homophobia as a significant independent risk factor for the development of psychological distress. However, the current study showed that the internalised homophobia-psychological distress association varied significantly between New Zealand gay, lesbian and bisexual individuals. Based on these results, the study highlighted the importance of testing models separately when conducting mental health research in LGB samples.

Additionally, the study showed that younger LGB individuals reported higher levels of internalised homophobia than older adults, but an association between age and internalised homophobia was only observed in gay men and bisexual women. Finally, the study suggested that *coming out* at an earlier age may not improve feelings of internalised homophobia, although the number of years since disclosing sexual orientation does seem to reduce internalised homophobia in gay men. These study results may have important clinical implications, and mental health clinicians are encouraged to rethink their approach to treating mental health concerns in their LGB clients by addressing feelings of internalised homophobia.

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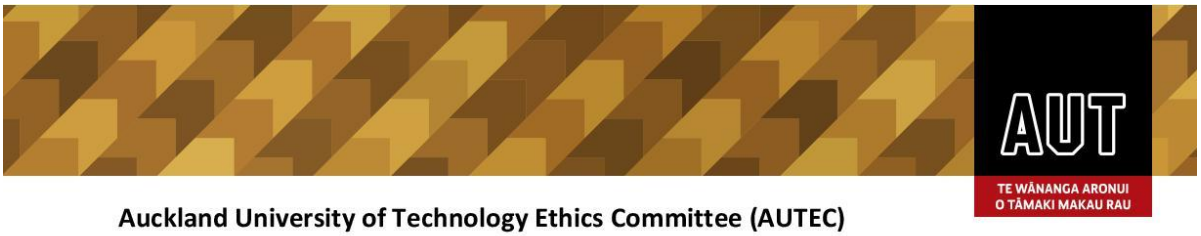
11. Appendices

Appendix A: Ethics Approval



Auckland University of Technology Ethics Committee (AUTEC)

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16 April 2021

Rita Csako
Faculty of Health and Environmental Sciences

Dear Rita

Re Ethics Application: **21/98 Internalised Homophobia in New Zealand: Correlations with Depression, Anxiety, Suicide Ideation and Age of Coming Out in the Gay, Lesbian and Bisexual community of New Zealand**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 16 April 2024.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard and that all the dates on the documents are updated.

AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through http://www.aut.ac.nz/research/researchethics

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: mfk7609@autuni.ac.nz

Appendix B: Survey Questionnaire

SECTION 1 – DEMOGRAPHICS

The following section will ask you some questions about yourself:

1. **Do you permanently live in New Zealand?**

a. Yes

b. No

2. **Would you consider yourself predominately:**

a. Gay man

b. Lesbian

c. Bisexual woman

d. Bisexual Man

e. Heterosexual (straight)

f. Unsure

g. Other

3. **Have you told one or more people that you are gay, lesbian or bisexual?**

a. Yes – At what age did you first tell someone you were gay, lesbian or bisexual:

b. No

4. **What gender do you identify as?**

a. Male

b. Female

c. Other (please specify):

5. **What is your age?**

6.

7. **What is your relationship status?**

a. Partnered

b. Single

c. Married

d. Separated/Divorced

e. Widowed

8. Which ethnic group do you most identify with?

a. European (Including New Zealand European)

b. Māori

c. Pacific Peoples

d. Asian

e. Middle Eastern/ Latin American/ African

f. Other (Please specify): ☐

g. Rather not say

h. Don't know

9. What is your highest level of education achieved?

a. Primary school

b. Secondary school: High School/College

c. Technical College

d. University Degree: Bachelor's (undergraduate) degree

e. University Degree: Postgraduate Degree, PhD, doctorate

10. What is your gross income per year?

a. < $10,000

b. $10,000 - $19,999

c. $20,000 - $29,999

d. $30,000 - $39,999

e. $40,000 - $49,999

f. $50,000 - $59,999

g. $60,000 - $69,999

h. $70,000 - $79,999

i. $80,000 - $89,999

j. $90,000 - $99,999

k. > $100,000

SECTION 2 – DASS-21

Please read each statement below and indicate how much the statement applied to you over the past week:

The rating scale is as follows:

0 Did not apply to me at all - NEVER

1 Applied to me to some degree, or some of the time - SOMETIMES

2 Applied to me to a considerable degree, or a good part of time - OFTEN

3 Applied to me very much, or most of the time - ALMOST ALWAYS

I was aware of dryness of my mouth.	0	1	2	3
I couldn't seem to experience any positive feeling at all	0	1	2	3
I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
I found it difficult to work up the initiative to do things.	0	1	2	3
I experienced trembling (e.g., in the hands)	0	1	2	3
I was worried about situations in which I might panic and make a fool of myself.	0	1	2	3
I felt that I had nothing to look forward to	0	1	2	3
I felt downhearted and blue	0	1	2	3
I felt I was close to panic.	0	1	2	3
I was unable to become enthusiastic about anything.	0	1	2	3
I felt I wasn't worth much as a person.	0	1	2	3
I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)	0	1	2	3
I felt scared without any good reason.	0	1	2	3
I felt that life was meaningless.	0	1	2	3

SECTION 3 –Internalised homophobia Scale*

The following are some statements that individuals can make about being gay, lesbian or bisexual. Read these statements carefully and decide the extent to which you agree.

	Strongly agree	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
Male homosexuality is a natural expression of sexuality in human males.					
I wish I was heterosexual (straight).					
When I am sexually attracted to another gay man, I do not mind if someone else knows how I feel.					

Most problems that homosexuals have come from their status as an oppressed minority, not from their homosexuality *per se*.					
Life as a homosexual is not as fulfilling as life as a heterosexual.					
I am glad to be gay.					
Whenever I think a lot about being gay, I feel critical about myself.					
I am confident that my homosexuality does not make me inferior.					
Whenever I think a lot about being gay, I feel depressed.					
If it were possible, I would accept the opportunity to be completely heterosexual (straight).					
I wish I could become more sexually attracted to women.					
If there were a pill that could change my sexual orientation, I would take it.					
I would not give up being gay even if I could.					
Homosexuality is deviant (abnormal).					
It would not bother me if I had children who were gay.					
Being gay is a satisfactory and acceptable way of life for me.					
If I were heterosexual (straight), I would probably be happier.					
Most gay people end up lonely and isolated.					
For the most part, I do not care who knows I am gay.					
I have no regrets about being gay.					
Male homosexuality is a natural expression of sexuality in human males.					
I wish I was heterosexual (straight).					
When I am sexually attracted to another gay man, I do not mind if someone else knows how I feel.					
Most problems that homosexuals have come from their status as an oppressed minority, not from their homosexuality *per se*.					
Life as a homosexual is not as fulfilling as life as a heterosexual.					

* The wording of the following set of 20 questions changed depending on the sexual orientation of the participant.

SECTION 4 – SIDAS

Please read each statement below and indicate how much the statement applied to you over the past month.

In the past month, how often have you had thoughts about suicide?

1	2	3	4	5	6	7	8	9	10

Never Always

In the past month, how much control have you had over these thoughts?

1	2	3	4	5	6	7	8	9	10

Never Always

In the past month, how close have you come to making a suicide attempt?

1	2	3	4	5	6	7	8	9	10

Never Always

In the past month, to what extent have you felt tormented by thoughts about suicide?

1	2	3	4	5	6	7	8	9	10

Never Always

In the past month, how much have thoughts about suicide interfered with your ability to carry out daily activities, such as work, household tasks or social activities?

1	2	3	4	5	6	7	8	9	10

Never Always

Appendix C: Participant Information Sheet and Consent Statement

Participant Information Sheet

Date Information Sheet Produced:

16 Mar 2021

Project Title

Internalised Homophobia in New Zealand: Correlations with Depression, Anxiety, Suicide Ideation and Age of Coming Out in the Gay, Lesbian, and Bisexual community of New Zealand.

An Invitation

Dear participant,

I am a postgraduate psychology student at AUT (Auckland University of Technology) based in Auckland, New Zealand. I would like to invite you to participate in this short research survey. This research forms part of my Master's degree in Psychology qualification. I sincerely want to thank you for taking the time to participate in this research.

What is the purpose of this research?

Several studies have shown that many people from the LGBTQI+ community experience some level of what is called "internalised homophobia". Internalised homophobia refers to negative attitudes and feelings towards one's own homosexuality. More recent research has indicated some links between internalised homophobia and developing symptoms of anxiety, depression, and even suicidal thinking. Unfortunately, none of these previous studies was conducted in the New Zealand LGBTQI+ community, and many of these studies also had several research limitations. The current study will address these limitations and assess the relationship between internalised homophobia and symptoms of depression, anxiety, and suicidal thinking in a sample of New Zealand gay, lesbian and bisexual individuals. The results of this study will add to our understanding of the relationship between internalised homophobia and psychological symptoms. What we learn from this study may also help mental healthcare workers effectively treat mental health concerns within the LGBTQI+ community.

How was I identified, and why am I being invited to participate in this research?

If you decide to participate, you will be 1 of at least 300 participants who will complete the survey questionnaire. Participants are recruited through different means from friends, family and colleagues sharing the survey link to directly accessing the link through social media. As a potential participant, you may share this survey link with as many people as you like. The survey is open to any person living in New Zealand, who is at least 16 years of age, and identifies as gay, lesbian or bisexual. Participants not meeting these criteria will be excluded from the research.

How do I agree to participate in this research?

Your participation in this research is voluntary (it is your choice), and whether you choose to participate will neither advantage nor disadvantage you. You can withdraw from the study at any time, however, because of the anonymous nature of the study, once your responses are submitted, they cannot be identified or removed. You can consent to participate in this research by completing the consent statement at the bottom of this Participant Information Sheet. By completing and submitting this survey, you affirm your willingness to participate and that you are at least 16 years of age. If you would like any additional information about the survey, please contact the researcher Johannes Hanekom. Contact details are listed at the end of this document.

What will happen in this research?

In the survey, you will be asked to answer 45 short multiple-choice questions. You can complete these questions either on a computer or cell phone connected to the internet. The survey will take you about 10 minutes to complete. You will be asked questions relating to your demographics (for example, your age, gender, educational level), mental health status and views about homosexuality. The survey will then conclude with one survey feedback question. Responses collected from the survey will only be used for this research. We kindly ask that all participants provide honest responses to the questions so that the research generate reliable results.

What are the discomforts and risks?

No major risks or discomforts are anticipated by participating in the survey. However, there is always a slight chance that some participants may feel some discomfort when answering personal questions. There is also a minor risk that some questions may be triggering for some participants or cause a sense of minor inconvenience.

How will these discomforts and risks be alleviated?

The survey is entirely anonymous. Questions that may be triggering or cause discomfort can be skipped. If you require any information or support relating to LGBTQI+ or mental health concerns, please contact any of the following free services:

- OUTLine NZ – 0800 688 5463
- Youthline - Call 0800 37 66 33 or free text to 234
- Suicide Crisis Helpline – 0508 828 865
- Need to talk? Free call or text 1737

What are the benefits?

The researcher does not foresee any benefits for you as the participant other than the knowledge that you contributed to academic research. As a token of appreciation for participating in this survey, you may choose to enter a draw to win one of five $20 gift cards. You can choose to participate in this draw at the end of the survey. The researcher will benefit from this research by obtaining a postgraduate qualification. The research may also contribute to research scholarships in the field.

The wider academic community may benefit from this research in several ways. To date, no research has been conducted in New Zealand to quantitively investigate the relationship between internalised homophobia and anxiety, depression and suicidal thinking. This research project will contribute to the academic knowledge of internalised homophobia in the New Zealand context and reduce the research gap. Furthermore, this study's results may produce valuable data that could be applied to clinical practice when working with LGBTQI+ clients in the mental health sector.

How will my privacy be protected?

This is a voluntary and completely anonymous online survey. No identifiable information will be collected from you, nor can your participation be linked back to you. The researcher will only see raw numerical data from survey responses. If you decide to enter the draw for a gift card, your email address will be requested for entry into the random draw. Please note that your email address is collected separately and cannot be linked back to your survey responses.

What are the costs of participating in this research?

The survey will take you 10 minutes to complete the 45 questions.

What opportunity do I have to consider this invitation?

The survey will be active for three months, during which time you have the opportunity to participate.

Will I receive feedback on the results of this research?

Yes. A summary of the results will be available at the same link used to access the survey once the project has concluded.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor: Dr Rita Csako: rita.csako@aut.ac.nz, +64 (0)9 921 9999 ext. 7970.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, ethics@aut.ac.nz, (+649) 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep a copy of this Participant Information Sheet for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Johannes Hanekom: mfk7609@autuni.ac.nz

Project Supervisor Contact Details:

Dr Rita Csako: rita.csako@aut.ac.nz, +64 (0)9 921 9999 ext 7970.