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DISTRESS AND INTERNALIZED HOMOPHOBIA AMONG LESBIAN WOMEN TREATED FOR EARLY STAGE BREAST CANCER

Bonnie A. McGregor, Charles S. Carver, Michael H. Antoni, Sharlene Weiss, Susan E. Yount, and Gail Ironson
University of Miami

A convenience sample of 57 lesbian women who had been recruited for a study of adjustment to breast cancer completed measures of internalized homophobia, degree of disclosure of sexual orientation, social support, self-esteem, and distress. Consistent with our prediction, internalized homophobia related to greater distress. Contrary to our prediction, disclosure did not relate to lower distress. Path models were consistent with the position that internalized homophobia promotes distress through lower self-esteem and perceived unavailability of social support. However, the data were also consistent with a model in which low self-esteem leads to internalized homophobia by way of elevated distress. Internalized homophobia also related inversely to utilization of health care resources. Our discussion centers on the need for more information regarding this understudied population.

Little is known about the emotional well-being of lesbians (cf. Solarz, 1999). One reason for this lack of knowledge is that research on this population is difficult. Lesbians are often hard to identify in the general population (White & Dull, 1997). Many remain "closeted" (i.e., not all women whose primary relationships are with women will identify themselves as lesbian). Indeed, some lesbians do not completely identify themselves as such. Some women who are lesbians may have just recently become aware of this facet of themselves.

The coming out process has been conceptualized by Lewis (1984) as a series of stages proceeding from an initial awareness of being different through dissonance, grieving, and inner conflict to gradually building a stable lesbian identity complete with long-term relationships. As lesbians move through the coming out process, they begin to disclose their sexual orientation to others. Bradford, Ryan, and Rothblum (1994) have argued that sound mental health for lesbians requires a workable integration of both an internal aspect, in which they are comfortable with that aspect of their identity, and a social aspect, in which they make decisions about who can be trusted to know about this aspect of their identity.

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Address correspondence and reprint requests to: Bonnie A. McGregor, Fred Hutchinson Cancer Research Center, 1100 Fairview Avenue N., MP 702, Seattle, WA 98109. E-mail: bmcgrego@fhcrc.org

COMING OUT AND EMOTIONAL WELL-BEING

Let us consider each of these posited criteria for well-being. First is establishing a stable identity for oneself as a lesbian. This itself is a challenge. Societal attitudes toward sex, gender, and homosexuality are generally internalized before individuals recognize their own sexual orientation. When homosexuals become aware of their homosexuality, they experience toward themselves the attitudes they have internalized (Herek, 1996). The phrase *internalized homophobia* refers to holding a negative attitude about homosexuality and applying it to oneself.

There is considerable evidence from samples of gay men that internalized homophobia can be a source of distress. In one study of over 700 gay men (Meyer, 1995), higher levels of internalized homophobia related to higher levels of distress (see also Hammersmith & Wienberg, 1973; Leserman, DiSantostefano, Perkins, & Evans, 1994; Lewis, 1984; Meyer & Dean, 1995; Nicholson & Long, 1990; Weinberg & Williams, 1974). In one project on this question, researchers sampled both gay men and lesbians (Miranda & Storms, 1989) and found that

having a negative sexual identity related to poorer psychological adjustment. However, the researchers did not test the generality of the association across gender—they simply combined the sample. An earlier project involving lesbians might be seen as being informative on this question (Bell & Weinberg, 1978), but its authors confounded negative sexual identity with a broader array of dysfunctional attitudes. Thus a relation between internalized homophobia and distress remains to be demonstrated among lesbians.

The second posited criterion for well-being is taking the step of trusting others with the knowledge of one's sexual identity. The idea that disclosing one's sexual orientation relates to better mental health is supported in several studies of homosexual men (Bell & Weinberg, 1978; Leserman et al., 1994; Maylon, 1982; Zuckerman, 1997). Two other studies that included both gay men and lesbians yielded similar results: Day and Schoenrade (1997) found that homosexual employees who did not disclose their sexual orientation at work had more role conflict and lower job satisfaction than did openly homosexual or heterosexual employees. Miranda and Storms (1989) similarly found reports of less disclosure related to poorer adjustment. However, researchers in these projects did not test for the generality of the association across genders but instead just combined the sample. Thus, again, it remains to be demonstrated that the relation holds among lesbians.

Potential Mediators: Self-Esteem and Perceptions of Social Support

The idea that internalized homophobia predicts poorer psychological well-being is relatively straightforward. To have a negative reaction to an important aspect of the self is to carry within oneself a constant threat to self-esteem. Consistent with this idea of self-esteem threat, Nicholson and Long (1990) found that having positive feelings about oneself as a gay man related to higher overall self-esteem. There is also evidence that internalized homophobia among gay men relates to perceptions of less available social support (Nicholson & Long, 1990; see also Ross & Rosser, 1996). Again, however, apparently no information bearing on such associations has been reported regarding lesbians.

Why disclosure of one's sexual orientation should enhance well-being is perhaps less obvious. One possibility is that greater disclosure enhances perceptions of social support, as more persons become available to use freely as support resources. However, disclosure of sexual orientation is potentially a double-edged sword. Disclosing a homosexual orientation opens the real possibility of rejection by family, loss of employment, loss of housing, and even physical harm in the form of hate crimes. Thus unrestrained disclosure is not necessarily prudent. Common sense suggests that a critical balance must be maintained between the need for personal security and the need to build intimate supportive relationships with others (Bradford et al., 1994; Kempler, 1987).

Present Research

In this study, we examined the variables just discussed as correlates of emotional well-being in a sample of lesbian women. This was a sample of convenience for exploring these questions. The women who participated in this study were initially recruited for an examination of their adaptation to breast cancer. Their availability, however, gave us a unique opportunity to examine the roles of the variables just discussed.

Because having positive feelings about oneself as a homosexual has been related to better mental health in male homosexuals (Meyer & Dean, 1995), we expected that positive feelings about oneself as a homosexual (i.e., lower internalized homophobia) would relate to better mental health among lesbians. On the basis of findings among gay men (e.g., Leserman et al., 1994; Maylon, 1982; Zuckerman, 1997), we also predicted that higher disclosure of sexual orientation would relate to better emotional well-being. Because studies of gay men have linked internalized homophobia to lower self-esteem and perceived unavailability of social support (Nicholson & Long, 1990; Ross & Rosser, 1996), we examined these variables as well. Indeed, we extended previous research by testing—by means of path analysis—the possibility that self-esteem and perceived social support might mediate between internalized homophobia and emotional well-being.

Also reported here is one other variable that differs greatly in focus from those discussed thus far. This variable is utilization of certain health care practices that are relevant to breast and gynecological cancers. There is evidence that internalized homophobia among gay men relates to poorer health care practices (Meyer & Dean, 1995), and we sought to investigate whether this is true among lesbians as well. The women were asked to indicate how frequently they saw gynecologists for routine checkups, how often they had Pap smears, how often they had breast examinations done by medical professionals, and how often they conducted breast self-examinations. The fact that we asked about both physician-administered and self-administered practices permitted us to explore whether any association that emerged would be specific to health care involving external providers or would extend to health care practices that do not require the involvement of others.

METHOD

We recruited participants for the study through nationwide distribution of advertisements and flyers that described a study of adaptation to breast cancer among

lesbian women and asked interested parties to call a toll-free telephone number. The flyers were distributed through existing women's networks, physicians and health care delivery systems, and lesbian community resource centers. Women who responded received an oral explanation of what participation would entail. Those who wished to participate were mailed an informed consent form and a questionnaire packet. Upon completion and return of the questionnaires, each participant was paid $25 for her time.[1]

Of the 57 women who completed the measures described below, 5 had been diagnosed with stage 0, 39 with stage I, 19 with stage II, and 2 with stage III breast cancer. They ranged in age from 33 to 71 years (M = 49.11, SD = 8.45). Fifty-three of the women identified themselves as White, 2 as African American, and 2 as Hispanic. Thirty-seven women identified themselves as "married or otherwise partnered," 16 as single, 3 as divorced, and 1 as separated. The number of years of education ranged from 12 to 26 (M = 16.7, SD = 2.92). Thirty of the women were employed full-time, 10 were employed part-time, and 17 were not employed. Twenty women identified themselves as non-Catholic Christian, 12 as Catholic, 7 as Jewish, and 18 as "other." All participants confirmed their status as lesbians.

The length of time since treatment varied substantially, ranging from 2 months to 24.6 years (M = 43.05 months, SD = 59.36 months). The majority (72%, n = 41) had had either a mastectomy or bilateral mastectomy; the remaining 28% (n = 16) had had lumpectomies. Fifty-four percent of the women underwent some form of chemotherapy (n = 31); 35% of the women underwent radiation therapy (n = 20).

Measures

Health care practices. Several questions were included in the packet that pertained to the participants' health care practices prior to their being diagnosed with cancer. Specifically, the women were asked to indicate how frequently they saw gynecologists for routine checkups, how often they had Pap smears, how often they had breast examinations from medical professionals, and how often they conducted breast self-examinations. Response options ranged from *never* (1) to *more than twice a year* (7), with verbal labels provided for all numbered choices. Responses averaged 3.86 (SD = 1.57) for routine gynecological exams (roughly equivalent to "every 2 years"), 4.18 (SD = 1.22) for Pap smears (roughly "every 2 years"), 4.38 (SD = 1.48) for breast examinations by medical professionals (between "every 2 years" and "every year"), and 4.49 (SD = 2.58) for breast self-examinations (halfway between "every 2 years" and "every year").

Mood states. Emotional distress was assessed with brief scales used in earlier breast cancer research by Carver et al. (1993), consisting of a series of adjectives describing distinct feelings. Respondents indicated the degree to which they had experienced each feeling "during the past week including today," responding on a scale ranging from *never* (1) to *always* (5), with higher scores reflecting greater distress. Responses to the items of a given scale were averaged (thus placing distress scores on the metric of the response options). The scales examined here assess anxiety (tense, nervous, and anxious; M = 2.21, SD = .87), depression (helpless, unhappy, worthless, hopeless; M = 1.50, SD = .63), and anger (angry, resentful, grouchy; M = 1.92, SD = .70). Alphas for these scales ranged from .75 to .83. In a sample of 235 students, these brief scales correlated .87, .93, and .87, respectively, with the comparable scales from the Profile of Mood States (McNair, Lorr, & Droppelman, 1971).

Depressive symptoms. The Center for Epidemiological Studies Depression scale, or CES-D (Radloff, 1977) is a 20-item scale used to assess depressive symptoms. It has been used extensively as a research instrument. Respondents indicated the extent to which they have had a variety of experiences over the past week by responding to a series of statements (e. g., "I felt I was just as good as other people" and "My sleep was restless"). Response options ranged from *rarely or none of the time—less than 1 day* (0) to *most or all of the time—5–7 days* (3). Items were summed, with larger numbers indicating greater levels of depressive symptoms (total score M = 9.00, SD = 8.49, α = .93).

Social support. Perceived available social support was measured with a 6-item abbreviated version of the Interpersonal Support Evaluation List (ISEL; Cohen, Kamarck, & Mermelstein, 1983), a widely used measure of social support. The full ISEL was designed to assess the perceived availability of social support in four domains: tangible or material aid, belonging, self-esteem, and appraisal of one's problems. The items refer to support "in general," as opposed to support that might be specific to breast cancer. The abbreviated version used here incorporated two items from each domain of perceived support other than self-esteem. The items were: "When I feel lonely, there are several people I can talk to" (belonging); "I often meet or talk with family and friends" (belonging); "If I were sick, I could easily find someone to help me with my daily chores" (tangible); "When I need suggestions on how to deal with a personal problem, I know someone I can turn to" (appraisal); "If I had to go out of town for a few weeks, it would be difficult to find someone to look after my house or apartment" (tangible, reverse-coded); and "There is at least one person I know whose advice I really trust" (appraisal). Response options ranged from *definitely true* (1) to *definitely false* (4). Responses were summed across items, with higher scores reflecting higher perceived support (α = .74, M = 21.1, SD = 3.1).

Self-esteem. Self-esteem was measured with the Rosenberg (1965) self-esteem scale, a widely-used measure of self-esteem. It consists of 10 statements reflecting various aspects of self-esteem, with half worded negatively (e.g., "At times I think I am no good at all") and half worded positively (e.g., "I feel I have a number of good qualities"). Respondents answered each item on a scale ranging from *strongly disagree* (1) to *strongly agree* (4). After appropriate item reversals, the items were summed to yield a total score, with higher scores indicating higher self-esteem. Alpha in this sample was .84 (M = 33.5, SD = 5.6).

Internalized homophobia. The Internalized Homophobia Questionnaire, or IHQ (Weinberg & Williams, 1974; Zuckerman, 1997), is an 11-item measure that assesses respondents' beliefs about their own homosexual orientation and about homosexuality in general. Respondents rated how much they agreed with statements such as "I have no regrets about being gay" and "homosexuality is deviant." Participants responded on a 5-point scale from *strongly agree* (1) to *strongly disagree* (5). A total was obtained by summing the responses to all items after appropriate reversals, such that higher scores reflect higher levels of internalized homophobia (α = .73). Participants scored a mean total of 18.54 (SD = 5.35), which translates into a mean per-item score of 1.68. This represents a response somewhere between "disagree" and "strongly disagree" to an item such as "homosexuality is deviant."

Disclosure of sexual orientation. On the Sexual Orientation Disclosure Questionnaire (Weinberg & Williams, 1974; adapted by Zuckerman, 1997), the respondents indicated the extent to which they have divulged their sexual orientation to various members of their social support network. Participants responded on a 4-point scale, ranging from *I have talked in full detail with him/her about my sexual preference; he/she knows me in this respect and could describe my sexual preference accurately* (1) to *I have misrepresented myself to him/her about my sexual preference so that he/she has a false picture of me* (4). If the participant had no one in the role referred to by an item, she was asked to respond with "not applicable." Roles named were mother, father, brother(s), sister(s), other relatives, coworkers, employer, best female heterosexual friend, best male heterosexual friend, and husband or ex-husband.

These 10 items were reverse-scored, so that higher scores are associated with higher levels of disclosure. An average disclosure score was calculated for each respondent by averaging responses other than those marked "not applicable." The mean level of sexual orientation disclosure for this group (M = 3.19, SD = 0.59) corresponds roughly to the response "I have talked to him/her in general terms about my sexual preference. He/she has only a general idea about my sexual preference." It thus would appear that the women in this sample were fairly open about their sexual orientation. These values were similar to those found in the Zuckerman (1997) study of HIV+ gay men (M = 3.1, SD = 0.8). It will be noted that the items reference other persons who vary greatly in intimacy to the respondent and toward whom the respondent can thus be expected to vary in behaviors reflective of closeness. Despite this, the internal reliability of the measure was reasonably high (α = .59).

RESULTS

Data Reduction and Control Variables

The first step in data analysis was to determine whether the distress measures could be combined. The adjective-rating subscales for anger, anxiety, and depression all correlated strongly with each other and with the CES-D (average r = .50). Because of this, the four variables were combined by computing z scores for each measure and averaging the z scores into an index of distress (α for the index using the four z scores = .80).

The next step was to compute correlations between outcome variables and demographic and treatment variables, in order to assess the need for incorporating controls in subsequent analyses. Distress did not correlate significantly with marital status, education, presence of adjuvant chemotherapy or radiation, or stage of cancer. Age did correlate negatively with distress, r (55) = –.27, p = .04. Given this association, age was used as a control variable in analyses where distress was the dependent variable.

Internalized Homophobia and Disclosure of Sexual Orientation

Extent of disclosure of sexual orientation was inversely related to both age, r (55) = –.43, p < .01, and internalized homophobia, r (55) = –.45, p < .01. Given the change in social climate in recent years, it is not surprising that older lesbians would report less disclosure of their sexual orientation. Nor is it surprising that disclosure of sexual orientation would correlate inversely with internalized homophobia.

Internalized homophobia was correlated at the bivariate level with the distress index, r (55) = .30, p = .03, and it remained a significant predictor of the distress index after controlling for age in a multiple regression equation, β = .28, p = .03. Contrary to our prediction, however, the association between disclosure of sexual orientation and the distress index did not approach significance. Nor did such an association emerge in a multivariate test that included internalized homophobia, β = –.14, p = .34. We

also tested for evidence of a curvilinear association between disclosure and distress, but found no evidence of such an association.

Internalized Homophobia, Social Support, and Self-Esteem

Perceived availability of social support can diminish or prevent feelings of distress (Cohen & Wills, 1985). Given previous findings (Nicholson & Long, 1990), it seems reasonable to ask if perceptions of social support might be implicated in the relationship between internalized homophobia and distress. The first step in considering this possibility was to assess relations between perceived support and those two variables. Perceived support, as measured by the ISEL, correlated inversely with internalized homophobia, r (55) = –.32, p = .02. Perceived support also related inversely to distress, r (55) = –.50, p < .001.

Another correlate of emotional well-being is a strong sense of self-esteem. In our sample, there was also a significant inverse correlation between self-esteem and distress, r (55) = –.67, p < .001. A negative correlation between internalized homophobia and self-esteem approached significance, r (55) = –.21, p = .058, one-tailed.

To test the possibility that a relation between internalized homophobia and distress is mediated by a third variable requires several conditions to be met (Baron & Kenny, 1986). Internalized homophobia must relate to distress, internalized homophobia must relate to the proposed mediator, and the proposed mediator must relate to distress. The preceding analyses established these relations for perceived support and (marginally) for self-esteem as potential mediators of the link between internalized homophobia and emotional distress. Thus we proceeded to test for such mediational relations.[2]

Mediation was tested by hierarchical regression analyses, with distress as the dependent variable. Age was entered first as a control variable, then as the distal predictor (internalized homophobia), and then as the proposed mediator. As shown in Figure 1, internalized homophobia was a significant predictor of distress by itself (controlling for age), but when social support was added, the relation between internalized homophobia and distress was substantially reduced. Perceived support remained a significant predictor of distress, nearly as strong as when it was tested without internalized

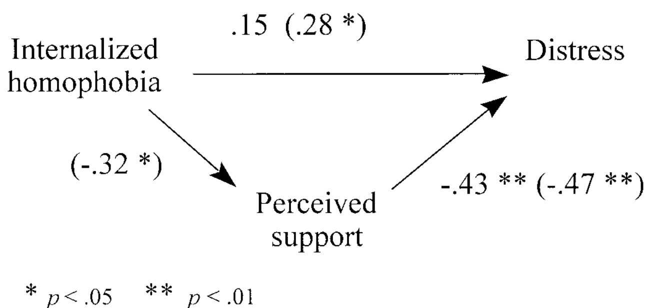

Fig. 1. Path analysis testing perceived support as a potential mediator of the association between internalized homophobia and distress.

Note: Age is omitted from the diagram but is included in all equations predicting distress. Standardized regression coefficients for simple relationships are in parentheses; regression coefficients from the test involving both distal predictors are outside the parentheses.

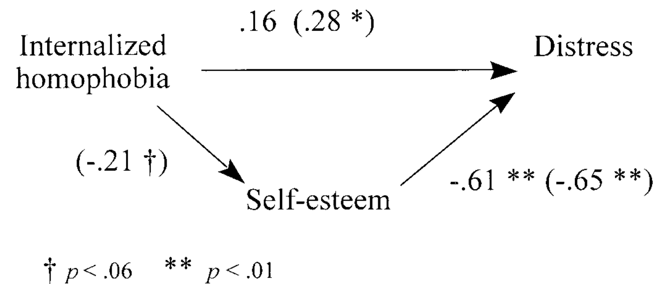

Fig. 2. Path analysis testing self-esteem as a potential mediator of the association between internalized homophobia and distress.

Note: Age is omitted from the diagram but is included in all equations predicting distress. Standardized regression coefficients for simple relationships are in parentheses; regression coefficients from the test involving both distal predictors are outside the parentheses.

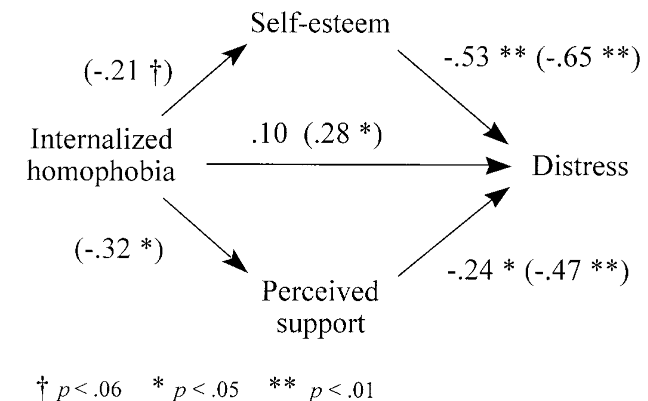

Fig. 3. Path analysis testing perceived support and self-esteem as potential mediators of the association between internalized homophobia and distress.

Note: Age is omitted from the diagram but is included in all equations predicting distress. Standardized regression coefficients for simple relationships are in parentheses; regression coefficients from the test involving both distal predictors are outside the parentheses.

homophobia. Thus, the pattern is consistent with the view that perceived social support is a partial mediator of the relationship between internalized homophobia and distress.

Similar analyses were conducted to test for mediation by self-esteem. When self-esteem was entered, the relation between internalized homophobia and distress again was substantially reduced (Figure 2). Self-esteem was a significant predictor of distress, nearly as strong as when it was tested without internalized homophobia. This pattern is consistent with the view that self-esteem is a partial mediator of the relationship between internalized homophobia and distress.

We then tested the possibility of simultaneous mediational roles for perceived support and self-esteem (Figure 3). When self-esteem, perceived support, and internalized homophobia were entered together (along with age), both self-esteem and social support were significant predictors of distress, but internalized homophobia was not. This pattern is consistent with the view that both self-esteem and perceived support are partial mediators of the relationship between internalized homophobia and distress.

Alternative Mediational Models

Testing the plausibility of a mediational model in cross-sectional data carries the responsibility to test alternative models as well. We tested several such alternatives. Only one other model proved plausible—one in which internalized homophobia was the result, rather than the cause, of low self-esteem and distress. When self-esteem was entered as distal predictor, and distress as mediator, the effect for self-esteem fell to near zero, whereas the effect for distress fell only very slightly (Figure 4). This pattern would be consistent with a view in which having low self-esteem yields subjective distress, which in turn induces an attitude of internalized homophobia. A path model of the same form was tested for social support, but it did not yield evidence of mediation. No other alternative model yielded evidence consistent with mediation.

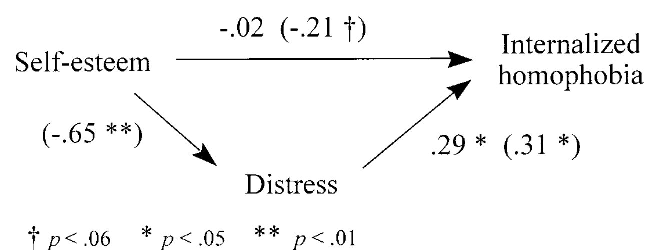

Fig. 4. Path analysis testing distress as a potential mediator of the association between self-esteem and internalized homophobia.

Note: Age is omitted from the diagram but is included in all equations predicting distress. Standardized regression coefficients for simple relationships are in parentheses; regression coefficients from the test involving both distal predictors are outside the parentheses.

Internalized Homophobia and Health Care

Apart from the findings described thus far, there was evidence in the data that internalized homophobia related to certain health care practices. Specifically, internalized homophobia related to less frequent gynecological visits prior to the cancer diagnosis, r (56) = .34, $p < .01$, less frequent Pap smears, r (56) = –.25, p = .03, and less frequent breast examinations by medical professionals, r (56) = –.33, $p < .01$. These health behaviors were highly interrelated (r = .68 to .71), which is not surprising, as they are all elements of routine gynecologic examinations. In contrast, internalized homophobia was unrelated to breast self-examination, a health care behavior that is performed by the women themselves.

DISCUSSION

The data from this study revealed several associations between levels of internalized homophobia and other variables. For one, internalized homophobia related to lower levels of certain health care behaviors—frequency of Pap smears and gynecologic examinations. It is noteworthy that the health care behaviors for which this relationship held involved health care providers—no association was found for breast self-examination. Other researchers have similarly found that lesbians underutilize conventional health care (such as routine gynecologic care), due to discomfort with the medical establishment (Stevens & Hall, 1988; Tippet & Bain, 1992; White & Dull, 1997). It has been reported that this discomfort relates to expectations of homophobia among medical caregivers (Matthews, 1998). Our data appear to suggest that the discomfort may be rooted partly in a negative attitude about the women's own homosexuality.

Internalized Homophobia and Distress

The data from this study also indicate a link between extent of internalized homophobia and psychological distress. Once again, this finding replicates those of several previous studies among gay men and mixed-gender samples (Leserman et al., 1994; Lewis, 1984; Meyer, 1995; Meyer & Dean, 1995; Miranda & Storms, 1989; Nicholson & Long, 1990). We also replicated previous findings among gay men by showing that internalized homophobia related to lower overall self-esteem (Nicholson & Long, 1990) and perceived unavailability of social support (Nicholson & Long, 1990; Ross &

Rossner, 1996). However, our findings appear to be the first such demonstrations using a sample composed entirely of lesbians.

We also went beyond previous studies in testing mediational possibilities in the data by means of path analysis. The primary set of analyses showed that the pattern of associations was consistent with a model in which the link between internalized homophobia and distress operated through low self-esteem and perceptions of a lack of social support. When these two variables were taken into account (along with age as a control variable), little residual relation remained between homophobia and distress.

However, another path model also was consistent with aspects of the data, raising a conceptual ambiguity. This alternative model was not derived from theory. Rather, it arose from empirical exploration of plausible patterns of associations among variables. This model started with self-esteem, treated distress as mediator, and treated internalized homophobia as "outcome." The psychological conceptualization that is reflected in this second model is quite different from the view with which we entered the study. This second model suggests that a general lack of self-esteem is the core problem, and internalized homophobia is one indirect manifestation of that more general problem.

Disclosure of Sexual Orientation

In contrast to this pattern of findings for internalized homophobia, we found no evidence of an association between distress and extent of disclosure of sexual orientation. This finding fails to replicate previous findings in gay men (Nicholson & Long, 1990; Zuckerman, 1997). How should we interpret this failure?

One possibility is that our sample may have had a restricted range of disclosure. Because the study was advertised as a study for lesbians with breast cancer, with flyers distributed through women's networks, health care delivery systems, and lesbian community resource centers, the recruitment technique inevitably created a sampling bias. That is, any woman calling about the study would of necessity be personally identified with, and relatively comfortable disclosing, her sexual orientation. However, the mean and standard deviation of the disclosure measure were similar to those of the Zuckerman (1997) study of HIV+ gay men (and the sample was larger, though not as large as that of Nicholson & Long, 1990), which did find a relation between disclosure and lower distress. This tends to militate against this interpretation.

Another possibility is that the relationship between disclosure and subjective well-being is simply stronger and more reliable among men than women. Perhaps the adverse consequences of disclosure are more salient to women than to men, thereby undercutting any positive effects that disclosure produces. This speculation merits further investigation in future research.

A final possibility stems from the fact that the internal reliability of the measure of disclosure was not as great as it might have been. Although we believe that this reflects differences among the persons to whom participants did and did not disclose their sexual orientation, it remains possible that it reflects instead a greater amount of measurement error.

Limitations

This study has limitations that must be kept in mind in interpreting the results. First, the data are cross-sectional. Although the path analyses provide information about whether a causal ordering is plausible (given the relations among variables), it is impossible to make strong inferences about causality from this design.

Second, this was a sample of convenience, recruited primarily for reasons other than those explored in this article. It is reasonable to ask whether the results were affected in any way by the fact that the participants all had been treated for breast cancer. For example, perhaps these women had had usually frequent interaction with members of their social support networks, which might have served to sharpen their perceptions of how much support they had. This, in turn, might have enhanced the relation between internalized homophobia and perceptions of support. We cannot rule out the possibility that similar associations would not emerge in a sample of lesbian women who had not had a comparably stressful experience.

Finally, the association of internalized homophobia with self-esteem was weak, not attaining significance at the bivariate level. This limited association urges caution with respect to conclusions about the mediating effects of self-esteem.

Closing Comment

In a society that is largely hostile to homosexuals, lesbians and gay men must travel a difficult path by which they recognize their sexual orientation, develop an identity based on it, and disclose their sexual orientation to others. Having been socialized in a heterosexual world, lesbians and gay men often experience some degree of negative feelings toward themselves—internalized homophobia—when they first recognize their homosexuality. Psychological adjustment appears to be best among those who have accepted and integrated their sexuality and are committed to a gay or lesbian identity.

Although the data from this study are consistent with this viewpoint, they are not without ambiguity. In particular, the data are also consistent with a view in which a low level of general self-esteem is the core problem.

In this view, low self-esteem relates to higher ambient distress, which in turn relates to negative attitudes about homosexuality in general and oneself as a homosexual in particular. This view was not part of the reasoning with which we entered the study, but its plausibility cannot be entirely discounted. Whether the lack of acceptance of one's sexual identity is a determinant or a consequence of self-esteem difficulties in this understudied population is a matter that can be resolved only by further research.

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NOTES

1. Participants in this study were a subset of a larger sample who completed a battery of measures focused on coping with breast cancer, most of which are beyond the scope of this article. The subsample described here consists of the entire sample or participants who completed measures of disclosure of sexual orientation and internalized homophobia (described below). As these measures were added to the battery after data collection in the larger project had begun, this group is smaller than the overall sample.
2. We also tested for the possibility of moderation, such that high levels of either social support or self-esteem would differentially diminish the association between internalized homophobia and distress. No such effect was found.

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