Western Undergraduate Psychology Journal

Volume 1 | Issue 1 Article 3

1-3-2014

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The current paper's aim is to facilitate the understanding of how cultural norms embodied by society can have incontrovertible effects on the mental health of those who do not conform. Embedded cultural terms of masculinity and femininity remain cognizant in a way which recognizes that these terms are simply created by culture. Internalized homo-negativity studies conclude that internalized homo-negativity is correlated with severe depression on all three clinical scales of depression, overall sexual health, psychosexual maturation, comfort with sexual orientation, peer socialization, comfort with sexual acts and social integration. Narcissistic tendencies in male homosexuals were found to be significantly correlated with homosexuality when considering the Rorschach Reflection scale. Eating disorders were found to be highly correlated with body dissatisfaction, which were more prevalent among homosexuals, where femininity was found to not significantly contribute to body dissatisfaction. Furthermore body dissatisfaction among heterosexuals and homosexuals was found to be related to high body mass index, high pressure from society and peers, low masculinity and from perceived societal and peer pressure due to sexual orientation. Studies investigating suicide attempt prevalence among homosexuals in the United States concluded that those who attempted suicide felt more victimized by peers and society, physically and verbally, and acknowledged more mental health problems. In conclusion, the significance of this paper is to contribute to the understanding, and by extension reconstruction of oppressive attitudes and behaviours towards homosexuals.

Societal pressure due to ingrained cultural notions is often stratified so deeply into society that they can be extremely problematic to change. These societal pressures are often learned behaviours through enculturation of the population. Homosexuality is often stigmatized in Western culture and around the world. This stigmatization is habitually reinforced by societal pressures and in turn, these pressures can have a negative impact on an individual who identifies as homosexual, specifically in terms of their mental health. In the analysis of societal implications on the mental health of homosexuals, the phenomenon of homo-negativity will first be examined. Subsequently, narcissism and eating disorder prevalence in homosexuals will be addressed, followed by suicide prevalence among homosexuals. Consequently, the implications of negative societal pressures on the individual mental health of homosexuals will be elucidated, and discussed further in relation to the minority stress hypothesis. However, it is first important to define gender and homosexuality in terms of Western culture, as these terms are social constructs which inevitably vary between cultures. Furthermore, it should be noted that there is a bias towards investigating male homosexuals in the literature related to this topic. This does not reflect a study selection bias from the author.

Homosexuality in Western Society

Homosexuality, and by extension heterosexuality, is a recent ideology in Western culture (Lancaster & Leonardo, 1997). In modern Western society, one's identity is partly constructed by means of their sexual orientation. This externally produced identity not only affects how one thinks and behaves, but also how society perceives that individual. These social constructs, which are responsible for molding identity, emerged approximately around the same time the United States enforced a sobering segregation between people who are

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"Black" and people who are "White" (Lancaster & Leonardo, 1997).

Due to the fact that people are strongly defined by their sexuality in modern Westernized society, individuals are encouraged to view themselves, and thus to behave in terms of their sexual orientation (Caplan, 1997). In Western society, heterosexuality, that is sexual attraction to the opposite sex, is the norm, and individuals whom do not conform to this ideology experience prejudice, as "non-conformity to the norms of heterosexuality threatens the dominant ideology's view of sex as 'innate' and 'natural'" (Caplan, 1997, p. 37). Male homosexuality is thought to undermine male domination and superiority, while female homosexuality is thought to defy cultural norms of the traditionally submissive women. Theoretically, sex differences are considered biologically differentiable, and society has thus tried to categorize gender and sexuality in the same way. This can be viewed as a universal tendency among humans. To facilitate understanding, humans map their perceptions into theoretical cognitive categories (Caplan, 1997). Non-conformance to normative sexual orientation categories and gender roles are discouraged, while sex-change operations are generally not discouraged because it removes sexual abnormalities and allows one to easily fit into the social categories culture has assigned (Caplan, 1997).

What is masculine and what is feminine? These terms are merely social constructs that are developed and maintained within a specific culture. In Western society, a primary aspect of one's identity is gender (Bonvillain, 1998), this is why gender roles are learned and reinforced at a young age. Socialization teaches children appropriate behaviour specific to their gender. Especially in modern Westernized culture, these categories are mutually exclusive to sex, and leave little to no room for modification or individuality. The English language, which includes only two genders, she and he, further reinforces a gender dichotomy, as does many other languages. Individuals therefore acquire social identities, insinuating that society has a substantial impact on one's behaviour and expectations of that behaviour within a culture.

Different cultures have different definitions and beliefs about gender and sexuality (or lack thereof), so for the purpose of this analysis, homosexuality will be examined in terms of modern Western society which has also been defined to participants prior to conducting the experiments that will subsequently be discussed. That is, homosexuality is defined as the consistency of being sexually attracted to individuals of the same sex or consistently engaging in sexual intercourse with members of the same sex (Lancaster and Leonardo, 1997). For most of these studies, bisexual individuals, "those whom direct sexual desires toward members of both sexes" (Lancaster and Leonardo, 1997, p. 52), were excluded because the degree to which they would experience homosexual societal stigmatization is unknown. Furthermore, there are also discrepancies when taking into consideration the gender with which an individual identifies, especially when examining cultures with more than one gender.

To begin the discussion of societal stigmatization and its effect on mental health, internalized homo-negativity will first be analyzed.

Homo-negativity Study

In a study conducted by Rosser et al. (2008), results showed that internalized homo-negativity plays a key role in the mental health of homosexuals. In this study, internalized homo-negativity is defined as "a basic mistrust for one's sexual and interpersonal identity" (Stein & Cohen, 1984, p. 182). Although the study showed that identification of being homosexual does illustrate acceptance from society, it does not dissolve heterosexism, that is, "external societal discrimination favouring heterosexuals" (Neisen, 1993, p. 5). In fact, Neison argues that these individuals may be more susceptible to mental health abnormalities, and that homo-negativity and cultural victimization may be in concordance with the effects of sexual and physical abuse.

In this study, 442 males were recruited from a homosexual health seminar. To be eligible they must have identified as "either a homosexual engaging in homosexual activity" or "as being attracted to other men" (Rosser et al., 2008, p. 153). Exclusively heterosexual men were excluded from the study because they would theoretically not experience internalized homo-negativity on the same scale as homosexual men. Sexual identification, internalized homo-negativity (including comfort of publicly identifying as homosexual, perceived stigmatization for being homosexual, comfort level with other homosexuals, moral homo-negativity and religious homo-negativity), mental health, sexual health and social integration were all measured via questionnaire analysis.

It was found that the degree of homosexuality across a continuum scale was not associated with any of the measured cognitive factors mentioned above. However, homo-negativity was found to be negatively correlated to mental health, sexual health and social integration. High degrees of homosexuality were found to be related to depression only when coupled with high levels of homo-negativity. Thus because internalized homo-negativity, not homosexuality, is associated with overall sexual health, psychosexual maturation, comfort with sexual orientation, peer socialization, depression, comfort with sexual acts as well as social integration, it is suggested that homo-negativity plays a significant role in one's mental health.

Although this study demonstrates how ingrained cultural values can have a negative impact on the mental health of homosexuals, it also has a number of limitations. First, the sample consists of selection and sample bias. All participants were recruited from an all-male homosexual seminar. Severely homo-negative individuals may be unlikely to attend these seminars where they are publicly identified as homosexual. Last, not all homosexuals gender identify as male. Lesbians and transgendered individuals are not represented in this study. Therefore, Rosser arguably does not have an accurate representation of the gay community and these results can only be generalized to male homosexuals. Apart from these limitations, it is apparent that society can have a negative impact on mental health, specifically depression, as numerous other studies have supported this relationship (e.g., Ingartua & Karine, 2003).

In a study conducted by Ingartua and Karine et al. (2003), the effects of internalized homophobia on depression, anxiety and suicide were examined. 220 participants were recruited in order to complete two self-report questionnaires. The first questionnaire examined internalized homophobia (the degree of aversion to homosexual tendencies directed towards the self), depression, anxiety, suicide, and substance abuse, while the second analyzed the time period through one's life in which they would be most vulnerable to suicide. Note that internalized homophobia refers to a basic mistrust for one's sexual and interpersonal identity, while internalized homophobia refers to an aversion. It should also be noted that these two constructs are not mutually exclusive.

Finding a representative sample of the homosexual population was challenging for Ingartia and colleagues for two reasons. The first being that it is difficult to determine who is homosexual and who is not. Secondly, sexual orientation is not two mutually exclusive categories of homosexual and heterosexual, but rather a continuum. Nonetheless, participants were chosen using multiple sampling techniques. They were chosen from McGill University's Sexual Identity Centre, a psychiatric out-patient clinic catering to the gay, lesbian and transgender population, as well as those questioning their sexuality. Surveys were distributed to university queer discussion groups, gay and lesbian film festivals, gay and lesbian bookstores, sports teams, McGill University's Health Clinic and finally, restaurants, bars and cafes in the gay village. Participants were also recruited through various social networks in order to gather input from individuals who are homosexual but not involved in the gay community.

Psychological distress, alcohol abuse, sexual orientation and internalized homophobia were all assessed via separate scales within the questionnaires. To determine proper variation within the sample, descriptive statistics were first extracted for socioeconomic status, religion, ethnicity and education, which were found to be nonsignificant.

Analysis of data shows that internalized homophobia is significantly correlated with levels of depression, anxiety and suicidal impulses. Most interestingly, the self-sub-scale measuring negative emotional cognition of one's own homosexuality was the best predictor of distress. However, this study did not find any correlation between alcohol abuse and homosexuality, perhaps because the majority of the participants were relatively young. A more age-diverse longitudinal study may have revealed different results. However, internalized homophobia failed to predict suicidal tendencies once other psychological distress factors were accounted for. Thus, it seems likely that internalized homophobia has an indirect effect on suicide by significantly contributing to depression. Interestingly, societal stigmatization has also been found to be correlated with narcissistic defense mechanisms (Alexander, 1996).

Narcissism and Male Homosexuality

Using a Rorschach test, which have proven to be a reliable indicator of narcissism, Alexander (1996) found that reflection responses were to be two and a half times more likely in homosexual men (i.e., higher reflection scores indicate higher narcissistic tendencies). Based on Alexander's clinical experience, where majority of gay men seek mental help to establish a positive self-image and self-esteem, he argued that homosexual men might seek self-assurance to convince themselves that they are not inherently damaged. He also found that in homosexual men, low self-esteem and internalized homophobia are correlated with severe anxiety, depression, sexual dysfunction and relationship failures. In lieu of external/internal validation, Alexander inferred that it may be difficult for one to develop self-esteem. Therefore, homosexual men may often use defense mechanisms to mask feelings of depression, guilt and shame. Furthermore it has been suggested that those who are willing to undergo lengthy series of psychological tests may have more narcissistic tendencies. It is apparent that there is some narcissistic vulnerability in homosexual men, but to what degree and to how much the vulnerability manifests into narcissism remains unknown. However, some insight into this question was provided by a study over a decade later (Rubinstein, 2010).

In the study carried out by Rubinstein (2010), multiple measures of narcissism were administered to the participants including Pincus et al.'s (2008) Pathological Narcissism Inventory and Raskin and Hall's (1981) Narcissistic Personality Inventory. Significantly higher scores of narcissism were found among homosexual men compared to that of heterosexual men on both scales. Furthermore higher scores of narcissism were found to be negatively correlated to self-esteem. Rubinstein's explanation for these findings includes an environmental attribute. Rubinstein suggests that these narcissistic tendencies may be a result of "the oppressive homophobic power of the heterosexual society" (Rubinstein, 2010, p. 15). Moreover it is suggested that the homosexual community may create additional pressure among its members due to its emphasis on appearance, which might augment a narcissistic tendency.

Another cognitive abnormality mediated by societal stigmatization worth of interest to examine is the eating disorder prevalence among homosexual men.

Eating Disorder Prevalence

It was discovered that, in the United States, there is an over-representation of homosexual men in eating disorder clinics than there is in the general population. In fact, about 20-40 percent of individuals enrolled in eating disorder clinics are homosexual (Russell & Keel, 2002). Therefore, the question arises, what

about male homosexuality makes males more susceptible to eating disorders? The most common theory in the literature is that body dissatisfaction are more prevalent among homosexual males, which plays an instrumental role in the prognosis of eating disorders. Furthermore, the body dissatisfaction among homosexuals differed from that of heterosexual. Body dissatisfaction in homosexual men involved not only idealized low body mass, but also muscularity. Thus, there is an increased demand among homosexuals in conforming to the perfect model of the male form, hence resulting in increasing socio-cultural pressure on homosexuals and body dissatisfaction.

Some researchers attempt to attribute high body dissatisfaction among homosexuals to their more "feminine characteristics," compared to that of heterosexual men, as there is a heavy cultural influence on females in Western society to be thin. However, homosexuality in males does not cause femininity, as femininity and masculinity are mere social construct, hence, culturally relative. Therefore it cannot be concluded that a higher prevalence of body dissatisfaction is a direct result of sexual orientation due to characterized gender roles (Meyer et al., 2001; Strong et al. 2000).

A more likely account for the lower body satisfaction among homosexuals is their lower self-esteem. Supporting this account, studies found that self-esteem was negatively correlated with body dissatisfaction (Cervera et al., 2003), a significantly lower amount of self-esteem in homosexual men (Yellond & Tiggenann, 2003), and that self-esteem is greatly influenced by homo-negativity (Williamson & Hartley, 1998).

Taking these previously mentioned factors related to body dissatisfaction into account, Hospers and Jansen (2005) conducted a study investigating the relationship between male homosexuality and eating disorders, while also examining factors of masculinity, femininity and peer pressure in the gay community.

In this study, male participants were recruited in two ways. First, being an advertisement poster on a popular Dutch homosexual website, allowing anonymous participation in the study via online questionnaire. Secondly, participants were recruited from the Maastricht University to participate in an eating disorder and behaviour questionnaire. This method of recruitment and obtaining a sample is appropriate for three reasons. First, it allows researchers to sample men who might shy away from the study because they do not want to be publicly labeled as homosexual, as their anonymity is maintained with the online questionnaire. Secondly, by naming the study an "Eating Behaviour Questionnaire", it allowed one to sample those who would originally be reluctant to participate in a questionnaire under a homosexual label. Lastly, Hospers and Jansen used two administration methods, which add to the representativeness of the sample. In total, the sample size was substantial, 241 participants, 70 being exclusively attracted to men, and 169 exclusively attracted to women.

The results of the study suggest that eating disorder prevalence is highly correlated to body dissatisfaction and not self-esteem. By further examining body dissatisfaction, it was found that body dissatisfaction was related to body mass index, and among homosexuals, pressure from peers to conform to an ideal body type. Body dissatisfaction was more prevalent in homosexuals, and femininity did not play a role in body dissatisfaction. Also, among both heterosexuals and homosexuals, prevalence of body dissatisfaction was related to high body mass index, low masculinity, and from perceived societal and peer pressure due to sexual orientation. However, this study does have a number of limitations, the first being that because of the cross analysis of the multiple variables, it is difficult to determine the causality of the relationship. Furthermore, not all scales used were validated by homosexual men.

Nonetheless, this study clearly illustrates how societal pressures to conform can have a negative impact on the individual. Specifically high pressure due to being a sexual minority can

have a negative impact on one's mental health, whether they are homosexual or heterosexual. Not conforming to dominant gender roles and heterosexism can have a negative impact for all those whom rebel, whether gay or straight. Furthermore, it is now apparent that these psychological stressors can result in major health implications, including suicide.

Psychological Stressors Contributing to Suicide Among Homosexuals

Sexual minority groups are exposed to stressors youth commonly experience as well as other categories of stressors related to stigmatization of their sexual orientation. Fear of the outcomes of sexual disclosure to family and friends also has a negative impact on sexual minorities (Boxer et al., 1991). In a study conducted by D'Augelli and Hashberger (1993), over half of the participants (all homosexuals) studied reported fear in disclosing their sexual orientation to their families, and about a quarter reported the prospect to be extremely troubling. Of those sexual minorities who disclosed their sexual orientation to their families, eight percent of mothers were intolerant but not rejecting, while 12 percent were rejecting. Furthermore, 20 percent of fathers were intolerant but not rejecting, while 18 percent were rejecting. Among sexual minorities, rejection by friends was also found to be a major psychological stressor. Additionally, 33 percent of the participants studied feared losing friends upon disclosure, and 46 percent reported they had lost friends when disclosing their sexual orientation. In another study, 41 percent of their sample was found to experience strong negative reactions from members of their social group upon disclosing (Remafedi, 1987).

Apart from psychological stressors of sexual disclosure, it was found that sexual minority groups experience substantial verbal and physical abuse. In a study conducted by Pilkinton and D'Augelli (1995), 80 percent of the sample experienced verbal insults based on their sexual orientation, 44 percent experienced physical threats, 33 percent had objects thrown at them with intent to injure, 31 percent had been chased or followed, 13 percent reported being spat on, 20 percent had been physically assaulted and 22 percent reported at least one sexual assault. These findings by Pilkinton and D'Augelli are consistent with other studies investigating verbal and physical abuse to homosexual individuals (Berrill, 1990; Deon, Wu and Martin, 1992; Gross, Aurand, and Adessa, 1998; Hunter, 1990).

In a study conducted by Alexander (2005), the over representation of homosexuals in suicide attempt statistics were examined. Participants from 14 gay and lesbian youth groups in metropolitan cities across the United States were recruited. The final sample consisted of 194 participants, 73 percent male, 27 percent female, ranging from 15 to 20 years old with the average age being 18.86. There was also considerable variation among ethnic groups in this study, 61 percent being Caucasian, 15 percent African American, five percent Asian American, five percent Hispanic American, and four percent Native American.

Via questionnaire analysis, the results of this study showed that 42 percent of the sample had attempted suicide on at least one occasion, ranging from one to 15 attempts, methods of which varied. Notably, no differences in men and women were found in attempts of suicide. Of the sample, 60 percent reported having thoughts about killing themselves, while eight percent reported having these thoughts often. However, males reported more dissatisfaction in sexual activity, more depression, more anxiety and more worry about HIV/AIDS. From those participants who attempted suicide, they were found to be more open to disclosing their sexual orientation, had greater numbers of same sex partners, engaged in more social activities, had more lesbian/gay friends, and overall more positive relations with their families. Furthermore, those that had attempted suicide had parents whom were more acknowledging of their sexual orientation then those who had not attempted suicide. Thus this study suggests that acceptance from one's family has a less important role, and that acceptance from one's peers and societal attitudes are instrumental in

the prevalence of suicide attempts among sexual minorities, and in turn their mental health.

Conclusion

Based on previous research, it is apparent that negative views of homosexuality from society can have serious implications on one's mental health. This is also predicted by the minority stress hypothesis, which states that minorities within a society are culturally predisposed to more psychological stress as they are subjected to more prejudice and stigmatization (Meyer, 2010). It is through this view that sexual minorities are predicted to be at a greater risk to mental illness.

In modern Westernized society, where identity is partly based on one's sexual orientation, one's sexual orientation significantly affects how society in turn views that individual (Caplan, 1997). Internalized homo-negativity studies conclude that embodied internalized homo-negativity is correlated with severe depression on all clinical scales of depression, overall sexual health, psychosexual maturation, comfort with sexual orientation, peer socialization, depression, comfort with sexual acts and social integration. Thus suggesting that homo-negativity plays a significant role in one's mental health (Rosser et al., 2008). Furthermore, internalized homophobia was found to be significantly correlated to levels of depression, anxiety, and suicidal impulses by Ingartua and Karine et al. (2003). These negative thoughts about homosexuality were found to only have an impact on mental health when they were in regards to the individual themselves, and not others regardless of sexual orientation. This suggests that society can have a negative impact on an individual regardless of their sexual orientation when stereotyped behaviours are stigmatized by society. Narcissistic tendencies in male homosexuals were also found to be significantly correlated to homosexuality when considering the Rorschach Reflection scale. It is suggested that narcissistic tendencies among homosexuals results from the absence of internal and external validation; homosexual men then seek self-assurance that they are not inherently damaged. Eating disorders were also found to be highly correlated with body dissatisfaction, both of which were more prevalent among homosexuals (Hosper & Jansen, 2009). Furthermore body dissatisfaction among heterosexuals and homosexuals was related to high body mass index, high pressure from society and peers, low masculinity and from perceived societal and peer pressure due to sexual orientation.

Lastly, suicide attempt prevalence among homosexuals in the United States was examined, where 42 percent of the sample had tried on at least one occasion, ranging from one to 15 attempts of suicide. Notably there were no differences among gender, and 60 percent of the sample reported having suicidal thoughts, while eight percent report having these thoughts often. Those who had attempted suicide felt more victimized by peers and society, physically and verbally, and acknowledged more mental health problems. This study therefore suggests that acceptance from society and peers play a major role in the prevalence of suicide attempts among homosexuals. After exploring these main components of mental health abnormalities among sexual minorities, it is apparent that societal pressures and ideologies can significantly influence the mental health of homosexuals.

First Received: 1/13/2013

Final Revision Received: 4/12/2013

ISBN: 978-0-7714-3038-1

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