Original Research Article

Perceived Social Support and Internalized Homophobia among Lesbian, Gay and Bisexual Individuals

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ABSTRACT

Background: The LGBTQIA+ community faces relentless discrimination and negative social attitudes despite the overhaul of IPC Section 377 in India, which are sometimes projected inwards as internalized homophobia. The present study aims to investigate the relationship between perceived social support and internalized homophobia and assess the level of internalized homophobia among lesbian, gay and bisexual individuals.
Methodology: A correlational research design was used with a sample of individuals identifying as either gay, lesbian or bisexual (n = 109) recruited using mixed-snowball sampling method for the study and the data was analysed using statistical methods like Spearman's correlation, Welch's ANOVA and linear regression. Internalized homophobia was measured using the Internalized Homophobia Scale (IHS) and Lesbian Internalized Homophobia Scale (LIHS), whereas perceived social support was assessed using the Multidimensional Scale of Perceived Social Support (MSPSS).
Results: The results revealed a significant relationship between perceived social support and internalized homophobia among male participants and higher levels of internalized homophobia among non-heterosexual women compared to non-heterosexual men. The findings indicate that lacking perceived social support can contribute to increasing internalized homophobia, which in turn reduces perceived social support within a negative, self-perpetuating cycle. The intersectionality of gender-based violence targeting one's identity as a woman and a non-heterosexual individual, may contribute to heightened levels of internalized homophobia among women. The study provides important findings that may help to formulate instructive queer affirmative mental health policies and practices.
Conclusions: Perceived social support can extensively contribute toward the development of internalized homophobia among LGB individuals.

Keywords: Homophobia, Social Support, Sexual Minorities, Gender Minorities, Sexual Behavior.

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INTRODUCTION

Sexual minorities routinely face discrimination due to pervasive stigma and heteronormative beliefs held by society. Until 2017, IPC Section 377 was actively implemented, which stated that "whoever has carnal intercourse against the order of nature with any man, woman or animal, shall be punished with imprisonment for life, or with imprisonment of either description for a term which may extend to 10 years, and shall also be liable to fine." On 6 September 2018, the verdict striking down the colonial law was released by a five judges' bench, clearly stating that it was unconstitutional (Navtej Singh Johar v. Union of India) And yet members of the LGBTQIA+ community (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual etc.) routinely face harassment, poor mental health, unemployment, and other forms of physical and mental abuse. The dearth of psychological and psychiatric literature clearly prevents mental health

professionals from formulating mental health options that are tailored to ameliorate existing issues faced by sexual minorities.

Lesbian Gay Bisexual Transgender (or LGBT) is used as a social self-designation term in place of, what was formerly known as the "gay community" and has also come to emphasize a diversity of "sexuality and gender identity-based cultures". Thus, it is sometimes used to refer to anyone who is non-heterosexual instead of exclusively to people who are homosexual, bisexual, or transgender [1]. Other forms of sexual orientations and gender designations incorporated into the acronym are 'queer', 'intersex' and 'asexual', thus forming the LGBTQIA terminology.

Members of sexual minorities are often exposed to societal pressures in conforming to existing heteronormative beliefs and attitudes, can lead to implicit stress and difficulties among members of minorities. According to the Minority Stress model [2], minority group members experience two forms of stressors: distal and proximal stressors. Distal stressors are those stressful situations, attitudes, or beliefs such as homophobic rhetoric, discrimination and prejudice which are threatening to the minority individual. Proximal stressors are cognitions involving one's identity as a minority, for example, fear of perceived embarrassment or rejection by outgroup, ruminating negative thoughts and beliefs or previous negative experiences of harassment or bullying. Meyer regarded internalized homophobia as one among many proximal stressors that can adversely affect LGB individuals. Internalized homophobia represents "the gay person's direction of negative social attitudes toward the self" [3 p.161]. Research conducted by Shidlo [4], briefly discusses the importance of internalized homophobia. Firstly, internalized homophobia is the direct product of varying degrees of lived experiences within a heteronormative society that contains prejudiced views of homosexuality. The study states that it can indirectly affect the LGB individual, by manifesting through a wide range of mental health issues such as depression and low self-esteem and prevent him or her, from developing and maintaining healthy, intimate relationships. Moreover, it can also be seen as an intervening factor in effectively accessing treatment for psychosocial issues and in the prevention of psychological distress.

When the prevalent homophobic attitudes of a heteronormative society are internalized into a pattern of information or "schema", of attitudes involving self-loathing, lowered self-efficacy and poor self-esteem, it can inevitably lead to a wide range of psychological and psychiatric issues – which maybe ameliorated to some extent in the presence of social support. Social support is defined as information from others that one is loved, cared for, esteemed and values and part of a network of connection and mutual obligations [5]. One way of conceptualizing social support examines the size of our social network and the number of links that we have to other people—family members, friends, acquaintances, and others. Social network measures help us to identify who might be socially isolated, for example, with few friends and family members nearby.' Barrera et al. [6] identified that social support consists of 'various forms of aid and assistance supplied by family members, friends, neighbours, and others' and may include social embeddedness, enacted support and perceived support [7]. The importance of social support is delineated by the 'direct-effects hypothesis', which maintains that social support is equally beneficial during both stressful and non-stressful situations, whereas the 'buffering hypothesis' states that benefits of social support are more evident during stressful situations (workplace discrimination on the basis of one's sexual orientation, stigmatized attitudes towards the LGB individuals at hospitals or therapy centres etc.) But often certain obstacles exist in seeking out social support especially for sexual minority individuals – such as feelings of "guilt" over utilizing social support resources (time and empathy) from others.

Very few, if any, studies have assessed the relationship between perceived social support and internalized homophobia among LGB individuals, especially in the Indian context. The results of studies conducted by Cain et al. [8] on the mediating effects of internalized homonegativity and social support on the relationship between mental health correlates and population density among gay and bisexual men reported higher internalized homonegativity among multiracial men, compared to white men. Results of the study also indicated that men with four-year degrees reported increased social support and decreased depressive symptoms. Internalized homonegativity and depressive symptoms showed a relationship whereas social support and depressive symptoms were inversely correlated. Thus, it is possible to deduce that depressive symptoms increase considerably due to higher internalized homonegativity which in turn, occurs due to lower social support amongst GBM living in lower population density areas. The higher prevalence of social

support groups for GBM population, as well as awareness and adequate mental health service provisions in urban and semi-urban areas maybe reasons for lesser depressive symptoms mediated by low internalized homonegativity. A similar study was conducted by Lyons and Pepping [9] to determine the prospective effects of internalized homonegativity and sexual identity concealment among middle-aged and older gay men. The findings suggested lower internalized homonegativity among gay Australian men, on receiving higher baseline tangible and practical support as well as findings predicting that lower sexual identity concealment maybe significantly associated with receiving higher emotional or psychological support, over a follow-up after 12 months. Although initial assumptions that, receiving greater community and government support would correlate with lower internalized homonegativity, was not found in the study.

Herek et al. [10] studied the relationship between internalized homophobia and its correlates among gay and lesbian individuals using measures to assess internalized homophobia, perceptions of community, outness and psychological well-being and the results found higher internalized homophobia among gay men than lesbian women, and higher IH among bisexuals than homosexuals. Lesbians and gay men showing greater IHP also showed significantly greater depressive symptoms and men with higher IHP scores showed lower self-esteem than men with lower IHP scores. The study explains that, because heterosexual men have repeatedly shown greater negative attitudes towards gay men than towards lesbians, gay men are more likely to internalize hostile attitudes towards 'homosexuality' in general than lesbian women since gay men and lesbian women undergo similar socialization processes as heterosexual individuals.

Other qualitative studies examine internalized homophobia among lesbians [11] have extensively evaluated the five dimensions of lesbian internalized homophobia as "(1) connection with the lesbian community (CLC), (2) public identification as a lesbian (PIL), (3) personal feelings about being a lesbian (PFL), (4) moral and religious attitudes toward lesbianism (MRATL), and (5) attitudes toward other lesbians (ATOL)".

Similarly, Wandrey et al. [12] identified levels of homophobia and biphobia affecting coming out process of bisexual women to family and friends on a sample of 17 participants. The study evaluated key themes of coming out including the presence of homophobia and biphobia, usage of alternative terms to defend biphobic feelings, the preference to approach coming out in a casual manner, ability to 'pass' as heterosexual or lesbian according to situational demands etc. Results indicate the prevalence of sexualization of bisexuality in women to fulfil certain heterosexual male fantasies, the evaluation of bisexuality as being "context-specific" i.e., to the experience of university life rather than an enduring pattern of attraction, usage of terms such as "pansexual, queer, fluid" over "bisexual" in order to avoid biphobic attitudes perpetuated by both heterosexual and homosexual men and women.

The general objective of the present study was to examine the level of internalized homophobia among lesbian, gay and bisexual individuals and study the relationship between perceived social support and internalized homophobia among lesbian, gay and bisexual individuals.

METHODOLOGY

Design: A cross-sectional, correlational research design, where two or more sets of data were collected from the different groups to determine whether any relationship between the variables exist was adopted.

Population: The individuals who participated in this study self-identified as either gay, lesbian or bisexual (men and women). A total of 109 participants were recruited to be part of the study, consisting of 72 cisgender men, 35 cisgender women and 2 non-binary individuals. The study consisted of 22 bisexual men (average age= 23.27 years), 51 gay men (average age= 23.47 years), 21 lesbian women (average age= 25.47 years) and 15 bisexual women (average age= 21.86 years). Exclusion criteria of the study population were pansexual, asexual, aromantic, intersex, queer, transmen, transwomen individuals etc. Henceforth in the present study, gay and bisexual men are termed together as 'GB' men while lesbian and bisexual women are termed together as 'LB' women.

Tools

1. **Multidimensional Scale of Perceived Social Support:** This scale was developed by Zimet [12], of Indiana University of Medicine and it consists of 12-items measuring the adequacy of perceived

social support received from three sources: family, friends and significant others. Each of these three subscales are measured using 4 items on a 7-point Likert-type scale that ranges from 1 (very strongly disagree) to 7 (very strongly agree). Higher the score received on the scale, greater the perceived social support. The scale has good internal consistency with reported alpha coefficient of 0.91 for total score and 0.95 for each subscale over 2-3 months' time interval.

2. **Internalized Homophobia Scale:** The Internalized Homophobia Scale (IHS) is a 20-item expansion of the Nungesser Homosexual Attitudes Inventory [13] developed by Wagner et al. [14]. Internal consistency was found to be 0.92 for the original sample, and Wagner et al. [15] found positive correlations ($r = 0.46$) between acceptance of a gay identity and internalized homophobia and found internal consistency to be 0.93 within the sample of gay men. Responses are recorded using a 5-point Likert-type scale, from 1 (strongly disagree) to 5(strongly agree). Higher the score received on the scale, higher the internalized homophobia. The internal consistency of the scale for the present study on a small pilot sample ($n = 22$) was estimated at $\alpha = 0.87$, indicating 'excellent' reliability.
3. **Lesbian Internalized Homophobia Scale:** Chung and Szymanski [11] constructed the Lesbian Internalized Homophobia Scale consisting of 52-items and responses are recorded using a 7-point Likert-type scale that ranges from 1 (strongly disagree) to 7 (strongly agree). The higher the score, received by the individual on the scale, the greater they hold internalized homophobic feelings or attitudes. The internal consistency of the scale for the present study on a small pilot sample ($n = 19$) was estimated at $\alpha = 0.91$, indicating 'excellent' reliability.

Data collection

Data collected from various Indian states mainly from Kerala, Tamil Nadu, Karnataka, Delhi and Maharashtra. Nonprobability sampling technique was employed in the study, specifically snowball sampling procedure where self-identified LGB individuals in turn, identify friends or associates belonging to the community, forming a concrete social pattern or constellation of networks. Such sampling methods are useful for conducting research among less easily identifiable populations. Personal Data Sheet (information regarding relevant demographic variables including email addresses, age, sexual orientation, educational grade level, gender, marital status, partner/spouse's sexual orientation, religion, frequency of attending religious services and their current geographical address), Multidimensional Scale of Perceived Social Support, Internalized Homophobia Scale (IHS), Lesbian Internalized Homophobia Scale (LIHS). The questionnaires used in the study were distributed for procuring data, via E-forms or Google forms and informed consent about voluntary participation in the study was also provided to all participants. Sample participants were identified and consequently recruited, via personal contacts, and through social support groups (Queerala, Queerhythm, Orinam etc). Programs conducted by such organizations were important venues to meet self-identified LGB individuals and other participants were emailed or contacted via WhatsApp with attached e-forms of the questionnaires.

Data analysis

The data analysis was conducted using SPSS 21.0 version (Statistical Package for Social Sciences) and consisted of descriptive statistical measures such as mean and standard deviation. Inferential statistics used included non-parametric testing such as Spearman's rank correlation, Welch's ANOVA and linear regression.

Ethical clearance

The ethical considerations of the study included the informed consent form indicating the study objectives, voluntary nature of participation, confidentiality in managing the data provided by the participant and the right to discontinue participation in the study without any consequences. The form was emailed to participants prior to administering the questionnaires and participants were allowed to proceed only after fully verifying the ethical considerations and informed consent form. All ethical standards complied with the Helsinki Guidelines [16].

RESULTS

The study consisted of 109 self-identified lesbian, gay and bisexual participants who completed the survey. Upon using the Shapiro-Wilk test for investigating normality of data, it was found that the datasets were not normally distributed. Baseline sociodemographic characteristics of the participants are depicted in Table 1.

Table 1: Baseline sociodemographic characteristics of participants.

Demographic variable	Types	Sample size (approx. %)
Gender	Male	73 (66.97)
	Female	36 (33.03)
Age group (in years)	17-21	43 (39.44)
	22-29	56 (51.37)
	30-39	8 (7.33)
	40-49	1 (0.91)
	50-59	1 (0.91)
Educational Level	Higher Secondary	19 (17.43)
	Undergraduate	50 (45.87)
	Postgraduate	13 (11.92)
	Working Professional	27 (24.77)
Sexual Orientation	Lesbian	21 (19.26)
	Gay	51 (46.78)
	Bisexual	37 (33.94)
Religious Affiliation	Hindu	50 (45.87)
	Jainism	1 (0.9)
	Buddhism	2 (1.83)
	Christian	4 (3.66)
	Muslim	5 (4.58)
	Atheist	23 (21.10)
	Agnostic	21 (19.26)
	Prefer not to say	3 (2.75)
Current relationship status	Single	85 (77.98)
	In a Committed Relationship	23 (21.10)
	In a Civil Union/Partnership	1 (0.9)
Geographical area	Urban	67 (61.46)
	Suburban	35 (32.11)
	Rural	7 (6.42)

Table 2: Relationship between perceived social support and internalized homophobia among non-heterosexual men and women

Variable	Perceived Social Support	
	Non heterosexual men (n = 73)	Non heterosexual women (n = 36)
Internalized Homophobia	-0.28*	-0.29

Note. *p<0.05

Table 1 summarizes the sociodemographic characteristics of the sample. Considering the normality of the data (p<0.01), Spearman's correlation was used to investigate the relationship between perceived social support and internalized homophobia. The study showed a significant negative relationship (r= -0.28, p= 0.044) between perceived social support (Mean= 57.95, SD= 11.61) and internalized homophobia (Mean= 45.68, SD= 11.79) among GB men. Perceived social support (Mean= 54.34, SD= 14.09) was negatively correlated with internalized homophobia (Mean= 54.34, SD= 14.09) among LB women (r = -0.29, p = 0.085, two-tailed), but the results were not significant. To further analyse the relationship between the two

variables among non-heterosexual men (X or independent variable = 'Perceived social support' and Y or dependent variable = 'Internalized homophobia'), univariate linear regression was conducted. These findings have been illustrated within Table 2.

Table 3: Regression analysis to predict internalized homophobia among non-heterosexual men

Variable	B	CI	β	T	*p*
Non heterosexual men (n = 73)					
Constant	71.176	[45.946, 96.405]		5.885	0.000
Perceived Social Support	-0.440	[-0.867, -0.013]	-0.433	-2.148*	0.044

Note. CI = Confidence interval; R square = 5.1%; *p<0.05

A simple linear regression was calculated to predict internalized homophobia based on perceived social support for non-heterosexual men and women separately as indicated in Table 3. A significant regression equation was found (F (1, 71) =4.87, p< 0.05) with an adjusted R^2 of 5.1 (or 5.1% of variance in internalized homophobia can be explained by perceived social support), thus perceived social support predicted internalized homophobia among GB men. Perceived social support emerged as a negative predictor for internalized homophobia.

Table 4: Gender-wise differences in levels of internalized homophobia among male and female individuals.

Variable	Men (N=73)		Women (N=36)		t	F	*p*
	Mean	SD	Mean	SD			
Internalized Homophobia	54.34	14.09	113.39	27.09	-150.93	224.99*	0.000

Note. SD = Standard deviation; *p<0.05 is considered significant

Since the assumption of homogeneity of variance was not met for this data, and due to unequal sample sizes, we used the obtained Welch's t-test (or Welch's one-way ANOVA). Mean internalized homophobia scores differed significantly by the individual's gender according to a Welch's test, F (1, 44.58) = 224.99, (p<0.01). Non-heterosexual women (Mean=113.39, Standard deviation [SD] = 27.09) scored significantly higher than non-heterosexual men (Mean = 54.34, Standard deviation [SD] = 14.09) on internalized homophobia levels. The results of the Welch t-test have been indicated within Table 4.

DISCUSSION

A possible explanation for the present findings results from studies conducted by Cain et al. [8] which indicates strong evidence for mediating effects of social support and internalized homonegativity on association between population density and mental health among gay and bisexual men. Regression analysis conducted reveals the relationship between the independent variable (perceived social support) and dependent variable (internalized homophobia), also supported by Cain et al. [8] that residing in lower population density areas can mean poorer forms of social support. It can be proposed that mere access to social support for participants may not significantly amount to actual assurance of any substantial social support in times of crisis, especially due to poor connectivity for most GB individuals to affirmative social groups in Indian societies and lack of economic, political or social backing. The lack of perceived social support may in turn, provide lesser resistance to countering homonegative attitudes prevalent in the society and media. Receiving social support may also foster guilt over monopolizing others attention for perceived "trivial" reasons and can threaten one's self esteem due to perceived dependency on others for emotionally support [17].

One way that IH is likely to increase psychological distress is through decreasing interpersonal support. Previous work suggests that gay men and lesbians who report higher levels of IH report lower levels of

outness, which likely results in having less LGBQ-specific social support. In the Indian context, prevailing heterosexist and heteronormative attitudes can have implicit damaging effects on men. Rigidly defined masculine and feminine appropriating behaviours as well as conservative and religious beliefs can be correlated with heterosexist attitudes [18]. Most Judeo-Christian or Abrahamic religious followers (Judaism, Christianity and Islam) condemn homosexuality as a 'sin', further perpetuating internalized homophobic attitudes amongst gay and bisexual men [19]. Malcolm and Rowen [20] explain the relationship in more subtle terms, asserting that the idea of 'repressed social environments' are a function of "perceived" social environmental repression or the LGB individual's choice to remain to micro-social repressive environments rather than actual repressive environments. Ross [21] corroborates these results by suggesting that IH is related more towards perceived social repression than actual social oppression. Internalized homophobia may also affect negatively impact romantic relationships, further deepening self-loathing, in turn, leading to increased internalized homonegative attitudes. Similarly, Ross and Rosser [22] demonstrated that among gay and bisexual men, internalized homophobia was negatively associated with relationship quality and the length of individuals' longest relationships.

The results also indicate significant gender differences in internalized homophobia with women holding more homonegative views compared to men. This contradicts previous findings, [10, 23] which may be due to vast socio-cultural differences in socialization and community-roles of women compared to men, in India. Studies conducted by Human Dignity Trust [24] on the impacts of criminalisation of lesbian and bisexual women in India, corroborate the research findings of this study. Multifaceted societal pressures with respect to marriage, child rearing practices and general personal autonomy can prove to be challenging for lesbian and bisexual women to navigate their respective sexual identities. UNHCR[25] reports that lesbian women show greater chances of conforming to societal pressures and marrying heterosexual men, due to cultural norms that require women to display 'compulsory heterosexuality' in order to, bear children and uphold the family's dignity. Failing to do so, can result in murder in certain cultures. Such societal norms can be especially damaging to a woman's sense of self-worth considering her dual minority status, both as a sexual minority and as an underprivileged member of the society in comparison to men (heterosexual and homosexual). Unlike gay or bisexual men, who hold greater freedom to alternatively explore their sexual lives while being in "sham marriages", women are subjected to more intensely controlling lifestyles, often at the hands of her husband- with very little autonomy over her body, and financial resources.

Biphobic actions and behavior are relentlessly perpetuated by both heterosexual and non-heterosexual individuals towards bisexual women [26]. The notion of bisexuality as a "sham" or "passing fancy" for experimentation and its subsequent sexualization for male fantasy entertainment for example, viewing women as sexual objects to be evaluated in terms of their physical attractiveness [27] can be deduced as important causes for increased internalized biphobic attitudes held by bisexual women. While the present study largely concentrates on internalized homophobia, findings from the results can also be effectively interpreted to some extent, for internalized biphobia among bisexual women.

Thus, it can be concluded that higher levels of internalized homophobia among Indian lesbian and bisexual women are partly attributable to male objectification, particularly with respect to same-sex sexual acts; however, a critical difference for bisexual women is that the heterosexual male observers realistically have the possibility of engaging sexually with bisexual women (ogling, voyeuristic behaviors and catcalling) whereas this is not likely the case for lesbian women [28]. This may exacerbate internalized homonegativity among bisexual women with respect to any same-sex attraction they experience.

Limitations of the study include the relatively small sample size from a narrower and relatively urban population frame. The broader implications of the present study are relevant, given the recent, increased spate of harmful therapeutic measures, such as conversion therapy, done by mental health professionals under the pretext of "curing" homosexuality in the Indian subcontinent. Scientific literature clearly provides evidence against reparative therapeutic measures and details the psychological harm of such practices. Gay affirmative therapy is an approach often used working when with LGB individuals in which the minority position is valued as equal to the dominant position, and in which the practice is informed from knowledge of the minority's community and of their issues and their needs. This approach is likely to be beneficial in tackling internalized homophobia. The findings from the present study may help to better understand pertinent issues in combating internalized homophobia.

CONCLUSION

The present study concludes that there exists relationship between perceived social support and internalized homophobia among male individuals and higher levels of internalized homophobia among non-heterosexual Indian women compared to non-heterosexual Indian men.

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