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Internalized homophobia and depression in homosexual and bisexual men and women: LGBT+ health survey, 2020

Thales Santos Batista (https://orcid.org/0009-0000-7974-259X) [1]
Filipe Marques de Pinho Tavares (https://orcid.org/0009-0008-0560-2875) [1]
Gabriela Persio Gonçalves (https://orcid.org/0000-0001-7586-7782) [2]
Juliana Lustosa Torres (https://orcid.org/0000-0002-3687-897X) [3]

Abstract *This study aimed to analyze the association between internalized homophobia and its domains and depression in homosexual and bisexual individuals and to quantify its results in depression. This is a cross-sectional online and anonymous study based on the LGBT+ health study conducted in Brazil from August to November, 2020, summing 926 respondents. Depression was self-reported. Internalized Homophobia was measured by the Brazilian Internalized Homophobia Scale for Gays and Lesbians, using 80% percentile to classify elevated total and by domain scores. Statistical analysis was based on Poisson Regression models with robust variance. Depression prevalence was 23.7%. The results revealed that internalized homophobia was positively associated with depression only among homosexuals (Prevalence Ratio (RP) = 1.80; 95% confidence interval (95%CI) 1.12-2.90). We found no statistical association for stigma and oppression domains. Population attributable fraction of depression was 2.3% (95%CI 0.1-4.5) in relation to internalized homophobia. Our findings highlight the need of controlling internalized homophobia to decrease the prevalence of depression among homosexuals.*

Key words *Mental health, Depression, Sexual and gender minorities, Sexism, Homophobia*

[1] Departamento de Fonoaudiologia, Universidade Federal de Minas Gerais (UFMG).
[2] Médica da Família e Comunidade, Prefeitura Municipal de Belo Horizonte. Belo Horizonte MG Brasil.
[3] Departamento de Medicina Preventiva e Social, Faculdade de Medicina, UFMG. Belo Horizonte MG Brasil. Av. Professor Alfredo Balena 190, Santa Efigênia. 30130-100 Belo Horizonte MG Brasil.
jlt.fisioufmg@hotmail.com

Introduction

Mental health is a public health problem that has gained prominence mainly since the onset of the COVID-19 pandemic in 2020, given that its main prevention measure, before the implementation of vaccination in 2021, was social distancing[1]. Despite this, in sexual and gender minorities, which include Lesbians, Gays, Bisexuals, *Travesti*, Trans, and related identities (LGBT+), mental health had already been the focus of study well before the onset of the pandemic, with emphasis placed on depression, with a prevalence of 35% in cis bisexual women, as compared to a prevalence of 16% in cis heterosexual women[2]. Among cis gay men, the lifetime prevalence reaches 20%, almost 2.4 times higher than that of cis heterosexual men[2].

In the population of sexual and gender minorities, one of the theories that attempts to explain this excess prevalence of depression is the Minority Stress Theory[3]. The concept of "minority stress", proposed by Meyer[3], can be applied to groups that are considered minorities, not because of their prevalence in the population, but because they do not hold the hegemonic power to control the narrative about themselves: the black population, women, economically vulnerable individuals, and the population of sexual and gender minorities. When the term "stress of sexual and gender minorities" is used, reference is made to this condition, which impacts the formation of subjectivity, the construction of self-perception and self-care, as well as the construction of social relationships by these individuals, considering the external and internal aspects of stress to which they are subjected[3].

According to the minority stress theory, constant situations of stigma and prejudice can lead to the deterioration of mental health, which, in addition to the diagnosis of depression, can be characterized by psychological stress[4,5], loneliness, social isolation, and/or low emotional support[6-8]. Data indicate that 65% of sexual and gender minorities have suffered discrimination due to their non-heterosexual emotional orientation by family members and neighbors[9], with the home being the main place of occurrence, according to the Notifiable Diseases Information System (SINAN) of 2015-2017[10]. Furthermore, such situations can affect the perception of these individuals in society, so that they can reject their own identity (proximal minority stress), causing negative and distressing feelings known as internalized homophobia[11].

Systematic reviews have consistently shown that at least one component of minority stress theory is related to biological[12] and mental[13] outcomes. Regarding internalized homophobia, one study conducted in Cyprus with 110 adults (aged 18 years or older) showed a positive association between internalized homophobia and depression in a univariate analysis[14]. Data from 543 couples of homosexual men in the United States also confirmed this positive correlation[15]. Similar results were found in 2,178 adults (aged 19 years or older) from South Korea[16] and in 581 adult women from Taiwan (aged 20 years or older), after the relevant adjustments[17].

Despite the international evidence cited above[12-17], not all studies demonstrated independence of the association between internalized homophobia and depression[14,15]. In Brazil, no studies were found on this topic, despite the country having a society marked by high rates of violence against sexual and gender minorities, reaching almost one report of violence perpetrated against these people per hour[10]. Therefore, the present study sought was to analyze the association between internalized homophobia, its domains, and the diagnosis of depression in homosexual and bisexual men and women living in Brazil, and quantify the result of its decrease in the prevalence of depression.

Methods

Design and sampling

This work is a cross-sectional study based on data from the LGBT+ health survey, carried out in Brazil from August to November 2020, through a self-completed online and anonymous link, with individual questions and standardized questionnaires about sociodemographic and health-related characteristics. Although not representative of the entire population, as it is a non-probabilistic sample, the survey was disseminated nationally on social networks, such as Facebook, Instagram, and WhatsApp, via a link, through snowball dissemination. More information about the study and research team can be found in another publication[18]. The inclusion criteria were: being 18 years old or over, living in one of the five Brazilian regions, self-declared as an individual from the sexual and gender minority population, having access to the Internet to fill out the questionnaire, and agreeing to participate in the research. For the present analysis,

individuals who reported an affective orientation other than homosexual or bisexual (n=39) were excluded due to the characteristic of the independent variable, totaling 937 participants.

The LGBT+ health survey was approved by the Ethics and Research Committee of the Federal University of Minas Gerais (CAAE 34123920.9.0000.5149) and followed all recommendations from the National Health Council.

Dependent variable

The dependent variable of this study was self-reported medical diagnosis of depression (yes, no), assessed through the question "Has a doctor or health professional ever told you that you have depression?".

Independent variable

The independent variable was internalized homophobia, measured using the validated scale of Internalized Homophobia for Brazilian Gays and Lesbians[19], consisting of 19 items with a score of up to 57 points. Each item ranges from 0-3 points (from "totally agree" to "totally disagree"), with higher scores representing higher levels of internalized homophobia. The scale is divided into two domains, with 15 items related to the internal perception of stigma (maximum score of 45 points), such as the items "homosexuality is morally acceptable" and "I feel comfortable talking about homosexuality/bisexuality in a public place" and 4 items related to the social perception of oppression (maximum score of 12 points), such as the items "most people have negative reactions to homosexuality/bisexuality" and "discrimination against gays and lesbians is still common". The 80% percentiles were used as a cutoff point to classify the total score and the scores per domain as high or not high.

Potential confounding variables

Potential confounding variables in this study were divided into blocks of variables, named according to minority stress theory, as follows: (1) Socioeconomic circumstances and type of minority: affective orientation (homosexual or bisexual); gender identity (cisgender woman, cisgender man, or other gender minorities); age group (18-29 years, 30-49 years, ≥50 years); education (high school or less, incomplete or complete undergraduate degree, incomplete or complete postgraduate degree); race/color (black/brown/other, white); (2) General and minority stressors: loneliness, classified according to the score obtained by the 3-item UCLA Loneliness Scale[20], which varies from 3 to 9, with the higher the score, the higher the level of loneliness (none (score 3/ 4), mild (score 5/7), severe (score 8/9)); Discrimination related to emotional orientation by close family members, assessed by the frequency of perception of discriminatory attitudes (never/sometimes, frequent); (3) Coping strategies and social support from professionals: alcohol consumption, assessed through the weekly frequency of consumption and doses on each occasion (does not consume, up to 2x/week in low doses, up to 2x/week in high doses (above 3 doses on one occasion), 3x/week or more; smoking, considering current cigarette consumption (yes, no); health professionals in the quality of care (yes, no).

Statistical analysis

For data analysis, first, a descriptive analysis of the sample was carried out, considering Pearson's chi-square test to evaluate differences between frequencies in each category of depression. Poisson regression with robust variance was used to estimate crude and adjusted Prevalence Ratios (PR) and their 95% confidence intervals (95%CI) to investigate the association between a high internalized homophobia score and its domains and depression in sexual and gender minorities. All study variables were maintained in the adjusted models, regardless of statistical significance, adopting adequacy to the proposed theoretical model as a criterion.

Based on the adjusted models, the decrease in the prevalence of depression was estimated in scenarios with internalized homophobia scores below 80% and each of its domains, through the population attributable fraction, which considers, in addition to the strength of association between the variables, the prevalence of the independent variable in the studied population. All analyses included the post-stratification procedure with weights by geographic region, according to the population estimate from the National Health Survey (NHS 2019)[21]. Additionally, the categories of homosexual and bisexual emotional orientation were analyzed separately, as they may differ in relation to homophobia. All statistical analyses were performed using Stata 17.0 SE software (Stata-Corp., College Station, Texas, USA).

Results

Of the 937 participants included in this work, 11 had no information about depression, making a final sample of 926 participants. Of these, 219 (23.7%; 95%CI 19.0-29.1) reported having a medical diagnosis of depression. Participants were mainly homosexual (75%) and cisgender men (57.2%). All sociodemographic characteristics of the respondents can be seen in Table 1. The sociodemographic characteristics that varied according to living with children were age group, race/color, and presence of a partner, which was more common in the age group of 30-49 years, among blacks, browns, or races other than white, and among those who have a partner.

Table 2 shows the results of the raw and adjusted models of the association between internalized homophobia and its domains and the diagnosis of depression in Brazilian sexual and gender minorities. Considering the final models, only a high total internalized homophobia score was positively associated with depression (PR=1.70; 95%CI 1.09-2.65).

Although not presented in Table 2, there was a significant difference between the prevalence of depression in homosexual and bisexual individuals (PR=0.54; 95%CI 0.33-0.90, data not shown), which was lower when comparing bisexual individuals to homosexuals. Considering this and the fact that internalized homophobia can impact homosexual individuals more frequently than bisexual individuals, the same sequential models were carried out separately for each category of affective orientation (homosexuals and bisexuals). As shown by the final models presented in Table 3, total internalized homophobia was positively associated with depression only among homosexual individuals (PR=1.80; 95%CI 1.12-2.90). None of the domains of internalized homophobia were independently associated with depression.

To quantify the change in the prevalence of depression due to a decrease in the total internalized homophobia score and its domains, the difference in the prevalence of depression, considering the observed scenario and scenarios with internalized homophobia scores below 80%, was plotted in Figure 1. In a scenario with internalized homophobia scores below 80%, the prevalence of depression in homosexuals has a potential reduction of 2.30% (95%CI 0.14-4.46), falling from 23.37% to 21.07%. Lower prevalences of depression were not observed in scenarios with scores for each of the internalized homophobia domains below 80%.

Discussion

This study found a high prevalence of the diagnosis of depression in the studied population, regardless of the level of internalized homophobia, and similar to the prevalence reported in the United States[2]. Furthermore, those individuals with high internalized homophobia were more likely to present depression, showing that internalized homophobia scores above 80% are associated with a higher prevalence of depression in homosexual individuals.

The main findings of this study corroborate previous studies, which showed a positive association between internalized homophobia and depression[14-17]. The biological explanation for this association is based on the fact that experiences of stigma and prejudice generate negative and distressing feelings (stress)[3], which are moderated by adaptive psychological and behavioral responses, regulated by the nervous system[22]. The regulation of the nervous system is compromised when there is depression, causing hormonal dysregulation[22], and generating a cycle between hormonal dysregulation, chronic stress, and the onset and development of depression[23]. This cycle generates a worsening of physical[12] and mental[13] health if there is no control of the stress mechanism or control of the damage caused by depression.

Based on this explanation, medical science, still heavily influenced by the biomedical paradigm, sometimes offers solutions for depression in a non-integrated way, using medications from different classes[24] and/or psychotherapy (psychoanalysis, cognitive behavioral therapy, among several other lines). However, based on advances in the understanding of human beings through the paradigm of biopsychosocial-spiritual complexity[25], in which the processes of illness are understood as the result of an interaction of factors (biological, spiritual, sociocultural, psychological, existential, and environmental), it is understood that the mechanisms to diminish depression must be multiple.

In this sense, considering sociocultural and environmental factors, this study demonstrates that collective health actions need to focus on combating internalized homophobia in general. These actions should not only be at an individual level, treating biological consequences of internalized homophobia, but also expand their scope to social organisms. After all, homophobia is internalized from homophobic experiences lived in family and society.

Table 1. Characteristics of participants according to the diagnosis of depression. LGBT+ Health Survey, Brazil, August-November, 2020.

	Total (%)	Depression		P-value
		No (%)	Yes (%)	
Homosexual emotional orientation	79.1	76.8	23.2	0.745
Gender identity				0.044*
Cisgender woman	31.2	66.8	33.2	
Cisgender man	58.6	81.4	18.6	
Transsexual, *travesti*, non-binary, or other gender minorities	10.2	75.9	24.1	
Age range				0.149
18-29 years of age	53.5	74.8	25.2	
30-49 years of age	37.7	75.5	24.5	
≥50 years	8.8	91.0	9.0	
Education				0.144
High school or less	12.9	74.4	25.6	
Incomplete or complete degree	47.4	71.4	28.6	
Incomplete or complete postgraduate degree	38.7	82.8	17.2	
White race/color	56.0	73.1	26.9	0.165
Loneliness				< 0.001*
None	23.0	89.4	10.6	
Mild	69.4	76.1	23.9	
Severe	7.6	38.9	61.1	
Frequent discrimination related to emotional orientation by close family members	27.4	63.7	36.3	0.003*
Alcohol consumption				0.319
Does not consume	16.5	68.6	31.4	
Up to 2x/week in low doses	30.7	74.7	25.3	
Up to 2x/week in high doses (more than 3 doses on one occasion)	39.9	82.1	17.9	
3x/week or more	12.9	76.7	23.3	
Smoking	19.1	60.4	39.6	0.002*
Feel comfortable opening up to healthcare professionals	59.6	77.5	22.5	0.549
Realize the interest of health professionals in the quality of care	70.4	78.1	21.9	0.261
High total score1 for internalized homophobia	16.2	66.4	33.6	0.091
Score in the domain of internal perception of high stigma[1]	23.2	71.7	28.3	0.343
Score in the domain of social perception of high oppression[1]	26.2	69.5	30.5	0.113
N total	926	707	219	

[1] High score: values above 80%.

Source: Authors.

It is important to remember that society encompasses health services. In this way, the use of the National Comprehensive Health Policy for Lesbians, Gays, Bisexuals, *Travestis*, and Trans, implemented in 2011, is reinforced, whose objectives include the elimination of discrimination and institutional prejudice[26]. In addition to the national level, more regionalized actions that respond to local specificities are also important, such as the State Policy for Comprehensive Health for Lesbians, Gays, Bisexuals, *Travestis*, and Transsexuals of Minas Gerais[27], which expanded the financing of health actions aimed at this population.

However, sexual and gender minority populations are not always similar in all their characteristics. Conducting a more in-depth exploration of internalized homophobia among homosexuals and bisexuals, it was found that internalized homophobia was only positively associated with depression in homosexual individuals. Unlike these findings, one prior study found no difference between homosexual and bisexual women[17], while another study was unable to find

Table 2. Crude and adjusted models of the association between internalized homophobia and its domains, and the diagnosis of depression in homosexual and bisexual men and women. LGBT+ Health Survey, Brazil, August-November, 2020.

	Crude models		Adjusted models [1]	
	PR	**95%CI**	**PR**	**95%CI**
Total internalized homophobia score				
Not high	1.00		1.00	
High	1.54	0.95-2.50	**1.70**	**1.09-2.65**
Internal stigma perception domain score				
Not high	1.00		1.00	
High	1.27	0.78-2.06	1.42	0.92-2.18
Social Perception of Oppression Domain Score				
Not high	1.00		1.00	
High	1.44	0.93-2.24	1.28	0.79-2.06

Note: Note: PR: Prevalence ratio; 95%CI: 95% Confidence Interval. Bold: p<0.05, based on the Poisson regression model with robust variance. 1 Adjusted for socioeconomic circumstances and type of minority; general and minority stressors; and coping strategies and social support from health professionals, N=902.

Source: Authors.

Table 3. Crude and adjusted models of the association between internalized homophobia and its domains, and the diagnosis of depression according to homosexual and bisexual affective orientation. LGBT+ Health Survey, Brazil, August-November, 2020.

	Homosexuals (N=686)				Bisexuals (N=216)			
	Crude models		Adjusted models[1]		Crude models		Adjusted models[1]	
	RP	**IC95%**	**RP**	**IC95%**	**RP**	**IC95%**	**RP**	**IC95%**
Total internalized homophobia score								
Not high	1.00		1.00		1.00		1.00	
High	**1.73**	**1.01-2.96**	**1.80**	**1.12-2.90**	0.75	0.23-2.50	0.89	0.41-1.92
Score in the domain of internal perception of stigma								
Not high	1.00		1.00		1.00		1.00	
High	1.48	0.87-2.53	1.53	0.97-2.43	0.54	0.16-1.85	1.00	0.45-2.26
Score in the domain of social perception of oppression								
Not high	1.00		1.00		1.00		1.00	
High	1.60	0.96-2.65	1.47	0.88-2.47	0.67	0.26-1.70	0.83	0.42-1.64

Note: RP: PR: Prevalence ratio; 95%CI: Confidence Interval. Bold: p<0.05, based on the Poisson regression model with robust variance. [1] Adjusted for socioeconomic circumstances and type of minority; general and minority stressors; and coping strategies and social support from health professionals.

Source: Authors.

different levels of internalized homophobia between homosexual and bisexual men[28]. Despite this, a study conducted in the Netherlands that evaluated the general mental health levels of heterosexual, bisexual, and homosexual individuals found that the general mental health levels of bisexual individuals were similar to heterosexual individuals, which, in turn, were better than the levels of homosexual individuals[29].

Some characteristics may explain the differences found between homosexuals and bisexuals in relation to depression, although they are not always found in the literature, and are sometimes divergent[30]. The main one is the type

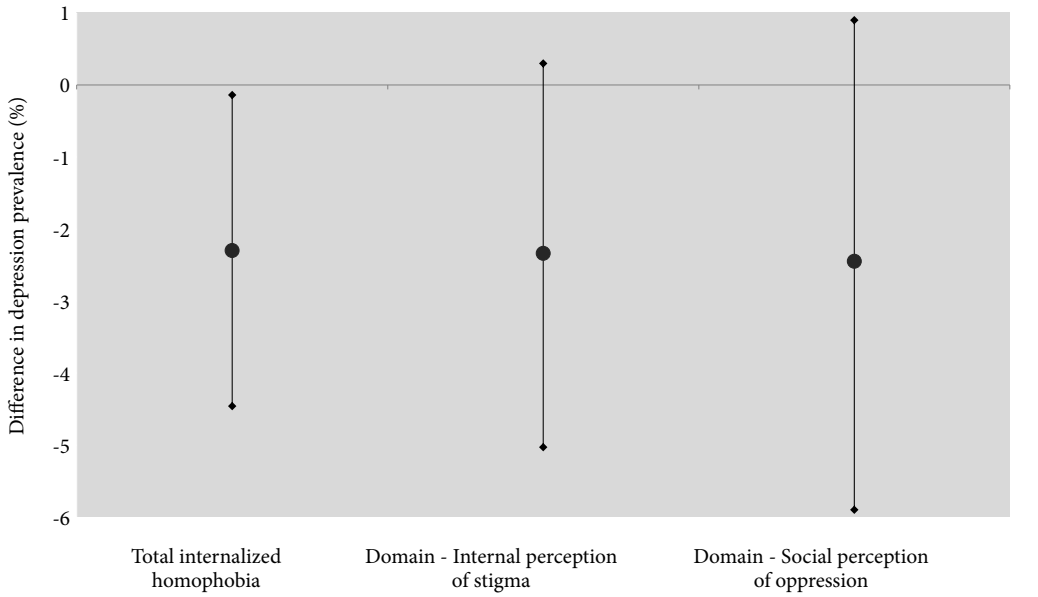

Figure 1. Decrease in the prevalence of depression considering the observed scenario and ideal scenarios with lower levels of internalized homophobia and each of its domains among homosexual men and women. LGBT+ Health Survey, Brazil, August-November, 2020, N=686.

Source: Authors.

of social relationship. Because they belong to a cisheteronormative society, bisexual individuals may have heterosexual romantic relationships more regularly and, casually, have homosexual relationships[31]. In this sense, the bisexual affective orientation is partially hidden, causing these individuals to suffer fewer episodes of discrimination than homosexual individuals, partially explaining the lack of association between internalized homophobia and depression in bisexual individuals in the present study.

Furthermore, the findings indicate that preventive actions related to internalized homophobia have the potential to reduce depression in homosexual women and men by 2.3%. One study carried out in European countries demonstrated that the lack of acceptance of sexuality at a societal level is one of the factors that diminishes the subjective well-being of individuals in same-sex relationships[32]. Furthermore, family stigma is directly associated with greater internalized homophobia[33] and both increase depression in homosexual individuals[28] and can culminate in suicidal ideation[34].

Based on these findings, some structural-level interventions have already been proposed to reduce the effects of minority stress. Highlights include the creation of organizations that generate "safe spaces" for homosexuals, the increased visibility of sexual minorities in the media and physical spaces, and teaching about "heterosexual privilege" in schools and universities[35]. Finally, considering that, in Brazil, the home is main place where violence occurs due to affective orientation[10], enforcing the primary health care attribute of family orientation is essential in the prevention of internalized homophobia and the creation of more effective mechanisms to deal with stigma and oppression.

Strengths and limitations

As strengths, the novelty of the research stands out in evaluating the implications of internalized homophobia in Brazilian sexual and gender minorities, considering a survey carried out with participants from the five Brazilian regions and the use of post-stratification in the statistical analysis.

However, as a limitation of this study, the use of a sample from an online survey stands out, which is limited to the participation of the

population with less social vulnerability due to internet access, despite being a recurrent method to reach populations of difficult access. Second, depression was assessed through self-reports; therefore, the possibility of information bias generating erroneous classification in the groups of absent or present depression cannot be ruled out, given that it can decrease the strength of association. Third, the possibility of reverse causality cannot be eliminated due to the study design, despite the explanatory model presupposing a hormonal dysregulation in the cycle, allowing one to infer the bidirectionality of the association found in this study. Finally, as the differences in the proportions of depression in each of the domains of internalized homophobia were small, the absence of associations by domain in the present study may have occurred due to insufficient test power for the sample size (<0,80). Therefore, it is recommended that future studies with larger samples of sexual and gender minorities explore the association between depression and the domains of internalized homophobia.

Conclusions

The findings of the present study reinforce the crucial role of internalized homophobia in the prevalence of depression among homosexual individuals. Therefore, public policies must contain mechanisms that promote societies with reduced levels of homophobia among homosexual individuals in order to promote improvements in the mental health of these individuals.

Collaborations

TS Batista and JL Torres contributed to the study design, analysis and interpretation of results, writing the manuscript and approving the final version. FMP Tavares and GP Gonçalves contributed to the study design, writing the manuscript and approving the final version.

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