It makes me sick

Heterosexism, homophobia and the health of Gay men and Bisexual men

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Briefing Paper

Preface

This Briefing Paper is part of an on-going series that forms one strand of the research and development programme supporting CHAPS, the national HIV prevention programme for Gay men, Bisexual men and other homosexually active men. It is intended to explore the issue of homophobia, heterosexism, health and HIV risk among Gay men and Bisexual men. The topic was chosen by CHAPS partners as an area of interest to their organisations and others engaged in HIV prevention and sexual health promotion.

The intended audience for this paper includes HIV prevention and sexual health promotion practitioners, policy makers, health service commissioners and researchers, especially those concerned with sex between men.

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1.1 BACKGROUND

The third edition of *Making it Count* [MiC III] (Hickson *et al.* 2003a) develops our collective approach to HIV prevention for homosexually active men by placing greater emphasis on the social contexts and structural factors contributing to HIV exposure and transmission. It argues that the health and well-being of Gay men and Bisexual men is compromised by pervasive social discrimination. It prioritises tackling homophobic and heterosexist practices at personal, institutional and structural levels and describes the roles of individuals, communities, services and policy makers in doing so. In this way, it forges a link between the HIV prevention needs of individuals, social inequality and their broader health.

This paper explores the relationship between heterosexism, homophobia, social inequality and the health of homosexually active men. This section critically examines our current understandings of terms such as homophobia and heterosexism, highlighting theoretical and practical difficulties. Section 2 examines research on inequalities and discrimination within a range of settings. Section 3 considers research evidence for linking discrimination to reduced health outcomes among homosexually active men. Finally, Section 4 discusses the ways in which limitations in our understanding in this area give rise to a narrow set of health promotion interventions.

1.2 RESEARCHING HEALTH, HETEROSEXISM AND HOMOPHOBIA

In order to understand the relationship between inequality and health, we must focus not only on socio-economic factors such as poverty, class, unemployment *etc*. (Townsend & Davidson 1982; Acheson 1998) but also on individual factors such as personal isolation and stigmatisation.

> **As social beings, we need not only good material conditions but, from early childhood onwards, we need to feel valued and appreciated.**
> **Wilkinson and Marmot 2003: 9**

Adverse health outcomes caused by socio-economic factors can be reduced or increased depending on the strength and nature of social support and social networks (White & Cant 2003). Such networks have the capacity to counter exclusion, discrimination and victimisation which contribute to increased morbidity and mortality in a range of populations (Wilkinson & Marmot 2003).

If we assume homosexuality is randomly distributed amongst the population, we must also assume that men with homosexual desires and practices suffer from the same levels of socio-economic inequality as all other people. That is, there are homosexually active men in all classes, all income groups and all ethnic groups in the UK. The question with regard to such men is, to what extent does a Gay or Bisexual identity exacerbate or ameliorate pre-existing inequalities that have an adverse effect on health? Does a Gay or Bisexual identity have the capacity to increase inequality and hence ill-health or can it have the opposite effect of reducing inequality and ill-health?

In order to address this question, it is necessary to examine the concepts of heterosexism and homophobia as they are currently understood.

1.3 HETEROSEXISM AND HOMOPHOBIA

Heterosexism has been defined as 'the widespread social assumption that heterosexuality may be taken for granted as normal, natural and right' (Wilton 1999: 156). That is, *heterosexism* describes the processes whereby heterosexual norms and behaviours are maintained as the dominant way of understanding the world. The maintenance of heterosexism is integral to the fabric of industrialised capitalist societies that utilise heterosexual family units as a primary means of ensuring economic and social stability (Wilton 1999). Government as well as church and civil institutions are generally oriented towards supporting heterosexism. The outcome of such structural heterosexism is the widespread practice of simply presuming that everyone is heterosexual (Douglas Scott *et al.* 2004: 31). Therefore, heterosexism is all-pervasive and operates on all levels, from the law (placing legal restrictions on the contexts of homosexual sex) to Government policy (restricting civil union to heterosexual couples) to the workplace (restricting pension provision to 'married' spouses only) to health and social care settings (hospitals with narrowly defined next-of-kin visiting rights) to the family (a grandmother asking her grandson if he has found a nice young woman yet).

Heterosexism is all around us, all the time. It is a successful means of reinforcing the boundaries between what is deemed by the majority to be acceptable, and what is not (Steinberg *et al.* 1997). Thus homosexuality is constructed as 'alien' to normal ways of being, and by extension, as a threat to social, economic and cultural stability. This, in turn, fosters the development of the anti-Gay feeling in groups and individuals, which can be considered as *homophobia*. Homophobia has been variously described as individual fear and dislike directed toward Lesbians and Gay men (Wilton 1999: 156), or as an anti-Gay sentiment that reinforces negative stereotypes (Bernstein 2004: 42). Others have also described the actions that are likely to follow from such attitudes.

> **Homophobia: An irrational fear and dislike of lesbian, gay and bisexual people, which can lead to hatred resulting in verbal and physical attacks and abuse.**
> **Douglas Scott *et al*. 2004: 31**

The term *homophobia* came into use in the early 1970s, most popularly in Weinberg's (1972) *Society and the healthy homosexual*. Herek (2004) points to the vital role that this term played in the emergent Gay and Lesbian liberation movement. He describes Weinberg's conceptualisation of homophobia as providing an important step forward for both scholars and activists, as it located the 'problem' of homosexuality not among Gay men and Lesbians themselves, but with the intolerance that was endemic within heterosexual (or 'mainstream') culture. Such an approach turned traditional thinking about homosexuality on its head, at the same time giving those pressing for civil rights and social change a means of describing the impact of the oppressive social environments in which they lived (Herek 2004: 7-8).

Heterosexism and homophobia can be considered different aspects of the same phenomena: discrimination against Lesbian, Gay, Bisexual and Transgendered (LGBT) people. Heterosexism can be thought of as the social or structural manifestation of discrimination against LGBT people. It is one way in which society keeps LGBT people powerless (laws, policies, social norms *etc*). Homophobia on the other hand can be thought of as the individual or psychological manifestation of discrimination against LGBT people. That is, it is the anti-Gay actions and thoughts of an individual. These might manifest in personal discrimination (an individual not hiring a Gay candidate for a job) or abuse (either verbal or physical). As homophobia has come to be understood as intrinsically psychological, some have gone further to designate it as a class of psychological disorder. That homophobia is often deemed to be an 'irrational' fear of homosexuality, similar to claustrophobia, attests to this construction.

1.4 THE 'PROBLEM' OF INTERNALISED HOMOPHOBIA

The 'psychologisation' of homophobia took a further turn with the development of the concept of 'internalised homophobia'. This asserts that LGBT people acculturated within a heterosexist society will adopt negative attitudes toward their own sexuality, with often harmful results. Psychopathologies associated with homosexuality (such as mental health morbidity and substance use) come to be re-defined as symptoms of 'internalised homophobia'. Thus, a neat diagnostic or aetiological category is created for all LGBT people's ills. However, there are several theoretical, political and practical problems with the concept of internalised homophobia (Bergeron & Senn 2003, Heubner *et al.* 2002).

For all of its use in popular and therapeutic parlance, there is little rigorous evidence as to internalised homophobia's precise foundations and effects (Williamson 2000: 98). For instance, when comparing different scales that have been used as scoring mechanisms for internalised homophobia, Williamson has found low levels of internal reliability, and in some studies no relationship has been found between variables included in the "scale" (Williamson 2000: 98). He questions the feasibility of developing psychometrically robust measures which would contribute to generalisable findings on internalised homophobia.

Others have criticised the concept of internalised homophobia as maintaining the locus of the problem of homosexuality within the individual rather than insisting that the problem lies with society (Kitzinger 1997). In other words, the individual LGBT person is defined as 'sick' rather than the society that surrounds them. Although the term homophobia originated from the desire to attribute anti-Gay hostility to a dysfunctional society, the term has since been subsumed within a popular construction that *locates the problem within the dysfunctional homosexual individual*.

> **Instead of going to heterosexual therapists to be cured of our homosexuality, now Lesbians and Gay men are supposed to seek out Lesbian and Gay therapists to be cured of internalised homophobia.**
>
> **Kitzinger 1997: 211**

The final problem with the predominance of the notion of internalised homophobia is the nature of the remedial interventions it recommends. That is, these tend to be psychological and deal with the individual rather than dealing with the broader social causes of heterosexism. Although psychological interventions are appropriate, they are dealing only with the effects or symptoms rather than the cause.

Much of the research we review below is informed by this highly reductionist, individualist and psychologised notion of discrimination against LGBT people. Authors have pointed out this limitation (Bernstein 2004) calling for more sociological analysis of the relationship between heterosexism, homophobia and health. Indeed, some researchers working recently in the UK have pointed out that health and psychological morbidity among the Lesbian, Gay and Bisexual (LGB) people they studied 'would seem to have less to do with confusion about sexuality than confusion about how to express it openly in society' (King *et al.* 2003b: 557).

1.5 LIMITATIONS OF RESEARCH INTO HEALTH, HETEROSEXISM AND HOMOPHOBIA

Before examining the research literature in this area, it's worth considering its limitations. There are two problematic areas. The first is sampling. The second concerns interpreting the precise nature of the relationship between heterosexism, homophobia and health morbidity.

Most research which compares experiences and outcomes across comparative samples relies on the ability and willingness of individuals within those samples to take part in research. As such, it is difficult to assess how many homosexually active men refrain from identifying as Gay, or from participating in research relating to sexuality due to their concerns about the homophobic repercussions that could arise from doing so. These self-selection biases mean that developing a clear picture of the true impact of discrimination is all but impossible. Existing behavioural and health needs assessments can provide a great deal of information about men who are willing to identify themselves as homosexually active (and to participate in research), but nothing about those who do not openly make such identification.

On a population level, research repeatedly identifies both elevated levels of ill-health among LGBT people *and* the existence of heterosexism and homophobia. Although many researchers assume a link between the two when interpreting their findings (Garofalo *et al.*1998, D'Augelli & Grossman 2001, Stall *et al.* 2001, Cochran *et al.* 2003, 2004) few have set out to determine the specific nature of the relationship between individual experiences of victimisation and health outcomes. For our present purposes, we have identified two possible ways of attempting to establish this link: causative and interpretive.

A causative link is the hardest to demonstrate. Here research must show that ill-health is *directly caused* by homophobia either in the case of an individual or in a population. For an individual this is not so hard. For example, through qualitative interview we may demonstrate that an acute homophobic incident (for example a queer bashing) or of ongoing discrimination (harassment at work) led, in an individual case to psychological and perhaps physical disorders. On a population level, this is much harder. We can establish correlation between homophobia experienced and ill-health and with larger sample sizes, even map demographic variation in the levels of both homophobia and ill-health in a population of Gay men and Bisexual men. However, such correlation does not prove causation. This is a limitation of the capacity of research rather than an indication that such a link does not exist. If we are to insist on a causative link, the assumptions of researchers are far from adequate and attempting to provide definitive evidence for the specific causes of ill-health and increased risk-taking at an individual level can be highly problematic (Morrison & L'Heureux 2001: 41).

This brings us to the notion of an interpretive link. This is an easier and more useful way of understanding the relationship between heterosexism, homophobia and health. In this case, we interpret the available evidence as an *indication* of a causative link between heterosexism, homophobia and ill-health. If we are to accept that there is insufficient evidence to convince us of a causative link, interpretive differences come into play and the relationship becomes more politically imbued. We might say that heterosexism and homophobia are one among a range of factors contributing to increased health morbidity among LGBT populations. On the other hand, we may make a more political assertion that homophobia and heterosexism are by far the most significant factors affecting the health of LGBT populations. Different researchers and health promoters tend to interpret the nature and significance of this link in different ways. For example, recent research has been conducted with the express purpose of highlighting this link in order to galvanize Government and community commitment to combatting homophobia and heterosexism (Douglas Scott *et al.* 2004, see also Ryan & Chervin 2000 for a Canadian perspective).

One of the more useful ways of interpreting the relationship between heterosexism, homophobia and LGBT health is that of *minority stress*. Originating from both social and psychological theory, this approach focuses on the ongoing and pervasive effects of negative social attitudes on stigmatised individuals and populations from a holistic perspective (Meyer 1995). A significant proportion of LGBT people maintain an ongoing vigilance about their self-presentation, due to concerns about the potential negative outcomes of disclosure. For example, 42% of Gay men (and 48% of Lesbians) in the UK agreed with the statement *I have avoided same-sex affection in public because of fear of the consequences"* (Sigma Research, Lesbian & Gay Foundation and National AIDS Trust 2000). Those who take the minority stress approach argue that careful management of disclosure and non-disclosure generates a pervasive series of stressors that can have a deleterious effect on mental as well as physical health over the life-course (Meyer 1995). This theoretical approach provides a useful means of critiquing overly-simplistic and intuitive approaches to evidence-gathering and research in this area.

2 Research on the scale and experience of heterosexism and homophobia

In this section, we examine research into the scale and experiences of heterosexism and homophobia in a range of settings. This research usually consists of an investigation of the experiences of heterosexism of a sample of LGBT people and / or a similar investigation of the attitudes of a representative sample of individuals in society or in a particular group (for example healthcare professionals or teachers). We deal first with research which concentrates on social settings generally. We then move on to examine two particular settings: heterosexism / homophobia associated with young people (bullying) and heterosexism / homophobia experienced in healthcare settings.

2.1 HETEROSEXISM / HOMOPHOBIA IN ALL SOCIAL SETTINGS

As a part of the 2002 *Gay Men's Sex Survey*, men were asked about discrimination experienced because of their sexuality in the past year across a range of social and service related contexts. The following table provides an overview of the findings (Hickson *et al.* 2003b: 48).

In the last 12 months, have you experienced discrimination because of your sexuality in relation to ...	% entire sample (n= 16379)
strangers in public	25.6
workmates and colleagues	13.4
friendships	8.7
other family relationships (apart from children)	7.3
using bars or restaurants	6.6
using public transport and taxis	5.2
shopping	4.8
dealing with tradespeople and business services	4.6

One third (34.3%) of participants in this survey reported being verbally abused because of their sexuality in the prior year, and one in fourteen (7.1%) had been physically attacked (Hickson *et al.* 2003b: 49). The likelihood of abuse and discrimination linked to their sexuality was highest for young Gay men and for working class Gay men (Hickson *et al.* 2003b: 52, 56). Men from ethnic minorities faced more discrimination from friends and family than the white majority (Hickson *et al.* 2003b: 54).

In one American study, experiences of heterosexist discrimination and homophobic abuse over the life-course were assessed among 416 people who used LGBT services and were over the age of sixty (as contrasted with the data from GMSS which asked respondents to report events from the past year). Two thirds of older respondents (63%) had ever experienced verbal abuse because of their sexuality, 29% had been threatened with violence, and 16% had been physically attacked. Also, 29% had been threatened with the disclosure of their sexuality (D'Augelli & Grossman 2001: 1016). As in most other studies of LGBT victimisation, men were found to be much more likely to be subjected to physical attack and threats than women.

When we turn to heterosexist / homophobic attitudes in general populations, we find very little research. A recent MORI poll commissioned by Stonewall attempted to assess the levels of prejudice among the English population. From a representative sample of 1,693 adults over fifteen years old, one in six said that they 'felt less positive' about Lesbians and Gay men (Stonewall 2003: 18). This poll did not ask questions about how respondents had acted (or would act) towards Lesbians and Gay men who they encountered, since it was strictly geared toward attitudes.

2.2 HETEROSEXISM / HOMOPHOBIA AND YOUNG PEOPLE (BULLYING)

A number of studies focus on the experiences of heterosexism / homophobia among young people. Studies repeatedly find that samples of young LGBT people face significant abuse and discrimination related to their sexuality.

In a sub-sample of 107 young people extracted from a larger study of homophobia in Berkshire, just under half reported experiencing verbal abuse because of their sexuality (Mullen 1999: 248). Such abuse was most likely to occur at school and on the street. One in ten young LGB people surveyed reported being physically attacked because of their sexuality, with the most likely location of such attacks being at school and in the home (Mullen 1999: 252-253).

A retrospective investigation of Lesbian, Gay and Bisexual peoples' school experience found that 82% had experienced name calling, 71% had been ridiculed, 60% had been hit or kicked, 58% had been teased, 59% had the subject of rumours, 49% had experienced theft, and 52% had been frightened by a look or stare (Rivers 2001: 35-36).

One piece of comparative research conducted in the UK showed that, among boys, bullying on the basis of sexuality happens just as frequently as it does for other reasons (King *et al.* 2003b:556). While such findings allow us to put the practice of homophobic bullying in a wider context, the same study shows that the effects of homophobic bullying on the individual are particularly pernicious (see section 3). Other studies suggest that homophobic bullying is so disastrous for the individual precisely because those individuals who express their alternative sexuality at a young age often do so without sufficient support mechanisms (D'Augelli & Grossman 2001, Morrison & L'Heureux 2001).

If schools can be an unsafe place for a young person who is or is perceived to be Lesbian, Gay or Bisexual, what of the responses of teachers? In a survey of 307 secondary school teachers in England and Wales, 82% were aware of homophobic verbal bullying among students in the school, and 26% knew of incidents of homophobic physical bullying (Warwick *et al.* 2001: 134). This same investigation found that only 6% of participating schools' anti-bullying policies mentioned Lesbian and Gay issues (Warwick *et al.* 2001: 135). The question of bullying therefore demands specific and urgent attention. However, more research is needed to establish why the response is so inadequate given the nature and extent of the problem.

2.3 HOMOPHOBIA AND ACCESS TO HEALTH CARE

We move on to examine heterosexism and homophobia in healthcare settings. Most of the studies under review focus on primary care settings. A survey conducted over ten years ago found that 44% of homosexually active men who were registered with a GP had not disclosed their sexuality to their doctor (Fitzpatrick *et al.* 1994). Recent GMSS figures found that more than half of GP-registered respondents were sure that staff at their GP surgery did not know that they had sex with men (Keogh *et al.* 2004a: 9). Of these, 39% said they would not be happy for the staff to know. When asked for reasons for non-disclosure, men reported feeling shy or embarrassed to discuss sexuality with a GP, that they had concerns about the confidentiality of such information, as well as fear of homophobic and discriminatory responses (both inside and outside of the GP surgery, see Keogh *et al.* 2004a: 10-11). Studies concur that non-disclosure of sexuality in a health care context

is employed as a means of self-protection – due to fear of embarrassment or more serious negative outcomes (Taylor & Robertson 1994). Although some studies found that many men who did disclose to GPs said that their anxieties were unfounded (Keogh *et al.* 2004a) other studies report significant negative or inappropriate responses from healthcare professionals. In a survey of mental health service users, one third of Gay men, and one quarter of Bisexual men who had disclosed their sexuality to a mental health care professional reported a negative or mixed reaction (King *et al.* 2003a: 5).

This should not surprise us as studies have repeatedly concluded that homophobic attitudes are present among a significant proportion of health professionals (see Malley & Tasker 1999, Bridget 2001 for comprehensive reviews). Most recently, it has been estimated that homophobic attitudes are prevalent among 20% of UK medical providers (GLADD 2004: 4). One outcome of such attitudes can be either a negative overall reaction to a disclosure, or more commonly a clinical overemphasis on patients' sexual health at the expense of their health needs more generally (Taylor & Robertson 1994). In addition, health care professionals may be likely to attribute a presenting problem to a patient's sexuality, rather than taking diagnostic steps to establish causation. One investigation found that between one third and one fifth of mental health care professionals whose LGB clients had disclosed their sexuality had immediately jumped to the conclusion that the individuals' mental health morbidity must stem from their sexuality (King *et al.* 2003a).

Lack of disclosure and negative or inappropriate reactions can have profound effects on the quality of health care. In the case of primary care, non-disclosure is likely to impede the development of rapport with a GP. This means that consultations are rarely more than cursory and the clinician is limited in his ability to treat the patient holistically (Keogh *et al.* 2004a: 40).

Thus, studies have concluded that in settings where professionals have little understanding of Gay men's specific health needs, or little desire to better comprehend their social and sexual lives, the standard of care will be low (Taylor & Robertson 1994). The benefits to improving Gay and Bisexual men's ability to talk about sexuality with their health care providers are clear. Improved openness and honesty, where men are assured of a non-prejudicial response in advance of disclosure, will increase professional capacity to understand and support the whole patient and make a correct diagnosis when one is required.

> **It is only through an awareness of the diversity of sexual identities that the compromised health care of marginal groups can be reversed in all spheres of health provision.**
> **Albarran & Salmon 2000: 450**

As such, the most obvious (and often suggested) means of addressing this issue is to improve the quality of diversity training for all health care workers (for examples see Taylor and Robertson 1994, Malley & Tasker 1999, Albarran and Salmon 2000, Morrison & L'Hereux 2001, King *et al.* 2003b, GLADD 2004, Keogh *et al.* 2004a). It is recommended that such training focuses on the dignity and human rights of Lesbian, Gay, Bisexual and Transgendered clients and should be supported by non-discrimination and confidentiality policies that explicitly include sexuality.

3 Research into the effects of heterosexism / homophobia on health

The pervasiveness of heterosexism and homophobia in society is not in doubt. If we accept an interpretive link between this heterosexism, homophobia and health, the problem of researching and describing this link remains. In section one, we described the concept of 'minority stress'. That is, the extent to which Gay men find themselves in a position of 'passing' as straight in order to avoid homophobia. Such behaviour is often a successful means of coping with a hostile and stigmatising environment (Goffman 1963). The qualitative literature on Gay men's experience is replete with narratives about how they managed the disclosure of their sexual identity over time, and within specific social settings (Davies 1992, Flowers & Buston 2001, Keogh *et al.* 2004b, Keogh *et al.* 2004c). While there is little question that this can place considerable strain on an individual, it is an understandable (and perhaps effective) trade-off against the high likelihood of becoming a victim of abuse and wider discrimination (Rivers & Carragher 2003). The emphasis on stressors caused to the individual tends to lead us into research which is psychologically based. That is, the hypothesis is that if the nature of the stress on the individual is personal and psychological, the first area of his health to be affected by heterosexism and homophobia is likely to be mental health. Thus, studies in this area generally deal with the areas of mental health morbidity and substance use.

3.1 MENTAL HEALTH, SUICIDE AND SUBSTANCE USE

A significant number of studies have established that homosexually active men have disproportionately poor mental health in comparison to other groups (Cochran *et al.* 2003, King *et al.* 2003a, D'Augelli & Grossman 2001); a situation compounded when ethnic minority status, poverty and other forms of inequality are also taken into account (Diaz *et al.* 2001: 929). Therefore, it is unsurprising that Gay and Bisexual men are more likely than their heterosexual counterparts to seek support for emotional and mental health issues in primary and secondary care settings (King *et al.* 2003b: 556).

Other studies have found that LGB people are dramatically more likely than heterosexuals to contemplate and attempt suicide and participate in other forms of self-harm (Ramafedi 1999, Morrison & L'Heureux 2001, Hutchison *et al.* 2003, King *et al.* 2003b). However, the exact nature of the relationship between sexuality and self-harm (including suicide) remains far from clear. Ramafedi (1999) points out that much existing work has been criticized for samples that are potentially biassed or not representative, often lacking any comparison groups that might help to contextualise the data. However, even with these limitations, American samples show high rates of suicide attempts among homosexual youths – ranging from 20%-42% (Ramafedi 1999). Co-factors such as gender nonconformity, early awareness of homosexuality, stress, violence and lack of support were significantly associated with attempted suicide in these studies which demonstrated that being Gay was not a universal or attributable factor on its own (Ramafedi 1999). Larger population-based studies conducted more recently in the US and Canada offer comparison data that demonstrate higher rates of attempted suicide among homosexual youth. In some instances these findings relate to males only, which could have a link to particular risk factors for boys such as gender nonconformity (Ramafedi 1999).

UK research has found links between homophobic victimisation and self harm. In Rivers' (2001: 39-40) sample of 119 LGB adults who had experienced bullying at school, 53% had contemplated self-harm as a direct result, 40% had attempted self-harm or suicide on at least one occasion, and 30% had done so more than once. It is unclear whether such thoughts and actions mainly happened at the time of bullying during adolescence, or subsequently. Rivers (2001: 44) implies that early effects from bullying seem to be 'overcome' later in life, as victims demonstrate an increased tendency toward depression over the life-course, yet are not disproportionately subject to difficulties with anxiety, relationship possessiveness or self-esteem when compared with other population data-sets.

A study of young Gay and Bisexual men found that the ages 14-17 can be a time of acute stress (Hutchison *et al.* 2003). It was during this time when respondents were most likely to first consider taking their own lives. More than half of the respondents had seriously considered doing so at some point (with 39% thinking about it in the past year, and 15% in the past month). When asked an open-ended question about why they had considered suicide, the majority of responses related to homophobic victimisation, such as bullying, isolation, and rejection from family (Hutchison *et al.* 2003). Although this sample is somewhat limited by its size and scene-based recruitment and by restricting sampling to young Gay men, it overcomes the problem of recall and post-hoc interpretations inherent in studies of older men. In addition, by including open-ended questions about the reasons for suicidal ideation, the link between the experience of homophobia and heterosexism and mental health morbidity is made.

However, victimisation is not only the domain of LGBT youth. An investigation utilising a large comparative sample found that heterosexual men were almost equally as likely as Gay men to confront bullying at school, and to report physical and property attack in the past five years (Gay men experienced slightly more verbal abuse in that period) (King *et al.* 2003b: 555). The Gay men taking part in this study were significantly more likely to contemplate and attempt self-harm than their heterosexual male counterparts, as well as to seek professional support for mental health and emotional issues (King *et al.* 2003b: 555-556). The same study found a relationship between reported harassment and mental health need, yet the relationship between these issues was unclear and could not be presumed to be causal (Warner *et al.* 2004: 484). The authors remark that broader issues such as Gay men's experiences of discrimination, substance use, or perhaps a greater tendency to psychologise lived experience could contribute to increased mental health need, however this was speculative, as they did not provide an analysis of these co-factors (King *et al.* 2003b: 557).

American research investigating the link between lifetime disclosure of sexuality, victimisation and mental health outcomes found that LGB victims of physical attacks (most likely to be men) rated significantly lower on self-esteem measures, and had a higher tendency toward loneliness and what the researchers termed 'suicide-related internalized homophobia' (D'Augelli & Grossman 2001: 1008). There was evidence of a strong relationship between victimisation and attempted suicide, while at the same time revealing that suicidal ideation on its own was not related to experiences of harassment (D'Augelli & Grossman 2001: 1021). Numerous studies have demonstrated the increased incidence of attempted (and by extension, successful) suicide among LGBT youth – particularly young men (Morrison & L'Heureux 2001: 40). Finally, in addition to suicide, other studies have found that Gay and Bisexual men suffer significant levels of depression and anxiety (Cochran *et al.* 2003: 58).

Research among Gay and Bisexual men has historically reported disproportionately high incidence of substance use (Morrison & L'Heureux 2001: 44), although the extent of prevalent behaviours and the exact substances involved are a matter of debate (Stall *et al.* 2001, Hughes & Eliason 2002). Such studies may be biassed in terms of their reliance of recruitment at Gay scene venues (where alcohol and other drugs are traditionally widely available). Samples recruited elsewhere show less significant trends of substance use. The connection between substance use and homophobia and heterosexism is somewhat contested though. For example, among their sample of older

LGBT respondents, D'Augelli & Grossman (2001: 1020) found no significant difference in alcohol consumption between those who had encountered physical, verbal or no homophobic abuse over the course of their lifetime. Further work in the United States actually found an inverse relationship between experiences of verbal homophobic harassment and alcohol use, as well as finding that use of alcohol among Gay men was not any different than among the male population more generally (Stall *et al*. 2001: 1597-1598).

4 Discussion

In this brief review, we have found clear evidence of homophobia and heterosexism, both in terms of the experiences of Gay men and Bisexual men and in the attitudes and actions of other members of society. We have also seen some research into the connections between this homophobia, heterosexism and poor mental health (and increased substance use). This review has not provided an overview of research demonstrating a link between heterosexism / homophobia and HIV prevention need since no such evidence exists. However, common sense suggests that good mental health, a sense of control over substance use, and accessible information about HIV are all crucial to reducing Gay and Bisexual men's HIV prevention needs. *Making it Count* (Hickson *et al.* 2003a) also asserts that a society in which men socialise and have sex with other men without fear of persecution or discrimination is a basic requirement for successful HIV prevention. This provides the interpretive link between HIV prevention need and homophobia / heterosexism at a structural level.

Yet, the over-arching limitation of both the theory generated and the research carried out in this area is the heavy reliance on individualist concepts. That is, we must question the way in which discourses around heterosexism, homophobia and health are operationalised. In theorising heterosexism and homophobia we tend to concentrate on them as factors inherent to, and affecting, individuals rather than social or structural processes. Thus, rather than seeing these as a malaise of society at large, we see them as a malaise of the individual psyche. A particularly pernicious result of this is a tendency to use indicators of Gay men's and Bisexual men's ill-health to draw the heterosexist conclusion that homosexuality is unhealthy per se (for example by citing elevated prevalence of HIV infection or mental health morbidity among Gay men and Bisexual men). The logical conclusion to this argument is that people should be discouraged from developing a Gay, Lesbian or Bisexual identity in the interests of their own health.

People who behave in a heterosexist and / or homophobic manner can only do so with the tacit or explicit endorsement of those around them. In other words, in addition to concentrating on the perpetrator and victim of heterosexism and homophobia, we need to concentrate on the social processes and structures which perpetuate a prevailing and pervasive atmosphere which allows heterosexist views and homophobic actions.

Research carried out in this area tends to concentrate on how heterosexism and homophobia affect the individual psyche directly rather than examining how heterosexism and homophobia might exacerbate other structural or social factors (such as class or ethnicity) in order to make Gay and Bisexual men in certain groups less well educated, poorer, less powerful and therefore less healthy.

While we do not question the connection between heterosexism, homophobia and mental health morbidity, we are concerned that the limited research in this area and the concentration on individualised notions of health will give rise to a range of psychologistic and individualised interventions at the expense of social and / or structural ones. In short, concentrating on the psychological effects of discrimination and homophobia without seeking to address the social and structural causes is akin to merely bandaging the wounds of a man who is repeatedly beaten without trying also to apprehend his torturers.

4.1 AN INTEGRATED APPROACH TO TACKLING HETEROSEXISM AND HOMOPHOBIA

To tackle homophobia and heterosexism effectively, health promoters need to broaden the scope of their interventions (Dodds *et al.* 2004). With a few exceptions, the majority of current interventions deal with the outcome of homophobia and heterosexism. That is, they are remedial, attempting to undo or resolve trauma or psychological morbidity in the individual. We recommend that interventions deal not only with outcomes, but go further to minimise homophobic / heterosexist attitudes and actions (enacted homophobia / heterosexism) as well as redressing the power inequalities that homophobia and heterosexism perpetuate (structural homophobia / heterosexism).

We have shown that homophobia and heterosexism do not exist in a vacuum. Instead they fulfil the purpose of weakening the social position of Gay men and Bisexual men. That is, through the actions and thoughts of the majority, the minority are kept in a state of fear and subservience. Interventions on a structural level must recognise this social function and seek to counteract it. That is, fighting homophobia and heterosexism involves the empowerment of Gay men and Bisexual men. To a certain extent the relative economic and social power of sub-sections of the Gay population will already be bringing this about. However, Gay men in groups that are traditionally socially excluded are likely to suffer disproportionately from the ill effects of heterosexism and homophobia. That is, all individuals should have the opportunity to improve their capacity to resist homophobia and heterosexism. Such interventions should prioritise those who have less social and economic capital to resist homophobia and heterosexism.

However, in order to facilitate this, the structural sources of homophobia and heterosexism must be tackled. That is, the laws, policies and practices which make it acceptable for individuals and groups to act in a homophobic or heterosexist manner must be resisted. Thus, structural interventions are needed. These include but are not restricted to: promoting and enforcing anti-discrimination and incitement to hatred legislation; monitoring and challenging press coverage on homosexuality; monitoring and challenging homophobia or heterosexism amongst public figures including politicians, faith leaders, journalists, cultural and social leaders; improving Sex and Relationships education in schools *etc*.

When we turn to the notion of enacted homophobia and heterosexism, we are dealing with the actions of all individuals a Gay or Bisexual man comes across in the course of his life. Therefore, general population anti-homophobia interventions are appropriate as are those targeted at particular faith and cultural communities. Professional training must also be prioritised. For example, basic training for medical students, nurses and other health professionals might be improved. In addition, ensuring that all public bodies with a social care or public safety responsibility (for example local authorities, police authorities, the army, religious communities *etc.*) put in place anti-homophobia policies and training for staff.

The recommendations listed here are by no means exhaustive. However, by attending to them, health promoters will come closer to extricating the issue of homophobia, heterosexism and health from the narrowly defined individualistic framework within which it is currently defined.

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