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The Importance of Measuring Internalized Homophobia/ Homonegativity

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Newcomb and Mustanski (2009) are to be congratulated for attempting a meta-analysis of internalized homophobia/homonegativity (IH) and for recognizing the potential importance of this construct for HIV-related research in men who have sex with men (MSM). However, we disagree with their key conclusion that “researchers would be well-served to consider abandoning the investigation of IH as a predictor of risky sexual behavior in order to focus resources on more promising lines of research.” There are seven concerns.

First, their approach to meta-analysis used correlation coefficients; however, correlation coefficients in meta-analyses *are not* and *cannot* be effect sizes. Such standardized effect sizes “cannot reliably meet the goals of meta-analysis” (Cummings, 2004, p. 597) and Greenland, Maclure, Schlesselman, Poole, and Morgenstern (1991) note that the arguments “against traditionally standardized coefficients apply with even greater force against the use of correlation coefficients as measures of effect” (p. 392). They are inappropriate to use because (1) they are bounded by the distributional properties of each individual study; (2) following from that, a one SD change in one sample is, by definition, not equivalent to one SD in another study; (3) even if a correlation is high, the effect size could be quite modest. In contrast, a lower or no correlation could indicate a curvilinear relationship or variation around a stronger fixed effect; and (4) analysis of correlations negates the ability to interpret the *magnitude* of any observed association, leaving only the *direction*.

Second, the nine different IH measures used are simply not comparable, absent a study in which the different measures are given to the same population and the degree of association measured. The outcome measures also vary across studies, and there are insufficient data to determine how the outcomes were actually measured and what their distributions were. The fact that some IH scales factor into several subscales (Ross & Rosser, 1996), some but not all of which may be related to risk behaviors, further complicates a comparison of IH measures (as Newcomb and Mustanski note).

Third, one study used compulsive sexual behavior (CSB) as the outcome measure. That is inappropriate since it superimposes a deterministic relationship between CSB and risky sex,

not the appropriate probabilistic one. Unfortunately, the strong correlation there probably contributed to the observed effect.

Fourth, the recommendation not to study IH further is based upon their observing no direct relationship between IH and HIV risk. However, Newcomb and Mustanski readily acknowledge and reference studies showing clear indirect relationships that, in turn, may be helpful to the design of innovative interventions. The existence of several moot correlations could indicate conflicting pathways that haven't been explored. Should we determine some causal association of IH with other proximal determinants of risk behavior, then we will have a good idea of how to appropriately intervene on those factors. Ignoring IH in further risk behavior studies would prevent development of culturally specific and relevant interventions for MSM.

Fifth, the rather narrow choice of outcomes assumes that IH has a direct effect only on sexual behavior. Some data already indicate that IH or at least one component of it is associated with drug and alcohol abuse in MSM, and we know that drug and alcohol abuse are related to risky sexual behavior. It would make clinical as well as research sense to include other risk outcomes, such as drug and alcohol abuse, and measures of mood and affect as effects of IH which may themselves translate into sexual risk behavior. Further, the impact of IH on drug and alcohol abuse and other negative mental health outcomes (Rosser, Bockting, Ross, Miner, & Coleman, 2008) are in themselves clinically important for MSM, whether or not they translate into risky sexual behavior, and we concur with Newcomb and Mustanski on this.

Sixth, we already have data that suggest that IH operates through intervening variables. We demonstrated (Ross, Rosser, Neumaier, & the Positive Connections Team, 2008) that IH is significantly associated with HIV/STI risk through at least two intervening pathways (but has no *direct* effect). Serodiscordant unprotected anal intercourse is a function of men being less disclosing of their HIV serostatus, itself significantly associated with IH; and lower condom use through lower condom self-efficacy is itself also significantly associated with IH. There are almost certainly other important indirect pathways through which IH operates on risk behaviors waiting to be elucidated.

Finally, the most troubling aspect of their recommendation to abandon IH and HIV risk research is that the studies reviewed were overwhelmingly North American. Studies not in English were excluded. Worldwide, homonegativity and IH remain huge threats to the well-being of MSM. As we write, there is a wave of homonegativity sweeping Africa. Uganda has introduced legislation which provides for the death penalty for male homosexual acts. In Senegal, it is reported that the bodies of gay men have been dug up and desecrated. Outside North America and selected West European and Australasian countries, homonegativity appears an overwhelming and ever-present physical and psychological threat to MSM. To recommend not studying IH and its still poorly understood associations with risk behavior, simply because studies in the U.S. failed to observe direct relationships between IH and sexual risk behavior, makes no sense. Our study on IH in Ugandan MSM (Ross et al., 2010) will, we hope, stimulate other researchers to explore the construct and its direct and indirect health impacts in non-Western contexts and in non-Western MSM subcultures.

In summary, while Newcomb and Mustanski have produced a most thought-provoking article summarizing some studies on direct effects of IH on HIV risk behaviors, we encourage researchers to explore IH further, particularly through indirect effects and in contexts where homonegativity appears a major barrier to HIV prevention for MSM. We do not believe, as they suggest, that the "current utility of this construct for understanding sexual risk taking of MSM is called into question" for use by HIV/STI, sexuality and mental

health researchers. Outside of the West, homophobia and internalized homophobia do still matter.

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