

**CHALLENGES AND MENTAL HEALTH CONSEQUENCES  
FACED BY BLACK HOMOSEXUALS IN DISCLOSING  
SEXUAL ORIENTATION**

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Submitted in partial fulfilment of the requirement for the degree of  
Master of Social Sciences (Clinical Psychology), in the School of  
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Pietermaritzburg.

## Student's Declaration

I hereby declare that the work in this thesis is my own except for quotations and summaries which have been duly acknowledged.

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## Supervisor's Declaration

I hereby declare that I have checked this project and in my opinion this project is satisfactory in terms of the scope and quality for awarding the degree of Master of Social Science in Clinical Psychology.

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## **PREFACE**

### **Researcher's reflections**

I first started this research project with my own prejudice about homosexuality in Black South Africans. The review of the literature and the current study findings challenged my subjectivity. I was not aware that liberal Christians and ancestors condone homosexuality. I was inspired during the literature review to read that God's gender was questioned. The Bible indicates that men are expected to love their wives and God at the same time. When a man is expected to love another man and his wife at the same time, ideas of polygamy and bisexuality come to mind.

The current study has not only challenged my biases but it has brought insight and enables me to be more reflective with my own being. I now better understand the pain and dissonance that religious and cultural homosexuals go through. As a psychologist in training I experienced countertransference during the analysis of data. Reading through the participant's challenges I was emotionally touched and frustrated by the pain that they reported they had gone through. It also gave hope to read that some homosexuals had positive experiences and had been accepted unconditionally.

## **ABSTRACT**

This is a study of the mental health status of black homosexuals from LGTBI social organisations who have disclosed their sexual orientation. One hundred participants participated, fifty homosexuals and fifty heterosexuals. The heterosexual participants were used as comparative group. The General Health Questionnaire-28 and a self-designed categorical choice questionnaire were administered to the homosexual sample out of the closet. The heterosexual sample only answered the General Health Questionnaire-28. The designed questionnaire was tested in the pilot study with homosexual participants.

The current study seeks to determine whether there is a relationship between disclosure of sexual orientation and mental health. The results suggested that the homosexual population were mentally healthier than heterosexuals of the current study. Nevertheless homosexual people did face significant challenges in disclosing their sexual orientation. Regarding challenges that homosexuals face, some gender differences between gays and lesbians were found. Lesbians were found to be experiencing fewer challenges than gay participants. Being part of LGTBI social networks was found to be associated with positive mental health for homosexuals. Therefore, the study's general finding was that there is an association between disclosure and positive mental health for homosexuals belonging to LGTBI social networks.

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## **GLOSSARY OF TERMS AND ACRONYMS**

The following definitions are included in order to create a common understanding of constructs. They are also provided because the literature in this chapter may well not always define all terms.

**Bisexual** refers to men or women who have sexual and emotional attractions to both men and women (Hughes & Eliason, 2002). It is important to note that bisexual individuals do not necessarily engage in a sexual relationship with both men and women at the same time.

**Gender identity** is a person's internal sense of being masculine or feminine, or something other than or in between masculine and feminine (Ottosson, 2007).

**Hate crime or bias crime** refers to a crime against a person, property or organisation, motivated in whole or in part, by feelings of prejudice (American Psychological Association, 1998). Common sources of prejudice arise from perceived or real differences in race, ethnicity, nationality, religion, gender, sexual orientation and disability (Meyer, 2003).

**Homonegativity** refers to "conduct that displays sexual biases. Its extreme form can be displayed through hate crimes" (Tristan, McCammon, Thomas & Allred, 1998, p. 88).

**Homophobia** is a fear of and hostility towards homosexual people. It is often expressed verbally and at times violently (Moore & Rosenthal, 1993).

**Homosexual** refers to lesbians, gays and bisexuals.

**Intersex** refers to individuals who are born with reproductive organs and or chromosomes that are not exclusively male or female (Nel, 2005). Intersex people were previously referred to as hermaphrodites.

**Lesbian woman or gay man** refers to “a woman or man whose primary sexual and emotional attractions are to persons of the same sex” (Hughes & Eliason, 2002, p. 266). In the current study the word ‘lesbian’ is used to refer to a female homosexual and ‘gay’ refers to a male homosexual person.

**LGTBI** refers to a collective group of lesbians, gay, transsexual, bisexual and intersex people (Epstein, 2003).

**Sexual attraction** refers to sexual desires and attraction to another person. This includes sexual fantasy, sexual activity or behaviour and affection needs (Cabaj, Gorman, Pellicio, Ghandia & Neisen, 2001).

**Sexual orientation** refers to the relationship between the sex of the desired person and the sex of the person who is attracted (Cabaj, 1988). When the object of sexual attraction has the opposite sex, a heterosexual orientation is said to exist. When the object of sexual desire has the same sex as the person who is attracted, a homosexual orientation exists. This includes all sexual relationships that people engage in, namely, same-sex attraction only, opposite-sex attraction only and sexual attraction to both same-sex and opposite-sex (American Psychological Association, 2005).

**STIs** refers to sexual transmitted infections (Reddy & Louw, 2002).

**Transsexual** refers to an individual with biological characteristics of one sex who identifies himself or herself as the opposite gender. Transsexuals usually desire to change their bodies to fit their gender identities and do this through hormone treatment and gender reassignment surgery (US Department of Health and Human Services, 2001).

## **CHAPTER 1: RESEARCH PROBLEM**

### **1.1. Introduction**

For homosexual people, disclosure or ‘coming out’ is a significant and a lifelong process. It begins with individuals’ awareness and acknowledgement of their homosexual or bisexual identity. It is a process that requires willpower and motivation from a person who wishes to disclose. According to Coleman (2000), there are three levels of disclosure: disclosing to the self, to others close to the self, and to the public. Most of the problems that arise for the disclosing person come when it is time to disclose to the public. Even though disclosing to the public may bring about a sense of relief, this is often inhibited by society’s negative attitudes toward homosexuality. To some people, disclosure brings about traumatic experiences and to some it can also be a liberating experience that brings about positive mental health. The current study focuses on the mental health status of homosexuals and challenges they come across after disclosing their sexual orientation.

According to Benestard (2001), there is a great need for more insights into homosexual people’s experience of disclosure. Homosexuals are often marginalised in society and may tend to be silenced. They may be seen as sick, inhuman, feminine (male homosexuals), different from the dominant society and often ridiculed by members of the dominant society (Connell, 2009). Silencing is a way in which domination over homosexuals exists in communities. Becoming voiceless disempowers the silent group and empowers a group with a voice. However, listening to the experience of those who are silenced will give the researcher new ways of understanding the problem.

This study will, to a limited extent, assess opinions, current mental health, beliefs, feelings and attitudes of homosexuality in black South Africa. By black South African, the researcher refers to blacks South African citizens staying in KwaZulu-Natal, regardless of their home language. The study will examine factors that facilitate and inhibit disclosure of a homosexual or bisexual identity especially in the black community. Furthermore, the challenges faced during the process of ‘coming out’, as well as the benefits and costs of disclosure, will be discussed.



## **1.2. Background**

According to Hoad (2005) as cited in Hoad, Martin and Reid, 2005 (eds), legal and social restrictions which was against homosexuality during 1980s led to the establishment of the National Coalition for Gay and Lesbian Equality (NCGLE). NCGLE was formed to ensure the retention of the clause in the new Constitution of the post-apartheid state. In 1966, a gay party in Johannesburg got media coverage. This resulted into police raiding the party and some arrest. According to Gevisser (1995) as cited by Hoad (2005) in Hoad, Martin and Reid, 2005 (eds), the legislation made homosexuality punishable up to three years of imprisonment. For black homosexuals, the law was much strict for them since they were marginalised during the apartheid era. In 1980s, multiracial homosexual organisation started to be visible, aiming to cross the divide and affiliate with a wider liberation struggle. The Organisation of Lesbian and Gay Activists (OLGA) and Gay and Lesbian Organisation of the Witwatersrand (GLOW) affiliated in late 1980s.

In 2002 different LGTBI social organisations form a big organisation by the name of Joint Working Group (JWG). The working group aim was to represents, speak and act on behalf of LGTBI social organisations. Its mission statement was to work with partners across the human right spectrum, build alliances with those who share the same vision, towards social justice and transformation. After 2005 the JWG objectives was to sustain LGBTI social networks and to advocate for same sex marriages (Luis, 2012).

The revival of the feminist movement in the 1960s placed a new focus on gender. According to Gilbert (1985), feminists tend to believe that gender is constructed through historical and social processes, rooted in traditions and practices, rather than being due to biological factors. Feminist researchers have questioned the effectiveness of forcing all people into one sexual orientation, namely, heterosexuality. This movement, along with homosexuality movement (starting from the Stonewall incident, which was the LGTBI movement of 1969 in United State of America, Smith (2006)) has seen the rise of the 'queer theory' that incorporates the voices of homosexuals and other forms of sexualities. Butler (1993) points out that feminist have differentiated 'sex' and 'gender'. 'Sex' comes from biology and 'gender' is socially constructed. But she personally rejects the biological explanation and believes that people are socially constructed.

According to Luirink (2000), homosexuality is a universal phenomenon in a sense that homosexual people exist in all cultures and people, and is believed to have existed in Africa for centuries. According to Murray and Roscoe (1998), a public homosexual subculture was identified in Cape Town, South Africa, during the 1950s. During the 1980s, black homosexuals became more visible. Irrespective of homosexuality being legalised (equally acknowledged and protected) in South Africa, it is still shunned by the majority of South Africans across race, gender and culture. We live in a world where heterosexuality is a preferred and leading sexual orientation and homosexuality is classified as a deviation from societal norms and beliefs. Such societal beliefs and misconceptions about homosexuality are rooted in and internalised by people. Consequently, it seems that even homosexuals have internalised these negative perceptions about their sexual identity and thus are afraid to live openly as homosexuals. These misconceptions also make up many peoples' core beliefs such that it becomes difficult to uproot them (Luirink, 2000).

Even though South Africa has adopted a constitution that guarantees protection for lesbians and gay men, most blacks' societal norms forbid open discussions about sexual orientation, which makes it difficult to ascertain whether heterosexual individuals accept lesbians and gay men. According to Human Rights Watch (2001), the general law against discrimination of homosexuals does not change the prejudice that still persists against lesbians and gays. Lewis, Derlega, Griffin and Krowinski (2003) assert that the lives of lesbians and gay men are often punctuated with both blatant and subtle reminders of negative attitudes that still exist. As a result, anxiety is common for lesbian women and gay men, so that often they do not disclose their sexual identities.

Before Christianity came to South Africa, homosexuality was present but many people never disclosed it because of cultural norms that did not allow it. In relation to religion, Germond and De Gruchy (1997) argue that with the introduction of missionary Christianity in South Africa came a whole new way of thinking about the morality of sexual activity. The subject was surrounded by secrecy and taboos and homosexuality was, according to Luirink (2000), given a bad name by condemning it. Those who argue that homosexuality is new to Africa do so not in

order to draw attention to a historical novelty, but rather to condemn it as immoral. What needs to be done instead is to accept the presence of homosexuality in Africa (Luirink, 2000).

Different theorists describe the process of disclosure differently. Before the late 1960s, 'coming out' was viewed as a single event, the first time a homosexual individual exposed him or herself as homosexual (Hooker, 1956). Even though this view of coming out described the salient features of disclosing one's sexual identity, disclosure is complex and incorporates the process by which an individual constructs a sense of self-identity as a lesbian or a gay man. It is not an easy thing to do in a culture which has intense negative reactions to such a person. Homosexual identity formation models based their emphasis on finding out whether identity formation is internalised by an individual, disclosed to others, or if both processes take place (Cohen & Savin-Williams, 1996).

In Cass's (1979) model of homosexual identity formation, gay and lesbian identity development is a linear progression which includes stages such as identity confusion, identity comparison, identity tolerance, identity acceptance, identity pride and identity synthesis. Coleman (1982) argued that stages are centered on self-awareness, self-labelling, self-disclosure and stabilisation of the gay and lesbian identity. According to Lewis (2003), homosexual identity begins with an awareness of being different, then progresses with an inner dissonance and conflict, and ends with the acceptance of a homosexual identity. In this model a person's homosexual identity is complete when an individual starts to engage in intimate relationships with people of the same sex.

Harry (1993), however, argues that disclosure is the final step of homosexual identity formation. He further states that the process of coming out starts with having intense thoughts about it, and progressing through searching for places of habitation and having friends with a homosexual orientation. According to D'Augelli (1994), disclosure is a process that is influenced by an individual's personal biases, social relations and interactions with other homosexuals and social historical connections. Some authors, such as Dube (2000), reject rigid stage models of homosexual identity formation because they are inaccurate and not applicable to some

homosexuals. The stages are constructed with a belief that the process of homosexual identity formation is universal and these theorists ignore the heterogeneity that exists between them.

In South Africa, homosexuals are becoming more visible in rural areas, townships and urban areas. Despite the South African constitution, homosexuals are still victimized, marginalized and victims of hate crime. Research studies indicate that experiencing homophobia and victimisation due to sexual orientation can result in poor mental health (Lane, Mogale, Struthers, McIntyre & Kegeles, 2008). The mental health status of homosexuals is further complicated by the 'coming out' process. Deciding to come out to family members and to the rest of the community might be perceived as stressful for someone who wishes to disclose because of the unknown consequences of disclosure. According to Gonsiorek (1982) cited in Greene (1994), coming out is anxiety provoking and at times it may resemble feelings of severe pathology even when the homosexual individual does not have an underlying psychiatric disorder. Therefore, the current study aims to find a link between disclosure and mental health among homosexuals.

### **1.3. Aim and rationale**

The study aims to acquire knowledge about the current mental health status of homosexuals and their disclosure challenges. This includes indicating and identifying the challenges that black homosexuals face after disclosing their sexual orientation. Determining whether there is a relationship between disclosure and mental health of black homosexuals is important in the current study.

According to Mashaba (2005), the study will also be relevant for practitioners involved in counselling to inform themselves about black South African homosexuals' experiences in terms of disclosure, as they are likely to come across such people at some point in their practice.

Although homosexuality is becoming a visible phenomenon in the black African community, little research has been done to understand the life and world of this community. There is very little research on the process of disclosure of black homosexual orientation. Research on black homosexuals is lacking because it is difficult to find homosexuals who are open about their sexual orientation and who will be willing to participate in research studies. Homosexuals may

choose to live a private (closeted) life in order to protect themselves from victimisation and social discrimination. Another reason for limited research on the topic is that not many writers have a level of interest in this field. Considering that blacks were disenfranchised and that homosexuality was not legalised in South Africa prior to 1994, this might have contributed to this reservation about conducting gay and lesbian research. Therefore, this study aims to bridge the gaps of the past.

The study will explore the processes which black homosexuals go through in order to disclose their homosexual identities. However, the researcher is aware of negative consequences of disclosure which can inhibit people from disclosing their sexual orientation; negative consequences may include rape, rejection etc. Therefore, the study might be distressing for some participants.

The focus of the study is on black people because not much is known of what it takes for a black person to discover sexual identity. The black community is a very private community in which people do not talk openly about their sexuality. In some black communities, homosexuality is viewed as a western cultural practice, even though facts reveal that it does exist in black communities. The process may both reduce stress and cause new stresses, depending on the reactions of others.

Among the broad aims of the current study, the study aims to acquire knowledge on mental health and disclosing challenges. The broad aims include the following:

- a) To voice the challenges faced by homosexuals during the process of disclosure. Homosexuals' personal opinions, personal experiences, feelings and beliefs about disclosure will be recorded and outlined.
- b) To report the current understanding, perceptions and attitudes about disclosure and mental health within the lesbians, gays, bisexuals community. The GHQ-28 which is a mental health screening instrument results will bring awareness about the mental state of homosexuals.
- c) To document the experiences and challenges faced by the LGB community.

d) The study aims to explore the mental health of black homosexuals and the link with the 'coming out' process.

#### **1.4. Research questions**

The study hypothesizes that there is an association between mental health and challenges faced by homosexuals who have disclosed their sexual orientation. In achieving this, the following are research questions which will be used during the investigation.

- a) What challenges do black homosexual people face?
- b) What are the mental effects of disclosure of homosexual identity?
- c) Which factors facilitate and inhibit disclosure of sexual orientation?
- d) How is homosexual identity formed?
- e) Do gays, bisexuals and lesbians experience similar disclosing challenges?

#### **1.5. Structure of dissertation**

The current study comprises six chapters. Chapter 2 focuses on the history of homosexuality, theories of homosexuality, and influences of disclosure and mental health of homosexual individuals. It is followed by Chapter 3 with the methodology used on this research study. In Chapter 4 the results of the current study are presented. The outline of the participant's feedback session is presented in Chapter 5. Chapter 6 includes discussions of the findings of the current study.

## **CHAPTER 2: LITERATURE REVIEW**

### **2.1. Introduction**

This study focuses on mental health and challenges of homosexual people after disclosing their sexual orientation. Homosexuality is a complex phenomenon which has been a subject of interest for decades. Research emphasis has been placed on the causes of homosexuality and various theories have been put forward about the causes of a homosexual orientation (Blasius & Phelan, 1997).

The study partly looks at how homosexual people are influenced by stereotypic social norms, culture and religion. This chapter reviews literature on black homosexuals disclosure challenges in South Africa. However, it is important to note that the literature used is rather broad. This includes international studies and the inclusion of LGTBI rather than focusing on homosexuals only. The history of homosexuality in South Africa will be explored. The role of gays, lesbians and bisexuals social organisations will be explored. The relationship between homosexuality and mental health will be investigated. Theories about homosexuality will be used to explain homosexual identity formation and possible causes of homosexuality.

### **2.2. History of homosexuality in South Africa**

According to Gevisser (1994) as cited in Gevisser and Carmeron (1994), homosexuals first appeared in South Africa during 1950s. Homosexuals were more visible in big cities like Johannesburg, Cape Town and Durban. Most homosexuals at the time were white, male and middle-class. During 1920s to 1930s many black people moved from rural areas to urban areas for mining. Black miners used to stay for months and years at the mines without visiting their wives at home. Therefore some of miners practiced homosexuality because of a lack of appealing heterosexual alternative. The World War II also made it possible for a self-identified gay subculture. Gay people were meeting in bars. Lesbian identities were noted much later than gay identities. In South Africa, lesbian identities existed after the war in major cities. Lesbian meetings were through the word of mouth and through cliques. For identification purposes lesbians used to wear slacks and kept their hair short (Gevisser, 1994 as cited in Gevisser and Carmeron, 1994).

During the 1970s and earlier, sodomy was a serious crime in South Africa. It included oral and anal sex between men, and excluded sex between women. In the 1950s men were not allowed to practice any form of sexual behaviour involving other males especially when more than two people were present. It was only in the 1970s and 1980s that the LGTBI community was included in the human rights movement (Dunton, 1989).

The South African constitution was the first in the world to outlaw discrimination based on the sexual orientation of a person. On December 1<sup>st</sup> 2006, South Africa became the fifth country in the world and the first in Africa to legalise marriages for homosexual partners. It also became the only country to provide homosexuals with exactly the same rights as heterosexual individuals. These rights include adoption and being part of the military service (Hoad (2005), cited in Hoad, Martin & Reid, 2005).

### **2.3. Challenges facing homosexuals**

According to Wells and Polders (2006), homosexuals are part of a marginalised group and they are more likely to be victimised. Before 1994 homosexuality was illegal in South Africa and this made it impossible for them to report those who were victimising them. If they had reported they would have also considered as criminals because of their sexual orientation. After 1996, a new South African constitution prohibited victimisation and discrimination based on an individual's sexual orientation. But this does not mean that homosexuals are no longer victimised and discriminated against. Homosexual discrimination is divided into heterosexism and homophobia. Heterosexism involves viewing homosexuality as unacceptable; some even go to an extent of viewing it as immoral and abnormal. Homophobia involves violent acts directed to homosexuals due to their sexual orientation. This may include harassment (verbal or physical threats) and violence (gay-bashing, rapes, destruction of private property and murder).

The laws protecting homosexual people only theoretically ensure equality, but practical and observable social acceptance has not been noted, especially in rural areas. According to Cock (2003), lesbians from townships and other non-urban areas are often victims of beating and rape. The South African constitution does not have specific 'hate crime' legislation. The South African police services have been blamed by human rights organisations for failing to report hate crimes



and for being biased in their reporting of these crimes. To give an example, the Non-Governmental Organisation (NGO) by the name of Action Aid has accused the South African government of turning a blind eye to reported murders and sexual abuses of lesbians in homophobic attacks. Wells and Polders (2006) study indicated that some homosexuals are either unaware of their rights or afraid to put them into practice. The study further indicated that some homosexuals regard their incidents of victimisation as less serious. Most perpetrators of these hate crimes give an excuse such as that the idea behind rapes and killing acts is to ‘cure’ a lesbian from her homosexual sexual orientation (Cock, 2003).

South African homosexuals are vulnerable to hate crimes, which can be in a form of hate speech and violence (Herek, Gillis, Cogan & Glunt, 1997 as cited in Wells & Polders, 2006). For example, the Minister of Arts and Culture, Lulu Xingwana walked out of an exhibition featuring the work of Zanele Muholi, a lesbian artist. According to Cooper (2010), the Minister’s conduct was an illustration of a hate crime in a sense that it encourages others to hold negative attitudes towards homosexual people. According to former President Mbeki (as cited in Rok, 2001), South Africa’s good social relations with other African countries that criminalised homosexuality may have a negative impact.

In a positive light, South Africa might be a good influence and a role model to African countries that do not support homosexuality. The South African Broadcasting Commission (SABC) has taken a leading role by having programs that talk about living a homosexual life. With SABC homosexual life has been depicted on local television programs such as *After 9*, *Egoli*, *Generations*, *Rhythm City*, *Isidingo* and others.

#### **2.4. “But it is against our African culture!”**

“When you hear about attacks on minorities, whether sexual or whatever, it is not a good sign, because who is to define who is African? Such behaviour usually leads to the closing down of the cosmopolitan nature of what is African” (Salo, 2003, p. 26 cited by Horn (2005) in Salo and Gqola, 2006). The desire to resist moral corruption from Western countries can be found among African leaders. But in fact the anti-homosexual attitude came from the West to Africa through colonisation. The moral condemnation and persecution of homosexual behaviour is often

supported by laws criminalising ‘unnatural’ sex and the Bible. These laws and the Bible were introduced to South Africa through European colonisation and United States-driven Pentecostal evangelism (Salo & Gqola, 2006). This indicates that homophobia is not an original African tradition but it is a patriarchal tradition that has been imported into local cultural discourses.

There is a belief that homosexuality is ‘unAfrican’. In mid-1995 the President of Zimbabwe, Robert Mugabe declared that “gays are perverts and their behaviour is worse than that of pigs” (Luirink, 2000, p. 51). Mugabe said, “they are lower than dogs and pigs, for these animals don’t know homosexual behaviour” (Luirink, 2000, p. 51). He further encouraged the population “to take the law into its own hands, to arrest homosexuals, to report, and deport them”. Homosexuality is claimed to be “unAfrican and in conflict with black culture” (Luirink, 2000, p. 51). “Lesbianism is not part of Zimbabwean culture”, Mugabe claimed (The Star, April 24, 1998 as cited in Cock, 2003). Poiani (2010) argues that the above president’s statement is not true even of animals because homosexual behaviour is in fact common among social animals (mammals and birds), and is mainly expressed within the context of a bisexual orientation.

A letter which praised Mugabe was sent to Johannesburg newspaper, The Star, (cited in Cock, 2003) and it states that “he espouses and cherishes our traditions and customs”. “Homosexuality is an aberration to all thinking Africans and indeed to most of civilized mankind. Homosexuals are regarded as awful species, which must be punished and locked up”. The letter ends “Viva Robert Mugabe. . . who defends our continent from satanists, sodomists, and faggots” (The Star, August 21, 1995, cited in Cock, 2003). According to the researcher’s view, “Mugabe is right in one sense when he accuses Westerners of thrusting a phenomenon onto Africa. It is not homosexuality as such that has been imported, but rather a set of far more open and visible expressions of its supposed liberation that has developed over some time in the West” (Luirink, 2000, p. vi cited in Cock, 2003).

Most African societies believe in the myth that homosexuality is absent from Africa. Murray and Roscoe (1998) exposed this myth by demonstrating that homosexuality is both indigenous and traditional to some 50 African societies. Homosexual behaviour is widespread and diverse but identities that include people being called either gay or lesbian are not. This is because there are

people who engage sexually with same sex partners but never acknowledge their identity as gay or lesbian. According to Murray and Roscoe (1988), homosexual behaviour is probably universal but homosexual relationships, roles, and identities are not. They further argue that this poses difficult questions since modern gay rights movements insist on the assertion of a public homosexual identity.

According to Nkabinde (2008), homosexuality is as old as humanity in South Africa. She stated that even the great Zulu King, Shaka, recommended '*ukuhlobonga*' (thigh sex) to his soldiers when they were away from home for wars. During the apartheid time mine workers were not allowed to stay with their wives in the hostels. Miners had sexual relationships with boys and they were known as 'the wives of the mines' (Moodie, Ndatshe & Sibuyi, 1988). The young boys in the mines were not sexual partners only but they played the wife's role as they were also responsible for domestic and household activities (Moodie, Ndatshe & Sibuyi, 1988). But all of this was kept as a secret because Western ideas are saying it is un-African (Nkabinde, 2008).

## **2.5. The black community and homosexuality**

According to Murray and Roscoe (1998), understanding the prevalence of homophobia in the black community includes the discussion of how black sexuality has been viewed in South African society. When the subject of homosexuality is raised, social norms, stereotypes, tradition and religion are also raised as defence against the idea of homosexuality. Sexuality is perceived in a certain way among the black community. For example, males are associated with aggression and violence, and females are associated with nurturance and obedience to males. When black people deviate from these stereotyped perceptions, they are more likely to be scrutinised in terms of cultural and religious beliefs (Murray & Roscoe, 1998).

### **2.5.1. The black family**

In African countries there is a saying which says 'it takes a community to raise an African child'. This simply means that an individual does not exist alone; people value and help one another. This statement is further supported by Mkhize when he used the concept of '*umuntu ngumuntu ngabantu*' (as cited in Hook, Mkhize, Kiguwa, Collins, Burman & Parker, 2004). Families are valued as holding important roles in black communities. According to Boyd-Franklin (1989),

black families hold strong ties with members of the original family. This is even more so when compared with homosexuals and heterosexuals of other ethnic backgrounds. As stated in Chapter 1, little research has been done on black homosexuals who have openly disclosed their sexual orientation to their families (Mays, Chatters, Cochran & Mackness, 1998). In black communities there is a belief that homosexuality tears the family apart. This is because homosexual behaviours limit procreation which is valued among black communities. Petersen (1998) challenged the above statement through stating that the individual body's role is survival and reproduction.

According to Greene and Boyd-Franklin (1996), changing gender roles are apparent in black families but sexism also exists. Homosexuality is viewed as not suiting the gender roles that are socially expected to be performed by men and women in the family (Loiacano, 1989). Families are regarded as the main sources of emotional and social support for homosexuals, as indeed they are for all people. Due to the fact that there are strong ties within the members of the family, rejection from family members could be very damaging to a homosexual person. The main question is where and to whom do black homosexuals turn to for support if they have been deserted by their families of origin due to their sexual orientation.

### **2.5.2. Rethinking intimacy and homosociality in contemporary South Africa**

'Homosociality' means social bonds between persons of the same sex (Sedgwick, 1985 as cited in Gunkel, 2009) and it is different from homosexuality. In South Africa it has been evident mostly in boarding schools where an older girl will look after a younger girl and help her to adjust in a new school. On the other hand, the younger girl is expected to help the older girl with cleaning, washing and sometimes going to the shops for her. These kinds of relationships are called 'sweeties', 'mummy-baby', 'amachicken', and 'umama or ingane yokudlala'. The 'amachicken' term means they are allowed to hold hands and kiss, but more sexualised contact is not allowed. The 'amachicken' term is different from lesbianism in a sense that lesbianism is a sexual identity, while 'amachicken' is a culturally specific form of female same-sex intimacy. Some 'amachicken' relationships change from non-intimate to intimate relationships. For example, one of (Sedgwick, 1985 as cited in Gunkel, 2009) case studies report that the 'mummy-baby' relationship was very fulfilling, also sexually. The participant of the case study reported

that her '*mummy-baby*' relationship involved kissing, holding of hand and sex talks. This shows how some of the lesbian relationships begin.

## **2.6. Theories of homosexuality**

There is no single theory that best explains the existence of homosexuality. Rather than having one idea about the causes of homosexuality, different theorists suggest that there are multiple causes of homosexuality. This section gives an outline of how different theories explain homosexuality. According to the current literature, there are two main groups of theorists, namely, determinist and constructionist theorists. These main groups also have sub-types of paradigms underneath them.

The deterministic approach suggests that homosexuality is caused by both biological and psychological factors. According to Alexander and Sufka (1993), there is some evidence that pre-natal hormone levels influence homosexuality. According to Berenbaum and Snyder (1995), high levels of androgens are associated with masculine-typical behaviour in females and low levels of androgens are associated with feminine-typical behaviours in males. LeVay's (1991) study also had interesting findings which supported the idea that homosexuality is biological. The study found that both homosexual men and women had smaller nuclei of the hypothalamus which is a part of the brain which is involved in neuro-endocrine regulation.

Some evolutionists believe that homosexuality is passed from one generation to another. This means that homosexuality can be inherited. There is some evidence of the existence of a 'gay gene', which has been confirmed by studies showing that a high portion of gay brothers share particular genetic markers. According to Petersen (1998); Hamer & Copeland (1994), hypothesized that the gay homosexual's (male) gene is really a 'sissy' gene that provides the biological blueprint of effeminate behaviour. The hypothesis was tested by interviewing gay and heterosexual men to determine childhood experiences of masculine identity.

Psychological theorists such as Sigmund Freud suggest that homosexuality is caused by fixation at the phallic stage in psychosexual stages of development. According to Chodorow and Nancy (1991), the phallic stage is a developmental stage whereby male children and female children are

expected to identify themselves with the parent of the same sex. Being unable to identify with a parent of the same sex predisposes an individual to homosexuality. For males having absent fathers and too nurturing mothers predisposes them to be gay, and for females having cold mothers and too involved fathers predisposes them to be lesbians. According to psychoanalytical feminists, gender inequality comes from early childhood experiences, which lead men to believe they are masculine and women to believe they are feminine.

The constructionist approach to homosexuality involves the idea that homosexuality can be either be an individual choice or can be socially constructed and be learned by an individual from others. The individual theorists believe that homosexuality is an individual's choice and personal expression. On the other hand, the social theorists believe that homosexuality is an identity assigned by social processes along with stereotypes, rewards and punishments. Social theorists also put forward the importance of considering social roles that are assigned to individuals of the society. Social theorists argue that the important factors that determine the individual's sexuality are childhood playmates, interactions and relations with peers, parental behaviour toward male and female children, and the role of gender in the household (Thompson & Devine (2003) as cited in Johnson, 2003). The argument of social theorists is dated back to a well-known ancient Greek playwright, Aristophanes. When he depicted homosexuality in his plays, he depicted two souls that long to be together. Aristophanes further suggested that people's sexual desires are not strong enough to create homosexuality but they need a cultural environment that allows (or forbids) homosexual relationships to occur (Thorp (2003) as cited in Johnson, 2003).

### **2.6.1. Queer theory as non-normative**

According to Spargo (1999), queer theory is a systematic framework rather than a single approach. It is a collection of theorists with research interests in sex, gender and sexual desire. It further includes homosexual studies focusing on homosexual identities, social and political power relations of sexuality and critiques of the sex-gender system. During the 1980s it was against the institutionalisation of homosexuals. Queer theorists were fighting against the medical and psychiatric discourse of the 19<sup>th</sup> and 20<sup>th</sup> centuries which considered homosexuality as abnormal. According to Stein and Plummer (1994), queer theory understands sexuality in

different levels of social life, such as family life, economy and intimate relationships. Queer theory informs the sociology of homosexuality.

Queer theorists even questioned gays and lesbians organisations of that time who believed that they were liberating homosexuals, but they saw the 'liberation' as a form of social control and use of power. Queer theory is broken into two strains, namely, 'radical deconstructionism' and 'radical subversion'. Radical deconstructionism refers to the investigation of different types of sexual orientation such as transgender and intersex. Radical subversion is against the social belief of normalizing the heterosexual orientation and demoralizing the homosexual orientation (Green, 2007).

Prominent writers such as Butler (1997) as cited in McCormick (2012), criticised queer theory of operating as a performative act that shames subjects that it names and producing shame for naming the subject as such. According to Butler (1997) as cited in McCormick (2012), the term 'queer' has formed social bond over time by homophobic communities. The term 'queer' will always be an insult for homosexual people in South Africa, due to that it indicates self-loathing. It was originally used as an insult and it is up to homophobic discourses that formed it to change it. McCormick (2012) further argues that the term 'queer' should be broadened and expanded with an aim of making people to find out why it has become to organise and theorised around. The term claims to be inclusive but it is used differently by different groups in different contexts. This is one of the reasons why Butler (1997) as cited in McCormick (2012), suggested that it needs to be "revised, dispelled, rendered obsolete to the extent that it yields to the demands which resist the term precisely because of the exclusions by which it is mobilized" (Butler, 1997, cited from McCormick, 2012, p. 100). Halperin (1995) cited from McCormick (2012) argues that for queer theory to survive, it will need to preserve queer identity as an empty placeholder for an identity.

Queer theory has been further criticised for focusing more on LGBTI identities which have been misappropriation, misuse, and misunderstanding. This is because some people engage in same sex relationships but never identified themselves as either gay or lesbian. For example, Judith Butler uses phrases such "remain . . . never fully owned" (Butler, 1993, p. 228 cited in Giffney,

2004). Queer theory has also been criticised for not being a single framework; instead, this makes it difficult for any of its theoretical discourses to take full ownership (Giffney, 2004).

On a positive light, the critics of queer theory are shaping the development of the theory. It has become a method of investigating the pervasiveness of normative ideas about gender and sexuality. Theorists are of an understanding that queer is always changing, morphing, being revised and resisting being co-opted (McCormick, 2012).

### **2.7. The ‘coming out’ process**

Plummer (1975) defines disclosure as the process that follows after one has individually identified and accepted oneself as homosexual. This is followed by starting the process of revealing one’s sexuality to others. Plummer (1975) starts by distinguishing between individuation and disclosure. He describes ‘individuation’ as an internal psychological process whereby one recognises and accepts his or her homosexuality and ‘disclosure’ as the process whereby others learn about one’s homosexual identity.

The process of ‘coming out’ starts with one discovering and accepting one’s own homosexuality. The term ‘discovering’ is used because from an early age, children are socialised to be heterosexual and homosexuality is discouraged. All homosexual people start out showing ‘normal’ stereotypes. Before children reach puberty they are assigned sex-role activities. It is only when they realise that they do not fit into the prescribed norm of heterosexuality that they discover that they are homosexual. This discovery or realisation comes with cognitive changes. The individual becomes more aware of the existence of, and identifies with, the homosexual category. Before homosexual individuals identify themselves as homosexuals, they first need to have an understanding of what it is meant by being homosexual (Plummer, 1975).

When a homosexual individual is not open about his or her own homosexual orientation it is often because of homophobia and heterosexism (Simons, 1991). The decision to ‘come out’ as gay and lesbian is more than an individual decision; it is also a way of claiming an individual identity (Patterson, Ciabattari & Schwartz, 1999). It is common for most homosexual people to maintain multiple identities. Multiple identities of a homosexual individual were depicted in the



SABC 1 drama by the name of '*After 9*'. The drama was named as '*After 9*' because it was referring to a homosexual character who was in a heterosexual marriage during the daylight but who engages in intimate sexual intercourse with a same sex person at night.

Most homosexuals do not receive the same social support as that experienced by heterosexuals during times of crisis (Johnson & Colocci, 1999). Homosexual people can find themselves faced with contrasting thoughts: Do they endure the stresses of invisibility or risk the consequences of disclosure (Slater, 1995)? Another challenge is in negotiating the private and public identity as couples frequently function in two separate and conflicting worlds (Slater, 1995).

According to Patterson, Ciabattari and Schwartz (1999), fear is among the reasons that homosexuals do not disclose their sexual orientation. Some people may decide not to disclose their sexual orientation as a way of protecting themselves from unnecessary pain. According to Dworkin (2000), the disclosure of homosexual orientation is further complicated by cultural, religious and gender beliefs. Disclosure comes with the risks of being rejected and marginalised. On the other hand, not disclosing sexual orientation may lead to feelings of loneliness and of being isolated (Ossana, 2000).

## **2.8. Homosexual identity formation**

A psychological theory which describes individual mental, emotional, and behavioural aspects of homosexuality has been used for building models of homosexual identity formation. The embracing and disclosing of such an identity is understood as a political phenomenon occurring in a historical period during which identity politics has become a consuming occupation (Cox, Morg, Stephan & Cynthia, 1996). A number of stage models have been put forward by many theorists of homosexual identity formation. All models of homosexual identity agree that disclosing to the public suggests that the homosexual individual has accepted himself as either gay or lesbian (Mills, 1990).

Lipkin (1999) views 'coming out' as a developmental process by which an individual acknowledges his or her own sexual preferences for members of the same sex. The individual integrates feelings with his or her knowledge into personal preferences. The process starts off by

acknowledging being different from others. The sexual feelings for same sex people become clear and then the individual will fully identify him or herself as homosexual. The stages of homosexual identity formation have an inner potential, waiting to be discovered and expressed by an individual.

According to Cox et al. (1996), the LGTBI identity develops after an individual has dealt with conflicts and stresses that are related to sexual orientation. The aim behind forming a homosexual identity is to resolve inner conflicts, fears of rejection and discrimination that are perceived to be experienced by most homosexuals. Forming a homosexual identity helps an individual to have a positive sense of self and be able to express sexual feelings towards others. Cox et al's. (1996) idea seems to suggest that LGTBI people go through the same identifying experiences. Considering that identity theorists put forward that disclosure is the final stage of the models, the current study is hoping to identify mental problems because of these identities and their disclosure.

Different models of homosexual identity formation have different stages, but all models believe that individuals progress through stages in a sequential order. All models describe similar patterns of growth and progression from one stage to another as a sign of homosexual identity development. Theories of homosexual identity formation also believe that the formation of a homosexual identity can start in the presence of a social stigma. The presence of a stigma affects the process of identity formation and expression of homosexual identities. Proponents of homosexual identity formation also agree that the process of homosexual identity formation is a long process that involves growth and change in an individual (Cass, 1984). The process also involves acceptance of the label 'homosexual' as applied to the self. The process of disclosing homosexual identity also takes place at an individual level, to other homosexuals, to heterosexual friends, to family, to co-workers, and to the public at large (Coleman, 2000). For most homosexuals the process begins at an individual level and later on the individual can have social contact with other homosexuals (Cass, 1984).

### 2.8.1. Models of homosexuality identity formation

It has been stated that there are many models of homosexual identity formation but the scope of this study will look at only three. It is difficult to conduct a research study while homosexual individuals are at their early stages of homosexual identity formation; therefore, the models are based on adult recollection about feelings, reactions and behaviours that they have experienced. Most models of identity formation have stages that include the individual recognising being different, making sense and giving meaning to that experience, assigning 'homosexuality' as a name and disclosing the status as lesbian or gay (Savin-Williams, 2001). Models of homosexual identity formation are different from one another but they nearly always use stage sequences and they agree that the process starts from private and then becomes known by others external to the individual. The following Table 2.1 have different models of identity formation by different theories.

**Table 2.1: Summary table of identity models**

<b>Cass's model</b>	This is a six stage model. It is non-age specific and not linear. Being at different stages at the same time and returning to a previous stage is possible (Cass, 1984).
Identity confusion	Realisation of being different based on behaviour, action and feelings.
Identity comparison	Being different may be positive or negative but still hidden. When compared with peers, there are feelings of rejection and a sense of not belonging.
Identity tolerance	Involves looking for social contact and acceptance from other homosexuals. Contact with other homosexuals enhances self-esteem and social skills.
Identity acceptance	Reveal to some people, while denying it to others. Tries to live in two worlds because of social acceptance or rejection of homosexual identity.
Identity pride	Strong personal acceptance. One may have an 'us versus them' or 'straight versus queer' attitude.
Identity synthesis	Full acceptance of homosexual identity. It is viewed as one part of a multifaceted self.
<b>Coleman's model</b>	It was established in 1982 as a five stage model (Nardi & Schneider, 1998).

Pre-coming out	Slow and painful process of preconscious awareness of an attraction to members of the same sex. Individual may reject, deny, or repress his or her homosexuality. Stress of dealing with these feelings may result in depression and can lead to suicide.
Coming out	Involves initial acceptance and reconciliation to homosexuality. Positive response may lead to greater comfort and wider disclosure. Negative response could send the individual back to stage one.
Exploration	Experimentation with a new identity begins both sexually and socially.
First relationship	Involves attraction and sexual competence which may lead to the desire for deeper and more lasting relationships. This requires skills to maintain a same-gender connection in a hostile environment. Intense expectations, passiveness and mistrust can doom a first relationship. One partner may rebel by pursuing sex outside the relationship.
Integration	Mutual understanding and acceptance of the public and private selves. Self-acceptance leads to a greater confidence and the ability to sustain relationships.
<b>Troiden's model</b>	This is a four stage model. Troiden's theory has a sociological background. It represents a synthesis and elaboration of previous research. He called his model an ideal typical model of gay identity acquisition. This theory comes from 150 homosexual men who were interviewed by using the snowball sampling method (Troiden, 1988 as cited in Nardi & Schneider, 1998).
Sensitisation	Occurs before puberty. It involves generalised feelings of marginality and perceptions of being different from same sex peers.
Identity confusion	Involves the personalisation and sexualisation of specific things during adolescence. Individuals begin to be more reflective on their feelings and behaviours that could be regarded as homosexual. This leaves the individual with inner confusion and uncertainty around their ambiguous sexual status.
Identity assumption	Identity is first tolerated and then accepted later. The individual begins to have social relations with other homosexuals and explore homosexual subcultures. Sexual experimentation begins.

Commitment	Homosexuality is adopted. The individual accepts and is comfortable with a homosexual identity. Commitment consists of both internal and external dimensions.
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**2.8.2. Internal indicators of homosexual identity formation**

According to Troiden (1988), one of the internal measures of a person’s commitment to homosexuality is the fusion of same sex sexuality and emotionality into a significant whole. A person feels emotionally comfortable about being homosexual and looks forward to engaging in an emotional relationship with other homosexual persons. The perception of the homosexual identity as a valid self-identity is another sign of internal homosexual commitment. Homosexual identities and roles are seen as growing out of genuine needs and desires. Homosexuality is reconceptualised as ‘natural’ and ‘normal’ for the self. The degree of satisfaction expressed by people about their present identities and increased happiness are other measures of internal commitment (Nardi & Schneider, 1998).

**2.8.3. External indicators of homosexual identity formation**

One external sign of commitment to homosexuality is an intimate involvement with a same sex partner, which is a tangible manifestation of a synthesis of same sex emotionality and sexuality into a meaningful whole (Troiden, 1988). This is different from the *After 9* drama which the researcher made an example of earlier on. The drama suggests that intimate involvement is not a proof of homosexual commitment. Another external measure of commitment to homosexuality is characterised by an increased desire to ‘come out’ to heterosexuals. However, often people are reluctant to come out to everybody in their social environments due to anticipated homophobic reactions. Many homosexuals try several times to disclose, but the success of disclosure depends on many factors including personal, social, religious, cultural and professional circumstances. A shift in stigma management strategies to more mature strategies is another indicator of commitment (Nardi & Schneider, 1998).

**2.8.4. Critique of identity models**

According to Morris, Waldo and Rothblum (2001), Coleman and Troiden have been accused of male bias with their models. Horowitz and Newcomb (2002) have suggested that Troiden and

Coleman have no scientific evidence in their models. They pointed out that their models are too theoretical with no practical bases. Morris, Waldo and Rothblum (2001), points out that these entire theories are conservative; there is not much truth in them because they are only based on what has been recalled from an individual's childhood experiences. Adults are reporters of childhood experiences, which imply the possibility of having a shifted meaning makes it difficult to find out if they are adding or modifying some of the experiences.

If the same experiences were to be reported by children, the meaning can shift. The experiences would be of gender conforming or nonconforming behaviour and not about sexual behaviour. Children also lack the vocabulary to express their sexual feelings. As their vocabulary is limited it makes it difficult for children to begin to consider themselves as heterosexual or homosexual. The cultural stigma towards homosexuality has greater meaning in adults (Mills, 1990). Another critical point is that the various models of homosexual identity do not consider the historical times when gay and lesbian identities did not exist.

Cass's study of 1984, which was about homosexual identity formation, pointed out that identity may involve four stages instead of the proposed six. This raises the reliability and validity in the stages. The discriminant analysis used in the study suggested that the scoring keys might have been unable to measure the differences between groups. The results of Cass's study point out the importance of scrutinising the validity and reliability of other models of homosexual identity formation. It raises questions such as: Is it really a stage model applicable to all homosexual people? Is it sequential and time based? Is it possible for individuals to regress and to jump one of the stages? Which stage is considered to be the perfect terminal stage? Do these stages apply to black South Africans? What about sex differences between gays and lesbians? Hopefully, the current study might be able to answer some of these questions.

Even though the models of identity formation have pitfalls, it is important to note its valuable contribution to the field of homosexuality. It is not only that the theorists generalised on everything because some homosexuals might identify with some of the stages.

## **2.9. Possible facilitators and inhibitors of disclosure**

To some people disclosure brings about traumatic experiences and to some it can also be a liberating experience that brings about positive mental health. Access to literature, social clubs, family and peer support and urbanisation might positively enhance disclosure. However, the fear of being disowned, the fear of being raped and murdered, the fear of being stigmatised and discriminated against can inhibit disclosure. Variations in disclosure can be caused by factors that can both influence and inhibit individuals to disclose their homosexual identity. The current study will focus on religion as both an inhibiting and facilitating factor.

### **2.9.1. Religious beliefs**

According to McLachlan (2010), religious beliefs have strong influences not only in forming the spiritual identity but also the gender identity. This identity is formed not only through involvement in the religious community, but also by being called by the religious community into femininity and masculinity and being gendered by performing gender roles within the church (Butler, 1993). Religion play an important role in upholding and reinforcing the dominant gender and sexual norms and in framing non-conformity as a deviation and sinful. Homosexuality is depicted as unnatural in an evolutionary sense, as homosexual people are seen as unable to reproduce and furthermore, it is seen as unnatural as an assumption exists that it is not reflected in nature (Boswell, 1980). However, this assumption is not true because the history of homosexuality reveals that it is natural.

Queer theology engages with the believers and non-believers who are marginalised by the church and society for their sexual and gender indifference. Mainstream churches do not uphold queer theology and it is accepted that there is no space in these churches for people who do not conform to their set of norms and values (Loughlin, 2007).

#### **2.9.1.1. Christian views about homosexuality**

Christianity will be a form of the religion which the current study will focus on as it is the most dominant religion among the black African community. Christian denominations differ in the way they view homosexuality. Some still view it as sinful and some view it as morally acceptable. For Christian denominations that view homosexuality as sinful it is not clear whether it is just homosexual acts that are sinful, or homosexual orientation as well. It is also important to

consider that people from the same Christian denomination have different belief systems. For example, Bishop Rene Robison, in the Episcopal Church in the United States of America has a homosexual orientation and he never views homosexuality or homosexual acts as sinful but some branches of the Anglican Church have rejected homosexuality. Christian denominations that view homosexuality as sinful are called conservative Christians, and those that do not view it as sinful are called liberal Christians (Frost, 2008).

Liberal Christians believe that Biblical passages have been mistranslated. They believe that the scriptures in the Bible do not refer to homosexuality. Some also believe early Christians accepted homosexuality. Liberal Christian scholars and conservative Christian scholars both accept earlier versions of the Bible in Hebrew or Greek. But the liberals have interpreted some scriptures differently from past generations. They are worried that the misinterpretation might have been caused by copying errors, forgery and of biases among the translators of later Bibles. They believe that some scriptures are not applicable in today's life such as those that support slavery and women disempowerment. They also put forward that the verses are against God's will (Frost, 2008).

Conservative Christians suggest that familiar words are used in the religious scriptures. For example, the writings of Eusebius of Caesarea are easy to understand in that they condemn the union of women with women and men with men. Conservative Christians suggest that the original text in the scriptures should be translated using standard definitions of ancient words as it has been done by past generations and people who lived close to that time. Conservative scholars reject the claim by liberals of trying to give new meanings to terms and to question passages which are expressed in simple and common language. Most conservatives accept that the scriptures are written in plain language and have literal meanings. They provide clarification to those phrases that seem unclear and also argue that the examination of the whole body of the doctrine can resolve ambiguities that currently exist (Frost, 2008).



### **2.9.2. Cognitive dissonance and Christianity**

Festinger (1957) believes that dissonance can be reduced by changing the behaviour that creates dissonance and adding new cognitions to reduce the dissonance or by changing the social environment that reinforces the dissonance. According to Hunter (1983), there are two reasons why Christian homosexuals present with feelings of discomfort between their beliefs and homosexuality. For many Christians being homosexual is considered as sinful and against the will of God. It is difficult for homosexuals who were raised as Christians to accept their homosexual identity. This is because of the perception that their lifestyle is in conflict with religious beliefs. Christians value a traditional definition of family where there is a mother, father and children. The Christian family expects individuals to live and abide by strict traditional gender roles. According to Klatch (1987), social conservatives deny themselves the opportunity to see non-traditional families as fully functioning families. He further argues that conservatives deny homosexuals their basic human rights. Homosexuals who have been raised to believe in traditional families experience tension when they reject the traditional definition of family.

### **2.10. African traditional religion and homosexuality**

Dlamini (2006) puts forward that homosexuality is African. However, some people do not agree with Dlamini's statement. To name a few, Mokhobo (1989) says that the concept of homosexuality is abhorrent. According to Dlamini (2006), Mokhobo's statement brings two meanings, namely, not many people talk about homosexuality and it also implies that there are no homosexuals. Parrinder (1980) as cited in Dlamini (2006) also points out that homosexuality existed in traditional Africa, but rather argues that condemnation of homosexuality as unAfrican.

According to Swidler (1993) as cited in Dlamini (2006), the traditional religions of Africa value the spiritual power in sexuality and were not hostile towards homosexuality. Swidler (1993) cited in Dlamini (2006) supports the above statement by saying that Africans did not have time to fight and argue over sexuality but they have had to endure the imposition of white rule and loss of their land. The research emphasises the importance of noting that not many researchers or anthropologists have had a chance to research African sexuality.

Lee (1969), Parrinder (1980) and Swidler (1993) cited in Dlamini (2006) further argue that even though not much research has been done on African sexuality, homosexuality has nevertheless been present in Africa, and South Africa must not be excluded. They further suggest that in some instances, homosexual relations carry some religious and spiritual significance, as in the case of *izangoma*, *izinyanga* and other traditional healers. To give a case illustration, Nkunzi Zandile Nkabinde is a black sangoma who is a lesbian (Nkabinde, 2008). She prefers the female gender identity of her ancestral grandmother from that of her male ancestral guide. According to Nkabinde (2008), it is the ancestor who directs her to behave in certain ways and even chooses when to form attachments to men and women. She reports that she is more comfortable with her female gender identity, but still obeys the ancestral wish to assume a male identity. In this instance even her gender identity is subject to the will of her male ancestor.

Summer (1995) as cited in Dlamini (2006) is also in favour of idea of homosexuality being African. He further says that maybe the concept 'homosexuality' might have not existed historically but the acts and emotions were present. He also came up with an idea that maybe the term homosexuality should be used as an adjective so that it refers to acts and emotions rather than as a noun to avoid referring to people. This can benefit those who are uncomfortable with the term used on them.

According to Kripal (2001), Christian theology is gender biased. These religions present God as a male figure. He believes that it is hard not to believe that religion is homoerotic since men are expected to bow down, worship and mystically unite with this male God. Jordan (2000) clarifies that this does not mean that men who worship a male God are homosexually oriented. The important thing to consider with this argument is that Christianity is presented as homo-erotic and as approaches that feminise men. For example, the Bible talks about Israel walking in the veil of God. This brings more questions about how Christianity is presented as homo-erotic but at the same time against homosexuality. Religion brings more contradictions and no logic about how men are supposed to love their wives and at the same time love and worship the only man (God). The researcher's question is that does this mean that religious men are bisexual.

## **2.11. Homosexuality and mental health**

The study of mental health and the LGBTBI community has interesting debates as homosexuality was classified as a mental disorder during the 1960s and early 1970s. The debates put forward the gay-affirmative perspective which declassifies homosexuality as a mental disorder (Bayer, 1981). Many research studies have found that homosexuals are more at risk of having psychological problems than the heterosexual population (Meyer, 2003). Vincke and Van Heeringen (2002) suggest that homosexuals experience stress as a result of being stigmatised because of their sexual orientation and of being members of a social minority. Criminal victimisation and lack of support have been suggested to cause low self-esteem which further increases the chances of having other mental problems such as depression (Zea, 1999). The fear of victimisation also limits the individual's chances of disclosure. At the same time, not disclosing homosexual orientation reduces support structures for an individual and increases the chances of being depressed (Buzzella, Beals & Peplau, 2003). Many homosexuals have tried to alleviate their stress by using drugs and alcohol, but at the same time the use of drugs and alcohol may bring about depression (Meyer, 2003).

According to Cochran, Mays and Sullivan (2003), D'Augelli, Grossman, Hershberger and O'Connell (2001), Luhtanen (2003), Mays and Cochran (2001), Otis and Skinner (1996) and Zea (1999) international research has identified risk factors for depression. They found out that the risk factors include poor self-esteem, lack of social support, failure to disclose sexual orientation, victimisation, and alcohol and drug use. Chapter 4 of this study will indicate whether there is a direct relationship between disclosure of homosexual identity and mental health. It will also suggest whether homosexuals in social groups are at risk of having psychological problems or not.

### **2.11.1. Self-esteem and homosexuality**

According to Crocker (1999), self-esteem refers to personal feelings of self-worth, self-regard or self-acceptance. It indicates how one views and values oneself. Positive self-concepts have been evident in individuals with high self-esteem and negative self-concepts have been evident in individuals with low self-esteem. Studies of homosexuality have indicated that low self-esteem and depression are strongly related in homosexual individuals. Having higher self-esteem results

in lower levels of depression (Meyer, 2003; Luhtanen, 2003; Otis & Skinner, 1996; Zea, 1999). These studies have used different sample sizes, ages, educational levels and races but ended up with the same results showing consistencies between depression and mental health. This suggests that their results can be generalised and be applicable in the South African context. This leads to a conclusion that a high self-esteem decreases vulnerability to depression in homosexuals.

### **2.11.2. Resiliency among homosexual individuals**

For homosexual adolescents peer relationships are often unrewarding. Homosexual adolescents are often socially isolated from their peers. This also makes it difficult for adolescents to fully accept their sexual orientation. Finding positive and supportive peer environments is difficult for homosexual adolescents and many social organisations fear being accused of supporting homosexuality (Radkowsky & Siegel, 1997). It is easy for homosexual adolescents to lose important supportive relationships with their peers and parents during the process of disclosure. Homosexual adolescents have been displayed as being able to look for supportive relationships that boost their self-concept (Walker & Greene, 1987 as cited in Anderson, 1998).

Samuels (1977) indicated that when young homosexuals are faced with difficult circumstances, they tend to engage in an introspective process that provides them with a better understanding of themselves, others, and society. As they engage in these processes, their crisis management skills are further developed. During the developmental process of adolescent individuals, the social support from family members is important. Anderson (1998) suggested that support structures open chances for young homosexuals to disclose their sexual orientation.

### **2.11.3. Internalised homophobia**

Internalised homophobia is a stressful negative reaction that is internalised by a homosexual individual. Homosexuals may direct negative social values towards themselves because of their sexual orientation. According to Thoits (1985, p. 222), “role-taking abilities enable individuals to view themselves from the imagined perspective of others. One can anticipate and respond in advance to others’ reactions regarding a contemplated course of action”. Internalised homophobia represents the failure of the coming out process to ward off stigmas and thoroughly overcome negative self-perceptions and attitudes (Morris, Waldo & Rothblum, 2001).

It is common for most homosexual individuals to have internalised homophobia during their early stages of homosexual identity formation and it is unlikely that it disappears completely or decreases even when the person has accepted his or her homosexuality. Internalised homophobia remains an important factor in the gay person's psychological adjustment. This is because of socialisation experiences and exposure to attitudes which are against homosexuality. Internalised homophobia can lead to a negative self-view and further lead to mental health problems (Cabaj, 1988; Hetrick & Martin, 1984; Malyon, 1982; Nungesser, 1983).

Despite of challenges to measuring internalised homophobia and a lack of consistency in its conceptualisation, research has indicated that it is significantly correlated to mental health (Mayfield, 2001; Ross & Rosser, 1996). Mental health problems associated with internalised homophobia include depression and anxiety symptoms, substance abuse disorders and suicide. It is also correlated with various forms of self-harm, including eating disorders and HIV risk behaviours (Williamson, 2000). According to Nicholson and Long (1990), feelings of self-blame and poor coping strategies are used by an individual when faced with difficult situations. It is also associated with difficulties in intimate relationships and sexual functioning.

## **2.12. The Human Immunodeficiency Virus (HIV) discourse**

According to Reddy and Louw (2002), when HIV was first evident it was known as a homosexual disease. Changing that myth is not only for the AIDS political and health movements but it is everyone's responsibility. Even researchers in the field can help to alleviate the myth. People need to come to a realisation that HIV affects everyone and affects different classes of people. When looking at the South African research context, homosexuals sexual behaviour has been ignored. A South African and American study by Wagenaar, Sullivan and Stephenson (2012) indicated a gap in education about HIV and AIDS transmission. Their results pointed out that those gay men with low levels of education had significantly lower knowledge of HIV and AIDS. These results are different from what Arabsheibani, Marin and Wadsworth (2005) found because they pointed out that homosexuals have higher levels of education because they are discriminated against and attempt to compensate by acquiring more education. It is important to note that this does not imply that all homosexuals are educated but it implies that on average, homosexuals are better educated than other groups.

Increasing knowledge about HIV can be helpful in preventing transmission of the virus in South Africa. Among lesbian homosexuals the situation is worse because of the belief that lesbians have low chances of contracting HIV. Reddy and Louw (2002) conducted a study in Durban and found that not many research studies have been conducted on the transmission of HIV among lesbian homosexuals. It seems as if many researchers have been focusing more on gay rather than lesbian transmissions. This is worrying for a country like South Africa because everyone is either affected or infected by HIV.

Queer theory has tried to change that perception of a link between AIDS and homosexuality, because it increases public homophobia and discrimination directed against homosexuals. Several research studies conducted by Lane, McIntyre and Morin (2006) indicate that South African homosexuals engage in high-risk sexual behaviours. Their study further indicated that black South African homosexuals are highly vulnerable to the HIV infection. Lane et al.'s study (1996) also found that being stigmatized as an HIV-positive homosexual limits homosexuals' access to services such as voluntary HIV testing and counselling.

### **2.13. Concealment**

LGTBI people may conceal their sexual orientation as a way of protecting themselves from real harm. For example, they may protect themselves from being attacked, or getting fired from a job. This may occur out of shame or guilt, and concealment itself is a source of stress (D'Augelli & Grossman, 2001). According to Hetrick and Martin (1984), homosexuals learn to hide as a form of coping strategy and homosexuals tend to over-monitor their behaviour. For example, they might be careful and watchful of the way they dress, speak, walk and talk. Concealment also prevents LGTBI people from identifying and affiliating with other homosexuals. However, psychological literature has shown that affiliating with other homosexuals can have a positive impact on the life of homosexuals and enhance their self-esteem (Postmes & Branscombe, 2002).

The fear of being discriminated against and having to conceal sexual orientation has been identified by many work place studies as causing psychological, health, and job-related problems (Waldo, 1999). Homosexual identity disclosure and concealment strategies address the fear of discrimination on one hand and a need for self-integrity on the other. Strategies involve lying to

be seen as heterosexual; covering up, which involves censoring clues about one's self so that the LGBTBI identity is concealed; being implicitly out, which involves telling the truth without using explicit language that discloses one's sexual identity; and being explicitly out (Griffin (1992), as cited in Croteau, 1996).

#### **2.14. Conclusion**

With the given history of homosexuality in South Africa, clearly more research needs to be done on the subject of homosexuality. The literature review indicated that homosexuals have been discriminated against and marginalised in South Africa. When the subject of homosexuality is raised, those who are against it usually base their argument on religion and culture. The chapter further suggested that homosexuals face challenges after disclosing their sexual orientation. Some of the reason behind their struggle was associated with the myth that it is unAfrican. However, the literature made it clear that homosexuality is indeed African. Past research studies have suggested an association between mental health and sexual orientation, which is the current study's investigation. Theorists have different views around the cause of homosexuality and homosexual identity formation.

## **CHAPTER 3: METHODOLOGY**

### **3.1. Introduction**

The literature review has shown that disclosure of sexual orientation is influenced by both inhibiting and facilitating factors, which may include religion, culture, cognitive dissonance, resilience and societal norms. It has suggested that there is a direct relationship between the disclosure of homosexual identity and mental health, which is a topic of the present investigation. The methodology of the current study has two sections, starting with a pilot study section and ends with the main study. This chapter will outline the research methodology which was used during the process of data collection.

### **3.2. Pilot study**

A pilot study was conducted first in the current study. According to Singleton (1988), a pilot study means trying questions out on a small number of people who have characteristics similar to those of the target participants. The researcher designed a questionnaire on mental health and life challenges faced by homosexuals. To ensure the user-friendliness and reliability of the questionnaire, a pilot study was conducted with a small sample which was similar to the target sample that was intended to be used by the study. The pilot study was done to test whether the respondents interpreted the questions correctly and whether the response categories provided for the questions were suitable.

#### **3.2.1. The process of the pilot study**

The self-designed questionnaire and the GHQ-28 were given to five participants who identified themselves as homosexuals. This study had a questionnaire with categorical choice answers and open-ended questions designed by the researcher. The designed questionnaire was written in English and Zulu which enabled the respondents to understand well. It was conducted because the questionnaire was going to be answered by participants from different educational backgrounds. Therefore, it was meant to ensure that everyone had the same basic and common understanding of the questions.

Five participants participated on a voluntary basis and anonymously. These participants were University of KwaZulu-Natal students who were selected according to the criteria that they were



able to identify themselves as homosexual, black, above 18 years old and able to speak English or Zulu. Participants were also given evaluation forms to evaluate the questionnaire (see Appendix E). The self-designed questionnaire needed to be evaluated to ensure that it was user-friendly and also had questions which were understandable by the participants. The pilot study proved that the researcher was able to produce simple, clear and concise instructions. The questionnaire appeared as user-friendly since it had neat printing, a clear font and good quality paper. Respondents were able to complete the questionnaire within 30 minutes. It was found that the order of the questions was not confusing, the questions were introduced with basic information which made it easy to answer and this put the respondents at ease, and then it introduced the relevant questions of the study. This helped the researcher to fine-tune the study for the main inquiry.

### **3.3. Survey of homosexuals and heterosexuals using the GHQ-28**

A survey of fifty homosexual people from LGTBI social networks and fifty heterosexual post-graduate students was conducted to study their mental health. The homosexual group was compared with fifty heterosexuals from the UKZN post-graduate student population. Heterosexuals were used as a comparative group because it was convenient to get them to participate as participants than to find homosexuals not belonging in social organisations.

According to Kobus (2009), in a quantitative research study the findings from a pre-selected sample are generalised to the rest of the population. The current study is not in line with Kobus's idea of generalising the findings the rest of the population because the samples selected in this study might misrepresent the general population of homosexuals. This is because the homosexual participants used in this study belong to LGTBI social organisations. The study still took on the general principles of quantitative methods by quantifying data through statistical methods. In this study, the researcher attempted to quantify a number of challenges faced by homosexuals and quantify the relationship between disclosure and mental health.

### **3.4. Participants and sampling method**

Two social organisations for homosexual people in KwaZulu-Natal were used to locate participants, but the organisations did not select participants for this study. The sample for this

study was not an organisation but was rather the members of the two organisations. All organisations wanted to remain anonymous throughout the study, meaning that their names will not be revealed. Before participants started to fill in the questionnaires they were given letters stating that professional counselling would be offered to them should they experience distressing emotional consequences as a result of participating in this study.

There was no clear sampling frame in the current study but participants self-identified as either homosexual or heterosexual. This study used convenience sampling, meaning that participants were selected through their availability (Durrheim, Painter & Terre Blanche, 2006). The researcher chose this method because it saved time and the population was difficult to find.

The various studies carried out in this dissertation made use of one hundred and fifteen participants who identified themselves as either homosexual or heterosexual. A group of four participants participated for different reasons. The study started off with a group of five homosexual participants for the pilot study. Fifty participants participated because they self-identified as homosexual and they were all from LGTBI social organisations. These participants answered the self-designed questionnaire and GHQ-28. The following Table 3.1 depicts the demographic details for 50 homosexuals who participated on the study.

**Table 3.1: Demographic details for homosexual participants**

<b>Sexual orientation</b>	<b>Number of participants</b>	<b>Gender</b>	<b>Language</b>
Lesbians	18	Females only	1 Xhosa, 1 Sepedi, 16 Zulu
Gays	23	Males only	1 Xhosa, 1 Afrikaans, 21 Zulu
Bisexuals	8	4 Females and 4 males	1 Swahili, 1 Tswana, 6 Zulu
Did not specify	1	Male	1

Table 3.1. indicate that all 50 homosexual participants were black people, with 23 females and 27 males. Their age ranged from 18 to 36 years. Their ethnic background was mainly Zulu-

speaking, two English-speakers who were Black, one Afrikaans-speaker who was Black, a Swahili-speaker who was a Black South African, one Tswana-speaker, one Sepedi-speaker and two Xhosa-speakers. There were 8 bisexuals (with 4 females and 4 males), 23 gays and 18 lesbians and 1 male participant who did not classify himself as gay, lesbian or bisexual but has a history of being involved in intimate relationships with both genders.

A comparison group of participants was made up of fifty participants who self-identified as heterosexuals and they answered the GHQ-28 only. Fifty homosexuals and fifty heterosexuals both answered the GHQ-28 in order for their results to be compared with one another when assessing mental health status. The heterosexual participants were University of KwaZulu-Natal post-graduate students. It is important to note that these participants were selected during exam period as this might have an impact on the study's findings. Convenience sampling was used when selecting these students for participation. They were all black, their age ranged from 18 to 30 and the main requirement to participate was that they had to identify themselves as heterosexuals. Limited demographic information was collected from the heterosexual sample. Maintaining confidentiality was among reasons of limited demographics. Another reason was that the demographics seem less important in answering the question of the current study.

Another separate group of ten participants were selected regardless of their sexual orientation to scale the categorical choices in the categorical choice questionnaire during the data analysis process. They were also selected using convenience sampling. They were used to scale the responses of the ten categorical choice questions, judging on the basis of what they perceived would be their worst experience or situation compared to their best experience or situation (see Appendix K). Their responses were scaled from 1 to 6, depending on how many responses were given in each question. The reason for this was that when it came to data analysis, the distribution of a score between the homosexual group and heterosexual participants would be compared. A detailed analysis of this is included in Chapter 4 of this study.

### **3.5. Data collection method**

Data was collected through the use of a survey. According to McMillan and Schumacher (2001), when doing survey research, researchers select samples of respondents for administering a questionnaire to collect information about their attitudes, values, habits, ideas, demographics, feelings, opinions, perceptions, plans, and beliefs. According to Goodwin (2002), quantitative methods are best suited when investigating people's attitudes and challenges and this approach has been used successfully in many research studies. Therefore, a survey design in the current study was used to describe the mental health of homosexuals and compare it with the mental health of heterosexuals (Sarantakos, 1998). McMillan and Schumacher's ideas were not followed in the current study since the sampling frame was to approach LGTBI social networks because the researcher knew that the organisations were appropriate places to find participants. Heterosexual participants were selected through their availability and through them identifying their own sexual orientation.

#### **3.5.1. Instruments of data collection**

Data was collected by using two instruments of data collection namely, the General Health Questionnaire-28 and a self-designed categorical choice questionnaire with open-ended questions (see Appendices C and D). The researcher chose to administer the questionnaires in a group because many respondents were able to complete the questionnaires in a short period of time. The researcher was able to check the questionnaires for accuracy and was able to immediately assist with issues of the questionnaire which were not clear to the participants.

##### **3.5.1.1. General Health Questionnaire-28 (GHQ-28)**

The GHQ-28 was used to assess if the participants were at risk of any psychological conditions. According to Willmott (2008), the General Health Questionnaire-28 is a well-established screening instrument which is used for identifying psychiatric conditions within community settings. Several versions of the GHQ-28 of varying length have been produced (Goldberg, 1972; Goldberg & Williams, 1988). The GHQ-28 has four subscales, namely, somatic symptoms, anxiety and insomnia, social dysfunction and severe depression. The researcher chose to use the GHQ-28 because this version is well known as a good diagnostic tool for Axis I disorders listed in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. The GHQ-28 has 28 items.

The items ask respondents how they have experienced symptoms and behaviours in the past few weeks. The responses of respondents were rated on a 4-point Likert scale of severity ranging from 'better as usual' to 'much more or worse than usual'. The Likert style of scoring was chosen (Goldberg, 1972). The Likert scoring method was used because, according to Goldberg (1972), the GHQ-28 item has shown that when the Likert scale is used, better correlations with clinical measures are obtained. The scores for each subscale range between 0 and 21 points and the scores for overall severity range from 0 to 84.

The GHQ-28 was included in order to evaluate symptoms of psychological stress and mental health problems. Correlations and associations between the survey questions and the GHQ-28 were computed (see in Chapter 4).

#### **3.5.1.1.1. Validity and reliability of GHQ-28**

According to Smith (2007), over 50 validity studies had been published on the GHQ-28 by 1998. Goldberg and Hillier (1979) reported internal consistency coefficients ranging from 0.69 to 0.93. The Cronbach's alpha coefficients have ranged from 0.82 to 0.93, while the content validity and criterion validity have been established, and the median correlation of these assessments was 0.76 (Goldberg & Williams, 1988). The GHQ-28 in its four versions has been translated into 38 international languages and is used regularly across the world in varying cultures (Goldberg & Williams, 1988).

The GHQ-28 has been normed and standardised for black South Africans. It has also been used in many local studies, such as John (1996), where he was investigating the use of the General Health Questionnaire in a Zulu-speaking setting. The GHQ-28 has been used successfully in South Africa in an investigation into the relationship between independence and the psychological well-being of physically disabled males (David, 2000). It was also used in a study by Van der Walt (2002) into the general health and subjective well-being of stroke survivors. Smith (2007) also successfully used it in the study of psychofortology of post-graduate learners in the Faculty of Health Sciences at the Nelson Mandela Metropolitan University.

### **3.5.1.2. The self-designed categorical choice questionnaire**

The self-designed questionnaire consisted of both structured and open ended-questions. Structured questions were used because the researcher was looking for specific answers and Bell (2005) argues that structured questions are easier to analyse. These were in the form of categorical choice questions whereby participants chose the answer that best suited them. They were allowed to choose more than one answer per question, if more than one answer best suited them. The researcher did that in order to not limit their responses. Open-ended questions were included for participants to further elaborate on their categorical choice questions. According to Kobus (2009), open-ended questions enable the respondent to answer complex questions satisfactorily and to adequately reveal the participant's thinking.

#### **3.5.1.2.1. Questions included in the self-designed categorical choice questionnaire**

There were ten questions in the self-designed categorical choice questionnaire. The first question was concerned with the 'coming out' status of the participant. The participants needed to mention the type of disclosure that they had undertaken, such as self-disclosure and disclosing to everyone. This question was included because the researcher wanted to know the main people involved and type of people that is it is easy for homosexuals to disclose their sexual orientation to.

Question two asked about the method of discovering sexual orientation. This question was included because it can partly bridge and clear the controversy which was discussed in Chapter 2 whereby theorists had different ideas about the cause of homosexuality. Participants were explaining the ways in which they discovered sexual orientation such as discovering through reading homosexuality books and being informed about their sexual orientation by other people.

The third question was about assessing self-view and perception among homosexual participants. Chapter 2 indicated that some homosexuals may develop internalised homophobia as a result of stereotypic values and social norms being against them. Question four was about the experiences and encounters of homosexuals due to their sexual orientation. Chapter 2 highlighted that some homosexuals still experience violence, rape and assaults because of their sexual orientation.

The fifth question of the questionnaire asked the participants about the way in which homosexuals perceive themselves because of their sexual orientation. This question is also linked

with the third question of the questionnaire. Question six of the questionnaire asked participants about facilitators of disclosing homosexual orientation. In the literature review it was indicated that social support is one of the facilitating factors of disclosure. The seventh question asked homosexuals about the various ways they use to meet sexual partners. In the eighth question the participants were asked about the experience of keeping their homosexual identity as a secret. The ninth question asked participants about the steps they have undergone during the process of homosexual identity formation. In the tenth question the participants were asked about rumours and myths they have heard from others about themselves because of their homosexual sexual orientation.

### **3.6. Data analysis method**

Content analysis was used to analyse the open-ended questions and descriptive statistics were used as the analysis method for the categorical choice questions of the questionnaire. Other data analysis methods used include the chi-square, discriminant analysis and a multivariate t-Test.

#### **3.6.1. Content analysis**

Content analysis was used to analyse the open-ended questions of the categorical choice questionnaire. Content analysis is defined as a systematic and replicable method that compresses text into fewer content categories. It is done by using basic rules of coding (Berelson, 1952). According to Holsti (1969), content analysis is a method used for making inferences by objectively and systematically identifying specified characteristics of messages. Content analysis was used because it enables researchers to sort out large volumes of data with relative ease in a systematic fashion. It can be a useful technique for discovering and describing the focus of individual, group, institutional or social attention (Weber, 1990).

According to Stemler and Steve (2001), content analysis is a method used for counting the frequency of words, sentences and phrases. There are factors that are important and need to be considered when making conclusions about the word frequency count. The important factor to consider is that identical words, phrases and sentences may be used for stylistic reasons throughout a document. This may lead the researchers to underestimate the importance of a concept (Weber, 1990). It is important to consider that some words may not represent a category

equally well. Therefore, the researcher needs to be aware of this limitation in the use of word counts. The content analysis in this dissertation did not rely solely on words counted, but phrases were counted according to their similarity in meaning.

#### **3.6.1.1. Coding method**

According to Kobus (2009), coding involves reading through transcribed data and dividing it into meaningful analytical units. Categories of data are marked with symbols, descriptive words or unique identifying names. Coding enables the researcher to analyse and collect data recorded by respondents. There are different types of coding; the researcher chose to use emergent or inductive coding because codes were developed by the researcher by directly examining the data. This means that the researcher coded the answers that were given by the participants. Codes emerged directly from the data through a preliminary examination of the data (Konracki & Wellman, 2002).

It is important to note that during the process of coding it is possible to move back and forth between steps as new insights and understanding emerge from the data sources. After the transcribed data was coded, the researcher then inductively established themes or categories. Inductive categorisation implies that the researcher read through the identified codes and found themes and issues that recurred in the data. The categories then became the researcher's categories. Inductive categorisation allows themes to emerge from data. Once the categorisation was completed, the researcher reread the initial transcripts to check whether the essential insight that emerged from the data through coding was captured (Kobus, 2009).

#### **3.6.1.2. Reliability and validity of content analysis**

The next step was to bring order and structure into the categories identified. This was done by looking carefully at the categories and identifying how they were linked to other categories. Lastly, the researcher checked the reliability of the coding by means of a second coder, a 95% agreement is generally suggested for Cohen's Kappa (Howell, 1995). For the current study, 70% was accepted, which is a substantial agreement. Cohen's Kappa implies that a second coder independently reviews the questionnaires and comes out with themes that will be a measurement of agreement between coders. The researcher is bound to repeat the previous steps if the level of



reliability is not acceptable, meaning that if it is less than 70%. After the establishment of the accepted level of reliability, the coding was applied on a large scale basis. The final stage was a quality control check. After these steps, the researcher then started making sense of the data. The researcher's trick was to move away from a simple level of interpretation to an analytical understanding that began with explaining why and how things were presented as they were. According to Ritchie and Lewis (2003), coded data will reveal how much it agrees with existing theory and studies. It can end up bringing new knowledge and understanding to the body of knowledge.

#### **3.6.1.2.1. Training method of the coders**

The pilot study indicated that the data could be coded. The first coding was done by the researcher. All responses to each question were first read and the phrases with similar meanings were grouped together. The coding took the researcher a period of one week. The researcher approached the second coder to help with similar coding. The two coders had a training meeting with the purpose of clarifying the coding instructions and the terms and conditions of the coding process. Confidentiality issues were discussed and the second coder agreed to keep the information confidential. The second coder was chosen because he is an experienced psychology research master's student and was willing to work on a *pro-bono* basis. The questionnaires were then given to him and after a period of two weeks he had completed the coding process.

#### **3.6.1.2.2. Problems arising from content analysis**

The researcher was aware of the possibility that the analysis between the coders might not be reliable. That would imply the possibility of unclear coding instructions between the coders. It may also suggest the possibility of reformulating instructions from scratch or using another independent coder. In the current study, both coders agreed on most of the phrases and words, meaning that not many problems were experienced. Other than the inconsistencies between coders, some participants did not answer all categorical choice follow-up questions; hence, there was missing data. Again, the coders needed to agree on the number of participants with the missing data. There was also an overweighting problem due to participants who wrote about different ideas in a single leading question. Therefore, the researcher ended up compromising the

participant's information by only considering the idea which was written first as a response. This restriction was necessary to permit chi-square analysis.

### **3.6.2. Descriptive statistics**

Descriptive statistics were used to analyse the categorical choice questions of the questionnaire and the GHQ-28. Descriptive statistics analyses and describes data by looking at the distribution of scores and determines whether scores of the variable are related to each other or not (Durrheim, Painter & Terre Blanche, 2006). According to Goodwin (2002), descriptive statistics enable a researcher to understand large volumes of data by representing and converting the data into a very small set of numbers that can be more easily understood.

According to Howell (1995), descriptive statistics are divided into two categories, namely, graphical and numerical methods. Numerical data includes the measurement of data and categorical data. By measurement data (sometimes called quantitative data), the researcher means the results of any sort of measurement, for example, a score on a measure of a stressful disclosing experience. By categorical data (also known as frequency data or count data), the researcher means statements such as '80 participants had a positive disclosing experience and 20 participants had a negative disclosing experience'. In the current study, descriptive methods such as percentages, histogram graphs, pie charts and measures of central tendencies were used to analyse data. A comparison between the homosexual and the heterosexual sample is further discussed in Chapter 4 of the current study.

### **3.6.3. Inferential statistics**

The researcher aimed to go beyond just summarising and describing data, therefore inferential statistics were used to study the differences between the groups of participants and to find the associations between the variables. According to Kobus (2009), it is by means of probability that inferences are made. This simply means that inferential statistics allows the use of information obtained from the sample to draw conclusions about populations. In the current study, the above general rule did not apply because the homosexual participants were drawn from LGTBI social networks and it is unfair to generalise the findings to the rest of the population.

The inferential statistics methods used include chi-square test, multivariate data analysis and discriminant analysis. For variables to be significant they have to have a level of significance of not more than 0.05. If the level of significance exceeds 0.05, the researcher will use the rule of rejecting the null hypothesis. The 0.05 value stands for the probability which will make the researcher conclude that the variables measured display a statistical significance. The theory of probability suggests the determination of the extent to which the sample represents a population (Durrheim, Painter & Terre Blanche, 2006), therefore in this study, the sampling error will be ruled out. This is because the current study is an observational study and the samples pre-exist the study, and there are many differences that cannot be controlled between the samples.

#### **3.6.3.1. Chi-square (contingency tables)**

Chi-square is a type of non-parametric test which is appropriate when the researcher wants to examine the relationship between nominal variables (Kobus, 2009). This means that in the current study it is used for frequency and counted data. This test is used for the association between categorical variables (Tredoux & Durrheim, 2002). Chi-square tests the hypothesis that the survey data expressed as proportions are equal. A proportion is what you get when you find out how many people of all possible participants answer a certain way or have specific characteristics (Fink, 2009). Chi-square tests were used to analyse categorical choice questions from the questionnaire.

The statistical significance was investigated by making contingency tables and using the chi-square test. Contingency tables were two or more dimensions in which observations were classified on the basis of variables simultaneously, for instance, whether keeping homosexual identity secret made the participant feel guilty or not. Chi-square tests were used to test the researcher's hypothesis that there was no association between the two classifications.

##### **3.6.3.1.1. Problems arising with chi-square**

The researcher experienced problems with the computation of the chi-square since the participants were allowed to choose more than one response per question. The main reason for allowing the participants to choose more than one response was to accommodate those for whom more than one response was applicable. In creating contingency tables no participant was

expected to be double counted and categories had to be independent of one another. Therefore, there was a possible contradiction with the rule of chi-square which says that the participant's response must be counted once only (Lachenicht, 2002 as cited in Tredoux & Durrheim, 2002). This problem was solved through using 'AND grouping' of responses.

Questions which were given one response only by the participants were computed as they were presented. Questions with more than one response were grouped together through the use of the AND grouping method. This means that a new category was constructed from the combination of the two selected categories. The grouping of responses was also problematic because some questions had many categories. This contradicted the rule of chi-square which states that none of the cells are expected to have zero values and the tables in the resulting contingency table must have few cells with counts less than 5 per cell (Kranzler & Moursund, 1999). Chi-square assumes that observations are independent of one another. This assumption is violated if some respondents are counted more than once. To solve the problem of having a long list of categories, the categories were further grouped according to their similarities and according to the number of responses given per question. The further grouping of categories avoided the possibility that similar variables might appear in different categories.

#### **3.6.4. Multivariate data analysis**

A multivariate Hotellings t-Test was used to study the differences between several pairs of variables simultaneously (Durrheim, Painter & Terre Blanche, 2006). It is a special case of multivariate analysis of variance (MANOVA). In this study, MANOVA was used to study the relationship that co-exists between the homosexual and heterosexual population when comparing their GHQ-28 results.

##### **3.6.4.1. Discriminant analysis**

Durrheim, Painter and Terre Blanche (2006) argue that discriminant analysis is used to build regression models when the dependent variable is a categorical variable. Discriminant analysis was preferred to logistic regression because logistic regression is a large sample technique and the present study made use of fairly small samples. This statistical test was used to determine the association between the GHQ-28 of the homosexual population and their categorical choice

responses. Problems were experienced in the computation of discriminant analysis because the participants in the categorical choice questions were allowed to choose more than one response per question. This was handled through the scaling of multiple choice responses.

#### **3.6.4.1.1. Scaling of categorical choice question responses**

The initial sample of fifty homosexual participants was allowed to choose multiple responses in the same question. Multiple responses per question made it difficult to identify the main important and relevant response per question. This led to the inclusion of ten independent participants to rate the responses according to their level of importance. The participants were given ten pretence questions which were equivalent to the study's categorical choice questions (see Appendix K). The participants rated the responses on a scale of one to six. One was considered to be the most important option and six was considered as the least important option. The researcher compared the participant's responses with one another and came out with the rank of importance among the responses. The responses which were considered as the first and most important response were then applied to the questions containing multiple responses from the initial homosexual population. For example, if a respondent selected both option A and B, but B was ranked as more important than A, then the respondents were to be scored as if B had been selected.

#### **3.6.4.1.2. Dummy coding**

Dummy coding was used for categorical predictor variables in the discriminant analysis. According to Hutcheson and Sofroniou (1999), dummy coding is the process of transforming categorical data into a form which can be entered into a regression model. There are various methods of coding data but the researcher decided to use dummy coding. According to Nie, Hull, Jenkins, Steinbrenner and Bent (1975), dummy coding involves the assignment of the weights 1 and 0 to represent membership to the categories of the categorical variable. Discriminant analysis expects predictor variables to be continuous. However, it is known that dichotomies can be treated as continuous variables (Howell, 1995). In the current study the code of 0 referred to the absence of social dysfunction and the code of 1 indicate the presence of a psychological symptom. One level of each categorical variable was always omitted. This process is required to avoid problems arising from multicollinearity and is a normal part of the dummy coding method.

The dummy variable which is omitted is called the reference category and this is the category against which other dummy variables are compared. The reference category is also called an aliasing variable. The choice of the dummy code was arbitrary.

The rationale for doing dummy coding is that most categorical choice questions have many response categories. It is essential to determine which variable had the highest correlation with GHQ-28 psychological symptoms. The questions with more than two responses were coded through dummy coding. One GHQ-28 symptom, namely, social dysfunction was correlated with the categorical choice questions. Social dysfunction was chosen as participants reported it as their area of dysfunction.

### **3.6.5. Statistical software**

The Statistical Package for the Social Sciences (SPSS), version 18, was used to analyse the data and to give a clear understanding of what the researcher wanted to find out. SPSS is a computer software program which helped in summarising the data, compiling appropriate tables and graphs, examining the relationship among variables and to perform statistically significant tests based on the researcher's hypothesis (Babbie & Mouton, 2001).

### **3.7. The study's hypotheses**

The study hypothesises that there is a direct relationship between disclosure of homosexual identity and mental health. For some people, disclosure brings about positive mental health and to some people it brings about negative mental health. This hypothesis was tested through the use of the General Health Questionnaire-28. Another study hypothesis was that homosexuals experience challenges during the process of 'coming out'. This was tested through the inclusion of leading questions in the self-designed categorical choice questionnaire. The following are the main study's hypotheses.

- a) Homosexuals belonging in social organisations are more mentally healthy than heterosexuals.
- b) Homosexual identity formation progresses through a series of stages.
- c) LGTBI social organisations bring about positive mental health to homosexuals.

### **3.8. Ethical considerations**

After ethical approval was granted to the researcher by the Ethics Committee of the University of KwaZulu-Natal, the researcher started collecting data from the participants. Before the participants decided to partake in the study, the study's purpose was fully explained to them. The participants were informed about the storing, analysis and publication of the study.

After the participants agreed to participate, they signed an informed consent form as evidence that they were not forced and that they had agreed to participate. The informed consent form stated that the participants were free to withdraw at any point and that there would be no negative consequences for those who withdrew.

The participants were informed that their identity would be kept confidential. Confidentiality implies that the dignity of the participants was respected. Therefore, it was important for the participants not to provide any identifying information. The participants were informed that their confidential information would only be accessed by two people, namely, the researcher and the supervisor of the project. The informed consent form was not attached to the completed questionnaire to ensure confidentiality.

The researcher informed the participants that there would be no direct benefit from participation in the study, but that they would have full access to the research findings. After the completion of data analysis, feedback would be presented as a seminar to the participants via the two gay and lesbian organisations as a form of ethical obligation for the researcher.

The researcher noted that it was possible for participants to experience emotional problems especially if they were talking about painful experiences of disclosure. To minimize this risk, the University of KwaZulu-Natal (UKZN) Child and Family Centre agreed to assist any respondent from the Pietermaritzburg sample who became distressed as a result of participating in this study. The UKZN Student and Counselling Centre agreed to see participants from the pilot study in case they experienced any emotional issues as a result of participating in this study. The UKZN Centre for Applied Psychology agreed to see the participants from the Durban sample. None of the participants from the current study have actually made use of these facilities.

### **3.9. Feedback session to participants**

It was indicated on the participants' informed consent forms that the participants of the current study would be given feedback about the study's findings. After the data was analysed, the researcher contacted participants from the LGTBI social networks for a feedback session on the study's findings. Unfortunately, the researcher was unable to get hold of all the participants for the feedback session. Feedback outcomes and findings are further discussed in Chapter 5 of the current study.

### **3.10. Challenges and opportunities during data collection**

Even though it was social organisations linking participants in the study, it was still difficult for participants to agree to participate. Another hindrance for participation was that the researcher did not budget to provide transport for the participants. Some participants wanted to come and participate but because of transport issues they could not be present.

Data collection was challenging but it was a success. Most of the participants who agreed to participate were able to answer the questions without experiencing problems. For those who encountered problems, the researcher was available to immediately help them.

Initially, the researcher aimed to have an equal number of females and males from the two social organisations. However, due to the limited number of participants, the researcher was forced to link with another social organisation and to have 27 males and 23 females participate in the study.



## CHAPTER 4: RESULTS

### 4.1. Introduction

This chapter is the results of the data analysis. It starts off with the analysis of the GHQ-28 and then follows with the analysis of the categorical choice questionnaire. The data are analysed with descriptive statistics, inferential statistics and content analysis. Inferential statistics used include chi-square, multivariate Hotellings t-Test and discriminant analysis. It is important to consider that the current study used large numbers of statistical tests which suggests the possibility of some results being significant by chance.

### 4.2. Descriptive analysis of GHQ-28 of the homosexual sample

Fifty participants had a homosexual sexual orientation and answered both the GHQ-28 and the categorical choice questionnaire. The other fifty participants had a heterosexual sexual orientation and they only answered the GHQ-28. The reason for using both the homosexual and heterosexual samples was to compare the distribution of scores between the samples. In each subscale of the GHQ-28, a score of seven or higher was considered as evidence of a particular psychological symptom (Goldberg, 1972).

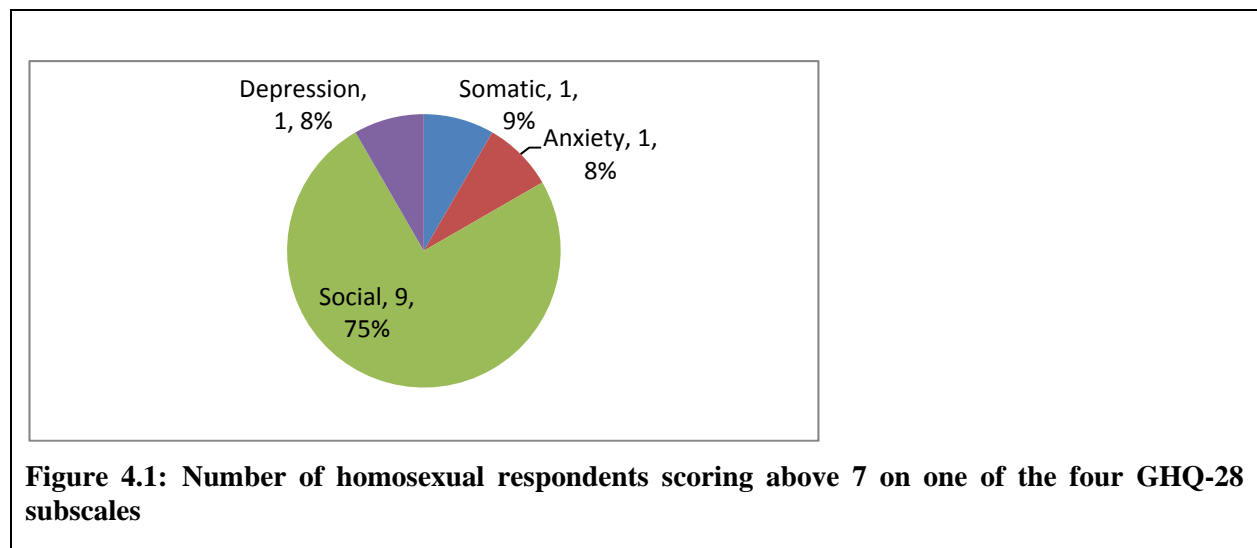
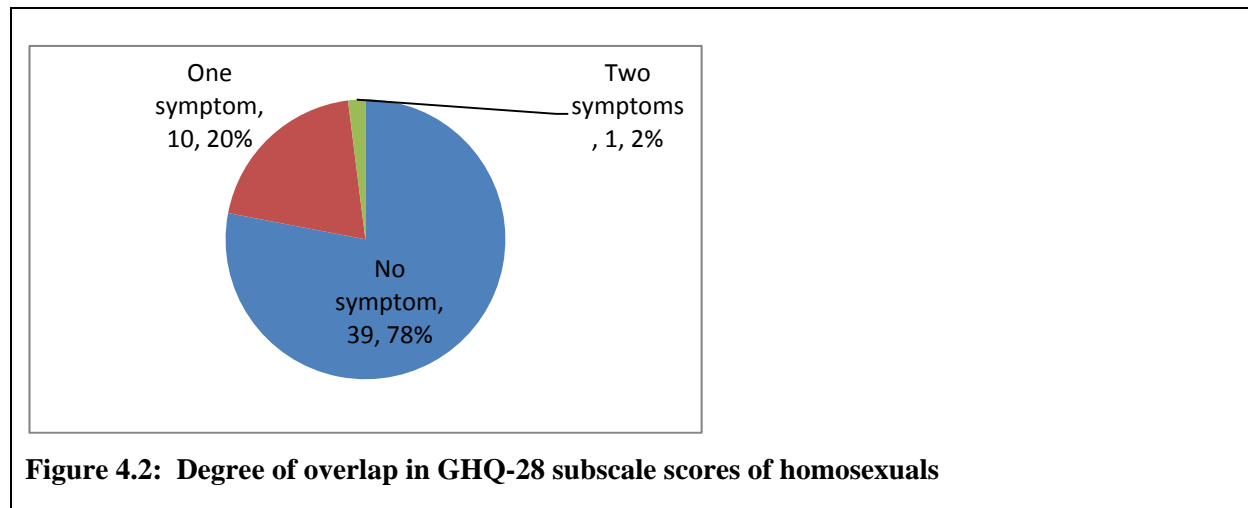
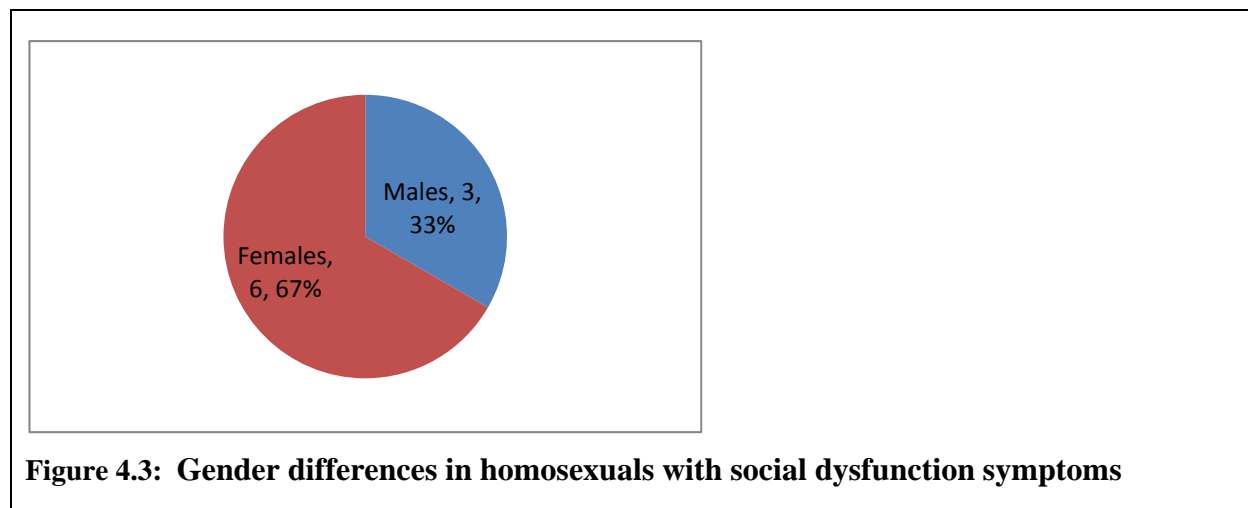


Figure 4.1 represents the GHQ-28 scores of the subscales for the homosexual sample. It shows that out of fifty participants, nine participants have social dysfunction symptoms. Three participants have one symptom in somatic symptoms, anxiety symptoms and depression. It is important to observe that social dysfunction is the predominant symptom among the GHQ-28

subscales. The pie chart in Figure 4.1 reads as if a total of 12 participants have GHQ-28 psychological symptoms. This is misleading as one participant presented with both social dysfunction and depression at the same time. Only 11 homosexual participants present with GHQ-28 psychological symptoms.



The pie chart in Figure 4.2 represents the degree of overlap within the GHQ-28 symptoms. It further indicates that 39 participants do not have any of the GHQ-28 symptoms, 10 participants have only one of the GHQ-28 symptom and 1 participant has two GHQ-28 symptoms at the same time.



Social dysfunction is the most dominant symptom of the homosexual sample among the GHQ-28 subscales. This indicates that the analysis of GHQ-28 showed focus on it. Figure 4.3 indicates that there are gender differences in homosexuals with social dysfunction symptoms. 67% of

males and 33% of males have social dysfunction. This further suggests that female homosexuals are more likely than male homosexuals to have social dysfunction. It is important to note that this difference may be the result of sampling error.

**Table 4.1: Measures of central tendency and measures of spread for the GHQ-28 overall scores of the homosexual sample**

N	Valid	50
	Missing	0
Mean		9.4200
Median		10.0000
Mode		16.00
Std. Deviation		6.14149
Variance		37.718
Skewness		.059
Std. Error of Skewness		.337
Kurtosis		-.912
Std. Error of Kurtosis		.662
Range		22.00
Lowest score		0
Sum		471.00
Percentiles	25	4.0000
	50	10.0000
	75	14.0000

Table 4.1 indicates that in the homosexual sample the lowest overall score is 0 and the maximum score is 22. The maximum value of 22 is a very low score when comparing it with Goldberg's (1972) statement which indicates that scores for each subscale range between 0 and 21 points. According to Goldberg (1972), the overall severity ranges from 0 to 84. When comparing the maximum value of the homosexual sample with Goldberg's (1972) overall severity range, the difference is 62.

The mean of the population equals to the value of 9.42. The middle value of the distribution which is the median equals to the value of 10, and the most occurring score which is the mode equals to the value of 16. The range, which is the difference between the highest and lowest score equals to the value of 22, with the interquartile range of 10. The third quartile is 14 and the

first quartile is 4. The variance value, which is the amount of spread of the data values around the mean value for the population is 37.7.

The mean and the median have nearly equal scores which suggests that the distribution is symmetrical. The mean score is lower than both the median and the mode of the graph. These results suggest that there is a moderate variation in the psychological health of the homosexual participants, with a standard deviation of 6.1 and with a range of 22.

#### 4.2.1. Total GHQ-28 scores for the homosexual sample

The frequency distribution curve in Figure 4.4 shows that the total GHQ-28 scores of the homosexual participants is positively skewed. The negative value of the kurtosis indicates that the distribution is platykurtic. This further means that the graph is abnormally flat.

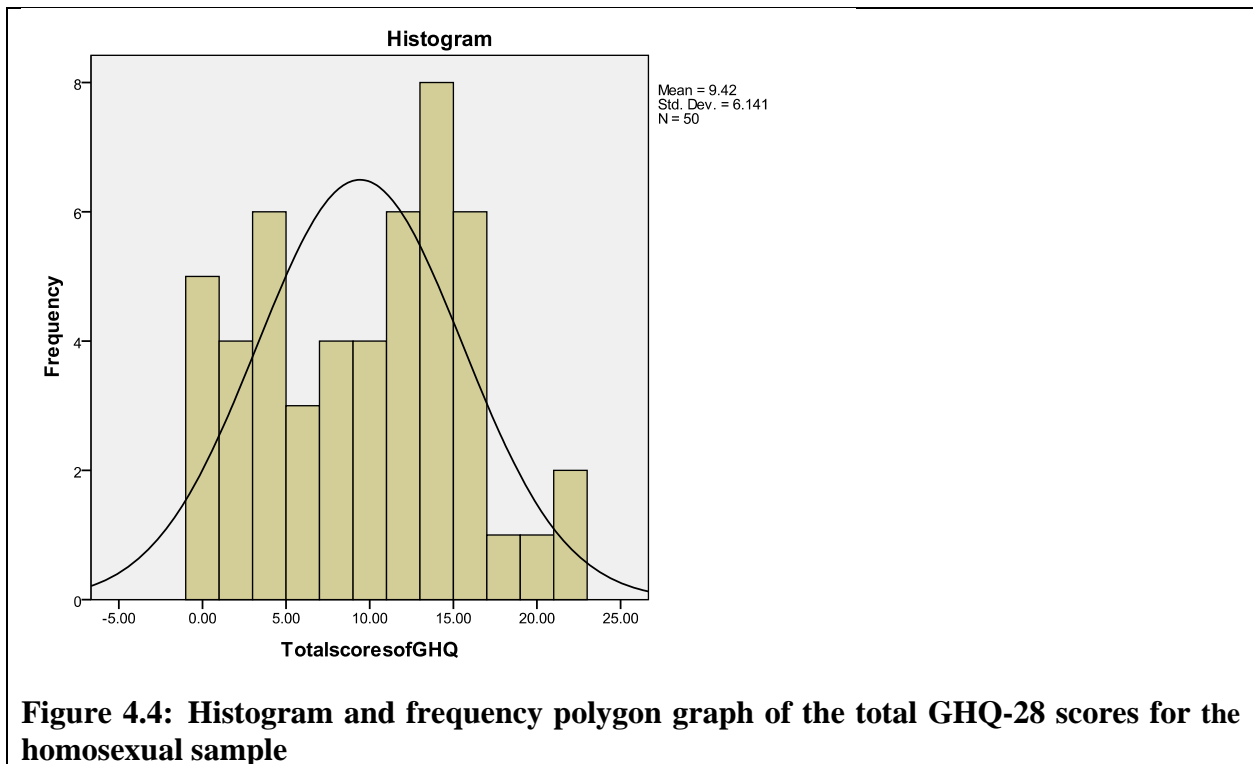
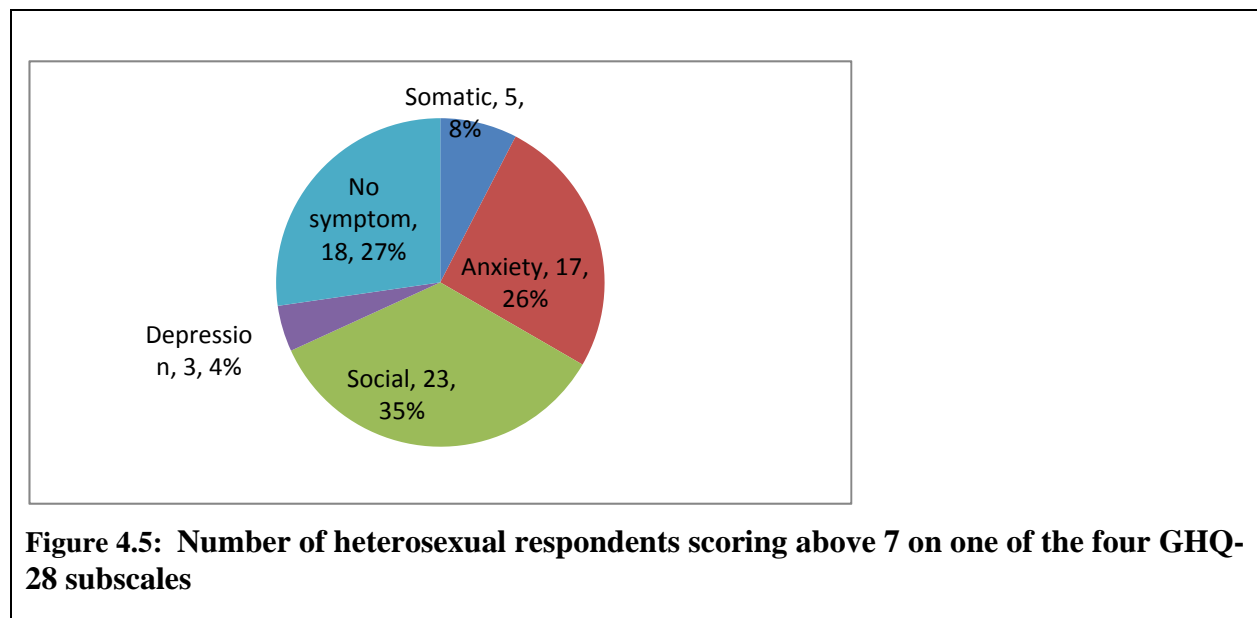


Figure 4.4 indicates that the distribution is bimodal. The two peaks of the graph are of different heights and widths. The first peak is low and wider than the second peak. The graph suggests that two groups exist within the homosexual sample. There is also a larger group which does not present with any of the GHQ-28 symptoms. The larger group has GHQ-28 subscale scores which

are between 0 and 6, and the smaller group has GHQ-28 subscale scores which are between 10 and 15.

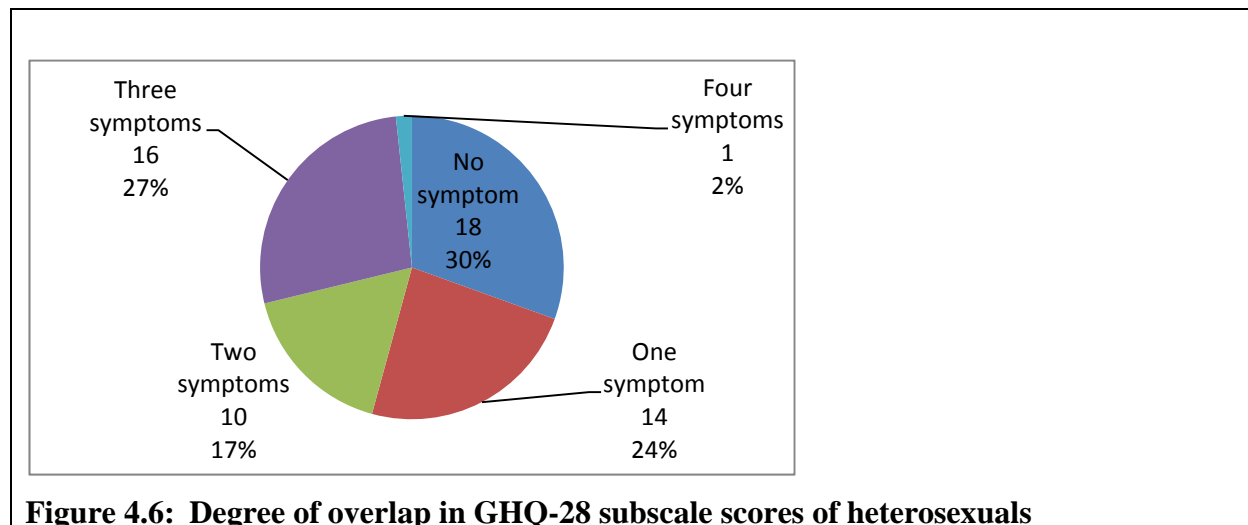
### 4.3. Descriptive analysis of GHQ-28 of the heterosexual sample

The following is a representation of the GHQ-28 subscales scores for the heterosexual sample. It indicates that out of 50 participants, 18 participants did not present with any of the psychological symptoms, 5 participants had somatic symptoms, 17 participants had anxiety symptoms, 3 participants had depression symptoms and 23 participants had social dysfunction symptoms. However, this information is misleading because it reads as if 66 heterosexuals participated on the study. It is due that some of the participants presented with more than one GHQ-28 symptoms. These GHQ-28 results for the heterosexual sample will be compared with the results of the GHQ-28 of the homosexual sample.



In the heterosexual sample there are many more participants who present with GHQ-28 symptoms than participants in the homosexual sample. The social dysfunction symptom is still the predominant symptom as it was in the homosexual sample. In the heterosexual sample the anxiety symptom is the second most dominant symptom which is not the same as the homosexual sample. In the homosexual sample there were GHQ-28 subscales which had an equal number of participants who had anxiety, depression and somatic symptoms. Only 18

participants in the heterosexual sample reported as not having GHQ-28 symptoms. This is different from the participants in the homosexual sample because 39 participants reported as not having GHQ-28 symptoms.



**Figure 4.6: Degree of overlap in GHQ-28 subscale scores of heterosexuals**

The pie chart in Figure 4.6 indicates that 30% of the heterosexual participants do not have GHQ-28 psychological symptoms. Goldberg and Williams (1988) indicated that there is inter-relatedness among the subscales of the GHQ-28. In the current study this claim is confirmed by participants of the heterosexual population. Only 24% of heterosexual participants present with one psychological symptom, 17% of heterosexual participants presented with two symptoms simultaneously, 27% of the population presented with three symptoms and 2% presented with four symptoms simultaneously.

The comorbidity within the GHQ-28 symptoms is not shown by the homosexual population because only one respondent had social dysfunction and depression symptoms simultaneously. None of the participants from the homosexual population presented with more than two symptoms of the GHQ-28. The homosexual sample is clearly different from the heterosexual sample. For example, among the heterosexual sample there is one respondent who presents with all four GHQ-28 symptoms.

**Table 4.2: Measures of central tendency and spread of the GHQ-28 overall scores for the heterosexual sample**

Valid	50
Mean	17.4000
Median	16.5000
Mode	9.00 <sup>a</sup>
Std. Deviation	9.00793
Variance	81.143
Skewness	.563
Std. Error of Skewness	.337
Kurtosis	-.042
Std. Error of Kurtosis	.662
Range	39.00
Minimum	3.00
Maximum	42.00
Sum	870.00
Percentiles	
25	10.0000
50	16.5000
75	23.2500

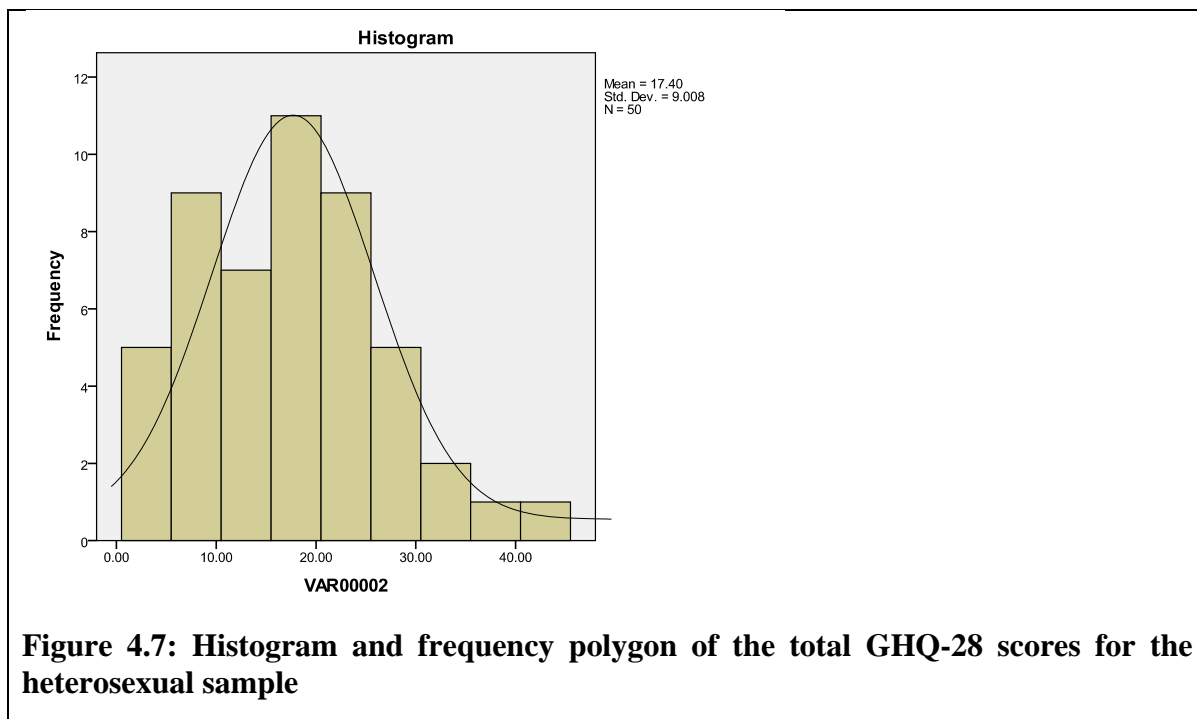
These statistics are similar to the homosexual population since the mean and the median for heterosexuals have similarities which also suggest a symmetrical distribution. However, the mean for the heterosexual population is much higher than the mean for the homosexual population. The distribution of the heterosexual sample is shifted to the right compared to the distribution of the homosexual sample.

The maximum value for the heterosexual sample is much higher than the maximum value of the homosexual sample. The difference between the maximum value of the heterosexual sample and the maximum value of the homosexual sample is 18. When comparing the maximum value of the heterosexual sample with Goldberg's (1972) overall severity range, the difference is 44. The overall difference from Goldberg's sample is much lower than that of the overall difference from the homosexual sample. The range of the heterosexual sample is greater than the range of the

homosexual sample. This suggests that in the heterosexual sample, many participants have higher subscale scores of the GHQ-28 than the participants from the homosexual sample.

#### 4.3.1. Total GHQ-28 scores for the heterosexual sample

The frequency distribution curve in Figure 4.7 shows that the total GHQ-28 scores for the heterosexual population is positively skewed. This is further suggested by the distribution which is skewed to the right. The kurtosis of the heterosexual sample has a negative value just like the kurtosis of the homosexual sample which indicates that the distribution is flat. The skewedness of the distribution and the negative value of the kurtosis in the heterosexual population suggest that similarities exist in both the homosexual and heterosexual populations. That is, both distributions are bimodal and that there are two groups of respondents in both of the samples. The histogram graphs for the homosexual and heterosexual samples are both platykurtic. Even though there are similarities between the samples, it is important to note that the kurtosis for the homosexual sample is larger than the kurtosis of the heterosexual population. This suggests that the distribution for the heterosexual population is not as flat as the distribution for the homosexual population.



**Figure 4.7: Histogram and frequency polygon of the total GHQ-28 scores for the heterosexual sample**



The standard deviation and skewedness of the histogram graph for the heterosexual sample are larger than those of the homosexual sample, as shown in Figure 4.4 and Figure 4.7. This suggests that there is a big spread of high scores in the heterosexual population. The two peaks of the heterosexual sample are close to one another. This is different from the homosexual sample as there was a large difference between the two peaks for the homosexual sample. The two peaks in the heterosexual sample also suggest that there is a small group of participants who do not have psychological symptoms and a large group who do have psychological symptoms. This is different from the homosexual sample as the large group was the one without psychological symptoms and the small group was the one which presented with psychological symptoms.

#### 4.4. Multivariate Hottellings t-Test

The multivariate method was used because it studies several variables at a time and it considers their joint distributions and relationships. Table 4.3 displays the statistical properties of the GHQ-28 subscales for the homosexual and heterosexual samples. The GHQ-28 subscales of the two samples will be compared with one another.

	<b>Variable or GHQ-28 symptoms</b>	<b>Mean</b>	<b>Std Dev.</b>	<b>Std Err</b>	<b>Lower 95%</b>	<b>Upper 95%</b>	<b>N</b>
<b>Homosexual Population</b>	Somatic symptoms	2.000	1.874	0.265	1.468	2.532	50
	Anxiety	2.340	2.255	0.319	1.699	2.981	50
	Social Dysfunction	3.520	2.549	0.361	2.795	4.245	50
	Depression	1.560	1.842	0.261	1.036	2.084	50
<b>Heterosexual Population</b>	Somatic symptoms	4.500	3.518	0.498	3.500	5.500	50
	Anxiety	4.880	3.805	0.538	3.799	5.961	50
	Social Dysfunction	6.060	2.951	0.417	5.221	6.899	50
	Depression	1.700	2.426	0.343	1.010	2.390	50

The difference between the mean scores of all GHQ-28 subscales for both samples is not less than 2.540. All subscales of the GHQ-28 for the heterosexual sample are higher than the

subscales of the homosexual sample. Table 4.4. indicates that the difference between the somatic, anxiety and social dysfunction subscales are much greater than the depression subscale. This suggests that both samples experience depression at slightly lower levels, with the heterosexual sample experiencing it more than the homosexual sample. Generally the heterosexual sample showed more symptoms than the homosexual sample in every category. It is important to note that the meaning of the difference between subscales of the GHQ-28 is difficult to interpret as it is determined by the sample.

<b>Table 4.4: Two-tailed Hottelling's t-Test of the GHQ-28 for the homosexual and heterosexual samples</b>								
<b>Contrast</b>	<b>Ho. Diff</b>	<b>Actual Diff</b>	<b>SE Diff</b>	<b>T2</b>	<b>DF for T<sup>2</sup></b>	<b>F</b>	<b>DF for F</b>	<b>P for F</b>
<b>Somatic Sy</b>	0.000	-2.500	0.080	38.601	4.98	9.355	4.95	0.000
<b>Anxiety</b>	0.000	-2.540	0.088					
<b>Social Dys</b>	0.000	-2.540	0.078					
<b>Depression</b>	0.000	-0.140	0.061					

According to Howell (1995), a two-tailed or non-directional test is the test that rejects extreme outcomes in either tail of the distribution. The null hypothesis suggests that there are no differences between the GHQ-28 subscales in both samples. The probability value is less than 0.0001. This suggests that the null hypothesis is rejected because differences exist between the samples. The F value which indicates the effect or the difference between the mean of the population is 9.355. Since the probability value is less than 0.05, it means that the F value is significant.

Therefore, it is concluded that the homosexual and heterosexual samples do differ significantly in their mental health status as measured by the GHQ-28, with the homosexual sample having fewer mental health symptoms than the heterosexual sample.

#### **4.5. Discriminant analysis**

Discriminant analysis was used to discriminate homosexual participants who had GHQ-28 subscale scores above seven from those who had total subscale scores less than seven. The GHQ-28 subscale total symptoms were grouped according to the cut-off point of seven, to indicate the presence of psychological problems. The social dysfunction subscale was the dominant GHQ-28 subscale, which means that it had the highest number of the participants who presented with it. Therefore it was used with the scaled categorical choice questionnaire in the discriminant analysis. The respondents were coded with zero if they did not have a social dysfunction score above seven and coded with one if they had a social dysfunction score of above seven. Discriminant analysis was therefore done to discriminate participants who had social dysfunction from those who did not.

##### **4.5.1. Dummy codes**

Categorical variables could not be directly entered into the discriminant analysis as predictors. These variables have to be coded before they can be used. Therefore dummy coding was used in the discriminant analysis for categories in the categorical choice questionnaire in the same way as dummy coding is used in multiple regression (Howell, 1995). Categories were firstly individually analysed before they were grouped together. The intention for first entering one question at a time was to locate questions which were not significant as early as possible. Out of ten different categorical choice questionnaires that were first individually entered, question four, six, seven, eight, nine and ten were the only significant questions. These six questions were then correlated as a group with the GHQ-28 social dysfunction subscale.

One variable for each categorical choice question was considered as the dummy reference code (see Appendix J). In the first question of the categorical choice questionnaire, the reference category was 'disclosure to everyone'. No dummy reference code was assigned for question two of the categorical choice questionnaire because after scaling the responses, the question ended up with only two variables. A similar dummy reference code was assigned for question three, four, five, seven, eight, nine and ten of the categorical choice questionnaire, which is 'none of the above responses'. The reference dummy code for question five was 'other response than the above mentioned'.

#### 4.5.2. Summary of canonical discriminant functions

Only one discriminant function was provided because the dependent variable, that is the social dysfunction subscale, only had two categories. Tables 4.5 and 4.6 provide information about the discriminant function.

**Table 4.5: Eigen values**

Function	Eigen value	% of Variance	Cumulative %	Canonical Correlation
1	5.180 <sup>a</sup>	100.0	100.0	.916

a. First 1 canonical discriminant functions were used in the analysis

**Table 4.6: Wilks' Lambda**

Test of Function(s)	Wilks' Lambda	Chi-square	df	Sig.
1	.162	62.834	27	.000

The above two tables (Table 4.5 and Table 4.6) suggest that the overall discriminant function model is statistically significant with a p value of 0.0001 (which is a significant value in Table 4.6) and with a canonical correlation value of 0.916. The canonical correlation gives the overall strength of the association between all the variables in the model and the presence or absence of social dysfunction. This suggests that there is an association between social dysfunction and the variables of the categorical choice questionnaire.

#### 4.5.3. Classification results

Table 4.7 predicts that out of 39 participants who recorded responses as without GHQ-28 psychological symptoms two of them were incorrectly classified by the discriminant function as having psychological symptoms. They were participant number six and participant number thirteen. Both participants had a slightly elevated score in the social dysfunction symptom, with a maximum value of 6.

**Table 4.7: Predicted group membership**

GHQ-28		Predicted Group Membership		Total
		None	Social dysfunction	
Original Count	None	39	2	41
	Social dysfunction	0	9	9
%	None	95.1	4.9	100.0
	Social dysfunction	.0	100.0	100.0

a. 96.0% of original grouped cases correctly classified

The following table, Table 4.8, provides significant discriminant variables for the homosexual sample with social dysfunction. In this table the researcher included items with statistical significance only, the whole table with both significant and insignificant items is included in Appendix I. ‘Q’ refers to the question numbers in the categorical choice questionnaire.

**Table 4.8: Significant discriminant variables of homosexuals with social dysfunction**

Questions	Wilks' Lambda	F	df1	df2	Sig.
Q4. Rejection	.905	5.016	1	48	.030
Q6. Pressure from others	.907	4.920	1	48	.031
Q8. Anxious	.932	3.517	1	48	.067

Table 4.8 suggests that rejection by family members and friends and being pressured to disclose sexual orientation significantly discriminate homosexuals with social dysfunction. The process of homosexual identity formation which is perceived as anxious (Q8. Anxious) is a borderline or nearly significant ( $p=0.067$ ) discriminator of homosexuals with social dysfunction. This suggests that the category of perceiving homosexual identity formation as anxious is approaching significance. This indicates that it might have been significant if the homosexual sample size had been bigger than 50.

#### 4.5.4. Discriminant function coefficients

Since there are only two categories being discriminated, only one discriminant function is generated. These coefficients can be standardised with a zero mean and standard deviation of one, or given in the original units in which they were measured. Since all the coefficients are measured in the same units when they are standardised, the standardised coefficients can be used to determine the relative size of the different variables. The unstandardised coefficients must be used when using a discriminant function to predict social dysfunction in a new group of people. The standardised coefficients for this function are shown in Table 4.9 below.

##### 4.5.4.1. Standardized coefficients for the homosexual population

The researcher decided to use standardised coefficients because they are comparable across the whole population. They are also used to judge the relative level of importance among the studied variables. The next table, Table 4.9, suggests that the gender of the homosexual participants is not important when disclosing homosexual orientation. This further suggests that gender is not a predictor of social dysfunction symptoms among homosexual individuals. Variables with discriminant coefficient were only included. This means the variables, namely, rejection, rape, education, context and STIs are associated with social dysfunction of the participants. ‘Q’ stands for question numbers in the categorical choice questionnaire.

	Function 1
Gender	-.170
Q4. Rejection	.275
Q4. Rape	.323
Q6. Education	-.327
Q7. Context	-.444
Q10. STIs	-.251

Experiencing rejection by family and friends is an important predictor of social dysfunction for homosexual participants. Being raped is an important discriminator between homosexuals with social dysfunction and homosexuals without social dysfunction symptoms. This suggests that the experience of rape is a predictor of social dysfunction.

Having prior awareness and education about homosexuality is considered as most important in facilitating the process of disclosure. This suggests that when a homosexual individual has prior knowledge and education about homosexuality, that individual is less likely to have social dysfunction. On the other hand, homosexuals without education about homosexuality are more likely to experience social dysfunction.

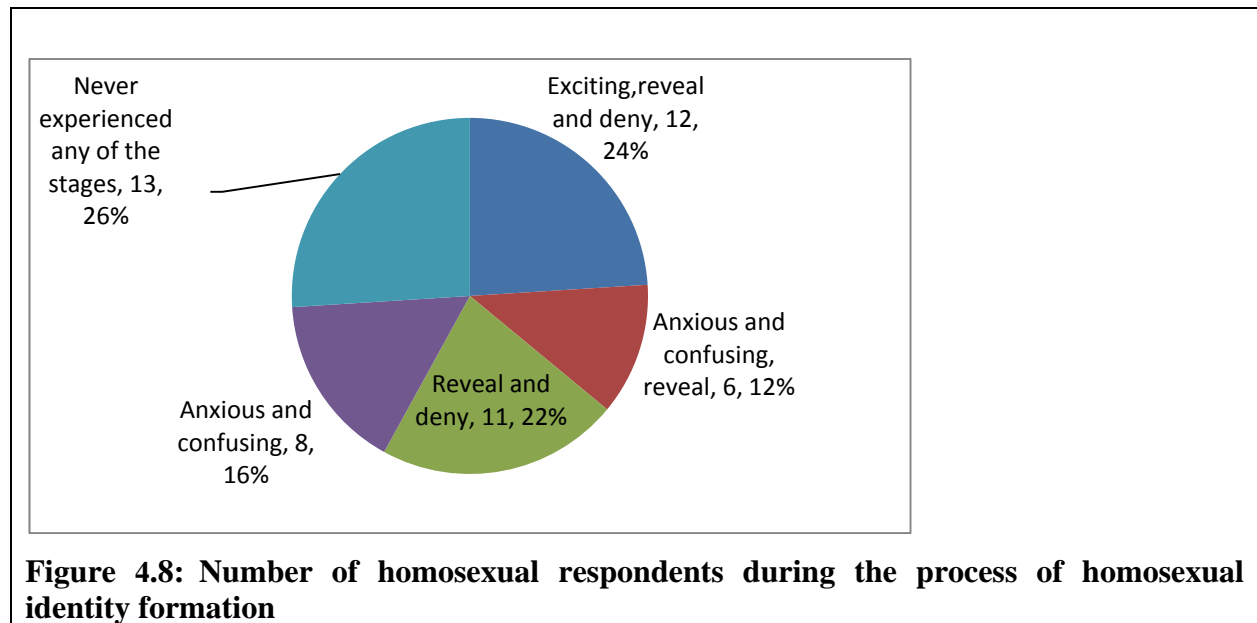
The social context is important for homosexual individuals when meeting sexual partners. This suggests that it is easy for most homosexuals to meet sexual partners in social contexts that accept homosexuality, such as social networks for homosexuals. This has the largest discriminant coefficient and can be considered the single most important discriminator. It is important to note that in social contexts that approve of homosexuality, there are fewer sexual partners for homosexual individuals to choose from. It is different from meeting sexual partners in a broader range and when not considering the approval of the social context.

Homosexual individuals who are aware and have come out to others regarding having sexually transmitted infections are less likely to experience social dysfunction. Homosexual individuals who have been suspected of having STIs and who never disclose to anyone are more likely to experience social dysfunction.

#### **4.6. Descriptive analysis of the categorical choice questionnaire and homosexual identity formation**

In Chapter 2 of the study reference was made to theorists of homosexual identity formation who suggest that during the process of identity formation, homosexual individuals progress from one stage to another. Among the theorists of homosexual identity formation, Cass's stage model (1979) was used in the current study to assess how participants progress, their experiences, their behaviour and their reactions during the process of identity formation. Cass's stage model was used in question nine of the self-designed categorical choice questionnaire of the current study. This indicated categorical responses similar to Cass's stage model. From these responses the researcher can assign participants to different stages of identity formation. In the current study homosexual individuals were found to be at two different stages at the same time. The following bar graph (Figure 4.8) depicts how homosexuals experience and react during the stages of identity formation. Figure 4.8 indicates that the findings of the current study are in line with

Cass's stage model of identity formation. The homosexual sample of 37 have experienced some of Cass's stages. It is important to note that 13 of the homosexual participants never experienced any of Cass's stages. This suggests that models of homosexual identity formation might not be applicable to some homosexual people.



#### 4.7. Chi-square and cross-tab statistics for the categorical choice questionnaire for the homosexual sample

The chi-square analysis method can be used to allow the researcher to make fewer assumptions about the population. It is used to compare the observed and expected frequencies of all variables in the population and to compare this to the gender of the participants. The main use for chi-square analysis is to determine the statistical significance of associations between variables through the use of cross tabulation (contingency tables). The chi-square test was used to analyse data from ten categorical choice questions. Some of the responses were grouped per category due to the participants being allowed to choose more than one response per question. The categories were compared with gender of the participants to show some degree of association. The following tables will only show the three variables that were found to be significant. The significant variables were level of disclosure, discovering sexual orientation and meeting sexual partners. The other six non-significant chi-square tables are attached in Appendix G. The analysis of chi-square tabulations will focus on the Fisher's Exact Test and the Pearson Chi-



Square test. The Fisher's Exact Test is included in the analysis because it is a good analysis measure for two by two tables.

**Table 4.10: Chi-square tests for the categorical choice questionnaire of the homosexual sample**

Questions	Chi-square	Df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)	Cramer's V (Approx. Sig.)
<b>Level of disclosure</b>	3.760 <sup>a</sup>	1	.053	.077	.049	.053
<b>Discovering sexual orientation</b>	5.346 <sup>a</sup>	1	.021	.044	.023	.021
<b>Meeting sexual partners</b>	3.945 <sup>a</sup>	1	.047	.088	.044	.047

#### **4.7.1. Level of disclosure for homosexual sample**

This question was asking the homosexual participants about their level of disclosure. They were asked to state whether they have disclosed their sexual identity to themselves only, to their friends and families and to other homosexuals. The above table, Table 4.10, indicates that the Pearson Chi-square Test p-value is 0.053 which is borderline significant since it is just above the cut-off limit. The likelihood ratio falls below the cut-off level, and is significant. Fisher's Exact Test has a p-value of 0.049. Therefore there is a statistical significance association between the disclosure of homosexual orientation and the gender of the participants. This means that the null hypothesis is rejected.

**Table 4.11: Level of disclosure cross-tabulation for the homosexual sample**

			Level of disclosure		Total
			Self and other homosexuals	Everyone	
Gender Male	Count	13	14	27	
	Expected Count	9.7	17.3	27.0	
	Std. Residual	1.1	-.8		
	Adjusted Residual	1.9	-1.9		
Female	Count	5	18	23	
	Expected Count	8.3	14.7	23.0	
	Std. Residual	-1.1	.9		
	Adjusted Residual	-1.9	1.9		
Total	Count	18	32	50	
	Expected Count	18.0	32.0	50.0	

The above cross-tabulation table for the level of disclosure suggests that 48.1% of males and 21.7% of female homosexuals have disclosed only to themselves and to other homosexual individuals. However, 51% of males and 78% of female homosexuals have disclosed their sexual orientation to everyone. This simply suggests that it is easier for female homosexuals than for male homosexuals to disclose sexual orientation to everyone. Male homosexuals seem to disclose their sexual orientation more to themselves and to other homosexual individuals, than do female homosexuals.

#### **4.7.2. Discovering sexual orientation for homosexual sample**

The participants were asked about ways that they discovered their sexual orientation. They chose from having sexual reactions and feelings toward same sex people, through observing and imitating other homosexuals and through reading on homosexuality.

Table 4.10 indicates that the Pearson Chi-square p-value is 0.021 and the Fisher's Exact Test value is 0.023. These statistics suggest that the null hypothesis is rejected. There is a statistically

significant association between discovering homosexual orientation and the gender of the participants.

**Table 4.12: Cross-tabulation for discovering sexual orientation for the homosexual sample**

			Discovering sexual orientation		Total
			Reactions and feelings	Books, articles and through observing others	
Sex	Male	Count	24	3	27
		Expected Count	20.5	6.5	27.0
		Adjusted Residual	2.3	-2.3	
	Female	Count	14	9	23
		Expected Count	17.5	5.5	23.0
		Adjusted Residual	-2.3	2.3	
Total		Count	38	12	50
		Expected Count	38.0	12.0	50.0

Table 4.12 suggests that 88% of male homosexuals and 60.1 % of female homosexuals discovered their sexual orientation through reactions and feelings towards same sex people. It further indicates that 22% are males and 39% are females discovered their sexual orientation through reading books and articles.

Table 4.12 generally indicates that most homosexual participants of the current study discovered their sexual orientation through reactions and feelings that they had for people of the same sex. This further suggests that male homosexuals discovered sexual orientation through feelings and reaction more than female homosexuals. More female homosexuals discovered their sexual orientation through reading books, articles and through observation of other homosexuals.

### 4.7.3. Meeting sexual partners for the homosexual sample

The participants were asked about their ways of meeting sexual partners. They were choosing from responses such as through observing the other partner’s behaviour, approaching partners only in social contexts that approve homosexuality or through approaching anyone without considering whether the social context approves homosexuality.

Table 4.10 indicates that there is significant association between gender of the participants and the methods that homosexuals use to meet sexual partners, with a p value of 0.047. Table 4.13 suggests that 62.9% of male participants and 34.7% of female participants reported meeting sexual partners through observing the behaviour of the partner and in social contexts that are homosexually appropriate. 37% of male participants and 65% of female participants indicated that they meet sexual partners through approaching anyone they come across as attractive.

**Table 4.13: Chi-square Tests for meeting sexual partners for the homosexual sample**

			Meeting sexual partners		Total
			Behaviour and context	Approach	
Sex	Males	Count	17	10	27
		Expected Count	13.5	13.5	27.0
	Adjusted Residual	2.0	-2.0		
	Females	Count	8	15	23
		Expected Count	11.5	11.5	23.0
		Adjusted Residual	-2.0	2.0	
Total		Count	25	25	50
		Expected Count	25.0	25.0	50.0

Table 4.13 further indicates gender differences among homosexuals when meeting sexual partners. Female homosexuals tend to meet sexual partners by approaching a potential partner at any place without considering if the social context accepts homosexuality. Male homosexuals seem to meet sexual partners by observing potential partners behaviour and considering social contexts that accepts homosexuality.

#### **4.8. Content analysis for homosexual sample**

Two coders independently coded open-ended responses to the leading questions for the categorical choice questionnaire. Both coders coded data through using emergent coding which was explained in Chapter 3 of this study. Cohen's Kappa statistic was used to calculate the reliability and to measure the agreement of coding between the two coders. Data was coded from question two to question ten of the categorical choice leading questions. It is important to note that there was no leading response for question one and it was not coded. This is because all the homosexual participants of the current study had disclosed their sexual orientation to someone else rather than having not disclosed their sexual orientation. The researcher ended up with nine leading questions to be coded.

##### **4.8.1. Reliability and validity between the coders**

A Cohen's Kappa value of 0.75 was found which suggested that the coding between the two coders was substantially reliable. This suggests that there was a statistically significant association between the two independent coders who coded the leading questions for the categorical choice questionnaire. The content analysis tables that calculated the reliability between the coders through the Cohen's Kappa and Chi-square tests are attached in Appendix F.

##### **4.8.2. Themes and phrases of content analysis**

The coders agreed to separate the participants' statements into three categories, namely, self, other and missing data. The 'self' category included direct statements which were recorded by the homosexual participants as their own. The 'other' category included statements which were recorded by the participants as said by other people to them regarding their homosexual orientation. The 'missing data' category represented the number of participants who did not answer the leading questions of the categorical choice questionnaire. A chi-square test was done on each of the nine coded questions. Three questions were significant, namely, question 4, 5 and 10. The other seven questions were not significant. The researcher is only presenting questions which were significant. The insignificant questions are attached in Appendix G. The next table, Table 4.14, depicts significant themes and phrases of content analysis for the homosexual sample.

**Table 4.14: Themes and phrases of content analysis for the homosexual sample**

Questions	Chi-square	Df	Asymp. Sig. (2-sided)	Cramer's V (Approx. Sig.)	Likelihood Ratio
<b>Q.4. Experiences</b>	9.940 <sup>a</sup>	2	.007	.007	.006
<b>Q.5. Self-view</b>	24.275 <sup>a</sup>	2	.000	.000	.000
<b>Q.10. Suspicions from others</b>	9.846 <sup>a</sup>	2	.007	.007	.005

#### 4.8.2.1. Experiences for homosexuals

The participants were asked about their experiences due to their sexual orientation. They were noting experiences such as being raped, physical and sexual abuse and experiencing rejection as a result of having a homosexual orientation. In Table 4.14 the probability value of 0.007 suggest that the null hypothesis is rejected. There is statistically significant association between the gender of participants and their experiences. The following table, Table 4.15, the 'self' category contains participants who have been accepted by communities regardless of their homosexual sexual orientation. The 'other' category contains homosexual participants who have experienced rejection, physical assault, psychological violence and sexual abuse because of their sexual orientation.

**Table 4.15: Cross-tabulation for experiences**

			Experiences			Total
			Self	Other	Missing	
Gender Male	Count	5	8	14	27	
	Expected Count	10.3	5.4	11.3	27.0	
	Residual	-5.3	2.6	2.7		
	Std. Residual	-1.6	1.1	.8		
	Adjusted Residual	-3.1	1.8	1.5		
Female	Count	14	2	7	23	
	Expected Count	8.7	4.6	9.7	23.0	
	Residual	5.3	-2.6	-2.7		
	Std. Residual	1.8	-1.2	-.9		
	Adjusted Residual	3.1	-1.8	-1.5		
Total	Count	19	10	21	50	
	Expected Count	19.0	10.0	21.0	50.0	

There were more females than males who had been accepted by others because of their sexual orientation. 18% of males and 61% of females had been accepted by others regardless of their homosexual orientation. 30% of males and 9% of females had experienced violence by others because of their sexual orientation. 52% of males and 30% of females did not supply information. This indicates that female homosexuals are fairly well accepted by communities compared to male homosexuals who may experience homophobia.

#### 4.8.2.2. Self-view for homosexuals

The participants were asked to state the way they view themselves as homosexuals. They were stating whether they view themselves as proud or not proud. Table 4.14 indicates the probability value of 0.001 which suggests that the null hypothesis is rejected. There is a statistically significant association between the gender of the participants and the way they view themselves because of their sexual orientation. In Table 4.16, the 'self' category contains homosexual participants who viewed themselves as proud, normal, comfortable and important because of

their sexual orientation. The ‘other’ category contained homosexuals who viewed themselves as respected by others because of their sexual orientation.

**Table 4.16: Cross-tabulation for self-view for the homosexual sample**

			Self-view			Total
			Self	Other	Missing	
Gender Males	Count	19	8	0	27	
	Expected Count	10.8	13.5	2.7	27.0	
	Residual	8.2	-5.5	-2.7		
	Std. Residual	2.5	-1.5	-1.6		
	Adjusted Residual	4.7	-3.1	-2.6		
Females	Count	1	17	5	23	
	Expected Count	9.2	11.5	2.3	23.0	
	Residual	-8.2	5.5	2.7		
	Std. Residual	-2.7	1.6	1.8		
	Adjusted Residual	-4.7	3.1	2.6		
Total	Count	20	25	5	50	
	Expected Count	20.0	25.0	5.0	50.0	

Table 4.16 shows that 70.3% of males and 4.3% of females viewed themselves as proud of their sexual orientation. However, 29.6% of males and 73.9% of females viewed themselves as respected by others because of their sexual orientation. None of the males and 21.7% of females disclosed how they view themselves because of their sexual orientation. This suggests that there are more males than females who considered themselves as proud of their sexual orientation. There are more females than males who viewed themselves as respected by others.

#### 4.8.2.3. Suspicions from heterosexuals for homosexuals

The participants were asked to state suspicions that they have heard about themselves because of their homosexual orientation. They were choosing from being suspected by others or suspecting themselves of having HIV because of their sexual orientation, and being suspected of having



demons and possessed by evil spirits. Table 4.14 indicates that the probability value is 0.007 which suggest that the null hypothesis is rejected. There is a statistically significant association between the gender of participants and suspicions that they have heard about themselves because of their homosexual sexual orientation.

In the next table, Table 4.17, the ‘self’ category contains homosexuals who suspected that they have lost weight and of being HIV-positive. The ‘other’ category contains homosexuals who have been suspected by others of being HIV-positive, being demon possessed and cursed because of their sexual orientation.

**Table 4.17: Cross-tabulation for suspicions from heterosexuals for homosexuals**

			Suspicions			Total
			Self	Other	Missing	
Gender	Males	Count	2	10	15	27
		Expected Count	6.5	7.0	13.5	27.0
		Residual	-4.5	3.0	1.5	
	Females	Count	10	3	10	23
		Expected Count	5.5	6.0	11.5	23.0
		Residual	4.5	-3.0	-1.5	
Total	Count	12	13	25	50	
	Expected Count	12.0	13.0	25.0	50.0	

Table 4.17 indicates that 7.4% of males and 43.4% of females have been suspected by heterosexuals of losing weight and of being HIV-positive. 37% of males and 13% of females have been suspected by others as having HIV and being possessed by demons. This suggests that more females than males suspect themselves as HIV-positive because of their sexual orientation. There were fewer males than females who have been suspected by others as having HIV. However, more males than females have been suspected by others of being possessed by

demons because of their homosexual orientation. There are also more males than females who did not explain the suspicions they had heard about themselves because of their homosexual sexual orientation.

**4.9. Content analysis of homosexual participants with social dysfunction and homosexual participants without social dysfunction**

Among the nine homosexual participants with social dysfunction, three of them were male and six of them were female. This suggests that female homosexuals are more likely to have social dysfunction than male homosexuals. A chi-square test was conducted to analyse the leading responses of the homosexual participants with social dysfunction and the homosexuals without social dysfunction. Out of nine questions that were coded, three of them were significant. The analysis will include the questions that are significant. The insignificant questions are attached in Appendix I.

The following table, Table 4.18, only includes content analysis significant categories for homosexual participants with social dysfunction and homosexual participants without social dysfunction.

**Table 4.18: Content analysis of homosexual participants with social dysfunction and homosexual participants without social dysfunction**

Questions	Chi-square	Df	Asymp. Sig. (2-sided)	Cramer's V (Approx. Sig.)	Likelihood Ratio
<b>Discovering sexual orientation</b>	6.705 <sup>a</sup>	2	.035	.035	.040
<b>Experiences</b>	8.634 <sup>a</sup>	2	.013	.013	.003
<b>Self-view</b>	31.396 <sup>a</sup>	2	.000	.000	.000

**4.9.1. Discovering sexual orientation for homosexuals with social dysfunction and without social dysfunction**

In Table 4.18 the probability value of 0.035 suggests that the null hypothesis is rejected. There is a statistically significant association between social dysfunction and discovering sexual orientation.

Table 4.19 has a ‘self’ category that contains participants who discovered their homosexual orientation through ‘sexual feelings that they had for people of the same sex’. The ‘other’ category contains homosexual participants who discovered their sexual orientation from being ‘told by others about their sexual orientation, through experiencing sexual relations with people of the same sex and being friends with other homosexuals’.

**Table 4.19: Cross-tabulation for discovering sexual orientation for homosexuals with social dysfunction and without social dysfunction**

		Discovering sexual orientation			Total
		Self	Other	Missing	
Social dysfunction	Count	0	2	7	9
	Expected Count	3.8	1.6	3.6	9.0
	Residual	-3.8	.4	3.4	
	Std. Residual	-1.9	.3	1.8	
	Adjusted Residual	-2.8	.4	2.6	
No-social dysfunction	Count	21	7	13	41
	Expected Count	17.2	7.4	16.4	41.0
	Residual	3.8	-.4	-3.4	
	Std. Residual	.9	-.1	-.8	
	Adjusted Residual	2.8	-.4	-2.6	
Total	Count	21	9	20	50
	Expected Count	21.0	9.0	20.0	50.0

Table 4.19 indicates that 0% of homosexuals with social dysfunction and 51% of homosexuals without social dysfunction discovered their homosexual orientation through reactions and

feelings they had for same sex people. However, 22.2% of homosexuals with social dysfunction and 17% of homosexuals without social dysfunction discovered their sexual orientation through sexual experiences with people of the same sex and through being told by others about their sexual orientation.

This suggests that there are few homosexuals with social dysfunction than homosexuals without social dysfunction who discovered their sexual orientation through sexual feelings they have for same sex people. There are more homosexuals without social dysfunction than homosexuals with social dysfunction who discovered their sexual orientation through sexual experiences with people of the same sex and by being told by others about their sexual orientation. There are more homosexuals without social dysfunction than homosexuals with social dysfunction who explained the method they used when discovering their sexual orientation.

#### **4.9.2. Experiences for homosexuals with social dysfunction and without social dysfunction**

In Table 4.18 the probability value of 0.013 suggests that the null hypothesis is rejected. There is a statistically significant association between social dysfunction and experiences of homosexuals. The 'self' category contains participants who have been accepted by communities regardless of their homosexual orientation. The 'other' category contains homosexual participants who have experienced rejection, physical assault, psychological violence and sexual abuse because of their sexual orientation.

Table 4.20 indicates that none of the homosexuals with social dysfunction and 51.2% of homosexuals without social dysfunction have been accepted by others regardless of their sexual orientation. However, 22.2% of homosexuals with social dysfunction and 17.0% of homosexuals without social dysfunction have experienced physical assaults, psychological violence and sexual abuse.

This suggests that there are more homosexuals without social dysfunction than homosexuals with social dysfunction who have been accepted by others regardless of their sexual orientation. There are more homosexuals with social dysfunction than homosexuals without social dysfunction who have experienced physical assaults, psychological violence and sexual abuse. There are more

homosexuals with social dysfunction than homosexuals without social dysfunction who did not explain their experiences.

**Table 4.20: Cross-tabulation for experiences for homosexuals with social dysfunction and without social dysfunction**

		Experiences			Total
		Self	Other	Missing	
Social dysfunction	Count	0	2	7	9
	Expected Count	3.8	1.6	3.6	9.0
	Residual	-3.8	.4	3.4	
	Std. Residual	-1.9	.3	1.8	
	Adjusted	-2.8	.4	2.6	
	Residual				
No-social dysfunction	Count	21	7	13	41
	Expected Count	17.2	7.4	16.4	41.0
	Residual	3.8	-.4	-3.4	
	Std. Residual	.9	-.1	-.8	
	Adjusted	2.8	-.4	-2.6	
	Residual				
Total	Count	21	9	20	50
	Expected Count	21.0	9.0	20.0	50.0

#### 4.9.3. Self-view for homosexuals with social dysfunction and without social dysfunction

The probability value of 0.001 in Table 4.18 suggests that the null hypothesis is rejected. There is a statistically significant association between social dysfunction and the way homosexuals with social dysfunction view themselves because of their sexual orientation.

In Table 4.21 the ‘self’ category contains homosexual participants who view themselves as proud, normal, comfortable and important because of their sexual orientation. The ‘other’ category contains homosexuals who view themselves as respected by others because of their sexual orientation.

**Table 4.21: Cross-tabulation for self-view for homosexuals with social dysfunction and without social dysfunction**

			Self-view			Total
			Self	Other	Missing	
Social dysfunction	Social dysfunction	Count	7	2	0	9
		Expected Count	1.4	5.6	2.0	9.0
		Residual	5.6	-3.6	-2.0	
		Std. Residual	4.6	-1.5	-1.4	
		Adjusted Residual	5.6	-2.7	-1.8	
	No social dysfunction	Count	1	29	11	41
		Expected Count	6.6	25.4	9.0	41.0
		Residual	-5.6	3.6	2.0	
		Std. Residual	-2.2	.7	.7	
		Adjusted Residual	-5.6	2.7	1.8	
Total		Count	8	31	11	50
		Expected Count	8.0	31.0	11.0	50.0

Table 4.21 indicates that 77.7% of homosexuals with social dysfunction and 2.4% of homosexuals without social dysfunction viewed themselves as proud of their sexual orientation. However, 22.2% of homosexuals with social dysfunction and 70.7% homosexuals without social dysfunction viewed themselves as respected by others regardless of their homosexual orientation.

This suggests that there are more homosexuals with social dysfunction than homosexuals without social dysfunction who view themselves as proud because of their sexual orientation. There are more homosexuals without social dysfunction than homosexuals with sexual dysfunction who view themselves as respected by others regardless of their homosexual orientation.

#### 4.10. Conclusion

The current study's data suggests that the sample of the heterosexual population used in the study is experiencing more psychological problems than the sample of the homosexual population used in the study. However, this does not mean that homosexuals participants are

not experiencing challenges due to their sexual orientation. The content analysis suggests that the homosexual population of the current study have been experiencing some problems and difficulties in society because of their sexual orientation. Gender differences were noted, with males experiencing more challenges than females.

## **CHAPTER 5: FEEDBACK OUTCOMES**

### **5.1. Introduction**

It was indicated on the participants' informed consent forms that after the data was analysed participants were going to be given feedback about the study's findings. After the data was analysed, the researcher contacted participants from the LGTBI social networks for a feedback session on the study's findings. Unfortunately the researcher was unable to get hold of all the participants for a feedback session. The LGTBI social networks reported that some of the participants had relocated due to various reasons which were not further elaborated.

With regards to the heterosexual sample, the researcher was unable to do the feedback session for the participants. Some of the reasons were that during the feedback period some of the participants have completed their studies and left the university as they were post-graduate students. The sampling method was convenient and the participants were not from a particular social organisation which made it impossible to get hold of them again. The participants also participated under anonymity clause and the researcher had limited demographic information.

Among other reasons of doing a feedback session was to confirm the results which have been discussed in Chapter 4 of the current study. Giving feedback to the participants also gave the researcher new insights about the study's findings. The participants were able to further explain the current study's findings and gave new meaning on the findings. The findings from Chapter 4 of the current study were validated through the feedback session. The researcher had a chance to thank the participants for making the current study a success. The researcher was able to gain new knowledge and new insight from conducting the feedback session. Therefore, this chapter will give an outline of the findings from the feedback session.

### **5.2. Findings from the feedback session**

The participants who attended the feedback session reported that their current positive mental health status could be explained by being part of LGTBI social organisations. Social organisations were described as their source of emotional support and a safe place for them to fully express who they are without fearing being judged and discriminated against. They also reported the LGTBI social organisations as influential in building their positive self-esteem. The



support groups and motivational talks offered by their organisations seem to be helping them a great deal.

The participants also pointed out that their positive mental health can also be influenced by the fact that they are living in urban areas. They reported themselves as having more resources than homosexuals who stay in rural areas. Resources include having LGTBI social organisations, HIV- prevention measures or instruments and support groups for emotional and social support. It seems as if in urban areas there is not as much discrimination as there is in rural areas. Most people in urban areas are coming to terms with homosexuality. Participants also reported that in non-urban areas people are less educated about homosexuality which also makes it difficult to accept it.

Generally, most people find social support from their families but the participants in the feedback session reported finding social and emotional support from LGTBI social organisations. They reported that their families still find it hard to accept their homosexual sexual identity. Some families even go to the extent of believing that having sexual feelings for same sex partners is a phase which will go away after some time.

The results of the current study are in line with the critics of the stages of homosexual identity formation. The participants from the feedback session also reported experiencing an aspect of the stages randomly. Some participants reported experiencing other parts of the stages at the same time and at times skipping other stages.

The participants explained why it is easier for lesbians than for gays to meet sexual partners. One of the reasons is that it is socially acceptable for females to be seen kissing, holding hands and hugging in public places. It seems as if approaching females also brings less violent acts than approaching males. The participants reported that in most cases lesbians are more likely to be asked out by girls first. Males reported that social networks are the safest space for them to look for sexual partners and they also limit the chances of them being victimised. This also links with the current study's findings of lesbians having more positive mental health than gay men. The

participants reported that homosexuals who do not engage in cross-dressing are less likely to be the victims of hate crime and homophobia because they are not easily identifiable.

The participants seen during the feedback session reported that they are more likely to be associated with HIV by random strangers because of the myth that HIV is a homosexual disease. They further reported that sometimes they are suspected by their family members and friends because they know about their past sexual history. The lesbian participants reported being at risk of contracting HIV. They reported that LGTBI social organisations do provide them with HIV-preventative measures. They further reported that the measures are expensive and not user-friendly for most of them. This puts a challenge on researchers to study lesbian identities and HIV issues among lesbians.

The participants reported being raised in families who believe in religious and cultural practices which are against homosexuality. Therefore they found themselves experiencing internalized homophobia because they have been diverting from the norm and their values of social upbringing. Some participants reported being in the closet about their sexual identity at their current churches because they are more likely to be rejected by the church. Some participants reported witnessing other homosexuals being chased out of the church because the church was aware of their homosexual sexual orientation.

### **5.3. Conclusion**

As much as homosexual participants from the feedback session reported experiencing warmth and acceptance from LGTBI social organisations, they also reported experiencing problems in the outside world. Gender differences were also noted with females experiencing fewer challenges than male homosexuals.

## **CHAPTER 6: DISCUSSION**

### **6.1. Introduction**

This chapter discusses the results presented in Chapter 4 of this study. The researcher will link the current study's findings to existing theories and literature. The discussion starts off with the study's general findings and later on the detailed findings will be explored. The current study's mental health differences between the homosexual and heterosexual population will be discussed. The challenges faced by the homosexuals in this study will be identified. It will also point out recommendations for future research. The pitfalls of the current study will be identified and the researcher's assumptions about the results of the study will also be outlined.

### **6.2. The study's general findings**

The GHQ-28 indicated that homosexuals of the current study are experiencing fewer less psychological symptoms than heterosexuals. It further indicated that female homosexuals experience more psychological symptoms than male homosexuals. Among the GHQ-28 subscales, social dysfunction was the most dominant set of symptoms in both the homosexual and heterosexual sample. The social dysfunction was found not to have strong correlation with the gender of the participants even though it was higher for females than for males. However, it was found to be more associated with being discriminated against because of having a homosexual orientation, being pressured to disclose sexual orientation and feeling anxious during the process of homosexual identity formation.

A chi-square test was used to analyse the categorical choice questionnaire for the homosexual sample. It indicated that gender differences exist when it comes to the level of disclosure of homosexual orientation. Female homosexuals were found to be more comfortable with disclosing their sexual orientation to everyone, while more male homosexuals disclose their sexual orientation to themselves and to other homosexuals.

There was not much gender difference noted when it came to discovering sexual orientation. Both genders reported discovering their sexual orientation through sexual feelings and reactions that they had for same sex partners. But there was a 20% difference, with males higher than females.

Gender differences were noted when it came to meeting sexual partners. Female homosexuals reported meeting sexual partners as an easy process for them which does not require them to consider whether the social context approves homosexuality. However, males reported having challenges when it comes to meeting sexual partners because they need to consider whether the social context approves of homosexuality.

The leading responses of open-ended questions of the categorical choice questionnaire were analysed by means of the content analysis. More females than males reported being accepted by other people in spite of their homosexual orientation. Males reported being the victims of homophobia because of their homosexual orientation.

Male homosexuals reported feeling proud about their homosexual orientation and females reported that other people seem to respect them because of their sexual orientation. It is a bit strange to find that male homosexuals report feeling proud even though they also reported being the victims of homophobia. This sounds like feeling proud is a personal reaction rather than a feeling about having a homosexual orientation. It is also important to note that the participants were from LGBTBI social networks where being proud of sexual orientation might be strongly encouraged.

Females reported that they also consider themselves at risk of contracting HIV because of their sexual orientation. Males reported being suspected by others such as being possessed by demons and evil spirits because of their sexual orientation.

Another content analysis was used to analyse the leading responses of the open-ended question for the categorical choice questionnaire between the homosexuals with social dysfunction and those without social dysfunction. Homosexuals with social dysfunctions were found to discover their homosexual orientation through sexual reactions and feelings that they had for partners of the same sex. Homosexual without social dysfunction reported discovering their sexual orientation through having sexual experiences with people of the same sex and through being told by others about their sexual orientation.

Homosexuals with social dysfunction reported being the victims of homophobia and homosexuals without sexual dysfunction reported being accepted by others in spite of their sexual orientation. Again, a higher proportion of homosexuals with social dysfunction reported feeling proud about their sexual orientation than homosexuals without social dysfunction. This further indicates that feeling proud about homosexual orientation may be a way of compensating or a feeling of reaction to the experiences of homophobia.

### **6.3. Homosexuals and mental health**

The overall results of the current study found that the homosexual population is mentally healthier than the heterosexual population which was a UKZN post-graduate student population. The findings of the current study are similar to Hooker's findings of 1957 in which he studied the health of homosexuals and heterosexuals through community organisations. His groundbreaking research pointed out that heterosexuals are not mentally healthier than homosexuals. Hooker's findings changed the way psychology views and treats homosexuals. His study was the first research study to test the assumption that homosexuals were mentally unhealthy and maladjusted (Hooker, 1957).

The GHQ-28 revealed that more people from the heterosexual sample presented with more psychological symptoms than the homosexual sample. The reason behind this may be that the homosexual participants used in this study have already disclosed their biggest secret in life. The researcher is unsure if the heterosexuals have had to deal with their biggest issues in life yet. Another reason may be that none of the participants from the heterosexual population reported being part of a social network or support group. It is important to consider that the heterosexual population was comprised mainly of students who participated in this study during the examination period. This further suggests why there were a high number of heterosexual participants who presented with anxiety symptoms in the GHQ-28. The social dysfunction symptom was the predominant GHQ-28 symptom for both populations, but the heterosexual population presented with it more than the homosexual population.

Among the GHQ-28 subscales there was a slight difference between the homosexual and heterosexual population in the depression symptoms. According to Meyer (2003), both

heterosexuals and homosexuals experience psychological problems which are caused by different stressors. The results of the present study partially agree with Meyer's statement. Both the homosexual and heterosexual population presented with depression and there is a possibility that their depression symptoms are due to different stressors. It is important to note that the results of the current study indicate that sexual orientation is not a predictor of psychological problems, especially for homosexual individuals belonging to LGBTBI social organisations.

#### **6.4. Disclosing challenges**

The overall results of the current study suggest that the homosexual population belonging to social support groups is psychologically healthier than the general heterosexual population. But the discriminant analysis, Chi-square tests and content analysis of the current study pointed out that some homosexuals still experience challenges and problems associated with the 'coming out' process.

##### **6.4.1. Social rejection by family and friends**

The current study indicated that the experience and anticipation of rejection from family and friends because of a homosexual orientation is associated with social dysfunction. Social dysfunction results from a state of disequilibrium which exists in disturbed and malfunctioning relationships. The rejected homosexual can develop social withdrawal because of feelings of being disconnected from and not belonging with those who discriminate against him or her. Some researchers have found similar findings as the current study. For example, a study of gay male undergraduate students found that homosexuals experienced social anxiety and feared being negatively evaluated. Their fear was more evident in situations that involved gender stereotypic behaviour such as family gatherings and sports (Pachankis & Goldfried, 2006).

Perhaps relevant to the current findings is a new construct called rejection sensitivity (Mendoza-Denton, Purdie, Downey & Davis, 2002). Rejection sensitivity relates to a type of rejection that is influenced by cognitive biases, namely, heightened emotional arousal and interpersonal difficulties (Goldfried & Sobocinski, 1975; Kuperminc & Heimberg, 1983; Morrison & Bellack, 1981). It suggests that some homosexual individuals might avoid going out and looking for social interactions because of strong beliefs that they are going to be discriminated against.

Mendoza-Denton et al. (2002) demonstrated in their study with African-American students that homosexuals with rejection sensitivity experienced both little social support and contact with other people from society.

#### **6.4.2. Forced disclosure ‘outing’**

The results of the current study pointed out that being forced to disclose sexual orientation is associated with social dysfunction. The term ‘outing’ refers to publicly revealing sexual orientation for homosexuals who would rather remain covert. The aim of outing is to challenge the hypocrisy of secretive and conservative homosexuals in positions of influence. Keeping a secret can also be a rational choice made by homosexuals in difficult social situations (Cain, 1991). According to Cain (1991), secret-keeping is associated with emotional issues that the homosexual individual has not dealt with yet. Many individuals do not freely choose to be secretive but are forced into the closet by the stigmatisation that surrounds homosexuality. The situation becomes worse when the homosexual individual is being forced into disclosure (Cain, 1991). Homosexuals are forced to keep their sexual orientation as a secret because of factors that need to be considered before disclosure. For example, a homosexual individual may need to assess the sources of support available and to evaluate the costs and benefits of disclosure.

According to Cain (1991), during the 1960s to early 1970s homosexuals were considered to be very secretive population. This is because homosexuality was still viewed as a psychopathic condition during this time. Forced disclosure can be facilitated by homosexual individuals who have already disclosed. Being forced to disclose sexual orientation is painful for homosexuals who do not want to ‘come out’. In addition, tension develops between the homosexual individual and the person who forced the homosexual individual to disclose their sexual orientation. The participants of the current study indicated that for most of the time it was their partners who forced disclosure on them. Their partners forced disclosure on them because of feelings of betrayal and of being used by those partners who were not ready to disclose.

#### **6.4.3. Homosexual identity formation**

According to homosexual identity theorists, the process of homosexual identity formation progresses through different stages. The current study noted that the most important predictor of

social dysfunction was being anxious and confused during the process of identity formation. The current study found that there were no gender differences during the process of identity formation. The same findings were found by Cass (1979). Even though there were similarities between the results of the current study and Cass's findings, some differences with the findings of the current study also exist. Cass (1979) suggested that homosexual individuals' progress through stages in a sequential order, but the current study indicated that there was a possibility of skipping one or some of the stages and experiencing two different stages at the same time.

DuBay, 1979 (as cited in Cass, 1984) argues that homosexual identity is a phrase which was invented by professionals in the field of gender studies. The theorists assume universality among homosexuals and ignore the fact that even people from the same group are not homogenous. The results of the current study add to the criticisms that were outlined in Chapter 2 of this study. Considering that not all participants of the current study experienced Cass's stages of homosexual identity formation, this indicates that homosexuals are not homogenous. This also questions the stages being called 'stages', and suggest the possibility that these could be viewed as experiences, reactions and behaviours that some homosexuals come across during identity formation. The researcher also questions the applicability of homosexual identity models to the black South African population. These models were constructed using Western populations and it is not known whether they have been adapted and standardised for the black South African population. It important to keep in mind that people from Western and African countries are raised in different social and cultural contexts.

#### **6.4.4. Corrective rape and being forced into marriage**

In the content analysis participants reported that the intention for perpetrators of sexual abuse is to change them from their homosexual orientation to a heterosexual orientation. According to Van Zyl (2009), rape is not considered a sexual crime but it is a crime of power and gender; 'it is a gender crime of assault'. The victims of gender crime are persecuted through rape and penetration in sexist and homophobic societies. When looking back at South African history, gay men have also been sexually assaulted and this was frequently done as a form of torture, meaning that the intension was to inflict pain as a way of changing gays 'immorality'. This is also the same for lesbians because the intention behind the rape is not only for sexual pleasure



but also to persecute the lesbian person. To further support Steyn and Van Zyl's argument, prominent theorists have come up with the concept of 'corrective rape'. This phrase implies that homosexuals are sexually abused because the perpetrators are aiming at changing their so called 'deviant behaviour' (homosexual orientation) into a 'normal' behaviour (heterosexual orientation) (Van Zyl, 2009). It is a bit confusing to believe that corrective rape is only aiming at correcting homosexuals from their 'deviant behaviour' but rather it sounds more like a perpetrator's excuse. Van Zyl (2009) did not mention the component of pleasure behind the sexual intercourse. If corrective rape does not bring sexual pleasure to the perpetrator then the researcher's main question is still unanswered about why heterosexuals, young girls and boys, and grandmothers are also sexually abused. This also brings the question of the exercise of power.

The current study noted that some of the participants have been forced by societal, cultural and religious beliefs and attitudes into the so called 'normal marriages'. This is due to a belief that marriage and parenthood will be a cure for homosexual behaviour (Miller, 1979). Many homosexuals marry to satisfy society's prejudices, while spreading feelings of unhappiness to themselves, their partners, their children and to the rest of their families. Due to the community perceiving and regarding homosexuality as abnormal, some homosexuals end up getting married and having children with non-homosexual partners. Van Zyl, de Gruchy, Lapinsky, Lewin and Reid (1999) argue that homosexuals end up being unhappy to the depths of their souls. Forced marriages among homosexuals do not usually serve their purpose but usually end up in unhappy marriages. This has also been seen on the SABC 1 drama by the name of 'After 9' which was discussed in Chapter 2 of this study.

#### **6.4.5. Social support**

Disclosure of homosexual identity also depends on the support structures available and their accessibility for an individual. Cornman, Goldman, Weinstein and Lin (2001) define social support as the degree in which a person is socially integrated and the level in which he receives support. This include sources of social support and their availability to the person in need. Social support is not only about the support that the individual is getting but it is also about the support that the individual perceives that he or she is getting. Perceived support is about the individual's

beliefs about the availability and the accessibility of support. Most participants reported that they receive more support from friends and LGBTBI social networks than family members. According to Chartrand and Julien (1996), homosexual partners perceive less family support, and relatively more support from friends and LGBTBI social networks. They often have more friends than family members as providers of support. For individuals who disclose their sexual orientation while they are already involved in social groups, their process of disclosure is more likely to be positive and self-fulfilling.

Being accepted and receiving social support after disclosing homosexual orientation is affected by changing times, globalisation and the diversity that exists in communities today. In the past most homosexuals never got the chance to disclose as most of them were protecting themselves from discrimination. For those who were able to disclose the process was likely to be painful and unbearable. Some ended up admitting guilt feelings and internalised homophobia because of their sexual orientation (Cain, 1991).

Currently the situation in South Africa surrounding homosexuality is gradually changing for the better. Homosexuals are allowed to marry one another, LGBTBI social networks have been established to offer them support, some liberal Christian churches are on good terms with homosexuality, the feminist movement fought for homosexuals to have equal rights and in most of South African urban areas, such as Durban and Cape Town, there are exclusive homosexual social clubs for leisure activities and entertainment. However, it is crucial to note that the law has changed but personal attitudes have not changed. This is because hate crimes and homophobia are still reported, although not all the participants of the current study reported having experienced homophobia and hate crimes. This suggests that homosexuals are reasonably accepted by most urban communities. This suggests the possibility of South Africa gradually coming to terms with homosexuality. South Africa might be adopting this from international countries, unlike other African countries such as Uganda and Zimbabwe where the situation is much worse. Furthermore, there have been some news reports about greater acceptance of homosexuals in America, in the military and homosexual marriages (Van Zyl, de Gruchy, Lapinsky, Lewin, & Reid, (1999).

#### **6.4.6. Culture, religion and self-consideration**

Some of the participants of the current study reported that they regard themselves as sinful with respect to their religion and rebellious towards their culture. According to object relations theory, if a homosexual individual experiences disapproval which is mainly about him or her as opposed to his or her behaviour, that individual begins to view self as bad, shameful and unlovable. This can result in a rigid interpersonal schema of approaching new social situations with expectations that others are not accepting, are hostile and will discriminate (St. Clair, 2004). This is similar to the concept of internalised homophobia. Homosexuals with internalised homophobia have internal schemas that guide their interpersonal perceptions and their interpretations of ambiguous situations. Object relations theory gives an understanding about why homosexuals of the current study have internalised homophobia as a result of viewing themselves as sinful and rebellious to their religion and culture.

Males of the current study reported viewing themselves as proud of their sexual orientation more than females. Being proud about one's sexual orientation was associated with social dysfunction, this suggests that the pride is a reaction to rejection. There is a possibility that this is because males are socially conditioned to feel less guilt and women tend to relieve guilt through religion and culture. Females are more attached to religion than males and God is viewed as a father figure to which they are emotionally attached (Argyle & Beit-Hallahmi, 1975). Suziedelis and Potvin (1981) suggest that women are more inclined towards religion, culture and to what other people say about them than males. Even when looking at childhood experiences of females among African cultures, it predisposes them to be more accepting of religious and cultural values than males. It is important to also note that when the subject of homosexuality is raised, cultural and religious stereotypes can be used in favour or against homosexuality. For instance, girl children spend most of the time at home learning about customs that need to be transferred from one generation to another. On the other hand, boy children spend much time out of the home looking for a means of providing and protecting their families.

Therefore, homosexuals who value religion and social-cultural beliefs may perceive themselves as inferior, immoral and shameful because of their sexual orientation which is in conflict with their values and beliefs (Shidlo, 1994). This can cause a homosexual individual to reject their

own homosexual identity. The current study disproved Greene and Herek's claim because many individuals considered themselves as proud of their sexual orientation. But is it important to keep in mind that the participants of the current study were members of LGTBI social networks where being proud of one's sexual orientation is socially desirable. If a homosexual individual is a member of an LGTBI social organisation and is not proud of his or her sexual orientation, the individual may be seen as a threat and a hypocrite. Considering that homosexuals have been discriminated against by society at large, it is more painful for them to be further discriminated against by LGTBI social organisations. Most homosexuals long for a feeling of belonging and it is not easy to jeopardise their last opportunity for this.

#### **6.4.7. Meeting sexual partners**

Gender differences were noted among homosexual individuals when it came to meeting sexual partners. It was difficult for male participants of the current study to meet sexual partners in any place other than those that approve of homosexuality, such as LGTBI social organisations and online social networks. It was easier for the female homosexuals to meet and approach sexual partners at any place just like heterosexual people. According to Herek (1988), this may be the case because men who do not conform to gender and sexual norms generally receive hostility than to lesbians. Steffens and Wagner's (2004) study indicated that there are also gender differences among people perpetrators of homophobia. They found that lesbians are accepted by heterosexual women and gays are often not accepted by heterosexual men. They suggested that gender differences are caused by men who are raised to believe that they are responsible for correcting the 'immorality' of society. The researcher finds Steffens and Wagner (2004) statement of men being responsible to correct society's wrong-doings as confusing and misleading; this is because the South African statistics indicates that there are more male prisoners than female prisoners. The question is why do males commit more crimes if they have the responsibility to correct the wrongness of the society

According to Mol (1985), females are socialised to be calm, resolve conflicts, submissive, gentle and nurturing. All these values are emphasised further by culture and religion. Kelley's study (2001) indicated that men are less tolerant than women. Kelley's findings point out that gender

differences vary across countries. Hence, this provides a chance for the researcher to question the applicability of past research studies to the South African population.

Even though it is difficult for most homosexuals to meet partners directly, most participants reported that social networks such as Face book, MXit and Google chat have been helpful. According to Milardo, 1986 (as cited in Larson and Bradney, 1988), homosexuals comprise the biggest percentage of people who use social networks. Milardo, 1986 (as cited in Larson & Bradney, 1988) argues that it makes sense that homosexuals share a large proportion of social networks because the social networks help them to create relationships with others. Social networks are user-friendly for homosexuals. Homosexuals can choose to remain anonymous which guarantees their safety. It is easy for social network users to accept and appreciate the presence of one another.

A paper by Rosenfeld and Thomas (2010) also suggests the usefulness of online social networks such as Facebook because individuals broadcast their relationship status instantly to all their friends and contacts. Social networks increase the opportunities of meeting sexual partners compared to only expecting to meet sexual partners in LGTBI social clubs.

#### **6.4.8. HIV and STIs**

Most participants of the current study reported experiencing being suspected of having sexually transmitted diseases. According to Nanín, Osubu, Walker, Powell, Powell and Jeffrey Parsons (2009), this may be because there is an untruthful rumour that HIV was first discovered in homosexual population. Research studies have shown that gay men have higher chances of contracting HIV than heterosexual men. In South African societies discussions about sex are not open. Therefore it becomes more difficult for homosexuals to talk about their sexual concerns as the South African public have limited resources. The situation becomes worse for homosexuals because they are more likely to encounter homophobic verbal harassment from health workers. Lane's study of 2002 (as cited in Sadoh, Fawole, Sadow, Oladimej & Satileyo, 2006) suggested that some health workers still hold conservative views about homosexuality. The fear of being judged may stop many homosexuals from getting help that they deserved. Some homosexual individuals have preferences for clinics that employed younger health care workers, suggesting

that homophobia is characteristic of the ‘ignorance’ or the social and religious values of an older generation (Lame (2002), as cited in Sadoh et al., 2006). Lame’s findings apply to the population of the current study because most of the participants were still in the process of building their careers thus suggesting the possibility of not having access to private health care facilities.

The current study pointed out that being suspected of having HIV is also associated with social dysfunction symptoms. This further suggests that homosexuals who have been suspected of having HIV are at risk of mental health problems. The results of the current study showed that among the homosexuals with social dysfunction symptoms, gender differences existed. Most female homosexuals considered themselves as at risk of contracting sexually transmitted diseases. According to a brief report by Kwakwa and Ghobrial (2002), lesbians should also be worried about being infected with HIV. This is because most lesbian sexual activities involve the sharing of sex toys which makes it possible for blood to transfer from one partner to another. Richardson (2000) argues that the policies of government need to bridge the gap of the past and cater for the needs of lesbians. HIV-prevention methods do not focus on lesbian risk factors but they all focus on gay men and heterosexuals. The current study argues that lesbian women who are part of LGTBI social organisations are aware that they can also contract HIV if they engage in unprotected sex. There is a possibility that LGTBI social networks provide them with education about the transmission of HIV among women who have sex with other women.

#### **6.4.9. Disclosure that leads to victimisation**

The general findings of the study indicate that ‘coming out’ is associated positive mental health to homosexuals in LGTBI social organisations. It is important to consider that female homosexuals are reported to have more positive experiences than gay men of the current study as a result of disclosing sexual orientation. Females of the current study also reported being able to disclose their homosexual orientation to everyone. This is different for males because most reported disclosing sexual orientation to themselves and to other homosexuals.

According to Walker (2005), since 1994 there has been an increase in reported rape and domestic violence. Furthermore, homosexuals were encouraged to come out of their closets. The increased visibility of homosexuals must be blamed because when they were still in their closets not many

people were discriminating against them. The new South African constitution has led homosexuals to more victimisation. This statement is the same as what Crisp (1977) indicated in his book whereby he was pointing out that disclosure runs the risk of victimization; if homophobic people do not know about a person's sexual orientation, they have low chances of victimizing them as homosexuals.

### **6.5. Disclosure differences**

The current study found that there are gender differences between lesbians and gay men when it comes to the process of 'coming out'. The study noted that lesbians face few challenges than gay men. In Chapter 5 during feedback session, participants reported that lesbians are less likely to experience violent situations than gay men. According to Morris (1997), gay men and lesbians face different challenges which are caused by different stressors. This is further suggested by many research studies either focusing on gay men or lesbians.

### **6.6. Disclosure facilitators**

Being part of the LGTBI social network is seen as a disclosure facilitator among homosexuals. This is further supported by the fact that homosexuals of the current study have disclosed their sexual orientation and belong in social organisations because they get social support. This is similar to the study done by Grossman, D'Augelli and Hershberger (2000) where they found that LGTBI social networks are sources of social support for homosexuals. They also found that LGTBI social networks bring about disclosure and increase self-esteem in homosexuals. The males of the current study reported that their disclosure was facilitated further by being tired of living a double life. On the other hand, the females' disclosure was facilitated by a prior awareness and education about homosexuality. Rye and Meaney (2009) studied the effectiveness of workshops on attitudes toward homosexuality. They found that after the workshops, participants were less homophobic than participants from the control group. The participants were also more comfortable talking about sexual matters. Their study results also noted gender differences in that the female participants were more positive about the workshop than the male participants.

According to Rye and Meaney (2009), the gender differences in their study implied that women are more prepared to appreciate and to use the information that they share with others. Morris is an African-American woman whose disclosure was facilitated by reading books and articles on homosexuality. She said: “I needed a book, a classroom, a written page between myself and the hostile world. I wanted to be able to articulate where I fell on the continuum of history, of justice” (Morris, 1995, p. 94).

### **6.7. Discovering homosexual orientation**

Both genders of the current study discovered their sexual orientation through the feelings and sexual reactions that they had for attractive same sex people. The lesbians further confirmed their sexual orientation through reading books and articles about homosexuality. According to Morris (1995), reading about homosexuality is a recent thing. Previously not many people were interested in this field as it was regarded as deviant behaviour. It was during the 1950’s that people started to show an interest in literature of a homosexual nature. According to Poiani (2010) as discussed in Chapter 2 of this study, even farmers knew about homosexual acts among animals but because homosexuality was considered taboo, not many of them talked about it. In Chapter 5 of the current study, the impression of most of the participants was that their sexual orientation was associated with feelings and sexual reactions for same sex people. Therefore, this partially resembles the findings of Iemmola and Ciani (2009) that homosexuality is largely caused by biological and genetic factors.

### **6.8. Differences between the results of the GHQ-28 and categorical choice questionnaire**

The GHQ-28 indicated that female homosexuals have more psychological problems than male homosexuals. This is different from the findings of the categorical choice questionnaire which indicated that male homosexuals experience more disclosing challenges than female homosexuals. There is a possibility that the psychological symptoms being depicted by the GHQ-28 among female homosexuals are not related to their sexual orientation. This suggests that they might have been experiencing other psychological problems being associated with other problems of living such as finances.



The GHQ-28 is a general psychometric measure which can pick up any psychological related problem regardless of the person's sexual orientation. This is further proven by the heterosexual sample experiencing psychological problems more than the homosexual sample.

The GHQ-28 also indicated that the homosexual sample experience fewer psychological problems than the heterosexual orientation sample. This also raises a possibility of some of heterosexual participants participating in the study while in fact belonging in the homosexual sample. They might have been homosexuals who are still in the closet about their sexual orientation. Of course they might be different reasons for them to do this, such as proving to others that there are heterosexuals in order to protect themselves from victimization.

#### **6.9. The researcher's assumptions about the study's results**

The homosexual population was selected from well-established and fully functioning LGBTBI social organisations and networks. This suggests the possibility that the social organisations are helpful in terms of offering social and emotional support to their members. Many of the participants have been in social groups for a while. Nine homosexual participants reported having psychological problems. This suggests that their disclosing process was not as positive as the other participants. There is another possibility that they may be facing problems which are unrelated to their sexual orientation just like the heterosexual sample.

The discriminant analysis suggested that from the homosexual sample two participants were incorrectly classified as having psychological symptoms. The same problem may have occurred within the heterosexual population. There is a possibility that some of the participants who participated as heterosexuals may be homosexuals who are still in the closet and who have strong feelings of internalised homophobia.

The homosexual population in this study is classified as a healthy population which suggests the possibility that South Africa is coming to terms with homosexuality. This might suggest reduced internalised homophobia among homosexuals who are starting to proudly acknowledge their sexual identity. It also suggests the effectiveness of the new laws which are against the

discrimination of homosexuals. As more homosexuals are starting to be more open about their sexual orientation and experiences, this is therapeutic and brings positive mental health.

#### **6.10. Achieving aims of the study**

The current study had broad aims that needed to be achieved as listed in Chapter 1. The study was able to explore the disclosing challenges of black homosexuals. The relationship between mental health and disclosure consequences has also been explored. The current study had limited scope but it was able to bridge the gap that exists in the field of black homosexual sexual identities. Among the broad aims of the study, helping health practitioners involved in counselling people who struggle with sexual identity and stereotypical issues around homosexuality was included. Therefore the study's results can be used to better understand experiences of homosexuals. For health practitioners involved in counselling it is important for them to note that the psychological problems that homosexual individuals may present with might be either related to or not related to their sexual orientation. The sexual orientation of an individual does not guarantee the presence of psychological problems since they may be caused by different stressors.

#### **6.11. Interesting and surprising findings**

The researcher was not expecting the homosexual population of the current study to be a healthier population than the heterosexual population. Many past studies have stated that homosexuals are more at risk of having psychological problems than heterosexuals. The study's main hypothesis which was that there is a relationship between disclosure and mental health has been accepted conditionally. The condition is that if homosexual individuals are in social organisations they are more likely to have positive mental health.

Gender differences exist among homosexuals of the current study. Gay men were found to be experiencing more challenges than lesbian women. According to Kaplan (1993), Greek literature reveals that there is much more evidence about male sexual behaviour than female sexual behaviour in the 4<sup>th</sup> and the 5<sup>th</sup> centuries. Lesbian identities are a much more recent social phenomenon. Kaplan's study may also explain the reason that lesbians experience fewer challenges as the perpetrators may be less aware of them.

## **6.12. Limitations of the study**

The current study recruited homosexual participants who were in social organisations which might have affected and impacted the results. This is because the researcher does not know the mental health status for homosexuals who are not part of LGTBI social organisations. A heterosexual student population was compared with a homosexual population, thus the possibility might occur that these populations face different and unrelated problems and stressors.

Data collection was done in the cities of Pietermaritzburg and Durban which might have been another limiting factor since these cities are developed and well-resourced and offer the possibility of catering for homosexuals. The researcher could not find a similar study which was done in rural areas in order to compare the current findings with it. Social networks have been reported to be present in urban areas only, which suggests the possibility that homosexuals in rural communities might be facing far greater challenges than homosexuals in urban areas. Chapter 2 of the current study indicated that big South African cities such as Cape Town and Durban are currently catering for homosexuals. According to Aldrich (2004), there is evidence that homosexuals come to cities for a better life and for support organisations.

The GHQ-28 has been used in many studies with heterosexuals and it is norm-appropriate for heterosexuals, but the researcher is uncertain if it is norm-appropriate for the South African homosexual population. According to Hooker (1957), many studies on homosexuality are likely to find unreliable information because of traditional assessment procedures. The GHQ-28 might not have been an appropriate measure of the health status in the current study because it only assessed the individual's health status over the past few months. This raises the possibility that the individual might have gone through the stage of being distressed for months or years. Some individuals may also not recognise the symptoms if they are just at their initial stage of development.

It is difficult to generalise the current study's findings to the general population of homosexuals because the sample was not a best representation of the homosexual population. This is because the sample was only made of homosexuals belonging to LGTBI social networks. The current

study used large numbers of statistical tests which suggests the possibility of results being significant by chance.

### **6.13. Future plans and recommendations**

In future studies the researcher might focus on comparing the health status of homosexuals in social groups and those who are not part of social groups. It would also be important to draw conclusions from homosexuals in rural areas and homosexuals in urban areas.

For future studies the researcher is planning to investigate the effectiveness of expressive writing to assist with traumatic and stressful experiences. According to Frattaroli (2006), expressive writing of difficult experiences and events can be beneficial to an individual's psychological and physical wellbeing.

The current study suggested that disclosure of sexual orientation is a painful experience, but totally worth it. Homosexuals who do not disclose their sexual orientation may be at a greater risk of developing psychological problems. Therefore disclosure and being part of an LGBTBI social network are recommended for positive mental health.

The utilisation of online social networks and social clubs are also recommended as a stress-free and easy method of meeting sexual partners.

Being in psychotherapy and being part of the LGBTBI society are recommended as sources of support for the homosexual population. This was further supported by Grella, Greenwell, Mays and Cochran (2009).

The present study noted that families of black homosexuals have a great impact in how homosexuals view and perceive themselves. Therefore psycho-education about homosexuality specifically for families can be helpful and can bring positive mental health to both the family and the homosexual individual.

The literature review and the results of the current study indicated that homosexuals are perceived as being more at risk than heterosexuals of contracting HIV. The literature also indicated that not many research studies and campaigns have focused on HIV-prevention methods among homosexuals. Therefore, a future study by the researcher may focus on HIV risk factors and prevention methods for homosexuals.

#### **6.14. Conclusion**

The overall results of the current study suggest that the homosexual population who belong to LGBTBI organisations is significantly more mentally healthy than the heterosexual population of postgraduate students. The results also suggest that there are gender differences among the challenges that homosexual individuals face. Lesbians are more likely to experience physical and sexual assaults. Feelings of internalised homophobia have also been noted among lesbians. Gay men have experienced problems with disclosing their sexual orientation to everyone and have experienced social rejection just like lesbians.

The South African society is gradually coming to terms with homosexuality and laws have been created to protect against discrimination of marginalised groups. South Africans are learning to be racial and gender tolerant and to acknowledge diversity among members of the society. Being aware of our own personal prejudices and biases and guarding against imposing our own values onto others are one of the steps towards a new and united South Africa.

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## **APPENDICES**

### **Appendix A: Consent Form**

**School of Psychology**

**P/Bag X01 Scottville**

**PMB, 3209**

I..... hereby give consent to answering a questionnaire about my experience as a homosexual individual and the General Health Questionnaire. These questionnaires may be used by Ntombifuthi Mbatha in the research she is conducting. I do understand that the researcher will be discussing and analysing the questionnaire with her supervisor.

I have been informed that my personal details will be protected to the best of the researcher's abilities and that the questionnaire will be kept in a safe and locked cupboard. The interpretation of data will be available as Masters' dissertation. My name will not appear on the questionnaire. Feedback about the research will be available at the end of the research project. My participation is on a voluntary basis and I know I can withdraw at anytime without negative consequences. My social organisation did not force me to participate in this study. If I experience any distress as a result of answering the questionnaires I know that I can consult the UKZN Child and Family Centre (CFC), UKZN Student and Counselling Centre (SCC) or Centre for Applied Psychology (CAP) for professional help.

Signature of Participant \_\_\_\_\_

Date \_\_\_\_\_

**Appendix B: Letter from Student Counselling Centre (SCC), Child and Family Centre (CFC) and Centre for Applied Psychology (CAP)**

Student Counsellor  
Counselling Psychologist  
Student Counselling and Careers Centre  
University of KwaZulu-Natal  
Private Bag X01, Scottsville  
3209  
033-260 5233

Dear Ntombifuthi

Thank you for your email which Ms Nyembezi, Acting Deputy Dean, has asked me to reply to. Should there be any psychological distress in any of the subjects of your study, as result of your study, please feel free to refer them to me in my capacity as a student counsellor at the Student Counselling Centre, on the Pietermaritzburg campus. I am happy to fulfil this function, or to find counsellors who can, should I not be able to.

This letter has sufficed for previous ethics applications.

Best of luck with your study.

Sincerely  
Margot

## Appendix C: Self-designed Categorical Choice Questionnaire

(English version)

### Instruction

In this questionnaire, you are requested to respond according to your experiences, opinions, and feelings about asked questions. Shade the circle next to an answer(s) with a pencil or pen that best suit you. If more than one answer best suits you, you are allowed to mark more than one answer.

### General Information

Age:.....

Gender:.....

Home language:.....

Sexual orientation (gay, lesbian or bisexual):.....

1. Have you “come out”?

- To yourself
- To other gay people
- To your family
- To everyone

If not, why not?

.....

.....

.....

2. How did you find out that you were homosexual or bisexual?

- By yourself, thinking about your reactions to people of the same sex
- From books or articles about gay people or homosexuality
- From someone else telling you
- Through observing others

Please explain how according to your answer.

.....  
.....  
.....  
.....

3. Do you consider yourself as.....

- Hated by others because of your sexual orientation
- Sinful in terms of your religion
- Rebellious to your culture
- None of the above

Please elaborate according to the answer of choice.

.....  
.....  
.....  
.....

4. Have you ever experienced one or more of the following because of your sexual orientation?

- Physical violence
- Psychological violence
- Rape
- Any kind of abuse
- Rejection from family and friends
- Kicked out of school or work

If you have experienced any of these, please explain how it happened.

.....  
.....  
.....  
.....

5. With the given status of your sexual orientation, do you view yourself with any of the following?

- Useless
- Unimportant
- Inferior
- Proud
- None of the above

Explain how you view yourself.

.....

.....

.....

.....

6. What facilitated your disclosure?

- You decided and got support from others
- Pressure from others who already knew
- Level of education or awareness
- Was it something you thought was appropriate to do?
- Other

Explain how?

.....

.....

.....

.....

7. When meeting someone who is sexually attractive to you:

- Do you look for certain behaviours that will tell you that he or she is also homosexual?
- Do you have signals that indicate that a person is homosexual?
- Do you approach and ask if that person is homosexual?
- Do you only approach people in a context or venue that is gay or lesbian appropriate

- None of the above

Please specify on how you meet partners.

.....  
.....  
.....  
.....

8. Before disclosing your sexual orientation, did you find keeping your identity secret as:

- Stressful (angry, irritated)
- Not stressful
- Something that took up a great deal of your thoughts and time
- Something that made you anxious or nervous

Please explain how it was according to your answer of choice.

.....  
.....  
.....  
.....

9. During your homosexual identity formation, did you go through any of the following?

- Finding it was anxious and confusing
- Finding it was exciting but you hid it because of the fear of others' reaction
- Reveal to some people that you are homosexual, while denying it to others
- Criticism from others shook your pride, but interaction with other homosexuals encouraged pride in accepting homosexual identity

Explain how you felt when experiencing the above-mentioned.

.....  
.....  
.....  
.....

10. With the given status of your sexual orientation, have you heard that people suspect that you to have any of the followings?

- HIV or AIDS
- STI's
- Barrenness
- Other illness

Please explain what have you heard.

.....

.....

.....

.....

Thank you for your participation in this study.



**(Zulu version)**

## **Ungomo**

Kulemibuzo uyanxuswa ukuba uphendule ngokwazi kwakho kanye ngombono wakho. Xikiza impendulo noma izimpendulo ohambisana nazo ngosiba lomsizi okanye oluka-inki. Uvumelakile ukukhetha izimpendulo ezingaphezulu kweyodwa.

### **Ulwazi olujwayelekile**

Iminyaka:.....

Ubulili:.....

Ulimi lwasekhaya:.....

Ubudlelwano (bobulili obufanayo noma bobulili obufanayo kanye nobungafani):.....

1. Usubudalulile yini ubudlelwano bakho?

- Kuwe uqobo
- Kozakwenu
- Emndenini wakho
- Kuwowonke umuntu

Uma ungakabudaluli, kungani?

.....  
.....  
.....

2. Wazi kanjani ukuthi uthanda abantu bobulili obufanayo?

- Wazizwelwa wena, ngokucabanga ngemizwa onayo nabobulili obufanayo
- Ngokufunda izincwadi okanye iziqephu ngabantu abathanda ubulili obufanayo
- Watshwelwa ngabanye abantu
- Wazi ngokubukela abanye bobulili obufanayo

Chaza kabanzi mayelana nempendulo oyikhethile.

.....  
.....

.....  
.....

3. Uzibona njengalokhu okulandelayo.....

- Uzondwa abantu ngenxa yokuthanda ubulili obufanayo
- Uyisoni enkolweni yakho
- Ulahle isiko lobuntu bakho
- Akukho kulezi zimpendulo

Yenaba kabanzi ngempendulo oyikhethile.

.....  
.....  
.....  
.....

4. Sewuke wahlangabezana nalokhu okulandelayo ngenxa yokuthandana nabantu bobulili obufanayo?

- Ukushawa
- Ukuhlukumezeka komqondo
- Ukudlengulwa
- Enye yezindlela zokhlukumezeka
- Ukungamukelwa ekhaya kanye nabangani
- Ukuxoshwa esikoleni noma emsebnzini

Uma usuke wahlangabezana nakho, shono ukuthi kwenzeka kanjani.

.....  
.....  
.....  
.....

5. Ngokuthanda ubulili obufanayo, uzibona njengomuntu onjani?

- Ongenamsebenzi walutho
- Ongabalulekile
- Omncinyana
- Oziqhenyayo
- Akukho kulezi zimpendulo

Chaza ukuthi uzibona njengomuntu onjani.

.....

.....

.....

.....

6. Yini eyenza ukuthi uphumele obala?

- Wathatha isinqumo base bayakweseka abanye
- Incindezi yalaba ababesebazi
- Izinga lokufundiseka
- Ingabe yinto owacabanga ukuthi kufanele uyenze
- Okunye

Chaza ukuthi kwenzeka kanjani?

.....

.....

.....

.....

7. Uma ufana ukuqala ubudlelwano bobulili obufanayo wenza kanjani?

- Ingabe ubuka indlela umuntu aziphatha ngayo ukuze ubone ukuthi naye uthanda ubulili obufanayo?
- Ingabe kukhona indlela otholangayo ukuthi omunye umuntu uthanda ubulili obufanayo?
- Ingabe uyamubuza umuntu ukuthi uthandana nabuphi ubulili?
- Ingabe kukhona izindawo ozisebenzisayo ezilungele.

- Akukho kulezi zimpendulo

Chaza ukuthi ubakha kanjani ubudlelwano.

.....  
.....  
.....  
.....

8. Ngaphambi kokuba uzidalule, ukugcina imfihlo kwakunjani?

- Kwakukhathaza emoyeni (kukucasula)
- Kwakungakhathazi emoyeni
- Wawuchitha isikhathi eside ucabanga ngakho
- Kwakukushayisa ngovalo futhi wesabe

Chaza ukuthi kwakunjani ukugcina imfihlo.

.....  
.....  
.....  
.....

9. Ngenkathi usanda kuzidalula, kwakekwenzeka yini lokhu okulandelayo.

- Ukudideka
- Ukuziqhathanisa
- Ukuzamukela
- Ukizigqhenya

Chaza kabanzi ukuthi wawuzizwa kanjani.

.....  
.....  
.....  
.....

10. Ngokuthanda ubulili obufanayo kwakho, ukewezwa ukuthi abantu bathi unalokhu okulandelayo.

- Ingculazi
- Izifo zocansi
- Uyinyumba
- Ezinye izifo

Chaza ukuthi wezwa ukuthi bathini.

.....

.....

.....

.....

Ngiyabonga ngokubambisana nawe.

## Appendix D: General Health Questionnaire (GHQ-28)

Name or Nickname:

Date:

### QUESTIONNAIREGHQ28

David Goldberg

Please read this carefully.

We should like to know if you have had any medical complaints and how your health has been in general, *over the past few weeks*. Please answer ALL the questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past.

It is important that you try to answer ALL the questions.

Thank you very much for your co-operation.

---

Have you recently

A1	Been feeling perfectly well and in good health	Better as usual	Same than usual	Worse than usual	Much worse than usual
A2	Been feeling in need of a good tonic?	Not at all	No more than usual	Rather more than usual	Much more than usual
A3	Been feeling run down and out of sorts?	Not at all	No more than usual	Rather more than usual	Much more than usual
A4	Felt that you are ill?	Not at all	No more than usual	Rather more than usual	Much more than usual
A5	Been getting pains in your head?	Not at all	No more	Rather more	Much more

			than usual	than usual	than usual
A6	Been getting a feeling of tightness or pressure in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
A7	Been having hot or cold spells?	Not at all	No more than usual	Rather more than usual	Much more than usual
B1	Lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
B2	Had difficulty in staying asleep?	Not at all	No more than usual	Rather more than usual	Much more than usual
B3	Felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
B4	Been getting edgy and bad tempered?	Not at all	No more than usual	Rather more than usual	Much more than usual
B5	Been getting scared or panicky for no good reason?	Not at all	No more than usual	Rather more than usual	Much more than usual
B6	Found everything on top of you?	Not at all	No more than usual	Rather more than usual	Much more than usual
B7	Been feeling nervous and strung up all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual
C1	Been managing to keep yourself busy and occupied?	More so than usual	Same as usual	Rather less than usual	Much less than usual
C2	Been taking longer over the things you do?	Quicker than usual	Same as usual	Longer than usual	Much less than usual
C3	Felt on the whole you were doing things well?	Better than usual	About the same	Less so than usual	Much less than usual
C4	Been satisfied with the way you've carried out your task?	More satisfied	About same	Less so than	Much less than

			as usual	usual	usual
C5	Felt that you are playing a useful part in things?	More so than usual	Same as usual	Less so than usual	Much less than usual
C6	Felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less than usual
C7	Been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
D1	Been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
D2	Felt that life is entirely hopeless?	Not at all	No more than usual	Rather more than usual	Much more than usual
D3	Felt that life isn't worth living?	Not at all	No more than usual	Rather more than usual	Much more than usual
D4	Thought of the possibility that you might make away with yourself?	Definitely not	I don't think so	Has crossed my mind	Definitely has
D5	Found at times you couldn't do anything because your nerves were too bad?	Not at all	No more than usual	Rather more than usual	Much more than usual
D6	Found yourself wishing you were dead and away from it all?	Not at all	No more than usual	Rather more than usual	Much more than usual
D7	Found that the idea of taking your own life kept coming into your head?	Definitely not	I don't think so	Has crossed my mind	Definitely has

A	B	C	D	TOTAL
---	---	---	---	-------



**Appendix E: Evaluation form for the pilot study**  
**(English version)**

**Evaluation form for questionnaire**

What do think the purpose of this questionnaire was?

.....  
.....  
.....

Were the questions easy to understand?

Yes	No
-----	----

Were there questions that you didn't understand? If "yes" please list the question numbers below:

.....  
.....

How can you rate the structure of the questionnaire?

Very Good	Good	Bad	Very Bad
-----------	------	-----	----------

How much time did you invest when you were answering questions?

Less than 30 minutes	Less than 1 hour	1 Hour and 30 minutes	2 Hours
----------------------	------------------	-----------------------	---------

What do you think should be changed in this questionnaire?

.....  
.....  
.....

Are there some questions that you think I should add to the questionnaire? If 'yes' please answer the question below:

.....  
.....  
.....

**(Zulu version)**

**Ukuhlolwa kwemibuzo**

Ucabanga ukuthi bekuyini inhloso yalemibuzo?

.....  
.....  
.....

Bekulula yini ukuyiqonda?

Yebo	Cha
------	-----

Ikhona yini imibuzo ongayiqondanga. Uma ikhona bhala izinombolo zaleyo mibuzo.

.....  
.....

Ingayinika liphi izinga lemibuzo.

Mihle kakhulu	Mihle	Mibi	Mibi kakhulu
---------------	-------	------	--------------

Kukuthathe isikhathi esingakanani ukuphendula lemibuzo?

Ngaphansi kwemizuzu ewu-30	Ihora	Ihora kanye nemizuzu ewu-30	Amahora awu-2
----------------------------	-------	-----------------------------	---------------

Yini ofisa ukuba ishintshwe kulemibuzo?

.....  
.....  
.....

Ikhona yini imibuzo ofuna ukuyengeza. Uma ikhona yibhale.

.....  
.....  
.....

**Appendix F: Content analysis table which was used in the calculation of Cohen’s Kappa**

A Cohen’s Kappa value of 0.75 was found which suggested that the coding between the two coders was substantially reliable.

	CODER 1			
CODER 2	Myself	Other	Missing data	
Myself	17	4	0	<b>21</b>
Other	1	19	0	<b>20</b>
Missing data	0	0	9	<b>9</b>
	<b>18</b>	<b>23</b>	<b>9</b>	<b>50</b>

**Appendix G: Chi-square tests for insignificant questions for responses of the categorical choice questionnaire**

	Value	Df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)	Cramer’s V (Approx. Sig.)
<b>Self-consideration</b>	.725 <sup>a</sup>	1	.395	.571	.285	.395
<b>Experiences</b>	2.348 <sup>a</sup>	2	.309			.309
<b>Self-view</b>	.402 <sup>a</sup>	1	.526	.747	.380	.526
<b>Disclosure facilitator</b>	.349 <sup>a</sup>	2	.840			.840
<b>Secret keeping</b>	.152 <sup>a</sup>	1	.697	.767	.465	.697
<b>Homosexual identity formation</b>	1.708 <sup>a</sup>	1	.191	.215	.163	.191
<b>Suspicious from others</b>	4.256 <sup>a</sup>	2	.119			.119

**Appendix H: Chi-square tests for the leading responses of categorical choice questionnaire, depicting gender differences**

	<b>Value</b>	<b>Df</b>	<b>Asymp. Sig. (2-sided)</b>	<b>Cramer's V (Approx. Sig.)</b>
<b>Self-consideration</b>	2.562 <sup>a</sup>	2	.278	.278
<b>Discovering sexual orientation</b>	.359 <sup>a</sup>	2	.836	.836
<b>Disclosure facilitator</b>	1.022 <sup>a</sup>	2	.600	.600
<b>Meeting sexual partners</b>	.810 <sup>a</sup>	2	.667	.667
<b>Secret keeping</b>	2.579 <sup>a</sup>	2	.275	.275
<b>Identity formation</b>	1.042 <sup>a</sup>	2	.594	

**Appendix I: Chi-square tests for the leading responses of categorical choice questionnaire, depicting differences in participants with and without social dysfunction**

	<b>Value</b>	<b>Df</b>	<b>Asymp. Sig. (2-sided)</b>	<b>Cramer's V (Approx. Sig.)</b>
<b>Discovering sexual orientation</b>	.322 <sup>a</sup>	2	.851	.851
<b>Disclosure facilitator</b>	.832 <sup>a</sup>	2	.660	.660
<b>Meeting sexual partners</b>	1.172 <sup>a</sup>	2	.557	.557
<b>Secret keeping</b>	3.252 <sup>a</sup>	2	.197	.197
<b>Identity formation</b>	4.887 <sup>a</sup>	2	.087	.087
<b>Suspicious</b>	.991 <sup>a</sup>	2	.609	.609

**Appendix J: Dummy codes**

Question 1- 'Everyone' is the dummy code.

Question 2- 'No dummy' is the dummy code.

Question 3- 'None of the above' is the dummy code.

Question 4- 'None of the above' is the dummy code.

Question 5- 'No dummy' is the dummy code.

Question 6- 'Other' is the dummy code.

Question 7- 'None of the above' is the dummy code.

Question 8- 'None of the above' is the dummy code.

Question 9- 'None of the above' is the dummy code.

Question 10- 'None of the above' is the dummy code.

**Appendix K: The scaling of categorical choice questionnaire**

Please rate these responses according to their level of importance to you. 1 Being your first option, 2 being your second option, 3 being your third option, 4 being your fourth option, 5 being your fifth option and 6 being your last option.

<b>Q.1 If you have a secret. Will you first disclose it to.....</b>	<b>Q.2. Let's say you are homosexual. How will you discover your sexual orientation?</b>	<b>Q.3. Let's say you are doing something which many people consider as wrong, will you consider yourself as...</b>	<b>Q.4. Let's pretend as if you have done wrong, which option will you consider as your worse punishment.</b>
Yourself	Reactions and attraction to people of the same sex	Hated	Physical violence
Other people who have the same secret	From reading books or articles	Sinful to your culture	Psychological violence
Family and friends	Someone else telling you	Sinful to your religion	Rejection from family and friends
Everyone	Observing other homosexuals		Any kind of abuse
			Kicked out of school or work
			Rape

<b>Q.5. Let's say you have a secret again, what can best facilitate your disclosure</b>	<b>Q.6. Let's say you are homosexual again, when meeting someone who is sexually attractive to you, which option will you first look at?</b>	<b>Q.7. Keeping a secret to you, has the following effect</b>	<b>Q.8. Let's say you are doing a new makeover for your identity, will you find the transition...</b>
Support from others	Person's certain behaviours	Takes your time and thoughts	Anxious and confusing
Pressure from others who already knew	Signals that indicate that a person is homosexual	Stressful	Exciting but to be hidden because of the fear of others' reaction
Level of education or awareness	Approach and ask if the person is homosexual.	Makes you anxious and nervous	Easy to reveal to some people, but deny it to others
Simply disclose it because it is an appropriate thing to do	Only approach in social contexts that are for homosexuals.		Criticism from others shakes your pride, but interaction with supportive others brings encouragement.

Signature.....

Thank you for your participation.