



Executive Summary

FEELING QUEER AND BLUE: A REVIEW OF THE LITERATURE ON DEPRESSION AND RELATED ISSUES AMONG GAY, LESBIAN, BISEXUAL AND OTHER HOMOSEXUALLY ACTIVE PEOPLE

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**A Report from the Australian Research Centre in Sex, Health and
Society, La Trobe University, prepared for *beyondblue: the national
depression initiative***



This Project was supported by a grant from *beyondblue*.

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Suggested Citation:

Corboz, Julianne, Dowsett, Gary, Mitchell, Anne, Couch, Murray, Agius, Paul, and Pitts, Marian (2008), *Feeling Queer and Blue: A Review of the Literature on Depression and Related Issues among Gay, Lesbian, Bisexual and Other Homosexually Active People*, A Report from the Australian Research Centre in Sex, Health and Society, La Trobe University, prepared for *beyondblue*: The National Depression Initiative. Melbourne: La Trobe University, Australian Research Centre in Sex, Health and Society

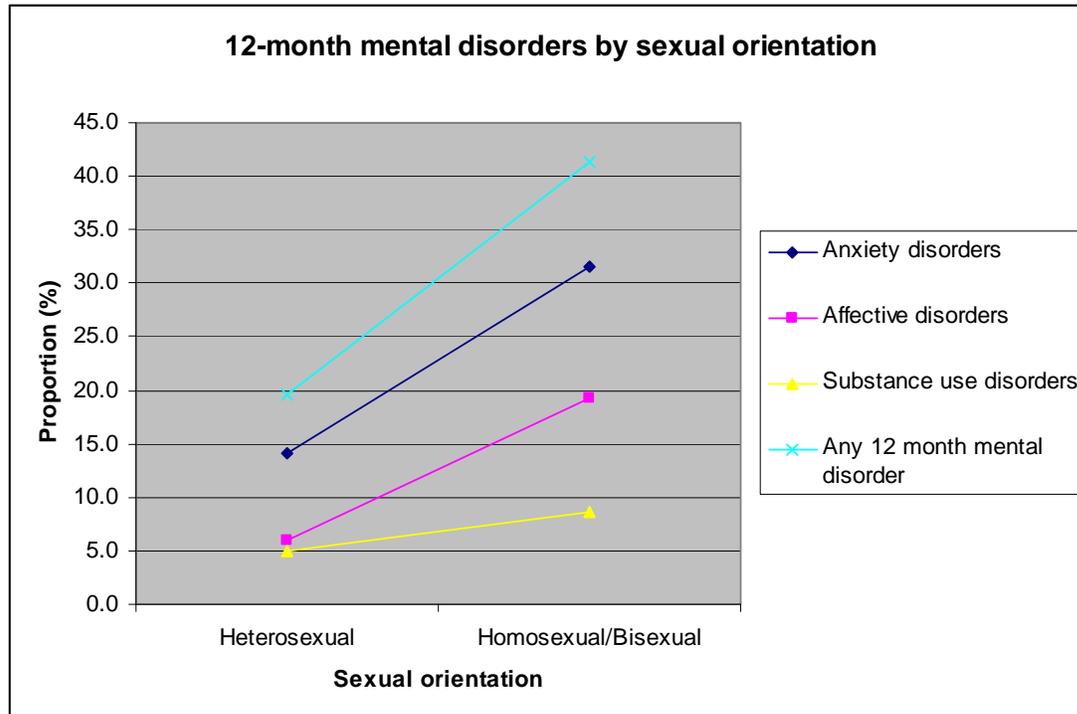
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Introduction and terminology

There is a growing body of evidence, both international and Australian, to suggest that non-heterosexual people experience anxiety and depression at higher rates than their heterosexual peers and are at greater risk of suicide and self-harm. Yet, there has been little recognition of the implications of this for policy and practice. Contested debates on the influence of genes on sexual orientation aside, non-heterosexual people are not physiologically different from their heterosexual peers to all intents and purposes. However, they are likely to have different life experiences that contribute to at least two areas of particular need in relation to mental health and depression: managing the effects of homophobia and its consequences on a daily basis through the life course; and gaining access to mental health services that are able respond to their needs in socially and culturally competent ways. The invisibility of these issues prompted the partnership between Beyond Blue and the Australian Research Centre in Sex, Health and Society (ARCSHS) at La Trobe University to undertake a systematic and targeted international literature review of the evidence base on depression and related issues among non-heterosexual people, published between the years 2000 and 2008. In addition, data from existing Australian studies undertaken by ARCSHS was analysed specifically to contribute to this paper. Difficulties were encountered in reviewing and exploring similarities and differences between empirical studies of non-heterosexual groups because of complex ways of measuring sexual orientation. Similar difficulties were encountered in an analysis of the varying ways of defining depression, its diverse forms and the different tools used to measure it. These are fully discussed in the primary report and decisions about terminology for this document have been made.

Prevalence: depressive symptoms and clinical depression in non-heterosexual people

Mental disorders and sexual orientation



The Australian Bureau of Statistics National Survey of Mental Health and Wellbeing (2007)¹ reports on the 12 month prevalence rates of anxiety disorders, affective disorders and substance use disorders, by sexual orientation.

According to this data, people who report being homosexual/bisexual have higher levels of anxiety disorders (31.5% vs. 14.1%), affective disorders (19.2% vs. 6%) and substance use disorders (8.6% vs. 5.0%).

In order to capture the potential variability between different groups, rates of depressive symptoms and clinical depression in non-heterosexual people were explored separately according to the following categories: (1) young people; (2) lesbian and other homosexually active women; (3) gay and other homosexually active men; (4) bisexual people; and (5) general gay/lesbian/bisexual (GLB) populations.

The literature on depressive symptoms in young people robustly shows that gay/lesbian and same-sex-attracted young people exhibit significantly more depressive symptoms than heterosexual and other-sex-attracted young people. This was consistently found across studies that sampled participants from the USA, Canada, New Zealand, the Netherlands, Hong Kong and Australia. For instance, in one international study (D'Augelli 2002), young GLB people aged between 14 and 21 scored significantly higher on the depression subscale of the Brief Symptom Inventory than a general comparison sample (1.22 vs. 0.82, $t = 8.62$, $p < .01$). The Australian studies conducted by ARCSHS gesture clearly in the same direction and, further, suggest that same-sex-attracted young people also suffer from poorer general health. In the *Secondary Students and Sexual Health* (SSSH) study, same-sex-attracted and both-sex-attracted students reported lower general health on the SF-36 General Health Scale than those who were attracted to the opposite sex only (63.1 vs. 70.5, $F_{1,2316} = 18.45$, $p < .001$). Both the international and Australian literature strongly suggests that both-sex-attracted and bisexual young people, and those questioning their sexual orientation, are also at higher risk of suffering depressive symptoms.

Lesbian and other homosexually active women consistently show higher rates of depression than heterosexual women; however, the literature showed mixed results in relation to prevalence time frame. Five studies (four conducted in the USA and one in the Netherlands) that measured past-year major depression indicated that while prevalence rates varied between 7.3 and 16.8 percent among heterosexual women, rates were higher for lesbian and other homosexually active women, ranging between 11.6 and 34.5 percent. Nevertheless, three out of these five studies showed statistically insignificant results. The results for longer prevalence of major depression were much more robust. For instance, a longitudinal study conducted in New Zealand (Fergusson et al. 2005) showed that rates of major depression over a four-year period increased significantly according to increasing non-heterosexual identity. According to the findings, 41.6 percent of predominantly homosexual women met criteria for major depression, compared with 32.7 percent of predominantly heterosexual and 24.9 percent of exclusively heterosexual women. Moreover, all the studies reviewed that measured lifetime prevalence of major

depression showed significantly higher rates for lesbian and other homosexually active women when compared with heterosexual women. There is also evidence to suggest that rates of depression among lesbian and other homosexually active women vary according to age. In particular, younger and older lesbians appear to be at a higher risk of depression than mid-age lesbians.

There are few studies that address the issue of depression in non-heterosexual parents or parents-to-be, but there is some evidence to suggest that lesbian and bisexual biological mothers may be at higher risk for depression when compared with heterosexual biological mothers. In a study conducted in Canada, Ross et al. (2007) found that lesbian/bisexual biological mothers had significantly higher depression scores on the Edinburgh Postnatal Depression Scale (EPDS) at 16 weeks postpartum than heterosexual biological mothers (7.39 vs. 4.91, $t = 2.03$, $p < .05$). Further, bisexual women's mean EPDS scores were significantly higher than those of lesbian respondents (8.82 vs. 5.62, $t = -2.41$, $p < 0.05$). There is little evidence to suggest that lesbian non-biological or pre-adoptive mothers are at a higher risk for depression. Nevertheless, it is probable that they are at least at the same risk for depression as their heterosexual counterparts and, further, the literature suggests that they may experience specific stressors related to their sexual orientation.

Similar to the literature on lesbian and other homosexually active women, studies on depression in gay and other homosexually active men show a trend toward higher rates of depression that also vary according to 12-month and longer prevalence time frames when compared with heterosexual men. Across four representative population studies, 12-month prevalence rates of major depression varied between 9.8 and 31 percent for homosexually active men compared with rates between 3.9 and 10.2 percent for heterosexual men. Three out of four of these studies showed significant differences between these two groups. Two other probability surveys support these results, showing significantly higher current and past-year depression in gay and other homosexually active men when compared with heterosexual men in the general population. The results for longer prevalence of depression were less consistent. Fergusson et al. (2005) found

that over a four-year time period 75.5 percent of predominantly homosexual men met criteria for major depression compared with 42.3 percent of predominantly heterosexual and 14.2 percent of exclusively heterosexual men. However, studies measuring lifetime prevalence of major depression show different results. Although gay and other homosexually active men still show higher lifetime prevalence rates of major depression than their heterosexual counterparts (15 percent vs. 6.5 percent in one study, and 29.3 percent vs. 10.9 percent in another study), these differences were not significant. It appears that the trend for significantly higher 12-month and non-significantly higher lifetime prevalence of depression in gay and other homosexually active men is the inverse of the trend identified in lesbian and other homosexually active women. Further, in relation to age, younger gay and homosexually active men appear to be at higher risk for 12-month prevalence of depression than their older counterparts.

Gay and other homosexually active men are in an HIV high-risk category, and thus it is important to examine how much depression in gay and other homosexually active men can be accounted for by HIV infection. Although HIV infection may lead to higher rates of depression and depressive symptoms in both heterosexual and non-heterosexual men, five international studies, conducted in the USA, the Netherlands and Australia, suggest that higher rates of depressive disorders in gay and other homosexually active men cannot be accounted for, entirely or largely, by HIV status. For instance, in one Australian study conducted in Adelaide, Rogers et al. (2003) found that in a sample of 460 gay and homosexually active men (35 percent of whom were HIV-positive), 28 percent met the criteria for current major depression and this rate was exactly the same for HIV-positive and HIV-negative men. Nevertheless, one ARCSHS study did find a significant difference in depressive symptoms between HIV-positive and HIV-negative same-sex-attracted men, highlighting the need for additional research in this area.

There is a pervasive tendency in the literature to exclude bisexual people or to obscure them by collapsing bisexual samples into gay, lesbian or same-sex-attracted categories. The studies that did explore bisexual people separately from homosexual people consistently showed that bisexuals have higher rates of depression or depressive

symptoms than heterosexual people and, further, in some cases are at the same or even higher risk of depression than homosexuals. In an important study that analysed data from the *Australian Longitudinal Study on Women's Health*, McNair et al. (2005) found that in a cohort of women aged 22 to 27 years, bisexual women showed consistently poorer mental health outcomes than exclusively heterosexual, bisexual and exclusively/mainly homosexual women on almost all measures. Further, in a cohort of women aged 50 to 55, mainly heterosexual women had the poorest mental health outcomes on *all* measures when compared with women in any other group. In another Australian study conducted in Canberra, Jorm et al. (2002) sampled both men and women and found that the bisexual group had significantly higher depressive symptom scores than the homosexual group which, in turn, had significantly higher depressive symptoms scores than the heterosexual group (respectively: 3.93 vs. 2.93 vs. 2.62, $p < .001$). These results are strongly confirmed by the ARCSHS studies. For instance, in the *Writing Themselves in Again* study (Hillier et al. 2005), young bisexual people were significantly more likely than homosexual respondents to report dissatisfaction with both themselves (23.3 percent vs. 14.5 percent, $z = 4.02$, $p < .001$) and their lives (17.2 percent vs. 6.7 percent, $z = 6.26$, $p < .001$). Overall, the literature suggests that higher rates of depression in non-heterosexual people may be slightly inflated due to even higher rates of depressive symptoms in bisexuals.

The literature that samples general GLB populations confirms the various trends that have been identified above. In particular, the studies reviewed point toward higher rates of depressive symptoms and poorer mental and physical health in non-heterosexual people when compared with heterosexual people. For instance, a key finding, extracted from the Australian Bureau of Statistics (2008) *National Survey of Mental Health and Wellbeing*, conducted in 2007, shows that homosexual/bisexual respondents had higher levels of affective disorders (which include bipolar disorder, major depression and dysthymia) than heterosexual respondents (19.2 percent vs. 6 percent). The literature on GLB populations (predominantly the ARCSHS studies) also confirms the findings reported above that show even poorer mental health outcomes for bisexuals.

Risk and protective factors for depression in non-heterosexual people

The literature on risk and protective factors for depression in non-heterosexual people was reviewed to explore the various psychosocial processes that make non-heterosexual people more vulnerable to depression. A key problem identified in the literature was a lack of research methodologies that allowed for the identification of causal factors for depression in non-heterosexual people. Several studies included multivariate analysis and correlation analysis, both of which can establish an association or relationship between variables, but neither can establish causality.

Being in a relationship appears to be a significant protective factor, both for non-heterosexual women and men. For instance, in one Canadian study, Ayala and Coleman (2000) found that mean depressive symptom scores were significantly lower for lesbians in a relationship when compared with those not in a relationship (23.88 vs. 33.02, $t = 2.95$, $p < .01$). However, it is important to keep in mind that relationship status also appears to be an influential variable for heterosexual people. Further, the results of some studies suggested that higher rates of depressive symptoms in non-heterosexual people persisted after factoring in demographic variables such as relationship status. Thus, not being in a romantic relationship is probably only one small part of the puzzle.

Residential context (living in metropolitan, suburban or rural areas) predicts depressive symptoms in some non-heterosexual samples, particularly when factoring in other variables such as sex. Two studies suggested that non-heterosexual young people (particularly young women) and HIV-positive gay/bisexual men are more vulnerable to depression when living in rural or suburban contexts rather than metropolitan ones. In the ARCSHS *Private Lives* study (Pitts et al. 2006), GLB people living in rural/remote areas were more likely than those in metropolitan areas to report feeling depressed on more than half the days in the past two years (39.2 percent vs. 31.8 percent, $\chi^2(1) = 13.95$, $p < .001$) and were more likely to contemplate self-harm or feel they were 'better off dead' (21.0 percent vs. 14.2 percent, $\chi^2(1) = 20.52$, $p < .001$). The data on bisexuals is

inconclusive. While one study suggested that both-sex-attracted young women living in non-metropolitan contexts may be at even higher risk for depression, the *Private Lives* data did not show the same pattern for bisexual respondents.

Social support from peers, friends and family emerges as a fairly robust protective factor against depressive symptoms in most non-heterosexual samples. Poor peer and family relationships predict increased levels of depressive symptoms in young people in general, and since non-heterosexual young people have poorer relationships with their peers and families they typically have significantly more depressive symptoms than heterosexual or other-sex-attracted young people. It appears that for lesbians support from friends, particularly lesbian friends, is a stronger protective factor against depressive symptoms than family support. For instance, Oetjen and Rothblum (2000) found that in a sample of lesbian women, while lower depressive symptom scores were significantly correlated with both perceived social support from friends ($r^2 = -.301, p < .0001$) and perceived social support from family ($r^2 = -.244, p < .01$), the former relationship was much stronger. There is some evidence to suggest that bisexual people may receive less social support than both heterosexuals and homosexuals, which may contribute to their consistently poorer mental health outcomes in the literature.

Feeling like one belongs to a community is a protective factor against depression in both heterosexual and non-heterosexual people; however, in some studies non-heterosexual people reported lower sense of belonging to the general community than heterosexuals and this leads to significantly more depressive symptoms. A series of publications based on research conducted in Victoria, Australia, suggest that this is true for both gay men and lesbian women. For instance, McLaren et al. (2007) found that across a sample of gay and heterosexual men, feeling a sense of belonging to the general community was associated with fewer depressive symptoms and, further, heterosexual identity was associated with feeling a stronger sense of belonging ($r = -.30, p < .001$) and less depressive symptoms ($r = -.21, p < .001$). Feeling a sense of belonging to the GLB community or participating in GLB community organisations also appears to be an important protective factor against symptoms of depression in GLB people, particularly

gay men. For instance, in the ARCSHS *Private Lives* study (Pitts et al. 2006), respondents who rated themselves as either ‘somewhat’, ‘rarely’ or ‘not at all’ connected to the GLBTI community were more likely than those reporting stronger connection to the community to have felt little interest or pleasure in doing things (35.6 percent vs. 23.6 percent, $\chi^2(1) = 69.81$, $p < .001$) and to have felt down, depressed or hopeless (44.0 percent vs. 32.7 percent, $\chi^2(1) = 55.7$, $p < .001$) in the two weeks prior to being interviewed.

The literature that examines disclosure of sexual orientation and its effects on depressive symptoms reveals contradictory results. Some studies show no relationship between these two variables, while others suggest that disclosure of one’s sexual orientation to family and friends predicts fewer depressive symptoms. In a study conducted in the USA, Lewis et al. (2001) found that depressive symptom scores were associated with degree of sexual orientation disclosure, such that gay men and lesbians who carefully concealed their sexual orientation had the highest depressive symptom scores (mean = 25.81) and those who were extremely open about their sexual orientation had the lowest depressive symptom scores (mean = 16.87). It is possible that disclosing one’s sexual identity may be a protective factor for depressive symptoms by lowering sense of isolation from the GLB community. On the other hand, concealing one’s sexual identity might also be a coping mechanism, or even a protective factor against depressive symptoms, by allowing non-heterosexual people to avoid discrimination, victimisation and stigmatisation.

Non-heterosexual young people appear to be at particularly high risk of having experiences of victimisation. In an international sample, D’Augelli (2002) found disturbingly high rates of victimisation among non-heterosexual young people. For example, 81 percent of the sample had been the victims of verbal abuse because of their sexual orientation. Further, 15 percent had suffered serious physical assault and 16 percent had been the victims of sexual assault. In the ARCSHS study *Writing Themselves In Again* (Hillier et al. 2005), a substantial number of young non-heterosexual people reported experiencing either verbal (44 percent) or physical abuse (16 percent). Moreover, a history of verbal, sexual and/or physical victimisation and abuse appears to

be associated with higher levels of depressive symptoms in non-heterosexual people. In a sample of gay men and lesbian women in the USA, Lewis et al. (2001) found that higher depressive symptom scores were significantly associated with threats and experiences of violence and harassment due to sexual orientation ($r = .29, p < .01$). There is evidence to suggest that same-sex-attracted younger gay men are subjected more frequently to physical violence than their female counterparts; further, fear and experiences of anti-gay violence in adulthood are particularly strong predictors of depressive symptoms in gay and other homosexually active men.

In relation to the impact of stigma and discrimination, the literature suggests that depressive symptoms in non-heterosexual people are associated with both ‘distal’ discriminatory events (that is, objective social acts or events in which non-heterosexual people are subjected to prejudice and discrimination), and ‘proximal’ processes (which include the subjective interpretation of discriminatory events, and the internalisation of discrimination and negative stereotypes). All the studies that measured ‘distal’ events showed that discrimination based on sexual orientation was associated with higher rates of depressive symptoms. For instance, Lewis et al. (2001) found that general discrimination, which included lack of access to mental health, housing and social services because of sexual orientation was significantly associated with higher depressive symptom scores ($r = .19, p < .01$). Work discrimination (which included actual and potential job loss) because of sexual orientation was also significantly associated with higher depressive symptom scores ($r = .21, p < .01$). The literature on ‘proximal’ processes focuses predominantly on the effects of ‘internalised homophobia’, and suggests that the internalisation of negative stereotypes associated with non-heterosexual orientation is associated with more depressive symptoms. It is interesting to note that overall, the literature on ‘proximal’ processes greatly outnumbers the literature on discriminatory acts and events, reflecting an overall tendency to reflect the focus back onto the psyches of non-heterosexual people themselves rather than exploring the social root of the problem—stigma and homophobia.

Interventions

The literature points towards a strong tendency for non-heterosexual people to exhibit higher rates of depression and depressive symptoms than heterosexual people. Further, there is evidence of a variety of potential risk factors for depression among non-heterosexual people. Several studies that explored these risk factors noted the potential for interventions that could lead to the improvement of mental health indicators in non-heterosexual people. Nevertheless, there were only two intervention studies that targeted depression in these people. These studies certainly appear to suggest that psychosocial interventions that draw from cognitive behavioural therapy models, or that aim to increase social support for participants, may be effective in reducing depressive symptoms in non-heterosexual people. For instance, Vincke and Van Heeringen (2002) found that among GLB young people who participated in GLB holiday camps in Belgium, increased confidant support as a result of the camp was significantly associated with lower depressive symptom scores ($B = -0.25, p < .01$). Curiously, there were no social intervention studies that targeted social processes such as victimisation, homophobia, and discrimination: the probable root of poor mental health in non-heterosexual people.

Outcomes of depression in non-homosexual people

Just as it is difficult to determine a causal link between depression and certain risk factors for depression, it is equally difficult to establish outcomes of depression due to a lack of appropriate research methodologies. Thus, it was difficult to determine whether depression was the cause or consequence of behaviours often connected to poor mental health. Nevertheless, the literature appears to suggest that depression is linked to three key outcomes among non-heterosexual people: sexual risk; alcohol and drug use; and suicidal behaviours.

Although depression and depressive symptoms in gay and other homosexually active men have been consistently associated with high-risk sexual behaviours in the literature, this review found mixed results. In two out of the four studies that measured both depression and sexual risk, unprotected anal intercourse among gay and other homosexually active men was not associated with depressive symptoms. However, the other two studies appear to suggest a connection between sexual risk and depression. Interestingly, Rogers et al. (2003) found that among a sample of South Australian homosexually active men, unprotected anal intercourse was not significantly associated with major depression but, rather, with dysthymia only. Twenty-nine percent of the sample suffering from dysthymia had engaged in unprotected anal sex in the past six months compared with 15 percent of those not suffering from a dysthymic disorder. Nevertheless, the results of this study do not support an overall relationship between depressive disorders and high-risk sexual behaviours.

Although non-heterosexual people (both men and women) tend to have higher rates of alcohol and drug use and dependency than heterosexual people, these differences are not always significant; however, there appears to be a more robust tendency for bisexuals to suffer from substance use and dependency disorders. Meyer et al. (2008) found that 51.4 percent of bisexuals compared with 35.5 percent of lesbians and gay men met the criteria for lifetime prevalence of any substance use disorder. There is also evidence that alcohol and drug misuse is associated with high rates of depressive symptoms, particularly in non-heterosexual women. Bostwick et al. (2005) found that, after adjusting for potentially confounding demographic variables, past-year depression significantly predicted past-year alcohol dependence among lesbians (OR = 2.03, $p < .01$). The literature suggests that substance use may be a coping strategy to deal with the stress related to living in homophobic environments.

Depression has been recognised as an important predictor of suicidal behaviour (e.g. suicidal thoughts, plans and attempts) in heterosexual populations and the same pattern is

true for non-heterosexual people, particularly for same-sex attracted young people. Further, it appears that higher prevalence rates of depression and depressive symptoms in non-heterosexual people are likely to predict higher rates of suicidal behaviour in this population when compared with heterosexual people; however, these findings are not always significant. In line with bisexual people's consistently poor mental health outcomes, bisexuals appeared to be at the same or higher risk for suicidal behaviour than homosexuals. For instance, McNair et al. (2005) found that in a cohort of 22 to 27 year-old Australian women, rates of feeling that life in the last week had not been worth living elevated according to ascending non-heterosexual identity. Further, mainly heterosexual (11.1 percent), bisexual (18.7 percent) and exclusively/mainly homosexual (17.3 percent) women were significantly more likely to report either harming or attempting to kill themselves in the last six months compared with exclusively heterosexual women (2.7 percent). McNair et al. found that in a mid-aged cohort (50 to 55 years), bisexual women had the highest rates of having had attempted suicide in the last six months (16.1 percent compared with 0.8 percent of exclusively heterosexual women, 4 percent of mainly heterosexual women, and 2 percent of exclusively/mainly homosexual women). Few studies explored the relationship between depression and suicide; however, the results of these studies show a strong link between these two variables. For instance, Botnick et al. (2002) found that in a sample of gay and other homosexually active men, depressive symptom scores were significantly higher for gay and other homosexually active men who had attempted suicide compared with those who had not (14 vs. 12, $p < .001$). Further, men who had attempted suicide were significantly more likely than those who had not to have been diagnosed with a mood disorder such as major depression.

Conclusions

A large majority of non-heterosexual people do not suffer from depression or any other mental disorder; however, most of the studies reviewed indicated a higher risk for depression, and various outcomes associated with it, in non-heterosexual people. The results of this literature review point to strong trends towards higher rates of depression,

more depressive symptoms, and poorer mental health outcomes for non-heterosexual people when compared with heterosexual people. Young non-heterosexual people clearly show significantly higher prevalence of depressive symptoms than their heterosexual counterparts. The literature also points to alarming rates of abuse and victimisation of young non-heterosexual people and, further, significantly higher rates of suicidal behaviour when compared with heterosexual young people. Although the results are less consistent for gay, lesbian and other homosexually active adult women and men, the data are still compelling. The theme that runs throughout this review is the effects of homophobia and heterosexism on the mental health of non-heterosexual people. In many ways, this points to a burden of poor mental health that may well be entirely preventable. In addressing depression for non-heterosexual people, the most effective response will be to institute measures to combat homophobia and discrimination in the general community and seek to level out many of the differences documented in this report.

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