

Systematic Review

Variables of Negative Impact on Mental Health in the LGBT Population: Identification of Measurement Scales—A Systematic Review

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Abstract

The scientific literature was reviewed to systematically identify and characterize validated scales measuring homophobia, lesbophobia, biphobia, and transphobia, as well as the biopsychosocial consequences derived from these attitudes in sexual and gender minority (SGM) populations. The search was conducted in the WOS, Scopus, and Medline databases, limited to studies published between January 2015 and January 2024. This review was registered in the International Prospective Register of Systematic Reviews, and its quality was evaluated using the Effective Public Health Practice Project instrument. The criteria of the PRISMA declaration for systematic reviews were applied. Among the 78 articles initially selected, 9 met the established eligibility criteria. In these 9 articles, 13 validated scales were identified, covering attitudes toward sexual and gender minorities, internalised stigma, minority stress and resilience, parental acceptance, and experiences of bullying and cyberbullying in SGM populations. The findings reveal substantial fragmentation in the available measurement landscape, with most instruments lacking cross-cultural validation, measurement invariance testing, and construct coverage beyond Western, English- or Spanish-speaking contexts. These results should be interpreted with caution given the limited number of included studies and the absence of meta-analytic quantification. This review proposes the development of a novel intermodular measurement system as a priority research agenda and identifies key implications for specialized psychiatric and clinical practice, public health surveillance, and future research.

Keywords: education; health care; homophobia; public health; transphobia



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1. Introduction

Human beings are multidimensional, with complex and comprehensive characteristics, whose primordial dimensions include intellectual, biological, volitional–social or relational, and ethical–moral dimensions [1]. Moreover, people are also historical and situated beings who interact with each other, as well as sexual beings. However, the patriarchal society has attempted to omit or hide the latter dimension (sexuality) based on religious ideas, and it continues to be assumed as taboo nowadays [2].

From a physiological perspective, biological sex is a multidimensional construct determined by characteristics such as chromosomes, gonads, hormones, and reproductive anatomy, whose combination gives rise, in most cases, to bodies classified as male or female—although biological variability, as seen in intersex cases, demonstrates that such classification is neither absolute nor binary—[3]. Sex (a biological variable) and gender (a social, cultural, and structural variable) are distinct concepts that operate both independently and in ways that can complement, reinforce, diminish, or negate one another [4]. Thus, based on the sex assigned at birth, social and cultural structures—including the patriarchal order—impose a system of meanings that defines what is expected of a person according to that category: this is what is known as gender. In practice, sex and gender are often conflated under the assumption that they mutually determine each other and do not differ, despite the widely held understanding that sex refers to biological characteristics while gender refers to social and behavioral ones [5]. Gender roles—that is, the set of behaviors, attitudes, and expectations that society attributes to the masculine or the feminine—do not, therefore, emerge from the body itself, but from the social interpretation made of it: it is the point of intersection where biology and culture articulate and mutually influence one another, without either dimension being reducible to the other.

Sexual orientation is defined as the pattern of emotional, romantic, affectional, and/or sexual attraction that a person experiences toward others and constitutes a dimension of human sexuality that is conceptually independent from both biological sex and gender identity. Far from being dichotomous categories, sexual orientation exists along a continuum, with natural variations among individuals and cultures in terms of its expression and identification [6]. Regarding its typology, various sexual orientations are recognized: heterosexuality, homosexuality, bisexuality, pansexuality, demisexuality, and asexuality, among others, reflecting the plurality and fluidity of human desire. As for its origins, there is no scientific consensus on the exact reasons why a person develops a particular sexual orientation; research has examined possible biological, developmental, social, and cultural influences, without any evidence linking sexual orientation to a single factor [7]. Current estimates suggest that genetic factors account for approximately 32% of the variance in sexual orientation [7], indicating that prenatal hormonal, neurological, and environmental factors also contribute significantly to its configuration. Sexual orientation is therefore not a deliberate choice, but rather the result of a complex interaction between biological, cognitive, and contextual variables that generally manifests during the early stages of development. Therefore, despite the beliefs of certain groups, there are no therapies that can change the sexual orientation or identity of people. Throughout the 20th century and the early 21st century, the lesbian, gay, bisexual, and transgender (LGBT) community experienced significant advances in the recognition of its rights: the decriminalization of homosexuality in numerous countries, the approval of same-sex marriage in more than 35 nations, and growing visibility in public and institutional spaces marked decades of sustained progress [8,9]. However, in recent years this progress has begun to reverse in different parts of the world. Countries such as Russia, Uganda, and Hungary have promoted legislation that restricts LGBT rights and criminalizes their public expression, while in societies with a longer tradition of tolerance, a resurgence of hostile discourse has also been observed, fueled in part by populist and conservative political movements [10,11]. ILGA World [12] and Human Rights Watch [13] warn of an increase in hate crimes against LGBT people, particularly against the transgender population, reflecting that the rights that have been won are not irreversible and that social acceptance remains a permanently contested terrain [14,15].

In this context, hateful conduct or behaviours may emerge, such as homophobia toward the sexual diversity of some people. Homophobia, lesbophobia, biphobia and

transphobia constitute the four central constructs of this work. Homophobia refers to the devalued status of non-heterosexual behaviors, identities, interactions or communities, as well as the hostile attitude toward sexual minority groups generated from that status [16–18]. Lesbophobia, in turn, is defined as the fear, hatred, prejudice or discrimination toward lesbian women, often rooted in both homophobia and sexism [19]. Regarding biphobia, it is interpreted by bisexual activism as a distinctive mode of oppression different from homophobia, encompassing sets of stereotypes, forms of denial—such as the assertion that “bisexuals do not exist”—or invisibilization through appropriation, which can be experienced in both heterosexual and lesbian–gay spaces [20]. Finally, transphobia is defined as the prejudice, discrimination and gender-based violence resulting from negative attitudes toward transgender identity [21,22]. These four constructs belong to the same conceptual family linked to stigma, discrimination and violence directed toward the LGBT population, and their negative effects on gay, lesbian, and transgender people are highly significant and have been the subject of numerous studies, which point to a significant relationship between experiences of discrimination and mental disorders in sexual minorities [23,24]. Research on mental health in LGBT populations has been primarily developed within the framework of the Minority Stress Model, proposed by Meyer [25], which constitutes the predominant theoretical reference in this field. This model posits that individuals belonging to sexual and gender minorities are exposed to unique and chronic stressors—such as discrimination, internalized stigma, and identity concealment—which compound the general stressors of everyday life and generate an excess of psychological burden with negative consequences for mental health [25,26]. Within this model, discrimination operates as a distal stressor that activates stress responses and increases the psychological vulnerability of these populations [27]. From this perspective, understanding the mechanisms through which discrimination affects mental health is essential to explaining the health inequalities observed in LGBT communities [28]. It is important to note, however, that while homophobia, lesbophobia, biphobia, and transphobia share a common conceptual family rooted in stigma and discrimination, the psychiatric mechanisms underlying stigma related to sexual orientation and those related to gender identity are not interchangeable. Transphobia operates through distinct pathways—including non-affirmation of gender identity, misgendering, and exclusion from gender-congruent spaces—that differ qualitatively from the mechanisms underlying homophobia or biphobia, which the Minority Stress Model has begun to address specifically through extensions such as the Gender Minority Stress framework proposed by Hendricks and Testa [26]. This distinction has direct implications for measurement: instruments designed to assess sexual orientation-related stigma cannot be assumed to capture gender identity-related stigma with equivalent validity, and vice versa. Knowing the negative attitudes toward homosexuality is especially relevant due to their strong impact on sexual minority people, not only at the physical level but also at the psychological level. For instance, it has been reported that sexual minority students have experienced high levels of anxiety, somatic discomfort, and even post-traumatic stress symptoms. All these manifestations have a negative effect on the people who suffer them and, therefore, on their quality of life [29].

In order to identify attitudes of this sort toward LGBT people and carry out adequate interventions, it is necessary to develop valid detection instruments. However, although a number of validated scales exist to assess homophobia, lesbophobia, biphobia, and transphobia, the available instruments remain highly fragmented, lack cross-cultural validation in diverse contexts, and show considerable heterogeneity in the constructs they measure, which limits their comparability and the systematic accumulation of evidence.

However, despite growing research interest in stigma toward sexual and gender minorities, one of the main methodological challenges in this field is the absence of a

consolidated set of psychometrically validated measurement instruments for assessing homophobia, lesbophobia, biphobia, and transphobia [16,30]. The proliferation of ad hoc scales developed with little or no evidence of validity and reliability hinders comparability across studies and limits the robustness of the conclusions drawn [31]. Therefore, the aim of this study was to identify studies that have used validated scales to measure variables related to homophobia, lesbophobia, biphobia and/or transphobia, as well as possible biopsychosocial consequences derived from them.

2. Materials and Methods

In this study, a systematic review of the scientific literature was performed, gathering research related to the identification of variables of negative impact on the health of the LGBT population. Studies measuring attitudes of aggression, harassment, or rejection based on sexual orientation were identified and analysed. The following aspects were collected: homophobia, lesbophobia, biphobia and transphobia; identification of risk factors; and possible consequences derived from these behaviours. The criteria of the PRISMA declaration [32] for systematic reviews were applied, thoroughly analysing the articles selected (Table S2). This work was registered in the International Prospective Register of Systematic Reviews (PROSPERO).

The PEO (Population, Exposure, Outcome) format was used, and the following was formulated:

- P: LGBT population (lesbians, gays, bisexuals, and transgender people).
- E: negative attitudes (homophobia, lesbophobia, transphobia, biphobia).
- O: validated psychometric scales/instruments and negative consequences on mental health because of negative attitudes.

2.1. Selection Criteria

This systematic review was carried out between December 2023 and March 2024 in the Web of Science (WOS), SCOPUS and Medline databases, gathering studies published in the last 9 years, i.e., between 2015 and 2024, and selecting only open-access articles. The temporal scope was deliberately set to capture recent validation studies of measurement instruments, ensuring that the psychometric data reported reflects contemporary clinical and research practice. Notably, foundational scales developed prior to 2015—such as the ATLG or the MHS—are nonetheless represented in this review, as they were selected and employed by researchers within the defined timeframe, which itself confirms their continued relevance and validity in the current scientific literature. The combination of Medline, WOS and Scopus has been identified as the optimal combination in systematic reviews, achieving an overall retrieval rate of 98.3% [33], which supports the suitability of the search strategy employed in this work. Furthermore, given the substantial indexing overlap between PsycINFO and MEDLINE in the domain of mental health and behavioural sciences, the risk of having missed eligible studies through the non-inclusion of PsycINFO is considered minimal, though this remains acknowledged as a limitation of the present review.

2.2. Search Strategy

The keywords used to conduct the search were obtained from MeSH descriptors, elaborated by the National Library of Medicine, and the thesauri of Spanish Social Science descriptors (DeCS). Boolean operators AND and OR were employed. This decision ensured terminological consistency and methodological rigour, as MeSH and DeCS constitute the standard controlled vocabularies for systematic indexing in biomedical and health sciences literature. More contemporary terms such as ‘homonegativism’, ‘sexual prejudice’, or ‘gender minority stigma’, while increasingly present in recent empirical literature, had

not been consolidated as standardised MeSH or DeCS descriptors at the time the search was conducted, and their use as free-text terms outside controlled vocabulary would have introduced retrieval inconsistency. Conceptually, however, the constructs captured by the selected descriptors—homophobia, lesbophobia, biphobia, and transphobia—encompass the same attitudinal and stigma-related phenomena designated by this more contemporary terminology, as supported by the theoretical framework of the Minority Stress Model [25] and the construct definitions adopted in this review [16–22].

In order to operationalize the main constructs of homophobia, lesbophobia, biphobia and transphobia in the search strategy of the present systematic review, each of them was translated into specific search terms. Homophobia was used as the main search term, given that it refers to the devalued status of non-heterosexual behaviors, identities and interactions, as well as the hostile attitudes toward sexual minority groups generated from that status [16–18]. Lesbophobia was included as an independent term, as it designates a specific form of discrimination toward lesbian women, often rooted in both homophobia and sexism, and therefore requires a differentiated search [19]. Biphobia was likewise incorporated independently, since it constitutes a distinctive mode of oppression different from homophobia, which can be experienced in both heterosexual and lesbian–gay spaces, thus justifying its treatment as an autonomous construct in the search [20]. Finally, transphobia was included as a specific search term as it refers to the prejudice, discrimination and gender-based violence resulting from negative attitudes toward transgender identity, a conceptually distinct phenomenon from the above that particularly affects transgender people [21,22].

The search strategy combined natural and controlled vocabulary using Boolean operators adapted to each database. The general search strategy was as follows: (“LGTB” OR “Sexual and Gender Minorities”) AND (“homophobia” OR “lesbophobia” OR “biphobia” OR “transphobia”) AND (“homophobia scale” OR “lesbophobia scale” OR “biphobia scale” OR “transphobia scale” OR “mental health”). The complete strategies are available in the Supplementary Material (Table S1). Additionally, the references in relevant bibliographic reviews were manually screened to identify possible additional records that had not been found in the database search.

2.3. Inclusion and Exclusion Criteria

The following inclusion criteria were used: (a) studies that identified homophobic, lesbophobic, biphobic and transphobic attitudes, as well as the biopsychosocial consequences derived from these behaviours; (b) studies that used validated scales; (c) articles published in scientific journals; and (d) studies whose samples were preferably constituted by young populations. However, studies involving adult or middle-aged populations were also considered eligible when they met all remaining inclusion criteria and contributed validated psychometric instruments of particular relevance to the objectives of the review. Therefore, only original articles were included.

The following exclusion criteria were applied: (a) Studies conducted in contexts where homophobia, lesbophobia, biphobia or transphobia are legally institutionalized, since in these settings the measurement of attitudes may be severely conditioned by social desirability and legal repression, compromising the validity of the data obtained and preventing meaningful cross-contextual comparisons; the findings of this review are therefore intended to be generalizable to contexts characterized by legal protection or neutrality toward SGM populations and not to contexts of state-sponsored institutional repression, which constitute a qualitatively distinct research domain requiring specific methodological approaches. (b) Studies in which homophobia, lesbophobia, biphobia or transphobia were not the primary focus of the research but appeared only as secondary or

control variables, as their marginal treatment would not allow for an adequate extraction of data on attitudes and their biopsychosocial consequences. (c) Opinions, perspectives, systematic and bibliographic reviews, letters to editors, and commentaries. In order to increase the reliability and safety of the process, the suitability of the selected articles with the study object and the inclusion criteria was verified by two of the authors of the current work (J.-R.G.-S. and F.-J.G.-V.). When doubts about inclusion emerged after reading the title, abstract and keywords of any article, the third author (E.M.-S.) mediated the decision on its inclusion or exclusion. This approach to addressing selection bias was conducted across the databases.

The identification and selection of all articles (both included and excluded) and the reason for their exclusion in the screening and selection phase are shown in the following flowchart (Figure 1), in compliance with the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) declaration [32].

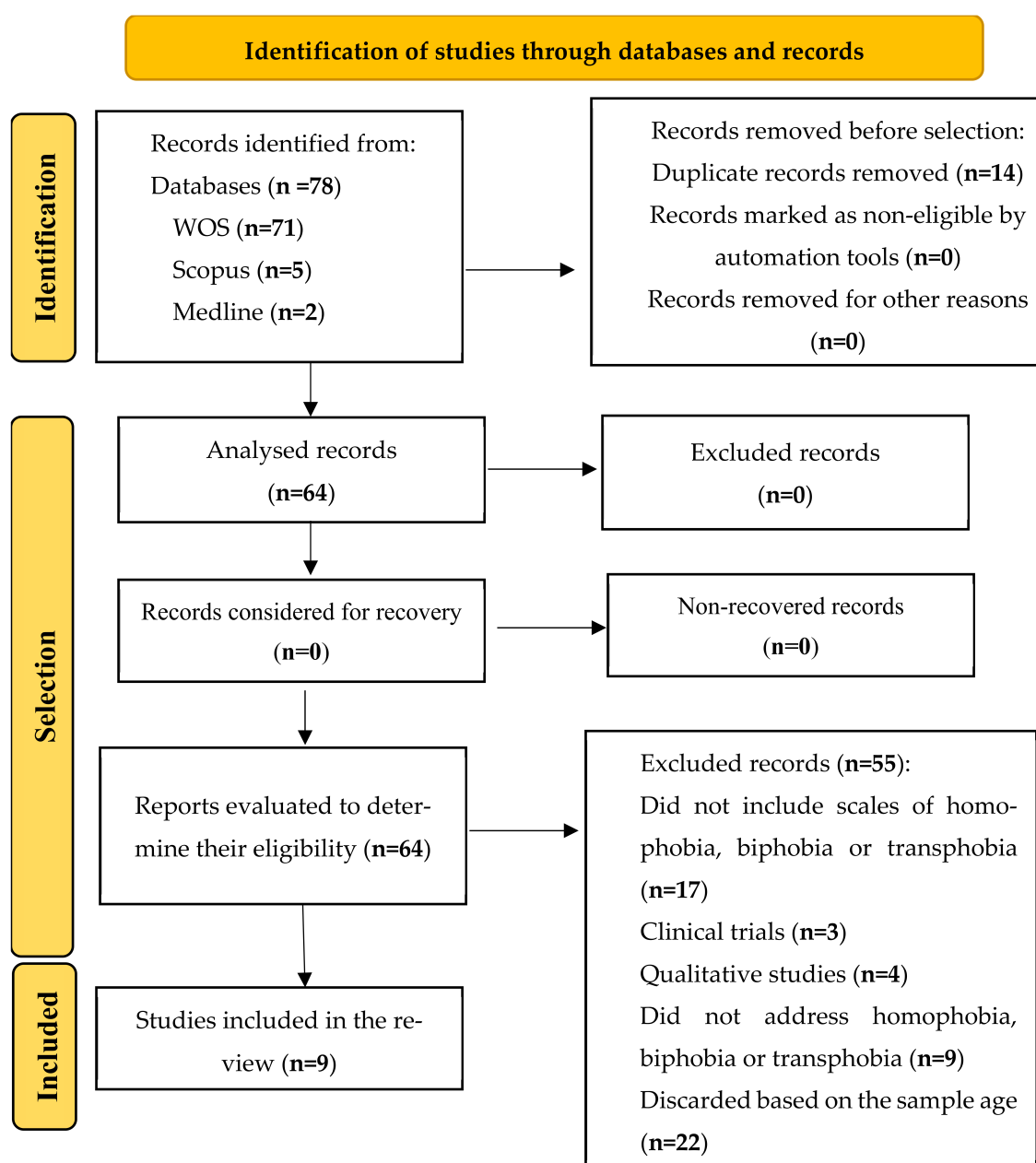


Figure 1. Flowchart of the systematic review process according to the PRISMA protocol declarations.

2.4. Data Extraction

The adjustment of the selected articles to the study object and inclusion criteria, with the aim of increasing the reliability and certainty of the process, was performed as established in the PRISMA declaration.

This process resulted in numerous judgements and actions after the search. To this end, the authors began, primordially and thoroughly, by reviewing the title, abstract, method, results and conclusions of each article, and the data were extracted as they were found in their respective studies when they were reviewed.

This systematic review also included variables following the PICOS acronym. This acronym was used in the data extraction strategy since, although the PEO format was adopted for the research question, the PICOS acronym can also be used as a guide for data extraction; referring to five components: the population or disease addressed (P), the interventions or exposure (I), the comparator group (C), the outcome or result (O), and the chosen study design (S). In the case of this research, the “I” has been used to refer to exposure [34]. With this strategy, it was possible to delimit the inclusion criteria and, based on them, carry out a qualitative analysis of the results. Moreover, this study included other variables that were considered relevant: reference citation, country, article reference, study objectives, measurement variables, and scales [35].

After this analysis, it was possible to select, more accurately, the most suitable articles to be included in this review.

2.5. Presentation of the Results: Adherence to Quality Initiatives (PRISMA)

The results of the primary studies, obtained through a systematic and reproducible methodology, were presented qualitatively and quantitatively (Figure 1).

2.6. Quality Evaluation

For the selection of articles, a quality analysis was conducted, following the components of quality evaluation and the ratings of the Effective Public Health Practice Project (EPHPP) instrument [36]. With this instrument, a general rating of each article was carried out, evaluating six components (Table 1). Those without weak ratings and with at least four strong ratings were considered strong. Those with less than four strong ratings and one weak rating were considered moderate. Lastly, those with two or more weak ratings were considered weak [36,37].

The conclusions of this analysis are shown in Table 1. Of the nine articles included, seven of them presented a moderate global score [38–44] and one showed a weak global score [29,45]. It is worth highlighting that all studies presented strong internal components in variables such as data gathering or the percentage of participants who reached the end of the intervention. These internal components are relevant and prioritisable with respect to other components, since they represent a greater connection to the study object of this systematic review. Thus, although some studies presented moderate or weak internal components, since their most relevant internal components were strong, they were included in this work. Furthermore, none of the studies obtained a weak score in the confounding factors or in the risk of bias.

Table 1. Components of quality evaluation and ratings for the EPHPP instrument.

Articles	COMPONENTS **						Global Score *
	1	2	3	4	5	6	
García-Sánchez et al., [29]	M	W	M	W	S	S	W
López-Sáez et al., [38]	S	W	S	M	S	S	M
Henderson et al., [45]	M	W	M	W	S	S	W

Table 1. Cont.

Articles	COMPONENTS **						Global Score *
	1	2	3	4	5	6	
Katz-Wise et al., [39]	M	W	M	M	S	S	M
Meanley et al., [40]	S	M	M	M	S	S	M
Conn et al., [41]	S	M	M	M	S	S	M
Vance et al., [42]	S	W	M	M	S	S	M
Lin et al., [43]	M	W	M	M	S	S	M
García-Berbén et al., [44]	M	W	M	M	S	S	M

* W = Weak; M = Moderate; S = Strong. ** 1 = Risk of bias; 2 = Design; 3 = Confounding factors; 4 = Masking; 5 = Data gathering; 6 = Exclusions and withdrawals.

3. Results

3.1. Selection of Studies and Data Extraction Process

After the search, the title, abstract and keywords of each article were reviewed, with the aim of selecting those that could be relevant and discarding those that did not meet the inclusion criteria.

The searches were carried out and the inclusion criteria were applied, obtaining a total of 78 articles. The first search was performed in Web of Science (WOS), where 71 articles were found; the second search was conducted in Scopus, gathering 5 articles; and the third search was carried out in Medline, obtaining a total of 2 articles.

Fourteen duplicate articles were discarded, resulting in a sample of 69 articles for full-text review. After applying the eligibility criteria, 60 articles were excluded, obtaining a final sample of 9 articles. The reason for excluding those 60 articles from the systematic review was that, although they initially met the inclusion criteria, after a more exhaustive reading, it was detected that they were either clinical trials because their primary objective was to evaluate the effectiveness of an intervention program and not the measurement of homophobic, lesbophobic, biphobic and transphobic attitudes and their biopsychosocial consequences in the population ($n = 3$) or qualitative studies without validated scales ($n = 4$), whereas others did not meet the study objective, as they did not include specific scales ($n = 17$) or did not address homophobia, biphobia or transphobia ($n = 9$); the rest of them did not correspond to the characteristics of the study population ($n = 27$). With the aim of reducing the risk of selection bias, each article was reviewed independently by two of the authors of this study (J.-R.G.-S. and F.-J.G.-V.) to decide whether each article met the established criteria. If they did not reach a consensus on the inclusion of an article, the third author (E.M.-S.) mediated the decision. This new selection bias assessment was performed following the final selection of articles.

3.2. Characteristics of the Studies: Results Synthesis

Table 2 presents the following data of each of the studies included in this review: reference citation, country, type of study, comparisons, study objectives, participants, measurement variables and instruments, interventions and results.

Table 2. Characteristics of the results of the studies included in the systematic review.

Reference Citation; Country	Study Design	Comparisons	Study Objectives	Participants	Measured Variables (Measurement Scales)	Interventions	Results/ Conclusions
[29]; Spain	Quantitative, descriptive and cross-sectional study	A single study group (Andalusian population aged 18–80 years).	Identify homophobic and lesbophobic attitudes in a young Spanish population, analysing the relationship of these attitudes with sociodemographic, cultural, political and personal variables.	The participants of the study were 325 people aged 18–30 years (214 women and 111 men).	Homophobia and lesbophobia (Modern Homophobia Scale by Raja and Stokes).	A validated scale was virtually administered to the study population, and the study variables were analysed.	The men showed a more negative attitude toward gay and lesbian people compared to the women. The participants with a higher education level presented more positive attitudes toward gay and lesbian people. The youngest participants with heterosexual orientation showed more negative attitudes toward gay and lesbian people. The participants with a right-wing political tendency showed a greater percentage of negative attitudes toward LGBT people.
[38]; Spain	Quantitative, analytical, descriptive, cross-sectional and correlational study	A single study group (population aged 17–49 years).	Evaluate the correlations between sexism, homonegativity, binegativity, pro-trans attitudes, political affiliation, contact with LGBT people and perceived stigma among psychology students.	655 cis women (471 heterosexual, 179 bisexual and lesbian) and 174 cis men (120 heterosexual, 54 bisexual or gay).	Contemporary negative attitudes toward gays and lesbians (Modern Homonegativity Scale). Negative attitudes toward bisexuality (Biphobia Scale). Negative attitudes toward trans people. (Transgender Attitude and Belief Scale).	All participants completed a validated scale online. The answers were gathered and analysed.	In general, the groups of men and heterosexuals obtained higher negativity scores and lower acceptance scores, with significant correlations being more frequent in the heterosexual group. The predictive models confirmed the literature about social and ideological conservatism.
[45]; USA	Descriptive and qualitative study	A single study group (population composed of adolescents aged 14–18 years).	Qualitatively describe the ways in which young people of sexual and gender minorities (SGMY) experience bullying victimisation.	20 participants (10 bisexual, 6 lesbian and 4 gay).	Semi-structured interviews for the gathering of detailed data about bullying victimisation experiences (validated interview developed by the authors).	Semi-structured interviews were administered online through social networks to the recruited population of participants. The data were gathered and analysed.	A high prevalence of bullying victimisation was observed in SGMY. The different types of bullying identified were verbal, physical, sexual, gender vigilance, and other actions aimed at excluding the participants.
[39]; USA	Longitudinal and quantitative study	A single group (trans adolescents aged 13–17 years).	Examine the longitudinal effects of the stressful factors of gender minorities on substance consumption in adolescents, as well as the associated risk factors and protective factors derived from internalised transphobia.	30 trans adolescents (11 female trans, 15 male trans and 4 non-binary).	An 8-item subscale of the “Gender Minority Stress and Resilience Measure (GMSR)” was used to evaluate internalised transphobia in adolescents. This subscale is used to measure how internalised transphobia affects adolescents and how it is related to substance consumption and other risk and protective factors.	Online questionnaires were administered to the participant population every six months for two years. The data were gathered and analysed.	Exposure to stressful factors of gender minorities was associated with greater probabilities of alcohol consumption. In all models, internalised transphobia, resilience and gender-related pride were the most significant mediators in the relationship between stressful factors and substance consumption. Family and social networks significantly moderated the association between stressful factors of gender minorities and alcohol consumption, although only at the lowest stress levels.
[40]; USA	Multicentric cohort study	A single group composed of middle-aged and older men of sexual minorities.	Evaluate the psychometric properties of a homophobia management scale.	The sample included 798 cisgender middle-aged and older men of sexual minorities (91.5% homosexual).	Psychological resilience and psychological attachment toward gay people and capacity of gay and bisexual men to manage homophobia (Homophobia Management Scale, Internalised Homophobia Scale).	The data were gathered through self-administered questionnaires that could be completed in paper or on a Tablet. The results were gathered and analysed.	The participants who reported greater levels of psychological resilience and stronger attachment toward the gay community tended to better manage homophobia and stress and presented a greater capacity to face discrimination.

Table 2. Cont.

Reference Citation; Country	Study Design	Comparisons	Study Objectives	Participants	Measured Variables (Measurement Scales)	Interventions	Results/Conclusions
[41]; USA	Quantitative, cross-sectional and descriptive study	A single group of transgender young people aged 12–20 years who wanted to initiate hormone therapy.	Examine the association between internalised transphobia and the symptoms of depression and anxiety, as well as whether higher levels of gender-identity pride may reduce the association between internalised transphobia and the symptoms of depression.	The sample consisted of 315 transgender and gender-diverse (TGD) young people [60.3% male trans, 33.7% female trans; 3.8% non-binary, 1.3% gender-fluid and 1% other].	Symptoms of anxiety (Revised Children's Manifest Anxiety Scale), symptoms of depression (Beck Depression Inventory-II) and stress and resilience associated with gender identity (Gender Minority Stress and Resilience Measure for Adolescents).	A convenience sampling was conducted among young people who wanted to initiate hormone therapy through pediatric clinics. The selected sample completed the study scales online. The data were gathered and analysed.	Greater internalised transphobia poses an increase in the symptoms of depression and anxiety. Gender-identity pride moderates the relationship between internalised transphobia and the symptoms of depression. Parental support was associated with lower levels of depression and anxiety.
[42]; USA	Quantitative, observational, cross-sectional and comparative study	Transgender and non-binary young people aged 12–20 years who had initiated hormone therapy. Two groups: -BLTY: Black/Latino youths. -WTY: White youths.	Compare the symptoms of mental health and gender affirmation between Black/Latino (BLTY) and White (WTY) transgender/non-binary young people; establish associations between gender affirmation and symptoms of mental health and whether these associations are different according to race/ethnicity subgroup.	262 transgender/non-binary young people (92 BLTY and 170 WTY).	Presence of depression and its severity (Beck Depression Inventory-II), symptoms of anxiety (Revised Children's Manifest Anxiety Scale, Second Edition), parental support (Perceived Parental Acceptance Subscale) and stress and resilience associated with gender identity (Gender Minority Stress and Resilience Measure for Adolescents).	The participants were recruited from the cohort of the hormone therapy and gender affirmation study Trans Youth Care United States between 2016 and 2019. Self-administered questionnaires were completed online. The data were gathered and analysed.	No significant differences were obtained in the symptoms of depression and anxiety between transgender and non-binary Black, Latino and White youths. The White youths presented a greater suicidal tendency. No significant differences were detected in parental acceptance, non-affirmation, internalised transphobia or community connectivity. The greater the parental acceptance, the lower the probability to suffer from depression. Not living with the affirmed gender was associated with a greater probability of depression. Greater levels of non-affirmation and internalised transphobia were related to a greater probability of depression, suicidal ideation, and anxiety.
[43]; China	Quantitative and cross-sectional study	A single group composed of gay and bisexual young people aged 20–25 years.	Analyse the associations between homophobic bullying victimisation during childhood and the symptoms of borderline personality disorder (BPD) in early adulthood and explore the mediating effect of depression and perceived family support.	The study population was composed of 500 gay and bisexual men from Taiwan aged 20–25 years.	Homophobic bullying in childhood (Mandarin Chinese version of the School Bullying Experience Questionnaire), homophobic cyberbullying in childhood (Cyberbullying Experiences Questionnaire), borderline personality disorder (Mandarin Chinese version of the Borderline Symptom List), symptoms of depression (Mandarin Chinese version of the Centre for Epidemiologic Studies Depression Scale), and family support (Mandarin Chinese version of the Family Adaptation, Partnership, Growth, Affection, and Resolve (FAPGAR) scale).	The participants were recruited through adverts published in social networks such as Facebook, Twitter, and LINE, online bulletin boards, and three health promotion and counseling centres for lesbians, gays and bisexuals (LGB) in Taiwan. The participants responded to the online questionnaires after sending their written informed consent. The data were gathered and analysed.	Homophobic bullying in childhood (physical, verbal, social and cyberbullying) was significantly associated with an increase in BPD symptoms. Homophobic bullying in childhood was related to a greater probability of developing symptoms of depression, which also contributed to symptoms of BPD. Family support moderates these symptoms of depression and BPD.

Table 2. Cont.

Reference Citation; Country	Study Design	Comparisons	Study Objectives	Participants	Measured Variables (Measurement Scales)	Interventions	Results/ Conclusions
[44]; Portugal	Quantitative, cross-sectional and psychometric validation study.	A single group composed of Portuguese students aged 18–27 years.	Adapt and validate the Portuguese version of the Modern Homonegativity Scale (MHS) and analyse modern homonegativity among Portuguese university students, evaluating the sociodemographic differences.	641 Portuguese university students (82.2% heterosexual).	Contemporary negative attitudes toward gay and lesbian people (Modern Homonegativity Scale), general attitudes toward homosexual people—gays and lesbians (Attitudes Toward Lesbians and Gay Men Scale).	The participants were recruited through adverts in social networks and e-mails sent to coordinators of BSc and MSc degrees in different universities and polytechnic centres in Portugal. The data were gathered online and analysed.	MHS showed a strong and positive correlation. The men showed a greater modern homonegativity toward gays and lesbians. The heterosexual participants presented higher levels of modern homonegativity. Although the participants who practised a religion showed higher levels of modern homonegativity, the differences were not statistically significant.

Of the nine articles included in this review, five (55.56%) were descriptive, cross-sectional, quantitative and correlational [29,38,41–43], one (11.11%) was descriptive and quantitative [45], one (11.11%) was longitudinal and quantitative [39], one (11.11%) was a multi-centric cohort study [40] and one (11.11%) was a quantitative, cross-sectional and psychometric-validation study [44].

Regarding the countries in which the different studies were carried out, two of the studies were conducted in Spain (22.22%) [29,38]; five studies were performed in USA (55.56%) [39–42,45]; one was carried out in China (11.11%) [43]; and one was conducted in Portugal (11.11%) [44].

With regard to the study population, it was observed that 33.33% of the studies used people with diverse gender identity and sexual orientation (heterosexual, gay, lesbian, bisexual and transgender people) [29,38,44]. In 33.33% of the studies, only transgender people participated [39,41,42]. In 22.22%, the samples were constituted by cis men of sexual minorities (homosexuals and bisexuals) [40,43]. Lastly, 11.11% of the studies only used homosexual people (gays and lesbians) [45].

Regarding the age of the participating population, the sample of 44.44% of the studies was composed of adolescents aged between 12 and 20 years [39,41,42,45]. Other works (44.44%) analysed samples of youths aged 18–30 years [29,38,43,44]. One study (11.11%) used an adult population [38]. Lastly, the sample of one study (11.11%) was constituted by middle-aged participants [40]. Although the review prioritised younger populations in line with its inclusion criteria, the inclusion of studies with broader age ranges was justified by their contribution of psychometrically validated instruments that addressed the core constructs of this review and met all other eligibility criteria.

3.3. Identified Scales on Sexual Minority Stigma

Next, we detail the identified scales (Table 3).

A cross-scale reading of the instruments identified reveals several critical psychometric limitations that transcend individual tools and reflect structural gaps in the field as a whole.

First, construct overlap is a recurrent problem: the MHS (Raja & Stokes), the MHS (Morrison & Morrison), and the ATLG all measure attitudinal prejudice toward gay and lesbian people using partially overlapping item content and similar Likert formats, yet without established convergent or discriminant validity evidence between them, making it difficult to determine what each instrument uniquely captures.

Second, measurement invariance across groups has rarely been tested. Most scales were validated in a single population (typically White, Western, university-educated adults) and subsequently applied to different demographic groups without formal invariance testing, which compromises the comparability of scores across subgroups and limits the generalizability of findings.

Third, cross-cultural validation gaps are substantial. Of the 13 scales, only the ATLG and the MHS (Raja & Stokes) have been validated in more than four countries, and even these validations are concentrated in Western, English-speaking, or Spanish-speaking contexts. Instruments such as the GMSR-A, the HMS, and the PAGES-Y have been validated exclusively in the United States, and predominantly in White, middle-class samples. Non-Western cultural contexts—including Latin America beyond Spain, Sub-Saharan Africa, Southeast Asia, and the Middle East—are almost entirely absent from the validation literature.

Table 3. Identified scales.

Scale	Abbreviation	Reliability (α)	Factor Structure	Target Population	Cross-Cultural Validation	Strengths	Limitations
Modern Homophobia Scale	MHS (Raja & Stokes)	$\alpha = 0.92\text{--}0.95$	2 parallel unidimensional subscales (MHS-G and MHS-L). 5-point Likert scale.	Heterosexual adults	USA, Chile, Spain, Portugal	Measures modern homophobia (institutional and subtle); parallel versions by gender target (gay/lesbian); extensive international track record.	Does not assess bisexual or transgender individuals; designed for heterosexual respondents only; variability in reverse-scored items across adaptations.
Modern Homonegativity Scale	MHS (Morrison & Morrison)	$\alpha = 0.85\text{--}0.93$	12 items, two parallel forms (MHS-G and MHS-L). Unidimensional (~45–47% variance explained).	General adults	Canada, Ireland, USA, Brazil, Spain, Portugal	Measures modern prejudice (not moral/religious); parallel instruments by gender target; robust evidence across multiple languages.	Requires administering two separate scales; 12-item model fit sometimes questionable; reverse-scored items problematic.
Biphobia Scale	BS	$\alpha = 0.95 / \omega = 0.96$	Single factor. Validated with Spanish sample ($n = 466$).	General population (adults)	USA (original); Spanish adaptation (López-Sáez et al.)	Excellent internal consistency; unidimensional and easy to use; one of the first validated instruments in Spanish for biphobia.	Validation almost exclusively in a Spanish sample; no data in adolescents or clinical samples; does not assess internalized biphobia in bisexual individuals.
Transgender Attitude and Belief Scale	TABS	$\alpha = 0.88\text{--}0.98$	29 items, 3 factors: interpersonal comfort, gender identity beliefs, human value.	General adults	USA, Spain, Canada (nurses)	Nuanced conceptualization beyond simple transphobia; high internal consistency replicated across countries; linguistically updatable without compromising psychometric properties.	Gender identity beliefs subscale shows low variability in homogeneous samples; primarily used in university settings; does not differentiate attitudes toward trans men vs. trans women.
Gender Minority Stress and Resilience Measure (adults)	GMSR	$\alpha = 0.62\text{--}0.89$	9 subscales: discrimination, rejection, victimization, non-affirmation, internalized transphobia, negative expectations, non-disclosure, pride, community connectedness.	TGNC adults	USA, Spain, Mexico (Tijuana), Hungary	First psychometrically validated measure for gender minority stress (multidimensional); captures distal/proximal stressors and resilience; strong theoretical foundation (Meyer's minority stress model).	Complex scoring (dichotomous + Likert); discrimination subscale consistently shows low reliability; not designed directly for adolescents.
Gender Minority Stress and Resilience Measure (adolescents)	GMSR-A	$\alpha = 0.69\text{--}0.89$	Adaptation of the 9 adult GMSR subscales with minimal rewording. One additional victimization item added.	TGNC adolescents (ages 12–18)	USA (pediatric gender clinics)	First psychometrically validated adaptation of the GMSR for individuals under 18; demonstrated clinical utility; theoretical coherence with the adult version.	Validation primarily in US gender clinics (predominantly White sample); no cross-cultural validation outside the Anglo-Saxon context; complex scoring system retained from adult version.

Table 3. Cont.

Scale	Abbreviation	Reliability (α)	Factor Structure	Target Population	Cross-Cultural Validation	Strengths	Limitations
Homophobia Management Scale	HMS	$\alpha = 0.69$	Unidimensional. 6 items. CFA confirmed single-factor structure.	Middle-aged and older sexual minority men	USA only (MACS study)	First validated scale measuring active management of homophobic stigmatization; brief (6 items) and theoretically grounded in proactive coping model; useful for aging and health research.	Modest internal consistency ($\alpha = 0.69$); validated only with cisgender middle-aged/older men; no validation outside the USA.
Internalised Homophobia Scale	IHP/SIHS	$\alpha = 0.80\text{--}0.90$	Unidimensional. 10 items (Likert 0–4). Some reverse-scored items.	Gay and bisexual men	USA, Turkey, Eastern Europe and Central Asia	Widely used and replicated internationally; high internal consistency; theoretically grounded in the internalized stigma construct.	Developed with gay/bisexual men; requires linguistic adaptation for lesbian women; may not capture contemporary subtle forms of internalized homonegativity; first-person items may elicit socially desirable responses.
Perceived Parental Acceptance Subscale	PAGES-Y	$\alpha = 0.87$	14 items, 2 subscales: perceived parental non-affirmation and perceived parental acceptance. Derived from EFA in a clinical sample.	Trans/gender-expansive adolescents and young adults (ages 12–24)	USA only (pediatric gender clinic, Midwest)	Specifically designed to capture parental attitudes toward the adolescent's gender expression; differentiates parental non-affirmation from active parental acceptance; validated in specialized gender healthcare samples.	Preliminary psychometric evidence with relatively small sample; no validation outside the USA or in other languages; limited generalizability beyond specialized clinical samples.
School Bullying Experience Questionnaire (Mandarin Chinese version)	C-SBEQ	$\alpha = 0.77\text{--}0.82$	6 items, 2 factors: verbal ridicule/relational exclusion; physical aggression/theft of belongings. 4-point Likert scale (0–3).	Adult gay and bisexual men (retrospective)	Taiwan (Mandarin Chinese-speaking population)	Contextualized for school bullying in Chinese-speaking settings; distinguishes types of bullying (verbal–relational vs. physical); brief and easy to administer retrospectively.	3-item subscales with modest internal consistency; possible memory bias from retrospective recall; validated primarily with adult gay/bisexual men in Taiwan.
Cyberbullying Experiences Questionnaire	CEQ	$\alpha = 0.79\text{--}0.82$	3 items: negative online comments, posting of disturbing images/videos, spreading rumors. 4-point Likert scale (0–3).	Adult sexual minority men (retrospective)	Taiwan (Mandarin Chinese-speaking context)	Captures cyberbullying as a distinct form of victimization; adapted to the current technological context (social media, blogs); brief and easy to incorporate alongside other measures.	Only 3 items; potentially insufficient content coverage; retrospective validation with adults only; limited generalizability (sexual minority men in Taiwan).

Table 3. Cont.

Scale	Abbreviation	Reliability (α)	Factor Structure	Target Population	Cross-Cultural Validation	Strengths	Limitations
Family APGAR (Mandarin Chinese version)	C-FAPGAR	$\alpha = 0.80\text{--}0.85$	5 items (one per dimension: Adaptation, Partnership, Growth, Affection, Resolve). Unidimensional. 3-point Likert scale (0–2).	General adults; gay and bisexual men in Taiwan	Widely adapted across multiple languages (Spanish, Chinese, Portuguese, among others)	Very brief (5 items); low administration burden; extensive evidence base for the original instrument; well-known in primary care and community health.	Only 5 items on a 3-point scale; assesses subjective perception of family functioning, not actual functioning; limited psychometric evidence specifically for sexual minority populations.
Attitudes Toward Lesbians and Gay Men Scale	ATLG	$\alpha = 0.85\text{--}0.96$	20 items (ATG: 10; ATL: 10). Short versions of 3, 4, or 5 items with $r > 0.95$ with full versions. Hierarchical third-order model confirmed.	Heterosexual adults	USA, Netherlands, Chile, Brazil, China, Singapore, Turkey, Spain	Most widely used scale internationally for measuring attitudes toward gay and lesbian people; short versions maintain excellent psychometric properties; free to use in non-profit research.	Does not assess attitudes toward bisexual, transgender, or other gender/sexual identity individuals; some items contain anachronistic legislative references; designed for heterosexual respondents; item ordering effects observed in telephone surveys.

Fourth, cisnormative and heteronormative assumptions are embedded in several instruments. The MHS (Raja & Stokes), the MHS (Morrison & Morrison), the IHP, and the ATLG were all designed for heterosexual and/or cisgender respondents, positioning non-heterosexual and transgender identities as the object of measurement rather than as the perspective from which measurement is conducted. This design logic reflects a cisnormative and heteronormative frame that limits the applicability of these tools in affirmative clinical or community settings.

Fifth, bisexual-specific validated instruments are notably scarce. The Biphobia Scale is the only instrument in this review specifically designed to assess biphobia, and its validation is almost entirely restricted to a Spanish adult sample. Bisexuality as a distinct identity and its specific forms of stigmatisation—including erasure, delegitimisation, and double discrimination from both heterosexual and gay/lesbian communities—remain largely unmeasured by the available tools.

Sixth, intersectionality is systematically absent from all 13 instruments. None of the identified scales incorporates race, ethnicity, socioeconomic status, disability, or religion as moderating dimensions of stigma experience, despite growing evidence that SGM individuals from racially or ethnically minoritised groups face compounded and qualitatively distinct forms of discrimination that cannot be captured by instruments designed around a single axis of minority identity.

Beyond the psychometric limitations described above, a theoretically important gap concerns the mapping of the identified instruments onto the specific dimensions of the Minority Stress Model [25,26]. A systematic reading of the 13 scales reveals a clear distinction between instruments that primarily measure external, distal stressors—that is, stigmatising attitudes and discriminatory behaviours directed toward SGM individuals from the social environment—and those that measure internal, proximal stressors, such as internalised stigma, identity concealment, and negative expectations. The ATLG, the MHS (Raja & Stokes), the MHS (Morrison & Morrison), the IHP, and the TABS fall predominantly into the first category: they assess the attitudes of third parties toward SGM people and, as such, function as measures of the external stigma environment. By contrast, the IHS, the HMS, and the internalized transphobia subscale of the GMSR fall into the second category, capturing the degree to which SGM individuals have internalised stigmatising social messages about their own identity. The GMSR and GMSR-A occupy a more integrative position, covering both distal and proximal stressors as well as resilience factors, in closer alignment with the full theoretical architecture of the Minority Stress Model. The PAGES-Y and the C-SBEQ focus specifically on victimisation as a distal stressor in educational contexts, while the Biphobia Scale and the C-FAPGAR address attitudinal and relational dimensions, respectively. Critically, this mapping also reveals that the majority of instruments were developed and validated for constructs related to sexual orientation stigma, with only a subset—notably the GMSR, GMSR-A, and TABS—specifically addressing gender identity-related stigma, underscoring the need for measurement frameworks that treat these as conceptually and psychiatrically distinct domains requiring separate, targeted instrumentation, as the Gender Minority Stress framework proposed by Hendricks and Testa [26] has begun to identify.

3.4. Biopsychosocial Consequences Derived from Homophobic, Lesbophobic and Transphobic Attitudes

Important biopsychosocial consequences derived from homophobic, lesbophobic and transphobic attitudes were detected. These consequences affect both the physical and mental health of LGBT people. Next, we describe these findings.

1. Mental health problems:

- Depression, anxiety and low self-esteem: it has been observed that internalised transphobia is related to depression and anxiety symptoms among transgender and gender-diverse youths [41]. LGBT people face high levels of verbal, physical and sexual harassment. These result in social exclusion and thus a deterioration of mental health. Henderson et al. [45] reported that homophobic and transphobic bullying generates profound emotional consequences that may lead to depression and low self-esteem. In addition, the internalisation of homophobic and transphobic attitudes may significantly reduce self-esteem and generate an internal conflict with respect to one's own sexual identity, which increases the risk of mental health problems [40].
 - Borderline personality disorder (BPD): Lin et al. [43] demonstrated that victimisation by homophobic bullying during childhood is associated with BPD symptoms in early adulthood. It begins with depression, and the lack of family support worsens these conditions.
2. Substance consumption:
 - Use of alcohol and drugs: rejection toward certain minorities and suffering this discrimination may increase the probability of alcohol and marihuana consumption and smoking in adolescents [39].
 3. Suicidal ideation:
 - Vance et al. [42] found that transgender/non-binary Black and Latin youths showed higher rates of depression and suicidal ideation compared to their White counterparts due to lower gender affirmation and greater social rejection.
 4. Social and relational problems:
 - Social exclusion and marginalisation: people who experience homophobic and transphobic attitudes often encounter social rejection and exclusion, which has a negative impact on their interpersonal relations and psychological well-being [45].
 - Lack of family or parental support: having no family support may worsen the mental health of victims of homophobia, lesbophobia, biphobia or transphobia [42,43].

Thus, homophobic, lesbophobic and transphobic attitudes have profound biopsychosocial effects, including the development of psychological disorders, physical health problems and damaged social relations.

4. Discussion

The general aim of this systematic review was to identify studies that had used validated scales to measure variables related to homophobia, lesbophobia, transphobia or gender minorities, as well as the possible biopsychosocial consequences derived from these attitudes.

The limited number of articles retrieved in this systematic review ($n = 9$) reflects the scarcity of validated measurement instruments that comprehensively address prejudice toward the LGBT population. This finding is consistent with what has been reported by other similar reviews [46–50]. Costa et al. [51], in their systematic review of instruments measuring homophobia and related constructs, identified only 115 relevant studies out of an initial pool of 1076 results, with the majority of citations concentrated around just five instruments. Likewise, more recent reviews have noted that the existing literature suffers from insufficient attention to constructs such as lesbophobia, biphobia, and transphobia as distinct dimensions, as well as a notable absence of instruments that fully meet international psychometric standards [52,53]. The fragmented nature of the literature and the presence of relevant studies in grey literature sources, such as doctoral dissertations, further hinder

their identification in systematic searches [54]. Taken together, these findings highlight a methodological gap that directly limits the number of studies eligible for reviews such as the present one [51]. The findings of the present systematic review highlight the heterogeneity of measurement instruments available to assess the experiences and attitudes of sexual and gender minorities. This instrumental diversity is consistent with the multidimensional nature of the LGBT community, whose experiences range from processes of internalized stigma—widely recognized as a risk factor for the mental health of individuals with minority sexual orientations [55]—to situations of bullying and cyber-bullying, areas in which LGBT youth experience disproportionately higher rates of victimization than their heterosexual and cisgender peers [56]. The presence of scales focused on parental acceptance and resilience is also supported by the literature, which underscores the buffering role of family support against the negative health consequences of homophobic cyberbullying among LGBT adolescents [57]. However, the dispersion of scales also reveals a lack of methodological consensus in the field, which hinders comparability across studies and the systematic accumulation of evidence, as noted by research that warns of the inaccuracies arising from the use of generic bullying instruments when applied to LGBT populations [58]. Against this backdrop, the present review's primary contribution lies in systematically mapping the psychometric properties, target populations, cross-cultural validations, and construct coverage of the 13 scales identified, thereby providing a structured reference for researchers and clinicians seeking to select appropriate measurement tools in this field.

The psychometric critique outlined in the Section 3 points to a set of structural limitations that collectively constrain the scientific progress of this field beyond what any individual instrument's limitations can explain. The concentration of validated tools in Western, English- and Spanish-speaking, cisgender, and predominantly White samples not only limits generalizability but also reflects a research agenda that has historically centred the most visible and institutionally privileged segments of the SGM population. The near-absence of measurement invariance testing means that score comparisons across age groups, gender identities, racial or ethnic groups, and cultural contexts rest on untested assumptions. The heteronormative and cisnormative design logic embedded in several of the most widely used instruments—which position LGB and transgender identities as objects of external measurement rather than as agentic perspectives—further limits their applicability in affirmative clinical contexts. Taken together, these gaps suggest that the field does not merely need more instruments; it needs instruments of a different kind: intersectional in their design, invariance-tested across relevant subgroups, validated beyond Western contexts, and developed in genuine co-production with the communities they seek to measure.

It should be noted that the following synthesis is based on a limited number of studies ($n = 9$) with predominantly moderate or weak methodological quality according to the EPHPP appraisal tool, and without meta-analytic quantification. Findings should therefore be interpreted with caution, as they are indicative rather than definitive. The biopsychosocial consequences identified across the reviewed studies—including bullying victimisation, substance use, depression, BPD symptoms, and suicidal ideation—underscore the clinical urgency of having psychometrically robust measurement tools. Within the Minority Stress Model framework, these pathways operate through two distinct mechanisms: distal stressors—such as bullying victimisation and external discrimination—dysregulate impulse regulation and affective control systems, constituting the environmental trigger of BPD symptomatology in individuals with underlying temperamental reactivity [59–65], while proximal stressors—such as internalised stigma and identity concealment—operate through cognitive mechanisms of chronic shame and rumination that independently predict depression and anxiety outcomes [43]. This mechanistic distinction has direct implications

for measurement: instruments assessing only external stigma exposure cannot capture the proximal stress processes through which stigma is psychiatrically metabolised, highlighting the need for instruments that address both levels simultaneously. Notably, several of the scales identified in this review (e.g., the GMSR-A, the HMS, the PAGES-Y) were specifically designed to capture both stigma exposure and resilience and protective factors, reflecting a theoretical shift in the field toward more comprehensive, strengths-based measurement frameworks [55,56]. This diversity of constructs, however, also illustrates the fragmentation of the measurement landscape: while some instruments focus on internalised stigma, others assess bullying victimisation, parental acceptance, or coping capacity, making cross-study comparability difficult and highlighting the need for integrative measurement approaches [58–62].

The presence of resilience-oriented scales among the identified instruments—such as the GMSR and GMSR-A, which include subscales for community connectedness and gender-identity pride, and the HMS, designed to measure active management of homophobic stigma—reflects a growing recognition in the field that measurement tools must capture protective factors alongside risk indicators. This is particularly relevant given the evidence that parental support and community attachment significantly buffer the mental health consequences of stigma exposure [66,67]. From a clinical and community practice standpoint, the availability of validated instruments sensitive to both risk and resilience dimensions enables more nuanced and actionable assessments, particularly in specialized mental health services and school health contexts [68,69].

Lastly, it is important to point out that this systematic review found a considerable volume of relevant content to identify negative attitudes toward sexual minority people, as well as possible consequences for the mental health of these populations. Nevertheless, it also presents a series of limitations. Firstly, it was difficult to find in the databases a broad diversity of studies about the study topic. This situation could be due to the fact that the objectives of this study have been poorly addressed, and the inclusion criteria applied in it are novel, that is, there is little information about them at present. Secondly, the reported findings reveal a critical gap in the measurement landscape: no existing validated instrument simultaneously addresses homophobia, lesbophobia, biphobia, and transphobia alongside their associated biopsychosocial consequences within a single coordinated protocol. This gap points not to the need for a simple unified scale—which would risk conflating conceptually distinct constructs—but rather to the opportunity for developing a novel intermodular measurement system: a psychometrically rigorous protocol composed of theoretically grounded, independently validated modules, each capturing a specific stigma-related construct and its distinctive attitudinal, internalised, and resilience dimensions, and designed to be administered flexibly in full or in targeted combinations depending on the research or clinical context. Such a system would constitute a genuinely novel contribution to the field, as no existing instrument—nor any combination of currently available tools—provides this level of integrated yet construct-sensitive coverage. Finally, it is worth highlighting as another possible limitation the non-inclusion of PsycINFO in the search strategy. Although the databases used (WOS, Scopus and MEDLINE) have been identified as the optimal combination for systematic reviews, with a retrieval rate of 98.3% [33], PsycINFO specifically indexes empirical literature in behavioral sciences and mental health [70], and therefore its inclusion in future reviews on this topic could broaden the results obtained. A further limitation of this review concerns the restriction of the search to open-access articles only. This decision may have excluded relevant studies published in subscription-based journals, potentially introducing a selection bias in the retrieved literature. However, it should be noted that this work was conceived as an exploratory systematic review aimed at providing an initial approximation of the state of

the art on validated measurement instruments for homophobia, lesbophobia, biphobia, and transphobia. As such, it constitutes a first step in a broader line of research, and it is the authors' intention to conduct increasingly comprehensive systematic reviews in future work, progressively removing such restrictions in order to obtain a more complete picture of the available evidence. An additional limitation concerns the deliberate exclusion of studies conducted in contexts where homophobia, lesbophobia, biphobia, or transphobia are legally institutionalized. This decision was methodologically justified: in contexts where same-sex relations or gender non-conformity are criminalized, responses to attitude measurement scales cannot be interpreted as genuine expressions of individual attitudes, but rather as socially and legally constrained responses, which fundamentally compromises measurement equivalence and prevents valid cross-contextual comparisons. From a psychometric standpoint, this is precisely the kind of measurement non-invariance that would render cross-contextual score comparisons meaningless. However, this decision also implies that the findings of this review do not capture the psychiatric impact of severe, state-sponsored stigma on SGM populations living under institutional repression—a clinically and epidemiologically critical gap, particularly for global psychiatric practitioners working in or with patients from such contexts. Research on stigma measurement in legally repressive contexts constitutes a distinct and urgent field of inquiry, requiring methodological approaches specifically designed to address the constraints imposed by legal repression, including indirect measurement strategies, community-based participatory methods, and cross-national collaborations with local researchers operating under appropriate ethical safeguards.

Therefore, future research should propose systematic reviews adapted to differential factors of a specific population, with very specific aspects of the study population, with the aim of attaining the necessary findings to plan wide and specific interventions with a scientific foundation. It is also important to perform meta-analyses in future systematic reviews in order to obtain the most significant results possible.

Clinical, Public Health, Research, and Pedagogical Implications

The primary contribution of this review is the systematic identification and characterization of 13 psychometrically validated scales designed to detect and measure homophobic, lesbophobic, biphobic, and transphobic attitudes and behaviours. By mapping their psychometric properties, target populations, cross-cultural validations, strengths, and limitations, this review offers a structured evidence base to guide the selection of measurement instruments across clinical, public health, and research contexts.

From a specialized clinical practice standpoint, the instruments identified are directly relevant for psychiatrists, clinical psychologists, and other mental health professionals in at least three ways. First, as tools for assessing the stigma environment of SGM patients: scales such as the ATLG, the MHS, and the IHP can be used within the clinical formulation of a case to evaluate and quantify the degree of homophobic, lesbophobic, biphobic, or transphobic attitudes present in the patient's immediate environment—family, social network, workplace, or healthcare setting itself—thereby identifying external stigma stressors that, in accordance with the Minority Stress Model, operate as distal risk factors for mental health deterioration. This information enriches the clinical understanding of the patient's context and can directly inform treatment planning in affirmative psychotherapy and trauma-focused interventions. Second, as instruments to detect stigmatising attitudes in healthcare professionals and caregivers: several of the scales identified—particularly those designed for use with general adult or professional populations, such as the ATLG and the TABS—can be applied in training, supervision, and quality assurance processes in mental health services to identify and address potentially stigmatising attitudes that may

compromise the quality of care received by SGM patients. Third, as outcome measures in clinical research and stigma reduction interventions: the validated scales characterized in this review constitute a directly usable measurement toolkit for psychiatric and clinical psychology research, including the design and evaluation of affirmative interventions, longitudinal studies on minority stress, and cross-cultural comparative research on stigma in SGM populations. Beyond specialized settings, instruments validated in adolescent populations—such as the GMSR-A and the PAGES-Y—also offer mental health professionals working in school-based mental health services evidence-based tools for early detection of stigma exposure, functioning as a first level of identification that can facilitate timely referral to specialized care.

From a public health perspective, the availability of psychometrically validated instruments for detecting homophobic, lesbophobic, biphobic, and transphobic attitudes is a foundational requirement for population-level surveillance of hate-related behaviours and their consequences in SGM communities. The scales identified can inform the design of anti-bullying and stigma reduction policies by providing measurable, standardized indicators of the attitudinal dimensions that such policies seek to address. Stigma reduction interventions—whether delivered in specialized mental health services, community mental health centres, primary care, or educational settings—require validated outcome measures to evaluate their effectiveness; the instruments characterized in this review constitute a directly usable resource for this purpose.

From a research perspective, three priority directions emerge. First, longitudinal validation studies are needed to assess the stability, sensitivity to change, and predictive validity of the identified instruments over time, as most existing validations are cross-sectional. Second, the development of intersectional measurement instruments—capable of capturing the compounded stigma experiences of SGM individuals who simultaneously belong to racially, ethnically, or socioeconomically minoritised groups—represents an urgent and largely unmet methodological need. Third, the intermodular measurement system proposed in this review constitutes a concrete and original research agenda: its development and validation across diverse cultural, linguistic, and clinical contexts would represent a significant methodological advance for the field.

Finally, from a pedagogical standpoint, the systematic characterization of these instruments offers a structured resource for higher clinical education. Incorporating the measurement of homophobic, lesbophobic, biphobic, and transphobic attitudes into graduate and postgraduate curricula in psychiatry, clinical psychology, and related health professions would equip future clinicians with the theoretical grounding and practical competence needed to identify stigma as a determinant of mental health in SGM populations. Training programmes could draw on the instruments reviewed here to design case-based learning activities, clinical simulation scenarios, and reflective practice exercises, fostering both technical proficiency in psychometric assessment and the development of affirmative clinical attitudes.

5. Conclusions

This systematic review identifies a critical and unmet gap in the measurement of SGM-related stigma: no existing validated tool simultaneously addresses homophobia, lesbophobia, biphobia, and transphobia alongside their associated biopsychosocial consequences within a single coordinated measurement protocol. Future research should therefore pursue the development and validation of a novel intermodular measurement system—a psychometrically rigorous protocol comprising independently validated modules, each grounded in the specific theoretical and construct logic of its target domain, and designed for flexible administration either in full or in selected combinations. As Meyer [25]

and Hendricks and Testa [26] have argued, the cumulative and intersecting nature of minority stress demands measurement frameworks that honour this multidimensionality without collapsing it. The fragmented nature of currently available tools not only increases respondent burden but also systematically limits cross-study comparability [51,52]. A well-designed intermodular system would not replace existing domain-specific scales but would represent a meaningful and original methodological advance: the first protocol capable of providing integrated, construct-sensitive, and clinically actionable assessments of the full spectrum of stigma-related experiences in SGM populations [53,54]. Finally, this review offers preliminary evidence suggesting that homophobia, lesbophobia, biphobia, and transphobia are associated with negative biopsychosocial consequences for SGM populations. These findings should be interpreted with caution given the limited number of included studies and the absence of meta-analytic quantification and point to the potential value of interventions promoting family support, inclusive education, and the strengthening of gender identity pride.

Supplementary Materials: The following supporting information can be downloaded at: <https://www.mdpi.com/article/10.3390/psychiatryint7040146/s1>, Table S1: Search strategies; Table S2: PRISMA checklist.

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