COMPONENTS OF INTERNALIZED HOMOPHOBIA, SELF-DISCLOSURE OF SEXUAL ORIENTATION TO PHYSICIAN, AND DURABLE POWER OF ATTORNEY FOR HEALTH CARE COMPLETION IN OLDER GAY MEN

A dissertation submitted to the Kent State University Graduate School of Education in partial fulfillment of the requirements for the degree of Doctor of Philosophy

by

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CHAPTER I

INTRODUCTION TO THE PROBLEM

Harry and Jack met in 1961. At the time, they were 25 years old and worked at the same department store. Harry and Jack had argued about moving in together, given Jack’s concerns about social discrimination and Harry’s desire to be open about their relationship. After 42 years together, Harry had two strokes, and Jack became his primary caregiver. Jack reluctantly allowed a geriatric mental health worker into their home because he required assistance attending to Harry’s needs. Only after ridding the house of all signs of their life together—including pictures of both of them together with their many friends—did Jack allow the health care worker into their home. In addition, Jack carefully moved most of his clothes into the guest bedroom feeling that, if he were less obvious about their relationship, Harry might receive better treatment.

If Harry and Jack had chosen to disclose their sexual orientation to a gay-affirming physician, that physician could have provided access to a Durable Power of Attorney for Health Care (DPAHC). The DPAHC would have guaranteed the right of one partner to make health care decisions for the other in the event of incapacity, honoring the commitment that the two men had made 30 years prior. Moreover, Harry and Jack could have had counseling about possible nursing home placement, and its effect on their mutual finances.
Gay and lesbian couples currently do not have legal access to Medicaid programs that allow the spouse of an individual living in a nursing home to remain in their own home rather than liquidating their joint assets (Cahill, Vaid, & Spade, 2000). If Harry and Jack continued to keep their relationship hidden or secret from others (i.e., closeted), when the time came for nursing home placement for Harry, Jack might not be aware of his legal options and liabilities. They could be in danger of having to sell their home. In the absence of a completed DPAHC, it is not even clear if Jack could make health care decisions for Harry.

The current study was intended to determine the relationship between components of internalized homophobia and the variables of self-disclosure of sexual orientation to one’s physician (SDSOP) and completion of the Durable Power of Attorney for Health Care (DPAHC), with consideration of age cohort. Research indicating a relationship between high levels of internalized homophobia and poor coping choices is delineated in this chapter. The possible relationship between stigma management and these health care choices is explored. Friend’s (1990) theory of successful aging suggests the occurrence of healthier coping choices in older gay men who successfully have integrated their sexual orientation into their lives. It is posited that lower levels of components of internalized homophobia are correlated to more positive health care choices.

This chapter provides a statement of the problem regarding the health care choices of older gay men. The research question is stated, and six hypotheses developed from this question are listed. The literature review includes a discussion of social developmental
theories of aging, contextualizes the critical concepts of internalized homophobia and
stigma management, and relates this study to previous research in advance directives
completion and sexual orientation disclosure. The rationale and significance of the study
are discussed and definitions for several key terms are provided. The first chapter
concludes with a summary of the themes in the literature supporting the hypotheses.

Statement of the Problem

A review of the literature relevant to the research question demonstrates that little
is known about the relationship between internalized homophobia and the health care
choices of older gay men. Older gay men face numerous obstacles to a healthy quality of
life as they age, including the effects of social prejudice and discrimination due to age,
culture, and sexual orientation (Getzel, 1997), the effects of internalized homophobia
(Guttierez, 1992), and legal discrimination and differential access to social welfare and
health care programs (Cahill et al., 2000).

The literature suggests that many older gay men show a high degree of self-
acceptance (Cruikshank, 1991). Friend’s (1990) theory of successful gay aging suggests
that older gay men who use stigma management techniques based on concealment of
sexual orientation may be less likely to self-advocate in a way that has positive effects on
their health care choices. Stigma management functions as a coping mechanism for
individuals possessing a stigmatized identity, such as a gay identity. Possible expressions
of stigma management in gay men include concealment, selective disclosure, and full
disclosure. These choices are related to Friend’s levels of adjustment to gay aging with
concealment corresponding to the stereotypic response, selective disclosure correlating to the passing response, and full disclosure relating to the affirmative gay aging response. Effective management of stigma is one of the developmental tasks for an affirmative identity as an aging gay man.

Gay men have experienced differing levels of stigma and discrimination depending on where and when they have lived. Gay men who were 65 years or older in 1991 were characterized as “living the major part of their lives through historical periods described as actively hostile and oppressive toward homosexuality” (Friend, 1991, p. 103). Gay men in 1948 may have seen a New York Times article quoting the Republican National Party chairperson as saying, “Sexual perverts who have infiltrated our government in recent years were perhaps as dangerous as the actual Communists” (as cited in Katz, 1976, p. 141). In this instance, gay men were characterized for their sexual orientations as potential traitors to the government.

Men who were 65 years of age in 2003 were born in 1938 and were 20 years old in 1958, during the beginning of the Cold War in America. Men who were 70 years of age in 2003 were born in 1933, were depression era children, and were 20 years old during the Korean War conflict. Eighty-year-old men in 2003, born in 1923, were 20 years old in 1943, and were likely to have either served or been declined for the draft for the U.S. Armed Forces. The United States of the 1940s, 1950s, and 1960s could be highly medically oppressive for men identified as homosexual. Specifically, treatment for homosexual men in the 1940s through the 1960s ranged from reparative psychotherapy to
more extreme responses such as aversion therapy using emetics, castration, and lobotomy (Katz, 1976).

Dawson (1982) characterized the then-current cohort of older gay people as having been labeled sick by doctors, immoral by clergy, unfit by the military, and a menace by police and legislators. If identified as homosexual, they risked the loss of job, home, friends, and family. The need for secrecy caused an isolation that imperiled their most intimate relationships. And the greatest damage was done to those gay people who believed what society said about them, and thus lived in corrosive shame and self-loathing. (p. 5)

Older gay men may remain hidden purposely because of the relatively greater social stigma and discrimination endured during their young adulthood (Kimmel, 1978). Each succeeding cohort of older gay men may have very different relationships with the concept of self-disclosure of sexual orientation. For many of the older gay men, for much of their lives, it has been more functional not to self-disclose. It is now considered highly functional for gay people to disclose their sexual orientation to supportive others. It is unclear if any cohort differences are due to aging per se, or to the historical context of the life of the individual.

Although previous research has measured aspects of internalized homophobia of older gay men, it remains unclear how differential responses to life-long societal stigma affects health care choices. Two health care choices that may be influenced by
components of internalized homophobia and experiences of cultural and age oppression are the decision to disclose one’s sexual orientation to one’s physician and the decision to arrange formal autonomy over future health care decisions in the form of a DPAHC. In both cases, disclosure of sexual orientation to others in a medical/professional milieu may be required.

Research Question and Hypotheses

The primary question that guided this research was, “What are the differences in self-disclosure of sexual orientation to physician (SDSOP) and execution of Durable Power of Attorney for Health Care (DPAHC) when one considers age cohort and two components of internalized homophobia for a sample of 100 self-identified older gay men?” Six hypotheses were developed from this original question.

1. For individuals 65–74 years of age and for those 75 years of age and older, there is no difference between observed and expected rates of self-disclosure of sexual orientation to one’s physician.

2. For individuals who have disclosed their sexual orientation to their physician and for individuals who have not disclosed to their physician, there is no difference between observed and expected rates of DPAHC completion.

3. Individuals who have disclosed their sexual orientation to their physician are more likely to endorse lower levels of two components of internalized homophobia compared to those who have not disclosed their sexual orientation to their physician.
4. Individuals 75 years of age and older who have disclosed their sexual orientation to their physician are more likely to endorse lower levels of two components of internalized homophobia compared to those individuals 75 years of age and older who have not disclosed their sexual orientation to their physician.

5. There is no relationship between the identified predictor variables (age cohort, two components of internalized homophobia, and disclosure of sexual orientation to physician) and completion of the DPAHC.

6. There is no relationship between the identified predictor variables (age cohort, two components of internalized homophobia, and completion of the DPAHC) and self-disclosure of sexual orientation to physician (SDSOP).

Definition of Terms

*Advance directives* are written documents “used to guide treatment decisions if a person is incompetent to make health care decisions” (Ott, 1999, p. 514), and “allow individuals to maintain control of health care decisions” (Inman, 2002, p. 40)

*Crisis competence* refers to the development of psychological skills by older gay men to recognize and manage developmental crises in aging through generalization of their lessons in sexual orientation adjustment (Friend, 1991).

*Durable Power of Attorney for Health Care (DPAHC)* is a legal document in which an individual designates another person to make their health care decisions, in the event that the nominator becomes unable to make such decisions (Ott, 1999).
Gay refers to people who share affectional and/or sexual attractions to others of the same sex and to “identities and to the culture and communities that have developed among people who share those identities” (American Psychological Association [APA], 2001, p. 67). The “term gay man is preferable to homosexual when referring to specific groups” (APA, 2001, p. 67). Icard (1986) used the term gay to indicate a person romantically or sexually attracted to same-gender people who self-identify as such.

Heterosexism has been defined by Herek (1996) as an ideological system that devalues and stigmatizes non-heterosexual behavior, relationships, and community

Homophobia is the “irrational fear, hatred, and intolerance of gay, lesbian, and bisexual persons” (Gelberg & Chojnacki, 1996, p. 21).

Internalized homophobia is defined as a “set of negative attitudes and affects towards homosexuality in other persons and towards homosexual features in oneself” (Shidlo, 1994, p. 178). Homophobia means fear of same, and suggests a “functional bias in favor of a phobic” conceptualization of this phenomenon (p. 177). The term internalized homonegativity (Ross & Rosser, 1996; Shidlo, 1994) may offer a more accurate description of this complex phenomenon. However, as internalized homophobia is well understood, this term was used in this study.

Older refers to adults aged 65 years or older “because available summary demographic data for older groups are usually presented for persons 65 years of age and over” (Mangum, 1997, p. 17). Additionally, this is the age traditionally seen as the
beginning of “old age” as full retirement traditionally began in the U. S. Social Security system at 65 years (Deming & Cutler, 1983).

*Older gay man* refers to a male, 65 years or older, who self-identifies as a gay man.

*Passing* “is the social process whereby the homosexual presents himself or herself to the world as heterosexual . . . passing embodies a complex set of attitudes and behaviors that varies with personal or situational factors” (Berger, 1990, p. 328). The concept of passing is closely related to the concept of being in the closet, or choosing to disclose one’s sexual orientation to very few people. Passing is an antonym to coming out of the closet, which is a normative gay identity development process during which a person begins assimilation of this identity into their lives through the process of disclosure of their sexual orientation to others (de Monteflores & Schultz, 1978).

*Self-disclosure of sexual orientation to physician (SDSOP)* refers to the act of self-disclosure by an individual to his or her physician or primary health care provider concerning his or her sexual orientation.

*Stigma* is defined as an “undesired differentness” or “spoiled identity” due to an individual’s apparent or unapparent and discrediting attribute, condition, or handicap that disqualifies a person from full social acceptance (Goffman, 1963). Three broad classifications of stigma include physical deformities of the body, blemishes of character, and tribal stigma of race, nationality, and religion (p. 4).
**Stigma management** refers to those “strategies used by an individual when choosing whether to conceal or reveal his or her stigmatized condition to others” (Dindia, 1998, p. 88). Stigma management strategies specific to older gay men include: stereotypic (concealment of sexual orientation identity) response, passing (selective disclosure) response, and affirmative (full disclosure) response (Dindia, 1998; Friend, 1990).

**Surrogate decision-maker** refers to the individual legally designated by the care receiver to make choices for health care for the care receiver among a range of choices of formal and informal care in the present or in the future. Persons nominated by the care receiver (a) decide financial matters when the receiver is unable, (b) decide upon the receiver’s health care decisions (see DPAHC above), (c) arrange personal care, and (d) choose assisted living and nursing home care when required.

**Review of the Literature**

This study was undertaken with the intention of identifying significant differences in self-disclosure of sexual orientation to physician (SDSOP) and execution of Durable Power of Attorney for Health Care (DPAHC) among a sample of older, self-identified gay men when age cohort and two components of internalized homophobia were considered. The review of the literature has been developed to proceed from the definition of the population, to theoretical foundations, and to a review of the literature related to gay men and the health care choices of self-disclosure of sexual orientation to one’s physician and extending autonomy over health care decisions through a DPAHC.
This literature review provides the contextual foundation regarding the investigation of related variables in this study of gay male aging.

The first section presents the definition, prevalence, and social developmental theory related to the concept of older gay men. The second section explains the interrelated concepts of stigma management, internalized homophobia, and identity development in gay men. The final section reviews empirical studies conducted concerning gay men and the health care choices of sexual orientation disclosure and the use of advance directives. The chapter concludes with three short sections: rationale, significance, and summary.

*Gay Men and Aging*

**Definition and Prevalence**

Gay males, or men, refer to individuals who have a primary sexual or affectional temperament oriented towards other men. Gay men constitute 3% to 10% of the population of men in the United States (Atkinson & Hackett, 1988; Berger & Kelly, 1995a; Kinsey, Pomeroy, & Martin, 1948; Laumann, Gagnon, Michael, & Michael, 1994). The numbers of older gay men will increase rapidly at the same time that the Baby Boom demographic bubble of older adults must be addressed by the aging services sector. Approximately 12.4% of the total U. S. population is currently aged 65 and above. Older men represent 14.4 million people of the 34.9 million adults aged 65 and older (U. S. Census, 2004a). In the 2000 U. S. Census, gay couples reported living in 96% of all counties surveyed (U. S. Census, 2003a). The 2000 U. S. Census identified 595,000
same-sex households reporting as unmarried households living together, approximately 1.2 million individuals (Smith & Gates, 2001). The life expectancy for a male born in the United States in 2001 is 74.4; for a male already 65 years of age, the life expectancy is an additional 16.2 years, or 81.2 years (Centers for Disease Control [CDC], 2003).

In the area served by the Western Reserve Area Agency on Aging—the five county area surrounding Cleveland, Ohio, from which 50.5% of the participants for this study were drawn—there were over 311,579 persons over the age of 65 (Salling, Bliss, & McNamara, 2003, p. 4). Of these older adults in the five-county area, 124,577 were men, or 39.9% (p. 6). It has been estimated that there may be as many as 12,000 gay men and lesbians over 60 years of age in this same area (Mostade et al., 2003). Based on this population estimate, and using a conservative estimate of 40% of that population as male, there may be as many as 4,800 gay men over the age of 60 in the five-county area.

Defining what is meant by a gay man is hampered by lack of a clear definition of the term, the concatenation of behavior with identity, and a confusing social science history. Karoly Benkert of Hungary coined the term homosexual in 1869 (Lauritsen & Thorstad, 1974) to describe a type of person who engaged in sexual behavior primarily with other members of the same sex. Benkert was a Hungarian physician writing to the German Minister of the Interior to oppose the legal sanctions placed upon homosexual acts in Prussia at that time. Before this, only behaviors such as sodomy or pederasty were discredited, illegal, or sinful. The term homosexual introduced a category of persons based on sexual behavior, which was new, and did not gain currency in the United States.
until after the turn of the 20th century (Halperin, 1989). Although a clinical neologism, this term for a category of person based on his or her sexual behavior retained the entire legal, moral, and social stigma previously associated only with the behaviors.

Increased medicalization marked the definitional shift for homosexual behavior which for centuries was marked as sinful, becoming criminal in the 17th-21st centuries, and finally referred to as a medical condition from the early 20th century until its deletion as a pathological classification by the American Psychiatric Association in 1973 (American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 1968, 1980; D’Emilio, 1983). The category of “ego dystonic homosexuality” was included in 1980, and was eliminated in the 1987 edition (DSM-III, 1980; DSM-III-R, 1987). Homosexuality is now viewed as a “non-pathological variation of human sexual development and expression” (Cain, 1991, p. 67). Homosexuality is not only as naturally occurring as heterosexuality, but also has biological components in its development and expression (Gladue, 1988).

The formation of a gay identity is the “result of a system of interacting influences that include life experiences, cultural and religious values, social reaction, self-attribution, and association with others” (Berger, 1983, p. 135). Sexual orientation is established in early childhood, although the literature varies on the timing of this occurrence and significance of any co-occurring factors (Gonsiorek, Sell, & Weinrich, 1995; R. Green, 1988; Greene, 1994).
A definition for the term gay offered by Boswell (1980) suggested that individuals are “conscious of erotic inclination toward their own gender as a distinguishing characteristic” (p. 44). The term gay is used to indicate a person romantically or sexually attracted to same gender people who self-identify as such (Icard, 1986). Self-identification is the major criterion.

Defining and estimating the prevalence of gay men is complex and not very satisfactorily accomplished. There is a history of the confounding of a gay sexual orientation with transvestism, gender variant behavior, and situational sexual behavior (D’Emilio, 1983). Some of the difficulties involve differentiating gay men from bisexual men (Bell & Weinberg, 1978), under-reporting and sampling problems related to reticence about sexual orientation self-disclosure in a heterosexist society (Laumann et al., 1994), and reaching out to a statistically hidden group. Additional information on the definition and measurement of sexual orientation is available (Gonsiorek et al., 1995).

Prevalence studies of gay people have more than a 50-year history. The prevalence statistics reported by Kinsey et al. (1948) remain somewhat relevant as the sample involved 17,000 individuals. Approximately 4% of men were lifelong homosexuals, between 10–15% of the adult male population reported engaging in significant same-sex behavior or fantasy since puberty, and 37% of males reported some lifetime homosexual activity. This last category included instances of bisexuality and situational homosexuality, types of behavior excluded in this study.
Studies of prevalence of homosexuality include cross-cultural studies of sexual orientation. Homosexuality prevalence surveys reviewed and summarized by Gebhard (1972) for exclusive homosexuality in men were in the range of 2–5%. Laumann et al. (1994, p. 297) found that 2.8% of men reported identifying with a label that denoted same-gender sexuality. Cross-cultural studies from France (Spira et al., 1993, as cited in Laumann et al., 1994, original available only in French) reported a 4.1% occurrence, and a British study (Wellings, Field, Johnson, & Wadsworth, 1994) reported 6.1% of men reporting lifelong homosexual behavior. That these estimates are lower than the commonly mis-cited aggregate statistic of 10% may be attributed to Kinsey’s (Kinsey et al., 1948) research relying on a non-probability sample and self-report bias (Laumann et al., 1994).

The commonly cited prevalence heuristic of 10% may also be the artifact of gay politics as much as anything else (D’Emilio, 1983), and represents the oversimplification of a range of human sexual behavior into the binary identities of homosexual and heterosexual (Laumann et al., 1994). The choice to use the one oversimplified figure of 10% from the Kinsey data (Kinsey et al., 1948) represents a compromise between counting those individuals who engage in homosexual activity without assuming the label of gay and excluding those who have sparse or incidental experience, a political rather than statistical compromise of “neither too small nor too large” (Laumann et al., 1994, p. 289). Gay men nevertheless represent a common minority of the U. S. population
(Gonsiorek et al., 1995). This range of 2–5% remains relatively consistent over cultures and over time (Gladue, 1988, p. 84).

Cultural factors are highly relevant in determining, defining, and estimating homosexual experience. Culture, race, ethnicity, age, and socioeconomic class are variables that determine the level of homophobia a person experiences or internalizes (Gonsiorek et al., 1995). These factors may influence the willingness to self-identify as gay. One's self-concept may be more culturally bound than the gay identity primarily formulated by middle-class, Anglo-European influences for some communities of diversity, especially for some men of color (Chan, 1992; Espin, 1993; Hawley & Mostade, 1999; Loiacano, 1989; Rust, 1996). Gender, gender role, and sexual orientation were often conflated by participants, invalidating the use of the label “gay” in studies of Latino gay and bisexual men (Zea, Reisen, & Diaz, 2003). Participants considered anal active partners to be “men,” and anal receptive partners to be “gay.” Some Latino men who engage in homosexual behavior do not self-identify as gay, locating their identity in their function within the behavior rather than on the sexual object choice (Gonzalez & Espin, 1996, p. 587). For some men, penetration is the defining act or characteristic of machismo; that is, being sexually active rather than passive preserves an individual’s self-identity as a man. Only a gay man would take the passive position in male sexual behavior in this social construction concerning sexual orientation definition. Some Native American communities have a similar social construction (Tafoya, 1996, p. 611),
determining a “gay” identity through functional behavior rather than sexual/affectional object choice.

A cultural construction of homosexual behavior based on phallic insertion is different from the gay pride identity formulated in the 1960s and 1970s. The gay pride identity movement gained real impetus in the politicization of the 1960s, and was influenced by civil rights, anti-war, and feminist movements of the times (Altman, 1988). “For many blacks, homosexuality is a cultural phenomenon of whites—a white problem inimical to the interest of the blacks” (Icard, 1986, p. 86). Tafoya (1996) cautioned against assuming that non-European American people of alternative sexuality will follow a standardized “homosexual developmental process” (p. 613).

Differences exist between the individualistic nature of modern consumerist America and the collectivist nature of some cultures. Cultures differ in their openness about sexuality in general, acceptable form of sexual expression, sexual proscriptions, and the consequences of non-compliance (Coon, 2003). Differences in cultural and cohort experience regarding sexual orientation disclosure may affect coping styles and health care behaviors and preferences.

An individual’s openness and disclosure of his or her gay identity may be more problematic than the tolerance extended to an unacknowledged same-sex relationship (Coon, 2003). Families help protect individuals against the consequences of racism, but the alliance of the individual with other members of the lesbian, gay, bisexual, and transgendered community may help protect against homophobia (Coon).
In research and programming conducted with communities of color regarding HIV prevention and detection, the National Institute of Health and the Centers for Disease Control (CDC) created the acronym MSM. This acronym indicates men who have sex with men, men who otherwise do not identity with gay culture or communities (CDC, 2001). While by another definition, a man who engages in homosexual sex might be considered homosexual, or gay; in this case the use of these terms was discouraging access to information, risk processing, education, and testing among minority men in communities of color (Health Resources and Services Administration [HRSA], 1995). The stigma attached to acknowledging homosexual behavior may inhibit cultural minority MSM from identifying themselves as gay. Social construction of an identity based on sexual orientation remains problematic in research. Some men find their support in the gay community; other individuals may be more likely to identify with cultural communities of birth. The current study focuses on older gay men who self-identify as gay.

**Social Aging Theories**

An examination of a wide range of discourses must be undertaken in order to bridge conceptual gaps among theories of social aging, gay identity development, caregiving, and social service delivery that would describe older gay men and their health care choices. Social theories of aging that illuminate this wide-ranging inquiry include Role Theory, Activity Theory, Disengagement Theory, Continuity Theory, and especially, Socioenvironmental Theory (Applegate, 1997, p. 1). In general, counselors
and other mental health providers have been slow to incorporate concepts from social aging theory into their practice (Fry, 1992). Although various social aging theories have some utility as heuristic devices for research into aging, no single theory captures the heterogeneity of the individual adjustments to aging (Fry). A survey of the major aging theories is reviewed in this section, although most are not used in this study. Friend’s Theory of Successful Gay Aging informs the variable choices and is related to the socioenvironmental theories.

*Role theory* (Rosow, 1976) explains that aging involves a potentially damaging loss of usual social roles. For example, American culture rewards occupational success. A loss of status concomitant with role loss such as could be experienced through retirement, could therefore be especially discomforting for men (Applegate, 1997, p. 7). Active stigma management techniques of gay men include role flexibility (Friend, 1990), crisis competence (Friend, 1991), and mastery of independence (Berger, 1986; Francher & Henkin, 1973) gained through a lifetime in a subculture not normalized by rigid gender roles. The experience of being gay and developing stigma management techniques may inoculate gay men against the devastation of role loss. As many gay men in earlier cohorts experienced loss of family support and occupations or threatened loss through exposure as gay (Katz, 1976), such losses may not be novel with them. Although role theory has some attraction as an explanation for the aging of some individuals heavily invested in their work and social roles, it has limited empirical support (Fry, 1992).
Activity Theory (Neugarten, Havighurst, & Tobin, 1968) suggests that a loss of well-being accompanies the decline in usual activities by older adults. This theory suggests that services and policies that promote continued activity throughout the aging process could have both beneficial and preventive health effects (Applegate, 1997, p. 7). Criticized for its ageism (Baum & Baum, 1980), the practical application of activity theory involves a “continuous struggle to remain middle aged” (Fry, 1992, p. 265). This study examines the health care choices of older gay men and explores the relationship between components of internalized homophobia and proactive health care decision-making. As this study is not examining service, policies, or an activity, this theory is of little utility to the exploration of the variables in this study.

Proponents of Disengagement Theory (Cummings & Henry, 1961) asserted that as people age, they gradually withdraw from the organizational structures of society, spending less time with society in general, and even in relationships. Disengagement is a formal social theory of aging developed through the work of Cummings and Henry in the 1960s (Fry, 1992). Although disengagement theory has a history of academic favor, it has been accused of ethnocentrism (Fry). The optimistic suggestion of disengagement theory is that a person reaches an acceptance of this change and grows more introspective. Previous studies with older gay men have suggested that maintaining an active involvement with a gay friendship network, or the gay community, results in a greater sense of well-being (Berger, 1980, 1982a; Friend, 1987; Kelly, 1977). This finding does not appear to fit the pattern expected by disengagement theory. Disengagement theory
seems to offer little utility in the exploration of internalized homophobia and health care
choices as the choice to disclose is one of engagement.

*Continuity Theory* (Palmore, 1968) encompasses the preceding theories and goes
further to suggest that individuals maintain “unique patterns of traits and behaviors that
persist across the lifespan into old age and retain their predictability” (Applegate, 1997, p.
8), even as they cope with role loss, disengagement from society, and decline in their
social activities. In this model, coping patterns developed by adults earlier in their lives
may be the pattern on which they rely later to cope with change. Unlike Activity or
Disengagement Theories, Continuity Theory does not suggest a single developmental life
course for all older adults. This theory offers some utility to counseling professionals by
suggesting the use of past coping strategies to construct new responses and expand the
options of the older adult (Fry, 1992). This study may help illuminate the differences
between effective and ineffective coping strategies and their association with internalized
homophobia. This knowledge can be used to formulate increasingly useful interventions
to interrupt ineffective patterns earlier in the lives of gay individuals.

*Socioenvironmental Theories* consider the important and necessary interaction
between the personal resources of a person and the social resources that he or she is able
to access (Applegate, 1997, p. 7). These theories are more sophisticated than the simple
duality and linearity of many earlier social theories of aging and are flexible enough to
accommodate individual motivations, life histories, and choices in multiple contexts (Fry,
1992). Socioenvironmental Theories are especially applicable to the current study, as
Friend’s (1990) theory of successful aging for gay men offers a model for understanding how individuals expressing an affirmative style of adjustment to their gay aging can take a proactive part in their own coping choices and engage the social resources available to them.

A study by Lachman (1986), testing the principles of Socioenvironmental Theory, demonstrated that individuals who were encouraged to develop their personal and social resources responded with higher levels of life satisfaction. The reconstruing of stigmatized identities to increasingly positive self-affirmation occurs because of an interaction between self and environment. Socioenvironmental Theory often fails to take into account factors such as experience of gender oppression and “other politically charged aspects of diversity” (Applegate, 1997, p. 8).

*Theory of successful gay aging*. The orientation for Friend’s (1990) model of successful gay aging occurs at the nexus of social construction theory and individual psychology. Social Construction Theory suggests that sexual orientation has no intrinsic value; it is given value and meaning by society (Friend, 1990, p. 100). Gay individuals can resist societal definition and stigma by reconstruing the meaning of their sexual orientation to one that is more positive or affirmational. Another less functional resolution would involve the assimilation of negative societal beliefs into one’s belief system. This is known when it occurs within gay people, as internalized homophobia. Individual developmental processes occur when the individual applies the reconstrued, more positive identity to himself or herself in the process of stigma management. Friend
stated that resistance to societal labeling and internalized homophobia are at opposite ends of a cognitive behavioral response continuum for the gay person faced with a heterosexist society. A person can decide to live openly as gay in defiance of community norms or can play out the role assigned to a “closet queen” of internalized homophobia and the charade of a straight identity. These are two extreme responses on a continuum of possible responses to societal heterosexism.

One aspect of the model of successful gay aging (Friend, 1990) asserts that individuals construct highly divergent responses to their aging as gay people. Friend further characterized these responses as affirming, passing, or stereotyping. Individuals with an affirmative response to their gay identity reconstruct the meaning of homosexuality in such a way as to promote their successful aging. The “passing” response involves an accommodation to the negative characterization of gay people by society, often by carefully maintained pretense of heterosexual life and values. Stereotypic responses involve the acceptance of the negative characterizations of society and internalization of these values. In Friend’s theory, the stigma management styles characterized as affirmational (reconstruction), passing (accommodation), and stereotypic (internalization) would affect the coping choices of older gay men. Affirmational responses could include disclosure to family, friends, work associates, physicians, and other health care providers. Passing or stereotypic responses might preclude sexual orientation self-disclosure to physician, possibly affecting health care advice and choices (Cain, 1991).
According to Friend’s (1990) theory, the cohort of gay men currently 65 years and older grew up in a historical period when homophobia and heterosexism were the enforced norm. Resistance was possible, but not often rewarded. A choice continuum exists along which one’s internalization of this societal belief system could be represented. On one end, an individual accepts societal myths and beliefs. This is internalized homophobia and is associated with low self-esteem, feelings of self-hatred, and depression (Friend, 1990; Ross & Rosser, 1996; Shidlo, 1994). On the other end of the gay adjustment spectrum, the resistant personality rejects societal belief systems and reconstructs this belief to a more positive one. This is associated with increased self-acceptance, higher self-esteem, and self-affirmation. The middle of the continuum is associated with the passing response. Not all the negative introjects are accepted; nevertheless, individuals maintain a concealed identity, going out of their way to avoid detection as gay persons. Friend’s (1990) model of successful aging is similar to identity development models designed to describe lesbian, gay, and bisexual identity development and formation, but it describes this development specifically among older gay adults (Cass, 1979; Coleman, 1982; J. Lee, 1987; Minton & McDonald, 1983/1984).

Methodological Issues in the Study of Older Gay Men

Berger’s study (1980) identified four factors related to healthy psychological adaptation to aging for gay men: (a) integration into the gay community, (b) a commitment to homosexuality, (c) low concern with concealment of sexual orientation, and (d) a satisfactory sex life. High concealers of sexual orientation information reported
more anxiety regarding their homosexuality and fears of aging and death, but they did not have poorer self-acceptance. Older gay men who had integrated younger gay men into their patterns of socialization showed the best adjustment.

Berger’s (1980) study of the psychological adjustment of older gay men was based on a sample of 112 gay men aged 40 years and older and was highly skewed toward White, middle-class, younger, and well-educated men. Berger defined older as meaning 40 years of age and above. Of the 112 total participants, however, only 33 men were older than 60 years; 19.6% were between the ages of 60-69 ($n = 21$) and 10.7% between the ages of 70-79 ($n = 12$). Internalized homophobia itself was not assessed, but concealment (i.e., passing, choosing not to disclose) was. The three items comprising the score for concealment included one question about associating with a person with a homosexual reputation, one about being seen with a person with a homosexual reputation, and one question asking if it concerned the respondent if others knew of his homosexuality. Questions similar to these are now contained within multiple-item measures of internalized homophobia; such single-item assessments of internalized homophobia were typical of the late 1970s and early 1980s (Shidlo, 1994). The most interesting result of Berger’s study was the finding that concerns about concealment and disclosure seemed to lead to anxiety, but that the actual extent of disclosure seemed not to have an effect on social or psychological adjustment.

Friend (1980) distributed questionnaires to 43 self-identified older gay men (mean age = 48.15) and targeted 25 for intensive follow-up interviews. Although the sample was
skewed again towards a White, well-educated, higher-income sample, the results did show a statistically significant \( r = .34, p < .02 \) correlation between psychological adjustment and the number of areas of one’s life in which one chose to self-disclose sexual orientation. Friend’s study also showed that sex role flexibility is related to successful aging. M. S. Weinberg and Williams (1979a) found that role flexibility showed higher levels of psychological adjustment as measured by levels of self-esteem and self-acceptance.

Gray and Dressel (1985) performed a secondary analysis of data from the largest sample of homosexual men aged 50 years and over available at that time, a 1977 report of the self-administered questionnaire responses for 4,212 gay males (Jay & Young, 1979), which used a non-probability sampling of gay men aged 16 through 78—with 9% of the sample being 50 years of age and older \( (n = 379) \). Gray and Dressel’s (1985) secondary analysis of the data showed a greater tendency for older gay men to want to conceal their homosexuality from significant others such as friends, relatives, and work colleagues. The authors noted that this was likely due to cohort effects among older gay men and not typical of what future cohorts of older gay men may choose as their behavior regarding disclosure.

Kimmel (1979) interviewed 14 gay men between the ages of 55 and 81 about their life histories and experiences as gay men. The average age of his sample was 64.9 years; the median was 63. Only one respondent was younger than 60 years, and the sample included working and retired individuals. Kimmel concluded that diverse patterns of
aging exist in older gay men. He noted that several of the men associated a high degree of life satisfaction with a positive pattern of aging. Kimmel suggested that this demonstrated that gay aging did not necessarily lead to despair and other negative stereotypes associated with older gay men. This earliest research appeared to be primarily exploratory and seemed to refute existing stereotypes.

J. Lee (1987) conducted a 4-year longitudinal study of 47 men ranging in ages from 50-80. The researcher explored happiness and investigated whether successful resolution of the personal question of sexual orientation disclosure provided alternate resources in aging. Some of the measures included: (a) life satisfaction, (b) self-image, (c) family and friendship networks, (d) achievement of personal and career goals, (e) degree of openness about sexual orientation, and (f) attitudes towards younger and older homosexuals. Lee found that the variables most significantly related to high satisfaction and adjustment in aging for older gay men were the same as those in heterosexual studies on happiness and aging: (a) health, (b) wealth, and (c) loneliness (p. 58). The happiest gay men were also the ones most involved in the gay community. Lee suggested in his analysis that gay people are more similar to heterosexuals than dissimilar, unlike Berger (1980, 1982a, 1982b) who posited that heterosexual and gay populations have different strengths in coping with aging. Lee also reported no negative relationship between staying in the closet and life satisfaction, unlike many of the other gay aging studies.

A review of the definitions and history of a gay identity in the United States reveals that the definitions themselves have been in flux. Gay men are a commonly
occurring minority in the United States. Factors such as age, age cohort, ethnicity, race, and socioeconomic class may influence the levels of homophobia that a person internalizes (Gonsiorek et al., 1995). Developmental tasks for current cohorts of older gay men include recognition of homonegative discrimination, formulation of a response to internalized homophobia, and management of sexual orientation disclosure. These tasks are the remnants of the experiences of older gay men raised during periods of socially enforced heterosexism.

**Stigma Management**

This section explains the inter-related concepts of stigma management, internalized homophobia, and identity development in gay men. Understanding how internalized homophobia affects and interacts with stigma management and identity development is important to understanding health care choice in this study. Internalized homophobia is a “central construct in the symptomatology and treatment of gay men and lesbians” (Ross & Rosser, 1996, p. 15). Population challenges such as social prejudice, legal discrimination, racism, ageism, and heterosexism are delineated and their relationship to internalized homophobia noted. Population resources such as stigma management, role flexibility, disclosure habits, and social support are explored.

**Stigma**

Stigma comes from the Greek word meaning the mark left by a “brand” or “pointed stick” (*Oxford English Dictionary*, 1971). Stigma originally referred to the bodily signs inflicted by authorities to expose something negative about the moral status
of the signifier. It has come to refer to the discrediting feature itself rather than the sign (Goffman, 1963). The internalization of negative societal views by members of stigmatized target groups was described by Goffman. This process occurs as a member of a stigmatized social group internalizes the societal belief system that all members of the stigmatized group are alike. Negative connotations accrue to individual members of the stigmatized group, and these negative connotations become the salient characteristics of group membership as well as for the individual.

Stigma has been characterized as occurring from three distinct etiologies: (a) blemishes or deformities of the body; (b) blemishes of character such as “dishonesty . . . mental disorder, imprisonment, addiction, alcoholism, homosexuality;” and (c) tribal stigma of “race, nation, and religion” (Goffman, 1963, p. 5). Individual stigma may be considered “discredited,” which is visually confirmable (e.g., physical abnormalities, skin color), or “discreditable,” which must be revealed (e.g., homosexuality, alcoholism; Goffman, p. 4). A homosexual or gay identity is a discreditable stigma. The management of discreditable information with regard to interpersonal action is known as stigma management (Goffman).

Black minority identity development concepts (Cross, 1971) provided a model for other identity development work, and antedate those of gay identity development (Goffman, 1963, p. 4). The Cross model proposed four stages in minority identity development: (a) pre-encounter, (b) encounter, (c) immersion/emersion, and (d) synthesis/commitment. The successful resolution of this four-stage model involves the
acceptance by the minority individual of his or her stigmatized status, while keeping a sense of dignity. This stigma management technique is a coping method to maintain quality of life with a stigmatized identity. The analogy for a gay person involves “coming out,” or disclosure of sexual orientation, to affirm a healthy resolution of self-identity (Cass, 1979). The additive stigma that results from ageism and/or racism may affect health care preferences and behaviors of older minority gay men. That is, they would have not only the discreditable stigma of homosexuality, but also the discredited identities of age and minority status, to incorporate into their identities. The literature does not address the effects of internalized homophobia on health care behaviors in older gay men, nor does it address those same behaviors at the nexus of gay identity with age and minority status. The purpose of the present study, therefore, was to identify health care preferences and behaviors in a sample of older gay men.

Models of identity development were designed to describe the way that marginalized minority members make sense of the discrimination and stigma in their lives and adjust to it. These are models of normative patterns of coping with a stigmatized identity in a discriminatory society. Multiple models of identity development have been designed to help developmentalists and other helping professionals understand the ways in which African American individuals (Atkinson, Morton, & Sue, 1979; Cross, 1971; Parham & Helms, 1981), Asian American individuals (Chan, 1989, 1992; Ibrahim, Ohnishi, & Sandhu, 1997), Native American individuals (Garrett & Pichotte, 2000; Harry, 1986), and individuals of Latino descent (Espin, 1993, Padilla & de Snyder, 1985)
have successfully negotiated an affirmative identity in the face of oppression, discrimination, and stigma.

The concepts of identity development and internalized homophobia are closely inter-related, in that the successful resolution of internalized homophobia is a prerequisite for developing an affirmative gay identity. As this is an organizing concept, a discussion of internalized homophobia will precede the examination of identity development. The literature has little to say about cultural differences in gay identity development and coming out (A. Smith, 1997). Many research and clinical assumptions are based on empirical studies conducted with White, middle class, gay men and women (Smith). This is more thoroughly examined below in a section concerning the multiple jeopardy that results from racism and ageism combined with heterosexism. Stigma management comprises the coping resources of a stigmatized population. As the stigma management techniques may vary from cohort to cohort of older gay men, it is important to gather information from this population regarding their attitudes and behaviors.

Internalized Homophobia

Internalized homophobia is a “set of negative attitudes and affects towards homosexuality in other persons and towards homosexual features in oneself” (Shidlo, 1994, p. 178). Since the introduction of the concept of internalized homophobia by G. Weinberg (1972), several attempts have been made to carefully operationalize and measure this construct (Malyon, 1993). The importance of the conceptualization of internalized homophobia may be in understanding its effects on the normative
development of gay men (Shidlo, 1994). Internalized homophobia is also referred to as internalized homonegativity (Ross & Rosser, 1996), as phobia implies a fear of homosexuals rather than the internalization of negative societal beliefs about gay people.

Internalized homophobia has been associated with a range of behaviors such as low self-esteem, acceptance of popular myths of homosexuality, self-imposed limits on career aspirations (Cabaj, 1988, p. 14), substance abuse, paranoia, delusional disorders, suicide, sexual dysfunction (J. Smith, 1988), denial, fear, anxiety, depression, sense of inferiority, confusion (Cabaj, 1994, p. 789), loneliness and alcoholism (Finnegan & Cook, 1984).

In adolescents, internalized homophobia has been correlated with reactive depression, conduct disorders (A. Smith, 1997), and increased risk of suicide (Harstein, 1996). Gibson (1989) found suicide to be highly prevalent among lesbian, gay, and bisexual youth. Research asserting an increased lifetime prevalence of suicidal ideation and suicide attempts in lesbian, gay, and bisexual people (Bell & Weinberg, 1978; D’Augelli & Hershberger, 1993) does not solve the debate about the relationship between suicide and a gay identity. Some studies, especially earlier ones, have been criticized for their use of unclear theoretical constructs and methodological issues including selection bias and inadequate measurement (Meyer, 2003).

Recent studies using unambiguous definitions, random probability sampling, and improved measures of suicidality have also found evidence of increased suicide related problems among lesbian, gay, and bisexual persons (Meyer, 2003). Garofalo, Woolf,
Kessel, Palfrey, and DuRant (1998) found that lesbian, gay, bisexual, and questioning (those unsure of their sexual orientation) adolescents were three times more likely than their heterosexual peers to have reported a suicide attempt in the year prior to the survey. This research also revealed that sexual orientation was particularly a predictor for boys rather than girls for suicide attempts.

The coming-out process—the decision about when and to whom to disclose one’s sexual orientation—is stressful, and sexual minority youth may be very vulnerable to effects of this stress (DiPlacido, 1998). Coping with high levels of stressors has been related to high-risk sexual behavior amongst gay and bisexual youth (Folkman, Chesney, Pollack, & Phillips, 1992) and to delinquent behaviors in Black and Hispanic gay male youth (Rotheram-Borus, Rosario, Van-Rossem, Reid, & Gillis, 1995). The National School Climate Survey (Gay, Lesbian, Straight Education Network, 2001) reported 83.2% of lesbian, gay, bisexual, and transgendered (LGBT) students were harassed for their sexual orientation and 21.1% reported being physically assaulted for the same reason. Remafedi, Farrow, and Deisher (1991) reported that 30% of their sample of gay adolescents had attempted suicide. Likewise, Garofalo, Woolf, Lawrence, and Wissow (1999) found a suicide attempt rate of 30.6% for sexuality minority identified youth versus 9.1% for heterosexually identified adolescents. In a study of 194 lesbian, gay, and bisexual youth designed to determine stressors in response to their sexual orientation, 42% of the sample had attempted suicide (D’Augelli & Hershberger, 1993). Predictors of suicide attempts included “low self-esteem, alcohol abuse, depression, loss of friends due
to sexual orientation, and fear of familial reaction to disclosure” (p. 444). Self-identified gay/bisexual male adolescents were reported to be at a 7-times greater risk for a suicide attempt compared to a heterosexual male adolescent in a sample of 36,254 Minnesota students (Remafedi et al, 1998).

Internalization of negative societal views may have a dampening effect on sexual orientation disclosure. A person who has a same-sex affectional/sexual behavior but does not self-identify as gay, lesbian, or bisexual may be described as having internalized homophobia, according to models of affirmative gay counseling. This decision about disclosure of sexual orientation is shared by all gay people and is referred to as coming-out. Hawley and Mostade (1999) stated that this is not a single event, but rather a decisional process that repeats itself. Coming out is a life-long process that will often involve selective disclosure or non-disclosure of sexual orientation to heterosexual others and in institutional settings (Troiden, 1988).

Internalized homophobia may have an effect on choices made by older gay men by generational cohort. That is, different age cohorts of older gay men may have had disparate experiences with disclosure and oppression, affecting the sense of safety that they felt with others. These different experiences may lead to different choices by older gay men of different ages. Cohler and Galatzer-Levy (2000) conducted a meta-analysis of several studies of lesbian, gay, and bisexual people that described three age cohorts of lesbians and gay men and their primary differences. An older generation, which came of age before the gay liberation movement, had been most affected by experiences of
discrimination and stigma. The middle (and middle-aged) generation, responsible for moving the lesbian, gay, bisexual civil rights movement forward, has benefited from the social and political advances. The youngest generation, including the present generation of young adults, is characterized as having an “ease about their sexuality” (p. 40).

The absence of internalized homophobia would seem to indicate a greater adjustment or successful resolution of the process of identity development. In this process, much attention is focused on the identification of internalized homophobia and its successful resolution and of the act of self-disclosure of sexual orientation to significant non-gay and gay others. Models of gay identity development (Cass, 1979; Coleman, 1982) suggest that individuals who are confused about their sexual orientation are less likely to self-disclose and will have higher levels of internalized homophobia. Internalized homophobia remains a major developmental challenge for gay men (Rowen & Malcolm, 2002).

Identity Development

Several concepts of normative identity development for gay men were articulated in the late 1970s and early 1980s. These models of normative gay identity development (Cass, 1979; Coleman, 1982; Coleman & Remafedi, 1989; Harry, 1993; Hetrick & Martin, 1987; Malyon, 1993; Remafedi, 1987; Troiden, 1988, 1989) allowed clinicians to consider that pathologies apparent in their gay male clients might be due as much to cultural oppression as to their sexual orientation. Included in most of these models was
the concept that impairment is caused by low self-esteem and by unexamined internalized homophobia.

Since the American Psychiatric Association removed homosexuality as a psychiatric disorder from the 3rd edition of the DSM (1980; Krajeski, 1994), the depathologizing of individuals allowed the development of models of normative gay identity development (Cass, 1984). Increasing openness and the development of a commercial subculture allow greater numbers of American men and women to self-identify as gay and develop their identity in a more affirmational way (Herdt, 1992, p. 29). Increased research into the experience and demographics of the gay population has followed this increasing societal openness. Older gay men may remain hidden purposely because of the relatively greater social stigma and discrimination endured during their young adulthood (Kimmel, 1978), despite increased societal acceptance in recent years. These individuals remain elusive and unreachable by choice.

Debate on the nature versus nurture components of homosexuality has a long history (Mohr, 1992). A historical view suggested that sexual orientation more likely partook of both biological and psychosocial input (Gladue, 1988). However, recent studies suggest the following: a familial and genetic component to sexual orientation in twin studies (Dawood, Pillard, Horvath, Revelle, & Bailey, 2000; Kirk, Bailey, Dunne, & Martin, 2000); genetic evidence for a heritable component and a correlation to birth order in males (Bogaert, 2003; Rahman & Wilson, 2003a); sexual orientation differences for performance on cognitive tasks (Rahman & Wilson, 2003b); evidence for the effect of
pre-natal hormones on sexual orientation (Rahman & Wilson, 2003c); and correlations between handedness and sexual orientation (Lippa, 2003). Pillard and Bailey (1995) noted correlations and linkages illustrating genetic components to sexual orientation through (a) twin studies, (b) family studies, (c) genetic linkage studies, (d) sex hormones studies, and (e) brain difference studies. Whatever the outcome to the nature versus nurture debate, the gay individual must still adjust to a stigmatized identity in a discriminatory environment.

A developmental model proposed by D’Augelli (1994) suggests that an adjustment to the realization of a difference in sexual orientation from others is more of a process than a stage model. Initially, individuals are confused or unsure of their perceptions and pull away from this realization. Later, as they gather more understanding or leave home, they begin a process of coming out, or self-disclosure to significant others. The model of normative gay identity development proposed by Cass (1979) suggested that emancipation begins as the person begins to self-disclose their sexual orientation to others, which results in greater adjustment.

Most models of normative gay identity development have in common a stage theory involving the gradual acceptance of a gay identity that is then incorporated into the concept of self (Cass, 1979, 1984; Coleman, 1982; Harry, 1993; Hetrick & Martin, 1987; Malyon, 1993; Troiden, 1988, 1989). Cass (1979, 1984) proposed a widely referenced theory of normative gay identity development that utilizes a linear six-step stage model of acceptance of self as gay. Here, a person begins in a state of identity confusion.
characterized by self-questioning and the use of denial, projection, or other coping mechanisms to protect the self-identity. This is followed by a stage of identity comparison, during which a person begins to confront fantasies and ideation, yet these decisions remain an internal process. Identity tolerance occurs as individuals begin to express publicly their feelings and behaviors. They may have ventured out to establishments in the gay subculture or acknowledged their new information to a very few trusted gay-identified others. Their fear of non-acceptance may never be higher. In the fourth stage of identity acceptance, the person may come out to trusted non-gay friends. Gay individuals at this stage often continue to pass as straight, but eventually grow uncomfortable with the incongruence between their private and public selves. Identity pride is the fifth stage, characterized by investment of self into the gay world and resultant gay identity. Gay pride was the equivalent formulation in the identity politics arena. For a person at this stage, the world may seem divided between gay and non-gay people; this identity may become the central self-identification of the person. The final stage, identity synthesis, acknowledges the healthy incorporation of diverse aspects of the person’s self-identity into his or her self-concept. An individual acknowledges that both gay and non-gay people are highly diverse, acknowledges this diversity in him or herself, and focuses on living outside of narrow cultural roles. Psychological well-being was associated in higher levels of gay identity development in a study by Brady and Busse (1994), who developed an assessment tool based on the work of Cass (1979, 1984). Men
in the earlier stages of identity development displayed more psychological distress than those who were resolved about their sexual identities.

In many ways, the psychosocial developmental course for later adulthood is similar for gay and non-gay people (Berger, 1984; Friend, 1987; Kelly, 1977). Positive gay identity was associated with socializing with other gay men and psychological adjustment to aging in a study by Berger (1982b), suggesting that greater disclosure and self-labeling of sexual identity strengthens their psychological development. From the resolution of sexual and affectional needs in young adulthood (D’Augelli, 1994; Greene, 1994) to the physical and social adjustments of aging (Berger, 1980, 1982a, 1982b, 1983, 1984, 1986, 1992; Friend 1980, 1987, 1990, 1991), disclosure needs remain similar for a self-affirming gay person. Concealing one’s sexual orientation, though often used as a coping strategy, may be more stressful than the act of disclosure (Meyer, 2003). There is additive burden and strain experienced in the adjustment of living a healthy life in the face of stigmatizations, barriers to service, and legal restraint. The additive stress felt by stigmatized individuals has been characterized as minority stress (Meyer).

The development of healthy self-esteem is described as a developmental pitfall in the normative gay identity development literature (Hetrick & Martin, 1987) and as inversely linked to higher levels of internalized homophobia. Gay men who successfully complete this task of identity development are likely to be higher self-disclosers of sexual orientation by assumption of these normative models of gay identity development (Berger, 1983; Cass, 1979; Coleman, 1982). Normalization of overt homosexuality has
resulted in the pathologizing of a covert gay identity (Cain, 1991). The participants in the present study were young men when having a covert identity may have been more functional. The process of adjustment to their sexual orientation in earlier, more homophobic times may have affected their current health care choices.

**Population Challenges**

Since the pioneering work of Hooker (1956) demonstrated the relative mental health of a non-clinically obtained sample of homosexuals, research concerning the psychology of gay men has shifted from a focus on pathology toward increasingly descriptive explorations of the behavior and experience of gay men (Campbell, 2000). Beliefs about older gay men as lonely pedophiles are influenced by the stigma attached to homosexuality and by societal ignorance about the actual lives of older gay people (Getzel, 1997).

Early research efforts focused on disproving stereotypes of older gay men as “depressed, lonely, oversexed, and lacking support of family and friends” (Kelly, 1977, p. 328). Gay men have been portrayed as happy, psychologically well-adjusted, self-accepting, and successfully aging (Berger, 1982a, 1982b; Francher & Henkin, 1973; Friend, 1980; Kelly, 1977; Kimmel, 1977, 1978; G. Weinberg, 1972). Kimmel noted the importance of focusing on real needs in addition to disproving stereotypes. He indicated that older gay men especially need assistance with bereavement, assistance with physical disabilities, and a reduction in stigmatization (Kimmel, 1993).
Little formal research has been conducted concerning the realities, adjustment, challenges, nature, and identity of older gay men (Brown, Sarosy, Cook, & Quarto, 1997). The pioneering studies of Weinberg and Williams (1979a), Kelly (1977), Bell and Weinberg (1978), and Berger (1980) dispelled the myths and stereotypes about older gay men as depressed, lonely, oversexed loners, psychologically maladjusted, and lacking in social support (Kelly, 1977). Despite the difficulties in precisely defining and accessing this population for research, there is a small body of literature representing exploratory studies of older gay men (Getzel, 1997, p. 134).

Berger (1984) found that age was not correlated to measures of self-acceptance, life satisfaction, anxiety about homosexuality, or fear of aging. Several of these studies have found evidence of solid social support networks built on friendship rather than kinship (Berger & Kelly, 1995b; Friend, 1990; Kimmel, 1993). These networks are seen as “family equivalents” (Getzel, 1997, p. 136) and considered vital sources of care and support. A recent study (Dorfman et al., 1995) matched homosexual and heterosexual participants aged 60–93 years and found that they did not differ on levels of depression after controlling for age, educational level, partner status, or gender. One striking difference was that older gay men had significantly fewer kin identified as supports than lesbian women, heterosexual women, and heterosexual men. The overall strength of the identified social support network did not differ significantly for these groups, however (Dorfman et al.). This conclusion differs sharply with Friend’s (1980) conclusion that gay
men used their friendship network to reinforce, rather than replace, their kinship care network.

**Multiple jeopardy: Racism, ageism, and heterosexism.** The cultural background of a person is a fundamental dimension to consider in the provision of mental health and health care services (Ersek, Kagawa-Singer, Barnes, Blackhall, & Koenig, 1998). An older gay man may have to contend with more than the combined effects of ageism and heterosexism; if he is a member of a cultural or ethnic minority population, he may also have to contend with racism. This burden of additional oppressions is tantamount to multiple jeopardy and may include stigma, discrimination, and harassment (A. Smith, 1997). Ethnic minority gay men live as “minorities within minorities, with the multiple levels of oppression and discrimination that accompany such status” (Greene, 1997, p. 232).

A social and political history of discrimination and abuse can influence health care decisions (Ersek et al., 1998). African-American male participants showed decreased participation and utilization of health services in a study of the effects of knowledge of the Tuskegee Syphilis Experiment (Green, Maisiak, Wang, Britt, & Ebeling, 1997) on their health care choices. The Tuskegee Syphilis Experiment involved a study by the U.S. Public Health Service from 1932–1972 of 400 African-American farmers misled by their physicians and left untreated for syphilis, even after penicillin was discovered to cure the disease in the mid 1950s. Over 100 men died of complications related to the untreated syphilis, and the distrust in the African-American community today continues to hamper
HIV education and prevention efforts (Thomas & Quinn, 1991). From a distrust of the American health care system by African Americans (Ersek et al., 1998), lack of trust in physicians and other health care providers (Thomas & Quinn, 1991), and differences in family decision-making styles among many people of color (Baker, 2002, p. 37), it is evident that cultural values affect care preferences and choices. Minorities are also less likely to access healthcare, one of the major health disparities of African-Americans as compared to European-American in the United States currently (Gay and Lesbian Medical Association [GLMA], 2001).

The normative integration of a gay identity into the sense of self is known as gay identity development. The predominant empirical research describing gay men and lesbian women is based on a primarily White, middle-class sample (Chan, 1989, 1992; Greene, 1997; Gutiierrez & Dworkin, 1992; Morales, 1992), and research on minority populations often neglects differences in sexual orientation (Greene, 1997), leaving a void in our understanding of the interaction between minority identity development and gay identity development. There has been little exploration of the interaction between gay identity development and minority identity development and of the healthy integration of an individual’s multiple identities into a congruent whole (Greene, 1997). Such neglect in the literature leaves clinicians with little to guide their counseling of older gay men who are also members of cultural and ethnic minority groups.

*Legal discrimination.* Heterosexism has been defined by Herek (1996) as an ideological system that devalues and stigmatizes non-heterosexual behavior,
relationships, and community. The problems of older gay men are often the same as most older adults (e.g., lack of health, finances, and loneliness). Beyond these common experiences, older gay men experience discrimination and adjustment to stigma. Berger (1982a) indicated four major problems of older gay people: (a) institutional policies, (b) legal discrimination, (c) neglect by social service agencies, and (d) social invisibility to health care providers. Intentional self-disclosure of sexual orientation to the physician mitigates being overlooked by health care providers, but it does not guarantee access to culturally competent care.

Family medicine residents were surveyed about attitudes towards homosexuals, and 37.6% indicated discomfort working with homosexuals (Prichard et al., 1988). In a study of homophobia among physicians and nurses, mean scores for both men and women were in the range for low-grade homophobia (Douglas, Kalman, & Kalman, 1985); 10% of participants felt that homosexuals “deserved” to contract AIDS. Discomfort with providing health care to homosexual patients with HIV appeared to be associated with the race and the religion of the health care worker (Wallack, 1989). In a survey of gay, lesbian, and bisexual physicians concerning their experiences witnessing anti-gay discrimination in medicine, 67% of the respondents witnessed patients who received reduced or no care based on their sexual orientation (Schatz & O’Hanlon, 1994). In a study of 575 gay men and lesbian women (Stein & Bonuck, 2001a), 70% had disclosed their sexual orientation to their health care provider, although only 29% had been asked about their sexual orientation.
Negative public stigma and belief systems support social discrimination, negative public attitude, homophobia, limitations in certain professions, negative family values, and loss of family support. Older gay men experience legal discrimination in inheritance, disability, marriage eligibility, workplace discrimination (Brown et al., 1997), ineligibility for Social Security survivor’s benefits, and unequal treatment by Medicare and Medicaid federal programs (Cahill et al., 2000).

Older gay couples are treated unequally by the U. S. Social Security and Medicaid systems, according to a study released by the National Gay and Lesbian Task Force (Cahill et al., 2000), and cause these unmarried couples to expend funds otherwise available for self-care. Taxation of pensions and 401(k) plans limit savings for gay couples. Despite this, gay couples are also ineligible for benefits that heterosexual, married couples expect such as: (a) Social Security survivor benefits, (b) spousal benefits, and (c) the pension income from the deceased spouse. Basic rights such as hospital visitation and the option to live together in the same long-term care facility have been denied to older gay couples. Health promotion and disease prevention strategies often ignore older gay people. Medicaid regulations allow married individuals to retain their homes without jeopardizing their spouses’ eligibility for Medicaid coverage of nursing home care; this protection does not apply to same-sex couples (Cahill et al.).

For example, older married adults are typically eligible to “set-aside” the value of their portion of a jointly owned home when their spouse enters a nursing facility with Medicaid authorization for payment. An unmarried heterosexual or gay couple, even if
jointly providing support for each other, must sell their joint assets to qualify (Cahill et al., 2000). The independence of the community-dwelling person might be compromised through this unequal treatment.

Gay men and lesbians may be more likely to experience barriers to care and preventive services; additionally ethnic and racial minority membership status, lack of health insurance, low income, or chronic conditions may only serve to exacerbate the lack of access that a gay person would otherwise face (GLMA, 2001). Experiences with discrimination may result in individuals choosing not to interact with health care agencies, an internal barrier on the part of the individual, rather than a barrier from external agencies or society. Negative experiences may result in an unwillingness to disclose sexual orientation, even when such information is relevant to health care decisions (e.g., the need for HIV testing). Discriminatory experiences may further affect health care decisions. Knowledge of patients’ “sexual orientation and behavior is critical for the development of a productive therapeutic relationship, accurate risk assessment, and the provision of pertinent preventive counseling” (Potter, 2002, p. 341).

Berger and Kelly (1995a) have referred to older gay men and lesbian women as the unseen minority of the 20th century. Despite evidence for successful aging among older gay men described in the literature, this evidence is based on results with a sampling bias skewed towards middle class, non-minority individuals (Cahill et al., 2000). Little information is available about the health care behaviors of older gay men, and accordingly, how these behaviors are affected by internalized homophobia, age,
and/or cultural identity. The current study investigated the relationship of age cohort, minority status, and two components of internalized homophobia with the health care behaviors of DPAHC completion and SDSOP.

**Barriers to service.** It is paramount to consider the barriers to social services that older gay men perceive or have experienced in their lives. Researchers (Berger, 1982b; Kelly, 1977; Kimmel, 1978) have suggested that older gay men find their needs to be more like than unlike their heterosexual counterparts. They have similar needs for medical care, socialization, financial support, household tasks support, and transportation (Ehrenberg, 1996). Older gay men's perceptions of barriers to formal and informal care may include the realization that they are likely to encounter both covert and overt forms of prejudice and hostility (Ehrenberg).

Studies report that older gay men still experience overt discrimination based on age or sexual orientation or both (Berger, 1982b; Cahill et al., 2000; Kelly, 1977, 1980). They may be dealing with overt ageism in the gay community and overt homophobia in the greater community. Declining physical abilities and health, along with a loss of physical attractiveness, are among the most difficult aspects of growing older, according to attitudinal research conducted with older gay men (Berger, 1982b; Brown et al., 1997; Kelly, 1977, 1980).

Barriers to service for older gay men occur on four levels: (a) systemic, (b) organizational, (c) group, and (d) individual (Anetzberger, Ishler, Mostade, & Blair, 2004). System barriers include the lack of legal protection, lack of funding for gay related
health research and programming, absence of affirmative housing and health care, lack of recognition of life partners and cultural family networks, failure to identify such a population on community sponsored needs assessments, and the lack of eligibility for government benefits such as Medicaid and survivor’s benefits (Cahill et al., 2000).

Organizational barriers to service for older gay people include the absence of sexual orientation nondiscrimination policies, lack of domestic partner benefits, the exclusion of this population from diversity and other staff training, lack of resources and other directories targeting information for this population, and lack of role models for leadership within organizations for older gay people.

Group barriers include a misperception on the part of the public regarding the degree of uniformity and communication of the gay population, a failure to recognize the special needs of the older portion of this community within the youth oriented gay culture, and misperceptions regarding the size and needs of this population. These first three barriers are very much external barriers and not under the control of the individual. The final barriers are individual, and these barriers may be the responsibility of the gay person or the social service provider. Social service providers may be reluctant to assist because of their homophobia; the gay person might be reluctant to accept help because of his or her internalized homophobia. Internalized homophobia generates barriers for older gay people that include: (a) a desire to remain invisible, (b) experiences on the part of older gay people that “bad” things happen when people self-disclose their sexual orientation, and (c) distrust of authority and establishment organizations by a cohort of
older gay men who lived through police raids and McCarthyism (Mostade et al., 2003, pp. 4-6).

Population Resources

Older gay men exhibit several resources associated with the successful resolution of their gay identities. These include crisis competence (Francher & Henkin, 1973; Friend, 1980; Kimmel, 1978), also expressed as “mastery of crisis” by Berger (1980, 1982a); gender role flexibility (Friend, 1989); extensive friendship networks (Francher & Henkin, 1973; Friend, 1980, 1989); “surrogate families” (Bell & Weinberg, 1978); and good psychological adjustment (Berger, 1982a, 1982b; Friend, 1980; Kimmel, 1977, 1978; Francher & Henkin, 1973; Kelly, 1977; Weinberg, 1972). J. Lee (1987) criticized the finding of crisis competence as an artifact of a sampling bias in favor of middle class, middle-aged, White men (p. 54).

The psychological and social adjustment of gay men has been an item of research since the Kinsey reports of 1948 and 1953 (Berger, 1982a). This research ranged from studies that regarded homosexuality as a developmental disorder (Bieber et al., 1962; Simon & Gagnon, 1967), to those that compared adjustment between homosexuals and heterosexuals (Bell & Weinberg, 1978; Hooker, 1956; Saghir & Robins, 1973; Weinberg & Williams, 1975), to descriptive research about the nature of the adjustment of self-described gay men (Berger, 1982a, 1985; Francher & Henkin, 1973; Friend, 1991; Kelly, 1977).
The literature supports the notion that psychologically well adjusted, self-accepting, and successfully aging gay men are a substantial portion of the cohort of older gay men (Berger, 1982a, 1982b; Cahill et al., 2000; Dorfman et al., 1995; Francher & Henkin, 1973; Friend, 1980, 1991; GLMA, 2001; Kelly, 1977; Kimmel, 1977, 1978; Weinberg, 1972). “Older homosexual and heterosexual men are more alike than dislike” (J. Lee, 1987, p. 68). That is, high satisfaction and enjoyment in life are related primarily to health, wealth, and absence of loneliness (Lee). It is unclear, however, whether these studies have been measuring the relative class comfort and educational attainment of their samples of primarily White, middle-class men (Brown et al., 1997; A. Smith, 1997), or the positive stigma management techniques of a generation of older gay men. This is an unexplored area and provides a rationale for assessing the health care choices and levels of homophobia in older gay men. Additionally, there may be further significant differences in the levels of homophobia and health care choices between minority and non-minority older gay men, and earlier and later age cohorts of older gay men.

Older gay men in a study by Weinberg and Williams (1979) demonstrated higher levels of psychological adjustment such as self-esteem and self-acceptance than did younger gay men. It was theorized that as these individuals retired, they had “less to lose” by acknowledging their gay identity (Weinberg & Williams). Friend (1989, p. 260) called for research to examine the identity and stigma management strategies of different cohorts of older gay men. The current study represents a response to that call in that it
compared components of internalized homophobia and health care preferences with regard to age cohort.

Self-disclosure. Self-disclosure to non-gay others has come to be seen as evidence of the resolution of some of the stages of gay identity development (Cass, 1979, 1984; D’Augelli, 1994; Greene, 1994; Icard, 1986). Self-disclosure and public self-labeling as gay have serious effects on a person’s fiscal and social well-being (Getzel, 1997, p. 133). Both J. Lee (1987) and Berger (1982a) suggested that concealment of sexual orientation leads to problems with self-esteem and forming social support networks. Friend (1980) found that increased sexual orientation self-disclosure was associated with higher scores on assessments of self-esteem. Lee (1987) reported, to his “chagrin” (p. 57), that life satisfaction did not correlate with the level or numbers of self-disclosure. This led to his conjecture that concealment could be an effective stigma management tool. In some settings, this concealment of identity may have been more functional. These contradictory findings suggest a need for further study about the function of concealment or disclosure of sexual identity.

A study of the disclosure habits and the management of stigmatizing information (Cain, 1991, p. 69) revealed six rationales used by gay men to decide to self-disclose potentially discrediting information. These types of disclosure included (a) therapeutic, (b) relationship-building, (c) problem-solving, (d) preventive, (e) political, and (f) spontaneous. Cain disagreed that disclosure determines the level of gay identity development, and proposed instead that gay men employ a range of responses to self-
disclosure or concealment of sexual orientation. The development of strategies to manage disclosure of sexual identity occurs during identity development (Cain).

As the social climate and levels of public tolerance have shifted dramatically in the lives of gay men aged 65 and over, these men may have developed differential stigma management techniques based on their experience of time (age cohort) and perceived identity (minority status). Stigma management techniques that developed at the time of one’s first coming out—whether in the 1940s, 1950s, or 1960s—may have influenced levels of trust, internalized homophobia, and willingness to self-disclose to anyone, even health care providers and physicians.

_Social support and social lives._ Little is known about the social lives, family relationships, retirement issues, bereavement responses, health care choices, relationship choices, or coping responses of older gay men. There is a great gap in the literature about gay men. What little is known is based on skewed samplings of this hidden population resulting in little generalizability concerning race, culture, ethnicity, income, disability, education, or income levels (Brown et al., 1997).

It is known that older gay men reinforce family support with friends (Friend, 1980), and form networks of friendships (Francher & Henkin, 1973), and surrogate families (Bell & Weinberg, 1978). For the 1.2 million adults living in unmarried same-sex households, (U. S. Census, 2004c), it will become increasingly important to understand how older gay men and lesbian women structure their patterns of care, as it will for single household older gay men and lesbians. Involvement with the gay
community seems to allow a healthy validation of the otherwise stigmatized self, allowing self-acceptance to emerge. Self-acceptance then encourages community involvement with other gay people, which leads to identification with that community (Berger, 1984; Friend, 1987; Kelly, 1977). Such self-affirming gay older adults find strength and empowerment in a gay community with which they can connect (Friend, 1989).

**Health Care Choices and Gay Men**

This final section reviews empirical studies conducted concerning gay men and self-disclosure of sexual orientation to one’s physician and the completion of the Durable Power of Attorney for Health Care. The research regarding older gay men is summarized thematically around issues of sampling, variables of focus, and suggestions for future studies. Empirical studies exploring SDSOP and DPAHC in gay men are discussed.

Care preference studies in health care evolved primarily from the need to make available supportive interventions to families providing care to frail and elderly people (Barer & Johnson, 1990; Gordon, Benner, & Noddings, 1996). Caregiving as a field of study involves studies ranging from informal to formal support networks, from studies of the emotional life of informal family caregivers to studies of the impact of mental health interventions on the health of the care recipient. Informal care may include help with groceries by a neighbor or supervision of the checkbook and finances by an adult child. Formal care can range from transportation and meal provision to senior housing and total
supervision. Older adults have values and preferences in receiving both formal and informal care.

Caregiving research has focused primarily on older adults, although normative and non-normative caregiving occurs throughout the lifespan (Zarit & Pearlin, 1993). All care occurs within a cultural context, and an understanding of the context facilitates treatment planning, interventions, and care responses (Davis & Wykle, 1998). The focus of many studies has been to assess the practices, feelings, and coping mechanisms of the caregivers rather than those of the care recipients (Parris-Stephens, 1993). Barer and Johnson (1990, p. 28) urged that attention be paid to the care preferences of the potential care receivers, their subjective experiences, and their experience of care received.

Many explorations of caregiving theory have focused on such issues as family burden (Barer & Johnson, 1990; Zarit, Todd, & Zarit, 1986); indeed, it has been noted that the underlying assumption is that all informal caregiving occurs primarily within the context of a consanguineous, heterosexual family paradigm (Quam & Whitford, 1992). Recent references in the literature on AIDS refer to an ethic of care articulated from a gay community response (Callery, 2000). Additionally, as women provide the bulk of the informal and formal caregiving in the U. S. currently, an exploration of care choices among older gay men adds to an understanding of a gendered response to care. Men are providing an increasing amount of care to their immediate relatives and families as the aging population in the United States increases (Kaye, 1997).
Although there have been limited studies of care preferences with underserved groups such as ethnic and cultural minorities, people with low incomes, low education, and inner city residents (Rakowski, 1998, p. 104), the experience of African-American caregivers has been presented (Wykle & Haug, 1993), and studies have looked at the experiences of gay men as caregivers in response to the AIDS health crisis (Callery, 2000). Callery found that caregivers in the gay and lesbian community had experiences similar to heterosexuals concerning financial, emotional, and physical burden in response to their caregiving roles. What made them different from other cultural groups of caregivers was the make-up and structure of their support systems. These support systems were often composed of friends and fewer family members than the other cultural groups. Gay men may have differing expectations for care as they age, whether as caregivers, care receivers, or both.

Although studies have focused on the experiences of gay men and lesbian women over the age of 50 (Berger, 1992; Kehoe, 1988; Kelly, 1977; Kimmel, 1978), these studies have focused primarily on the experiences of their adjustment to the developmental tasks of aging. This literature does not penetrate the experiences of health care preference or behavior, and little is known about the health care preferences of older gay men. Most frequently, studies have focused on family relationships, restricting interest to spouse, adult children, or other relatives (Barer & Johnson, 1990), thus limiting the sampling of friends or life partners as caregivers and receiver dyads.
Barer and Johnson (1990) found four omissions in the literature on caregiving: (a) a paucity of studies involving the subjective experiences, desires, and expectations of the care recipient; (b) multiple definitions of a single concept; (c) sample biases such as neglect of the entire support network; and (d) neglect in determining whether the needs of the care recipient were met. Horowitz (1985) pointed out the irony of a field of study so exclusively focused on the providers of care that it forgets the original focus of need—the recipient of care, and his or her choices and preferences.

Older lesbian and gay people who have a will and power of attorney are better equipped than those who do not have such documents to manage hospital policies that may exclude lovers and friends from decisions regarding care and even visiting privileges (Kimmel, 1978). “Many affirmative older lesbian and gay people have planned for their own futures” (Friend, 1989, p. 259). With the use of these advance directives, individuals are able to extend their decision-making autonomy to cover health care issues not yet encountered.

As people age there is an increased possibility that psychological or physiological decline will occur, necessitating the use of informal and formal care to alleviate this effect on the autonomy of the individual (Schaie, 1993). Informal care for older adults is provided primarily by family members (Zarit, Pearlin, & Schaie, 1993) but may also be provided by friends or neighbors. Access to formal systems of care, such as hospitals, physicians, social service agencies, assisted living facilities, and community centers, is often initially facilitated by the individuals providing informal care to an older adult
(Zarit et al.). Most of the caregiving literature has focused on older adults as recipients and providers of care, although adults do play caregiving roles at other “normative and non-normative” times in their lives (Zarit et al., p. 4).

As caring is embedded in the study of reciprocal relationships (Tarlow, 1996), each caregiving relationship involves at least two participants—the caregiver and the care receiver. There are also informal and formal caregivers. Informal caregivers are those members of the family, friendship network, or neighborhood who provide instrumental care or primary emotional support for a care recipient who requires assistance with activities of daily living or independent activities of daily living due to chronic or acute illness. Formal caregivers are physicians, nurses, nurse’s aides, drivers for the Meals on Wheels programs, and other people providing care services on a hired basis, and may include volunteers organized into a formal care situation. Reciprocity is less of a determining factor in the relationship for formal providers of care.

There is reason for concern about the future of care provision in the United States. The U.S. population of people over the age of 65 will grow from 12.3% in 2003 to 20% in 2030 (U.S. Department of Health and Human Services, 2004); at the same time, life expectancy is likely to jump from 72 years to 86 years for men by the year 2050 (Arias, 2004). In 2000, the number of older adults 65 years or older was almost 35 million (U. S. Census, 2004a). With this increasing life expectancy, the population of adults 65 years of age and over will soar, with individuals 85 years and older expected to increase 400%. By the year 2040, projections indicate a U.S. population wherein nearly 70 million people
will be above the age of 65 (Kayser-Jones, 1986). Many of these individuals will require some sort of care at some point in their lives. The need to provide care to older adults will grow significantly, as will the need to understand both the caregiver’s and the care receiver’s experience (Kaye, 1997).

With the increase in the length of average life expectancy, the actual number of older adults has increased exponentially (Mangum, 1997). Some are experiencing severe psychological and physical disabilities that necessitate the use of formal and informal systems of care (Harrington, 1993). Although referred to as two separate systems of care, informal and formal systems of care are actually complementary, coexisting, and interdependent, and occur simultaneously (Zarit & Pearlin, 1993). Most linkages between the two systems are monitored by an informal caregiver who provides “an executive function in arranging and monitoring care” (Zarit & Pearlin, p. 304).

A method of characterizing the range of interdependencies possible for the interface of these two systems of care was proposed by Noelker and Bass (1989). These interdependencies range from (a) kin independence, or the absence of the use of formal services; (b) to formal service specialization, where the formal system provides one or more care tasks and the balance is provided through informal care; (c) to dual specialization, in which both systems provide non-overlapping task provision; (d) to substitution, in which formal systems of care provide all task provision. Understanding client preferences for care should be an integral part of the management of formal and informal systems of care. In the year 2030, as 70 million U.S. citizens reach the age of 65
Much of the focus of caregiving research, however, has been on the experiences of caregivers of persons who have dementia to the detriment of understanding either the care recipients’ experiences or the nature of this relationship concerning other diseases, illness, and impairments (Matthews, 1993). “Self-care behavior takes place in the context of attempts to maintain control of life and to do so with competence, autonomy, and self-reliance” (Konrad, 1998, p. 9). Researchers have called for increased focus on self-care behavior (Konrad), care preferences (DeFriese, Ory, & Vickery, 1998), roles of informal caregivers in self-care behaviors (Konrad), and the range of diversities in older gay men (Getzel, 1997).

**Self-Disclosure of Sexual Orientation to Physician**

Gay male patients believe their physicians will provide less attention to diagnosis and treatment if patients fail to disclose their sexual orientation, yet they report fear in initiating this disclosure (Owen, 1989, 1996). Self-disclosure of sexual orientation to a physician was assessed in the context of a sexually transmitted disease clinic in a study of 604 Men Who Have Sex with Men (MSM; Ross, 1985). This study showed that reluctance to self-disclose sexual orientation to one’s physician was correlated with a decreased likelihood of disclosure of sexual orientation to others, increased expectation of negative reactions to homosexuality, belief in more conservative sex roles for both men and women, and increased likelihood that the individuals considered themselves
bisexual. Client beliefs, whether the result of physician bias or internalized homophobia, can impede the exchange of important medical information. Responsibility for assessment of sexual practices and orientation may accrue to the clinician.

Disclosure of sexual orientation can be initiated by either the physician or the patient. It is important for physicians to facilitate a complete sexual history of their patients, while acknowledging that stigma may lead their patients to conceal their sexual orientation (Owen, 1996). Physicians may inquire about a client’s sexual orientation as part of the intake assessment. “Knowledge of each patient’s sexual orientation and behaviors is critical for the development of a productive therapeutic relationship, accurate risk assessment, and the provision of pertinent preventive counseling” (Potter, 2002, p. 341). In a survey of 600 men recruited through an ad in a gay community newspaper, 49% indicated that they had disclosed their sexual orientation to their physician (Dardick & Grady, 1980).

What the patient fears may, in fact, occur. In a summary of eight studies between 1978 and 1994 examining attitudes of individual physicians toward homosexuality, Owen (1996) noted that a substantial minority of physicians feels uncomfortable around gay people and a majority of physicians does not inquire about sexual orientation. In a 1970 survey of 900 Oregon physicians, fewer physicians reported homophobic behaviors on their own part than the higher percentage that the respondents attributed to their colleagues (Pauly & Goldstein, 1970). In a 1978 survey of 200 physicians, a significant minority of physicians (35%) revealed discomfort when treating gay patients (Golin,
More recently, in 1994, members of the organization titled Physicians for Human Rights were surveyed and 91% reported awareness of bias against patients who were known to be gay, lesbian, or bisexual (Schatz & O’Hanlon, 1994).

Physician reluctance to initiate the discussion of sexuality and sexual orientation may be as much a part of the failure to inquire, as is client internalized homophobia. In a 1992 study of over 2,545 physicians, 27% reported inquiring about the sexual orientation of their clients (Loft, Marder, Bresolin, & Rinaldi, 1994). The vast majority of the physicians in this study did not inquire about sexual orientation, leaving the decision to disclose and initiate the discussion to their patient. There is little information about gay men who are currently 65 years and older and even less about their health care preferences and behavior. It may be important to track behavioral changes in this population over time. New cohorts may develop increasingly functional stigma management techniques and other coping strategies, resulting in changes in health care preferences and behavior.

Psychological adjustment is highest among those people committed to a sense of gay identity and exhibiting higher rates of self-disclosure of sexual orientation to others (Herek, 1996, p. 107). Low self-disclosure of sexual orientation is correlated with higher levels of internalized homophobia (Shidlo, 1994). Higher levels of internalized homophobia have been correlated to difficulties in intimate relationships (Friedman, 1991), unsafe sex (Shidlo, 1994), loneliness (Finnegan & Cook, 1984), alcoholism (Finnegan & Cook), and the use of avoidant coping strategies in gay men testing positive.
for HIV (Nicholson & Long, 1990). Little research is available to understand the disclosure patterns of older gay men and their relationship to components of internalized homophobia. No research exists to assist with the question of how these patterns affect health care preferences and behaviors.

_Durable Power of Attorney for Health Care_

The passage into law in 1990 of the Patient Self Determination Act (PSDA) by the U.S. Congress formalized an individual’s right to refuse future treatments and therapy (Leland, 2001). Any hospital or medical facility that accepts Medicaid or Medicare must make available to each client information about his or her right to execute advance directives and document whether they have been completed (Leland; Prendergast, 2001). Glick, Mackay, Balasingam, Dolan, and Casper-Isaac (1998) pointed out that if an individual has not appointed a proxy decision maker or discussed his or her wishes with family or a health care provider, both formal and informal caregivers are left guessing about the incapacitated person’s care preferences.

Advance directives “allow individuals to maintain control of health care decisions” (Inman, 2002, p. 40). Advance directives come in two forms: treatment directives and proxy directives (Church, 2000; Fischer, Arnold, & Tulsky, 2000). A treatment directive specifies preferred treatments, whereas a proxy directive appoints someone else to make health decisions for the specified individual. A living will is one example of a treatment directive; a Durable Power of Attorney for Health Care (DPAHC) is an example of a proxy directive.
The living will is the oldest and most widely recognized form of an advance
directive (Church, 2000). The living will is a treatment directive that expresses decisions
regarding future possible medical procedures to prolong life. It also stipulates certain
interventions that would be desired and certain interventions that would be refused. This
may include such procedures as Do Not Resuscitate orders, mechanical ventilation,
hydration, tube feeding, and other possible medical procedures (Ott, 1999, p. 514).

A second form of advance directive is known as the Durable Power of Attorney
for Health Care (DPAHC). The DPAHC is an advance care document that names a
substitute health care decision maker selected by the individual executing the document
(Ott, 1999). The proxy has the legal right to make medical and other health care decisions
for the named individual when the named individual is incapacitated, or otherwise does
not have decision-making capacity—as in dementia related disorders (Ott). The legal
question of durability is important with this document. Other Powers of Attorney cease to
be effective when a person can no longer make decisions because of mental or physical
incapacity; the DPAHC becomes effective only at that point (Baker, 2002; Williams,

The actual rate of completion of advance directives by individuals in the United
States had been estimated in 1991 to be somewhere between 4% and 17.5% (La Puma,
Orentlicher, & Moss, 1991, p. 402). Less than a quarter of older adults has completed an
advance directive (Leland, 2001), despite the underlying assumption of the Patient Self
Determination Act (PSDA) that if individuals were presented with the option to complete
advance directives, they would do so (High, 1993). Three barriers to completion of advance directives posited by Glick et al. (1998, p. 6) are lack of education about advance directives; difficulties with paperwork completion; and discordance among patient, family members, proxy, and provider.

When advance directives are not stipulated nor a proxy executed, the decisional recourse may be legal guardianship, although some states have specified an automatic surrogacy for decision makers, as in the Illinois Health Care Surrogate Act (Church, 2000). This act allows individuals to act as surrogate health care decision makers in the following priorities: (a) patient’s guardian, (b) patient’s spouse, (c) patient’s adult son or daughter, (d) any parent, (e) any adult sibling, (f) any adult grandchild, (g) a close friend, or (h) patient’s guardian of estate or conservator (Church). A gay person’s partner may be lost in the process, if a family member chooses to usurp the partner’s decisions. This leaves the partner with little legal authority to question health care decisions. Furthermore, family members may have little idea of the values of the incapacitated individual (Church). In any non-marital relationship arrangement, heterosexual or homosexual, the best practice is to draft a DPAHC document (Church). If, as is historically possible, older gay men may be estranged from family or have friends who act as family members-of-choice, executing the DPAHC is a way to extend the individual’s autonomy regarding health care treatment preferences and decisions.

Ersek et al. (1998, p. 1684) pointed out significant differences among diverse cultural groups regarding the use of advance directives. They posited four Eurocentric
values that underlie the Patient Self Determination Act (PSDA, 1990) and DPAHC: (a) client autonomy, (b) informed decision-making, (c) truth-telling, and (d) control over the death process. Cross-cultural explorations of the completion rates for and decision-making about advance directives include a study by Murphy et al. (1996) with 800 participants from each of four cultural groups: European-American, African-American, Korean-American, and Mexican-American. Results found minority individuals less likely to have completed an advance directive. They hypothesized that this was influenced by cultural values regarding dying, family decision-making, and truth-telling. A survey of the empirical literature regarding advance directives completion reveals that minority individuals complete advance directives less often than non-minority individuals (Baker, 2002; Caralis, Davis, Wright, & Marcial, 1993; Lindesay, Jagger, Hibbett, Peet, & Moledina, 1997). At the same time, minority individuals who do complete advance directives tend to indicate the use of aggressive end-of-life measures, unlike non-minority individuals (Caralis et al., 1993; Murphy et al., 1996). It is unclear if these differences are influenced as much by education, finances, and access to health care as by culture.

Significant relationships between higher completion rates of advance directives include being female, having a completed will, and maintaining a close relationship with a sibling (Inman, 2002, p. 44). There are no data on the completion rates for DPAHC for gay men or lesbian women, let alone older gay men. Owen (1996) insisted that, as part of a physician’s thorough assessment of his or her patient’s sexual orientation and sexual history, the gay patient be urged to complete a DPAHC.
Ethnic and cultural minorities are often undersampled in research on the use of advance directives, but the limited empirical evidence is consistent in showing that minority adults complete advance directives less often than do non-minority adults (Baker, 2002). Specifically, European Americans were most likely to have heard about and executed advance directives. However, even when controlling for knowledge of advance directives, minority individuals were less likely to complete advance directives. This indicates that there may be important cultural differences in the approach to disclosure and execution of advance directives.

Few studies have paid attention to the experience of sexual orientation and older adults (Capuzzi & Friel, 1990). Further research should include not only a broader sampling of ethnic and cultural minorities (Ersek et al., 1998), but also sexual and other minorities. Research has suggested that non-minority adults are more likely to have completed advance directives than minority adults even when controlling for age, gender, education, and income (Baker, 2002). In another study, age, race, religion, and education showed a weak positive relationship to advance directives completion (Inman, 2002). The current study explored the relationships of DPAHC completion with components of internalized homophobia and age cohort.

Further research concerning the completion rates for the DPAHC is needed. Ott (1999, p. 318) called for studies to examine the influence of age, ethnicity, religion, and social variables on advance directives implementation. The DPAHC helps to frame the discussion for care preferences within the values of the individual executing the
document (Leland, 2001). In the absence of family or supportive family, an individual may want to appoint a DPAHC to ensure that his or her values inform decision-making in the event this becomes necessary (Leland).

Rationale for the Study

The purpose of the current study was to compare endorsement rates of two components of internalized homophobia in older gay men to the following health care decisions: (a) the execution of a Durable Power of Attorney for Health Care (DPAHC) and (b) self-disclosure of sexual orientation to one’s physician or other health care provider (SDSOP). Additionally, each of these decisions was related to age cohort (i.e., 65–74 years, and 75 years and older). In order to link components of internalized homophobia to these health care decisions, the differential impact of stigma and resultant stigma management strategies of the individual must be considered. Identity development tasks for gay men include: (a) management of the awareness of discrimination, (b) confrontation of internalized homophobia (Cass, 1979), and (c) selective adjustment of stigma management techniques, including selective disclosure.

Selective self-disclosure is one of the stigma management tools available to gay men, and these decisions involve a personal sense of resolution of internalized homophobia and gay identity development. Stigma management techniques are both highly personal and may reflect cohort experiences of oppression and stigma. Cohort experiences may influence individuals toward certain choices in selective disclosure within naturally occurring historical age cohorts. As gay men age, they must begin to
incorporate their experience of age discrimination and stigma into their existing conceptual framework regarding their gay identity. Similarly, minority individuals will begin to incorporate their experience of age discrimination and stigma into their existing conceptual framework regarding both their gay identity and their identity as persons of color. The experiences of minority adults may influence their willingness to self-disclose their sexual orientation to health care providers. Each of these proactive health care decisions may involve disclosure to formal providers of health care.

Assessing differences between men who have disclosed their sexual orientation to their physicians and those who have not provides important information in constructing any intervention within this community regarding access to formal and informal care. The disclosure of sexual orientation to an individual’s physician and the execution of a DPAHC may indicate proactive health care behavior. Likewise, understanding differences between those older gay men who execute a DPAHC and those who do not provides some understanding of the proactive health care behaviors of older gay men.

Older gay men experience discrimination and stigma and must choose strategies to selectively manage their personal experience of stigma and their sexual orientation disclosure. Research has shown that increased self-disclosure of sexual orientation is one of the developmental tasks of the healthy development of gay identity (Cass, 1979, 1984). Older gay men who choose alternate strategies for stigma management—such as concealment of sexual identity—may be at increased risk for unhealthy behaviors, or health care choices (Friend, 1990). Empirically based information is relevant to the
current conversation about the relationships among components of internalized homophobia, self-disclosure of sexual orientation to physician, and execution of the DPAHC.

Significance of the Study

Little is known about older gay men in the United States, despite numbering perhaps 1 million men currently. Very little research has been undertaken to determine who cares for older men in the United States today (Applegate, 1997), what their preferences are for care, and whom they prefer to care for them. Understanding internalized homophobia, demographics, disclosure patterns, and health care choices for older gay men in the United States will allow the development of outreach programs, counseling, and provision of services to a potentially underserved and certainly misunderstood segment of our population.

Internalizing oppressions related to sexual orientation, age, or minority status may affect coping style choices and may have an effect on healthy, optimal, and successful aging. In this hidden population, access to services can be an important factor in wellness and safety. The importance of the current study is in the relationship between the historically oppressed statuses of age, sexual orientation, and minority membership and their effect on care choices, such as disclosure of sexual orientation to one’s physician and the execution of a Durable Power of Attorney for Health Care.
Summary

In this chapter, the statement of the problem, the research questions, and the hypotheses have been presented. A definition of terms has been provided. A review of the relevant literature related to each of the major organizing concepts of older gay identity development, stigma management, and two health care choices have been presented.

The methodology used in the current study is described and discussed in Chapter 2 and includes the research question, hypotheses, participants, instrumentation, procedures, and data analysis. Potential delimitations of the study are discussed. Chapter 3 provides the results of this study and analyses of data. Chapter 4 includes possible and alternate interpretations of the results of this study. Implications for future research involving older gay people are also discussed.

Older gay men experience discrimination, stigmatization, and oppression over the course of their lifetimes. Psychological well-being has been associated with higher levels of gay identity development (Brady & Busse, 1994). Additionally, gay men must incorporate their cultural identities and their identities as aging adults into their self-concept.

Critical developmental tasks for a gay man include confronting internalized homophobia, developing stigma management strategies regarding disclosure of sexual orientation to others, and the maintenance of healthy self-esteem in the face of discrimination and a stigmatized identity. It is also clear that higher levels of internalized
homophobia have been correlated to lower self-disclosure (Shidlo, 1994). A lifetime of oppressive experience may affect health care choices.
CHAPTER II
METHODOLOGY

This study investigated differences in self-disclosure of sexual orientation to physician (SDSOP) and execution of Durable Power of Attorney for Health Care (DPAHC) in a sample of 105 self-identified older gay men when two components of internalized homophobia and age cohort were considered. This chapter describes the methodology for exploring the relationships among the variables of components of internalized homophobia, age cohort, SDSOP, and execution of a DPAHC in older gay men. The research question and hypotheses are restated. Participant recruitment and characteristics, as well as instrumentation, are presented. Discussions of the procedure and data analyses conclude the chapter. Human Subjects Review Board Approval from Kent State University is found in Appendix A.

Research Question and Hypotheses

The primary research question that guided this study was, “What are the differences in self-disclosure of sexual orientation to physician (SDSOP) and execution of Durable Power of Attorney for Health Care (DPAHC) when levels of two components of internalized homophobia and age cohort are considered for a sample of self-identified older gay men?” Six hypotheses were developed from this original question.
1. For individuals 65–74 years of age and for those 75 years of age and older, there is no difference between observed and expected rates of self-disclosure of sexual orientation to one’s physician.

2. For individuals who have disclosed their sexual orientation to their physician and for individuals who have not disclosed to their physician, there is no difference between observed and expected rates of DPAHC completion.

3. Individuals who have disclosed their sexual orientation to their physician are more likely to endorse lower levels of two components of internalized homophobia compared to those who have not disclosed their sexual orientation to their physician.

4. Individuals 75 years of age and older who have disclosed their sexual orientation to their physician are more likely to endorse lower levels of two components of internalized homophobia compared to those individuals 75 years of age and older who have not disclosed their sexual orientation to their physician.

5. There is no relationship between the identified predictor variables (age cohort, two components of internalized homophobia, and disclosure of sexual orientation to physician) and completion of the DPAHC.

6. There is no relationship between the identified predictor variables (age cohort, two components of internalized homophobia, and completion of the DPAHC) and self-disclosure of sexual orientation to physician (SDSOP).
Participant Recruitment and Procedures

The population for this study consisted of self-identified gay men age 65 years and older who volunteered to participate in this research. There is a paucity of research about the experiences of older gay men, and what is available does not appear to be representative of the racial, cultural, socioeconomic, or other diversities of the community of older gay men (Getzel, 1997). Researchers have urged consideration of such diverse cultural identifications as Asian American gay men (Chan, 1989, 1992), African American gay men (Guttierez & Dworkin, 1992), Latino gay men (Morales, 1992), and the physically disabled (Boden, 1992). Previous studies have called for increased attention to populations outside the consistently oversampled group of European-Americans of higher income and educational profile (Christian & Keefe, 1997).

Participant eligibility consisted of men at least 65 years of age who identified as gay. The following characteristics were purposively sought in prospective participants: (a) cultural or ethnic background other than exclusively European-American; (b) having less than high school education; (c) any person with a disability or chronic illness; (d) those not currently involved in any lesbian, gay, bisexual, or transgendered community activities or support groups; and (e) age cohort of 75 years and older.

The intention was to capture a wide variety of age, cultural, socioeconomic, and health status diversity, to locate the “quintessential features common to this population within the heterogeneity of the maximum variation sampling” (Patton, 1990, p. 100).
Mean age of participants was thus highly skewed by sampling design. This sampling did not yield a random sample of older gay men, but it did provide a sample from a narrowly defined subset of the population, previously little sampled (i.e., gay men 65 years and older).

Recruitment utilized the following strategies, each discussed in this chapter: (a) advertising in the mainstream and gay press; (b) utilization of gay senior organizations, community centers, and social networks; and (c) referral through a snowball sampling technique. Procedures used in the study are discussed in the next section, and each method of recruitment is delineated.

Procedures

Participants were each provided with an informed consent document and a Gay Aging Survey packet. The informed consent document (Appendix B) provided a written description of the project and accompanied the Gay Aging Survey packet (Appendix C). Participants were asked to read and complete the informed consent document, which contained an original and a copy. The original was returned with the Gay Aging Survey packet; the copy was available to the participant.

The Gay Aging Survey packet contained: (a) the participant characteristic survey, (b) the two dichotomous health choice questions and follow-up questions, and (c) the Reactions to Homosexuality Scale (RHS; Ross & Rosser, 1996). The Gay Aging Survey packet was completed in group and individual formats as a self-administered pen-and-
paper survey. These were returned in person to the researcher in group settings or in the return envelope provided if the survey was mailed.

Over half of the surveys were completed and returned by postal mail ($n = 59, 56.2\%$), the second greatest number were administered in group formats ($n = 45, 42.8\%$), and specific outreach involved a home visit by the researcher to a single frail man with limited mobility and access to transportation. A luncheon opportunity (described below) was offered for survey participation, but for those unable to attend the luncheon, but desiring participation, arrangements were made for surveys to be mailed to them along with postage-paid return envelopes.

*Advertising*

Harry (1986) asserted that traditional sampling sources for participation by gay men such as bars, gay organizations, and friendship networks contribute to an over-representation of men who are more connected to the gay community and its organizations. Those who do not socialize within the gay community, and those who seldom choose to disclose their sexual orientation, may not be aware of an opportunity to participate, resulting in a sampling bias. Harry sampled 575 gay men and concluded that individuals contacted through commercial mainstream advertising showed less contact and activity with gay community organizations and businesses than those reached through traditional sampling means for gay men. Harry also demonstrated that sampling deficiencies of most studies of gay men lead to an undersampling of men under the age of 25 and over the age of 45.
Commercial advertising was designed to encourage individuals to attend the gratis luncheon and program. The researcher placed a newspaper ad (see Appendix D for text) on two occasions (one month and then 2 weeks prior to the luncheon) in the local lesbian, gay, bisexual, and transgendered community newspaper, known as the *Gay People’s Chronicle*. A Sunday advertisement was placed in the metropolitan daily, *The Plain Dealer*, two weeks prior to the event. In each advertisement, the opportunity to participate in the study was offered, and the text remained the same. Contact information was offered for those wishing to volunteer for the study. The intent of the ads was to encourage attendance at a free luncheon, although an opportunity to complete a survey packet individually by mail was also extended.

*Cultural and Social Networks*

Potential participants were also contacted through distribution of an advertisement as a circular (see Appendix D) to cultural, social, and professional networks of gay people. Groups specifically targeting older gay people included members of a Cleveland community group known as GrayPride, a group of gay men and lesbian women over the age of 50 that meets monthly in a suburban senior center; and PrimeTimers, a local branch of a national network and organization for older gay men. Interested individuals were encouraged to attend the community luncheon. If an individual was interested but unable to attend the luncheon, a questionnaire was mailed to that person with a postage-paid return envelope. Chronically ill individuals were also offered a home visit by the
researcher to facilitate completion of the Gay Aging Survey packet. Only one person elected to complete the survey through a home visit.

Presentations by the researcher were made to several groups to offer participation opportunities: (a) the Lesbian Gay Community Services Center; (b) Chevrai Tikva congregation of LGBT reform Jews; (c) PACT (People of All Colors Together); (d) Asians and Friends; (e) Insight, a local gay men’s professional networking organization; and (f) Human Rights Campaign Federal Club. In each case, participation in the senior luncheon was offered and encouraged. Gay Aging Survey packets and informed consent documents were mailed to those who expressed interest but were unable to attend the luncheon. These packets included pre-addressed, postage-paid envelopes for return.

*Snowball Sampling*

Participants were also contacted through a purposive chain sampling technique. Considering the historical oppression of this population and the limited availability of a readily identifiable population from which to draw participants, snowball sampling techniques have often been used (Shidlo, 1994). Current cohorts of older gay men were often raised in overtly homophobic and heterosexist environments. Previous experience with discrimination and prejudice may have led to a distrust of open discussion of their gay identities and has led to an informed reluctance to disclose.

Older gay men known to the researcher through community presentations or social contact were asked to participate and to recommend further individuals for participation. Referring individuals were given the recruitment circular (Appendix D) that
offered potential participants an opportunity to contact the researcher. When individuals expressed interest, the researcher mailed a Gay Aging Survey packet and consent form. Participants were encouraged to return their assessments within two weeks. Additionally, each participant was given the opportunity to identify additional prospective participants and convey the recruitment circular to them. Of the 105 data sets used in the study, 59 individuals were contacted in this way (56.2%).

An unplanned opportunity to gather participant surveys for this study was made available to the researcher by an older gay man. This participant, when approached about completing a survey, invited the researcher to attend an annual gathering in his home, attended by his friends, many of whom were over the age of 65. Participants were offered an opportunity to complete the survey during the gathering. Twenty individuals completed a survey at this gathering \( (n = 20, 19\%) \). Percentages of participation for these individuals were accounted for previously within the aggregate number of people completing a survey in a group format.

*Senior Luncheon*

Potential participants from the general community were targeted for participation. This was an attempt to reach the population unallied to gay social and support groups. A luncheon for gay men 65 years and older was planned with the cooperation of the Legal Aid Society of Cleveland and Fairhill Center for Aging in Cleveland, Ohio. Newspaper advertisements (see Appendix D) publicized the luncheon as described in a previous section. The Lesbian Gay Community Services Center of Greater Cleveland also
advertised the luncheon opportunity in their monthly membership newsletter using the same information.

The luncheon was held on Friday, October 31, 2003, at 11:30 a.m. at the Fairhill Center for Aging in Cleveland, Ohio. In a group format, attendees were informed about the purpose and procedures of the study by reviewing the distributed consent form with project description (see Appendix B). The voluntary nature of participation, as well as confidentiality of information provided, was emphasized. Consent was obtained from those interested in participating. The consent form indicated that each participant was 65 years of age or older, was willing to participate, and understood that he was free to withdraw from the study at any time without penalty. The Gay Aging Survey packet (see Appendix C) was distributed to each participant for completion, after the separate signed consent forms had been collected.

The opportunity to complete the Gay Aging Survey packet preceded the free luncheon and program. Participants were notified that they were welcome to attend both the luncheon and the program, even if they felt they did not wish to complete the survey packet. A program presented by an attorney from Legal Aid Society of Cleveland on the use of Advance Directives accompanied the complimentary luncheon. The entire luncheon, program, and survey packet completion opportunity lasted 2 hours. Twenty-five individuals elected to attend the Cleveland luncheon opportunity, 23.8% of the sample (n = 25), and all attendees completed the Gay Aging Survey packet. In all, 159
questionnaires were distributed and 116 were returned, a response rate of 72.96%. After exclusion of invalid responses, 105 participant surveys were used for analysis.

Instrumentation

Participants completed the Gay Aging Survey packet containing (a) the participant characteristic form, (b) the health choices assessment concerning self-disclosure of sexual orientation to one’s physician (SDSOP) and Durable Power of Attorney for Health Care completion (DPAHC), and (c) the Reactions to Homosexuality Scale (RHS; Ross & Rosser, 1996), designed to assess internalized homophobia. Permission granted by the developers to use the RHS in this research is located in Appendix E. Permission granted to conduct a factor analysis of RHS scores obtained from the current administration is located in Appendix F. Measures used are described in the order in which they were presented to participants. The Gay Aging Survey packet took participants approximately 20 minutes to complete.

Participant Characteristics Form

The participant characteristics form included in the Gay Aging Survey packet was used to collect information related to (a) age; (b) cultural identification; (c) retirement status; (d) living arrangement; (e) relational status, previous relational status, and duration; (f) legal marital status; (g) educational attainment; (h) household income; (i) religious identification; and (j) self-assessed number of chronic illnesses.
Health Care Choices

The variables of SDSOP and DPAHC completion were assessed using one question, each offering dichotomous response choices. In the case of SDSOP, the question asked was, “Have you disclosed your sexual orientation to your physician or other primary health care provider?” Response choices were Yes and No. A further question asked, “Why have you (or have you not) chosen to disclose your sexual orientation to your physician?”

In the case of DPAHC, the question was, “Have you completed a Durable Power of Attorney for Health Care?” The response choices were Yes and No. Contingent upon a Yes response, a further question asked, “Who serves as your Durable Power of Attorney for Health Care?” The multiple response choices were: (a) life partner; (b) legal spouse; (c) relative, with a blank line to specify type of relationship; (d) friend; (e) neighbor; (f) paid helper; (g) other, with a blank line for specification; and (h) don’t know. A further question asked, “Why have you (or have you not) chosen to complete a Durable Power of Attorney for Health Care?” This information was not required to test any of the hypotheses, but was included to assist with data analysis and interpretation of findings.

Reactions to Homosexuality Scale (RHS)

The Reactions to Homosexuality Scale (RHS; Ross & Rosser, 1996) is a 26-item instrument designed to assess internalized homophobia using a 7-point Likert response format ranging from 1 (Strongly Disagree) to 7 (Strongly Agree). Internalized homophobia has been defined as the negative reactions to homosexuality in others and in
oneself (Shidlo, 1994), and functions as an internal defense to experiences of discrimination and social stigma (Herek, 1996).

The RHS was designed to measure internalized homophobia in men who have sex with men. Ross and Rosser (1996) sampled 184 men who have sex with men who attended sexual health seminars in a large Midwestern city. Participants in that study reported a mean age of 37 years. The RHS has 8 positively scored and 18 negatively scored items to control for response bias. Higher total scores indicate relatively higher levels of internalized homophobia, but a cut-off score was not reported.

Principal components analysis (PCA) conducted by Ross and Rosser (1996) revealed four components of internalized homophobia in their sample, accounting for 45.1% of the total variance: (a) public identification as gay, (b) social comfort with gay people, (c) perception of stigma associated with being gay, and (d) moral and religious acceptability of a gay identity. The four components were used to construct subscales, which each yield a score with a range of 1 to 7, with 7 indicating higher levels of that dimension of internalized homophobia.

The RHS was constructed to reflect current notions of internalized homophobia and is composed of items derived from clinical and theoretical descriptions of internalized homophobia. The RHS shows acceptable reliability and significant concurrent validity. Ross and Rosser (1996, p. 18) reported Cronbach’s alphas for the four scales: public identification as gay ($r = .85$), perception of stigma associated with
being gay ($r = .69$), social comfort with gay men ($r = .64$), and moral and religious acceptability of a gay identity ($r = .62$). Total reliability scores were not reported.

Ross and Rosser (1996) correlated the subscale scores with responses concerning values derived from the clinical literature on internalized homophobia to provide a measure of concurrent validity for the RHS. The subscales were correlated with the following eight values: (a) duration of longest relationship, (b) extent of attraction to men, (c) extent of attraction to women, (d) relationship satisfaction, (e) proportion of social time with gays, (f) openly gay/bisexual in personal life, (g) openly gay/bisexual at work, and (h) number of persons known with HIV/AIDS. Significant associations were reported between each of the subscales and the following four values: (a) public identification as gay (associated with all eight values), (b) social comfort with gay men (associated with seven of the eight values), (c) moral and religious acceptability (associated with four of the values), and (d) perception of stigma as gay (associated with only the value of relationship satisfaction).

Statistically significant correlations were obtained between higher total scores of internalized homophobia and (a) low disclosure; (b) shorter length of and satisfaction with relationships; (c) lower degree of sexual attraction to men, and higher degree of attraction to women; and (d) less social time with gay people. The consistency of these relationships was seen as evidence that the RHS taps the clinical construct of internalized homophobia (Ross & Rosser, 1996, p. 19).
Internalized homophobia as a concept has been extrapolated from clinical observations of gay people and from normative gay identity development theory and constructs. It has not, however, been thoroughly conceptualized or measured (Williamson, 2000). Despite these challenges, research suggests some characteristics are associated with higher levels of internalized homophobia, such as depression, anxiety (Cabaj, 1994; DiPlacido, 1998; Meyer & Dean, 1998; Williamson, 2000), low self-esteem, low career aspirations (Cabaj, 1988), higher levels of drug use and suicidal ideation (DiPlacido, 1998; Meyer & Dean, 1998; J. Smith, 1988), and a sense of inferiority (Cabaj, 1994).

Higher individual scores on the RHS represent greater internalized homophobia. Therefore, higher scores indicate discomfort with public identification as a gay person, greater perception of stigma associated with a public gay identity, lessened comfort associating with gay people, and a lower perceived level of the moral and religious acceptability of a gay identity. Lower scores are associated with greater comfort with public identification as a gay person, lower perception of stigma associated with a public gay identity, greater comfort associating with gay people, and a greater sense of the moral and religious acceptability of a gay identity (Ross & Rosser, 1996).

Although a higher score on the RHS suggests greater internalized homophobia, no cut-off score was reported. Ross and Rosser (1996) elected to allow up to 25% missing values on items per subscale. For any subscale, a participant could miss 25% of the items and still be included using an adjusted mean. When a participant had more than 25% of
items missed on any one subscale, his data were deemed “incomplete/invalid” for the purpose of analysis, both in the Ross and Rosser study and in the current study.

Several instruments have been designed to assess internalized homophobia (Hudson & Ricketts, 1980; Nungesser, 1983; Ross & Rosser, 1996; Shidlo, 1994; Wagner, 1998). The Index of Homophobia (Hudson & Ricketts, 1980) is intended to assess homophobia, but not necessarily the internalized homophobia of gay people. The Nungesser Homosexual Attitudes Inventory (NHAI; Nungesser, 1983) was the first instrument developed specifically to be used with gay men to measure internalized homophobia, rather than homophobia. The NHAI tests for internalized homophobia using 34 questions; it was based on a study of 50 gay males. Internal consistency for the entire instrument was .94. Reliability coefficients for the three sub-scales were (a) .89 for attitudes towards one’s own homosexuality, (b) .68 for attitudes towards homosexuality in others, and (c) .93 for attitude toward disclosure of sexuality to others.

Shidlo (1994) has analyzed and suggested revisions to Nungesser’s (1983) measure of internalized homophobia. Face and construct validity criticisms were focused on some of the phrasing of items in Nungesser’s instrument. One item concerned the confidence of the respondent in his ability to form a long-term relationship with another man. Assessing internalized homophobia without confounding it with choices about personal intimacy would require a statement about the participant’s belief in the possibilities of relationships between gay men rather than the respondent’s personal beliefs about the quality of relationship within his or her own life (Shidlo, 1994).
In their review of the RHS, Corcoran and Fischer (2000) reported “fair concurrent validity, with three out of four of the subscales being significantly correlated to relationships with and attraction to men, amount of time spent with gays, and the extent to which the respondents were openly gay” (p. 399). In the current study the RHS was chosen for brevity, ease of scoring, concurrent validity of the scale constructs with clinically derived items, reliability above .60, incorporation of stigma perception as one of the components, and the contemporary wording. A review of the literature, however, suggests that it has never been administered to a sample limited to older gay men.

**Decision to Create Components**

Principal components analysis (PCA) with Varimax rotation was used to examine the underlying component structure of the items in the current sample. Component structure congruent with that obtained by Ross and Rosser (1996) was not found. Results were analyzed using PCA with various rotations. Unfortunately, this analysis did not support the use of the total RHS score.

Although the process to discern meaningful components is further described in Chapter 3, final analysis retained two components from a forced five-component solution. Three criteria were used to determine the appropriate number of components to retain: (a) eigenvalues greater than 1, (b) internal consistency reliability scores for the constructed subscales above .60, and (c) conceptual relatedness to the previously found Ross and Rosser (1996) subscales’ factors. Criteria indicated that two components exhibiting the greatest loadings, acceptable internal consistency reliability, and
relatedness to the original Ross and Rosser constructs from a five-component solution be
used for the study. Details of the development of the two components used to test the
hypotheses, rather than a total RHS score, are discussed in Chapter 3.

Participant Characteristics

Characteristics are reported for the total response set and for the two cohorts:
those 65–74 years of age, and those 75 years and older. The participant age is highly
skewed by design as only those age 65 years or older were eligible to participate. The
range was 65–87. Previous studies of “older” gay men have aggregated responses of fully
employed men who are 40 years old with fully retired men in their 70s, with diverse
issues and expectations.

Participant characteristics are reported in Table 1. The majority of participants in
this study reported never having been legally married to a partner of the opposite sex
(73.3%, n = 77). This is quite different from the current report of men 65 years of age and
older, 74% of whom were married in the general population (U.S. Census, 2004c).

The participants in this study were different in other ways from the general
population of U.S. men 65 years or older as reported in the U. S. Census. This sample of
participants was highly educated, with 70.5% (n = 74) of the participants earning a
bachelor’s degree or higher. Contrast this with the 21.1% of adults aged 25 years or older
in Ohio attaining a bachelor’s degree in the general population (U.S. Census, 2003b).

Household income was operationally defined using response categories selected
from a 2000 profile of selected economic characteristics for Ohio (U.S. Census, 2003b).
Table 1

*Participant Characteristics by Age Cohort for Older Gay Men (N = 105)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>65-74</th>
<th>75+</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Age (Range 65–87)</td>
<td>66.0</td>
<td>62.9</td>
</tr>
<tr>
<td>Mean</td>
<td>69.5</td>
<td>-</td>
</tr>
<tr>
<td>Median</td>
<td>70.0</td>
<td>-</td>
</tr>
<tr>
<td>Mode</td>
<td>67.0</td>
<td>-</td>
</tr>
<tr>
<td>U.S. Region</td>
<td></td>
<td></td>
</tr>
<tr>
<td>East</td>
<td>5</td>
<td>7.6</td>
</tr>
<tr>
<td>Midwest</td>
<td>49</td>
<td>74.2</td>
</tr>
<tr>
<td>West</td>
<td>12</td>
<td>18.2</td>
</tr>
<tr>
<td>Culture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>6</td>
<td>9.1</td>
</tr>
<tr>
<td>American Indian</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Asian American</td>
<td>2</td>
<td>3.0</td>
</tr>
<tr>
<td>European American</td>
<td>56</td>
<td>84.8</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>3.0</td>
</tr>
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</table>

*(table continues)*
Table 1 (continued)

*Participant Characteristics by Age Cohort for Older Gay Men (N = 105)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>65-74</th>
<th>75+</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td><strong>Retirement Status</strong></td>
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<td></td>
</tr>
<tr>
<td>Fully</td>
<td>47</td>
<td>71.2</td>
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<tr>
<td>Partially</td>
<td>9</td>
<td>13.6</td>
</tr>
<tr>
<td>Not</td>
<td>10</td>
<td>15.2</td>
</tr>
<tr>
<td><strong>Current Living Situation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alone</td>
<td>35</td>
<td>53.0</td>
</tr>
<tr>
<td>With partner only</td>
<td>25</td>
<td>37.9</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>9.1</td>
</tr>
<tr>
<td><strong>Legal Marital Status</strong></td>
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<td></td>
</tr>
<tr>
<td>Never Married</td>
<td>51</td>
<td>77.3</td>
</tr>
<tr>
<td>Currently Married</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Previously Married or Currently Separated</td>
<td>15</td>
<td>22.7</td>
</tr>
<tr>
<td><strong>Current Partnership Status (n = 103)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Partnered</td>
<td>22</td>
<td>33.8</td>
</tr>
<tr>
<td>Previously Partnered</td>
<td>15</td>
<td>23.1</td>
</tr>
<tr>
<td>&lt; 10 years</td>
<td>10</td>
<td>15.4</td>
</tr>
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</table>

*(table continues)*
Table 1 (continued)

*Participant Characteristics by Age Cohort for Older Gay Men (N = 105)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>65-74</th>
<th>75+</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>10–29 years</td>
<td>7</td>
<td>10.8</td>
</tr>
<tr>
<td>30 years and over</td>
<td>11</td>
<td>16.9</td>
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<tr>
<td>Highest Level Education</td>
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<td></td>
</tr>
<tr>
<td>K–8</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>High School</td>
<td>6</td>
<td>9.1</td>
</tr>
<tr>
<td>Some college</td>
<td>8</td>
<td>12.1</td>
</tr>
<tr>
<td>Tech School Grad</td>
<td>3</td>
<td>4.5</td>
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<tr>
<td>Associate Degree</td>
<td>2</td>
<td>3.0</td>
</tr>
<tr>
<td>Bachelor’s</td>
<td>16</td>
<td>24.2</td>
</tr>
<tr>
<td>Master’s</td>
<td>21</td>
<td>31.8</td>
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<tr>
<td>Ph.D., Terminal, or Professional</td>
<td>9</td>
<td>13.6</td>
</tr>
<tr>
<td>Current Household Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; $10,000</td>
<td>6</td>
<td>9.1</td>
</tr>
<tr>
<td>10,000–14,999</td>
<td>3</td>
<td>4.5</td>
</tr>
<tr>
<td>15,000–24,999</td>
<td>9</td>
<td>13.6</td>
</tr>
<tr>
<td>25,000–34,999</td>
<td>14</td>
<td>21.2</td>
</tr>
</tbody>
</table>

*(table continues)*
Table 1 (continued)

*Participant Characteristics by Age Cohort for Older Gay Men (N = 105)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>65-74</th>
<th></th>
<th></th>
<th>75+</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>35,000–49,999</td>
<td>9</td>
<td>13.6</td>
<td>14</td>
<td>37.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50,000–74,999</td>
<td>10</td>
<td>15.2</td>
<td>10</td>
<td>27.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>75,000–99,999</td>
<td>10</td>
<td>15.2</td>
<td>1</td>
<td>2.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>100,000–149,999</td>
<td>3</td>
<td>4.5</td>
<td>1</td>
<td>2.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; $150,000</td>
<td>2</td>
<td>3.0</td>
<td>0</td>
<td>-</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Religious Preference

<table>
<thead>
<tr>
<th></th>
<th>65-74</th>
<th></th>
<th></th>
<th>75+</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No preference</td>
<td>16</td>
<td>24.6</td>
<td>7</td>
<td>17.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atheist/Agnostic</td>
<td>9</td>
<td>13.8</td>
<td>4</td>
<td>10.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protestant</td>
<td>17</td>
<td>26.2</td>
<td>16</td>
<td>41.0</td>
<td></td>
<td></td>
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<tr>
<td>Catholic</td>
<td>13</td>
<td>20.0</td>
<td>5</td>
<td>12.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jewish</td>
<td>4</td>
<td>6.2</td>
<td>2</td>
<td>5.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>9.2</td>
<td>5</td>
<td>12.8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Current Chronic Medical Conditions

<table>
<thead>
<tr>
<th></th>
<th>65-74</th>
<th></th>
<th></th>
<th>75+</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>46</td>
<td>69.7</td>
<td>20</td>
<td>51.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One or more</td>
<td>20</td>
<td>30.3</td>
<td>19</td>
<td>48.7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Data not reported for two participants
The median U.S. household income for older adults in 1998 was $31,398 (U. S. Department of Health and Human Services and the American Association of Retired Persons, 1999), whereas the median household income for this sample was in the range of $35,000 to $49,999, which suggests that this sample may have been similar or slightly higher than the average U.S. household income of older adults.

In religious preference, 35.0% of study participants reported no religious affiliation, suggesting that the sample was dissimilar to the population in a 1992 Gallup Poll on American religious affiliations in which 91% of the participants reported some religious affiliation (Hoge, 1996). In 1997, 54.5% of Americans 65 years and older had one or more disabilities, and 37.7% had at least one severe disability (U. S. Census, 1997). In the current sample, 37.1% of participants reported having one or more chronic health conditions limiting mobility or otherwise causing a burden, suggesting that the current sample is healthier than the average U.S. older adult citizen.

Methods for Statistical Analysis

Data collected from the three instruments in the Gay Aging Survey packet were entered into the Statistical Package for the Social Sciences (SPSS, 2003) and several steps were conducted to analyze the data. All incomplete or missing data were identified and the procedures described below were used to include or exclude data. Frequency tables were calculated for all variables and participant characteristics.

Missing Data

In the case of missing data, two different procedures were used depending on the instrument from which the items were missing. In the case of the RHS, Ross and Rosser
(1996) designed the instrument to allow up to 25% missing items per subscale. An individual, therefore, could miss two items per subscale and still have the score included as an adjusted mean. When an individual in the current study had more than 25% of the items missing on any one final subscale, his responses were determined invalid. If participant characteristic questions involving age or culture were not answered, that individual’s data were not included in the study and deemed invalid (n = 1). Likewise, if either of the Health Choices questions were not completed, all of this individual’s data were omitted from analysis and deemed invalid.

**Analysis**

The dichotomous responses for self-disclosure of sexual orientation to one’s physician, age group, and Durable Power of Attorney for Health Care completion are used in separate chi-square analyses to test Hypotheses 1 and 2:

1. For individuals 65–74 years of age and for individuals 75 years of age and older, there is no difference between observed and expected rates of self-disclosure of sexual orientation to one’s physician.

2. For individuals who have disclosed their sexual orientation to their physician and for individuals who have not disclosed to their physician, there is no difference between observed and expected rates of DPAHC completion.

A t-test was used for each hypothesis to determine whether components of internalized homophobia mean scores were significantly different for comparison groups in Hypotheses 3 and 4. The scores for the two components, Discomfort with Gay Identity
(DGI) and Social Discomfort with Gay Men (SDGM), were used to test Hypotheses 3 to 6. Decisions to create the component subscales are fully discussed in Chapter 3.

3. Individuals who have disclosed their sexual orientations to their physician are more likely to endorse lower levels of two components of internalized homophobia (DGI and SDGM) compared to those who have not disclosed their sexual orientation to their physician.

4. Individuals 75 years of age and older who have disclosed their sexual orientation to their physician are more likely to endorse lower levels of two components of internalized homophobia (DGI and SDGM) compared to those individuals 75 years of age and older who have not disclosed their sexual orientation to their physician.

The fifth and sixth hypotheses were tested using stepwise logistic regression analyses. These two components of internalized homophobia were treated as continuous variables, whereas age cohort, SDSOP, and DPAHC were all treated as dichotomous. Initially, models were assessed for goodness of fit using the Model $\chi^2$ statistic and the change in the Model $\chi^2$. The odds ratios of individual predictor variables are reported in the results chapter when significant.

5. There is no relationship between the identified predictor variables (age cohort, two components of internalized homophobia, and disclosure of sexual orientation to physician) and completion of the DPAHC.
6. There is no relationship between the identified predictor variables (age cohort, two components of internalized homophobia, and completion of the DPAHC) and self-disclosure of sexual orientation to physician (SDSOP).

Summary

In this chapter, the methodology for this study was presented. The recruitment of participants, participant sample, instrumentation, and research procedures used were described. Additionally, the primary research question, six hypotheses, and data analyses procedures were offered. In the next chapter, the results of data analyses are presented.
CHAPTER III

RESULTS

This chapter presents the results of the analysis of the survey data. Descriptive and hypothesis-driven statistical analyses of the data are presented, followed by explanatory and exploratory analysis. Included are analyses of the participant responses using chi-square ($\chi^2$) tests for categorical variables, t-tests for the continuous data, and logistic regression analyses of dichotomous, dependent data. The .05 level of significance was the minimum chosen for use with all statistical tests.

Treatment of the Data

Data analyses were performed using the Statistical Package for Social Sciences (SPSS, 2003). Prior to testing the hypotheses, the geographic source of the survey, age, Durable Power of Attorney for Health Care completion (DPAHC), and Self Disclosure of Sexual Orientation to Physician (SDSOP) were examined for accuracy of data entry and missing values. One hundred and fifty-nine survey packets were distributed and 116 were returned, yielding a 73% response rate. Eleven cases were removed from the study for the following reasons: (a) missing consent forms ($n = 6$), (b) missing data regarding age ($n = 1$), (c) not meeting the age criterion ($n = 1$), and (d) non-United States participant ($n = 3$). Of the 116 survey packets returned, 105 were used for the study.
Statistical Analyses

Hypothesis 1

Chi-square analyses were used to test the null hypothesis that “For individuals 65–74 years of age and for those 75 years of age and older, there is no difference between observed and expected rates of self-disclosure of sexual orientation to one’s physician.” Table 2 presents age frequencies by cohort groups, and the Pearson $\chi^2$ values resulting from the analysis. The Pearson $\chi^2 = 1.25 \ (df = 1)$ was not significant at the .05 level and therefore, the null hypothesis was affirmed: In this sample, age cohort was not related to disclosure of sexual orientation to physician.

Although 69.7% of the younger cohort of gay men had disclosed their sexual orientation to their physician, and only 59% of the older cohort had disclosed their sexual orientation to their physician, the differences were not statistically significant. This can be clearly seen in Table 2.

Hypothesis 2

Hypothesis 2 was also tested using a chi-square analysis: “For individuals who have disclosed their sexual orientation to their physicians and for individuals who have not disclosed to their physicians, there is no difference between observed and expected rates of DPAHC completion.”

Table 3 presents DPAHC and SDSOP response frequencies and the $\chi^2$ analyses. In this case, the null hypothesis is rejected. The alternative hypothesis, that there is a difference between observed and expected rates of DPAHC completion (i.e., for
Table 2

*Chi-Square Analysis of Age Cohort and SDSOP*

<table>
<thead>
<tr>
<th>SDSOP</th>
<th>Age Cohort</th>
<th></th>
<th></th>
<th></th>
<th></th>
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<tbody>
<tr>
<td></td>
<td>65–74</td>
<td>75 +</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>O</td>
<td>E</td>
<td>%</td>
<td>O</td>
<td>E</td>
<td>%</td>
</tr>
<tr>
<td>Yes</td>
<td>46</td>
<td>43.4</td>
<td>69.7</td>
<td>23</td>
<td>25.6</td>
<td>59.0</td>
</tr>
<tr>
<td>No</td>
<td>20</td>
<td>22.6</td>
<td>30.3</td>
<td>16</td>
<td>13.4</td>
<td>41.0</td>
</tr>
</tbody>
</table>

*Note.* O = observed frequency, E = expected frequency, % = percentage within cohort of observed values.

Table 3

*Chi Square Comparison of SDSOP to DPAHC Completion*

<table>
<thead>
<tr>
<th>SDSOP</th>
<th>DPAHC</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Total</td>
<td>$\chi^2$ (df)</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Completed</td>
<td>54</td>
<td>15</td>
<td>69 (65.7%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Completed</td>
<td>19</td>
<td>17</td>
<td>36 (35.3%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>73 (69.5%)</td>
<td>32 (30.5%)</td>
<td>105</td>
<td>7.25(1)**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**p < .01**
individuals who have disclosed their sexual orientation to their physician and individuals who have not disclosed to their physician) was affirmed. Individuals who had disclosed their sexual orientation to their physician showed higher rates of DPAHC completion than those who had not disclosed. See Table 3 for details. Of the 73 (69.5%) individuals who had self-disclosed their sexual orientation to their physician, 54 (51.4%) had also completed a DPAHC. Nineteen (18.1%) of the participants had not chosen to complete a DPAHC, but had chosen to disclose their sexual orientation to their physician.

Principal Components Analysis of the RHS

Hypotheses 3 through 6 called for the use of the total RHS scale scores for the analyses. Initial examination indicated some problems with scoring of the RHS. Statistical descriptions are presented in Table 4 for the responses on the individual items contained in the RHS. Frequencies, means, and standard deviations for each item are presented.

Exploratory factor analysis, using principal components analysis (PCA) with Varimax rotation, was used to examine the component structure of the items. Eighty-three respondents had complete data on all items, and the number of valid responses for every item was never less than 100. Of the 22 surveys that were not complete on all items, mean replacement was used for missing values.

Component structure similar to that obtained by Ross and Rosser (1996) was not found, even after several adjustments. To evaluate the potential utility of computing a total RHS scale score, a PCA constrained to one component was conducted. The resulting
<table>
<thead>
<tr>
<th>Item #</th>
<th>Items</th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Obviously effeminate homosexual men make me feel uncomfortable.</td>
<td>105</td>
<td>3.93</td>
<td>1.88</td>
</tr>
<tr>
<td>2</td>
<td>I prefer to have anonymous sexual partners. (R)</td>
<td>101</td>
<td>2.59</td>
<td>1.81</td>
</tr>
<tr>
<td>3</td>
<td>It would be harder in life to be a homosexual man. (R)</td>
<td>103</td>
<td>4.45</td>
<td>1.93</td>
</tr>
<tr>
<td>4</td>
<td>Most of my friends are gay/bisexual men. (R)</td>
<td>100</td>
<td>4.19</td>
<td>2.01</td>
</tr>
<tr>
<td>5</td>
<td>Making an advance to another man is difficult for me.</td>
<td>102</td>
<td>4.10</td>
<td>1.93</td>
</tr>
<tr>
<td>6</td>
<td>I feel comfortable in gay bars. (R)</td>
<td>102</td>
<td>4.61</td>
<td>2.14</td>
</tr>
<tr>
<td>7</td>
<td>Social situations with gay men make me feel uncomfortable.</td>
<td>104</td>
<td>2.21</td>
<td>1.68</td>
</tr>
<tr>
<td>8</td>
<td>I avoid thinking about my homosexuality.</td>
<td>105</td>
<td>2.44</td>
<td>1.93</td>
</tr>
<tr>
<td>9</td>
<td>When I think about other homosexual men, I think of negative situations.</td>
<td>104</td>
<td>1.96</td>
<td>1.47</td>
</tr>
<tr>
<td>10</td>
<td>I feel comfortable being seen in public with an obviously gay person. (R)</td>
<td>105</td>
<td>4.56</td>
<td>1.97</td>
</tr>
<tr>
<td>11</td>
<td>I feel comfortable discussing homosexuality in a public situation. (R)</td>
<td>105</td>
<td>4.77</td>
<td>1.71</td>
</tr>
</tbody>
</table>

*(table continues)*
Table 4 (continued)

*RHS Item Frequencies and Descriptors*

<table>
<thead>
<tr>
<th>Item #</th>
<th>Items</th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>It is important to me to control who knows about my homosexuality.</td>
<td>105</td>
<td>4.11</td>
<td>2.02</td>
</tr>
<tr>
<td>13</td>
<td>Most people have negative reactions to homosexuality. (R)</td>
<td>105</td>
<td>4.19</td>
<td>1.35</td>
</tr>
<tr>
<td>14</td>
<td>Homosexuality is not against the will of God. (R)</td>
<td>103</td>
<td>6.08</td>
<td>1.86</td>
</tr>
<tr>
<td>15</td>
<td>Society still punishes people for being gay. (R)</td>
<td>103</td>
<td>5.06</td>
<td>1.55</td>
</tr>
<tr>
<td>16</td>
<td>I object if an anti-gay joke is told in my presence. (R)</td>
<td>104</td>
<td>4.13</td>
<td>2.00</td>
</tr>
<tr>
<td>17</td>
<td>I worry about becoming an old gay man. (R)</td>
<td>102</td>
<td>2.85</td>
<td>1.99</td>
</tr>
<tr>
<td>18</td>
<td>I worry about becoming unattractive. (R)</td>
<td>104</td>
<td>3.28</td>
<td>1.94</td>
</tr>
<tr>
<td>19</td>
<td>I would prefer to be more heterosexual.</td>
<td>102</td>
<td>2.40</td>
<td>1.91</td>
</tr>
<tr>
<td>20</td>
<td>Only a few people discriminate against homosexual men.</td>
<td>104</td>
<td>3.36</td>
<td>1.78</td>
</tr>
<tr>
<td>21</td>
<td>I feel comfortable being a homosexual man. (R)</td>
<td>104</td>
<td>5.88</td>
<td>1.56</td>
</tr>
<tr>
<td>22</td>
<td>Homosexuality is morally acceptable. (R)</td>
<td>103</td>
<td>5.85</td>
<td>1.52</td>
</tr>
<tr>
<td>23</td>
<td>I am comfortable about people finding out I am gay. (R)</td>
<td>104</td>
<td>5.11</td>
<td>1.83</td>
</tr>
<tr>
<td>24</td>
<td>Discrimination against gay people is still common. (R)</td>
<td>104</td>
<td>5.64</td>
<td>1.38</td>
</tr>
</tbody>
</table>
Table 4 (continued)

RHS Item Frequencies and Descriptors

<table>
<thead>
<tr>
<th>Item #</th>
<th>Items</th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>Even if I could change my sexual orientation, I would not. (R)</td>
<td>103</td>
<td>5.67</td>
<td>1.94</td>
</tr>
<tr>
<td>26</td>
<td>Homosexuality is as natural as heterosexual orientation. (R)</td>
<td>105</td>
<td>6.41</td>
<td>1.22</td>
</tr>
</tbody>
</table>

Note. 1 = Strongly Disagree to 7 = Strongly Agree; higher scores indicate greater presence of component of internalized homophobia. (R) = reverse scored.

Total scale score had acceptable internal consistency (α = .71), but this single component accounted for only 15% of the variance and several items did not load adequately (i.e., > .4) on this single component. Netemeyer, Bearden, and Sharma (2003) warned against using multidimensional scales as one-dimensional as this may lead to problems with interpretation of relationships among constructs. Thus, the current analysis did not support the use of the total RHS score.

Subsequent analyses of the RHS were conducted to determine the component structure that would provide the most reliable and interpretable components to use in further analyses. Inter-item correlations within a scale and the number of items in a scale
are the two main influences on the alpha level of a scale (DeVellis, 2003, p. 97). Two of the components derived from a forced five-factor solution—Component 1 and Component 2—demonstrated good psychometric properties (i.e., acceptable inter-item correlations, both with means of .27, and internal consistency estimates of .74 and .64, respectively). Components 1 and 2 were most closely related to two subscales used in the original work by Ross and Rosser (1996; i.e., Public Identification as Gay and Comfort with Gay Men). Components 1 and 2 were selected for all subsequent analyses, that is, the t-test and logistic regression analyses.

Initial inter-item correlations among RHS subscale items were run with items coded as proposed by Ross and Rosser (1996). Due to a number of negative inter-item correlations, each item was carefully examined. Such unusual scoring patterns may be illustrated with Item 2, “I prefer to have anonymous sex partners,” which, according to Ross and Rosser, is supposed to be reverse scored. Endorsement of a higher value on this item (1 = Strongly Disagree to 7 = Strongly Agree), however, presumably indicates greater levels of the components of internalized homophobia. After score reversal, strongly endorsing anonymous sex partners would indicate lower internalized homophobia, which is counter-intuitive. Item 2 appeared in different components depending on the number of forced components within the PCAs. Additionally, on face evaluation, this item seemed to examine beliefs about anonymous sex rather than specific beliefs about gay people.
In a personal communication (May 2004), M. Ross, one of the authors of the RHS scale, suggested that the non-conforming items not be reverse-scored, and supported a new principal components analysis with this sample of older gay men (see Appendix E). The decision was made to score Items 2 and 3 so that higher individual scores on these items would indicate higher internalized homophobia (i.e., score reversal was not used).

When the PCA was conducted without a predetermined number of components, nine components were generated with an eigenvalue > 1, which accounted for a combined 65% of the variance. Retaining only those components yielding an eigenvalue > 1 is known as the Kaiser criterion (Stevens, 2002). Although Netemeyer et al. (2003) acknowledged criticism of the Kaiser criterion, it is a recognized heuristic to determine the number of components to be interpreted. With nine components, however, there were problems with single item components, two components with less than three items, and multiple loadings < .4 that limited interpretability (Mertler & Vanatta, 2002).

Multiple PCAs with different rotations were conducted to determine the underlying structure for the measurement of components of internalized homophobia in this sample. The inspection of the initial PCA scree plots suggested that the 2-component solution would not be useful to examine as the elbow in the scree plot indicated three or more components (Mertler & Vanatta, 2002). A decision was made to examine the 3-, 4-, and 5-component solutions. A PCA with Varimax rotation was performed forcing three components, which accounted for 33.35% of the variance. In the forced 3-component analysis, one item did not load adequately, and third component had no loadings above
Another PCA with Varimax rotation was performed forcing four components, which accounted for 40.1% of the variance. There were cross-loadings and multiple low loadings < 0.4, again limiting interpretability (Mertler & Vanatta).

A PCA using Varimax rotation forcing five components was conducted. Five components explained 46.4% of the variance. However, items loading on Components 3, 4, and 5 showed substantial cross-loadings. A PCA forcing five components using an oblimin rotation method, in case the components were correlated (Stevens, 2002), did not provide any more useful components with clearly delineated conceptual relationships.

To discern the most interpretable and useful constructs, subscales were created with the SPSS (2003) using each of the 1-, 3-, 4-, and 5-principal components solutions to test the reliability of these solutions within the sample. The number of component items, Cronbach’s alpha, and the average inter-item correlations are reported for each solution and by component in Table 5.

After reliability testing of components derived from each of the component solutions, the decision was made to use two components from the forced 5-component solution using Varimx rotation. These two components (one with 8 items, the other with 5 items) had the highest average inter-item correlations (.27, .27), demonstrated acceptable reliability (.64 and .74, respectively), and were most closely related conceptually to two of Ross and Rosser’s original RHS subscales (i.e., Public Identification as Gay and Comfort with Gay Men, Ross & Rosser, 1996)
Table 5

*Number of Items, Average Inter-Item Correlations, and Cronbach’s Alpha Reliability Estimates for the RHS Using 1-, 3-, 4-, and 5-Component Solutions Principal Components Analyses With Varimax Rotation*

<table>
<thead>
<tr>
<th>Derived Components</th>
<th>1-Component</th>
<th>3-Component</th>
<th>4-Component</th>
<th>5-Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>7</td>
<td>.152</td>
<td>.557</td>
<td>.153</td>
</tr>
<tr>
<td>3</td>
<td>7</td>
<td>.095</td>
<td>.375</td>
<td>.107</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
<td>.250</td>
<td>.502</td>
<td>.180</td>
</tr>
<tr>
<td>5</td>
<td>4</td>
<td>-.035</td>
<td>-.161</td>
<td></td>
</tr>
</tbody>
</table>

*Note. Avg. I/C = Average Inter-item Correlation*
RHS Derived Components

The conceptual direction and naming of these components was determined by the underlying construct the RHS was designed to assess, components of internalized homophobia. Items loading less than .4 were not included in components in this study, as recommended by Stevens (2002). A component loading is interpreted as a Pearson correlation coefficient of an original variable with a component (Mertler & Vanatta, 2002).

A PCA is a linear transformation of the original variables and thus a reorganization of the actual data; PCAs attempt to elucidate the latent variables represented by the responses. Although the PCA can identify the structure of a component, it cannot identify the nature of the latent variable per se (DeVellis, 2003). When Components 1 and 2 were chosen for interpretation, the content of the item loading on them was examined for similarities and associations. The naming convention (Mertler & Vanatta, 2002) suggests utilizing the content represented by the item variable with the greatest loading within a component to represent the component. It is important to examine the content of other items in the same component to ensure cohesiveness and utility of the name.

After rotation, the first identified component accounted for 14.67% of the variance (see Table 6). Component 1 contained eight items with positive loadings ranging from .42 to .72. Component 1 was named Discomfort with Gay Identity (DGI). This identification and naming was determined through an examination of the highest loadings.
Table 6

Component Loadings and Shared Variances for the 5-Component Solution Derived From a Principal Components Analysis With Varimax Rotation to the RHS

<table>
<thead>
<tr>
<th>Item #</th>
<th>Item Wording</th>
<th>Loadings</th>
<th>h^2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Component 1 (DGI)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>I am comfortable about people finding out I am gay. (R)</td>
<td>.721</td>
<td>.509</td>
</tr>
<tr>
<td>21</td>
<td>I feel comfortable being a homosexual man. (R)</td>
<td>.686</td>
<td>.567</td>
</tr>
<tr>
<td>11</td>
<td>I feel comfortable discussing homosexuality in a public situation. (R)</td>
<td>.662</td>
<td>.510</td>
</tr>
<tr>
<td>25</td>
<td>Even if I could change my sexual orientation, I would not. (R)</td>
<td>.616</td>
<td>.370</td>
</tr>
<tr>
<td>22</td>
<td>Homosexuality is morally acceptable. (R)</td>
<td>.480</td>
<td>.615</td>
</tr>
<tr>
<td>19</td>
<td>I would prefer to be more heterosexual.</td>
<td>.452</td>
<td>.384</td>
</tr>
<tr>
<td>10</td>
<td>I feel comfortable being seen in public with an obviously gay person. (R)</td>
<td>.437</td>
<td>.311</td>
</tr>
<tr>
<td>12</td>
<td>It is important to me to control who knows about my homosexuality.</td>
<td>.422</td>
<td>.492</td>
</tr>
</tbody>
</table>

(14.67% of variance)

(table continues)
Table 6 (continued)

*Component Loadings and Shared Variances for the 5-Component Solution Derived From a Principal Components Analysis With Varimax Rotation to the RHS*

<table>
<thead>
<tr>
<th>Item #</th>
<th>Item Wording</th>
<th>Loadings</th>
<th>$h^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Making an advance to another man is difficult for me.</td>
<td>.672</td>
<td>.441</td>
</tr>
<tr>
<td>6</td>
<td>I feel comfortable in gay bars. (R)</td>
<td>.656</td>
<td>.506</td>
</tr>
<tr>
<td>7</td>
<td>Social situations with gay men make me feel uncomfortable.</td>
<td>.539</td>
<td>.612</td>
</tr>
<tr>
<td>9</td>
<td>When I think about other homosexual men, I think of negative situations.</td>
<td>.522</td>
<td>.351</td>
</tr>
<tr>
<td>18</td>
<td>I worry about becoming unattractive. (R)</td>
<td>.475</td>
<td>.494</td>
</tr>
</tbody>
</table>

(12.17% of variance)

Component 3

<table>
<thead>
<tr>
<th>Item #</th>
<th>Item Wording</th>
<th>Loadings</th>
<th>$h^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>Society still punishes people for being gay. (R)</td>
<td>.641</td>
<td>.406</td>
</tr>
<tr>
<td>3</td>
<td>It would be harder in life to be a homosexual man.</td>
<td>.637</td>
<td>.666</td>
</tr>
<tr>
<td>24</td>
<td>Discrimination against gay people is still common. (R)</td>
<td>.604</td>
<td>.622</td>
</tr>
<tr>
<td>26</td>
<td>Homosexuality is as natural as heterosexual orientation. (R)</td>
<td>.523</td>
<td>.592</td>
</tr>
<tr>
<td>13</td>
<td>Most people have negative reactions to homosexuality. (R)</td>
<td>.393</td>
<td>.391</td>
</tr>
</tbody>
</table>

(7.17% of variance) Mean, SD & Range
Table 6 (continued)

Component Loadings and Shared Variances for the 5-Component Solution Derived From a Principal Components Analysis With Varimax Rotation to the RHS

<table>
<thead>
<tr>
<th>Item #</th>
<th>Item Wording</th>
<th>Loadings</th>
<th>$h^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>I avoid thinking about my homosexuality.</td>
<td>.636</td>
<td>.481</td>
</tr>
<tr>
<td>14</td>
<td>Homosexuality is not against the will of God. (R)</td>
<td>-.581</td>
<td>.466</td>
</tr>
<tr>
<td>17</td>
<td>I worry about becoming an old gay man. (R)</td>
<td>.493</td>
<td>.496</td>
</tr>
<tr>
<td>2</td>
<td>I prefer to have anonymous sexual partners.</td>
<td>.480</td>
<td>.331</td>
</tr>
</tbody>
</table>

(6.72% of variance)

Component 5

<table>
<thead>
<tr>
<th>Item #</th>
<th>Item Wording</th>
<th>Loadings</th>
<th>$h^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>Only a few people discriminate against homosexual men.</td>
<td>.709</td>
<td>.489</td>
</tr>
<tr>
<td>16</td>
<td>I object if an anti-gay joke is told in my presence. (R)</td>
<td>-.510</td>
<td>.436</td>
</tr>
<tr>
<td>1</td>
<td>Obviously effeminate homosexual men make me feel uncomfortable.</td>
<td>.486</td>
<td>.207</td>
</tr>
<tr>
<td>4</td>
<td>Most of my friends are gay/bisexual men. (R)</td>
<td>-.456</td>
<td>.325</td>
</tr>
</tbody>
</table>

(5.71% of variance)

5 components explain 46.43% of the variance

*Note.* (R) = reverse-scored; $h^2$ = communality or shared variance
within the identified component. For example, item 23, “I feel comfortable about people finding out I am gay,” is reverse scored, thereby equating a low score with an aspect of internalized homophobia, that being discomfort with gay identity.

Components with four or more loadings above .60 in absolute value are considered reliable, regardless of sample size (Stevens, 2002, p. 395), supporting the DGI component. Component 1 was closely related to the Public Identification as Gay subscale as identified by Ross and Rosser (1996), containing 7 of the 10 original subscale items. Table 5 indicates the inter-item correlations and Cronbach’s alphas for determining decisions regarding which components to interpret.

Component 2 was composed of five items for which loadings ranged from .48-.67, and accounted for an additional 12.17% of the variance. Component 2 was named Social Discomfort with Gay Men (SDGM). This component was most closely related to the dimension, Comfort with Gay Men, identified by Ross and Rosser (1996), and contains four of the original six subscale items.

The naming of the identified components is expressed in the same conceptual direction as internalized homophobia, rather than in the positive direction as with Ross and Rosser’s (1996) subscale of Comfort with Gay Men. In Ross and Rosser’s conceptualization, if the conceptual direction were congruent with the concept, it would be better termed “Discomfort with Gay Men.” The 8-item DGI component (Cronbach’s $\alpha = .74$) and the 5-item SDGM component (Cronbach’s $\alpha = .64$) were used to test Hypotheses 3 through 6. Communalities, that is, the proportion of the variability for a
given variable explained by the factor (Mertler & Vanatta, 2002), and component loadings for the 5-component solution are reported in Table 6. As stated in Chapter 2, the two subscale scores in the Ross and Rosser study, measuring Public Identification as Gay and Comfort with Gay Men, exhibited the strongest and most consistent associations with theoretically and clinically derived variables for testing of criterion-related validity of these measures as components of internalized homophobia.

Hypothesis 3

This hypothesis was evaluated using an independent t-test with each of the two RHS-derived components. The directional hypothesis states that individuals responding Yes on SDSOP will demonstrate lower rates of endorsement on two of the components of internalized homophobia than individuals responding No on SDSOP. The eight-item DGI (i.e., Component 1) was found to be significant at the $p < .01$ level. The directional hypothesis is partially affirmed: Disclosers showed a lower discomfort with gay identity than non-disclosers. Disclosing participants scored a mean of 2.61 on the 7-point DGI scale, significantly lower in discomfort with gay identity than that scored by non-disclosers (Mean = 3.28).

Although non-disclosers scored somewhat higher on average on the five-item SDGM (i.e., Component 2) than disclosers, a significant difference was not found. Interpretations concerning a global concept of internalized homophobia are not useful. Participants who did not disclose showed higher scores on DGI, yet did not score significant differences on their scores for SDGM. Low self-disclosing gay men may be
socially comfortable with other gay men, while still uncomfortable with their gay identity. The t-test results are presented in Table 7.

Table 7

*Independent t-Test for Components of Internalized Homophobia and SDSOP*

<table>
<thead>
<tr>
<th>Components of Internalized Homophobia</th>
<th>SDSOP: NO ( (n = 36) )</th>
<th>SDSOP: YES ( (n = 69) )</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( M )</td>
<td>( SD )</td>
</tr>
<tr>
<td>DGI</td>
<td>3.28</td>
<td>1.07</td>
</tr>
<tr>
<td>SDGM</td>
<td>3.27</td>
<td>1.30</td>
</tr>
</tbody>
</table>

*Note.* **\( p < .01 \). DGI = Component 1, Discomfort with Gay Identity. SDGM = Component 2, Social Discomfort with Gay Men

*Hypothesis 4*

An independent t-test was conducted to examine responses of participants 75 years of age and older with regard to two of the components of internalized homophobia and SDSOP. The results are documented in Table 8. The hypothesis states, “Individuals 75 years of age and older who have disclosed their sexual orientation to their physician are more likely to endorse lower levels of two components of internalized homophobia...
Table 8

Independent t–Test for Components of Internalized Homophobia and Disclosure for Gay Men 75 years of Age and Older (n = 39)

<table>
<thead>
<tr>
<th>Components of Internalized Homophobia</th>
<th>SDSOP</th>
<th></th>
<th>YES</th>
<th></th>
<th>NO</th>
<th></th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>DGI</td>
<td>2.77</td>
<td>1.09</td>
<td>3.58</td>
<td>1.15</td>
<td>-2.22*</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>SDGM</td>
<td>2.66</td>
<td>1.14</td>
<td>3.46</td>
<td>1.36</td>
<td>-1.98</td>
<td>37</td>
<td></td>
</tr>
</tbody>
</table>

Note. *p < .05. DGI = Component 1, Discomfort with Gay Identity. SDGM = Component 2, Social Discomfort with Gay men.

compared to those individuals 75 years of age and older who have not disclosed their sexual orientation to their physician.”

The directional hypothesis was affirmed, that is, gay men 75 years of age and older who had disclosed their sexual orientation to their physician exhibited lower scores on the Discomfort with Gay Identity component compared to those individuals 75 years of age and older who had not disclosed their sexual orientation to their physician. Gay men 75 years of age and older in this group who had self-disclosed their sexuality to their physician scored a mean of 2.77 on the 7-point Discomfort with Gay Identity component (7 indicating the greatest discomfort with gay identity), whereas those men who had not self-disclosed scored a somewhat higher mean score of 3.58. This difference was
significant at the $p < .05$ level. There were no significant results on the SDGM component.

*Hypothesis 5*

Logistic regression model building and analysis was used to test Hypothesis 5: “There is no relationship between the identified predictor variables (age cohort, levels of two components of internalized homophobia, and SDSOP) and completion of the DPAHC.” Table 9 presents the standardized regression coefficients (standard error $SE_{b}$), odds ratio, 95% confidence intervals around the odds ratio (CI), Model $\chi^2$, -2 Log Likelihood, and the percentage of cases correctly classified by the logistic regression model.

A hierarchical analysis was conducted, and results from each step in the model are presented in Table 9, along with the change ($\Delta$) in model $\chi^2$ for each subsequent model. The equation was first run generating a constant ($K$), before adding any of the predictor variables. Model 1 introduced age cohort, Model 2 tested components of internalized homophobia while accounting for the changes associated with age cohort. In Model 3, the independent variable SDSOP was added. Models 1 and 2 were not statistically significant (as indicated by model $\chi^2$ and the $\Delta$ of model $\chi^2$). Model 3 introduced SDSOP. This improved the model’s Goodness of Fit, as indicated by statistically significant model $\chi^2$ and the $\Delta$ of model $\chi^2$ as can be seen in Table 9. With the addition of SDSOP to the equation, 71.4% of subjects could be accurately classified as either disclosing or non-disclosing.
Table 9

**Summary of Logistic Regression Analysis for Variables Predicting Durable Power of Attorney for Health Care Completion**

<table>
<thead>
<tr>
<th>Predictors</th>
<th>Model 1</th>
<th></th>
<th></th>
<th>Model 2</th>
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<th></th>
<th>Model 3</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>b</td>
<td>SE&lt;sub&gt;b&lt;/sub&gt;</td>
<td>Odds Ratio</td>
<td>95% CI</td>
<td>b</td>
<td>SE&lt;sub&gt;b&lt;/sub&gt;</td>
<td>Odds Ratio</td>
<td>95% CI</td>
<td>b</td>
</tr>
<tr>
<td>K (Constant)</td>
<td>.56</td>
<td>.26</td>
<td>1.80</td>
<td></td>
<td>1.11</td>
<td>.77</td>
<td>3.05</td>
<td></td>
<td>- .40</td>
</tr>
<tr>
<td>Age Cohort 75 and older</td>
<td>.80</td>
<td>.47</td>
<td>2.21</td>
<td>(.88 – 5.58)</td>
<td>.85</td>
<td>.48</td>
<td>2.34</td>
<td>(.91 – 6.06)</td>
<td>1.01</td>
</tr>
<tr>
<td>Components</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DGI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SDGM</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self Disclosure of Sexual</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Orientation to Physician</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.36</td>
<td>.49</td>
<td>3.89**</td>
<td>(1.49 – 10.19)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*(table continues)*
### Table 9 (continued)

**Summary of Logistic Regression Analysis for Variables Predicting Durable Power of Attorney for Health Care Completion**

<table>
<thead>
<tr>
<th></th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>-2 Log Likelihood</td>
<td>126.10</td>
<td>125.50</td>
<td>117.48</td>
</tr>
<tr>
<td>Model $\chi^2$</td>
<td>3.01 $(df = 1)$ $p = .08$</td>
<td>3.62 $(df = 3)$ $p = .31$</td>
<td>11.64 $(df = 4)$* $p = .02$</td>
</tr>
<tr>
<td>$\Delta \chi^2$</td>
<td>.61</td>
<td></td>
<td>8.02 $(df = 1)$ **</td>
</tr>
<tr>
<td>% Accurately Classified</td>
<td>69.5</td>
<td>69.5</td>
<td>71.4</td>
</tr>
</tbody>
</table>

*Note. $N = 105$. Initial $-2$ LL = 129.12. CI = 95% Confidence interval for Odds Ratio

*p < .05  **p < .01
Interpretations are based on using model $\chi^2$ (see Tables 9 and 10) to identify the models that provide the most accurate reflection of significant association among the variables. Model $\chi^2$ is computed using -2LL (also known as Deviation Chi Square) for the initial null model less the -2LL for the first research model. Model $\chi^2$ measures the improvement in fit that the explanatory variables make over the initial model. It is a measure of the difference between error without identification of the explanatory variables and the error when those variables are included in the model. This is a test of significance for the overall model, which does not ensure the significance of every independent variable.

The association between SDSOP and DPAHC was significant at the $p < .01$ level in Model 3 of this equation. The odds ratio here suggested that an individual who has disclosed his sexual orientation to his physician is 3.89 times more likely to have completed a Durable Power of Attorney for Health Care than an individual who has not disclosed. There was a relationship in Model 3 between age cohort and DPAHC, such that a gay men 75 years of age or older were 2.75 times more likely to have completed a DPAHC than were gay men 65–74 years of age.

Based on the overall findings, the null hypothesis is rejected. The logistic regression analysis indicated that there was a significant association between two of the predictor variables (age cohort and SDSOP) and completion of the DPAHC.

**Hypothesis 6**

Logistic regression analysis was used to test Hypothesis 6, “There is no relationship between the identified predictor variables (age cohort, two components of
internalized homophobia, and completion of the DPAHC) and SDSOP.” Table 10 presents the standardized regression coefficients, standard error (SE), odds ratio, 95% confidence intervals around the odds ratio (CI), Model $\chi^2$, - 2 Log Likelihood, and the percentage of cases correctly classified by the logistic regression model.

A hierarchical analysis was conducted, and results from each nested model are presented in Table 10, along with the change in model $\chi^2$ for each subsequent model. Model 1 introduced age cohort, as did the previous logistic regression equation. Model 2 then tested the components while accounting for the effects of age cohort. In Model 3 the independent variable DPAHC was tested while controlling for the effects of the variables from Models 1 and 2. In Model 1, age cohort did not significantly affect Goodness of Fit as measured by model $\chi^2$ and the $\Delta$ of model $\chi^2$. Model 2 added the components DGI and SDGM to explore internalized homophobia. For Model 2 both Goodness of Fit and the change in Goodness of Fit were significant (Table 10). At the conclusion of Model 2, 70.5% of participants could be accurately classified using the logistic regression model in terms of their disclosure status.

In Model 3, DPAHC was added to the equation and the change in model Goodness of Fit was statistically significant. Two variables were significant in this model: DGI and DPAHC. Discomfort with Gay Identity (DGI) had an odds ratio such that for each 1-unit increase on the DGI scale, an individual was only .56 times as likely to self-disclose his sexual orientation to his physician. In other words, an individual scoring one unit above the mean on the DGI component (Mean = 2.84) is 44% less likely
### Table 10

**Summary of Logistic Regression Analysis for Variables Predicting SDSOP**

<table>
<thead>
<tr>
<th>Predictors</th>
<th>Model 1</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>b</td>
<td>SE&lt;sub&gt;b&lt;/sub&gt;</td>
<td>Odds Ratio</td>
<td>95% CI</td>
<td>b</td>
<td>SE&lt;sub&gt;b&lt;/sub&gt;</td>
<td>Odds Ratio</td>
<td>95% CI</td>
<td>b</td>
</tr>
<tr>
<td>K (Constant)</td>
<td>0.65</td>
<td>0.21</td>
<td>1.92</td>
<td></td>
<td>3.10</td>
<td>0.85</td>
<td>22.24</td>
<td></td>
<td>2.29</td>
</tr>
<tr>
<td>Age Cohort 75 and older</td>
<td>-0.47</td>
<td>0.42</td>
<td>0.625</td>
<td>0.27 – 1.43</td>
<td>-0.25</td>
<td>0.45</td>
<td>0.78</td>
<td>0.32 – 1.90</td>
<td>-0.55</td>
</tr>
<tr>
<td>Components</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DGI</td>
<td>-0.56</td>
<td>0.22</td>
<td>0.57</td>
<td>0.37 – 0.88</td>
<td>-0.57</td>
<td>0.24</td>
<td>0.56*</td>
<td>0.36 – 0.89</td>
<td></td>
</tr>
<tr>
<td>SDGM</td>
<td>-0.23</td>
<td>0.19</td>
<td>0.79</td>
<td>0.55 – 1.15</td>
<td>-0.21</td>
<td>0.20</td>
<td>0.81</td>
<td>0.55 – 1.19</td>
<td></td>
</tr>
<tr>
<td>Durable Power of Attorney for Health Care</td>
<td>1.36</td>
<td>0.50</td>
<td>3.92**</td>
<td>1.48 – 10.37</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*(table continues)*
Table 10 (continued)

*Summary of Logistic Regression Analysis for Variables Predicting SDSOP*

<table>
<thead>
<tr>
<th></th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>- 2 Log Likelihood</td>
<td>133.77</td>
<td>123.53</td>
<td>115.58</td>
</tr>
<tr>
<td>Model $\chi^2$</td>
<td>1.24 ($df=1$). $p = .27$</td>
<td>11.48 ($df=3$)** $p = .009$</td>
<td>19.43 ($df=4$)** $p = .001$</td>
</tr>
<tr>
<td>$\Delta$ Model $\chi^2$</td>
<td></td>
<td>10.24 ($df=2$)**</td>
<td>7.95 ($df=1$)</td>
</tr>
<tr>
<td>% Accurately Classified</td>
<td>65.7</td>
<td>70.5</td>
<td>70.5</td>
</tr>
</tbody>
</table>

*Note.* $N = 105$. Initial $-2\text{ LL} = 135.01$. CI = 95% Confidence interval for Odds Ratio

*$p < .05$  **$p < .01$  ***$p = .001$*
to disclose his sexual orientation to his physician than is an individual scoring at the mean on the DGI component. Completion of the DPAHC was also a significant variable (see Table 10). The odds ratio here indicated that a participant who had completed a DPAHC was 3.92 times more likely to have disclosed his sexual orientation to his physician than is someone who had not completed the DPAHC.

Although DPAHC completion and Discomfort with Gay Identity (DGI) were significantly associated with SDSOP, it is important to note neither age cohort nor SDGM variables were significantly related to SDSOP. Based on the overall findings, the logistic regression model indicated an association between the predictor variables DGI and DPAHC, and the dependent variable of SDSOP. The null hypothesis is rejected.

Exploratory Analysis

Analyses were conducted in order to examine key constructs at a descriptive level. All results in the following section should be considered preliminary findings that have not been supported by hypothesis-based research.

*Durable Power of Attorney for Health Care*

Aside from the Yes/No dichotomous question concerning completion of the Durable Power of Attorney for Health Care, two other questions were asked of participants. In the first, a multiple-choice format identified the designated health care proxy if the participant responded Yes on the dichotomous portion of the question. The second question asked, *Why have you (or have you not) chosen to complete a Durable Power of Attorney for Health Care?*
Of the participants, 69.5% reported that they had completed a DPAHC \((n = 73)\) and 30.5% reported that they had not completed a DPAHC \((n = 32)\). Participants who completed a DPAHC reported the following persons designated as their health care proxy: Relative \((n = 26, 35.1\%)\); Life Partner \((n = 21, 28.4\%)\); Friend \((n = 17, 24.3\%)\); Other Specified DPAHC \((n = 7, 9.5\%)\); Legal spouse \((n = 2, 1.9\%)\); and Didn’t know \((n = 1, 1.4\%)\). Other Specified DPAHC included Attorney \((n = 3, 3.0\%)\); Co-trustee \((n = 1, 1.0\%)\); Daughter \((n = 1, 1.0\%)\); Domestic partner \((n = 1, 1.0\%)\); Financial Advisor \((n = 1, 1.0\%)\); Relative/Attorney \((n = 1, 1.0\%)\); and Son \((n = 1, 1.0\%)\).

Eighty-five men \((80.9\%)\) chose to respond to the open-ended question, *Why have you (or have you not) chosen to complete a Durable Power of Attorney for Health Care?* Most of the responses were less than 25 words in length, but one or two were a paragraph or more in length. The responses mostly seemed to occur in seven categories that comprised decisions both for and against DPAHC completion, plus a not applicable category used by two men.

Frequencies of these categories of responses are reported in Appendix G (Table G1). The categories explaining why they chose to complete a DPAHC included: Extend Autonomy \((n = 21, 24.7\%; \text{“I have completed a Power of Attorney so that in case of emergency my wishes will be carried out”})\); Best Interests \((n = 16, 18.8\%; \text{“Essential document for my well-being if I become incapacitated”})\); Legal/Estate Planning \((n = 15, 17.6\%; \text{“I re-did my will and the lawyer suggested I do the Durable Power of Attorney”})\); and Protect Partner \((n = 10, 11.8\%; \text{“Durable Power of Attorney is important to allow my...”})\).
partner to make decisions in my behalf. I do not want family members to interfere in these matters”).

Three categories were most often invoked to explain why a participant had chosen *not* to complete a DPAHC: Procrastination (*n* = 9, 10.6%; “Simply keep putting it off—I must deal with this”); Informed Choice (*n* = 7, 8.2%; “I have family who can make decisions for me. Have not signed DPAHC. Have signed legal Durable Power of Attorney and Living Will”); and Lack of Awareness (*n* = 5, 5.9%; “I don’t know if we have it. I will ask lawyer at our next visit”). Frequencies of responses may be found in Appendix G, Table G1.

**Self-Disclosure of Sexual Orientation to Physician**

All participants completed this section, in which there were two questions, the first a dichotomous Yes/No question inquiring whether the participant had disclosed his sexual orientation to his physician. A summary may be found in Appendix G (Table G2). The majority of respondents (*n* = 69, 65.7%) reported that they had disclosed their sexual orientation to their physician, whereas 34.3% (*n* = 36) reported that they had chosen *not* to disclose their sexual orientation to their physician. A qualitative summary of the second question concerning the reasoning behind their decisions to disclose, or not to disclose, their sexual orientation to their physician is reported below.

Many participants in the study (*n* = 96) chose to record a response to the question, *Why have you (or have you not) chosen to disclose your sexual orientation to your physician?* Of the affirmative categories (i.e., those who chose to disclose), the primary
reasons fell into six categories: Holism \( (n = 26; \text{“I think it is important that he know as it certainly is important in considering my whole being”}) \); Gay Health Concerns \( (n = 12; \text{“For health reasons to better help me as a gay man”}) \); Honesty \( (n = 6; \text{“Honesty”}) \); Physician Inquiry \( (n = 5; \text{“I did not with my doctor of 25 years. My new doctor followed a questionnaire when taking my history as a new patient. He asked me my sexual orientation and practices”}) \); Affirming, Gay, or Lesbian Physician \( (n = 4; \text{“I have chosen a gay physician. He knows me and my partner—he has a copy of my living will and power of attorney. He knows my needs both physical and emotional”}) \); and Sensible \( (n = 3; \text{“It seems like a plain vanilla thing to do”}) \).

Of the categories used to explain the choice \textit{not} to disclose their sexuality to their physician, participant responses fell into six categories: Physician Non-Inquiry \( (n = 11; \text{“Never came up”}) \); Assumption \( (n = 9; \text{“No particular reason, but I’m fairly certain he knows”}) \); Unnecessary/Not Applicable \( (n = 7; \text{“No interest”}) \); Privacy \( (n = 6; \text{“It is not an issue and has never interfered with my doctor/patient relationship. I do not feel the need to make a sexual orientation disclosure, as I feel completely at ease/confident with my physician/dentist”}) \); Unrelated to Health Concerns \( (n = 5; \text{“No relationship to my medical conditions”}) \); and Fear of Physician Reaction \( (n = 2; \text{“He never asked. My doctor is anti-gay. I believe most HMO DR’s are anti-gay”}) \). Results in tabular form may be found in Appendix G, Table G2.
Summary

Results of the Gay Aging Survey have been reported in this chapter. Of the two hypotheses analyzed using chi-square techniques, Hypothesis 1 was affirmed and Hypothesis 2 was rejected, indicating that individuals who had disclosed their sexual orientation to their physician showed significantly higher observed rates of completion of the Durable Power of Attorney for Health Care than did those who had not disclosed.

Using t-test techniques to analyze Hypotheses 3 and 4, both hypotheses were affirmed. In the case of Hypothesis 3, significant at the $p < .01$ level, individuals who chose not to disclose their sexual orientation to their physician showed higher discomfort with gay identity (DGI) than disclosers did. Hypothesis 4 results indicated that gay men 75 years of age and older who had disclosed their sexual orientation to their physician exhibited lower scores on the Discomfort with Gay Identity component compared to those individuals 75 years of age and older who had not disclosed their sexual orientation to their physician.

Tests of Hypotheses 5 and 6 indicated that there was a significant relationship between at least some of the predictor variables and each of the dependent variables, DPAHC and SDSOP. Model $\chi^2$ Goodness of Fit tests indicated that some of these predictor variables, as a set, had a significant effect on the dependent variables. Hypothesis 5 was concerned with the prediction of DPAHC completion. Findings can be summarized as follows: (a) the odds ratio indicated that older gay men who had self-disclosed their sexual orientation to their physicians were 3.89 times more likely to have
completed a Durable Power of Attorney for Health Care than older gay men who had not disclosed; and (b) gay men 75 years of age or older were 2.75 times more likely to have completed a DPAHC than were gay men 65–74 years of age.

In Hypothesis 6 there was an interest in prediction of self-disclosure of sexual orientation to physician (SDSOP). The Discomfort with Gay Identity (DGI) component was significant and the odds ratio indicated that for each 1-unit increase in score, an individual was only .56 times as likely to self-disclose their sexual orientation to their physician. That is, the greater the discomfort with gay identity, the less likely it was for that individual to self-disclose his sexual orientation to his physician. Another way of expressing this relationship is that each one-unit increased discomfort with gay identity score is associated with a 44% decreased likelihood of disclosure of sexual orientation to one’s physician. This decreased likelihood repeats with each one-unit increase in the score on the DGI component.

The second variable of significance, completion of the DPAHC, had an odds ratio that indicated that a participant who had completed a DPAHC was 3.92 times more likely to have disclosed his sexual orientation to his physician than was someone who had not completed the DPAHC.

The final chapter discusses the findings of this research project. Limitations and implications for future research are mentioned.
CHAPTER IV
DISCUSSION

This study was formulated to investigate differences in self-disclosure of sexual orientation to physician (SDSOP) and completion of Durable Powers of Attorney for Health Care (DPAHC) among a sample of 105 self-identified older gay men when components of internalized homophobia and age cohort were considered. Six hypotheses were developed from the original question.

Predictor variables measured in this study were two components of internalized homophobia and age cohort. Internalized homophobia was measured by two components derived from the current administration of the Reactions to Homosexuality Scale (RHS; Ross & Rosser, 1996). These components were developed through a principal components analysis (PCA) of responses on the RHS by the sample of older gay men in this study. The remaining predictor variable was age cohort, defined as 65 years to 74 years and 75 years and above. Outcome variables consisted of dichotomous indicators of participants’ health care choices: SDSOP and DPAHC.

The results of the study are presented in Chapter 3. In this chapter, findings are discussed by hypothesis, limitations to generalizability are presented, and implications for future research are noted. The research project is summarized at the conclusion of the chapter.
Findings of the Study

*Age Cohort and Sexual Orientation Disclosure*

The initial hypothesis concerned the differences between observed and expected rates of self-disclosure of sexual orientation to one’s physician in gay men 65 years to 74 years and 75 years of age and older. Data analysis failed to reject the null hypothesis, that is, the differences between observed and expected values for both cohorts of gay men on the variable of self-disclosure of sexual orientation to one’s physician were not significant. This nonsignificant result might be explained in several ways: (a) arbitrary decision point for age cohort, (b) sample size, and/or (c) lack of relationship between the variables.

Determining age cohort was arbitrary. Cohler and Galatzer-Levy (2000) described at least three cohorts of gay men, with an elder generation most deeply affected by stigma and homophobic prejudice. An individual 75 years old in 2003, born in 1928, just missed eligibility for service in World War II. Men older than 77 in 2003 were part of the so-called “greatest generation” (Brokaw, 1998), the men who came of age to serve during World War II. These men were adult by the time of the Stonewall Rebellion of 1969, the traditional marker of the beginning of gay pride (Lauritsen & Thorstad, 1974). Future research is needed to elucidate the naturally occurring age cohorts of gay men, if such exist. Further implications for research are detailed later in this chapter.

Sample sizes for the cohort of men 75 years and older (37%, n = 39) further obscure the ability to meaningfully interpret the differences between the two groups—
those 65 years to 74 years and those 75 years and older. There may be naturally occurring
cohorts of men that can be identified, based, for example, on age cohort experiences such
as the Depression, World War II, the Korean conflict, or the increased homophobia of the
McCarthy times (Friend, 1990). Increased internalized homophobia is related to lower
likelihood of disclosure of sexual orientation (Meyer, 2003).

Age cohort may not be significantly related to self-disclosure to physician,
although disclosure may be related to age as a continuous variable. Age as a continuous
variable was not tested in this study. Distinguishing the effects of age, period, and cohort
effects requires the use of multiple cohort and longitudinal panel designs (Newman &
Benz, 1998). It remains to be seen whether younger gay men will exhibit different
patterns concerning disclosure to physician and others as they age. For example, the
disclosure and health care choices made by older gay men may reflect: (a) chronological
age (age effect); (b) increase in current government homophobia such as Anti-Marriage
legislation (period effect); or (c) overt homophobia of the times in which they were raised
(cohort effect). These relationships would appear worthy of investigation.

Age may not be directly related to disclosure, but rather to mediating variables.
Age may be related to choice of living location, and choice of living location may be
related to choice about disclosure. A person living in an assisted living facility might feel
less free to disclose, depending on his or her social environment within the facility
(Cahill et al., 2000). Alternatively, increased disclosure could be related to living in an
urban area, for example. Individuals in an urban environment may be freer to disclose. At
least 50% of this sample of older gay men appeared to live in cities, although this
information was not formally tracked.

*DPAHC Completion and Sexual Orientation Disclosure*

Differences between observed and expected rates of DPAHC completion for
individuals who have disclosed their sexual orientation to their physician and for
individuals who have not disclosed to their physician were examined. The chi square
analysis found a significant relationship such that a *Yes* response on SDSOP was
associated with higher rates of DPAHC completion.

Completion of the DPAHC provides a legal mechanism for an individual to
maintain influence in future health care decisions (Aitken, 1999) through the appointment
of a proxy health care decision-maker in the event of “decisional incapacity” (Fischer et
al., 2000, p. 241). The relationship between observed and expected rates of DPAHC
completion and increased disclosure to physician was significant. It is unclear, therefore,
whether men who have disclosed their sexual orientation to their physicians completed
DPAHCs at higher rates, or conversely, whether those men who completed DPAHCs
chose also to disclose their sexual orientation to their physician. A confounding
variable—such as a supportive patient-physician relationship, which leads to both higher
SDSOP and higher rates of DPAHC completion—may influence the results. Future
research should attempt to identify and measure such other components.

Previous research has not focused on the relationship between SDSOP and
DPAHC completion. It is important to note that the significant results of this test
indirectly support Friend’s (1990) theory of successful aging that hypothesizes that the successfully aging older gay man makes healthier choices than does the less successfully aging older gay man. A DPAHC extends any individual’s influence on his or her own health care decisions. The decision to complete a DPAHC can become part of a dialogue in a healthy adjustment to aging.

**Two Components of Internalized Homophobia**

These two hypotheses each looked at differences in endorsement of two components of internalized homophobia derived from a PCA of the RHS (Ross & Rosser, 1996). The differences in levels of components of internalized homophobia were measured for two groups—those who had disclosed their sexual orientation to their physicians and those who had not. The hypotheses varied in the age focus of the examination. In Hypothesis 3, the entire sample was examined for endorsement of two components of internalized homophobia by an affirmative or negative response to the SDSOP question. In Hypothesis 4, the focus was on the disclosure results of only those gay men 75 years and older. Again, the differences were tested between those answering Yes or No on SDSOP.

In Hypothesis 3, the directional hypothesis was affirmed, that is, disclosers showed a lower endorsement of discomfort with gay identity (based on the scores of the RHS component, Discomfort with Gay Identity) than did non-disclosers. This is in keeping with the clinical literature, which referred to the SDSOP as a “preventive disclosure aimed at ensuring proper medical care” (Cain, 1991, p. 69). The research
literature associating SDSOP with internalized homophobia is sparse. SDSOP was related to the DGI component, an identified component of internalized homophobia, in a statistically significant way.

Using the 5-item Social Discomfort with Gay Men (SDGM; Cronbach’s \( \alpha = .64 \)) component, however, no significant differences were found. It is possible that one of the reasons for the lack of significance is that social discomfort with other gay men is not related to the individual’s comfort with disclosure of his sexual orientation to their physician. It may be another component of the phenomena comprising internalized homophobia, but unrelated to the decision whether to disclose one’s sexual orientation to one’s physician.

Likewise, in Hypothesis 4, older gay men 75 years of age and older who have disclosed their sexual orientation to their physician exhibited lower scores on the DGI component compared to those individuals 75 years of age and older who have not disclosed their sexual orientation to their physician. In both cases, disclosure of sexual orientation to one’s physician was associated with decreased Discomfort with Gay Identity. That is, disclosure of sexual orientation to one’s physician was associated with increased comfort with gay identity. Concealment of sexual orientation is considered a strategy to manage potential stigma associated with increased internalized homophobia (Cain, 1991).

In a study of openness between gay and lesbian individuals and their health care providers (Dardick & Grady, 1980), the more relatives to whom a gay person had
disclosed his or her sexual orientation, the likelier that person was to have disclosed his or her sexual orientation to his or her physician. Although 49% of the respondents had disclosed their sexual orientation to their physician (SDSOP), 7% responded they would not share their sexual orientation with their physician under any circumstance. Disclosure to one’s physician was associated with increased patient satisfaction, eased communications with physician, and increased testing for venereal disease (Dardick & Grady, 1980).

Stein and Bonuck (2001a), in their survey of 575 lesbian and gay men, found that 70% had affirmative responses on a measure of SDSOP. This was a much younger cohort than the current study with mean age of 45 and a range in age from 18 to 83. Among the reasons for nondisclosure of sexual orientation to one’s physician, 47% were concerned with bad reactions or treatment; a further 17% avoided seeking any medical attention because of fears of sexual orientation prejudice. Stein and Bonuck also noted that gay and lesbian adults over the age of 60 and those under the age of 30 showed lower rates of disclosure that may reflect greater concerns with discriminatory medical care and possibly higher rates of discomfort discussing this aspect of their personal lives.

In the current study, 65.7% (n = 69) of the 105 participants reported having disclosed their sexual orientation to their physician, which is in keeping with previous disclosure percentages; that is 49% (Dardick & Grady, 1980) and 70% (Stein & Bonuck, 2001a). The limited research leaves room for speculation about increases in disclosure since the 1980 study by Dardick and Grady; for example, “Were increases in disclosure
associated with changes in beliefs among a cohort of gay men?” Primary reasons for non-disclosure in the current sample were: (a) Physician Non-Inquiry \((n = 11)\); (b) Assumption That Physician Knows \((n = 9)\); (c) Unnecessary \((n = 7)\); (d) Private \((n = 6)\); (e) Unrelated to Health Concerns \((n = 5)\); and (f) Fear of Physician Reaction \((n = 2)\).

The clinical assumption involved was that higher levels of internalized homophobia inhibit disclosure of sexual orientation to one’s physician. Whereas non-disclosure may serve to protect individuals from possible adverse reaction (discrimination or stigmatization), non-disclosure also prevents individuals from experiencing possible positive responses on the part of their health care providers. Stein and Bonuck (2001b) considered supportive, open communication between physicians and their gay or lesbian clients to be essential to their health care needs—especially considering such issues as sexuality, sexual orientation, mental health, health care planning, and advanced directives. It would seem that physicians who are unaware of the sexual orientation of their clients may be unable to provide an affirmative standard of care.

*Models of Multiple Variables Affecting DPAHC and SDSOP*

The final two hypotheses each sought to explore the linkages between age cohort, two components of internalized homophobia, and the two health care behaviors of DPAHC completion and SDSOP. For each case, a stepwise logistic regression equation was built which added the identified demographic variable in Model 1, in this case age cohort, and then tested the significance of the Goodness of Fit of the model. In each case, the DGI and the SDGM components were added in Model 2 and again tested for the
significance of Model $\chi^2$ Goodness of Fit at the $p < .05$ level. In Model 3, the final case, the alternate dependent variable to the tested dependent variable was used as a predictor variable. In each case, the null hypothesis was rejected. A discussion of each hypothesis follows.

**DPAHC Completion**

The null hypothesis assumes no relationship between the identified predictor variables (age cohort, measures of two components of internalized homophobia, and SDSOP) and completion of the DPAHC. This hypothesis was rejected; the associations between SDSOP and age cohort (75 years and above) with DPAHC, were significant at the $p < .01$ level in Model 3 of this equation. Model 3 also exhibited significant Goodness of Fit. Interpretation is based on significant variables in models that exhibit significant Goodness of Fit using Model $\chi^2$.

With the addition of age cohort to Model 1, Model $\chi^2$ was not significant ($\chi^2 = 3.01, p = .08$) for the relationship between age cohort and DPAHC completion. In Model 2, the equation held constant the effects of age cohort while adding the variables DGI and SDGM. Model $\chi^2$ was not significant, nor were the variables added significant.

In Model 3, the variable of SDSOP was added to the model while accounting for the error variance of age cohort, DGI, and SDGM. The Model $\chi^2$ was significant ($\chi^2 = 11.64, df(4), p < .05$), as was the $\Delta$ of $\chi^2$, when all four variables were accounted for within the equation. In Model 3, neither DGI nor SDGM exhibited significant
associations to DPAHC completion; however, SDSOP and age cohort exhibited statistically significant associations.

The odds ratio of the significant association between SDSOP and DPAHC in Model 3 suggests that older gay men who disclosed their sexual orientation to their physicians were 3.89 times more likely to have completed a Durable Power of Attorney for Health Care than older gay men who had not disclosed their sexual orientation to their physicians. There was a relationship in Model 3 between age cohort and DPAHC, after controlling for components of internalized homophobia and SDSOP, which indicated that gay men 75 years of age or older were 2.75 times more likely to have completed a DPAHC than were gay men 65–74 years of age. The logistic regression analysis indicated that there was a significant association between the set of predictor variables and completion of the DPAHC.

It was not surprising to find a relationship between age and DPAHC completion. Most people “tend to equate the need for an advance directive with age” (Church, 2000, p. 565). Individuals may be more likely to fill out a DPAHC as they age, regardless of sexual orientation, simply because of the increased likelihood of contact between the individual and health institutions. The Patient Self Determination Act of 1990 (PSDA, 1990) requires hospitals and other health organizations that accept Medicare and Medicaid funds to offer clients the opportunity to complete a DPAHC, or decline to complete with a documented signature. The current study found statistically significant relationships between increased age and DPAHC, as well as between SDSOP and
DPAHC. Future research may focus on establishing the proportion of the variance explained by these components.

*Self-Disclosure of Sexual Orientation to Physician*

The null hypothesis was that there is no relationship between the identified predictor variables (age cohort, levels of two components of internalized homophobia, and completion of the DPAHC) and SDSOP. The null hypothesis was rejected. The logistic regression model indicated that there was an association between at least two of the predictor variables (DGI and DPAHC), and SDSOP.

In Model 1, there was no significance in the Model $\chi^2$, $\Delta \chi^2$, or with the variable age cohort at this step. In Model 2, the $\Delta \chi^2$ was statistically significant ($p < .01$) when the DGI and SDGM variables were added. Statistically significant associations between variables in statistically significant models are the criteria for interpretability. Model $\chi^2$ was statistically significant ($\chi^2 = 11.48, df (3), p = .009$), however, no variable of interest within the model met the criteria of significance.

In Model 3, DPAHC was added to the equation and the Model $\chi^2$ Goodness of Fit was significant ($\chi^2 = 19.43, df (4), p = .001$). The $\Delta$ of $\chi^2$ was not significant, indicating that although this model was a good fit for the data, it was not significantly better than model 2. Accounting for the error variance for the variables of age cohort, DGI, SDGM, and DPAHC in Models 1, 2, and 3 of the logistic equation allowed an increasingly accurate mathematical portioning of the error variance accounted for by the addition of each subsequent variable and assessing its significance.
DGI and DPAHC were two significant variables in Model 3. The Discomfort with Gay Identity (DGI) component exhibited an odds ratio such that for each one-unit increase in DGI score, participants were 0.56 times as likely to self-disclose their sexual orientation to their physicians. That is, increased discomfort with gay identity is associated with a 44% decreased likelihood of disclosure of sexual orientation to one’s physician. This 44% decreased likelihood occurs anew with each subsequent one-unit increase in the score on the DGI component. Past research has shown gay men over 60 demonstrated increasing discomfort in discussing these personal aspects of their lives (Stein & Bonuck, 2001b).

The DPAHC and other advanced directives are important to gay and lesbian older adults for the same reasons advanced directives are important to any individual—to extend their influence on decision-making despite their own decisional incapacity (Cahill et al., 2000). However, completion of the DPAHC is also vitally important when an older gay person has a significant relationship with another person of the same gender and hopes to have that person act as his or her surrogate in the face of health care decisions. Currently, a blood relative would have priority on that decision without a DPAHC naming a specific proxy (Church, 2000).

The completion of the DPAHC was also a significant variable in relation to SDSOP in the current study. The logistic regression generated odds ratio in this model indicated that a participant who had completed a DPAHC was 3.92 times more likely to self-disclose his sexual orientation to his physician than was a participant who had not.
completed a DPAHC. There has been no previous research relating the two variables of SDSOP and DPAHC. Barriers to effective communication lie with the physician, the patient, and the health care system (Leland, 2001). Future research may address additional variables associated with these behavioral choices.

Although the results were significant in the relationship between SDSOP and DPAHC completion, once again the directionality of the events is unknown. It is also unclear from the results whether disclosure was made in response to inquiry on the part of the physician or was internally motivated. Nonetheless, these findings suggest that physicians and other health care providers, who take responsibility for assessing the sexual orientation and sexuality of their older adult patients, as Stein and Bonuck (2001b) recommended, may be increasing the likelihood that their patients will also complete a DPAHC.

Friend’s (1990) Theory of Successful Aging asserts that aging gay men who feel comfortable disclosing their sexual orientation to others may receive health benefits, through the removal of additional stressors associated with concealment. In a survey of 575 lesbians and gay men (Stein & Bonuck, 2001a), 17% of the participants avoided seeking health care because of concerns about disclosure of their sexual orientation. It may be that barriers to SDSOP and higher levels of components of internalized homophobia may only be important for a minority of older adults, but this choice could significantly affect health care. Privacy issues may influence not only sexual orientation disclosure, but may also affect choices regarding the completion of a DPAHC.
In this study, Discomfort with Gay Identity (DGI) was the one component of internalized homophobia that correlated to any other variable, whereas Social Discomfort with Gay Men (SDGM) did not. The dependent variables in this study may have been more closely related to aspects of gay identity and disclosure rather than issues of socialization patterns with other gay men. In Ross and Rosser (1996, p. 19), the subscale, Public Identification as Gay, was significantly negatively correlated to being openly gay at work \( (r = -0.64, p < .01) \) or in one’s personal life \( (r = -0.57, p < .01) \), whereas the subscale Comfort with Gay Men was only moderately negatively correlated to being openly gay at work \( (r = -0.27, p < .01) \) and personal life \( (r = -0.36, p < .01) \). The findings of the current study are in line with the conclusions by Ross and Rosser that increased discomfort with gay identity is associated with decreased likelihood of self-disclosure of one’s sexual orientation.

The DGI component, measuring an aspect of internalized homophobia, showed a statistically significant relationship with SDSOP but not DPAHC completion. It appeared that some components of internalized homophobia may be more important for decisions about disclosure than DPAHC. The use of a DPAHC document does not require the disclosure of sexual orientation. Additionally, many older adults are offered an opportunity, as required by the Patient Self-Determination Act (PSDA, 1990), to fill out DPAHC at registration for a hospital visit. Substantial numbers of older adults are offered the opportunity to nominate a DPAHC. At the same time, very few older adults are assessed for their sexuality or sexual orientation.
Limitations and Strengths

There were several limitations and strengths to this study: (a) sampling, (b) measurement, (c) research method, and (d) other issues of applied utility.

Sampling

Sampling issues were the greatest threat to external validity in this study. There was no random selection of the participants. Most of the participants were involved or connected to the gay community through social organizations or through reading community literature. This may have had the effect of over-representing those who chose to self-disclose their sexual orientation to their physician. Additionally, although it would have been unethical to approach sampling in any other way, participation was through self-selection. In effect, a person needed to disclose his identity as a gay man to participate in this study. Rothblum (1995) suggested that the use of such constrained data does not affect the generalizability of the results as is usually thought, as participants are often representative of the gay people who are active in their communities.

The participants within this small sample consisted of quite well-educated, European-American men with higher incomes, a typical problem in sampling this community of older gay men (Brown et al., 1997; Quam & Whitford, 1992). This is a problem as a sample of well-educated, European-American men with higher socioeconomic status may have had differential access to the health care system than less-educated, poorer men, and possibly those of minority status. Future research should include larger and more diverse samples of older gay men. Additionally, respondents
could be queried concerning their experience with health care and their choices to disclose.

Although 56.2% \((n = 59)\) of participants were obtained through snowball referral, reliance on this method is one of the primary limitations of this study. Most of the individuals in this sample were part of gay social networks, whether through associations of interest, aging related gay associations, or friendship groups. These participants may then not be representative of the total population of older gay men, especially those men less allied to gay social organizations. It may be that these participants have been more widely disclosed about their sexual orientation than other more “closeted” individuals. The participants in this sample were referred through gay friends or gay organizations from the snowball contact, or they were self-referred after reading the announcement in the local metropolitan daily newspaper or through gay community periodicals. Future sampling strategies could include nationwide sampling of organizations of politically active gay men and lesbian women, specialized periodical subscription lists, and contact through nationwide gay and lesbian communities of faith.

A sampling strength of this study was the skewed focus on gay men 65 years and older \((\text{range} = 65–87\text{ years})\). The sample of 105 individuals 65 years or older is one of the larger sample sizes used for an exploration of behaviors in older gay men, with age 65 as the minimum age criterion. This focus was an attempt to address previous studies that often set the lower limit for studies of older gay men at 40 years of age and older \((\text{Brown et al., 1997})\), or that grouped men of wide range in age, such as all men in one category
from 40 years to 85 years (Quam & Whitford, 1992). Traditionally, 65 years of age has marked the beginning of old age in mainstream aging studies (Deming & Cutler, 1983).

The sample of 105 men, although statistically a small sample for use of non-parametric statistics, is larger than most of the samples of gay men and lesbians in previous research, with samples ranging from 14 (Kimmel, 1979) to 112 (Berger, 1982a), when the focus was on older gay men exclusively. When the sample sizes were larger, younger, and when they drew inferences to “older” gay men, they ranged from 478 participants (Bennett & Thompson, 1991) to a large sample of 1,057 participants (Weinberg & Williams, 1979a). Both of these studies, however, sampled men of a very wide age range from late adolescence through their 70s. The current study is unique in gay aging studies in its focus on the lower age limit of 65 years, the range of the skewed sample (65 years to 87 years), and the large sample size for a population often described as statistically unreachable.

Statistics and Measures

A limitation to this study pertained to the measurement of internalized homophobia. Although well accepted as a theoretical clinical construct, internalized homophobia is elusive because of ambiguity and the lack of concept operationalization (Williamson, 2000). In this study, the use of the Reactions to Homosexuality Scale (RHS; Ross & Rosser, 1996) to measure internalized homophobia required a new principal components analysis of data. This analysis generated two interpretable and reliable components (DGI & SDGM) comparable to two of Ross and Rosser’s RHS original
subscales. Other potential dimensions of internalized homophobia measured in the Ross and Rosser subscales (e.g., moral and religious unacceptability, perceived stigma, and perceived discrimination), however, were not measured.

Normative levels of internalized homophobia may vary by age, age cohort, and/or culture. The limited sample size and diversity of participants precluded an opportunity to explore the effects of culture on SDSOP and DPAHC. All measures in this study were made using self-report, making it possible for participants to provide socially desirable responses. Here, older gay men, in an effort to “look good” in the research may have distorted their answers in an effort to appear more comfortable with their homosexuality than they really feel. This effort to “look good” would have resulted in an under-reporting of components of internalized homophobia. This would in turn lead to underestimating of the effect of the components comprising internalized homophobia.

Strengths of this study in the areas of statistics and measurements included the use of principal components analysis to measure differential component structure for the sampled population of older gay men, the use of open ended questions to explore the reasoning behind health care decisions, and the use of logistic regression, which does not require a normal distribution, to examine the odds ratio of the respondents’ health care choices.

Research Methods

This study was an exploratory, descriptive, correlational study, not designed to test causality among the variables. For instance, in Hypothesis 2, statistically significant
differences were found for observed and expected responses for DPAHC completion and SDSOP. However, it is impossible to determine the causal direction in which this process occurred. It is very likely a bidirectional process, or is mediated by a third variable. Likewise, the association between DPAHC and SDSOP described through both logistic regression equations in Hypotheses 5 and 6 imply corresponding odds likelihoods that the associations were more likely to occur, but the direction of this relationship cannot be determined. In one case, SDSOP was associated with increased likelihood of DPAHC, and in the next case, DPAHC was the predictor of SDSOP.

The strength of this study was in restricting the focus to older men 65 years and above. Future research may investigate the direction of causality in these processes through the application of hypothesis driven longitudinal research. Despite obtaining statistically significant results, large amounts of variance were left unexplained for each of the hypotheses. This sample only serves to illuminate some of the health care behaviors and expressions of gay men 65 years and older who lived in nine states and the District of Columbia and who volunteered to complete this survey. This was an exploratory, correlational study, which provided a limited amount of information applicable to guiding future research.

Research Implications

This study has implications for future research in gay and lesbian aging and for the investigation of internalized homophobia. In future gay and lesbian studies, it may be possible to broaden research into health care decision-making and behaviors, and increase
analytical complexity with larger and more diverse samples. The other area in which this
study has implications is in the study of internalized homophobia, both in its
conceptualization and its measurement.

*Gay and Lesbian Aging Studies*

Future research should include analysis of age as a continuous variable. This
study did not demonstrate a significant relationship between age cohort, internalized
homophobia, and health care decisions but carefully designed studies using age as a
continuous variable may be able to elicit naturally occurring age cohorts in this
population.

Cohler and Galatzer-Levy (2000) noted great differences in successive cohorts of
lesbians and gay men. They describe an older generation deeply affected by stigma and
prejudice, a middle-aged cohort responsible for many of the phenomena of gay liberation,
and a current generation of young gay and lesbian people at ease with their sexual
orientations. Elucidation of these cohorts through cross-cohort analysis of longitudinal
data would allow a greater understanding of the changing impact of internalized
homophobia, experiences of stigma and discrimination, and health choices of gay men
across their lifespan. Analysis of longitudinal data may help describe a normative
developmental path of gay men across the lifespan from early adolescence through late
life.

Inclusion of all relevant background, health, and demographic details in statistical
models of analysis of health care decision-making will increase the accuracy of variance
accountability and increase our ability to identify significant relationships. Whereas the logistic regression models in this study demonstrated relationships among the variables, several participant characteristics may also be related to either SDSOP or DPAHC. For example, although it is clear that increased age is associated with DPAHC completion, it is also possible to control for co-occurring variables such as education, income, or length of significant relationships through statistical analysis. In another example, a logistic regression model predicting DPAHC could include such participant characteristics as culture, retirement status, health status indicators, mental health indicators, availability of health insurance, and other measures of interest. Many of the participants in this study lived in urban areas; samples of men living in rural or suburban areas might return different patterns of SDSOP or DPAHC completion. It may be possible to tease out the difference in effects for age alone versus age with sexual orientation disclosure. Future research might include variables such as these in the models and control for their contribution to the explained variance.

This study has demonstrated a relationship between self-disclosure of sexual orientation to one’s physician and completion of the Durable Power of Attorney for Health Care. The implication is that the additional stressors of internalized homophobia may affect the health care choices of gay men. It is unclear from existing research the ways in which the health care experiences of gay men differ from the experiences of lesbian women. Even less is known about the experiences of bisexual people and transgendered adults and their health care choices (Hawley & Mostade, 1999). It is also
unclear to what extent outcomes are related to aging, per se, versus aging with the effects of internalized homophobia.

**Research With Internalized Homophobia**

Older gay men were raised in less tolerant and more overtly homophobic eras, and greater internalized homophobia might be expected in this population. It is also unclear whether these measures can differentiate between perceived versus actual discrimination. Ross and Rosser (1996) stated that the perception of stigma associated with being gay is significantly associated with anticipated discrimination even more than the actual level of societal discrimination experienced. The effects of these additional stressors have also been referred to as minority stress issues and might include the measurement of differences in the adverse health impacts for lesbian, gay, and bisexual people who have experienced antigay discrimination versus those that have not (Meyer, 2003).

Continuing research regarding the relationship between internalized homophobia and health behaviors including physical and mental health outcomes may be helpful in obtaining additional understanding of health care issues for older gay men. It would appear that older gay men have been raised in less tolerant and more overtly homophobic eras and locations, and so greater internalized homophobia might be expected in this population. It is also unclear whether the RHS can differentiate between perceived versus actual discrimination. Additional work on measures of internalized homophobia is needed in order that more reliable and valid assessment of these dimensions might be developed.
Measurement of Internalized Homophobia Using the RHS

Research with these scales should be validated on diverse groups and age cohorts of older gay and lesbian people. Ross (see Appendix F) has found different factor structures in different populations, including a recent examination of the RHS with Hispanic men. Refinement of this scale could include augmentation of item content and examination of this scale with factor analysis to examine the factor structure with different populations.

Continuing refinement of the concept of internalized homophobia, or internalized homonegativity, will allow increasingly useful operationalization of the concept. Antecedents or consequences of internalized homophobia (such as problems forming relationships) should not be included in these assessments (Shidlo, 1994), to avoid further conflation of components of internalized homophobia. As the concept of internalized homophobia becomes accurately measured, scales can be developed and tested on various age- and culture-diverse gay men. Any measure of internalized homophobia should also be tested and normed for populations of lesbians to test differences in levels and experiences with the effects of internalized homophobia.

The RHS was not useful in this study as a unitary measure, in part because the construct of internalized homophobia is highly complex, it is not well-defined, nor is it stable from population to population. For example, although the Discomfort with Gay Identity (DGI) component was negatively correlated to SDSOP, SDSOP did not exhibit
an association with the SDGM component. A low-disclosing individual might show increased discomfort with gay identity, but show no social discomfort with gay men.

A consistent measure of internalized homophobia can then be used to research the impact of levels of internalized homophobia on health care choices and behaviors, physical health and illness, relationship formation, and choices in long-term care, for example. In older adults particularly, clear and consistent measures of levels of components of internalized homophobia and their relationship to health care choices can guide the development of community interventions with future generations of older gay men that strive to facilitate the wellness of these men.

Summary

In this study, the relationships and differences in self-disclosure of sexual orientation to physician and completion of Durable Power of Attorney for Health Care in a sample of older gay men were explored. Components of internalized homophobia and age cohort were used as additional predictor variables.

The relationships of two components of internalized homophobia in the RHS subscale and Self-Disclosure of Sexual Orientation to Physician were found to be significant, although no relationship was found between age cohort and the variables. The study also indicated that older gay men are available in the community to help develop an understanding of health care preferences and practices. Future research could help develop additional information for work with older gay and lesbian adults.
Disclosure of sexual orientation to one’s physician was significantly associated with the completion of the Durable Power of Attorney for Health Care. This study may have implications for removing barriers to self-disclosure of sexual orientation to physicians and completion of Durable Power of Attorney for Health Care.
APPENDIX A

HUMAN SUBJECTS REVIEW APPROVAL
KENT STATE UNIVERSITY INSTITUTIONAL REVIEW BOARD
APPLICATION FOR APPROVAL TO USE HUMAN RESEARCH PARTICIPANTS

Form can be downloaded from http://www.kent.edu/rota/alpha/forms/

LOG NUMBER 01-84

Please type all information. HANDWRITTEN FORMS WILL NOT BE ACCEPTED. Move through the document using TAB or Mouse. Do not use the enter key. To mark a box, click with the mouse.

Name: S. Jeffrey Mostade
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Department: ACHVE Faculty Rank/Student Status: Doctoral candidate

Project Title: Internalized Homophobia, Durable Power of Attorney for Health Care Completion, and Self Disclosure of Sexual Orientation to Physician in Older Gay Men

Type of Project: [ ] FACULTY RESEARCH [ ] External Funded (Agency: ) Include copy of proposal
[ ] STUDENT DIRECTED RESEARCH (Advisors: Dr. John West & Dr. Cynthia Osborn)
[ ] Thesis [ ] Dissertation [ ] Course Requirement (Course #: )
[ ] Other (Specify: )

Duration of Project: Starting Date: 15 SEP 2003 (But not before approval is obtained) Ending Date: 15 JUNE 2004

I certify that the research procedures for this project and the method of obtaining consent (if any), as approved by the Kent State University Institutional Review Board, will be followed during the period covered by this research project. Any future changes will be submitted for Board review and approval prior to implementation.

If this project involves approval/permission from other institutions, the principal investigator (and the faculty advisor if the PI is a student) must sign below to certify the following statement: "I/we will not begin research at other institutions before having obtained their permission to do so."

Principal Investigator Date

Action Taken:
By REVIEWER:
[ ] Level I, Category A
[ ] Level II, Category B
[ ] Level III, To Full Board

Project Involves:
[ ] Deception
[ ] Waiver of Consent

Primary Reviewer Date

IRB Level III Action:
[ ] Approved [ ] Disapproved [ ] Contingent Approval (Comments or Contingencies):

Chairperson, IRB Date

By KSU INSTITUTIONAL REVIEW BOARD:
[ ] Approved, Level I
[ ] Approved, Level II
IRB Comments:

Co-Reviewer (Level II) Date

Administrator, IRB Date

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APPENDIX B

PARTICIPANT CONSENT FORM
CONSENT FORM:
INTERNALIZED HOMOPHOBIA, DURABLE POWER OF ATTORNEY FOR
HEALTH CARE COMPLETION, AND SELF-DISCLOSURE OF SEXUAL
ORIENTATION TO PHYSICIAN IN OLDER GAY MEN

I am conducting research on the health choices of older gay men because very little is known
about the successful aging of this population. I invite you to take part in this research. If you take part in this
project, then gay men in the future may benefit from increased recognition of the characteristics, health
choices, and attitudes of this population. Taking part in this project is entirely up to you, and no one will hold
it against you if you decide not to do it. If you do take part, you may stop at any time without incurring a
penalty. If you decide to participate, you will be asked to complete the Gay Aging Survey packet that will
take approximately 20 minutes of your time. This packet will include 3 parts: (a) Participant Characteristics
Survey, (b) Gay Health Choices, and (c) Reactions to Homosexuality Scale.

It is not expected that there will be any risks associated with your participation in this project. If
you feel discomfort or have other concerns following your participation, please see the researcher for an
appropriate referral for counseling. No other medical treatment or financial compensation for injury from
participation in this project is available.

All information gathered will be separated from your consent form so that your responses will not be
linked to your name. Your answers will not correspond to your name or address. All data are gathered and
analyzed in aggregate form. After the data are analyzed for this study, all records will be stored at a secure
location in the Department of Adult, Counseling, Health, and Vocational Education at Kent State University
for three years, at which time they will be destroyed.

If you want to know more about this research project or would like to obtain a copy of the survey
results at the end of the project, please call me at my offices at Senex Eldercare at 216.421.1793. I am
conducting this research for my Ph.D. dissertation under supervision of faculty at Kent State University’s
College and Graduate School of Education. You may contact my co-advisors John D. West, Ed.D. or Cynthia
J. Osborn, Ph.D. at 330.672.2662. The project has been approved by the Institutional Review Board at Kent
State University. If you have questions about Kent State University’s rules for research, please call John L.
West, Ph.D., Interim Vice President and Dean, Division of Research and Graduate Studies (330.672.0700).

Sincerely,

Jeffrey Mostade MA, PCC, NCC
Doctoral candidate

CONSENT STATEMENT

I agree to take part in this project. I know what I will have to do and that I can stop at any time without
penalty. You will receive a copy of this consent form.

___________________________  ___________________________
Signature                                      Date

Department of Adult, Counseling, Health and Vocational Education
Counseling and Human Development Services Program
P.O. Box 5190 • Kent, Ohio 44242-0001
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Gay Aging Survey Packet

Please check, circle, or fill-in the one response in each question that best describes you.

I. Participant Characteristics

1. How old are you? __ __ (in years)

2. Please check your preferred Cultural/Racial Identity:
   a. ______ ASIAN (includes Japanese, Chinese, Korean, Filipino, Southeast Asian descent)
   b. ______ AFRICAN-AMERICAN/ BLACK, NON-HISPANIC (includes Afro-American, Jamaican, Trinidadian, West Indian, and African descent)
   c. ______ AMERICAN INDIAN & ALEUTIAN ISLANDERS
   d. ______ EUROPEAN-AMERICAN/WHITE, NON-HISPANIC
   e. ______ HISPANIC, LATINO/A, CHICANA/O (includes Mexican, Puerto Rican, Cuban, Latin American, or Spanish descent, regardless of race)
   f. ______ OTHER   Cultural Self-Identification___________________

3. At the present time are you:
   a. Fully retired?
   b. Partially retired?
   c. Not retired?

4. With whom do you currently live?
   a. Alone
   b. With my partner/lover only
   c. With my partner/lover and roommate(s)
   d. With roommate(s) only
   e. With family members only (children, relatives)
   f. In assisted care
   g. Other (please explain)_____________________________
5. If you are partnered, what is the present duration of your relationship?
   a. Previously partnered ___ ___ (duration in years)
   b. Not partnered
   c. Less than 1 year
   d. Greater than 1 and less than 5 years
   e. Greater than 5 and less than 10 years
   f. Greater than 10 and less than 20 years
   g. Greater than 20 and less than 30 years
   h. Greater than 30 and less than 40 years
   i. Greater than 40 and less than 50 years
   j. Greater than 50 years

6. At the present time what is your legal marital status?
   a. Never married
   b. Married
   c. Divorced
   d. Separated
   e. Widowed

7. What is the highest level of education you have completed?
   a. K - 8
   b. High school
   c. Some college or vocational school
   d. Career or technical school graduate
   e. Associate’s Degree
   f. Bachelor’s graduate
   g. Master’s degree
   h. Terminal, Doctoral, or Professional Degree

8. What is your current annual household income?
   a. Less than $10,000
   b. At least $10,000 but less than $14,999
   c. At least $15,000 but less than $24,999
   d. At least $25,000 but less than $34,999
   e. At least $35,000 but less than $49,999
   f. At least $50,000 but less than $74,999
   g. At least $75,000 but less than $99,999
   h. At least $100,000 but less than $149,999
   i. At least $150,000 but less than $199,999
   j. Greater than $200,000
9. What is your present religious preference?
   a. No religious preference
   b. Atheist, or agnostic
   c. Protestant
   d. Catholic
   e. Jewish
   f. Muslim
   g. Other (please specify______________________________)

10. How many chronic medical conditions (for example: diabetes, congestive heart failure) do you have that limit mobility or otherwise cause a burden?
    a. 0 or none
    b. 1
    c. 2
    d. 3 or more

II. Gay Health Choices

   The Durable Power of Attorney for Health Care is a written document that allows you to select another person to make health care decisions for you, if you are unable to make decisions yourself. This document can give another person the power to make all your health care decisions.

11. Have you completed a Durable Power of Attorney for Health Care?
    _____YES   _____NO

12. If you have completed a Durable Power of Attorney for Health Care, who serves as your designated attorney?
    _____Life partner
    _____Legal Spouse
    _____Relative
    _____Friend
    _____Neighbor
    _____Paid Helper
    _____Other: Please specify ______________________________
    _____Don’t Know

13. Why have you (or have you not) chosen to complete a Durable Power of Attorney for Health care? (Please answer below):
Disclosure of Sexual orientation to Physician

14. Have you disclosed your sexual orientation to your physician or other primary health care provider?
   _____YES   _____NO

15. Why have you (or have you not) chosen to disclose your sexual orientation to your physician? (Please answer below)

III Reactions to Homosexuality Scale

Fill out this scale by circling the number which best describes your response to the statement below. Give your first response and don’t spend too much time on any one item.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Obviously effeminate homosexual men make me feel uncomfortable</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>2. I prefer to have anonymous sexual partners</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>3. It would be harder in life to be a homosexual man</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>4. Most of my friends are gay/bisexual men</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>5. Making an advance to another man is difficult for me</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>6. I feel comfortable in gay bars</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>7. Social situations with gay men make me feel uncomfortable</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>8. I avoid thinking about my homosexuality</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>9. When I think about other homosexual men, I think of negative situations</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>10. I feel comfortable being seen in public with an obviously gay person</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
</tbody>
</table>
11. I feel comfortable discussing homosexuality in a public situation | 1 | 2 | 3 | 4 | 5 | 6 | 7

12. It is important to me to control who knows about my homosexuality | 1 | 2 | 3 | 4 | 5 | 6 | 7

13. Most people have negative reactions to homosexuality | 1 | 2 | 3 | 4 | 5 | 6 | 7

14. Homosexuality is not against the will of God | 1 | 2 | 3 | 4 | 5 | 6 | 7

15. Society still punishes people for being gay | 1 | 2 | 3 | 4 | 5 | 6 | 7

16. I object if an anti-gay joke is told in my presence | 1 | 2 | 3 | 4 | 5 | 6 | 7

17. I worry about becoming an old gay man | 1 | 2 | 3 | 4 | 5 | 6 | 7

18. I worry about becoming unattractive | 1 | 2 | 3 | 4 | 5 | 6 | 7

19. I would prefer to be more heterosexual | 1 | 2 | 3 | 4 | 5 | 6 | 7

20. Only a few people discriminate against homosexual men | 1 | 2 | 3 | 4 | 5 | 6 | 7

21. I feel comfortable being a homosexual man | 1 | 2 | 3 | 4 | 5 | 6 | 7

22. Homosexuality is morally acceptable | 1 | 2 | 3 | 4 | 5 | 6 | 7

23. I am comfortable about people finding out I am gay | 1 | 2 | 3 | 4 | 5 | 6 | 7

24. Discrimination against gay people is still common | 1 | 2 | 3 | 4 | 5 | 6 | 7

25. Even if I could change my sexual orientation, I wouldn’t | 1 | 2 | 3 | 4 | 5 | 6 | 7

26. Homosexuality is as natural as heterosexual orientation | 1 | 2 | 3 | 4 | 5 | 6 | 7
APPENDIX D

ADVERTISING TEXT
GAY MAN? 65 YEARS OR OLDER?

Research is being conducted on the characteristics, health choices, and attitudes about homosexuality of older gay men because very little is known about the successful aging of this population. If you are a gay man, and 65 years or older, then you are eligible to participate. If you decide to participate, you will be asked to complete the Gay Aging Survey packet that will take approximately 20 minutes of your time. This packet includes 3 parts: (a) Participant Characteristics Survey, (b) Gay Health Choices, and (c) Reactions to Homosexuality Scale.

There are two opportunities to participate. A free luncheon followed by a program concerning Advance Directives by the Legal Aid Society of Cleveland will be held for participants at 11:30 am on October 31st, 2003 at Fairhill Center, 12200 Fairhill Road, Cleveland, Ohio. Please call Jeffrey at 216.421.1793 and register your intention to attend by leaving your name, or even just your first name. This will assist us in knowing how much food to have prepared.

If you are unable to attend this luncheon, but would still like to participate, please call Jeffrey at 216.421.1793 for a 2nd option. We will arrange for a copy of the survey packet to be mailed to you along with stamped return envelopes. All data will be gathered in an aggregate form, with individual data held anonymous. Participation is strictly confidential. Individuals of color, those over the age of 75, and those who seldom participate in gay social organizations are especially sought. The goal is to capture the diversity of our community. Chronically ill or transport challenged individuals are offered a home visit by the researcher to facilitate completion of the Gay Aging Survey packet.

If you want to know more about this research project, please call Jeffrey Mostade at Senex Eldercare at 216.421.1793. This research is being conducted as part of a doctoral dissertation and is under supervision of faculty at Kent State University’s College and Graduate School of Education. You may contact co-advisors John D. West, Ed.D. or Cynthia J. Osborn, Ph.D. at 330.672.2662 for additional information pertaining to the study. The project has been approved by Kent State University Institutional Review Board. If you have questions about Kent State University's rules for research, please call John L. West, Ph.D., Interim Vice President and Dean, Division of Research and Graduate Studies (330.672.0700).
June 3, 2003

Dear Mr. Mostade:

Thank you for your query about the Reactions to Homosexuality scale, authored by Dr. Michael Ross and myself in 1996, and revised in 2000. I am pleased to confirm that you are free to use the scale for your studies as you see fit, and to confirm there is no charge for usage.

I wish you all the best in your research. I have found the study of homophobia/homo/negativity to be a fascinating one both clinically and scientifically, and so am excited when I learn of others also engaging in research on this.

If you have further questions please do not hesitate to contact me.

Sincerely,

B. R. Simon Rosset, PhD, MPH, LP
Professor and Director: Center for HIV/STI Intervention and Prevention Studies (HIPS)
University of Minnesota Medical School, Minneapolis, MN

Visiting Behavioral Scientist
Division of HIV/AIDS Prevention – Intervention, Research and Support
National Center for HIV/STD/TB Prevention
Centers for Disease Control and Prevention (CDC), Atlanta, GA.
APPENDIX F

PERMISSION TO CONDUCT PCA WITH THE RHS SCALE
Dear Jeffrey,

The internalized homophobia scale is not copyrighted, and so you actually don’t need our permission to work on the scale – but I’m happy to give it if that’s what your committee wants! With any scale, its applicability to particular samples or over time, or its structure is a matter for empirical research – we don’t “own” the data or the scale, the data belong to the community of science! So, please feel free to try whatever factor analyses (rotations, structure comparisons, any other statistics, etc.) that you need in order to understand your data! And let us know if we can be of any help in interpreting the data with you. Actually, we have got a somewhat different factor structure in a very recent exploratory analysis of Hispanic MSMs, so I am not surprised by your findings. Best wishes,

Yours sincerely,

Michael W. Ross, MA PhD MPH MHPEd DipTertEd DipSTD DipAppCrim
Professor
APPENDIX G

QUALITATIVE RESPONSE TO SURVEY QUESTIONS
Appendix Table G1

*Responses to Survey Question “Why have you (or have you not) chosen to complete a Durable Power of Attorney for Health care?” (n = 85)*

<table>
<thead>
<tr>
<th>Response</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Affirmative (n = 62, 72.9%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extend Autonomy</td>
<td>21</td>
<td>24.7</td>
</tr>
<tr>
<td>Best Interests</td>
<td>16</td>
<td>18.8</td>
</tr>
<tr>
<td>Estate &amp; Legal Planning</td>
<td>15</td>
<td>17.6</td>
</tr>
<tr>
<td>Protect Partner/ Proxy</td>
<td>10</td>
<td>11.8</td>
</tr>
<tr>
<td><strong>Negative (n = 23, 27.1%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procrastination</td>
<td>9</td>
<td>10.6</td>
</tr>
<tr>
<td>Informed Choice</td>
<td>7</td>
<td>8.3</td>
</tr>
<tr>
<td>Lack of Awareness</td>
<td>5</td>
<td>5.9</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>2</td>
<td>2.3</td>
</tr>
</tbody>
</table>
Appendix Table G2

Responses to Survey Question, “Why or why not did you choose to disclose your sexual orientation to your physician? (n = 96)

<table>
<thead>
<tr>
<th>Response</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Affirmative (n = 56, 58.3%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Holism</td>
<td>26</td>
<td>27.1</td>
</tr>
<tr>
<td>Related to Gay Health Concerns</td>
<td>12</td>
<td>12.5</td>
</tr>
<tr>
<td>Honesty</td>
<td>6</td>
<td>6.2</td>
</tr>
<tr>
<td>Physician Inquiry</td>
<td>5</td>
<td>5.2</td>
</tr>
<tr>
<td>Affirming or G/L Physician</td>
<td>4</td>
<td>4.2</td>
</tr>
<tr>
<td>Sensible</td>
<td>3</td>
<td>3.1</td>
</tr>
<tr>
<td><strong>Negative (n = 40, 41.7%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Non-Inquiry</td>
<td>11</td>
<td>11.4</td>
</tr>
<tr>
<td>Assume</td>
<td>9</td>
<td>9.7</td>
</tr>
<tr>
<td>Unnecessary/Not Applicable</td>
<td>7</td>
<td>7.2</td>
</tr>
<tr>
<td>Private</td>
<td>6</td>
<td>6.2</td>
</tr>
<tr>
<td>Unrelated to Health Concerns</td>
<td>5</td>
<td>5.2</td>
</tr>
<tr>
<td>Fear of Physician Reaction</td>
<td>2</td>
<td>2.0</td>
</tr>
</tbody>
</table>
REFERENCES
REFERENCES


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