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THE RELATIONSHIP BETWEEN MARITAL STATUS AND PSYCHOLOGICAL ADJUSTMENT IN THE HOMOSEXUAL MALE

by

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies for acceptance, a thesis entitled, "The Relationship Between Marital Status and Psychological Adjustment in the Homosexual Male" submitted by John G. Branton in partial fulfillment of the requirements for the degree of Master of Science.

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ABSTRACT

This study of male homosexuality sets out to test the hypothesis that there is a relationship between attempts to conform to a heterosexual lifestyle and psychological adjustment in the homosexual male. It includes a brief examination of the changing understanding of homosexuality by the social sciences in this century. Particular attention is given to what are thought to be factors influencing adjustment: degree of homosexual orientation, the sexual identity formation process, homosexual type, and the effects of the Acquired Immune Deficiency Syndrome (AIDS).

The study examines four variables thought to influence the homosexual male to conform to a heterosexual life style: expected societal rejection, anticipated societal discrimination, conceptualization of homosexuality as normal, and guilt about homosexual behavior. Three groups thought to vary in their attempts to conform to a heterosexual life style were selected: married (most conforming), separated/divorced (less conforming), and single (least conforming). Differences among these groups on the four variables listed above were examined, as were the relationships between a) expected societal rejection, anticipated societal discrimination, conceptualization of homosexuality as normal, and guilt about homosexual behavior on the one

hand, and b) a set of indices of psychological adjustment on the other.

The study found that those who attempted most to conform to a heterosexual life style (the married group) reported significantly greater anticipated societal discrimination, difficulty conceptualizing homosexuality as normal, and guilt about homosexual behavior than the other two groups. The separated/divorced and single groups were not significantly different on these variables. The married group manifesting the greatest effort to conform to a heterosexual life style, experienced the greatest difficulty in psychological adjustment. The implications of these results for counselling are discussed.

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CHAPTER 1

INTRODUCTION AND STATEMENT OF THE PROBLEM

"All that is left is to pretend. But to pretend to the end of one's life is the highest torment." This statement by one of the world's most famous homosexual men, Peter Ilych Tchaikovsky, was made following his marriage to his student Antonina Milyukov (Ross, 1983, p. 1). These words are echoed today by thousands of men and women who attempt to repress or hide their homosexuality and who live in fear of being discovered to be who they really are.

Throughout the history of western civilization homosexual persons have tended to be socially ostracized. They have been rejected as heretical by their religious communities, condemned as criminal by the state, and considered to be sick by their physicians (Szasz, 1970; McNeil, 1976; Katz, 1976; Boswell, 1980; Karlen, 1980; Lautmann, 1980). Weinberg (1972) examined social attitudes toward homosexual people and identified the hostility towards them as homophobia which he described as "the revulsion toward homosexuals and often the desire to inflict punishment as retribution" (p. 129).

To escape societal rejection many, like Tchaikovsky before them, "pretend" and presumably experience this

"highest torment" and its correlates of psychological maladjustment. Others who choose not to pretend, frequently experience the rejection of friends, family alienation, social isolation, shunning by the church, job loss, eviction from their homes, or all of these (Katz, 1976; McNaught, 1981; Goodman, Lakey, Lashof, & Thorne, 1983). Still others seem to be able to affirm their homosexual orientation with neither personal nor socially negative consequences.

In recent years there has been a growing awareness of the problems of sexual preference experienced by homosexual persons, their families, and communities. Since the middle of this century the importance of research on homosexuality has been recognized by a variety of disciplines, particularly psychiatry (Bayer, 1981), psychology (Paul, Weinrich, Gonsiorek, & Hotvedt, 1982), sociology (Plummer, 1981), social work (Woodman & Lenna, 1980), and religion (McNeil, 1976; Nelson, 1978; 1985). Reflecting this interest, the interdisciplinary Journal of Homosexuality, has been published since 1974 to provide a forum for the scientific study of homosexuality. The advent of AIDS (Acquired Immune Deficiency Syndrome) in the 1980s not only has increased public awareness of the homosexual presence in society but also of the difficulties faced by homosexual persons. Plummer (1975), concerned with sexual suffering and the

situation of the homosexual individual in particular, suggested that social scientists, seeking to improve the quality of human life, neglect research in sexuality at the peril of society and their own discipline.

Until the 1960s the usual response to homosexual people by political and mental health authorities had been either punishment or treatment, both of which were directed toward the extinction of their sexual and affectional behavior. However, the social climate in Canada and the United States changed markedly after the Stonewall Riots on June 29, 1969. That night the long-repressed rage of homosexuals erupted during a routine New York police raid at the Stonewell Bar on Christopher Street in Greenwich Village. Historically and symbolically these riots marked the beginning of a new consciousness among homosexual people not unlike that among blacks in the civil rights movement (Bayer, 1981). The Gay Liberation Front emerged from the Stonewall Riots and the movement for gay liberation was born. Coincidentally, in Canada, just two months after the Stonewall Riots, parliament repealed criminal penalties for homosexual acts between consenting adults.

Partly in response to the new social atmosphere and the efforts of the Gay Liberation Front, the American Psychiatric Association deleted homosexuality from its classification of mental illnesses. This de-

classification removed support for much of the medical, social, and civil oppression of homosexual men and women (Bayer, 1981). Social attitudes have continued to become more positive toward homosexual people over the succeeding years. However, at the present time there is some evidence that the AIDS epidemic may be causing a renewed social hostility. Just how much the attempts to encourage greater understanding and acceptance of homosexuality as a legitimate sexual preference and lifestyle have been offset by this new threat has yet to be determined.

As a result of the more positive approach of the social sciences in recent decades, research and practice have been directed increasingly to the study of adjustment problems connected with homosexual orientation and the social context in which homosexual people live (Weinberg & Williams, 1974; Bell & Weinberg, 1978; Masters & Johnson, 1979; T.S. Weinberg, 1983). Once researchers began to study non-clinical populations they discovered that many homosexual individuals functioned at normal or superior levels and experienced no more psychological problems than heterosexual people (Hooker, 1957). However, there were homosexual men and women who did experience significant and frequently debilitating adjustment problems related to their sexual preference. Such adjustment problems correlate negatively with

measures of psychological adjustment such as self-acceptance, faith in others, commitment to homosexuality, and stability of self-concept. They correlate positively with measures of depression, fear of nervous breakdown, passing, loneliness, anxiety about homosexuality, and psychosomatic symptoms (Weinberg & Williams, 1974; Bell & Weinberg, 1978; Ross, 1983).

There is evidence to suggest that homosexuality is simply one variant of sexual development and that psychopathology is no more inherent in homosexuality than in heterosexuality (Hooker, 1957, 1958; Weinberg & Williams 1974; Plummer, 1975, 1981; Bell & Weinberg, 1978). Indeed, Hoffmann (1969) has argued that heterosexual behavior is as much of a scientific puzzle as homosexual behavior and that until we understand the former we may not be able to understand the latter.

Masters and Johnson (1979) reached a similar conclusion in their investigation of homosexuality stating, "Until more is known about the origins of heterosexuality, it is difficult to believe that meaningful insights will be reached regarding the origins of homosexuality" (p. 411). Storms (1980, 1981) studied the development of erotic preference and discovered that homosexual and heterosexual development followed the same developmental pattern. He noted (1981) that, "One need not posit abnormal or even unusual social events to

account for the occurrence of homosexuality" (p. 351).

A number of researchers have come to regard homosexuality as within the "normal" range of sexual development. Working from societal reaction theory and similar perspectives they have hypothesized that the problems faced by the homosexual population are a result of societal hostility (Weinberg, 1972; Weinberg & Williams, 1974; Bell & Weinberg, 1978; Marmor, 1980) However, as important as societal reaction may be, Weinberg and Williams' (1974) extensive study of three societies with distinctly differing reactions to homosexuality failed to show that societal reaction is the critical variable in homosexual adjustment problems. Homosexual respondents in all three societies manifest significant adjustment difficulties. Therefore it seemed reasonable to conclude either that psychological maladjustment is inherent in homosexuality (Sagarin & Kelly, 1975; Beigel, 1974), or that there is some other yet unidentified causal variable involved.

Ross (1978) suggested that the critical variable is not societal reaction, as important as that may be, but rather it is the manner in which the individual perceives that reaction, how much he is threatened by it, and how he responds to it. The variable cited by Ross was originally introduced by Farrell and Morrione (1974) as "putative societal reaction" (P.S.R.). Ross (1978)

reformulated it as "perceived societal hostility" and finally (1983) as "expected societal reaction" (E.S.R.). In the present study, this same variable is referred to as "expected societal rejection" in order to emphasize that it is the degree to which the individual expects societal reaction to be negative, hostile, or rejecting that is critical.

Ross hypothesized that greater problems in psychological adjustment would be experienced by those who expect societal rejection, attempt to hide their homosexuality, and attempt to conform to societal expectations by living a heterosexual life style. He employed marital status as a criterion of conformity with married men being most conforming and single men least conforming.

The present research seeks to test the hypotheses suggested by Ross by examining the psychological adjustment of a sample of homosexual men. More specifically it seeks to:

a) determine the relationship between attempts to conform to a heterosexual life style, as reflected in marital status, and various indicators of psychological adjustment, and to

b) explore the implications of any observed relationship between marital status and psychological adjustment for counselling homosexual men.

CHAPTER 2

REVIEW OF THE LITERATURE

As a result of extensive research (Kinsey, 1948; Hooker, 1957, 1958; Hoffman, 1968; Weinberg, 1972; Weinberg & Williams, 1974; Tripp, 1975; Bell & Weinberg, 1978; Masters & Johnson, 1979; Marmor, 1980; Plummer, 1981; Hart & Richardson, 1981; Paul, Weinrich, Gonsiorek, & Hotvedt, 1982; Weinberg, 1983) and changing societal sexual attitudes over the past forty years, researchers and members of the helping professions are developing a new understanding of the nature and significance of homosexuality. This evolution in knowledge has contributed to a new more positive approach to homosexuality on the part of the heterosexual population, the homosexual population, and the helping professions. The following literature review explores the issues of definition, etiology, psychological adjustment, and affirmative approaches to counselling homosexual men.

Definition

In any scientific examination of homosexuality the first major problem to be addressed is how the study determines who is homosexual. Shively, Jones, and De

Cecco (1984) surveyed research literature on sexual orientation to determine how sexual orientation was conceptually and operationally defined. They found that homosexuality seldom was clearly defined and when it was, the definitions differed significantly from each other. It appeared that researchers frequently assume that subjects were homosexual because they frequented homosexual centers or simply declared themselves to be homosexual. Salzman (1980) noted that the term may be applied as much to persons who had the briefest same-sex contact, even years ago, as to those who have exclusive ongoing same-sex relations for years. He observed that the term "has no specificity or precision in a scientific sense" (p.321) and called for greater precision. Kinsey (1948) makes the same point. Since an individual may be biologically male, perceive himself as male, behave as a male socially, but relate sexually and affectionately with other males, the definitional problem becomes how to decide what degree of same-sex sexual and affectional preference is required to designate an individual as homosexual.

Kinsey's (1948) study showed how difficult such a decision is. His statistics included men who had physical contacts with other males to the point of orgasm between the beginning of adolescence and old age. A particularly careful and thorough analysis of his data

showed that up to 37% of males have had sexual contact to orgasm with another male. Further, among males unmarried until 35, 50% had such contact. Some of these men may have had only one overt experience while others may have participated regularly in homosexual relations throughout their lives. To complicate matters, Kinsey found that some males are primarily or even exclusively homosexual in terms of their erotic response, but completely abstain from overt sexual contact with other males.

Kinsey (1948) suggested that,"it would encourage clearer thinking on these matters if persons were not characterized as heterosexual or homosexual, but as individuals who had certain amounts of heterosexual experience and certain amounts of homosexual experience" (p. 617). He suggested that the terms "homosexual" and "heterosexual" not be used as nouns or even as adjectives, but as descriptors for sexual acts or erotic stimuli. Salzman (1980) concurred with this solution suggesting that, "it would be preferable to speak only of homosexual behavior, rather than of homosexuality. `Homosexual behavior' would then take on an operational meaning" (p. 321). Thus there would not be homosexuals or heterosexuals but rather individuals with varying degrees of same-sex or opposite-sex experience. Kinsey (1948) devised a seven point continuum based on erotic response and overt behavior and rated individuals as

follows:

0. Exclusively heterosexual
1. Predominantly heterosexual, only incidentally homosexual
2. Predominantly heterosexual, but more than incidentally homosexual
3. Equally heterosexual and homosexual
4. Predominantly homosexual, but more than incidentally heterosexual
5. Predominantly homosexual, but incidentally heterosexual
6. Exclusively homosexual (p.638).

Though Kinsey's (1948) work facilitated a new approach to defining populations for study, it raised another issue by revealing an extremely high incidence of bisexuality in the general population. He noted that "nearly half (46%) of the population engages in both heterosexual and homosexual activities, or reacts to persons of both sexes, in the course of their adult lives" (p. 656). Kinsey's research revealed large numbers of people who were exclusively homosexual or heterosexual in terms of overt behavior and erotic response. Still, there were significant numbers expressing both homosexual and heterosexual response in overt behavior and erotic attraction. He observed that some had more heterosexual experience, some more

homosexual experience, and others a more equal balance of the two. The bisexual factor has complicated and confused homosexual research because it has been difficult to agree on whether an individual on Kinsey's continuum is heterosexual, bisexual, or homosexual.

Weinberg and Williams (1974) distinguished between heterosexual, bisexual, and homosexual by combining scales ratings 0-1, 2-4, and 5-6 thus differentiating between the most exclusively homosexual respondents, the most exclusively heterosexual respondents, and those they classified as bisexuals. They did this on the basis that no significant differences were found within these categories, and that the combined categories distinguished adequately between the bisexual and the more exclusively homosexual and heterosexual respondents. Bell and Weinberg (1978) used the Kinsey scale to differentiate between homosexual and heterosexual orientation by totalling the scores for feelings and behavior. Other researchers have supported this practice (Marmor, 1980; MacDonald, 1982; Hansen & Evans, 1985).

MacDonald (1982) reviewed sexuality studies and found that researchers in homosexuality, including Weinberg and Williams (1974) and Bell and Weinberg (1978), tended to include bisexual subjects in their homosexual studies thus confounding their work. He suggested behavioral scientists frequently reflect the

popular press and media by providing theoretical and empirical data suggesting only two orientations -- homosexual and heterosexual. He pointed out in terms of subject selection that those who function bisexually face discrimination from both homosexual and heterosexual groups and tend not to report their bisexual behavior. Instead they often rate themselves as either heterosexual or homosexual.

The working definition of the homosexual person used in this research was suggested by Marmor (1980). His definition is, "one who is motivated in adult life by a definite preferential erotic attraction to members of the same sex and who usually (but not necessarily) engages in overt sexual relations with them" (p.5). This definition includes persons selecting categories four, five, or six for overt behavior or erotic attraction on the Kinsey scale.

Marmor pointed out that this definition excludes, "the transitory, opportunistic homosexual patterns of delinquents...the ambiguous, essentially meaningless, and non-operational concept of 'latent homosexuality'... incidental homosexual behavior of adolescents... (and) situational homosexual reactions of heterosexually-deprived persons" (p. 5). He further noted that the definition does not exclude those who have the capacity for heterosexual arousal nor those who have a strong

erotic response to the same sex but do not act on their feelings because of fear or moral considerations. He suggested that these latter persons are simply the counterparts of inhibited heterosexuals persons.

In contemporary usage there is an attempt to distinguish between the meaning of the terms "homosexual", "gay", and "lesbian". The term "homosexual" may be applied to everyone, male and female who has a predominantly or exclusively same-sex preference whether they are extremely secretive or very open. The term "gay" is often reserved for persons who affirm their homosexuality and identify with other homosexuals and the gay community (Morin & Schultz, 1978; G. Weinberg, 1972). Boswell (1980) notes that the term predates the term homosexual by several centuries. Weinberg (1972) defined homosexual as having, "an erotic preference for members of one's own sex" and gay in the following manner:

> A homosexual person is gay when he regards himself as happily gifted with whatever capacity he has to see people as romantically beautiful. It is to be free of shame, guilt, regret over the fact that one is homosexual...To be gay is to be free of the need for ongoing self-inquisition, the sort that preoccupies those who feel abandoned and are searching for a reason: "How did I become

> homosexual?"...Being gay means having freed oneself of misgivings over being homosexual. (p. 70)

Many homosexual women accept the term "gay" while others prefer "lesbian" to describe themselves. The present research will attempt to use the words "homosexual" and "gay" in the manner suggested by Weinberg (1972).

Etiology

Hart and Richardson (1981) pointed out that the one thing homosexual persons have in common which separates them from heterosexual persons is "the experience of having to ask and answer the question, `WHY AM I A HOMOSEXUAL?'"(p. 39). These authors suggested that the obsession with theorizing about the cause and treatment of homosexuality, "must be providing society with a powerful symbol, beyond any logical concern about its contribution to sexual behavior or other human conduct" (p. 38). Until the 1970's, with a few exceptions, research studies viewed homosexuality as a pathology and tended to be concerned primarily with etiology. It was hypothesized that if a cause could be found and the origin explained, a cure could be developed. Preoccupation with etiology frequently seemed to correlate with the belief that homosexuality is abnormal (i.e., pathological).

Scientific theories and models of homosexuality provided by heterosexuals have influenced society's views about and response to homosexuals (Hart & Richardson, 1981). The removal of homosexuality from the D.S.M. III classification of mental disorders was a political decision about a theoretical stance on homosexuality (Bayer, 1981). The American Psychiatric Association's action, rejecting the theoretical position of a powerful and vocal antihomosexual elite ultimately opened the door to greater social and legal reforms for homosexuals. Such an incident suggests that theories about homosexuality do affect the way society perceives and responds to homosexuals as well as the way homosexuals perceive and respond to themselves and to society.

Hart and Richardson, (1981) proposed that theories about the cause of homosexuality also influence the self-image of homosexuals. They contended, "We should...be aware that models of homosexuality will influence the meaning homosexuals themselves will ascribe to same-sex relationships and acts, and more importantly, their identification as homosexual" (p. 37). Attribution theory supports this contention. If one accepts a theory that his homosexuality is pathological and somehow a consequence of his own action (erotic response) he may then feel responsible for it and react to it with shame, guilt, anxiety, and self-rejection (Ross, 1983). He may

internalize the societal rejection and homophobia he encounters. However, if he believes that his homosexuality is not pathological but is externally determined, he like heterosexuals, may have few or no adjustment problems resulting from his homosexuality. Therefore, it might be argued that the theory one holds about the cause of his homosexual orientation will affect the nature of his psychological adjustment. Moreover, counsellors and the general public will also be affected by the theory to which they subscribe. If causal attribution affects adjustment, then the theoretical perspectives held in contemporary society will significantly affect homosexuals. The nature, status, and impact of five influential theories that include an emphasis on the etiology of homosexuality are noted here.

Psychoanalytic theory suggests that homosexuality is the result of disturbed family relationships and the failure to successfully negotiate the normal course of psychosexual development (Bieber & Bieber, 1979). Freud's explanation of homosexuality as a fixation supported the conceptualization of homosexuality as pathology (Bayer, 1981). Attempts to "cure" homosexuals through psychoanalysis had little success and a high "relapse" rate (Pillard, 1982; Coleman, 1982). Psychoanalytic understanding of homosexuality is not supported by current empirical study and research (Bell,

Weinberg, & Hammersmith, 1981; Bayer, 1981;). However, this theory has encouraged society's perception of homosexuality as an illness and has given rise to extensive and determined attempts to eradicate homosexual responsiveness wherever it is found. Cornett and Hudson (1985) and Schwanberg (1985) found that negative attitudes toward homosexuals were most prevalent among psychiatrists and social workers strongly influenced by psychoanalytic theory. Homosexuals influenced by this theory were encouraged to consider their sexual preference to be an illness and to reject their natural sexual responsiveness. The traditional psychoanalytic approach is now seen to be inadequate, destructive, and itself partly responsible for the problems faced by homosexuals in our society (Coleman, 1982; Pillard, 1982).

Behavior theory viewed homosexuality as maladaptive rather than pathological (Coleman, 1982; Bayer, 1981; Hart & Richardson, 1981). Assuming that the problem is homosexual adjustment and not society's reaction, behaviorists attempted to "cure" through systematic desensitization, aversion therapy, orgasmic reconditioning, and positive reinforcement for heterosexual responsiveness. These approaches had little success in changing sexual preference and, as Pillard (1982) suggested, basically they constitute "consumer

fraud" (p. 109) since there is no significant evidence that a "cure" is possible. Davison (1982) contended that homosexuals who seek change do so largely in response to societal discrimination and coercion. He added, "What brings them into the counselling centre is guilt, shame, and the loneliness that comes from their secret" (p.94). Behavioral interventions tended to reinforce negative societal attitudes and worked against self-acceptance in the homosexual individual.

Social learning theory (Rotter, 1954; Bandura, 1977; Mischel, 1977) stresses that behavior is learned in social situations where needs are satisfied through social mediation. It has shown ways in which stimuli can become eroticized and how homosexual persons learn to eroticize same sex stimuli (Storms, 1981). It suggests that early socialization processes lead to identification of stimuli as either sexual or non-sexual. For homosexual persons situational variables encourage the eroticization of same sex stimuli. Since social learning theory is concerned with description rather than causation (Rotter, 1972), it provides understanding about the nature of all sexual development and is not biased against homosexuality. Practice based on social learning theory does not attempt to change homosexuals. Social learning theory (Storms, 1981) attempts to explain both heterosexual and homosexual development in a manner that

is not negative toward homosexuality. It encourages more positive societal reaction and gives the homosexual individual an understanding of his orientation that is conducive to self-acceptance.

Social interactionist theory (Manis & Meltzer, 1972; Plummer, 1975, 1981) concerns itself not only with etiological issues of homosexuality but also with the effects of the interaction between society and the individual. Sexual identity is not a given but an identity constructed through social interaction. Concentration on the identity formation process contributes a greater understanding of the experience of becoming and being homosexual (Cass, 1979; Troiden, 1980, 1984; Coleman, 1982). Interactionist theory attends to the social variables involved in societal rejection of homosexuals, their perception of this societal rejection, and its effect on their response and consequent psychological adjustment. The theory is more influential in sociological and social psychological circles and has given rise to considerable research supportive of homosexuals. Certain aspects of this theory relating to the effects of peer relationships and labelling in the etiology of homosexuality were not supported in the Bell, Weinberg, and Hammersmith (1981) study. Because it does not view homosexuality as pathological but rather a normal process of development it provides the basis for

greater self-understanding and self-acceptance among homosexuals.

Although there is at present no consensus on the extent to which biology affects the development of sexual orientation, biological studies have contributed to theories of the origin of sexual orientation (Tourney, 1980; Hart & Richardson, 1981; Bell, Weinberg, & Hammersmith, 1981; Storms, 1981; Money, 1987). Bell, Weinberg, and Hammersmith (1981) obtained results in their extensive study of homosexuality, employing path analysis, that were not inconsistent with a biological basis for sexual orientation. They noted, "A large body of convincing research appears to suggest a biological foundation for homosexuality, at least among some people" (p. 220). Money (1987) has suggested that environment and biology are both involved. He found that hormones affected prenatal brain development in a way which influenced sexual orientation but that orienation is dependent on both prenatal homonalization and postnatal socialization. Again, Dorner (1976) found that in homosexual men ratios among male hormones differ from that in heterosexual men. Storms (1981) suggested that in homosexual persons hormones cause early sex drive development in a time when more homosexual cues are socially available setting the stage for eroticization of same sex stimuli. Bell, Weinberg, and Hammersmith (1981)

suggested that a purely biological explanation of homosexuality's origins could lead people to accept it as natural, remove or reduce moral condemnation, discrimination, and parental guilt so that homosexual persons might be comfortable with their orienation as heterosexuals are with theirs. However, such information could also be used (as it was in Nazi Germany) to prevent the birth of homosexual offspring and to eradicate same-sex erotic response in an attempt to obliterate human variation.

At this point in time there is not sufficient information or consensus to determine the etiology of sexual orientation. It appears that there is no single cause of homosexuality just as there is no single cause of heterosexuality. There may be several paths that lead to homosexual orientation (Masters & Johnson, 1979; Storms, 1981; Franken, 1982). It would appear that the safest approach at the present time is to assume that there is an interaction between both biological and psychosocial factors in the formation of homosexual orientation.

Psychological Adjustment

Research on Homosexual Adjustment

The transition to viewing homosexual behavior as a variant and functional sexual response rather than pathological or maladjusted behavior was given significant support by the work of Kinsey (1948). His extensive empirical study included four times the number of homosexual cases of any previous research (Pomeroy, 1972). Unlike most other studies of homosexuals Kinsey's subjects were taken from the general population rather than from clinical or criminal groups. His compassionate approach to his subjects elicited trust and cooperation from homosexuals who were willing to share their knowledge and experience more fully. Pomeroy (1972) noted that Kinsey obtained access to information that other less sympathetic researchers may have been denied. "People with problems of homosexual behavior learned quickly that this researcher would not make moral judgements about them, that he understood their anxieties and was honestly anxious to learn more about them and their lives. Their response was grateful and sometimes overwhelming" (p. 75).

Kinsey's work revealed hitherto unknown and entirely unexpected information about the extent and nature of homosexuality. He stated, regarding the high incidence

of homosexuality in his data, "These figures are, of course, higher than any which have previously been estimated; but as already shown...they must be understatements, if they are anything other than fact. We ourselves were totally unprepared to find such incidence data when this research was originally undertaken" (Kinsey, Pomeroy, & Martin, 1948, p. 625). For example, the data revealed such findings as:

> 37 per cent of the total male population has at least some overt homosexual experience to the point of orgasm between adolescence and old age...This accounts for nearly two males out of every five that one may meet.
>
> 18 percent of the males have at least as much of the homosexual as the heterosexual in their histories (i.e., rate 3-6 for at least three years between the ages of 16 and 55. This is more than one in six of the white male population.
>
> 10 per cent of the males are more or less exclusively homosexual (i.e., rate 5 or 6) for at least three years between the ages of 16 and 55. This is one male in ten in the white male population.
>
> 8 per cent of the males are exclusively homosexual (i.e., rate a 6) for at least three years between the ages of 16 and 55. This is one male in

every 13. (p. 650)

These results indicated that homosexuals comprise, not an insignificant minority of moderately to severely disturbed individuals, as was generally believed, but one of the largest minority groups in America, ranking with blacks and the aged in number. Such high incidence rates suggest that homosexuals must be functioning fairly well for so many to be invisibly present in the general population (Gagnon & Simon, 1973). Indeed, there is little evidence that homosexuals differ from the general adult population except in being disproportionately unmarried and childless (Gonsiorek, 1982).

Kinsey agreed that just as medical pathology interfered with physical well-being, so in a social sense, some sexual activities might cause social maladjustment. However, he found that sexual behaviors regarded as abnormal in text books, nevertheless, occur in as many as 30 to 70 per cent of the general population. He found no evidence that a departure from declared socially acceptable practice involved neurosis or psychosis and added that most of those practicing taboo sexual expressions seemed to make a satisfactory social adjustment.

Kinsey contended that the real clinical problem, "was to deal with personality defects that led clients or patients to crack up whenever they departed from averages

or socially accepted custom while millions of other persons embrace the very same behavior, and may have as high rates of activity, without personal or social disturbance" (p. 202). He observed that clinicians would have more incentive for going beyond the sexual behavior to personality issues if they were better acquainted with the normal frequencies of the so-called abnormal types of activity, and if they could acquire a wider acquaintance with the sexual histories of well-adjusted individuals.

Even in 1948 when the presumption of pathology was widely accepted, Kinsey observed that there are many psychiatrists who "make no attempt to re-direct behavior, but who devote their attention to helping an individual accept himself, and to conduct himself in such a manner that he does not come into open conflict with society" (p. 660). Kinsey's work played a crucial role in calling into serious question the assumptions about homosexuality generally held in our society up to the middle of this century. Moreover, his empirical methods set a new standard for a more rigorous and scientific study of homosexuality.

Evelyn Hooker (1957, 1958) produced the first major empirical psychological study of male homosexual adjustment. Her work is generally considered as pivotal in providing a justification for studies of homosexuality in a context of adjustment rather than pathology (Bayer,

1981). She found, in a major study of homosexuality and the Rorschach, that it was not possible to discriminate between homosexual and heterosexual men in terms of psychological adjustment.

Hooker's (1957) study based on the hypothesis that homosexuality is not necessarily a symptom of pathology suggests that:

1. Homosexuality as a clinical entity does not exist. Its forms are as varied as are those of heterosexuality.
2. Homosexuality may be a deviation in sexual pattern which is within the normal range, psychologically...
3. The role of particular forms of sexual desire and expression in personality structure and development may be less important than has been frequently assumed. Even if one assumes that homosexuality represents a severe form of maladjustment to society in the sexual sector of behavior, this does not necessarily mean that the homosexual must be severely maladjusted in other sectors of his behavior. (p.30)

Gagnon and Simon (1973) noted that frequently homosexuals are treated differently from heterosexuals in studies relating to adjustment. Heterosexuals tend to give the purely sexual dimension of the homosexual's life

an excessive significance that would not be tolerated in studies of heterosexuality. They pointed out that for heterosexuals there has been an implicit reconceptualization of mental health in recent years. This new understanding has scaled down earlier idealistic goals for human functioning to more pragmatic ones:

> Is the individual self-supporting? Does he manage to conduct his affairs without the intervention of the police or the growing number of mental health authorities? Does he have adequate sources of social support? Does he possess an adequately developed repertoire for gratification? Has he learned to accept himself? (p. 138)

When a heterosexual man meets these requirements of mental health he is vindicated, but no matter how good his adjustment in nonsexual areas of life, the homosexual man often remains suspect.

Weinberg and Williams (1974) examined homosexual adjustment from the perspective of societal reaction or labelling theory which suggests that homosexuals' problems result from society's antihomosexual attitudes and rejecting behavior. The study was based on a large sample (2,347) from the United States, Denmark, and Holland. It attempted to examine the difference in homosexual adaptation in cultures with differing degrees of societal rejection of homosexuals. The researchers

hypothesized that in the more hostile cultures, such as the United States, there would be greater maladjustment. However, they found that there were no major differences in levels of adjustment of the samples in spite of the difference in socio-cultural contexts.

Consequently they questioned the assumption that societal reaction in itself is as significant as had been anticipated. They proposed that the way an individual responds to the societal attitudes and adapts to his situation may be the critical factors in adjustment. Moreover, they noted that their study may not have given a true measure of the impact of societal rejection because subjects from the closeted, hidden, and therefore most deeply affected sector of the homosexual population, were probably not adequately represented. Their sample for testing societal attitude in the general population also was quite small (300 heterosexual men for Denmark and Holland with a response rate of 11% and 12% respectively). Other reports of European societal attitude, particularly a 1967 Dutch study, indicated a strong negative attitude that viewed homosexuals as comparable to the mentally disturbed. There was a strong aversion to accepting them although there was sympathy for them as long as they stayed to themselves. Weinberg and Williams considered this an attitude of "tolerance but not acceptance" (p. 84).

Sagarin and Kelly (1980) contended that since Weinberg and Williams' research showed no observable significant relationship between societal rejection and maladjustment, then such maladjustment suggests that "pathology precedes hostile societal reaction and would exist independent of it" (p. 371). Beigel (1974), a supporter of the inherent pathology position, in reviewing Weinberg and Williams' work originally, suggested that since it appears societal rejection is not the problem, it is more important than ever to discover, "what are reasons and causes of the disproportionate number of unhappy people in the 'gay' population, the number of suicides, depression, loneliness and similar psychological or neurotic problems" (p. 340).

Agreeing with Beigel and rejecting Wienberg and Williams position, Sagarin and Kelly (1980) argued against the appropriateness of using the concept of secondary deviation in connection with homosexuality. They contended that the issue here is primary deviation, that is, pathology. They further suggested that though societal reaction amplifies, it does not create pathology. Pathology is already there. Participation in the subculture simply enables the subject to accept the deviant role, become adjusted to it, and thus reduce distress and maladjustment. "The hostile societal reaction forces large numbers of deviants into a

subcultural milieu of their own, where they give one another mutual support and an ideology that enhances the ego and the self-image" (p. 372).

Plummer (1981) contended that there are both functional and dysfunctional homosexualities and that two important variables affecting psychological adjustment are the stage of homosexual identity development and the specific social context. Where there is a supportive context such as the gay community, there will be better psychological functioning. In the middle of the homosexual career, association with a positive reference group will lead to a positive identity. At later stages in their development homosexuals may function better than many heterosexuals because they have achieved emotional freedom from societal restrictions, coped with oppression and concomitant personal difficulties, and achieved a strong sense of self-acceptance and self-worth.

Since Weinberg and Williams (1974) could not support their hypothesis that societal rejection was responsible for maladjustment in homosexuals, and unwilling to accept the conclusion that homosexuals are inherently maladjusted or mentally ill, Ross (1978, 1983, 1985) completed a series of studies on homosexual adjustment in which he examined the effect of two variables. The first is what this research identifies as expected societal rejection (E.S.R.) and the second is what he described as

"conformity" referring to the response many homosexuals make when they expect societal rejection.

While not denying the very real impact of actual societal rejection as part of the problem encountered by homosexual men, he identified the perception of societal rejection, rather than the rejection itself, as the critical variable that accounts for differences in adjustment levels. Ross drew on the research of Farrell and Nelson (1976) and Farrell and Morrione (1974) who pointed out the significance of putative societal reaction for deviant populations. The evidence Ross produced supported neither the theory that pathology precedes societal rejection nor that pathology is the result of societal rejection. However, he found that when a homosexual man expects societal rejection he defines himself in the light of it and may shift to a homosexual self-definition and identify with the homosexual sub-culture or attempt to identify as heterosexual and conform to that model. He found that those with high E.S.R. attempted to conform to the heterosexual model and experienced significant adjustment difficulties. Finally, he found that those individuals who internalize the societal view that homosexuals are "sick" may conform to the pathology model rather than the heterosexual model and present in the way society expects. He suggested (Ross, 1978, 1983) that the

correlation between E.S.R. and conforming to a heterosexual life style is so high that E.S.R. can be taken as a measure of heterosexual conformity in homosexual men. This research is based essentially on the position developed by Ross.

In order to conceptualize more clearly the hypothesized relationship between expected societal rejection, attempts to conform to a heterosexual life style as an intervening variable, and psychological adjustment, it will be helpful to consider the influence of four factors thought to significantly affect the homosexual individual's degree of adjustment. These factors are: the degree of homosexual orienation, the identity formation process, the nature of one's homosexual expression (type), and the extent to which one is affected by the AIDS epidemic.

Factors Influencing Psychological Adjustment in Homosexual Men

Degree of Homosexual Orientation

One factor which must always be considered in a study of psychological adjustment of homosexual men is the degree of their homosexual orientation. The Kinsey sexual orientation scales, which have been discussed previously, indicate a wide variation in human sexual

response. Persons who consider themselves homosexual may score anywhere from three to six (Bell & Weinberg, 1978). Those who score toward the middle range may be bisexual, or in transition toward homosexuality, or they may be denying their homosexuality. Each of these possibilities has implications for psychological adjustment. Those at five or six may have identified themselves more clearly as homosexual, be accepting of their homosexuality, and consequently better adjusted (Ross, 1983).

Identity Formation

Another factor affecting the psychological adjustment of homosexual men is identity formation. Of critical importance to the present research are recent studies which have attempted to identify and describe the process involved in reaching an integrated sense of identity as a homosexual person. These studies have yielded significant findings about the experience of being homosexual and the roles played both by E.S.R. and heterosexual conformity in the psychological adjustment of homosexual men.

Dank (1971) noted that though extensive work had been done on etiology and behavior, little was understood about identity formation. He observed that some people experiencing homoerotic responsiveness identified themselves as heterosexual or bisexual, while others identified themselves as gay or homosexual. Dank sought

to discover "what conditions permit a person to say, `I am a homosexual' (p. 180). An awareness of the conditions and process of homosexual identity formation is very important in understanding variations in psychological adjustment among homosexuals. This process may last anywhere from a few years to forty or fifty years (Dank, 1972) and may give rise to a variety of adjustment problems. Dank isolated six factors in identity formation: the socialization process, the cognitive dimension, the elements of identification and acceptance, the effect of negative public labelling, the dynamics operating in the undeclared homosexual man, and the role played by the knowledge one has about homosexuality.

He observed that the socialization process for homosexual youth does not exist as it does for heterosexual youth. (See also, Whitam, 1977). There is only socialization as a heterosexual. Dank pointed out that parents of black youth communicate what it means to be black and how to be black. The parents of homosexual youth are unable to assist them in understanding what it means to be homosexual and how to be homosexual. There are no positive homosexual models affirmed by the parents or the community and reference to homosexuals is usually extremely negative.

Since homosexuality is negatively connoted in

society it is not surprising that Dank found that individuals tend to identify themselves as homosexual only after a change in the meaning of the cognitive category "homosexual". Usually it is after they make the distinction between the negative societal image of homosexuals and the positive image presented by self-affirming gay persons that homosexuals are able to think positively of themselves as homosexual. The use of the slogan "Gay is good" or "Gay and proud" by the homophile movement are examples of such a change in cognitive category.

Dank's study showed that self-acceptance usually, but not always, comes with identifying oneself as homosexual. Those who identify themselves as homosexual in isolation are more likely to feel guilt than those who identify themselves in the company of other homosexuals. He suggested that interaction with other homosexuals not only explains but justifies homosexual behavior. "The cognitive category of homosexual now becomes socially acceptable, and the subject can place himself in that category and yet preserve a sense of his esteem or self-worth" (p. 190). Fifty percent of Dank's sample "came out" while socializing with gay people. It is important to note that such self-identification may not result in any change in behavior and that for some no overt sexual behavior accompanies the process of coming out.

Occasionally men are arrested or fired from their jobs because of some kind of observed homosexual behavior that has caused them to be publicly and negatively labelled as homosexuals. No subject in Dank's study came out as a result of such negative labelling. On the basis of interviews with 4.5% of his sample who had been so labelled, Dank concluded that such public labelling inhibits the subject's decision to label himself as homosexual. Such labelling reinforces the negative stereotype and makes it difficult for the individual to place himself in the cognitive category of homosexual. Acceptance of the label may be avoided through rationalizing homoerotic behavior by indicating that it was a result of stress, the influence of drugs or alcohol, or a symptom of temporary emotional instability.

Denial of homosexual identity is found frequently (20% of Dank's sample) in men who have been homosexually responsive for years and who have frequently engaged in homosexual behavior. It appears that they have internalized the negative societal attitude toward the homosexual person to such an extent that they cannot accept a homosexual identity. They live in a state of tension and cognitive dissonance where what they feel and do is not consistent with their self-definition as heterosexual.

Dank suggested that the ability of homosexuals to

accept their orientation is closely connected with "the access of knowledge and information concerning homosexuals and homosexuality" (p. 193). He cited sociological research which indicates that knowledge is an important factor in deviant identity formation. If the individual has no knowledge of the existence of a category he cannot identify with it. Dank suggested that greater tolerance in society increases the availability of information about homosexuality so that those who experience themselves as homosexual have a richer context for self-understanding. Since such information includes contributions from gay affirmative sources there is now a challenge to negative societal stereotypes and some provision of positive models.

Others have confirmed Dank's findings and continued research in identity formation (Hammersmith & Weinberg, 1973; de Monteflores & Schultz, 1978; Lee, 1977; Cass 1979; Coleman, 1982; Maylon, 1982). Before reviewing literature on the components of sexual identity formation, three observations should be made. First, homosexual identity formation is a process comprising several developmental stages. De Monteflores and Schultz suggested that one-dimensional, linear progression models of this process are too simplistic. They conceptualized a feed-back loop to depict the frequent alternation between regress and progress on the way to achieving an

integrated homosexual identity. Subjects frequently reported moving back and forth between self-acceptance and self-rejection depending on a number of personal and social variables. Hammersmith and Weinberg (1973) had observed that a homosexual's actions may elicit certain societal responses which can modify his behavior. For example, if friends react less than positively to one's coming out, the level of self-acceptance may be reduced.

Second, homosexual self-identification usually takes place in adolescence and frequently results in suppression or denial. Maylon (1982) noted, "The simultaneous awareness of homoerotic desires, and the social odium associated with them, tends to bring about conflict and a pervasive suppression of homosexual promptings among many homosexual males" (335). He suggested that such experience inhibits the completing of the adolescent developmental tasks and a biphasic process takes place in which these tasks are completed much later, during the third decade or later in life. Thus aspects of homosexual identity formation resemble those found in the adolescent developmental stage.

Erikson (1950) believed that doubt about one's sexual identity may lead to delinquent and psychotic episodes. His explanation of human development in terms of bi-polar opposites which posits role confusion as the opposite of identity formation in adolescence, describes

the experience that many homosexuals report. Both society and the individual have more tolerance for such confusion in the teens than in the adult years. A major shift in the definition of oneself can be extremely disconcerting when one has for many years viewed himself to be stable and mature.

The third observation is that if the homosexual man is to achieve self-acceptance and a stable sense of identity a cognitive transformation which includes a re-casting of the past and appropriate self-labelling will be necessary (de Monteflores & Shultz, 1978). In re-casting the past, the homosexual individual becomes more aware of previously repressed incidents and experiences of same sex attraction. He begins to understand his present experience as not discontinuous with his past. He may even become angry at his failure to realize his orientation sooner with the consequent loss of many opportunities to enter into love relationships with others. Self-labelling has an integrating effect which enables an individual to synthesize events and experiences that had been in conflict. There is a recognition of deep emotional need for same sex affection which can now be seen as congruent with a homosexual identity.

Four more recent studies (Lee, 1977; Cass, 1979; Troiden, 1979; Coleman, 1982) used and extended Dank's

developmental approach yielding a variety of pertinent findings which together provide a composite picture that facilitates the understanding of homosexual identity formation and psychological adjustment. These studies describe homosexual identity formation in terms of stages similar to those employed for the human life span in developmental psychology.

Lee identified three stages: signification, coming out, and going public. Signification is a time of slowly acknowledging one's homosexual feelings while still being celibate. This period is characterized by four steps toward overt homosexual behavior: masturbation with same-sex imagery, anonymous sex, sometimes a secret long-term relationship with one man, and avoidance of any public identification with the gay community. Lee's second phase, coming out, consists of an exploration of the gay community and a decision "to be identified as gay in the straight world" (p.55). Exploration of the gay community consists of five steps: a tentative approach to a gay bar or other such meeting place, finally walking in, telling heterosexual friends about one's preference, being open in a restricted circle, and participating in the gay community life. Going completely public is a very difficult step accomplished by relatively few people. Lee noted that we have little research to indicate under what conditions homosexuals are willing to "drop the

mask" (58), a frequently costly decision. He noted that the high cost of "passing", of not dropping the mask, was fear, guilt, anxiety, loss of creativity and productivity, but most of all "hypocrisy, pretense and the inability to be oneself" (p. 62).

Cass (1979) based her classification on the interpersonal congruency perspective in interactionist theory positing that identity acquisition is a developmental process in which both stability and change are the results of interaction between the individual and the environment. She identified six stages: identity confusion, identity comparison, identity tolerance, identity acceptance, identity pride, and identity synthesis. She noted that at any stage in the developmental process identity foreclosure might occur and the individual may decide not to allow any further development. Identity confusion arises when an individual begins to identify his thoughts, feelings, or behavior as homosexual. Identity comparison begins with a feeling of growing alienation, of not belonging, and of being different. Identity tolerance involves working through increasing commitment to a homosexual identity from the place where one may say, "I probably am homosexual", to the place where he says, "I am a homosexual person". Identity acceptance is characterized by continuous and increasing contacts with other

homosexuals which tends to normalize the homosexual identity and way of life. Identity pride begins with an awareness of the incongruency between one's being acceptable to gay friends on the one hand, but unacceptable to society on the other. Affirming heterosexual people become part of one's social support system but rejecting heterosexual people are themselves rejected. Because his environment has become perceived as supportive, the homosexual man now can integrate his private and public sexual identity with other aspects of his self-identity. The homosexual component of his life becomes just one other part of of his personality and homosexual identity formation is completed.

Coleman (1982) outlined five stages in the developmental process: pre-coming out, coming out, exploration, first relationships, and integration. He described the first stage as consisting of "pre-conscious awareness of same-sex identity" (p.150) and noted that this had a negative impact on the self-concept when individuals begin to internalize negative societal reactions. The negative comments of friends, family, social, or religious leaders are taken personally, felt as deep rejection, and lead to greater secrecy about being homosexual. Coleman (1982) quoted Fisher who aptly described the experience.

Every time a homosexual denies the validity of his

> feelings or restrains himself from expressing (them), he does a small hurt to himself....The effect may be scarcely noticeable: joy may be a little less keen, happiness slightly subdued, he may simply feel a little run down, a little less tall. Over the years, these tiny denials have a cumulative effect. (p. 249)

The pre-coming out stage is a time of denial, suppression, and repression with symptoms of depression, poor self-concept, lack of direction in life, and usually poor interpersonal relationships. It is here that alternate solutions appear--suicide, disguised identity, and low-grade depression. Coleman (1982) suggested that the only healthy resolutions in this stage is the acknowledgement of erotic preference and progression to the coming out process.

The second stage (coming out) is the cessation of war with the self, a time of inner reconciliation and peacemaking with sexual identity. A positive response from others leads to a positive self-image and increased self-esteem while rejection leads to a return to the pre-coming out stage and usually a chronic low-grade depression. Coleman stressed the crucial value of a positive response from a significant other at this juncture. He observed how difficult this can be because friends and family members have to go through a process

of acceptance similar to that experienced by the gay person himself. He argued that family members need time to mourn the loss of their loved one as they knew him, and parents opportunity to grieve the lost dream of grandchildren.

In the third stage (exploration) there is a need to complete the adolescent developmental tasks regarding sexual identity. The task of sexual exploration is frequently viewed as promiscuity and negatively evaluated by others. However, the depression that often accompanies such exploration is simply a signal of growth and the need to accomplish this developmental task. Early encounters tend to be transitory and attempts to encourage persons at this stage to move into long-term commitments are not very helpful.

The fourth stage (first relationships), comes when gay men view themselves as capable of loving and being loved. The preceding period of exploration leaves a yearning for a stable relationship, a sense of personal attractiveness, and readiness for intimacy. In the final stage (integration), gay persons function fully in their society, behaving with openess, warmth, friendliness, and care for others. A sense of confidence and competence permits enduring relationships with a minimum of possessiveness and jealously. At this stage individuals have attained such a level of maturity that they are able

to achieve long-term relationships and, when necessary, accept rejection without reverting to dysfunctional patterns of behavior. McWhirter and Mattison's (1984) extensive research on the male couple explicates the dynamics and developmental stages of gay male relationships to which Coleman refers.

In addition to being aware of the impact of the dynamics of identity formation outlined by the preceding theorists, special reference needs to be made to the experience of homosexual males who are or have been married and are fathers. These men face identity formation issues which are different from those of their single counterparts. Fathers face not only the incongruity of having a homosexual identity and a heterosexual identity, but a third identity, that of father. This dimension of their lives needs to be worked out in the identity formation process. Bozett (1981) noted:

> The gay father may believe that fatherhood and homosexuality are antithetical...The gay father has two identities that are at opposite extremes of social acceptance: homosexuality as the negative extreme and fatherhood at the positive. His task, then, is to achieve convergence of the two identities so that cognitive dissonance is eliminated" (p. 552).

Bozett suggested that the greater the gay father's involvement in or experience with the gay community the easier will be his task. The characteristics of the gay world that give problems to the gay father include that it is a single world, it tends to be characterized by transient relationships, and it is youth-oriented. Frequently gay men are intolerant of children, but the needs of their children usually come first for gay fathers. Bozett observed that if the gay father nourishes significant heterosexual and homosexual relationships with people who accept his identity, in time the cognitive dissonance will be reduced or eliminated and he can place himself in the category of gay father, thus achieving an experience of congruence and self-acceptance.

A separate study exploring the relationship between commitment to a homosexual identity and psychological adjustment supported the observations of the preceding developmental stage theorists. Hammersmith and Weinberg (1973) conducted a study which sought to demonstrate that psychological adjustment would be significantly related to level of commitment to homosexual identity. Specifically they hypothesized that commitment to a homosexual identity would be:

1. positively related to stability of self-concept.
2. positively related to self-esteem.

3. negatively related to symptoms of maladjustment (such as anxiety symptoms or depression).
4. positively related to perceived support of significant others. (p. 59)

Their premise was that the homosexual individual, like all others, seeks to establish his identity and to receive validation through social interaction. The results revealed that "commitment to homosexuality is found to be positively related to stability of self-concept and to self-esteem, and negatively related to measures of psychological maladjustment" (p. 69) and that the more one is committed to his identity the more others will support that identity. If an individual can accept himself as homosexual he will tend to have positive self concept and high self-esteem. He will thereby experience less stress, anxiety, and depression and will elicit greater support from those who are important to him.

Weinberg and Williams (1974) found similarly that the more open and self-accepting homosexuals were, the higher they scored on a number of scales including health and happiness. Their scores were not significantly different from those of heterosexuals. The more hidden and closeted homosexuals showed decreased levels of personal functioning and satisfaction.

Therefore, it may be concluded that support for the homosexual man progressing through the various stages of

identity formation will result in commitment to his identity and consequently better psychological adjustment. Conversely, the individual who receives minimal or no support may regret his identity, reduce his commitment to it, experience higher E.S.R., and encounter greater problems in psychological adjustment.

Homosexual Type

A third factor affecting psychological adjustment is homosexual type. Following Weinberg and Williams' earlier study (1974) which failed to relate psychological adjustment to societal reaction, Bell and Weinberg (1978) conducted a second study to examine the variations among homosexuals that might explain differences in psychological adjustment. For the first time a major empirical study attempted to discover if there were significant differences among homosexual persons that could contribute to variation in behavior and adjustment. These researchers differentiated five major homosexual types based on measures of sexual experience and social and psychological adjustment. The five categories emerged from a cluster analysis of the standard scores of the responses of subjects. The discriminating variables included degree of coupledness, level of regret about being homosexual, number of sexual problems, number of sexual partners in the preceding year, amount of

cruising, and level of sexual activity.

Bell and Weinberg made no claim to an exhaustive or definitive classification scheme and expressed the hope that other investigators might be able to create typologies that are more comprehensive and discriminating. However, 71% of their sample fell clearly into one of the categories suggesting that such a schema might be helpful in assessing data regarding sexual, psychological, and social adjustment in homosexuals. Although the study included both male and female subjects, reference here pertains only to males. Responses of the subjects fell into five categories.

1. Close-Coupled. These subjects lived with a male partner in a committed relationship comparable to marriage and reported fewer sexual problems, fewer sexual partners, less cruising, fewer cruising worries, fewer difficulties in finding a suitable partner, fewer problems maintaining affection for the partner, less regret about their homosexuality, and more sexual activity than the typical respondent.

2. Open-Coupled. These men were involved in a committed relationship with another man but their standard scores were high on one or more of the following variables: number of sexual partners, number of sexual problems, and amount of cruising. Though they were coupled, these respondents could not be classified with

those whose relationship with another male had reduced their sexual problems or their interest in having a variety of sexual contacts. They tended to be more exclusively homosexual, to do more worrying in connection with their cruising, to report somewhat higher levels of sexual activity, to have engaged in a wider variety of sexual techniques, and to have more regret about their homosexuality than the close-coupled. Their partner's failure to respond to their sexual requests was the most prevalent sexual problem.

3. Functional. These men were single though they may have had an affair. Their standard scores were high on number of sexual partners and level of sexual activity, but low on regret over their homosexuality and number of sexual problems. They cruised more than the typical respondent, worried less about exposure through cruising, tended to be more overt, to have a higher level of sexual interest, more extensive sexual repertoires, and to rate their sex appeal higher. Compared with the average homosexual man they tend to experience less feeling that they did not have enough sex, less sexual inadequacy, and less sense that their homosexual activity was immoral.

4. Dysfunctional. These men had high standard scores on number of sexual partners, level of sexual activity, number of sexual problems, and regret over

their homosexuality. Compared with the average homosexual male, they felt more inadequate sexually and had more difficulty reaching orgasm, finding a compatible sexual partner, and experiencing affection for their partner. These men are closest to the stereotype of the tormented homosexual individual for they are troubled about their identity, experience little gratification, and have difficulty managing their daily lives. They are sexually, socially, and psychologically less adjusted than other homosexuals.

5. Asexual. Asexuals were not coupled, had low standard scores on sexual activity level, number of partners, and amount of cruising. They were older than the average respondent, experienced more difficulty in finding a partner, had less frequent sexual contact, lower levels of sexual interest, less varied sexual activity, greater regret about their homosexuality, lower homosexual ratings, and passed more often. They were less likely to have an affair or to view themselves as sexually appealing to other males and were characterized primarily by lack of social involvement, spending their time alone having little contact with friends. These men described themselves as lonely and unhappy.

The study found that different types of homosexuals compared differently with heterosexuals giving evidence that it is not possible to make valid comparisons between

homosexuals and heterosexuals as if they were uniform categories. Moreover, homosexuals of the same type are not entirely like others of the same type. Nearly one quarter of the subjects were relatively asexual indicating that many homosexuals do not fit the stereotype of being caught up in sexual pursuits. One-third of the respondents were close-coupled or functional managing their homosexuality well. That there were so few close-coupled subjects suggests that homosexual monogamy may be difficult to maintain. Bell and Weinberg (1978) concluded that, "the least ambiguous finding of our investigation is that homosexuality is not necessarily related to pathology" (p.231) and that few homosexual persons conform to the popular stereotype of being sexually irresponsible, a threat to the social order, or personally maladjusted.

Bell, Weinberg, and Hammersmith (1981) continued to examine homosexual variation and found other significant differences in terms of race, gender non-conformity, bisexuality, psychological therapy, and adult life-style. They found that the adult sexual adjustment and life-style of homosexuals tend not to be systematically related to childhood and adolescent experience.

In another typology, Ross (1983) included three groups: married, separated and divorced, and never married homosexuals. The married had significantly

higher scores on measures of perceived societal rejection and anxiety regarding homosexuality, and tended to conceive of homosexuality as abnormal. He observed, "It is clear that those homosexual men who marry are not only more open to social pressure but see social pressure as being more threatening towards their sexual orientation as well" (p.73) and the later the married homosexual man informed his wife about his orientation "the more likely he was to have married to hide or to try to cover his orientation" (p.96).

Homosexual "types" are subject to the limitations characteristic of all typologies. However, just as typologies are helpful in the study of personality, so too are homosexual typologies useful in studying the nature and dynamics of homosexual functioning.

Acquired Immune Deficiency Syndrome (AIDS)

A fourth factor affecting the psychological adjustment of homosexual men is the pervasive threat of AIDS. Accumulating evidence suggests that AIDS has significantly influenced both the psychological adjustment of homosexual persons and their perception of society's response to them. Until very recently AIDS was viewed as a problem primarily of homosexuals and secondarily of marginal minority groups. In September of 1983 the Atlanta Centre for Disease Control reported that

persons suffering with AIDS were: 71% gay or bisexual, 17% intravenous drug users, and 5% Haitian (Morin & Batchelor, 1984).

The first intimation of the impending tragedy to be experienced by homosexuals appeared in June of 1981 when the Atlanta Centre for Disease Control reported the cases of five young homosexual men suffering from an unusual disease, pneumocystis pneumonia, now recognized as one of the manifestations of AIDS (Drake, 1987). As early as November of 1981 the gay press reflected the concern. Mandate (1981) carried this brief announcement.

> A series of distressing statistics issued by the Federal Centre for Disease Control in Atlanta sent ripples of fear throughout the gay world. Doctors in New York and California have uncovered 41 cases of a rare and often rapidly fatal skin cancer which can appear as violet-coloured patches on the skin, infect the lymph glands and then spread throughout the body...All the victims were men, ages 26 to 51. All were homosexuals; most had had multiple and frequent sexual encounters with varying partners... Cancer, however, is commonly considered to be non-contagious. Next month's Mandate will include an in-depth article on the phenomenon" (p. 5).

A New York study (Martin, 1987) indicated that as early as the end of 1981, 55% of a sample of gay men had

heard about AIDS. Anxiety escalated into hysteria in the gay community as cases multiplied and medical science could neither identify the causal agent nor offer hope for its victims. By 1983 the AIDS phenomena was being described as the "gay plague" and fear of homosexuals (i.e., homophobia) was creating a backlash against the gay community.

Only in the latter part of 1986 did the magnitude of the AIDS threat begin to dawn on the general population as evidenced by themes in national magazines (Newsweek, November 24, 1986--"Future Shock: AIDS"; MacLeans, January 12, 1987 --"Sex in the Eighties"; Time, February, 16, 1987 --"The Big Chill: Fear of AIDS"). In June of 1987 an international conference on AIDS attracted six thousand clinicians, researchers, and other concerned persons from around the world. Following this conference Drake (1987) reported that AIDS had claimed 30,000 lives and that the projected death toll by 1992 was three million. At the end of the conference a four and one-half hour ABC special focused attention on the impending danger of the AIDS epidemic. It is not known how the new media hysteria about AIDS in relation to heterosexuals will affect the level of anguish already experienced by homosexuals. The press has reported evidence of increased societal rejection of homosexuals in reports of increased assaults on gay men (The Globe and

Mail, June 8, 1987; The Calgary Sun, June 16, 1987).

Studies (Morin, Charles, & Malyon, 1984; Morin & Batchelor, 1984; Coates, Temoshok, & Mandel, 1984; Mandel, 1986) confirm the suspicion that AIDS is affecting the psychological functioning of homosexual men whatever their medical status in relation to the disease. Morin and Batchelor (1984) reported a San Francisco survey of gay men which found that 75% had experienced increased anxiety since hearing about AIDS. In an article on the psychological consequences of AIDS for gay men, Morin, Charles, and Malyon (1984) described the dynamics they were observing:

> The psychological impact on gay men is omnipresent and profound. Gay men must shoulder the emotional impact of a devastating epidemic with few models or guidelines to follow. Existential issues are no longer abstract philosophical musings or gently nagging preoccupations; they are immediate and vivid concerns. The gay community is still reeling from the impact of the AIDS crisis and will continue to do so as the epidemic extends its destruction" (p. 1293).

Gay men who have not experienced increased anxiety as a result of the AIDS crisis might include those who are simply not informed as well as those who have been sexually inactive for many years. The extremely long

incubation period for the human immunodeficiency virus (HIV), ranging up to ten or more years, however, leaves little room for security.

Contemporary medical and psychosocial literature suggests that homosexual men find themselves in one of four categories: men with AIDS, men with ARC (AIDS-Related Complex); men with positive anti-body tests; and men who are well but worried. There is evidence that all groups, including the healthy, are experiencing significant and frequently debilitating stress. Mandel (1986) reported studies of the psychosocial consequences of AIDS on homosexual men in which the National Institute of Mental Health and the Biopsychosocial AIDS Project at the University of California examined the responses of four groups of men. The first was composed of patients with AIDS-related Kaposi's sarcoma (KS) and the second, patients with acute leukemia, both of which were studied soon after diagnosis. The third group was made up of healthy homosexual men and the fourth of healthy heterosexual men. Surprisingly, the responses of the healthy gay men were the same as the KS and the leukemia patients on measures of depression, anxiety, distress, and locus of control. These three groups were more dysphoric than the healthy heterosexual men and their mean dysphoria scores were at clinically significant levels.

Other studies corroborate the preceding findings. Valdiserri (1986) did research with healthy ego-dystonic homosexual men who believed that they had AIDS. He found that these individuals experienced profound distress in which belief that one has AIDS was experienced as punishment for repressed homosexual desires. He suggested that the reactions of these men may be more severe than those of homosexuals who are not so ambivalent about their sexual orientation. However, because of the extremely long incubation period of the AIDS virus all persons at risk are confronted with the possibility that they may have already contracted AIDS. Morin, Charles, and Malyon (1984) found that some asymptomatic gay men show signs of impaired functioning that include "panic attacks, generalized anxiety, and persistent hypochondriasis characterized by somatic reactions that mimic AIDS such as night sweats and fatigue. Often these episodes involve unfounded beliefs that the person actually does have AIDS and is dying" (p. 1290).

Mandel (1986) pointed out that healthy individuals who experience profound psychosocial dilemmas as a result of the AIDS epidemic may need help to cope with their distress. Thomas Hill (1987) pointed out that the work of Schuller, an immunologist at Pennsylvania State University, shows that psychosocial variables are

implicated in a variety of diseases. She noted evidence which indicates that stress may make an organism more vulnerable, particularly to diseases associated with immunologic mechanisms. Coates, Temoshok, and Mandel (1984) also provide evidence supporting this contention. Therefore, it is possible that the stress and anxiety around AIDS, particularly the extensive ambiguity and ignorance concerning the virus, the incubation period, and the treatment may increase susceptibility to the disease and reduce the ability to fight infection if it does occur.

Morin, Charles, and Malyon (1984) observed that AIDS-related issues affect most counselling with gay men including presenting problems not related to AIDS. Frequently, existential issues are not far from the surface. Morin, Charles, and Malyon (1984) found counselling issues include, "death, limits, feeling alone and helpless, and experiencing one's mortality" (p. 1291). Newsweek's (1986) description of events in the gay community support this contention.

> The pall of death is omnipresent, and many gays are suffering from what Michael Shernoff, a New York therapist calls, `bereavement overload'...There is no sense that it is going to end. It will be with us for a long time, and that fact is very difficult. The AIDS problem strains our coping ability. (p.32)

The Toronto Star (October 8, 1987) reported 16 deaths in one AIDS support group in the preceding month. Such increased confrontation with death brings not only the experience of loss of friends and lovers but also exacerbates anxiety when there is the fear that one may himself be under a death sentence as an asymptomatic carrier of the AIDS virus. It might be expected that married homosexuals will experience even greater anguish because of their isolation from the support of the gay community and the threat their behavior carries to their loved ones.

Frequent casualties for homosexual men in the context of AIDS are identity and intimacy. Acevedo (1986) observed that it is only in the past twenty years that many gay men have begun to accept themselves, and the validity of their sexual identity. Sexual identity has been closely related to sexual activities that are now excluded or severely restricted under the guidelines of safe sex. He suggested that as a consequence of AIDS, gay men are dealing "not only with loss of community members but are also faced with the loss of sexual activities and existential loss of identity" (p. 99). He compared the identity crisis and bereavement of many homosexual men to that of women experiencing a mastectomy with the attendant need to grieve.

That many sexual activities are being given up by

large numbers of gay men is evidenced by a San Francisco longitudinal study. Winkelstein et al., (1987) found that from the last six months of 1982 through the last six months of 1985 the monthly number of cases of anal/rectal gonorrhea fell from between 200 and 300 to fewer than 50. The average number of different male sexual partners per month declined from 6.3 in November 1982 to 3.9 in May 1984. In the same period the frequency of anal/genital contact with each partner with ejaculation declined from 1.9 to 0.7. A New York study (Martin, 1987) reports similar findings. The number of different sexual partners has declined by 78% with the threat of AIDS. Sexual episodes involving exchange of body fluids has declined by 70% and condom use has increased from 1.5% to 20%.

Morin, Charles, and Malyon (1984) noted that intimacy has been difficult for gay men, in part, because of the social prohibition against visibly coupled male relationships. The gay community itself is placing pressure on men to enter into such relationships and close formerly open relationships. Individuals who formerly met intimacy needs with multiple partners or short-term relationships or who presently have no partner find it confusing and frustrating to find partners in new ways and with the ever present question as to whether a potential partner might be HIV positive.

The preceding comments apply to all homosexual men regardless of their status related to AIDS. However, those who are diagnosed with AIDS or ARC (AIDS-related complex) face a formidable number of additional issues including, potential relationship crises with family, friends, and lovers; and changes in income, occupation, and even social identity. Though many of the issues are the same as those experienced by any terminally ill person, they are frequently exacerbated by concerns related to sexual orientation. For example, though one may have come to an acceptance and affirmation of his sexual orientation, he may regress to an earlier phase of self-rejection, particularly in light of the tendency of society to blame the victims of this disease for their predicament. Valdiserri (1986) reported that AIDS patients frequently relive the coming out process with an accompanying increase of internalized homophobia, self-hatred, and self-blame. For others, the issue of coming out, avoided for a life-time, is now forced on them while they are still unwilling or unprepared to deal with the repercussions. Mandel (1986) reported that 20% of diagnosed men in their study had not come out as being gay. These men tended not to discuss health problems with others, were more negative, and experienced greater distress.

Namir (1986) noted that the usual ways of coping

with a terminal illness were not available to persons with AIDS. She pointed out, "Their support networks often disappear, and their fears of transmitting the disease to others cause increased isolation. Little conclusive information is available, and talking about the disease often creates more alienation and discrimination. The routine of their lives is seriously disrupted" (p.87). She observed that the usual positive responses experienced by people with terminal illnesses are often absent because "social homophobia leads people to blame the victims" (p.89) and if an individual anticipates hostility from others his reaction will be either anger or guilt. She pointed out that if an individual accepts responsibility for his illness, "Feelings of inferiority, inadequacy, and rejection are easily aroused and can seriously impair the ability to cope" (p. 89).

In a similar vein Mandel (1986) reported that there seems to be a relationship between the kind of attributions one makes about the disease and how he copes with it. He observed, "Among men with AIDS, the attribution of illness to external sources, such as bad luck or the environment, seemed to be emotionally protective. Attributing responsibility to oneself for a life-threatening condition can be devastating" (p. 78). Finally, she reported that the more positive one is about

his homosexuality, the more effectively he will cope and the less emotional disturbance he will experience. There seems to be a need for greater support evidenced by the fact that Namir found that 81% of those surveyed wanted individual or group psychotherapy.

The review of literature regarding AIDS suggests that it is an important variable to consider in examining homosexual adjustment and interaction with society. It seems reasonable to conclude that the six years of high media visibility given to the disease and the increasing incidence of AIDS patients, even in smaller cities and remote communities, has affected the psychological functioning of most homosexuals and altered their expectation of societal rejection.

This review of factors affecting the psychological adjustment of homosexual persons shows that this population is as varied as the heterosexuals from whom they are distinguished primarily by a one variable--homoerotic responsiveness. It has been suggested that perhaps the single most important element affecting their adjustment is the extremely high level of homophobia in our culture (G. Weinberg, 1972; Hencken, 1982). However, the key factors to be noted in the present examination of adjustment are sexual orientation rating, stage of identity formation, characteristics of personal typology, and the impact of AIDS.

Counselling With Homosexual Male Clients

Important issues in counselling homosexual clients with adjustment difficulties include counsellor attitude, counsellor orientation, differential diagnosis, sexual identity, married homosexuals, relationships, sexual dysfunction, and AIDS.

Counsellor Attitude

A positive attitude toward homosexuals and an acceptance of homosexuality as a viable and acceptable sexual preference seems essential for effective counselling with homosexual clients. Saghir and Robins (1973) found that though most homosexual male clients in their study were positive about therapy (63%), a significant 37%, "felt negatively about their psychotherapeutic experience. They believed that it was of no value or that it even made things worse due to a lack of understanding by the therapist or to his personal prejudice against homosexuality" (p. 112). In light of the accumulated knowledge of the past forty years it appears that Coleman (1982) is correct in stating that the goal of counselling is "to enhance homosexual functioning rather than to try to eliminate it" (p. 85). There is no significant evidence that therapy can change homosexual orientation on a complete or permanent basis

(G. Weinberg, 1972; Saghir & Robins, 1973; Tripp, 1975; Coleman, 1982; Davison, 1982). In his presidential address to the Association for the Advancement of Behavioral Therapy in 1974, Davison argued that therapists should stop offering a cure for something that is no longer considered an illness. He contended that such promises to "cure" homosexuals seeking to change their orientation is unethical and suggested that therapists should work with their clients to, "combat the social system that has been responsible for unjustifiably creating their negative self-image" (p. 87).

Sexual Orientation of the Counsellor

Rochlin (1985) pointed out that though research has been done on the therapeutic effects of client-counselor similarity and difference in a variety of settings, little work has been done with this variable as it relates to homosexual persons because until recently homosexual therapists were unknown and unwilling to identify themselves. Homosexual clients have often fared badly in therapy (Weinberg, 1972; Tripp, 1975). Masters and Johnson (1979) cited examples of negative treatment of homosexuals in their study who had sought help and noted, "The available evidence certainly supports the homosexual population in their general contention that if they expected the worst from health care professionals,

they would rarely be disappointed" (p. 247). Rochlin (1985) reviewed the work of Rogers, Truax, Carkhuff, and Oden to conclude that the person of the therapist is the key factor in the success of counselling. He cited the small amount of research to date which suggests that congruence between client and counsellor in sexual orientation facilitates effective counselling because of client-counsellor similarity, counsellors' familiarity with the gay world, and their ability to serve as role models. Clark (1977) contended that non-gay counsellors, undisclosed (closeted) gay counsellors, and openly gay counsellors should not underestimate the need to be aware of their own conscious and unconscious fears of rejection of homosexuals which can contaminate the counselling process. Clark (1977) suggested that counsellors who wish to work with homosexual clients should seek gay positive consultation or supervision because of the subtle and not so subtle effects on counsellors produced by life in an extremely homophobic society.

Differential Diagnosis

Gonsiorek (1985), while accepting the validity of many of the concerns of those who oppose the practice of diagnosis, argued for the importance of careful diagnosis or assessment in discriminating between problems related to sexual orientation and those arising from

psychopathology. He observed that counsellors need to discriminate between symptoms of paranoid schizophrenia, hypomania, depression, and borderline disorders on the one hand, and the effects of the coming out crisis on the other.

Sexual Identity

Coleman (1985) and Woodman and Lenna (1980) have suggested that the accepting of sexual identity is one of the primary issues counsellors meet in their work with homosexual clients. They described the identity formation process discussed earlier and suggested possible counsellor responses. Woodman and Lenna (1980) proposed that counselling should assist the client in developing a positive self-image through working out responses to negative societal stereotypes and by creating a positive self-definition. In support of this perspective, Hodges and Hutter (1979) pointed out that it is self-oppression arising out of rejection of one's homosexuality that is the greatest enemy of the homosexual person and it is this which ultimately enables societal oppression to continue.

Married Homosexual Men

Coleman (1985) and Ross (1983) examined the situation of homosexual men who are involved in a

heterosexual marriage. Ross cited several studies indicating that a significant percentage of homosexual men have been involved in a relationship with a female (as high as 50% depending on the study). He also noted studies indicating that 1.5% to 2% of married men reported being three or more on the Kinsey sexual orientation scale. Therefore, counsellors should be aware of the possibility that homosexuality may be an issue for men experiencing marital difficulties. Regarding the success in maintaining a monogamous heterosexual relationship, Coleman's (1985) study indicated that very few homosexual men maintain such a relationship over any length of time (e.g., 14 of 31 remained married and 2 out of 31 in the study remained sexually monogamous). He included suggested criteria that need to be present for a marriage to continue. Ross (1985) presented a thorough, extensive, and empirical study of the key issues involving the married homosexual man. His results suggested that the goals of counselling for these clients should include work toward minimizing perceived societal rejection and anxiety about homosexuality as well as the reconceptualization of homosexuality as a normal variation. He warned that acceptance of homosexuality within marriage would likely lead ultimately to a termination of the marriage.

Relationships

McWhirter and Mattison (1984) studied 156 male couples to examine the nature of male relationships. On the basis of their results they identified the developmental process, stages, and tasks in male relationships. This work addressed some of the unique and not so unique issues involved in male relationships and provides helpful insights for counsellors. Clark (1977), a clinical psychologist, provided a guide for loving and relating to gay persons that has proved to be of great assistance to homosexual persons and to those close to them (parents, partners, children, and professionals). Fairchild and Hayward (1979), themselves parents of gay children, produced a resource that has been particularly helpful to gay parents.

Religious Issues

Religion has taken strong positions regarding homosexuality and is generally opposed to it. Homosexual persons are frequently troubled over the conflict between their sexual identity and their love for and participation in the church. An extensive literature on the issues has accumulated. A number of authors (Nelson, 1978, 1982; Boswell, 1980; McNaught, 1981) have produced material that attempts to deal with homosexuality in a positive manner.

Sexual Difficulties

Masters and Johnson (1979) noted that homosexual men were reluctant to seek help for sexual dysfunctions because of fear of the health professional's rejection of them, fear of treatment failure, or fear of social exposure. They described the major problems of the homosexual male as primary impotence (inability to attain and retain a full erection in masturbation, partner manipulation, or fellatio), and secondary impotence (current inability to respond effectively to one of these three forms of stimulation where there had been previous success). They suggested that failure to resolve these problems may cause men to withdraw from social and sexual interaction. They noted that ejaculatory incompetence has not been presented at the Institute, but indicated it would be treated in the same way as in heterosexuals because it could lead to performance fears and secondary impotence. Reece (1985) reported on research in group treatment of male homosexual sexual dysfunctions (general sexual anxiety, lack of desire, erectile difficulty, rapid ejaculation, and inhibited ejaculation) indicating success rates of between 50% and 80%. He found that subjects experiencing success in dealing with their dysfunctions reported significant (60% to 83%) improvement in self-confidence, comfort in intimate situations, and ability to function socially. These

results suggest that dealing with sexual dysfunction (where it exists) is important in attaining good psychological adjustment.

AIDS

Counsellors working with homosexual clients need to be aware of the impact of AIDS as noted in the section on AIDS. A large number of homosexual men are deeply affected by this disease through loss of friends, acquaintance with persons diagnosed as having AIDS or ARC, themselves testing HIV positive, or fear of being HIV positive. Mandel (1986) explored issues around reaction to diagnosis in self and others, problems with health care workers rejecting their concerns, desire of patients to focus on quality of life which some workers view as denial, need for social support, and above all, for hope. He observed:

> It is crucial that we support those with AIDS or ARC in their struggles to maintain hope. We must recognize that, as clinicians, we are not colluding in our patients' defenses, rather we are supporting something vital to the quality, and maybe even to the length, of their lives. (p.84)

Acevedo (1986) stressed the importance of accurate information on AIDS and safe sex, and noted that denial is often manifest by increased sexual activity and

substance abuse. Wirth (1986) contended that men need to internalize the available information about safe sex. He pointed out that mass education alone is insufficient because, "each gay man needs to approach AIDS prevention individually and in psychological depth" (p.134). He suggested that gay men need to redefine the meaning of being gay in order to move away from the immaturities that often go with self-identification as victim including compulsive and self-destructive behaviors.

The preceding literature review traces our evolving understanding of homosexual preference paying particular attention to the theory and research that address the psychological adjustment of homosexual men. Of the many factors which may thwart the development of a gay identity and create serious problems in psychological adjustment for homosexual men, the attempt to conform to a heterosexual life style through marriage is most salient to the present research. As clearly suggested by the literature, a number of psychological variables may motivate or persuade the homosexual man to attempt a heterosexual life style. Ranking high among these variables is expected societal rejection, anticipated societal discrimination, conceptualizing homosexuality as abnormal or pathological, and guilt about homosexual responsiveness. It was the purpose of this thesis to extend our empirical knowledge on this topic.

CHAPTER 3

METHODOLOGY

Hypotheses

The following hypotheses arise from previous research and theoretical discussion, in particular that of Weinberg and Williams (1974) and Ross (1978, 1983) who explored the relationship between a homosexual person's expected societal rejection on the one hand and his psychological adjustment on the other. These investigators also suggested a number of variables which might affect or reflect the psychological adjustment of homosexual men. The specific variables included in the following hypotheses were selected on the basis of existing literature on homosexual adjustment and homosexual identity formation and on the present investigator's professional experience in counselling male homosexual clients, work with the gay community (AIDS Calgary), and discussions with homosexual men and/or their families.

Four variables thought to motivate homosexual men to conform to the societal expectation of living a heterosexual life style were selected to be tested. Expected societal rejection attempts to measure the

degree of negative attitude one expects to find in family and significant others if his homosexuality becomes known to them. Anticipated societal discrimination attempts to measure the discrimination or rejection one expects to find in the wider social setting and in the work place if his homosexuality were to become known. Conceptualization of homosexuality as normal attempts to measure the degree to which one considers his homosexual preference to be normal or abnormal. Guilt about homosexual behavior attempts to measure the level of guilt experienced after engaging in homoerotic behavior.

For the purpose of the present research, psychological adjustment will be operationally defined in terms of a) eight indicators of positive adjustment: self-acceptance, trust (faith in others), stability of self-concept, openess to family, openess to the public, commitment to homosexual identity, conceptualization of homosexuality as normal, and happiness and b) eleven indicators of maladjustment: depression, fear of a nervous breakdown, loneliness, psychosomatic symptoms, reported alcohol problems, need for therapy, anxiety about one's homosexuality, guilt about one's homosexual behavior, incongruence of sexual self-concept and fantasy, passing, and perceived responsibility for homosexual orientation. The extent to which the first eight variables are present and the last eleven are

absent is taken as indicative of overall level of psychological adjustment.

Hypotheses regarding Expected Societal Rejection

H1 Homosexual males who are married and living with their wives will have expected societal rejection scores which are significantly higher than those of:

a) homosexual males who are separated or divorced, and

b) homosexual males who are single.

H2 Homosexual males who are separated or divorced will have expected societal rejection scores which are significantly higher than those of homosexual males who are single.

H3 Expected societal rejection scores will correlate positively and significantly with measures of:

a) depression,

b) fear of nervous breakdown,

c) loneliness,

d) psychosomatic symptoms,

e) reported alcohol problems,

f) experience in therapy,

g) anxiety about homosexuality,

h) guilt about homosexual behavior,

i) incongruence of self-concept and sexual

fantasy,

j) passing, and

k) responsibility for homosexuality.

H4 Expected societal rejection scores will correlate negatively and significantly with measures of:

a) self-acceptance,

b) faith in others,

c) stability of self-concept,

d) openess to family,

e) openess to public,

f) commitment to homosexual orientation,

g) conceptualization of homosexuality as normal, and

h) happiness.

Hypotheses Regarding Anticipated Discrimination

H5 Homosexual males who are married and living with their wives will have anticipated discrimination scores which are significantly higher than those of:

a) homosexual males who are separated or divorced, and

b) homosexual males who are single.

H6 Homosexual males who are separated or divorced will have anticipated discrimination scores which are significantly higher than those of homosexual

males who are single.

H7 Anticipated discrimination scores will correlate positively and significantly with measures of:

a) depression,

b) fear of nervous breakdown,

c) loneliness,

d) psychosomatic symptoms,

e) reported alcohol problems,

f) experience in therapy,

g) anxiety about homosexuality,

h) guilt about homosexual behavior,

i) incongruence of self-concept and sexual fantasy,

j) passing, and

k) responsibility for homosexuality.

H8 Anticipated discrimination scores will correlate negatively and significantly with measures of:

a) self-acceptance,

b) faith in others,

c) stability of self-concept,

d) openess to family,

e) openess to public,

f) commitment to homosexual orientation,

g) conceptualization of homosexuality as normal, and

h) happiness.

Hypotheses Regarding Conceptualization of Homosexuality as Normal

H9 Homosexual males who are married and living with their wives will have scores on conceptualizing homosexuality as normal that are significantly lower than those of:

a) homosexual males who are separated or divorced, and

b) homosexual males who are single.

H10 Homosexual males who are separated or divorced will have scores on conceptualizing homosexuality as normal that are significantly lower than those of homosexual males who are single.

H11 Conceptualization of homosexuality as normal will correlate negatively and significantly with measures of:

a) depression,

b) fear of nervous breakdown,

c) loneliness,

d) psychosomatic symptoms,

e) reported alcohol problems,

f) experience in therapy,

g) anxiety about homosexuality,

h) guilt about homosexual behavior

i) incongruence of self-concept and sexual

fantasy,

j) passing, and

k) responsibility for one's homosexuality.

H12 Conceptualization of homosexuality as normal will correlate positively and significantly with measures of:

a) self-acceptance,

b) faith in others,

c) stability of self-concept,

d) openess to family,

e) openess to public,

f) commitment to homosexual orientation, and

g) happiness.

Hypotheses Regarding Guilt About Homosexual Behavior

H13 Homosexual males who are married and living with their wives will have homosexual guilt scores which are significantly higher than those of:

a) homosexual males who are separated or divorced, and

b) homosexual males who are single.

H14 Homosexual males who are separated or divorced will have homosexual guilt scores which are significantly higher than those of homosexual males who are single.

H15 Homosexual guilt will correlate positively and significantly with measures of:

a) depression,

b) fear of nervous breakdown,

c) loneliness,

d) psychosomatic symptoms,

e) reported alcohol problems,

f) experience in therapy,

g) anxiety about homosexuality,

h) incongruence of self-concept and sexual fantasy,

i) passing, and

j) responsibility for homosexuality.

H16 Homosexual guilt will correlate negatively and significantly with measures of:

a) self-acceptance,

b) faith in others,

c) stability of self-concept,

d) openess to family,

e) openess to public,

f) commitment to homosexual orientation,

g) conceptualization of homosexuality as normal, and

h) happiness.

Sampling Procedure

The sampling problems encountered in research with homosexual populations are well known (Kinsey, 1948; Bell & Weinberg, 1978; Gonsiorek, 1982). Difficulties arise from the subjects' fear of exposure and the danger of social and economic reprisals should their identity be revealed. Homosexuals tend to be hidden, especially those who are living within a heterosexual marriage. Random sampling of a homosexual population therefore is not possible. Although private interviews have been used to gather data from known homosexuals, many research projects have made use of questionnaires and other instruments that can be widely distributed, self-administered, and returned anonymously (Weinberg & Williams, 1974; Ross, 1978, 1983). The present study was conducted on this basis.

The sample for this study was obtained by contacting homosexual subjects known to the researcher and asking them to complete and return a questionnaire adapted for this study. These same subjects were also asked to pass additional questionnaires on to other homosexual men known to them who might be willing to participate in the study. A total of 142 questionnaires were distributed and 96 were returned for a return rate of 68%. Ten questionnaires were retuned from Winnipeg, 2 from

Saskatoon, 3 from Vancouver, and 81 from Calgary.

For the purpose of this study, the sample was divided into three groups as follows:

1. Homosexual males still married and living with their wives (n=16).

2. Homosexual males who have been separated or divorced from their wives (n=18).

3. Homosexual males who have never married (n=60).

A one-way ANOVA was conducted in order to compare these three groups on the demographic variables--age, education, and occupational status--which might confound the results of hypothesis testing. An F-ratio of 27.06, $p < .001$ was found for age. The large and highly significant differences in age between the groups of subjects who had never married (mean age of 32.2 years) and those who were separated or divorced (mean age of 43.4 years) or currently married (mean age of 46.2 years) indicated the necessity of statistically controlling for age in any comparison of data for the these groups. The average level of education achieved by the respondents in the sample was college or technical school (mean score 3.68) and the mean rank on the Blishen socioeconomic index for occupations in Canada was 50.40.

Four questionnaire items were used to measure homosexual preference. The Kinsey scale was used to measure homosexual orientation and three modifications of

the scale were used to rate homosexual behavior, homosexual attraction, and homosexual fantasy. Two subjects who did not rate at least three (i.e., the homosexual at least as great as the heterosexual) on the orientation scale were not included in data analyses.

The Questionnaire

The questionnaire (included in the appendix) was adapted from one originally developed by the Kinsey Institute and used with 2,347 subjects (Weinberg & Williams, 1974). It set out to measure the nature of the subjects' relationship with the heterosexual and homosexual worlds and their psychological adjustment. Ross (1978, 1983, 1985) used scales and items from this questionnaire in his studies which included the examination of the relationship between perceived societal reaction and psychological adjustment in homosexual males. The greater part of the questionnaire employed in the present study has been used in these earlier projects. It was adapted for this study because it was developed specifically for use with a homosexual male population; it lends itself to the present research topic; it saves time and expense as well as avoiding unnecessary duplication of research effort; and it facilitates a comparison of results from the present

study with those of Weinberg and Williams (1974) and Ross (1978, 1983, 1985). Permission to use the questionnaire in this study was granted by Dr. M. S. Weinberg of the Department of Sociology at Indiana University, Bloomington, Indiana.

Eighteen scales in the original questionnaire have been tested for internal consistency. Weinberg and Williams (1974) computed the alpha coefficient, a generalized form of the Kuder-Richardson formulas 21 and 22 and reported reliabilities of between .60 and .88 for these scales. Ross (1983) carried out a factor analysis (varimax rotation) of the personality-related items of the Weinberg and Williams scales. He noted that "the research instrument, even without the factor analysis to confirm the grouping of items into scales, lends itself, by an analysis in terms of face validity of items individually, to in-depth analysis of attitudes and psychological factors affecting the respondents" (p.170). The computed alpha coefficients and characteristics of the questionnaire items are listed in Table 1.

All items and scales used were taken from the original instrument with the exception of those taken from Ross (1983): sex of partners (Item #13), experienced societal rejection (Item #20), and demographic variables (Items 4, 7, 8, 9, 11). Five items were developed for this research: sexual attraction (Item

Table 1

The Questionnaire

Item	Variable Measured	Alpha Coefficient
1-11	Demographic Data	
12	Sexual orientation	
13	Sex of partners	
14	Sexual attraction	
15	Sexual fantasy	
27,28	Experience of monogamous male sexual relationships	.22
32	Level of homosexual sexual activity	.91
32	Age of first homosexual experience	
33	Time as self-identified homosexual	
16	Extent of worry about AIDS	
17	Sexual behavior change as a result of AIDS	
18	Expected societal reaction as a result of AIDS	
19	Expected societal rejection	.85
21	Openess to the public	.88
22	Openess to family and friends	.70
23-26	Anticipated discrimination	.61
29-31	Heterosexual social involvement	.65
77-79	Homosexual social involvement	.81
34-43	Self-acceptance	.86
44-48 73	Depression	.88

Table 1

The Questionnaire (Continued)

Item	Variable Measured	Alpha Coefficient
49	Fear of a nervous breakdown	
50-54	Faith in others	.63
55,56	Loneliness	.60
57-59 70	Passing	.74
60,61	Commitment to homosexuality	.78
62,63	Conception of homosexuality as normal	.80
64, 68-69	Responsibility for one's homosexuality	
76	Experience in therapy	
80	Importance of traditional values	
81	Homosexuality as violating traditional values	
65-67 71,72	Stability of self-concept	.79
82	Psychosomatic symptoms	.85
82(i)	Alcohol problems	
26	Perceived negative feeling in others	
73	Happiness	
74	Anxiety about homosexuality	
75	Guilt after homosexual sexual behavior	

#14), sexual fantasy (Item #15), frequency of worry about AIDS (Item #16), sexual behavior change as a result of AIDS (Item #17), and expected societal reaction as a result of AIDS (Item #18).

Ethical Approval

Ethical approval of the research project was obtained from the Research Ethics Committee of the Department of Educational Psychology at the University of Calgary. Because of the sensitive nature of the topic considerable care has been taken to maintain rigorous ethical standards both in gathering the data and in reporting the results of the study.

Data Analyses

Hypotheses 1, 2, 5, 6, 9, 10, 13, and 14 were tested using a two-way analysis of variance to determine the proportion of variance in the variable under consideration that could be attributed to a) age, and b) group (i.e., marital status). When marital status was found to contribute significantly but age was found not to contribute significantly to the variance of the variable under consideration, a Scheffé test was conducted to determine the significance of specific

differences between observed group (single, separated/divorced, and married) means. When both marital status and age were found to contribute significantly to the variance of the variable under consideration, adjusted means for groups (single, separated/divorced, and married) controlling for age were calculated and a Scheffé test for the significance of a difference between specific adjusted means was carried out. A .05 level of significance was selected both for the F-ratio of the ANOVAs and for the post hoc Scheffé tests.

Hypotheses 3, 4, 7, 8, 11, 12, 15, and 16 were tested using the Pearson product-moment partial correlation coefficient to determine the direction and the strength of relationships when the effects of age differences are partialled out. A probability level of .05 was used to test the significance of correlation coefficients.

CHAPTER 4

RESULTS OF HYPOTHESES TESTING

The present study set out to determine the relationship between conforming to a heterosexual life style as reflected in marital status, and psychological adjustment in the homosexual male. It examined the relationship between a) four variables thought to motivate homosexual men to live heterosexual life styles (expected societal rejection; anticipated discrimination; conceptualization of homosexuality as abnormal, and guilt about homosexual behavior) and b) attempts to conform to a heterosexual life style as reflected in marital status. It also sought to examine the relationship between the same four variables thought to motivate male homosexuals to live heterosexual lifestyles and a) a set of indicators of psychological maladjustment, and b) a set of indicators of psychological adjustment.

Hypotheses Regarding Expected Societal Rejection

Table 2 presents the ANOVA results for testing Hypotheses 1 and 2. From Table 2 it will be observed that although age is a significant source of variance in measures of expected societal rejection, groups (i.e.,

Table 2

ANOVA on Expected Societal Rejection

Results for Testing Hypotheses 1 and 2 N = 93

Source	S S	df	M S	F	p
Age	432.18	1	432.18	6.798	.011
Groups	260.31	2	130.16	2.047	.135
Explained	692.50	3	230.83	3.631	.016
Residual	5530.69	87	63.57		
Total	6223.19	90	69.15		

Group	N	Mean	s.d.
Married	16	34.3	6.9
Sep./Div.	17	30.7	8.7
Single	58	27.5	8.0

marital status) is not. Accordingly, we must attribute the observed differences between the means of the three groups (see Table 2) to age rather than to marital status. Hence, Hypotheses 1 which predicts that married homosexual men will have expected societal rejection scores that are significantly higher than those of a) separated and divorced and b) single homosexual men is not supported by the data. Moreover, Hypothesis 2 which predicts that separated and divorced homosexual men will have expected societal rejection scores that are significantly higher than those of single homosexual men also fails to gain support from the data. Although the magnitude of the observed means is ordered among the three groups as predicted by H1 and H2, the apparent support which this observation lends to H1 and H2 is unwarranted. The mean level of expected societal rejection for the three groups parallels the mean age of the three groups and, as previously noted, must be attributed to that fact.

Table 3 presents the results for testing Hypothesis 3. The coefficients presented in Table 3 are partial correlation coefficients indicating the relationship between expected societal rejection and each of the listed variables when the variance due to age is partialled out. It will be noted that only 4 of the 11 indicators of psychological maladjustment correlate

Table 3

Correlates of Expected Societal Rejection

Results for Testing Hypothesis 3 N = 88

Variable	r	Sig.
a) Depression	.22	p <.05
b) Fear of nervous breakdown	.11	ns
c) Loneliness	.07	ns
d) Psychosomatic symptoms	.21	p <.05
e) Reported alcohol problems	-.05	ns
f) Experience in therapy	.13	ns
g) Anxiety about homosexuality	.31	p <.01
h) Guilt about homosexual behavior	.15	ns
i) Incongruence of sexual self-concept and sexual fantasy	.08	ns
j) Passing	.44	p <.01
k) Responsibility for homosexuality	.17	ns

positively and significantly with expected societal rejection. Hypothesis 3, therefore, receives very qualified support indicating a limited relationship between expected societal rejection and indicators of maladjustment. The data show that expected societal rejection is positively and significantly correlated with depression, psychosomatic symptoms, anxiety about homosexuality, and passing. A variance interpretation of the two largest correlation coefficients indicates that expected societal rejection, in this sample, accounts for about 10% of the variance in anxiety about homosexuality and about 20% of the variance in passing.

Table 4 presents the results for testing Hypothesis 4. As in Table 3, the coefficients presented in Table 4 are partial correlation coefficients with variance due to age partialled out. It will be noted that 5 of the 8 indicators of psychological adjustment are negatively and significantly correlated with expected societal rejection. Hypothesis 4, thus, is given partial but qualified support. Expected societal rejection does correlate negatively and significantly with some, but not all, indices of psychological adjustment. A variance interpretation of the three largest correlation coefficients indicates that expected societal rejection accounts for about 12% of the variance in conceptualizing homosexuality as abnormal, 12% of the variance in the

Table 4

Correlates of Expected Societal Rejection

Results for Testing Hypothesis 4 N = 88

Variable	r	Sig.
a) Self-acceptance	-.22	p <.05
b) Faith in others	-.13	ns
c) Stability of self-concept	-.16	ns
d) Openess to family	-.35	p <.01
e) Openess to the public	-.52	p <.01
f) Commitment to orientation	-.21	p <.05
g) Conceptualization of homosexuality as normal	-.34	p <.01
h) Happiness	-.11	ns

lack of openess to family, and about 27% of the variance in lack of openess to the public.

Hypotheses Regarding Anticipated Discrimination

Table 5 presents the ANOVA results for testing Hypotheses 5 and 6. It will be noted that age contributes significantly to the observed means of the three groups. In other words, a significant portion of the variance in the observed means of the three groups may be attributed to age alone. For this reason adjusted means for the three groups have been calculated and are presented in Table 5. For our purposes, these adjusted means may be interpreted as the means that we would "statistically expect" to get if the three groups were in fact equivalent with respect to age. A Scheffe test for the significance of a difference between the adjusted means indicates that the adjusted mean for the married group is significantly greater than that for the other two groups. The difference between the adjusted means of the separated/divorced group and the single group is not significant. We conclude, therefore, that Hypothesis 5 is supported by the data but Hypothesis 6 is not. Homosexual males who are married and living with their wives do have anticipated discrimination scores which are significantly higher than those of a) homosexual males

Table 5

ANOVA on Anticipated Discrimination

Results for Testing Hypothesis 5 and 6 N = 93

Source	S S	df	M S	F	p
Age	37.91	1	37.91	5.34	.023
Groups	79.72	2	39.86	5.62	.005
Explained	117.64	3	39.21	5.53	.002
Residual	638.72	90	7.10		
Total	756.35	93	8.13		

Group	N	Mean	s.d.	Adj. Mean
Married	16	7.7	2.4	7.6
Sep./Div.	18	5.2	2.4	5.1
Single	60	4.7	2.8	4.7

Note: Since both age and group were significant variables, a Scheffé test was performed on the adjusted means. The adjusted mean for the married group differed significantly at the .05 level from that of the separated and divorced groups.

who are separated or divorced, and b) homosexual males who are single. Homosexual males who are separated or divorced, however, do not have anticipated discrimination scores which are significantly higher than those of homosexual males who are single.

Table 6 presents the results for testing Hypothesis 7. The coefficients presented in Table 6 are partial correlation coefficients with variance due to age partialled out. It will be noted that 7 of the 11 indicators of psychological maladjustment correlate positively and significantly with anticipated discrimination. Hypothesis 7, thus, receives partial but qualified support. The data indicate that anticipated discrimination is positively and significantly correlated with depression, loneliness, psychosomatic symptoms, experience in therapy, anxiety about homosexuality, guilt about homosexual behavior, and passing. A variance interpretation of the five largest correlation coefficients indicates that anticipated discrimination accounts for about 11% of the variance in depression, 10% of the variance in psychosomatic symptoms, 24% of the variance in experience in therapy, 28% of the variance in anxiety about homosexuality, 10% of the variance in guilt about homosexual behavior, and 31% of the variance in passing.

Table 7 presents the results for testing Hypothesis

Table 6

Correlates of Anticipated Discrimination

Results for Testing Hypothesis 7 N = 91

Variable	r	Sig.
a) Depression	.33	p <.01
b) Fear of a nervous breakdown	.08	ns
c) Loneliness	.20	p <.05
d) Psychosomatic symptoms	.31	p <.01
e) Reported alcohol problems	-.14	ns
f) Experience in therapy	.49	p <.01
g) Anxiety about homosexuality	.53	p <.01
h) Guilt about homosexual behavior	.32	p <.01
i) Incongruence of sexual self-concept and fantasy	.14	ns
j) Passing	.56	p <.01
k) Responsibility for one's homosexuality	.12	ns

Table 7

Correlates of Anticipated Discrimination

Results for Testing Hypothesis 8 N = 91

Variable	r	Sig.
a) Self-acceptance	-.23	p <.05
b) Faith in others	-.40	p <.01
c) Stability of self-concept	-.19	p <.05
d) Openess to family	-.55	p <.01
e) Openess to the public	-.59	p <.01
f) Commitment to homosexual orientation	-.49	p <.01
g) Conceptualization of homosexuality as normal	-.37	p <.01
h) Happiness	-.28	p <.01

8. As in Table 6, the coefficients presented in Table 7 are partial correlation coefficients with variance due to age partialled out. It will be noted that all eight of the indicators of psychological adjustment are negatively and significantly correlated with anticipated discrimination. The data indicate that anticipated discrimination correlates negatively with self-acceptance, faith in others, stability of self-concept, openess to family, openess to the public, commitment to homosexual orientation, conceptualization of homosexuality as normal, and happiness. Hypothesis 8 is supported. A variance interpretation of the five largest correlation coefficients indicates that anticipated discrimination accounts for about 16% of the variance in lack of faith in others, 30% of the of the variance in lack of openess to family, 35% of the variance in lack of openess to the public, 24% of the variance in lack of commitment to homosexual orientation, and 14% of the variance in conceptualizing homosexuality as abnormal.

Hypotheses Regarding Conceptualizing Homosexuality As Normal

Table 8 presents the ANOVA results for testing Hypotheses 9 and 10. From Table 8 it will be observed that although groups (i.e., marital status) are a

Table 8

ANOVA on Conceptualizing Homosexuality as Normal Results for Testing Hypothesis 9 and 10 N = 93

Source	S S	df	M S	F	p
Age	1.06	1	1.06	0.60	.445
Groups	34.11	2	17.08	9.45	.000
Explained	35.18	3	11.70	6.49	.000
Residual	162.52	90	1.81		
Total	197.70	93	2.13		

Group	N	Mean	s.d.
Married	16	8.1	1.9
Sep./Div.	18	9.7	.7
Single	60	9.6	1.3

Note: Since age was not a significant variable, a Scheffé test was performed on the observed means. The observed mean for the married group differed significantly at the .05 level from that of the separated/divorced and single groups.

significant source of variance in measures of conceptualizing homosexuality as normal, age is not. A Scheffe test for the significance of a difference between observed means indicates that the observed mean for the married group is significantly lower than that for the other two groups. The difference between the observed means of the separated/divorced and the single group is not significant. We conclude, therefore, that Hypothesis 9 is supported by the data but that Hypothesis 10 is not. Homosexual males who are married and living with their wives do have conceptualization of homosexuality as normal scores that are significantly lower that those of a) homosexual males who are separated and divorced and b) homosexual males who are single. Homosexual males who are separated or divorced, however, do not have conceptualization of homosexuality as normal scores which are significantly lower than those of homosexual males who are single. This finding suggests that married homosexual men conceptualize homosexuality as less normal than do separated/divorced and single respondents. Separated/divorced respondents, however, do not conceptualize homosexuality to be less normal than do the single respondents.

Table 9 presents the results for testing hypothesis 11. The coefficients presented in Table 9 are partial correlation coefficients indicating the relationship

Table 9

Correlates of Conceptualizing Homosexuality as Normal

Results for Testing Hypothesis 11 N = 91

Variable	r	Sig.
a) Depression	-.26	p <.05
b) Fear of a nervous breakdown	.06	ns
c) Loneliness	-.28	p <.01
d) Psychosomatic symptoms	.06	ns
e) Reported alcohol problems	-.02	ns
f) Experience in therapy	-.04	ns
g) Anxiety about homosexuality	-.64	p <.01
h) Guilt about homosexual behavior	-.45	p <.01
i) Incongruence of self-concept and sexual fantasy	-.34	p <.01
j) Passing	-.43	p <.01
k) Responsibility for one's homosexuality	-.27	p <.01

between conceptualization of homosexuality as normal and each of the listed variables when the variance due to age is partialled out. It will be noted that 7 of the 11 indicators of psychological maladjustment correlate negatively and significantly with conceptualization of homosexuality as normal. Hypothesis 11 receives partial but qualified support. The data indicate that conceptualization of homosexuality as normal is negatively and significantly correlated with depression, loneliness, anxiety about homosexuality, guilt about homosexual behavior, incongruence of self-concept and sexual fantasy, passing, and responsibility for one's homosexuality. A variance interpretation of the four largest correlation coefficients indicates that conceptualization of homosexuality as abnormal accounts for about 41% of the variance in anxiety about homosexuality, 20% of the variance in guilt about homosexual behavior, 12% of the variance in incongruence between sexual self-concept and sexual fantasy, and 18% of the variance in passing.

Table 10 presents the results for testing Hypothesis 12. As in Table 9, the coefficients presented in Table 10 are partial correlation coefficients with variance due to age partialled out. It will be noted that 6 of the 7 indicators of psychological adjustment are positively and significantly correlated with conceptualization of

Table 10

Correlates of Conceptualizing Homosexuality as Normal

Results for Testing Hypothesis 12 N = 91

Variable	r	Sig.
a) Self-acceptance	.58	p <.01
b) Faith in others	.21	p <.05
c) Stability of self-concept	.07	ns
d) Openess to family	.50	p <.01
e) Openess to the public	.41	p <.01
f) Commitment to homosexual orientation	.55	p <.01
g) Happiness	.20	p <.05

homosexuality as normal. There is a positive and significant correlation between the conceptualization of homosexuality as normal and self-acceptance, faith in others, stability of self-concept, openess to family, openess to the public, commitment to homosexual orientation, and happiness. Hypothesis 12, thus, is given partial but qualified support. A variance interpretation of the four largest coefficients indicates that conceptualization of homosexuality as normal accounts for about 34% of the variance in self-acceptance, 25% of the variance in openess to family, 17% of the variance in openess to the public, and 30% of the variance in commitment to a homosexual orientation.

Hypotheses Regarding Guilt About Homosexual Behavior

Table 11 presents the ANOVA results for testing Hypotheses 13 and 14. From Table 11 it will be observed that although groups (i.e., marital status) are a significant source of variance in measures of conceptualizing homosexuality as normal, age is not. A Scheffe test for the significance of a difference between observed means indicates that the observed mean for the married group is significantly higher than that for the other two groups. The difference between the observed means of the separated/divorced and the single

Table 11

ANOVA on Guilt About Homosexual Behavior

Results for Testing Hypotheses 13 and 14 N = 93

Source	S S	df	M S	F	p
Age	0.21	1	0.21	0.116	.734
Groups	46.71	2	23.36	12.824	.000
Explained	46.93	3	15.64	8.588	.000
Residual	163.93	90	1.82		
Total	210.85	93	2.27		

Group	N	Mean	s.d.
Married	16	2.1	2.9
Sep./Div.	18	.2	.4
Single	60	.6	.9

Note: Since age was not a significant variable, a Scheffé test was performed on the observed means. The observed mean for the married group differed significantly at the .05 level from that of the separated/divorced and single groups.

group is not significant. We conclude, therefore, that Hypothesis 13 is supported by the data but that Hypothesis 14 is not. Homosexual males who are married and living with their wives do have guilt about homosexual behavior that is significantly greater than those of a) homosexual males who are separated and divorced and b) homosexual males who are single. Homosexual males who are separated or divorced, however, do not have guilt about homosexual behavior which is significantly greater than that of homosexual males who are single.

Table 12 presents the results for testing hypothesis 15. The coefficients presented in Table 12 are partial correlation coefficients indicating the relationship between guilt about homosexual behavior and each of the listed variables when the variance due to age is partialled out. It will be noted that 8 of the 11 indicators of psychological maladjustment correlate negatively and significantly with guilt about homosexual behavior. Hypothesis 15 receives partial but qualified support. The data indicate that guilt about homosexual behavior is positively and significantly correlated with depression, loneliness, psychosomatic symptoms, experience in therapy, anxiety about homosexuality, incongruence between self-concept and sexual fantasy, passing, and responsibility for one's homosexuality. A

Table 12

Correlates of Guilt about Homosexual Behavior

Results for Testing Hypothesis 15 N = 91

Variable	r	Sig.
a) Depression	.25	p <.01
b) Fear of a nervous breakdown	-.07	ns
c) Loneliness	.19	p <.05
d) Psychosomatic symptoms	.20	p <.05
e) Reported alcohol problems	-.15	ns
f) Experience in therapy	.20	p <.05
g) Anxiety about homosexuality	.54	p <.01
h) Incongruence of sexual self-concept and fantasy	.63	p <.01
j) Passing	.19	p <.05
k) Responsibility for one's homosexuality	.18	p <.05

variance interpretation of the two largest correlation coefficients indicates that guilt about homosexual behavior accounts for about 29% of the variance in anxiety about homosexuality and 40% of the variance in incongruence between self-concept and sexual fantasy.

Table 13 presents the results for testing Hypothesis 16. As in Table 12, the coefficients presented in Table 13 are partial correlation coefficients with variance due to age partialled out. It will be noted that 7 of the 8 indicators of psychological adjustment are negatively and significantly correlated with guilt about homosexual behavior. Hypothesis 11, thus, is given partial but qualified support. A variance interpretation of the six largest coefficients indicates guilt about homosexual behavior accounts for about 20% of the variance in lack of self-acceptance, 11% of the variance in lack of openess to family, 12% of the variance in lack of openess to the public, 20% of the variance in lack of commitment to homosexual orientation, 20% of the variance in conceptualizing homosexuality as abnormal, and 16% of the variance in unhappiness.

Table 13

Correlates of Guilt About Homosexual Behavior

Results for Testing Hypothesis 16 N = 91

Variable	r	Sig.
a) Self-acceptance	-.45	p <.01
b) Faith in others	-.07	ns
c) Stability of self-concept	-.19	p <.05
d) Openess to family	-.33	p <.01
e) Openess to the public	-.35	p <.01
f) Commitment to homosexual orientation	-.45	p <.01
g) Conceptualization of homosexuality as normal	-.45	p <.01
h) Happiness	-.40	p <.01

CHAPTER 5

ANCILLARY FINDINGS

In addition to meeting the requirements of à priori hypotheses testing, the data collected for this study have produced a number of ancillary findings. The more salient and significant of these findings--those which add to our understanding of the topic or which suggest novel hypotheses for future testing--are reported in this chapter.

Findings Regarding the Psychological Adjustment of Homosexual Men

The preceding chapter reports the results of hypotheses testing which compares the married, separated/divorced, and single groups on four variables thought to motivate homosexual men to attempt living a heterosexual life style (expected societal rejection, anticipated discrimination, conceptualization of homosexuality as abnormal, and guilt about homosexual behavior). This section presents further data comparing the married, separated/divorced, and single groups on a number of other variables indicative of psychological adjustment/maladjustment which appear most clearly

related to or affected by marital status.

Tables 14 through 21 portray a similar and remarkably consistent picture. Married homosexual men differ significantly from separated/divorced and single homosexual men in the following ways:

1. They experience greater anxiety about their homosexual orientation. (Table 14)
2. Their sexual fantasies are more incongruent with their sexual orientation. (Table 15)
3. They are less open to their families. (Table 16)
4. They are less open publicly. (Table 17)
5. They are more committed to passing. (Table 18)
6. They are less committed to homosexuality. (Table 19)
7. They experience greater depression (Table 20) and
8. They rate themselves as significantly less happy. (Table 21)

The separated/divorced group did not differ from the single group on any of these eight indices of adjustment. This was a totally unexpected finding. It would appear that the separated/divorced homosexual men have resolved identity issues at a level equal to that of homosexual men who never marry. Their psychological adjustment is seen to be significantly better than that of the married homosexual men in this sample.

Table 14

ANOVA on Anxiety About Homosexuality N = 94

Source	S S	df	M S	F	p
Age	4.84	1	4.84	7.046	.009
Groups	9.91	2	4.96	7.219	.001
Explained	14.75	3	4.92	7.162	.000
Residual	61.80	90	.69		
Total	76.55	93	.82		

Group	N	Mean	s.d.	Adj. Mean
Married	16	1.6	.7	1.5
Sep./Div.	18	.5	.6	.4
Single	60	.7	.9	.8

Note: A Scheffé test was performed on adjusted means and the married group was found to differ significantly from the separated/divorced and the single groups. The separated/divorced and single groups did not differ significantly from one another.

Table 15

ANOVA on Incongruence of Self-concept and Sexual Fantasy

N = 94

Source	S S	df	M S	F	p
Age	1.33	1	1.34	.649	.422
Groups	40.86	2	20.43	9.923	.000
Explained	42.20	3	14.07	6.832	.000
Residual	185.29	90	2.06		
Total	227.49	93	2.45		

Group	N	Mean	s.d.
Married	16	1.9	2.2
Sep./Div.	18	.1	.4
Single	60	.3	1.3

Note: A Scheffé test was performed on the observed means and the married group was found to differ significantly from the separated/divorced and single groups. The separated/divorced and single groups, however, did not differ significantly from one another.

Table 16

ANOVA on Openess to Family N = 94

Source	S S	df	M S	F	p
Age	799.49	1	799.49	26.567	.000
Groups	831.22	2	415.61	13.811	.000
Explained	1630.72	3	543.57	18.036	.000
Residual	2708.39	90	30.09		
Total	4339.11	93	46.66		

Group	N	Mean	s.d.	Adj. Mean
Married	16	3.5	4.0	5.8
Sep./Div.	18	14.1	5.6	15.7
Single	60	13.1	6.2	12.0

Note: A Scheffé test was performed on the adjusted means and the married group was found to differ significantly from the separated/divorced and single groups. The separated/divorced and single groups, however, did not differ significantly from one another.

Table 17

ANOVA on Openess to Public N = 94

Source	S S	df	M S	F	p
Age	2393.67	1	2393.67	11.190	0.001
Groups	3846.87	2	1923.43	8.991	0.000
Explained	6240.53	3	2080.18	9.724	0.000
Residual	19252.63	90	213.92		
Total	25493.16	93	274.120		

Group	N	Mean	s.d.	Adj. Mean
Married	16	6.3	5.1	8.2
Sep./Div.	18	25.0	13.8	27.2
Single	60	27.9	16.4	26.9

Note: A Scheffé test was performed on the adjusted means and the married group was found to differ significantly from the separated/divorced and single groups. The separated/divorced group did not differ significantly from the single group.

Table 18

ANOVA on Passing N = 94

Source	S S	df	M S	F	p
Age	110.596	1	110.596	6.596	.012
Groups	156.233	2	78.117	4.659	.012
Explained	266.83	3	88.94	5.304	.002
Residual	1509.09	90	16.77		
Total	1775.91	93	19.1		

Group	N	Mean	s.d.	Adj. Mean
Married	16	14.8	4.1	14.3
Sep./Div.	18	10.8	3.7	10.5
Single	60	10.3	4.2	10.5

Note: A Scheffé test was performed on the adjusted means and the married group was found to differ significantly from the separated/divorced and single groups. The separated/divorced and single groups, however, did not differ significantly from one another.

Table 19

ANOVA on Commitment to Homosexual Orientation N = 94

Source	S S	df	M S	F	p
Age	35.89	1	35.89	6.512	.012
Groups	75.88	2	37.94	6.883	.002
Explained	111.77	3	37.26	6.759	.000
Residual	496.06	90	5.51		
Total	607.83	93	6.54		

Group	N	Mean	s.d.	Adj. Mean
Married	16	4.7	2.3	5.0
Sep./Div.	18	7.6	2.5	7.8
Single	60	7.5	2.3	7.4

Note: A Scheffé test was performed on the adjusted means and the married group was found to differ significantly from the separated/divorced and single groups. The separated/divorced and single groups, however, did not differ significantly from one another.

Table 20

ANOVA on Depression N = 94

Source	S S	df	M S	F	p
Age	.00	1	.00	.00	.992
Groups	141.02	2	70.51	3.75	.027
Explained	141.02	3	47.01	2.50	.065
Residual	1694.09	90	18.82		
Total	1835.11	93	19.73		

Group	N	Mean	s.d.
Married	16	14.1	5.5
Sep./Div.	18	10.3	3.8
Single	60	11.4	4.1

Note. A Scheffé test was performed on the observed means and the married group was found to differ significantly from the separated and single groups. The separated/divorced and single groups, however, did not differ significantly from one another.

Table 21

ANOVA on Happiness N = 94

Source	S S	df	M S	F	p
Age	0.00	1	0.00	0.000	.997
Groups	5.31	2	2.66	6.861	.002
Explained	5.31	3	1.77	4.574	.005
Residual	34.83	90	.39		
Total	40.14	93	.43		

Group	N	Mean	s.d.
Married	16	2.6	.8
Sep./Div.	18	3.3	.5
Single	60	3.2	.6

Note: A Scheffé test was performed on the observed means and the married group was found to differ significantly from the separated/divorced groups. The separated/divorced group, however, did not differ significantly from the single group.

Findings Regarding AIDS

Since the AIDS epidemic appears to have a powerful impact on the gay community and especially on the psychological adjustment of homosexual men, three items regarding the threat of AIDS were included in the research questionnaire (Questions 16, 17, and 18). These questions were designed to assess the degree to which homosexual men worry about AIDS, the ways in which they have modified their sexual behavior as a result of AIDS, and how they perceive societal attitudes changing toward homosexuals as a result of AIDS.

Table 22 presents the frequency distribution of response to Item 16: "How frequently do you worry about AIDS?" The data indicate that worry about AIDS is pervasive with 60% of the sample indicating that they worry about AIDS "often" to "most of the time". About 25% of the married group "never" or "seldom" worry about AIDS. The single group appears to experience the greatest degree of worry.

Table 23 presents the frequency distribution for Item 17: "How has the fear of AIDS changed your sexual behavior?" A remarkably low 6% of the sample indicate that AIDS has made "no difference" to their sexual behavior. The most frequent response was "safe sex only", with about 54% of the sample indicating this

Table 22

Frequency Distribution of Responses to Item 16: "How frequently do you worry about AIDS?"

Response	f(m) n = 16	f(s/d) n = 18	f(s) n = 60	f(T) n = 94
Never	1 (6)	1 (6)	1 (2)	3 (3)
Seldom	3 (19)	2 (11)	2 (3)	7 (7)
Sometimes	4 (25)	6 (33)	18 (30)	28 (30)
Often	4 (25)	3 (17)	13 (22)	20 (21)
Very Often	1 (6)	4 (22)	14 (23)	19 (20)
Most of the time	3 (19)	2 (11)	12 (20)	17 (18)

Note: Numbers in parentheses are percentages.

Table 23

Frequency Distribution of Responses to Item 17:

"Has fear of AIDS changed your sexual behavior?"

Response	f(m) n = 16	f(s/d) n = 18	f(s) n = 60	f(T) n = 94
Made no difference	1 (6)	1 (6)	4 (7)	6 (6)
Reduced number of sexual partners	7 (44)	6 (33)	17 (28)	30 (32)
Practise monogamous sex	1 (6)	6 (33)	17 (28)	24 (25)
Use only safe sex	7 (44)	9 (53)	35 (58)	51 (54)
Stopped having sexual relations	2 (12)	0 (0)	5 (8)	7 (7)

Note: Numbers in parentheses are percentages.

Table 24

Frequency Distribution of Responses to Item 18: "How do you think the presence of AIDS has affected society's reaction to homosexuals?"

Response	f(m) n = 16	f(s/d) n = 18	f(s) n = 60	f(T) n = 94
Much increased acceptance	0 (0)	0 (0)	1 (2)	1 (1)
Some increased acceptance	3 (19)	2 (11)	10 (17)	15 (16)
No difference	1 (6)	3 (17)	5 (8)	9 (10)
Some greater intolerance	6 (38)	11 (61)	31 (52)	48 (51)
Much greater intolerance	6 (38)	2 (11)	13 (22)	21 (22)

Note: Numbers in parentheses are percentages.

response to the AIDS threat. About one-third of the sample indicate that they have reduced the number of their sexual partners and about one-quarter have restricted themselves to a monogamous sexual relationship. A substantial 12% of the married men and 8% of the single men have simply stopped having sexual relationships with others.

Table 24 presents the frequency distribution for Item 18: "How do you think the presence of AIDS has affected society's reaction to homosexuals?" About 17% of the sample perceive an increase in societal acceptance as a result of the AIDS crisis. About 10% perceive no difference in societal acceptance, and about 73% of the sample perceive greater societal intolerance of homosexual persons as a result of AIDS. The distribution of responses to this item is not markedly different for the three groups.

Respondents' Comments

The spontaneous comments offered by respondents often illuminate the issues and concerns that are crucial from their perspective. Thirty-six respondents (i.e., 39%) offered such comments. Comments were made by 25 single (S) respondents, 5 separated/divorced (S/D)

respondents, and 6 married (M) respondents. Table 25 presents a frequency distribution of the themes of these comments. Actual comments illustrative of these themes are also presented for the reader's perusal.

Comments Affirming Adjustment and Normality

I believe I'm basically a well adjusted human being, whose sexual partners are predominantly male; however, my dreams and goals are similar to those of other males with similar education and financial resources. (S/D)

Any `life-style' is difficult. You have to feel good about yourself and not spend too much time with the damn label but rather with who you are `as a person'. (S/D)

I'm a generally happy character, but I do have my flaws and problems... However, I'm actively trying to overcome these problems and to be a better and happier person. (M)

I lead a very happy life as a gay man and my family is very supportive. (S)

I feel extremely comfortable being a homosexual. (S)

I count myself fortunate to have an assortment of friends, excellent health, a good job, a comfortable home, and a wide range of interests to occupy my time.

I am a mature, healthy, hardworking, everyday normal

Table 25

Themes and Frequencies of Respondents' Comments

Theme	f
Affirmation of adjustment and normality	8
Alcohol problems and AA association	6
Criticism of the questionnaire	6
Difficulty accepting homosexuality	6
AIDS and ARC concerns	4
Concern over negative societal attitudes	2
Need for social and personal support	2
Unhappiness	2
Expression of gay pride	1
Regret of delay in not coming out sooner	1
Marriage	1

teenager who plans to get on with my life and to do my own thing, trying to hurt as few people as possible in doing so. What more can you do? (S)

I consider myself to be an individual who has potential for achievement. I also consider myself an asset to society. I do not accept my homosexuality as a disability and I refuse to let others treat it as such. (S)

Comments Regarding Problems with Alcohol and Association with AA

I am a member of alcoholics anonymous...Because of this twelve step program I was able to come out of the closet and be free of the great homophobia I had. (S/D)

Comments About the Questionnaire

Feeling questions were poor and elicited stereotype answers....It does not distinguish clearly between homosexual orientation (urges) and homosexual behavior. (M)

A lot of questions, make it sound as if I'm depressed, nervous, or whatever because of my homosexuality. A lot of my problems are caused by other situations, such as work, family problems etc. (S)

Questionnaire is weighted to give a desired (and obvious) conclusion. Factors outside of homosexuality are not considered. (S)

Objection to being described as a homosexual. 'Do not insult my humanity (which is most important to me) by displacing my membership in humanity by my sexual orientation'. (S)

I hope this survey will be given to heterosexuals also, to show that not just gay people are all degenerates. (S)

Comments Indicating Difficulty Accepting Homosexuality

I believe I had a much more difficult time accepting my homosexuality during the years after I came out. I was very hard on myself and at times I wished I was straight. I dealt with this negative thinking and today I am happy and accepting of my homosexuality. This early period of negative thoughts lasted one or two years. (S)

I was always worried that my 'discovery' would cause shame for my family whom I loved; who respected me so much; and who had so much pride in me. I am OK now but feel that I 'raised myself' as society offered few examples that I could follow while accepting my homosexuality. I basically lived a straight but celibate life until I was thirty. (S)

My comfort with my sexuality has been only in the last few years after prolonged treatment by a psychiatrist. (S)

I envy the freedom of young gays today...I sometimes feel that I have not lived who I really am--a great sadness for me. (M)

As a committed Christian I am called to resist my homosexual urges and I do this...with the help of Homosexuals Anonymous in which I am active in helping other Christian homosexuals overcome their homosexual temptations. (M)

Its not that I want desperately to be heterosexual. I just feel that life would be easier at this point in time, same as its still easier to be a man than a woman in this world. (e.g., heterosexuals don't get a hard time because of their sexual preference; also a family appeals to me). (S)

Comments Raising Concerns about AIDS and ARC

I cannot even have occasional sex...because of AIDS. (M)

The only thing that bothers me about being gay is the threat of catching AIDS. (S)

AIDS has caused changes in my sexual attitudes (and frequency), and is always a factor. Since I know I am

seropositive, I tend to worry about the possibility of developing AIDS and that affects the way I think about the future. It is difficult to make long-range plans, e.g., saving for retirement. Why bother? (S)

ARC has destroyed my life. (M)

Comments Expressing Concern Over Negative Societal Attitudes

I am a homosexual but not gay. One is a condition that is internal. The other is social. Most people I know but don't work with know that I am homosexual, but I still live in a closet out of fear of the power of ignorant biases. (S)

I don't think heterosexuals in general and especially those I deal with on a daily basis are comfortable with the idea of homosexuality. (S)

Comments Expressing a Need for Social and Personal Support

I would be very much happier if I was presently in a relationship that brought both of us closer to God and personal growth. (S)

We need role-models and a better understanding of one another. (S)

Comments Disclosing Unhappiness

I am lonely and live a life of a front. There is no way things can change. I will never have what I want and this makes life a life sentence...I get some satisfaction from being a good father but inside I am empty. (M)

Anxiety, depression, and despair occurred in my life during a specific period associated with job stress. (M)

Comments Expressing Gay Pride

I am a proud gay man and in no way would I want to change that fact. (M)

Comments Expressing Regret of Delay in Coming Out

Sometimes I wish I had not stopped having homosexual relationships at 18. (S/D)

Comments Regarding Marriage

No regret over marriage and family but regret over the 'heartache our families are involved in'. Wish I had come out sooner to avoid the pain for family. (S/D)

CHAPTER 6

DISCUSSION

The purpose of this study was to examine the relationship between a) attempts to conform to a heterosexual life style as reflected in marital status, and b) psychological adjustment for a sample of homosexual men. The present chapter discusses the results of the hypotheses testing, the ancillary findings generated by the study, and the voluntary comments of the respondents. The limitations of the study and its implications for counselling practice are also discussed. The chapter concludes with some suggestions for further research on the topic.

Discussion of Results of Hypotheses Testing

Chapter 4 presented the results of hypotheses testing. The ANOVA on expected societal rejection (see Table 2) failed to support the first hypothesis. The observed differences between the married, separated/divorced, and single groups on expected societal rejection were not significant. Although this finding is inconsistent with previous research, it must be noted that unlike the original Weinberg and Williams

questionnaire, the present study separated expected and experienced societal reaction. The rather small size of the present sample may also account for the difference in findings.

Although the expected societal rejection scores were not significantly different between groups they were significantly related to age. The greater expectation of societal rejection by those who are older may reflect attitudes learned in an earlier more repressive social context. Younger men may experience an increased sense of self-acceptance and less internalized homophobia as a result of their early awareness of gay positive messages now in the society and the presence of self-affirming gay men in their environment. As a result, younger homosexual men may not develop the negative expectations of their older counterparts. If societal change has affected the difference between the younger and older homosexual men in this way then there is some support for Weinberg and Williams' (1974) original hypothesis that the social milieu does affect adjustment. However that may be, if expected societal rejection does contribute significantly to older homosexual men's psychological maladjustment (anxiety about their homosexuality, their decision to pass as heterosexual, their conceptualization of homosexuality as abnormal, and their lack of openess to family and the public), it is an important variable in

the experience of this segment of the homosexual population.

The ANOVA on anticipated discrimination (Table 5) shows clearly that those who attempt most to conform to a heterosexual life style through marriage most anticipate discrimination from the wider society (i.e., problems at work, termination of social relationships, harassment, and disgust) should their homosexuality become known. Anticipated discrimination appears to be a salient factor persuading homosexual men to attempt to conform to a heterosexual life style. Separated/divorced and single respondents do not differ significantly from each other on anticipated discrimination. It appears that when homosexual men accept their homosexuality and strive to live authentically, they find either that there is less discrimination than they had feared or that such discrimination is of less consequence to them.

The ANOVA on conceptualization of homosexuality as normal (Table 8) indicates that those who most attempt to conform to a heterosexual life style also conceptualize their homosexuality as abnormal. Separated/divorced and single men are more likely to view their homosexuality as normal. Apparently normalization plays a significant role in the development of the homosexual male's ability to accept his sexual preference and enables him to reduce his attempts to conform to a heterosexual life style.

This finding supports the results obtained by Weinberg and Williams (1974) who suggested that such normalization may accompany increased participation in the gay world and the decision to be gay. It is possible that there is a reciprocal relationship between the two variables.

The ANOVA on guilt about homosexual behavior (Table 11) indicates that significantly greater guilt is experienced by those who attempt to conform to a heterosexual life style. Separated/divorced and single men apparently experience far less guilt about their homosexual responsiveness than do married men. It appears that guilt, like conceptualization of homosexuality as abnormal plays a significant role in dissuading the homosexual male from accepting his sexual preference and in persuading him to conform to a heterosexual life style.

The results of the correlational analyses in Chapter 4 show a comparatively small and weak relationship between expected societal rejection and psychological adjustment with only 5 of 18 indicators of adjustment/maladjustment reaching significance at $<.01$ level. Though E.S.R. does contribute to the variance in indicators of maladjustment it does not appear to have anywhere near the impact of anticipated discrimination, conceptualizing homosexuality as abnormal, and guilt about homosexual responsiveness.

The correlational analyses of anticipated discrimination (Tables 6 and 7) show a highly significant relationship between anticipated discrimination and most indicators of psychological adjustment/maladjustment. It appears that if a homosexual man anticipates, from society at large, a severely punitive response to being identified as homosexual, he will repress or at least hide any evidence of his sexual preference, and that this deception is achieved at considerable cost in terms of psychological adjustment. These results confirm the main contention of Ross (1978) that the expectation of societal hostility significantly relates to psychological maladjustment and that it is this rather than an inherent pathology that accounts for the difficulties experienced by many homosexual men.

The correlational analyses of conceptualization of homosexuality as normal (Tables 9 and 10) show that this variable correlates significantly with 13 indicators of psychological adjustment/maladjustment. It correlates strongly with reduced anxiety about homosexuality, reduced guilt about homosexual behavior, and reduced passing. Moreover, it appears to contribute more to self-acceptance and commitment to homosexual orientation than any other variable tested in this study.

Also relevant to this discussion is the finding that the largest number of voluntary comments by respondents

(Table 25) attest to a strong concern to affirm and normalize their homosexuality and that the second largest group of comments deal with difficulty in accepting a homosexual orientation. Since, married men conceptualize homosexuality as normal significantly less than separated/ divorced, or single respondents it appears reasonable to conclude that reframing homosexuality as normal may be a significant factor in the decision to live more authentically. Our data show that homosexual men who normalize their homosexuality achieve greater psychological adjustment than those who conceptualize homosexuality as abnormal. Weinberg and Williams (1974) point out that normalization is a method by which homosexual persons are able to adapt to their homosexual orientation and to achieve greater psychological well-being. The present research supports that position.

The correlational analyses of guilt about homosexual behavior (Tables 12 and 13) show that this variable correlates significantly with 15 of the 18 indicators of psychological adjustment/maladjustment. It appears to be not only critical but perhaps one of the most influential variables associated with maladjustment and heterosexual conformity. Once again, the present research supports the work of Weinberg and Williams (1974). The correlation between guilt about homosexual behavior, anxiety about being homosexual, and incongruence of

sexual self-concept and fantasy are very strong suggesting that the denial of one's authentic sexuality results in psychological turmoil experienced in part as anxiety and guilt. Those who have the most guilt about homosexual behavior (i.e., the married men) also have the most negative conceptualization of homosexuality, the most denial or incongruity between sexual self-concept and fantasy, the most anxiety about being homosexual, the most depression, and the most unhappiness. Clearly guilt is a major component and indicator of maladjustment among homosexual men.

The hypothesis testing and correlational analyses demonstrate that there is a definite relationship between attempts to conform to a heterosexual life style through marriage and psychological maladjustment. Those homosexual men who deny their sexual preference and who strive to live a heterosexual life style through marriage or otherwise pay a great psychological price for that decision. Those who separate or divorce appear to resolve adjustment problems around their sexuality and go on to live a happier lives. Like these men, those who are single appear to have achieved a comparatively happy existence in relation to their sexuality. This research confirms the findings of researchers from the time of Kinsey and Hooker to the present which indicate that self-affirming gay men are generally as happy, healthy,

and productive as the rest of society. It is those who, for whatever reason, deny their sexual preference that form the ranks of the maladjusted and troubled homosexual men.

Discussion of Ancillary Findings

Chapter 5 presented additional ancillary findings regarding the relationship between marital status and psychological adjustment among homosexual men. Findings regarding the psychological and behavioral impact of the AIDS crisis on the respondents and the spontaneous comments which they offered were also presented. These ancillary findings merit comment.

The finding that those who attempt to conform to a heterosexual life style through marriage experience greater anxiety, depression, and unhappiness than those who do not is further evidence that maladjustment is associated with denial and passing. The existence of denial is suggested by the fact that the married men show a significantly greater incongruence between sexual self-concept and fantasy. They rate themselves more heterosexual but their level of sexual fantasy is more homosexual. That the separated or divorced report slightly less depression, anxiety, and unhappiness than the single men suggests that the separated or divorced

men may have most fully resolved their identity issues having tried a heterosexual life style, rejected it, and now intentionally choose to be gay. The correlation between openess to family and openess to the public with commitment to homosexual identity supports the finding of Hammersmith and Weinberg (1973). When the homosexual person identifies himself as gay and authentically commits himself to a homosexual identity it appears that he may more effectively elicit the support of those around him. Though many gay men choose to pass for a variety of reasons not related to denial of their sexual preference (Weinberg & Williams, 1974) this study suggests that those who attempt to conform to heterosexual expectations are committed to passing, and as a result experience more psychological adjustment problems than those who are openly gay.

The results regarding AIDS anxiety support those obtained in United States studies (Morin & Batchelor, 1984). That 60% of the men in our sample worry "often" or "most of the time" about contracting a frightening and terminal illness indicates that they carry a heavy psychological burden which can be expected to severely affect all areas of their lives. There is not sufficient data to explain the meaning of the finding that 25% of the married group "never" or "seldom" worry about AIDS. Perhaps their sexual behavior has not put them at risk.

The fact that the single men are most worried suggests that being alone in such an epidemic leaves these men more vulnerable to anxiety and in need of the kind of support which others may get from their partners.

The results regarding behavior change in response to the AIDS crisis concur with those found in San Francisco (Winkelstein et al., 1987) and in New York (Martin, 1987) and are indicative of the responsibility gay men feel toward themselves and others. It is reassuring to find that 94% of the men in our sample have changed their sexual behavior and that 54% practise "safe sex only". Though this latter figure is still low, if we add those who have stopped having sex or who restrict themselves to a monogamous relationship we have a gratifying 85% who are acting in very significant ways to prevent the spread of AIDS.

The conviction that AIDS has increased social hostility towards homosexual men is shared by 73% of the men in our sample. Apparently, those who have tested societal response and have found it to be only moderately discriminating are now finding greater discrimination as a consequence of the AIDS threat. This suggests an increasing societal intolerance of homosexuality at the present time.

Although the spontaneous comments of respondents cannot be quantified and analysed to determine their

statistical significance, their deeply human significance emerges in the glimpse they give of what it means to be gay and homosexual in contemporary society. There is a strong, unequivocal conviction that being gay is good and that a gay life is not essentially different from any other. Such statements as: "I am a proud gay man", "My dreams and goals are similar to other males", "I lead a very happy life as a gay man and my family is very supportive", "I do not accept my homosexuality as a disability and I refuse to let others treat it as such", express the healthy, self-affirming spirit increasingly expressed by gay men. In a similar vein clear, articulate criticism of the questionnaire arose around parts that could be interpreted as inferring that the respondents were somehow less than healthy and not fully as acceptable as all other men.

However, there is a great poignancy in the descriptions of the pain and cost of being homosexual or gay expressed in such comments as, "I was very hard on myself...I wished I were straight", "I was always worried that my `discovery' would cause shame for my family whom I loved; who respected me so much, and who had so much pride in me". There is the longing for family that cannot be, "A family appeals to me". For some the experience of remaining married is reflected in this statement, "I am lonely and live the life of a front.

There is no way things can change. I will never have what I want and this makes life a life sentence...I get some satisfaction from being a good father but inside I am empty". And conversely, among the married who separate or divorce there is "regret over the heartache our families are involved in" while among those who remain married the feeling "I have not lived who I really am--a great sadness for me". For those who do not identify as gay there is the ongoing struggle to repress and deny their sexual identity, "As a committed Christian I am called to resist my homosexual urges", "I am a homosexual but not gay...I still live in the closet out of fear", "There is no way things can change...inside I am empty". For many the final irony of the struggle has come with AIDS, "I am seropositive...why bother?", "ARC has destroyed my life".

The quotations of the preceding paragraph eloquently express the pain and struggle often experienced by homosexual men. However, this is offset, though not denied, by the fact that the largest response category affirms pride and joy in being gay. It may be that the statements, "I wish I had not stopped having homosexual relationships at 18" and "I wish I had come out sooner..." express what the results of this study seem to suggest and what many appear to have discovered in accepting themselves. Living authentic lives even at a

high cost may be the better way.

Limitations of the Study

For obvious reasons, it was not possible to obtain a representative sample of homosexual men for this study. Moreover, it was very difficult to obtain respondents from the "most hidden" segment of the homosexual population--the married and formerly married homosexual men. The numbers of married (n = 16) and separated/divorced (n = 18) homosexual men in the sample are both disappointingly small and hardly representative of any known population. Care must be exercised, therefore, in generalizing the findings beyond this specific responding sample.

It must be emphasized at this point that the sample for this study was exclusively male. That fact places an obvious limit on our ability to generalize the findings. There is considerable evidence that the experience of homosexual women may be quite different from that of homosexual men, and any attempt to generalize the findings of this study to lesbian women, therefore, would be unwarranted.

The fact that the three groups (married, separated/divorced, and single) were markedly different in age and that age correlated significantly with so many

of the psychological variables of interest to the study made it necessary to statistically control for age. Although an entirely acceptable procedure, random samples, larger samples, and equivalence for age would have simplified the analysis, provided greater external validity to the study, and rendered the interpretation of the results less equivocal.

The hidden nature of the population necessitated the use of anonymous, mail-out, self-report forms to collect the data. Although this procedure restricted the kind of data that could be obtained, it gave the study access to subjects who would not have been available for face-to-face interviews.

The mail-out questionnaire included a few items that were not essential for hypotheses testing. These questions have provided very useful ancillary information. Since ancillary data, however, were not collected for the express purpose of testing à priori hypotheses, they should not be regarded as conclusive, but merely as suggestive of hypotheses which merit further empirical investigation.

Just as we should avoid gender-biased language in conducting and reporting the results of scientific research, so too should we avoid bias in the language we use to discuss sexual orientation. Although a sincere effort has been made in this regard, admittedly, its

achievement has been limited.

Implications for Counselling

The data suggests that homosexual men who strive to conform to a heterosexual life style through marriage experience numerous problems in psychological adjustment and are more likely to need counselling than openly gay men. Married homosexual men are most likely to anticipate societal discrimination, to conceptualize homosexuality as abnormal, and to feel guilt about their homosexual behavior. Since those most troubled about their homosexuality tend to be most secretive, they may not easily reveal their sexual concerns even to a counsellor. Rather, these concerns may be masked by such symptoms as depression, anxiety, or psychosomatic symptoms. Therefore, it is important for heterosexual counsellors working with homosexual persons to be clear about their gay-positive stance and for gay counsellors to be as appropriately open as possible about their own orientation.

Since the literature review suggests that there are no more grounds for guilt about homosexual preference than about heterosexual preference, the counsellor may regard homosexual guilt as unfounded and seek to help the client normalize his homosexuality and become committed

to it. Support for this approach is found in the literature (Hammersmith & Weinberg 1973) as well as in the results of the present study. Normalization correlates strongly with commitment to homosexuality, the absence of guilt, and generally to indicators of adjustment. Since the belief that one's sexual preference is abnormal appears to have come largely through social learning, then the modelling of acceptance of homosexuality by the counsellor, introduction to gay persons, and the provision of accurate information about homosexuality may enable the client to revise his own negative views and feelings. This study together with much of the literature reviewed shows that it is extremely important to deal with normalization, resolution of guilt, and passing (deceit and duplicity) if we are to be of any real assistance to homosexual clients who are struggling with their identity.

The literature points out that greater homosexual socialization appears to correlate with better psychological adjustment (Weinberg & Williams, 1974). Similarly, our findings suggest that normalization of homosexuality, reduction of guilt, and decrease in anticipated discrimination correlate with greater commitment to homosexuality, less passing, and greater public openess. Encouragement of such socialization appears to be critical to a client's progress toward

psychological adjustment.

Such evidence places the married homosexual man in a particularly difficult situation--a double-bind. If he normalizes his homosexuality, becomes more committed to his sexual preference, becomes more open, and openly socializes with gay men, he may increase his level of psychological adjustment but at the expense of others--"the heartaches" experienced by his family and the potential breakdown of his marriage. Even if his wife is accepting of his homosexuality she may find it extremely difficult to cope with the social repercussions (shame and disgrace) of her husband's greater homosexual commitment and openess. On the other hand, if he continues to anticipate discrimination, see his sexual preference as abnormal, maintain his guilt feelings, all of which appear to support his decision to conform to a heterosexual life style, it appears from this research that though he may protect his family and marriage, he does so at the considerable cost in terms of his own psychological well-being.

The surprising results that married homosexual men fare significantly less well on measures of psychological adjustment than do separated and divorced homosexual men raises serious ethical issues for the counsellor. Extreme caution must therefore be used in the application of these findings. First it must be noted that many

married homosexual men, for a variety of reasons, may be able to resolve the issues attending heterosexual marriage much more comfortably than those of our rather small sample. Accordingly, the counsellor should pay careful attention to the particulars of each case and must guard against premature solutions to the client's adjustment problems--especially the dissolution of marriage without careful assessment.

As Coleman observes (1985), we have no clear model for the married man with same-sex feelings who is committed to a heterosexual marriage. It appears that the goal of counselling should be to increase the level of psychological functioning in terms of reducing anticipated discrimination, conceptualization of homosexuality as abnormal, and guilt about homosexual responsiveness. Such change would decrease anxiety, depression, incongruence of sexual self-concept and fantasy, etc., enabling the married man to be clearer about his own feelings and to negotiate a more authentic relationship with his wife and family. The counsellor might be helped to assess the potential of the marriage by being aware of the factors that are found in marriages where spouses stay together while maintaining a good level of psychological adjustment (Coleman, 1985).

The literature on identity formation suggests that one's movement from denial of and and guilt about one's

sexual preference to be becoming a self-affirming gay person is developmental, often reflexive, and not necessarily linear. There may be a return to earlier stages so that guilt and normality anxieties may recur some time after the individual has recognized and accepted his homosexuality. Gay men, self-affirming and committed to their orientation, who approach a counsellor to deal with problems of individual psychological adjustment, sexual problems, or couple relationships, may need to deal with residual guilt, feelings of abnormality, anticipated discrimination, or internalized homophobia (McWhirter & Mattison, 1984) arising from more recent events in their lives.

This is becoming increasingly true in the 1980's since the data indicate that homosexual men experience considerable AIDS-related stress with frequent worry and a perception of greater hostility from society resulting from the AIDS threat. Eighty-eight of 94 respondents were making changes in the form of their sexual relations suggesting significant concern about AIDS. In light of such response it is to be expected that AIDS anxiety will be an issue in counselling throughout the present crisis. Since vocal minorities in the community and the media sometimes identify AIDS with punishment for homosexuality, homosexual men may experience the re-emergence of guilt in the context of AIDS. Counsellors

must help them deal with this guilt.

It is evident from the low status accorded to homosexual persons by our society, from findings regarding identity formation of gay men, and from the data of this research regarding adjustment, that there is a great need for gay social support groups. If the perception of this sample that antihomosexual attitudes are increasing in society is true and an indicator of a trend, homosexual persons may have to live through times not unlike those preceding the emergence of gay liberation. Social learning and symbolic interactionist theory underscore the need for social support if individuals are to attain a positive self-image and emotional stability. Woodman and Lenna (1980) suggest that professionals need to be aware that support networks often cannot be found easily by clients. Counsellors working with homosexual men need to be aware of the presence, nature, and ways to access existing support groups (eg., in Calgary: Metropolitan Community Church, Dignity, Lutherans Concerned, AIDS Calgary, Camp 181, Gay Lines, etc.) and to use these as a resource for their clients. Mach (1987) suggests that involvement in such groups can be a very powerful alternative or adjunct to counselling for they facilitate self-affirmation and the development of personal social support.

There is a need for psychoeducation in addition to

counselling and social support for the gay community which may not have the resources or expertise to mobilize itself (Woodman & Lenna, 1980). Moreover, some individuals in the early stages of developing their gay identity are unwilling to associate with an openly gay organization but might participate in a psychoeducational group in a more traditional agency setting. Groups focusing on issues such as coming out, relating to family, dating, relationships, sexuality, etc., could meet the need for social support as well as the need for developmental education. Such programs will be most effective if created in co-operation with the gay community and if gay facilitators are used where possible.

Recommendations for Further Research

The questionnaire developed by Weinberg and Williams (1974), used extensively by Ross (1978, 1983, 1985), and adapted for the present research provided an effective resource for this study. However, some observations regarding the adapted form of certain items may help to improve future research. Question 20, for example, regarding experienced societal rejection was unanswered by those who had not disclosed their sexual preference to anyone. This included half of the married sample thus

rendering group comparisons impossible.

A question about the number of sexual partners as well as the frequency of sexual relations (Item 32) would have been helpful, particularly for eliciting information regarding changes in behavior in response to the threat of AIDS. Without this information it was not possible to determine if "no change" in behavior meant continuing to have sexual relationships with a large number of partners or with only one.

It would have been helpful to know what the respondents understood by "safe sex". A question could be included to check their perceptions in this regard.

Question 33 should be rewritten to ensure that respondents would be specific regarding the length of time they had thought of themselves as homosexual rather than simply checking "never", "months", or "years".

Some effort could be made to explore the "expected societal rejection" and "anticipated societal discrimination" scales to compare their reliability and construct validity. Are they measuring the same or different dimensions of experience? As used in this study, the anticipated societal discrimination scale appeared to be considerably more powerful than the expected societal rejection scale in that it could account for much greater variance in measures of psychological adjustment/maladjustment. Its use in

future research is recommended.

In the present study, marital status was used as an index of attempts to conform to a heterosexual life style. Clearly, single homosexual men and those who have separated or divorced may diligently strive to conform to a heterosexual life style in other ways. Further research is needed to determine whether such alternative attempts to conform to a heterosexual life style are also related to problems in psychological adjustment.

Since the voluntary comments of respondents were very informative and willingly offered, future research might specifically ask for written response to some questions or include an interview with some individuals as did Ross (1983). Overall, the effectiveness of the scales and items from the Weinberg and Williams guestionnaire for this study supports Ross's recommendation (1983) of the instrument for use in further projects.

Research on psychological adjustment of homosexual persons, including the present study, has demonstrated that most problems arise not from being homosexual but from being homosexual in a homophobic society. As Mach (1987) points out, future research must therefore focus upon the dynamics of homophobia and how it may be reduced in a society which purports to value individual rights and freedoms.

The present research raises questions about the nature and origin of anticipated societal rejection, conceptualization of homosexuality as abnormal, and guilt that continues to afflict significant numbers of homosexual people. Why do some homosexual persons experience these reactions while others do not? How do some resolve these issues to live happier, well adjusted lives while others continue to struggle anxiously for years? From whence comes the anxiety, shame, and guilt that consumes the vitality of so many homosexual persons? Future research might productively address such questions.

Mowrer's observations about guilt (1964) suggest a direction in which answers may be found. He contends, against Freud, that "the primal pathogenic act" is not repression but "suppression from others of the whole truth about oneself". He believes that "in honest self-revelation and authentication, is the royal road to psychological freedom and personal wholeness" (p. 225). Again, Mowrer observes that "The crucial element in 'mental health' is the degree of 'openess' and 'communion' which a person has with his fellow men...He is a social being; and when he violates his human connectedness, he dies [psychologically]" (p. iii). When the married, and others attempting to live a heterosexual life style, choose to hide their sexual preference and

behavior from their primary group (parents, friends, wife, children), they violate their "human connectedness". Jourard (1964) likewise suggests that people run into trouble "because they do not disclose themselves in some optimum degree to the people in their lives" and that "self-disclosure is a means of ultimately achieving healthy personality" (p. 31). Further research might explore the possibility that the guilt, anxiety, shame, and other expressions of maladjustment experienced by the homosexual man relate not only to the expected societal rejection, the anticipated discrimination, and the conceptualizing of homosexuality as abnormal, but also to the cognitive dissonance involved in living a "double life", the stress involved in maintaining a false front, and perhaps primarily to the deception involved in relationships with significant others.

If this be the case then further research into the social support and primary relationships of homosexual and gay men would be useful. Research is needed on marriages involving a heterosexual and a homosexual partner in order to explore ways of sustaining such relationships more effectively or of dissolving them with the least possible suffering for those involved. There is need for research into the development and maintenance of male couple relationships as well as friendship

networks for gay and hidden homosexuals (married and otherwise) unable to come to terms with their identity. Discussion with men in the gay community indicate there is increased concern for establishing and maintaining enduring relationships (especially as a consequence of AIDS) but a lack of knowledge about how to accomplish this.

The preceding discussion of results of hypotheses testing and ancillary findings, limitations, implications for counselling, and suggestions for further research conclude the study. It is hoped that this research has made a small contribution to understanding and affirming the experience of homosexual persons and will help to make it less necessary for them to embrace Tchaikovsky's solution, "All that is left is to pretend. But to pretend to the end of one's life is the highest torment". May it encourage the readers, whatever their sexual preference, to live more open and authentic lives valuing their own uniqueness and sharing it with others.

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APPENDIX A

LETTER OF PERMISSION

INDIANA UNIVERSITY

DEPARTMENT OF SOCIOLOGY
Ballantine Hall
Bloomington, Indiana 47405
(812)

December 19, 1986

Mr. John Branton
1200 6th Street S.W.
Apt. 1110
Calgary, Alberta
CANADA

Dear John:

Please excuse my delay in answering your request. (I had misplaced my memo.) This letter is to grant you permission to use the questionnaire employed in Male Homosexuals. A condition is that you note this in the body of the paper (not just in a footnote).

We would like to receive a copy of your work when it is completed.

My best,

Martin S. Weinberg
Professor

MSW:es

APPENDIX B

COVERING LETTER

RESEARCH QUESTIONNAIRE

University of Calgary,
Department of Educational Psychology.

I would be grateful if you would fill out this questionnaire to assist with a research project. The project is designed to provide a greater understanding of the experience of being a male homosexual in our society and the ways homosexual men deal with the problems they encounter in daily living. Information collected in the course of this enquiry will be used for research purposes only. Moreover, those who collaborate in the project will not be identified in any report of results. Anonymity and confidentiality are assured.

There are no "right" or "wrong" answers. Simply give your own reaction to each question. Answer as many of the questions as possible.

Please return the questionnaire at your earliest convenience, preferably within the next few days. Send it to:

Mr. John Branton,
The Department of Educational Psychology,
The University of Calgary,
2500 University Drive,
Calgary, Alberta. T2N 1N4

Thank you for your time, interest and participation.

APPENDIX C

RESEARCH QUESTIONNAIRE

1. Age_____

2. What level of education have you completed? (Check one)

___ Junior High School

___ High School

___ College or Technical School

___ University

___ Graduate School

3. What kind of work do you do? (State below)

_____

4. With whom do you live? (Check one)

___ Parents

___ Alone

___ Roommate

___ Lover

___ Wife

___ Other (Specify)

For how long ?

_____

5. What is the approximate size of the community in which you live? (Check one)

___ Under 50,000

___ 50, 000 - 200,0000

___ 200,000 - 500,000

___ 500,000 - 1,000,000

___ 1,000,000 or more

6. Check the urban centre nearest you.

___ Vancouver ___ Saskatoon ___ Toronto

___ Calgary ___ Winnipeg ___ Montreal

7. Do your parents or close relatives live in the same area as you do? (Check)

___ Yes

___ No

8. Check your present marital status.

___ Single and never married

___ Married and living with your wife

___ Married but now separated

___ Divorced

9. If married, how long have (or did) you live with your wife?

_____

10. If divorced or separated, how long have you lived apart?_____

11. Do you have any children?_____

If so, how many?_____

12. Do you think of yourself as : (Check one)
___ exclusively homosexual
___ predominantly homosexual
___ more homosexual than heterosexual
___ bisexual
___ more heterosexual than homosexual
___ predominantly heterosexual
___ exclusively heterosexual

13. With whom do you have sex? (Check one)
    ___ men only
    ___ predominantly men
    ___ more men than women
    ___ equal numbers of both
    ___ more women than men
    ___ predominantly women
    ___ women only

14. To whom do you feel sexually attracted? (Check one)
    ___ men only
    ___ predominantly men
    ___ more men than women
    ___ equal numbers of both
    ___ more women than men
    ___ predominantly women
    ___ women only

15. Your sexual fantasies involve? (Check one)
    ___ men only
    ___ predominantly men
    ___ more men than women
    ___ equal numbers of both
    ___ more women than men
    ___ predominantly women
    ___ women only

16. How frequently do you worry about AIDS (Acquired Immune Deficiency Syndrome)? (Check one)

    ___ Never
    ___ Seldom
    ___ Sometimes
    ___ Often
    ___ Very often
    ___ Most of the time

17. How has fear of AIDS changed your sexual behavior? (Check one or more)

    ___ It has made no difference
    ___ I have reduced the number of my sexual partners
    ___ I have sex only with my partner
    ___ I use only safe sex practices
    ___ I have stopped having sex with others

18. How do you think the presence of AIDS has affected society's reaction to homosexuals? (Check one)

    ___ Society is now much more accepting/tolerant
    ___ Society is somewhat more accepting/tolerant
    ___ It has made no difference
    ___ Soceity is somewhat more negative/intolerant
    ___ Society is much more negative/intolerant

19. If the following persons do not know that you are homosexual, how do you think they would react to finding out? Check the appropriate items. If they already know, check "not applicable".

	Accepting	Understanding	Tolerant	Intolerant	Rejecting	Not applicable
Mother	_____	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____	_____	_____
Most aunts and uncles	_____	_____	_____	_____	_____	_____
Best heterosexual friend (same sex)	_____	_____	_____	_____	_____	_____
Most other heterosexual friends	_____	_____	_____	_____	_____	_____
Best heterosexual friend (opposite sex)	_____	_____	_____	_____	_____	_____
Wife	_____	_____	_____	_____	_____	_____
Most work associates	_____	_____	_____	_____	_____	_____
Employer	_____	_____	_____	_____	_____	_____
Most neighbours	_____	_____	_____	_____	_____	_____
Heterosexuals generally	_____	_____	_____	_____	_____	_____

20. If the following persons know that you are homosexual, indicate how they reacted when they found out. (Check the appropriate items).

	Accepting	Understanding	Tolerant	Intolerant	Rejecting	Not applicable
Mother	_____	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____	_____	_____
Most aunts and uncles	_____	_____	_____	_____	_____	_____
Best heterosexual friend (same sex)	_____	_____	_____	_____	_____	_____
Most other heterosexual friends	_____	_____	_____	_____	_____	_____
Best heterosexual friend (opposite sex)	_____	_____	_____	_____	_____	_____
Wife	_____	_____	_____	_____	_____	_____
Most work associates	_____	_____	_____	_____	_____	_____
Employer	_____	_____	_____	_____	_____	_____
Most neighbours	_____	_____	_____	_____	_____	_____
Heterosexuals generally	_____	_____	_____	_____	_____	_____

21. Of the following people, check how many know or suspect that you are homosexual.

	All	Most	More than half	About half	Less than half	Only a few	None
Hetero-sexuals you know	____	____	____	____	____	____	____
Male hetero-sexual friends	____	____	____	____	____	____	____
Female hetero-sexual friends	____	____	____	____	____	____	____
Aunts & uncles	____	____	____	____	____	____	____
Neigh-bours	____	____	____	____	____	____	____
Work assoc-iates	____	____	____	____	____	____	____
People you sus-pect or know are homosex-ual	____	____	____	____	____	____	____

22. Do any of the following know or suspect that you are homosexual? If any are deceased, put a "D" beside your checkmark.

	Definitely knows	Definitely or probably suspects	Do(es) not seem to know or suspect
Your mother	_____	_____	_____
Your father	_____	_____	_____
Brother(s)	_____	_____	_____
Sister(s)	_____	_____	_____
Best hetero-sexual friend of same sex	_____	_____	_____
Wife	_____	_____	_____
Best hetero-sexual friend of opposite sex	_____	_____	_____
Your employer	_____	_____	_____

23. Would there be problems at work if people found out that you were homosexual? (Check one)

___ No

___ Yes, but very little

___ Yes, some problems

___ Yes, major problems

___ Most people I work with already know

24. Do you think people are likely to break off social relationships with someone if they suspect he is homosexual? (Check one)

___ Yes, most people would

___ Yes, many would

___ Yes, a few would

___ No, most people would not

25. Do you think people are likely to make life difficult for persons they suspect are homosexual? (Check one)

___ Yes, most people would

___ Yes, many would

___ Yes, a few would

___ No, most people would not

26. How do you think most people feel about homosexuals? (Check one)

___ They feel disgusted or repelled by homosexuals

___ They dislike homosexuals

___ They have a "live and let live" attitude toward homosexuals

___ They have some liking for homosexuals

27. At the present time are another homosexual and yourself limiting your sexual relationships primarily to each other? (Check one)

___ No

___ Yes, we have been for less than a month

___ Yes. we have been for one to six months

___ Yes, we have been for six months to a year

___ Yes, we have been for more than a year

28. At some time in the past, did another homosexual and yourself limit your sexual relationships primarily to each other? (Check one)

___ No

___ Yes, for less than a month

___ Yes, for between one and six months

___ Yes, for between six months and a year

___ Yes, for more than a year

29. Of all your friends, how many are (to your knowledge) heterosexual? (Check one)

___ All

___ Most

___ More than half

___ About half

___ Less than half

___ Only a few

___ None

30. At the present time, how many close relationships do you have with heterosexuals? (Check one)

___ Many

___ Some

___ Very few

___ None

31. At the present time, how socially active are you in heterosexual circles? (Check one)

___ Very active

___ Somewhat active

___ Not too active

___ Not active at all

32. ___ In the last six months how many times have you had sexual relations with males?

___ In the last month, how many times have you had sexual relations with males?

___ At what age did you have your first homosexual experience?

33. For how long have you thought of yourself as being homosexual? (Check one)

___ Never

___ Number of months

___ Number of years

Indicate the extent to which you agree that the statements below characterize you and your feelings.
After reading each statement:

CIRCLE	IF YOU
SA	STRONGLY AGREE
A	AGREE
?	ARE NOT SURE
D	DISAGREE
SD	STRONGLY DISAGREE

34. I feel I have a number of good qualities.....SA A ? D SD

35. I feel that I am a person of worth, at least on an equal plane with others.....SA A ? D SD

36. All in all, I am inclined to feel that I am a failure.....SA A ? D SD

37. I am able to do things as well as most other people.....SA A ? D SD

38. I feel that I do not have much to be proud of.....SA A ? D SD

39. I take a positive attitude toward myself.....SA A ? D SD

40. On the whole, I am satisfied with myself.....SA A ? D SD

41. I wish I could have more respect for myself.....SA A ? D SD

42. At times I think I am no good at all.....SA A ? D SD

43. I certanly feel useless at times.....SA A ? D SD

44. On the whole, I think I am quite a happy person.....SA A ? D SD

45. I get a lot of fun out of life.....SA A ? D SD

46. I am not as happy as others seem to be.....SA A ? D SD

47. In general, I feel in low spirits most of the time.....SA A ? D SD

48. I often feel downcast and dejected....SA A ? D SD

49. There have been times when I felt I was going to have a nervous breakdown.....SA A ? D SD

50. No one is going to care much what happens to you when get right down to it.....SA A ? D SD

51. Human nature is really cooperative....SA A ? D SD

52. Most people can be trusted .....SA A ? D SD

53. Most people are inclined to look out for themselves.....SA A ? D SD

54. If you don't watch out for yourself people will take advantage of you.....SA A ? D SD

55. I feel that I don't have enough friends.....SA A ? D SD

56. Do you feel lonely? .....SA A ? D SD

57. I do not care who knows about my homosexuality.....SA A ? D SD

58. I do not like to associate with a SA A ? D SD
person who has a reputation (among heterosexuals of being a homosexual.....SA A ? D SD

59. I would not mind being seen in public with a person who has the reputation (among heterosexuals) of being a homosexual.....SA A ? D SD

60. I wish I were not a homosexual.....SA A ? D SD

61. I would not want to give up my homosexuality even if I could.....SA A ? D SD

62. Homosexuality may be best described as an illness.....SA A ? D SD

63. Homosexuality may be best described as a mental illness.....SA A ? D SD

64. Being a homosexual is something that is completely beyond one's control.....SA A ? D SD

65. I have noticed that my ideas about myself seem to change very quickly....SA A ? D SD

66. Some days I have a very good opinion of myself. On other days I have a very poor opinion of myself.....SA A ? D SD

67. I feel that nothing, or almost nothing can change the opinion I currently hold of myself.....SA A ? D SD

68. A person is born homosexual or heterosexual.....SA A ? D SD

69. I am probably responsible for the fact that I am a homosexual.....SA A ? D SD

70. From how many heterosexuals do you try to conceal your homosexuality? (Check one)

___ All

___ Most

___ More than half

___ About half

___ Only a few

___ None

71. Does the opinion you have of yourself tend to change? (Check one)

___ Changes a great deal

___ Changes somewhat

___ Changes very little

___ Does not change

72. Do you ever find that on one day you have one opinion of yourself and on another day you have a different opinion? (Check one)

___ Yes, often

___ Yes, sometimes

___ Yes, but rarely

___ No, never

73. Taking all things together, how would you say things are these days? Are you:

___ Very happy

___ More happy than unhappy

___ More unhappy than happy

___ Very unhappy

74. Does knowing you are a homosexual "weigh on your mind", make you feel guilty, depressed, anxious or ashamed? (Check one)

___ A great deal

___ Somewhat

___ Not very much

___ Not at all

75. At the present time do you ever experience shame, guilt or anxiety after sexual homosexual relations? (Check one)

___ Nearly always

___ More often than not

___ Not very often

___ Never

76. Have you ever visited a psychiatrist or counsellor for help in dealing with your homosexuality?

___ Yes

___ No

77. Even though it may be difficult, please specify the number of people you consider to be your close friends (eg. 0, 1, 2, 3, ...) _____

Of these close friends how many are homosexual?_____

78. What proportion of your leisure time is spent socializing with homosexuals? (Check one)

___ Most

___ More than half

___ About half

___ Less than half

___ Only a small amount

___ None

79. How many of your friends are homosexuals? (Check one)

___ All

___ Most

___ More than half

___ About half

___ Less than half

___ Only a small amount

___ None

80. Check how important you think each of the following is:

	Very Important- ant	Somewhat Important- ant	Not Very Important- ant	Not At All Important- ant
Formal Religion	____	____	____	____
Traditional morality	____	____	____	____
Conformity in general	____	____	____	____

81. Check to what degree you think homosexuality violates the following :

	Very Much	Somewhat	Not Too Much	Not At All
Formal Religion	____	____	____	____
Traditional Morality	____	____	____	____
Conformity in General	____	____	____	____

82. How often do the following things happen to you?

	Never	Seldom	Fairly Often	Nearly all the time
Do you ever have any trouble getting to sleep or staying asleep?	_____	_____	_____	_____
Have you ever been bothered by nervousness, feeling fidgety and tense?	_____	_____	_____	_____
Are you ever troubled by headaches or pains in the head?	_____	_____	_____	_____
Do you have loss of appetite?	_____	_____	_____	_____
How often are you bothered by having an upset stomach?	_____	_____	_____	_____
Do you find it difficult to get up in the morning?	_____	_____	_____	_____
Have you ever been bothered by shortness of breath when you were not exercising or working hard?	_____	_____	_____	_____
Have you ever been bothered by your heart beating hard?	_____	_____	_____	_____
Do you drink more than you should?	_____	_____	_____	_____
Have you ever had spells of dizziness?	_____	_____	_____	_____
Are you ever bothered by nightmares?	_____	_____	_____	_____
Do you tend to lose weight when you have something important bothering you?	_____	_____	_____	_____

	Never	Seldom	Fairly Often	Nearly All the Time
Do your hands ever tremble enough to bother you?	_____	_____	_____	_____
Are you troubled by your hands sweating so that you feel damp and clammy?	_____	_____	_____	_____
Have there ever been times when you just couldn't get going?	_____	_____	_____	_____

If there is anything you wish to add or comment on, please do so in the space below.

Again, thank you for assisting with this research.