

Identity and Community Among Gay and Bisexual Men in the AIDS Era: Preliminary Findings From The Sacramento Men's Health Study

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This chapter describes preliminary results from an ongoing study of the linkages between gay and bisexual men's sense of identity and community and their HIV-related risk behavior and psychological functioning in the AIDS era. Recognizing that AIDS now represents an ongoing fact of life and death for the gay community rather than a transient crisis, an increasing body of empirical research conceptualizes AIDS as one of many stressors confronting the community (e.g., Dean, this volume). Some researchers have addressed issues such as the psychological impact of AIDS-related bereavement (e.g., Folkman, 1993; Martin, 1988; Martin & Dean, 1993) and the broader impact of HIV on the community (Levine, Nardi, & Gagnon, forthcoming). Others have discussed ways in which variations in the construction of identity can affect risk behaviors (e.g., Carballo-Diéguez, this volume). Still others have demonstrated the value of incorporating issues of community and identity into AIDS intervention programs (e.g., Hays & Peterson, 1994).

In our research, we are collecting questionnaire and interview data from a sample of gay and bisexual men in Sacramento (CA) to examine how various facets of personal identity and community involvement are related to personal risk reduction and healthy psychological functioning in the era of AIDS. In

this chapter, we present preliminary data relevant to three questions. First, to what extent do variables related to identity and community help us to understand gay and bisexual men's HIV risk-reduction behaviors? Second, to what extent do those variables help us to understand how gay and bisexual men are functioning psychologically in the era of AIDS? Third, how are qualitative variations in men's personal constructions of community and identity linked to their risk reduction and psychological functioning?

Conceptual Framework *Identity and Community*

The concept of *identity* has been defined in a variety of ways to apply to lesbians, gay men, and bisexual people (Cass, 1983/1984; Troiden, 1988). Most researchers would agree that identity is distinct from sexual behavior. Many men have sexual relations with others of their same gender but do not label themselves as gay or bisexual (e.g., Carballo-Diéguez, this volume; Doll et al., 1992). In the present chapter, we consider men to have a gay or bisexual identity to the extent that their sexual orientation constitutes a stable and central component of their overall self concept, one that is relevant to many different social interactions and facets of their life in addition to their sexual behaviors. Put simply, a man can be considered to have adopted a gay or bisexual identity to the extent that he feels that being gay or bisexual is an important part of who he is. Commitment to the identity involves attaching salience to being gay or bisexual in a broad array of social situations and expressing an unwillingness to change one's sexual orientation, even if that were possible.

Like identity, the term *community* has been used in various ways in discourse on AIDS. It has been equated with concepts as diverse as a specific geographic location (e.g., residence in a census tract or neighborhood), membership in a socially recognized minority group (e.g., African Americans, gay people), and a collection of individuals who simply share a particular behavior (e.g., the “injecting drug users’ community”) or demographic characteristic (e.g., the “heterosexual community”). In the present chapter, we use community to refer to a subjective experience: the sense of connection that gay men, lesbians, and bisexuals feel because of their shared sexual orientation and their common sense of oppression by a heterosexual society (see Hunter & Riger, 1986; McMillan & Chavis, 1986).

In discussing the many dynamic components of the sense of community, McMillan and Chavis (1986) stressed four elements, each of which is applicable to the lesbian and gay community. First, its constituents feel a sense of membership: They perceive boundaries to the community (who belongs and who does not); experience a sense of belonging and identification; invest themselves personally in the community (e.g., through the process of coming out); and share common symbols, myths, rituals, and holidays. Second, members of the gay community mutually influence each other and are influenced by the community as a whole. Third, membership in the community serves individual needs, both tangible (e.g., needs for information, mutual protection, recreation) and intangible (e.g., the need for coming together with others who share one’s own values and goals). Finally, community members share an emotional connection, often on the basis of sharing a sense of the community’s history, spiritual bonds, and humor.

HIV Risk Reduction, Identity, and Community

The theoretical models that have been commonly used to understand AIDS risk reduction generally focus on the actor’s appraisal of outcomes and the utility of specific

behaviors in achieving them. Perhaps the most widely employed conceptual framework has been the Health Belief Model, or HBM (Janz & Becker, 1984; Kirscht & Joseph, 1989). The HBM posits that health-related behaviors can be understood primarily in terms of four dimensions: (1) a person’s perceived susceptibility or vulnerability to an illness or condition; (2) the latter’s perceived severity; (3) the benefits associated with a particular course of action (usually conceptualized in terms of personal efficacy and beliefs about the effectiveness of the action for preventing illness); and (4) perceived barriers to undertaking the recommended behavior. In addition, the model allows for a variety of modifying personal and social factors and internal or external cues to action that affect behaviors.

Although the Health Belief Model has proved useful in framing previous AIDS research, its key variables have not consistently demonstrated a high level of predictive power (Kirscht & Joseph, 1989; McCusker, Stoddard, Zapka, Zorn, & Mayer, 1989). Partly in response to shortcomings in the HBM, Catania and his colleagues (Catania, Kegeles, & Coates, 1990) proposed an AIDS Risk Reduction Model (ARRM). The ARRM shares many expectancy-value constructs with the HBM, but it differentiates among three steps in behavior change: (1) labeling high-risk behaviors as problematic (which is influenced by knowledge of how HIV is transmitted, the belief that one is susceptible to infection, and the desire to avoid contracting AIDS); (2) deciding to change (which is influenced by perceived efficacy of risk-reduction behaviors, self efficacy, and the level of enjoyment derived from high-risk and low-risk activities); and (3) enacting the behavior (which is influenced by the outcomes of seeking information and assistance from others, and communicating with one’s sexual partners). Social support and perceived norms are hypothesized to influence the process at all three levels.

In the research reported here, we assessed the extent to which these existing theoretical

models might be augmented with principles derived from social identity theory (Tajfel & Turner, 1986), symbolic interactionism (Stryker, 1980), and community psychology (McMillan & Chavis, 1986). We investigated the extent to which variables related to identity and community influence key constructs derived from the ARRM and HBM. We hypothesized that both models would have greater explanatory power when they explicitly include consideration of identity and community.

Community, Identity, and Psychological Adjustment

Whereas HIV risk-reduction studies have focused largely on uninfected gay and bisexual men, most studies of gay and bisexual men's psychological functioning in the context of AIDS have concentrated primarily on men who have AIDS or are seropositive (see Folkman, 1993, for a review). One of the most consistent findings in this area of research has been that the availability of social support and satisfaction with it are important predictors of psychological well-being (e.g., Rabkin, Williams, Neugebauer, Remien, & Goetz, 1990; Hays, Catania, McKusick, & Coates, 1990; Hays, Chauncey, & Tobey, 1990; see also Kurdek, 1988). The AIDS epidemic, however, has decimated many gay social networks (Dean, this volume; Levine, 1992).

As with risk reduction, we expected that intensive examination of variables related to community and identity will provide new insights into psychological adjustment among gay and bisexual men in the era of AIDS. Men who identify with and are more integrated into the gay community may be at greater risk than others for stress related to AIDS; they may experience a greater number of personal losses and may consequently be more likely to experience psychological distress. At the same time, they may be more likely than other men to have access to social supports that can meet both instrumental and expressive needs. If they have lost a lover or close friend to AIDS, they may have more opportunities for interaction with other individuals who are similarly bereaved and who can provide the basis for social comparison.

They also have more opportunities than do less integrated men for establishing new intimate relationships and for reconstituting lost networks with new gay and bisexual friends. In addition, community involvement and commitment to a gay/bisexual identity can assist men in making intergroup comparisons that bolster their own self-esteem (Tajfel & Turner, 1986). Crocker and Major (1989), for example, suggested that members of a stigmatized group might have higher self-esteem to the extent that they are able to attribute negative life events and personal setbacks to societal prejudice rather than to their own merits or abilities. Such interpretations of the world, they suggested, are more readily available to individuals who are embedded in a minority community.

METHOD

We report here our findings from two pilot studies conducted in 1993 with men from the greater Sacramento (CA) metropolitan area. The sample for Study 1 consisted of men who were recruited in May and June of 1993 through a variety of Sacramento venues. These included a coming out group, student organizations, church groups, individuals contacted through social networks, and the Lambda Freedom Fair (the local community's June commemoration of Stonewall). Participants were paid \$10 for completing the questionnaire, which required approximately 45 minutes. A total of 106 usable questionnaires were obtained. Our principal goal in Study 1 was to pretest questionnaire materials that we developed for our ongoing study of gay men and AIDS. In addition, we also used the data to explore in a preliminary fashion the connections among risk reduction, psychological functioning, and variables related to identity and community.

After analyzing the responses from the Study 1 sample, we revised the questionnaire as needed and administered it to a second community sample. The Study 2 sample consisted of 100 men who were recruited in September of 1993 at the Rainbow Festival, a large lesbian/gay street fair held annually during the Labor Day weekend and sponsored by the Lambda Center, Sacramento's gay and lesbian

community center. Attendance at the 1993 festival was estimated by organizers to have exceeded 4000. The research team sponsored a booth at the Festival, from which participants were recruited. Respondents were paid \$5 and given a soft drink while they completed the questionnaire, which required approximately 40 minutes. Four of the questionnaires were substantially incomplete and were discarded, leaving a final sample of 96. Our primary goal in Study 2 was to utilize the revised questionnaires to identify principal predictors of high-risk sexual behaviors and various aspects of psychological functioning.

Measures

Sexual Behavior and Intentions

We assessed both past sexual behavior and intentions for future sexual behavior. Respondents used an extensive checklist to describe their sexual behaviors during the previous 30 days. The questions were asked separately for the respondent's sexual behavior with his lover or primary partner (if applicable) and with all other partners. Intentions for future sexual behavior were assessed with questions about the likelihood that respondents would use a condom the next time that they engaged in each of four kinds of sex: receptive anal sex, insertive anal sex, receptive oral sex, and insertive oral sex. The same four questions were asked separately about the respondent's intentions in his next sexual interaction with his lover or primary partner (if applicable) and with a male partner who is not his lover.

HBM/ARRM Variables

Based on the HBM and ARRM, we used a combination of new items and items from previous research (Hays, Kegeles, & Coates, 1990; J. Kelly, personal communication, December 18, 1991; Martin & Dean, 1988, 1991) to assess five categories of variables: (1) *Perceived vulnerability to AIDS*, including measures of appraisal of subjective threat from AIDS and labeling one's own behaviors as high or low risk; (2) *perceived benefits associated with risk reduction*, including measures of personal efficacy in risk reduction and beliefs about the effectiveness of behaviors such as

condom use for preventing HIV transmission; (3) *perceived barriers to risk reduction*, measured by beliefs about partners' (and potential partners') likely willingness to use condoms and practice safe sex; (4) *social norms relevant to risk reduction*, measured by respondents' perceptions that their friends support and practice safe sex; and (5) *pleasure associated with high-risk and low-risk activities*, assessed through respondents' ratings of pleasure associated with various types of sexual behaviors.

Psychological Functioning

We focused on three aspects of psychological functioning. First, *depression* and related symptoms were assessed with the Center for Epidemiologic Studies Depression scale, or CES-D (Radloff, 1977). To maintain consistency throughout the questionnaire, CES-D items were administered with a 5-point response scale (rather than the 4-point scale on which scale norms are based). Second, we assessed *self-esteem* with a short form of Rosenberg's (1965) scale. Third, we adapted Martin's (1988) measure of *AIDS-related traumatic stress response* (AIDS PTSD) for use as a self-administered questionnaire (SAQ). This instrument includes items assessing preoccupation with troubling thoughts about AIDS, purposeful avoidance of reminders of AIDS, problems in daily functioning due to AIDS worries, dreams and nightmares about AIDS, panic attacks due to AIDS, and numbing and detachment experiences.

Gay/Bisexual Identity And Community

We identified four general domains of variables within the broad categories of identity and community: (1) Personal identity related to sexual orientation; (2) attitudes toward and involvement with the larger gay community; (3) integration of gay/bisexual identity and community with other aspects of one's life; and (4) perceptions related to stigma. These measures are described below (the final forms of newly-developed or adapted scales - as used in Study 2 - are reproduced in the Appendix).

Personal identity. Gay/bisexual identity was assessed in four ways. First, *self-esteem as*

a gay/bisexual man was assessed with SAQ items adapted from the Rosenberg (1965) Self Esteem Scale; the items were rephrased in the general format of “As a gay/bisexual man, I feel...” Second, a measure of self acceptance of homosexual feelings (*ego-dystonic homosexuality*, or internalized homophobia) was included. It was adapted for SAQ format from interview items developed by Martin and Dean (1988; see also Meyer, 1995), based on the diagnostic criteria for ego-dystonic homosexuality contained in the Diagnostic and Statistical Manual (DSM-III; American Psychiatric Association, 1980). Third, a 4-item measure was developed to assess the extent to which respondents believed that their sexual orientation represented a *personal choice*. Finally, respondents were asked to indicate the amount of importance that they attached to four types of activities related to their sexual orientation: *community involvement*, *socializing*, *sexual cruising*, and *having anal sex*.

Integration of identity and community with other aspects of one’s life. Respondents were asked about their relationship status and about the extent to which they have disclosed their sexual orientation to friends (heterosexual and bisexual/gay, current and past). They also were asked whether they had come out to their mother or father. In addition, we computed the amount of time that the respondent had been self-identified as gay or bisexual (computed by subtracting age at first self-labeling from current age).

Community attitudes and involvement. Guided by the conceptualization of McMillan and Chavis (1986), we operationalized respondents’ sense of relationship to the gay and bisexual community in terms of their feelings of membership, mutual influence, individual needs, and emotional connection with others. These constructs were assessed through four measures. (1) Respondents’ sense of connection to other gay/bisexual men was assessed with a measure of *community consciousness*. (2) Their feelings about being part of the gay/bisexual community and the extent to which their status is important to their identity were assessed with a measure of

collective self-esteem adapted from Luhtanen and Crocker (1991). (3) Feelings of liking or disliking for the Sacramento gay/bisexual community were assessed with a scale of *local community satisfaction*. (4) We assessed respondents’ ratings of the importance of *shared symbols* - such as the pink triangle and the rainbow flag - to their sense of being gay/bisexual.

Perceptions of stigma. We developed two new measures, one to assess respondents’ perceptions of stigma in the Sacramento area (*local stigma*), and the other to assess their tendency to attribute negative life events and setbacks to societal prejudice against homosexuality and gay people (*attributions to prejudice*), based on the theoretical framework proposed by Crocker and Major (1989).

RESULTS

Sample Description

Demographic characteristics. Although they were recruited at different times and in different locations, the two samples were demographically similar in most respects. Respondents ranged in age from 17 to 70, with a mean age of 32 in both samples. Both samples were predominantly White (74% in Study 1, 83% in Study 2), with 3-5% Black and 6-9% Latino. The men were highly educated, with almost half of each sample having attained a bachelor’s degree. Less than one-sixth of each sample had never attended college or a post-secondary trade school. Despite their high educational levels, the men reported fairly low annual incomes. An annual income of at least \$35,000 was reported by only 12% of the men in Study 1 and by 23% of the men in Study 2, whereas income less than \$15,000 was reported by, respectively, 55% and 30% of the samples.

Sexual history and behavior. On average, the men reported having been first attracted to males at approximately 10 years of age (range = 3 to 55). Developmentally, the men’s histories evidenced a general progression from sexual contact with a male (mean age for first orgasm with another male was 17 years in both samples), to deciding or realizing that they were gay or bisexual (mean ages = 17 in Study 1 and

21 in Study 2), to disclosing their gay or bisexual orientation to others (mean ages for first disclosure = 20 in Study 1 and 22 in Study 2). Almost half of the respondents reported that they had never been sexually attracted to a female (41% in Study 1 and 38% in Study 2) or had never had an orgasm with a female partner (42% and 32%, respectively). Of those who reported heterosexual experiences, the mean age for first being attracted to a female was between 12-14 years and the mean age for first orgasm with a female was 18-19 years. Using a Kinsey-type continuum, almost all of the men reported that their sexual behavior in the past year (Study 1) or past three years (Study 2) was entirely or almost entirely with men (94% in Study 1, 98% in Study 2). When asked about the number of sexual partners in the past year, the medians for both studies were 3-4 male partners and no female partners (the possible range for both variables was from 0 to 6 or more).

Identity and self-labeling. When asked about the labels they apply to themselves, most of the men (88%) reported that they called themselves *GAY* often, usually, or always. Fewer than 4% never used this term to describe themselves - these men typically referred to themselves as *BISEXUAL*. Whereas 24% of the men in Study 1 and 9% of the men in Study 2 often used the label *QUEER* to describe themselves, roughly half of the samples (45-51%) reported that they never used this term. In contrast, only 14-15% of the men reported that they never used *HOMOSEXUAL* to describe themselves. Thus, even though the word homosexual is often criticized as an overly clinical term, it was rejected as a self descriptor by fewer men in our samples than was the term queer.

Relationship status. Approximately one-half of the men reported that they were currently in an ongoing relationship with another man. Of the men who had been in their relationship for at least 1 year (22 in Study 1 and 26 in Study 2), slightly more than half reported having sex outside the relationship in the past 12 months. In that same subgroup, 18% of the men in Study 1 and 31% of those in Study 2 reported knowing

that their partner had had sex outside the relationship in the past year.

HIV/AIDS. Most of the men (89-91%) had been tested for HIV. Of those who had been tested, 11 of the men in Study 1 and 17 of those in Study 2 reported testing positive. Five of the men in Study 1 and seven of the men in Study 2 had been diagnosed with AIDS. The social networks of most of the men had been affected by the epidemic. On average, the men had lost 2 lovers or close friends to AIDS, and 3 casual friends or acquaintances. Substantial minorities of the samples reported having lost at least 5 close friends or lovers (27-31%) or casual friends (36-42%). Fewer than two-fifths had not lost any close friends, and only one-fourth had not lost any casual friends. The men reported having an average of 3 close friends and 3 casual friends currently living with HIV. One-third or more had at least 5 HIV-positive close friends. Fewer than one-third had no HIV-positive close friends.

The responses from Study 1 were used primarily for evaluating and refining the measures contained in the self-administered questionnaires. The revised items and scales were then used in Study 2. The remainder of this chapter focuses on the results from Study 2.

Sexual Behavior and Intentions

Using self reports of sexual behavior during the previous 30 days, we categorized the men's level of risk with a modified version of the Sexual Behavior Risk Index developed by researchers at the University of Michigan (e.g., Joseph, Adib, Koopman, & Ostrow, 1990). This scale included four ordinal categories: (1) *No Risk/Celibate* (no reported sexual activity during the past 30 days; $n = 12$); (2) *Low Risk* (men in a monogamous relationship with no unprotected anal intercourse *or* men not in a monogamous relationship who did not have any anal intercourse; $n = 29$); (3) *Modified High Risk* (unprotected anal sex only with primary partner *or* protected anal sex with men other than primary partner; $n = 30$); (4) *High Risk* (unprotected anal sex with a man who is not the respondent's primary partner *or* unprotected anal sex with a non-monogamous primary

partner; $n = 17$). Eight men could not be categorized because of missing data about their sexual behavior.

Examination of responses to the questions about future intentions suggested that the men attached different perceptions of risk to unprotected oral and anal sex. Whereas nearly four-fifths of the men (75, or 78.1%) expressed intentions to use condoms the next time they had anal sex with a nonlover (or indicated that they would not have anal sex with a nonlover at all), almost the same number (70, or 72.9%) indicated some likelihood that they would have unprotected oral sex with a nonlover. This finding is consistent with our informal observation that many gay and bisexual men in the Sacramento area, as elsewhere, do not perceive unprotected oral sex to be a high-risk act.

We observed a variety of patterns of sexual exclusivity and safe sex among the men who had a lover or primary partner. Two-thirds (30) of the men with a lover stated that they were monogamous; another 15 were not sexually exclusive (the remaining 2 men who reported having a lover did not provide complete data about their sexual behavior). Of the men in a monogamous relationship, 17 reported engaging in unprotected anal sex with their lover during the previous 30 days. Of the men in non-exclusive relationships, 2 reported engaging in unprotected anal sex with their lover but not with other partners, 9 reported engaging in unprotected anal sex with their lover and with other partners, and 4 men reported not engaging in unprotected anal sex with anyone. All of the men in a relationship who engaged in unprotected anal sex with a non-lover also reported unprotected anal sex with their primary partner. In other words, whereas some men in non-exclusive relationships manifested a pattern of practicing safe sex outside the relationship and unsafe sex in the relationship, none displayed the opposite pattern (i.e., safe sex with a lover but unsafe sex with other partners). Because only one-half of the men had a lover or primary partner, we focus in the remainder of

the chapter on respondents' intentions for sexual behavior with other partners.

Correlates and Predictors of High-Risk Sexual Behavior and Intentions

One of the principal questions to be addressed in our research project is whether an understanding of identity and community among gay and bisexual men can help to explain their patterns of HIV risk reduction. As a first step in considering this question with data from our pilot sample, we assessed the extent to which the variables identified by the Health Belief Model and the AIDS Risk Reduction Model were associated with past sexual behavior and intentions for future behavior. As shown in Table 1, we found that the HBM/ARRM variables were indeed highly correlated with high-risk behaviors and intentions. Correlation coefficients ranged in absolute value from less than .20 to .45.

Insert Table 1 about here

We then assessed the same variables' explanatory power, using multiple regression analysis and logistic regression analysis with, respectively, the 4-item ordinal Sexual Behavior Risk Index and a dichotomous measure of safe-sex intentions with nonlovers (no possibility of engaging in unprotected anal intercourse = 0, any possibility = 1).¹ The variance in scores on the behavior risk index was explained primarily by levels of perceived vulnerability (as indicated by self-labeling for risk) ($b = .0685$, $\beta = .2794$, $p < .05$), with pleasure derived from high-risk sexual acts a secondary predictor ($b = .0409$, $\beta = .2032$, $p = .06$; total adjusted $R^2 = .0748$, $p = .05$). Men who had engaged in high-risk behaviors during the past 30 days were more likely than others to perceive their own behavior

¹ The intentions variable was dichotomized because of the highly skewed nature of the distribution of responses to it; most respondents expressed the intention to engage only in protected anal intercourse or to avoid anal intercourse entirely.

to place them at risk for HIV and to derive high levels of pleasure from unsafe sex.

Future intentions to engage in unsafe sex were predicted primarily by feelings of low self efficacy in risk reduction ($b = -.4266, p < .01$), with pleasure derived from high-risk sexual acts (unprotected anal or oral intercourse) a secondary predictor ($b = .1647, p = .055$; overall $chi-square = 20.839, p < .001$). Men were less likely to express safe-sex intentions to the extent that they felt unable to get their partner to use a condom and to the extent that they derived high levels of pleasure from unsafe sex.

Although the other HBM/ARRM variables were not significant predictors of past behaviors or future intentions, further analyses indicated that these variables contributed significantly to the variance in self efficacy, self labeling, and pleasure associated with high-risk sex. We interpret this pattern as an indication that the variables specified by the HBM and ARRM collectively account for a significant (albeit relatively small) proportion of the variance in past risk behaviors and future intentions. Although self efficacy and self labeling emerged as the principal predictors in the present analysis, this pattern may have resulted from specific properties of the small sample and should not be generalized to the population of gay and bisexual men. Other HBM and ARRM variables might prove to be significant predictors in other samples of gay and bisexual men.

We next assessed whether the variables related to gay identity and community could improve upon the HBM or ARRM models by explaining additional variance in the outcome variables. Because of the large number of identity and community variables that were assessed relative to the sample size, we first conducted preliminary multiple regression and logistic regression analyses to select a subset of variables. For these exploratory analyses, we entered small groups of conceptually-related independent variables and assessed the increment in R^2 for each. From these analyses, the following variables explained a statistically

significant amount of variance in at least one of the dependent measures and thus were included in the final equations: (1) importance of anal sex, (2) relationship status, (3) attitudes toward the Sacramento gay community, and (4) ego-dystonic homosexuality. In addition, the final equation included the HBM/ARRM variables described above.

We found that the variables related to identity and community did not explain additional variance in risk behaviors or intentions beyond that associated with the HBM/ARRM variables. In other words, knowing about respondents' sense of identity and community did not enable us to predict their risk behaviors or intentions with more accuracy than did simply knowing their scores on HBM and ARRM variables. We next examined, therefore, the extent to which the community and identity variables explained variation in the HBM and ARRM variables.

Using a similar data-reduction procedure as before, we identified three variables – one each from the variable groupings of identity, community, and integration, described above – that were significantly related to two or more of the HBM/ARRM variables. (Neither of the variables related to stigma was a significant predictor of HBM/ARRM variables.) First, respondents who scored high on ego-dystonic homosexuality were more likely than others to report feelings of low self efficacy for safe sex and were more likely to perceive interpersonal barriers to enactment of safe sex practices. Second, respondents with higher levels of gay community consciousness were more likely to have feelings of high self efficacy, to believe in the effectiveness of safe sex practices, and to perceive social support for safe sex. Third, respondents who were more out of the closet to their heterosexual friends were also more likely than others to perceive social support for safe sex. Those who were less out of the closet were more likely to perceive interpersonal barriers to safe sex.

We conclude from these findings that some aspects of community and identity, although not directly predictive of risk behavior or intentions,

are nevertheless important for gay men's enactment of safer sex because they are related to some of the variables that influence whether a man engages in safe or unsafe behavior. Specifically, to the extent that men are out of the closet, have positive feelings about their sexual orientation, and feel a sense of connection to other gay and bisexual men, they are more likely to perceive social support for safe sex practices and to feel empowered to practice safe sex with their partner, and are less likely to perceive interpersonal barriers to safe sex. Conversely, men who are in the closet, who manifest a high degree of internalized homophobia, and who do not feel a sense of gay community are less likely to feel able to practice safe sex because of their lack of personal empowerment, their expectation that sexual partners will refuse to cooperate, and their sense that others in their social world do not support safe sex practices.

Psychological Functioning

Another major focus of our project is to examine the factors that contribute to psychological distress and psychological well-being in gay and bisexual men in the era of AIDS. As with the analysis of variables predicting high-risk behaviors and intentions, we first identified the significant correlates of self-esteem, depression, and AIDS-related stress responses, and then assessed their relative predictive power through ordinary least squares regression.

Because variables that were positively associated with self-esteem tended to be negatively correlated with depression, we included the same subset of variables in the regression model for both measures.² In the

² The regression equations for self-esteem and depression both included the following variables: (1) ego-dystonic homosexuality, (2) collective self-esteem, (3) attributions of personal setbacks to antigay prejudice, (4) importance attached to socializing with gay/bisexual friends, (5) importance attached to community involvement, (6) importance attached to sexual cruising, (7) importance attached to having anal sex, (8) perceived social support for safe sex, and (9) disclosure of one's sexual orientation to one's father. These independent

final model, higher levels of self-esteem were predicted primarily by (1) lower ego-dystonic homosexuality and (2) tending *not* to attribute personal setbacks to homophobia. The best predictors of higher levels of depression were: (1) attributing personal setbacks to homophobia; (2) attaching greater importance to anal sex; (3) higher levels of ego-dystonic homosexuality; and (4) perceptions that social norms do not support safe sex. Thus, men were likely to manifest higher self-esteem and feel less depressed to the extent that they accepted their homosexual feelings and did not perceive that most of their personal setbacks were the result of society's antigay prejudice. In addition, men were less depressed to the extent that they did not regard having anal sex as an important part of their identity and perceived that their immediate reference group encouraged safe sex practices.

Following a similar procedure, we found that the primary predictors of AIDS-related PTSD were: (1) stronger feelings of subjective threat from AIDS, (2) lower levels of perceived self efficacy for engaging in safe sex, (3) higher levels of importance attached to involvement in the larger gay/bisexual community, and (4) lower levels of disclosure of one's sexual orientation to heterosexual friends and acquaintances (i.e., being in the closet).³ Thus, the men who manifested more symptoms of AIDS-related stress were those who perceived their own risk for HIV to be highest, did not feel competent or empowered to ensure that their sexual interactions were safe, attached considerable importance to being actively involved in the gay/bisexual community, and

variables accounted for a total of 42.8% of the variance in self-esteem scores ($F(9,86) = 7.17, p < .001$) and 24% of the variance in depression scores ($F(9,86) = 6.26, p < .001$).

³ The other variables included in the equation for AIDS PTSD were time since self-labeling, attributing personal setbacks to antigay prejudice, HIV serostatus, and number of close friends who have died of AIDS. The regression equation that included the 8 variables explained 38.1% of the variance in AIDS PTSD ($F(8,87) = 6.6859, p < .001$).

were more closeted than other men with heterosexual friends and acquaintances.

Psychological Functioning and Risk Reduction

Using ANOVA, we compared levels of self-esteem, depression, and AIDS PTSD for men in the four categories of the Michigan Sexual Behavior Risk Index. No significant differences were observed across risk categories for self-esteem or depression. However, men in the *high risk* category scored significantly higher on AIDS PTSD than did men in the *low risk* or *modified high risk* categories ($F(3,83) = 3.42, p < .05$). Mean PTSD scores were 19.00 for high risk, 11.55 for modified high risk, and 10.17 for low risk. Men in the *celibate* category were intermediate in their AIDS PTSD scores (mean = 14.17), and did not differ significantly from any of the other groups (comparisons were conducted with the Newman-Keuls test).

This finding suggests that the men in our sample who engaged in high-risk behaviors also were more likely to have experienced distress related to AIDS, such as troubling thoughts, nightmares, or somatic symptoms. In addition, it appears that the men in the celibate category may also have experienced somewhat elevated levels of AIDS-related distress compared to men who were engaging in low-risk sexual activities. Because our measure of sexual behavior focused only on the previous month, we cannot be certain whether men in the celibate category had refrained from sex for a long period of time, or if they had only recently adopted this behavior pattern. Nor can we know the motivation for their sexual abstinence. We expect to explore these questions in the next phase of the study.

Identity, risk, and psychological functioning. Based on the men's self-labeling, we identified four tentative categories of identity: (1) Gay men ($n=30$; 31%), (2) Bisexual men ($n=17$; 18%), (3) Queer men ($n=35$; 36%), and (4) Queer/Bisexual men ($n=12$; 12.5%).⁴

⁴ Although the Study 2 sample was recruited through somewhat different procedures than the Study 1 sample, the distribution of identity labels was surprisingly stable. In Study 1, the proportions of

These identities are not synonymous with sexual behavior or self-described sexual orientation. Some men who reported having had female sexual partners did not identify themselves as bisexual, for example, and some who identified as bisexual reported having only male partners. Of these four groups, two displayed distinctive characteristics of particular relevance to the present chapter (all differences reported below were significant at $p < .05$, using ANOVAs with the Newman-Keuls test).

First, the *Bisexual men* ($n = 17$) were those who identified themselves as "bisexual," some exclusively and some in conjunction with identifying themselves as "gay" (but never identifying themselves as "queer"). Perhaps not surprisingly, they were more likely than men in the other groups to believe that they had some choice concerning their sexual orientation.⁵ The men in this group appeared to be the least integrated into the larger gay community. They scored lower than the other groups on gay self-esteem and collective self-esteem; were least likely to have disclosed their sexual orientation to their friends, parents, or coworkers; and were least satisfied with the local gay/bisexual community. This lack of integration was accompanied by psychological distress. The Bisexual men manifested higher levels of ego-

men in each category were, respectively, 32%, 12%, 34%, and 15%.

⁵ The mean scores for the 4-item scale assessing perceptions of choice about sexual orientation were 6.7 for the self-labeled Queer men, 7.75 for Gay men, 7.75 for Bisexual/Queer men, and 10.0 for Bisexual men (higher scores indicate greater perception of choice; maximum possible score = 20). Comparison by ANOVA with the Newman-Keuls test indicated that the Bisexual men scored significantly higher ($p < .05$) than the Queer or Gay men in the direction of perceiving that they had a choice about their personal sexual orientation. In response to a separate question that asked "How much choice do you feel that you had about being gay/bisexual/homosexual." the vast majority of the Gay, Queer, and Queer/Bisexual men (78%, 82%, and 91%, respectively) indicated that they felt they had "no choice at all" about their sexual orientation; only 47% of the Bisexual men felt that they had no choice, with 35% reporting "some choice" and 18% reporting "a lot of choice."

dystonic homosexuality and depression, and lower levels of self-esteem than the other men. Some of these patterns may reflect developmental differences: The Bisexual men had been out of the closet (both in terms of self-labeling and disclosure to others) significantly fewer years than any of the other groups.

None of the Bisexual men were HIV-infected themselves, and they reported the smallest numbers of friends and acquaintances who had died of AIDS or were living with HIV. In terms of sexual behavior and risk, the Bisexual men were more likely than men in the other groups to report having engaged in unprotected oral sex in the past 30 days as the insertive partner, and they placed greater importance upon solitary sexual activities such as masturbation, use of pornography, and telephone sex.

The second group of particular relevance to the present discussion was the *Queer men* ($n = 35$), that is, those who used the “queer” label for themselves at least some of the time, but never used “bisexual.” (All men who reported using “queer” for themselves also reported using “gay” for themselves at least some of the time.) The Queer men displayed a strong sense of community identification: They attached the greatest importance of any group to community activism and political symbols, and scored highest on collective self-esteem. They also were more likely than men in the other categories to be out of the closet to friends and parents. They manifested the lowest levels of ego-dystonic homosexuality.

The Queer men appeared to have experienced the greatest impact from the AIDS epidemic. More than one-third were HIV-infected, and several of these men had been diagnosed with AIDS. They reported more losses to their social network due to AIDS, and had more friends (both close and casual) living with HIV than any group. For the most part, they did not differ from other men in their sexual behavior or risk reduction, except that they attached the most importance of any group to sexual cruising and they reported the highest levels of social support for safe sex. They also

displayed the highest level of AIDS-related fears (as measured by subjective threat from AIDS) of any group.

We used moderated regression to assess whether the predictors of AIDS risk behaviors might differ among the identity groups (Aiken & West, 1991; Jaccard, Turrissi, & Wan, 1990). We computed a series of two-step regression equations for risk intentions and past risk behaviors. Three variables were entered on the first step of each equation: two dummy variables representing identity and a continuous predictor variable (e.g., ego-dystonic homosexuality, depressive symptoms). Because of the small sample size, Bisexual and Queer/Bisexual men were combined into a single group for this analysis; Gay men were coded as the index group. To avoid problems of multicollinearity, the continuous predictor variable was centered in all cases, that is, its values were transformed to deviation scores by subtracting the aggregate mean from each individual score (Aiken & West, 1991). On the second step, we entered two multiplicative interaction terms, representing the product of the continuous predictor variable with each of the two identity dummy variables. If either interaction term was associated with a statistically significant unstandardized regression coefficient, we concluded that group differences existed in the predictors of high-risk intentions or behaviors.

Our findings suggested some identity-based differences in the predictors of AIDS-related risk behaviors and intentions. It appeared that depressive symptoms and community consciousness were important predictors of risk for self-described Queer men. Queer men were more likely to express intentions to engage in unprotected anal sex to the extent that they manifested lower community consciousness and greater levels of depression. Other variables appeared to distinguish the self-described Bisexual men. Bisexual men were more likely to have engaged in high-risk behavior or to express intentions for high-risk behavior to the extent that they manifested higher levels of ego-dystonic homosexuality, attributed their own

misfortunes to homophobia, and had self-identified as bisexual only recently.⁶

DISCUSSION

Because the data reported here are from pilot studies with relatively small samples, our conclusions are necessarily tentative. Nevertheless, the findings reported above suggest promising hypotheses, which we are now examining with a larger sample.

1. *A strong sense of gay/bisexual identity and community is not directly related to risk reduction in sexual behavior.* AIDS-related risk was generally predicted by measures of perceived susceptibility to HIV, knowledge about HIV transmission, perceived efficacy of risk-reduction behaviors, self efficacy, social norms concerning safe sex, and levels of enjoyment derived from safe and high-risk sexual activities (these are collectively referred to here as the HBM/ARRM variables). Variables related to gay/bisexual identity and community were, for the most part, not directly associated with sexual behaviors and intentions. The few identity and community variables that were significantly correlated with the outcome variables (e.g., gay self-esteem, community consciousness) did not emerge as significant predictors of behavior or intentions when they were combined in a regression equation with the HBM/ARRM variables.

2. *A strong sense of gay/bisexual identity and community is indirectly related to risk reduction in sexual behavior through its relationship to the precursors of sexual risk*

⁶ We describe here the general trends rather than the actual regression coefficients because we wish to emphasize the preliminary nature of our findings, coming as they do from a small convenience sample. Furthermore, because moderated regression analyses are highly prone to Type II errors in nonexperimental studies (McClelland & Judd, 1993), we adopted a less conservative standard for significance levels than is customary. Although such a strategy is methodologically defensible (McClelland & Judd, 1993; Pedhazur, 1982), we recognize that it carries the risk of Type I errors and therefore wished to frame our findings more as hypotheses for future research than as definitive conclusions.

reduction. Although not directly related to sexual behaviors and intentions, some of the community and identity variables were significant predictors of HBM/ARRM variables. We were able to identify variables related to identity (ego-dystonic homosexuality), community (gay community consciousness), and integration of gay/bisexual identity with other aspects of one's life (outness to heterosexual friends) that were significantly associated with at least two of the HBM/ARRM variables. Men who were out of the closet, had positive feelings about their sexual orientation, and felt a sense of community with other gay and bisexual men were more likely also to have the beliefs and attitudes that foster HIV risk reduction.

3. *A strong sense of identity and community is important for gay/bisexual men's mental health in the AIDS era.* We found that men tended to manifest higher self-esteem and less depression to the extent that they had a positive gay/bisexual identity and did not perceive that their personal setbacks were attributable to antigay prejudice. The latter finding is particularly interesting because it contradicts the prediction by Crocker and Major (1989) that attributing negative life outcomes to an external cause - namely, prejudice based on one's minority group status - should protect self-esteem. Our data suggest the opposite: For gay and bisexual men, a tendency to make such attributions appears to be associated with lower levels of self-esteem and higher levels of depression. Perhaps believing that the causes of one's negative experiences are beyond one's own control (e.g., that they are caused by societal prejudice) is indicative of general feelings of powerlessness and helplessness. If so, individuals who make external attributions selectively rather than globally may be more likely than others to manifest high self-esteem. That is, higher self-esteem may be associated with an ability to explain *some* personal setbacks as the result of societal prejudice while simultaneously retaining a sense of control over other aspects of one's life.

We found that ego-dystonic homosexuality (which might also be termed internalized

homophobia) was associated with a wide range of community and identity variables. In addition to its relationship to depression, self-esteem, sexual self efficacy, and perception of interpersonal barriers to safe sex (all described above), higher levels of ego-dystonic homosexuality were significantly correlated with lower collective self-esteem, lower community consciousness, less importance attached to community involvements, less disclosure or outness to heterosexual friends, higher dissatisfaction with the local gay/bisexual community, less importance attached to political symbols, and a greater tendency to attribute setbacks to antigay prejudice (all $r_s > .30$). Thus, ego-dystonic homosexuality - as measured by the Martin and Dean (1988) scale - appears to be an important factor in gay/bisexual men's psychological functioning as well as their motivation and ability to practice safe sex. We plan to examine this variable more closely in our future research.

We observed higher levels of depression among men for whom engaging in anal sex was an important component of personal identity. We speculate that the AIDS epidemic may signify not only a health crisis for these men, but also an identity crisis. To the extent that having unprotected anal sex has been a core component of their sexual behavior and personal identity, avoidance of HIV may represent a dilemma: Give up an integral part of one's self or risk infection. Either choice is likely to be a source of significant psychological stress.

4. *Men who practice HIV risk reduction experience less AIDS-related stress than do men who engage in high-risk sex.* Men whose sexual behavior during the previous 30 days was classified as low or modified high risk manifested fewer symptoms of AIDS-related stress than did men in the high risk category. We cannot know from the data reported here whether high-risk behaviors produced the elevated stress, or represented an attempt to reduce the anxiety associated with such stress. Alternatively, both the risk behaviors and the stress may have had a common source (e.g., a fatalistic sense that HIV infection is inevitable).

It is interesting that the men who had been celibate during the previous 30 days manifested higher AIDS-related stress than did the men in the low and modified high risk groups. Again, however, we are unable to draw conclusions about any causal direction in this relationship.

5. *Men with different patterns of identity are likely to differ in their risk reduction and psychological functioning.* The previous conclusions were reached through analyses of the aggregate data. Our findings of group differences based on self-labeling suggest that examination of individual differences in personal identity construction may yield useful information about risk reduction and psychological functioning. Different variables may predict psychological distress and sexual risk behaviors among men with different types of identities.

In the present study, the self-identified Queer men were more prone than others to psychological distress because of the impact that the AIDS epidemic has had on them and on their social networks. In turn, higher levels of depression were more predictive of sexual risk behaviors for the Queers than for other men. In contrast, the Bisexual men were at greater risk than others for psychological distress because of their low degree of self-acceptance concerning their sexual orientation. In turn, Bisexuals' difficulty accepting their homosexual feelings was predictive of sexual risk.

These patterns highlight the importance of recognizing the variety of patterns of identity and community integration that characterize gay and bisexual men. To the extent that different men confront different stressors, understand their own sexuality in different ways, and are integrated into different kinds of communities (or have different kinds of relationships with the same community), they are likely to be affected differently by the same HIV intervention. Whereas an intervention for Queer men might more effectively promote sustained risk reduction by grappling with depression and bereavement, for example, an intervention with Bisexual men might be more effective if it confronts internalized homophobia.

Our results also suggest answers to some of the questions raised by Sandfort (this volume) concerning the relationships between risk reduction and variables such as self-esteem, community integration, and social support. We hypothesize that at least some of the seemingly contradictory findings in the AIDS research literature might be resolved if the gay and bisexual male population were understood not as a monolithic group but as a collection of subgroups with varying constructions of personal identity and community. We have made only a tentative step in this direction with our extremely simple categorization based on the terms used to describe one's identity. Further inquiry in this area may yield useful insights for HIV prevention, as well as a better understanding of what it means to be gay or bisexual in contemporary society.

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Table 1
 Correlations of HBM Variables with Sexual Risk Behaviors and Intentions

Intentions	Past High Risk Behaviors	High-Risk
Perceived Safe Sex Norms	ns	-.34***
Interpersonal Barriers to Risk Reduction	ns	ns
Self Efficacy for Practicing Safe Sex	ns	-.45***
Self-Labeling as High Risk	.31**	.29**
Beliefs About Effectiveness of Safe Sex	ns	ns
Fear of AIDS	ns	ns
Pleasure from High Risk Sex	.28*	.32*
Pleasure from Low Risk Sex	ns	ns
Pleasure from Safe Sex	ns	ns

Past high-risk behaviors occurred during the previous 30 days. High-risk intentions were for sexual behavior with a man other than the respondent's lover or primary partner. For all nonsignificant (ns) coefficients, $r < .20$.

APPENDIX
Measures Related to Identity and Community

Gay/Bisexual Self-Esteem^a (adapted from Rosenberg, 1965). [Cronbach's $\alpha = .87$]

1. As a gay/bisexual man, I feel that I am a person of worth, at least on an equal basis with others.
2. As a gay/bisexual man, I take a positive attitude toward myself.
3. On the whole I am satisfied with myself as a gay/bisexual man.
4. As a gay/bisexual man, I sometimes feel useless. (Reversed)
5. When I think of myself as a gay/bisexual man, I'm inclined to think that I'm a failure. (Reversed)
6. When I think of myself as a gay/bisexual man, I sometimes feel I am no good at all. (Reversed)
7. As a gay/bisexual man, I feel that I have many good qualities.

Ego-Dystonic Homosexuality^a (adapted from Martin & Dean, 1988). [$\alpha = .85$]

1. I often feel it best to avoid personal or social involvement with other gay/bisexual men.
2. I have tried to stop being attracted to men in general.
3. If someone offered me the chance to be completely heterosexual, I would accept the chance.
4. I wish I weren't gay/bisexual.
5. I feel alienated from myself because of being gay/bisexual.
6. I wish that I could develop more erotic feelings about women.
7. I feel that being gay/bisexual is a personal shortcoming for me.
8. I would like to get professional help in order to change my sexual orientation from gay/bisexual to straight.
9. I have tried to become more sexually attracted to women.

Importance of Gay/Bisexual Community Activities^b (adapted from Martin & Dean, 1988). Respondents rate how important each of the following activities is to them.

A. *Importance of Political/Community Involvement* [$\alpha = .89$]

1. being politically active in the gay/bisexual community.
2. doing volunteer work in the gay/bisexual community.
3. knowing what is going on in the local gay/bisexual community.
4. giving money to gay/bisexual organizations.
5. reading community newspapers and magazines for news about the gay/bisexual community.
6. being openly gay/bisexual when you're around heterosexual people.

B. *Importance of Socializing* [$\alpha = .88$]

1. having gay/bisexual friends.
2. partying with gay/bisexual men.
3. going to bars with gay/bisexual friends.
4. going dancing in gay/bisexual clubs.
5. going out with gay/bisexual friends.

C. *Importance of Sexual Cruising.* [$\alpha = .71$]

1. having sex with new partners.
2. going to the baths.
3. cruising for sex.

D. *Importance of Anal Sex.* [$\alpha = .70$]

1. receiving anal sex (getting fucked).
2. performing anal sex (fucking).

Personal Choice Ideology.^a [$\alpha = .65$]

1. I feel that I've always been homosexual. (Reversed)
2. Being gay or bisexual is a part of me over which I have no choice. (Reversed)
3. I freely chose my gay/bisexual orientation.
4. There was a time in my life when I could have decided to be a heterosexual.

Community Consciousness^a [$\alpha = .76$]

1. If we work together, gay/bisexual people can solve the problems facing us.
2. I feel that it is important to keep informed about gay and bisexual issues.
3. I actively support national gay/bisexual causes.
4. I feel a bond with other men who are gay or bisexual.
5. I think that most gay/bisexual men share a common sense of purpose in the need to work toward equal rights.
6. I think that all gay/bisexual men should join together to end homophobia.

Collective Self-Esteem^a (adapted from Luhtanen & Crocker, 1991). [$\alpha = .86$]

1. I'm glad I belong to the gay/bisexual community.
2. I regret belonging to the gay/bisexual community. (Reversed)
3. My membership in the gay/bisexual community is an important reflection of who I am.
4. I feel good about belonging to the gay/bisexual community.
5. I make a positive contribution to the gay/bisexual community.
6. Belonging to the gay/bisexual community is an important part of my self image.
7. I feel I don't have much to offer to the gay/bisexual community. (Reversed)
8. I feel that belonging to the gay bisexual community is *not* a good thing for me. (Reversed)
9. My membership in the gay/bisexual community has very little to do with how I feel about myself. (Reversed)

Local Community Perceptions^a [$\alpha = .85$]

1. I feel that I am a member of the Sacramento area gay community.
2. I plan to stay in the Sacramento area for a long time.
3. I have many gay/bisexual male friends in the Sacramento area.
4. I have many lesbian/bisexual women friends in the Sacramento area.
5. I wish that I could live someplace with a stronger gay/bisexual community than the Sacramento area. (Reversed)
6. I regularly attend gay events and meetings in the Sacramento area.
7. The Sacramento area is a bad place for me to live as a gay/bisexual man. (Reversed)
8. I feel at home in the Sacramento area gay/bisexual community.
9. As a gay/bisexual man, I enjoy living in the Sacramento area.

Shared Symbols.^b [Respondents rate how important each symbol, event, or organization is to his own sense of what it means to be gay/bisexual] [$\alpha = .91$]

1. The Rainbow Flag
2. The AIDS Quilt
3. Lesbian/Gay Pride Parade
4. Lambda Freedom Fair
5. The Pink Triangle
6. The Lambda Symbol

Perceptions Of Local Stigma^a [$\alpha = .88$]

1. Most people in the Sacramento area believe that a gay/bisexual man is just as trustworthy as the average heterosexual citizen. (Reversed)
2. Most employers in the Sacramento area will hire a gay/bisexual man if he is qualified for the job. (Reversed)
3. Most people in the Sacramento area feel that homosexuality is a sign of personal failure.
4. Most people in the Sacramento area would *not* hire a gay/bisexual man to take care of their children.
5. Most people in the Sacramento area think less of a person who is gay/bisexual.
6. Most people in the Sacramento area would treat a gay/bisexual man just as they would treat anyone. (Reversed)
7. Most people in the Sacramento area will willingly accept a gay/bisexual man as a close friend. (Reversed)

Attributions Of Personal Setbacks To Prejudice^a [$\alpha = .90$]

1. In general, my own failures and setbacks have happened because I'm gay/bisexual in a homophobic world.
2. Most of the bad things in my life happen because of homophobia.
3. Most of the bad things that have happened to me were because I'm gay/bisexual.
4. Most of my own setbacks in life have happened because of homophobia.

^aThese items were accompanied by a 5-point Likert-type response scale ranging from *strongly disagree* to *strongly agree*.

^bThese items were accompanied by a 4-point Likert-type response scale ranging from *not at all important to you* to *very important to you*.