The Effect of Acquired Immune Deficiency Syndrome on Homosexual Identity

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THE EFFECT OF ACQUIRED IMMUNE DEFICIENCY SYNDROME
ON HOMOSEXUAL IDENTITY

BY

ROBERT STEPHEN SCHULMAN
B.A., University of Florida, 1974

THESIS

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The Effects of Acquired Immune Deficiency Syndrome on Homosexual Identity

by

Robert Stephen Schulman

March, 1986

A study was conducted to assess the effect of Acquired Immune Deficiency Syndrome (AIDS) on homosexual identity in a sample of homosexual men with an active AIDS diagnosis. Forty-two gay men with AIDS and 102 healthy gay men were handed questionnaires measuring various components of homosexual identity, broken down into 9 scales. A comparison of the total scores on these scales indicated that both groups of gay men had similar positive attitudes regarding their homosexuality.

An examination of paired scales between groups provided evidence that men with AIDS are experiencing increased conflicts with heterosexual society, anticipating greater discrimination resulting from the disclosure of their homosexuality and perceive society as less accepting towards homosexuals compared to the healthy respondents. Additionally, the AIDS respondents reported greater social involvement with other homosexuals, were more accustomed
to common homosexual practices, and had a history of homosexual relationships of longer duration compared to the healthy subjects. There were also indications that the AIDS subjects were experiencing increased anxiety regarding being homosexual. It is believed that this increase is associated with the rejection and ostracism gay men with AIDS are experiencing from society.
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REVIEW OF THE LITERATURE - AIDS

AIDS: An Overview

One of the most mysterious and perplexing diseases to confront modern medicine is AIDS (acquired immune deficiency syndrome). The Center for Disease Control's definition of AIDS is a "disease syndrome characterized by an unexplained severe loss of natural immunity resulting in the emergence of cancer or infection that would not ordinarily be seen or that would not otherwise occur with life-threatening severity" (Batchelor, 1984, p. 1280). AIDS is considered the "number one priority" of the United States Public Health Service (Brandt, 1983, p. 306). Although AIDS was initially identified in 1981, the first reported case was actually in 1979 (Curran, 1983). The incidence of AIDS has doubled every succeeding 6 months (Brandt, 1983). Since 1979 more than 80% of those diagnosed with AIDS have died within 2 years of diagnosis (Dowdle, 1983). Statistics from the CDC (1984) indicate that new cases of AIDS are being reported at an average rate of 80 to 100 per week. Additionally, statistics show from 1979 to November 1984 there have been 5,200 individuals who have contracted AIDS, with a mortality rate of 45%. It has been estimated that shortly there will be 6,500 cases of AIDS and possibly as many as 20,000 by June
Individuals who contract AIDS tend to be between the ages of 20 and 40 (Batchelor, 1984).

Witti and Goldberg (1983) have described the immunological characteristics found in AIDS patients:

AIDS patients have normal or elevated concentrations of antibodies in their blood. However their ability to respond to a new antigenic stimulus with immunoglobulin is reduced. These patients have half or less than half of the normal number of peripheral blood lymphocytes. Antibody secreting B-lymphocytes do not appear to be affected but T-lymphocytes, the cells associated with cell-mediated immunity are low in number and their distribution is abnormal. The helper T-cell subpopulation is greatly depleted and may even be absent whereas the suppressor T-cell subpopulation is normal.

Helper T-cells aid other types of immune cells in performing their functions and suppressor T-cells inhibit the functioning of these other immune cells. The loss of helper cells, while the suppressor cell population remains intact, can produce a significant suppression of cellular immunity. The loss of those components of the cell-mediated immune system may allow opportunistic infections to occur and small numbers of transformed cells ordinarily destroyed by the immune system to develop into life-threatening tumors (p. 313).

Eighty-five percent of the people with AIDS most often contract an unusual form of skin cancer, Kaposi Sarcoma and/or Pneumocystic Carinii Pneumonia (Dowdle, 1983). "These rare conditions were once unheard of outside medical circles; now, however, these diagnoses are well known and generally thought of as being equivalent to a death sentence" (Deuchar, 1984, p. 615). While physicians have been able to treat the opportunistic infections, there is no treatment or cure for AIDS, consequently once a person is diagnosed with AIDS, the course has been set (Batchelor, 1984).
The Public Health Service (1984) has classified individuals with AIDS into specific risk groups: non-monogamous gay or bisexual men, female sexual partners of bisexual men, people who mainline drugs into their bloodstream and their sexual partners, immigrants from Haiti and hemophiliacs who require transfusions of whole blood (Batchelor, 1984). Due to the high proportion of gay men with AIDS (gay and bisexual men have represented 71% of the total), there had been initial speculation that certain aspects of the gay lifestyle could be responsible (Brandt, 1983). Several medical investigators have focused on the immune systems of gay men (Reuben, et al., 1983) and examined how the lifestyles of these men differed in comparison with other individuals (Oleske, et al. 1983). With the discovery that AIDS was also present in Haitians (Vierra, Frank, Spira & Landesman, 1983) it was theorized that AIDS was a virus, possibly a mutation of African Swine flu virus (Batchelor, 1984).

The Public Health Service hypothesized that AIDS is transmitted through sexual contact involving contact with semen, through the sharing of needles by users of IV drugs and by transfusions of blood or blood products. The incubation period between initial contact with the virus and diagnosis has been estimated at between 9 months and 3 years. At this time it has not been determined whether it is infectious during or after that period (Batchelor, 1984).
At the present time, medical researchers have postulated that AIDS is caused by a virus. This has been referred to as the "germ theory" or "viral theory" of causation. Witti and Goldberg (1983) believe that this AIDS-causing virus is a mutation of another virus present in another species which has adapted to humans. Martin and Vance (1984) refer to Sonnabend, Witkin and Pertilo (1984) who have proposed another theory to explain the etiology of AIDS, the "immunologic overload theory". This model differs to some degree from the germ theory as it relates to the process in which the illness occurs. This theory contends that as opposed to a biological cause, the contraction of AIDS is due to the lifestyle of the gay male. These authors point to the repeated abuse of the immune system which influences one's susceptibility to contract the illness. Factors which have been found to affect the immune system include: poor health habits, the use of prescription and recreational drugs, repeated exposure to semen and exposure to viruses such as cytomegalovirus (Giraldo & Beth, 1980), and the Epstein-Barr virus (DeWade, Shieleman & VanCamp, 1981).

Coates, Temoshok and Mandel (1984) have referred to a study by Levy and Ziegler (1983), who proposed still another theory to shed light on why only certain individuals in the high-risk group develop AIDS. Levy and Ziegler believe the AIDS is itself an opportunistic infection and is a result of individuals who previously had
weakened or dysfunctional immune systems. They believe that several factors have contributed to this weakened state, such as: repeated infections, drug use, repeated viral assaults and excessive use of antibiotics. Other factors which might also be responsible are the individuals' health habits, social support and psychological stress.

Coates et al. (1984) make reference to several studies in the field of psychoneuroimmunology, which studies the mechanisms by which psychosocial factors influence a predisposition to contract illnesses (Jenmmot & Locke, 1984; Solomon & Moor, 1969; Thornton & Stein, 1983; Ader & Cohen, 1975). These scientists have proposed four models which they believe explain the immunosuppression observed in AIDS. The first model theorizes that immunosuppression and stress are related.

Jenmmot and Locke (1984) believe that immunosuppression is associated with a predisposition to contract immunologically related diseases. Solomon (1979), for instance, was able to show that stress in rats affects primary and secondary immune responses. Bartrop and Lazarus (1977) and Thornton and Stein (1983) showed that bereavement is associated with immunosuppression. Kaplan (in press) proposed the second theory which ties psychosocial factors to immunosuppression and a tendency to contract immunologically related diseases. This theory suggests that other psychosocial factors in addition to
stress can affect the immune system, such as depression, life satisfaction and hopelessness.

The third theory is based on research conducted by Ader and Cohen (1975, 1982). This theory suggests that "conditioned learning is linked to immunosuppression, which in turn is linked to immunologically related diseases" (p. 1311). Ader and Cohen base this theory on an experiment that induced "activated antibody response" (p. 1311) in a group of behaviorally conditioned rats without the presence of any immunosuppressing drugs. They hypothesized, based on this research, that the immunosuppression observed in AIDS patients is related to a "learned tendency" to respond with immunosuppression to certain environmental events that originally induced or were once paired with immunosuppression. Coates et al. see the last model incorporating certain aspects of the first three models; this model suggests that psychosocial factors contribute to the "susceptibility" to environmental stressors. Additionally, genetic and environmental factors also contribute to the susceptibility to stress. Thus this last model postulates that psychosocial genetic and environmental factors combine to influence an individual's predisposition to disease and also affects the course of the disease once contracted.
The Psychological Implications of AIDS

Although members within the medical community have been describing AIDS as a mysterious and deadly illness, there are now increasing indications that this disease has significant psychological implications. Several investigators within the psychology community have observed the psychological effects of this devastating disease, particularly in gay men (Goulden, Todd, Hay & Dykes, 1984; Deuchar, 1984; Nichols, 1983; Morin & Batchelor, 1984; Malyon & Pinka, 1984; Morin, Charles & Malyon, 1984). As Morin and Batchelor (1984) state, "The mental health aspects of the AIDS crisis begin with the individual person, expand to friends and family, include health caseworkers who treat people with AIDS and have begun to include whole segments of society" (p. 4). Martin and Vance (1984) and Coates et al. have suggested that due to the serious psychological implications associated with AIDS, it is vital that studies are implemented to determine the full scope of this catastrophic illness, with particular emphasis on gay men and the gay community.

Reactions to this frightening disease have been varied within the gay community (Morin et al., 1984; Morin & Batchelor, 1984). Morin and Batchelor (1984), referring to a survey conducted by Hausman (1983) assessing the degree AIDS was affecting the gay community in San Francisco, state that "approximately 75% of the respondents indicated increased anxiety since they had found out about AIDS."
Denial of the problem associated with AIDS was low, only 3% agreed with the statement that 'one need not worry because a cure was forthcoming.' Only 8% of the respondents felt that they had heard too much about AIDS and only 7% indicated that AIDS had not affected them at all" (p. 8).

It is the purpose of this section of the proposal to review and examine these issues. At this time researchers speak of three separate groups within the gay community who have all been affected by AIDS. These are the "worried well", those individuals who are presently healthy but worry about contracting the disease, the "pre-AIDS" individuals who have symptoms of AIDS (decreased immune functioning) -- they are sometimes referred to as being in the "gray zone" -- and the final group, individuals who have the illness. In order to fully understand how AIDS has affected each, this review will be broken into five sections: Section I will review how AIDS has affected the "worried well"; Section II focuses on those individuals labeled pre-AIDS; Section III focuses on the AIDS victim, and Section IV will address the psychotherapeutic treatment approach to AIDS and Section V will address the psychotherapeutic treatment approach with lovers, families and friends. It must be mentioned that due to the fairly recent outbreak of AIDS, a number of the researchers quoted in this paper have relied on what they refer to as their own observations and therapy experiences with gay men and men who have AIDS.
Indications in the Worried Well

At the present time these individuals are healthy; however, an increasing number of gay men are exhibiting behavior which Paroski (1984) labels "AIDS panic". Paroski defines this as an anxiety state associated with a belief that any health related problem such as a cough or lesion is probably a sign of AIDS (Deuchar, 1984). Schwartz (1983) has been able to show that individuals who suffer from AIDS panic tend to have obsessive and paranoid tendencies. In a study examining the psychological components of an individual exhibiting AIDS panic, Schwartz administered the C.P.I. to a group of gay men who were showing up at their doctor's office repeatedly. The results of this testing revealed individuals who tended to be obsessive and paranoid. Morin et al. (1984), referring to the extent anxiety associated with AIDS is affecting the gay community of San Francisco state, "anxiety is channelled into obsessional thinking about disease, death and fear of loss of physical attractiveness" (p. 1289). Additionally, these authors have observed that AIDS-related anxiety has contributed to conflicts involving jobs and career, friendships and primary partner relationships.

In studies by Malyon and Pinka (1984) and McKusick and Horstman (1983), the worried well are exhibiting psychological symptoms that are similar to AIDS symptoms. McKusick and Horstman (1983) administered a questionnaire assessing psychological adjustment. Their results show the
worried well suffer from depression, feelings of helplessness and hopelessness and anger.

AIDS panic is also having an affect on homosexual promiscuity (Schechter and Jeffries, 1984; Golubjatnikov, 1983). A study conducted by Golubjatnikov (1983) in Madison, Wisconsin, indicated that among male homosexuals (between February 1982 and July 1983) there had been a steady decrease in the reported frequency of sexual contacts.

This study was carried out in a doctor's office which primarily caters to gay men. A questionnaire was administered assessing frequency of sexual contact between the dates mentioned. Initially respondents reported a high frequency of sexual activity; by July their data showed that respondents reported a decrease in sexual activity. Golubjatnikov (1983) believes in the absence of apparent reason, that this decrease was due to the fear of contracting AIDS.

The worried well have displayed a variety of responses in accepting AIDS as a deadly and serious illness (Batchelor, 1984). A number of these individuals have preferred to avoid the AIDS issue because, "it is simply too frightening for them to confront" (Morin & Batchelor, 1984, p. 7). Morin et al. (1984) noted the various responses associated with the acceptance that AIDS is a serious illness. Through interviews with members of the gay community, they stated, "responses fall along a continuum
from maladaptive to adaptive. A maladaptive example of acceptance is shown when a gay man believes that AIDS is simply another sexually transmitted disease" (p. 1292).

Indications in the Pre-AIDS Patient

Another group of gay men affected by AIDS are those that have been classified as having "pre-AIDS" or "prodromal AIDS" (Morin et al., 1984; Morin & Batchelor, 1984; Deuchar, 1984). From a medical perspective, individuals in this group have suppressed immune systems without any indication of an opportunistic disease. Quite often men in this group suffer from lymphoadenopathy (thrust), chronic fatigue, night sweats and diarrhea (Brandt, 1983). Clinically they are described as having inverted T-cell ratios (Helper/suppressor), a condition suggestive of decreased immune functioning (Wittit & Goldberg, 1983).

Several writers have observed that individuals with this condition exhibit indications of being under tremendous psychological stress (Morin et al., 1984; Morin & Batchelor, 1984). As Morin et al. (1984) believe, this stress is associated with not knowing if their condition will change and they too will be diagnosed with AIDS. As a result, "This painful situation constitutes grounds for the development of a variety of anxiety disorders" (p. 1289).

Morin et al. (1984) and Deuchar (1984) have observed the worried well experiencing conflicts associated with
isolation, frustration and exhaustion, problems maintaining jobs and friendships, lack of motivation associated with reminders of their condition and the ambiguity of what the future will bring. Additionally, people in the "gray zone", like AIDS victims, can feel shame and fear of being stigmatized. These authors were not able to substantiate their statements with research data; however, claim that these are psychological responses that they observed through interviews and statements from people often associating with this group.

Indications in AIDS Patients

Individuals who are eventually diagnosed with AIDS have been periodically ill before ever finding out that they have the disease (Morin et al., 1984). Due to the poor prognosis of AIDS, just hearing the diagnosis can be an overwhelming experience (Morin & Batchelor, 1984). Morin et al., referring to the period before diagnosis, have observed anxiety and psychological distress. Additionally, AIDS has a powerful stigma attached to it and as a result, this stigma "marks the starting point of the emotional problems that a person with AIDS encounters" (Deuchar, 1984, p. 615). Several writers, referring to the emotional reactions they have observed in AIDS patients, observe shock, guilt, denial, fear, anger, sadness and bargaining, the very same responses to death, dying and bereavement described by Kubler-Ross (1969) (Deuchar, 1984;
Nichols, 1983; Morin et al., 1984; Malyon & Pinka, 1984). Morin et al., through their work with AIDS patients, have described the psychological reactions associated with an AIDS diagnosis. These include: fear of death and dying, guilt, loss of self-esteem, fears of decreased social support and increased dependency, and "the overriding sense of gloom and helplessness associated with a degenerative illness" (p. 1288).

Deuchar describes at length the emotional responses he has observed working with AIDS patients, which is appropriate here.

Shock is almost always the initial reaction manifested by sleep disorders, derealization and depersonalization, which can be viewed as a form of denial in which the identity of the person is denied. Early in the illness expressions of guilt are displayed as patients search for some reason for their being singled out for their illness. This reaction is followed by denial of the fact that the patient has a potentially fatal condition.

At various times patients express enormous anger and hostility against society, old or new sexual partners, and their families and health care workers. They are angry because of their increased isolation, changes in their lifestyle, lack of response to this disease by the government and why were they stricken when so many others with similar lifestyles and risk factors have escaped. There usually is a resurgence of anti-homosexual feelings no matter how well-adjusted they have been to their sexuality. Sadness may drift into depression as the disease progresses, patients stop eating, display suicidal ideation, become obsessed with the daily changes they see or imagine. Superimposed on this complex set of reactions are emotional crises arising out of patients’ mounting isolation. Rejected from society and ostracized by other patients, many AIDS victims report 'feeling dirty.' Further psychosocial trauma may spring from the fact that a patient who has AIDS may not have 'come out'. Added to the problems of having the disease, he now has the extra burden of coping with his family and friends' reaction to his homo-
sexuality. Along with the rejection from society there is often additional rejection from families and lovers. Once in the hospital yet more rejection is suffered by AIDS patients, this time from professional staff and patients who interact with them at the end of a rather long barge-pole, still under the misconception that AIDS is highly contagious (p. 615).

Treatment Implications

In this section a closer look at the mental health outlook both for gay men with AIDS and without, as well as the psychological effects this disease is having on friends, families and lovers. "It is essential that anyone that comes into contact with AIDS patients understand the basic psychological reactions to the disease" (Deuchar, 1984, p. 616).

Because gay men are the most likely to contract AIDS, issues involving disclosure of their homosexuality, particularly to physicians, has surfaced (Morin & Batchelor, 1984). Dardick and Grady (1980) believe that due to the perceived negative responses associated with the disclosure of their homosexuality, many gay men have elected not to let their physicians know about their lifestyle. Ironically, they point out, in order for gay men to receive the best medical care, their physicians need to know that they are homosexual.

Dardick and Grady (1980) attempted to determine the degree that homosexuals disclose their lifestyle to physicians and how physicians' reactions to this affect their appraisal of that physician. In their sample, 47% of gay
men told their physician that they were homosexual. Based on conclusions in this study they stated: "Openness led to greater satisfaction with the primary health care provider and that attitudes of health professionals toward homosexuals were an important concern" (p. 117).

Several writers have suggested that mental health professionals, like physicians, need to assess their feelings about homosexuality (Morin & Batchelor, 1984; Deuchar, 1984; Morin & Garfinkle, 1978). As Garfinkle and Morin (1978) point out, professionals in the mental health field are not always familiar with the crucial concerns of gay men and lesbians. Additionally, they believe a significant number of mental health professionals see homosexuality as a disturbance or problem. With this in mind, Garfinkle and Morin studied how psychotherapists view homosexual clients versus heterosexual clients, with the belief that therapists would be biased against the homosexual client. The results of their study indicate "that the homosexual clients were seen as significantly less healthy than the heterosexual clients". The authors attributed this to the psychotherapeutic attitude and belief "that homosexuality violates sex roles" (p. 109).

Because of the severity of this disease leading to isolation and lack of emotional support, it has become increasingly essential that mental health professionals become adept at recognizing the needs of AIDS patients (Morin & Batchelor, 1984; Deucher, 1984). Morin and
Batchelor state "health care providers might be able to assist in alleviating patients' psychological distress and aid in facilitating initial and continuing medical treatment of patients through psychological assessment and intervention. The practitioner's awareness of emotional factors can help prevent the patient's fear and anger from being transformed into self-destructive behavior" (p. 5).

Psychotherapy and Psychotherapeutic Issues with Gay Men

As Morin et al. (1984) and Goulden et al. (1984) have noted, due to the nature of this illness, psychotherapy with gay men is now focused in a different direction. As Morin et al. note, "Tolerance for ambiguity and uncertainty are often topics of therapy, but now they have taken on a new significance and immediacy" (p. 1291). Sexual issues and concerns, which are typically an important aspect of psychotherapy with gay men has now become the primary focus (Morin & Batchelor, 1984). As Malyon and Pinka note, therapy has begun to focus on the basic issues of life and death, isolation, frustration, and on the overall sense of despair, issues that before the AIDS crisis were not typically part of therapy. In addition, many gay men who have observed the death of friends have begun reappraising their own lives (Morin & Batchelor, 1984; Morin et al., 1984).

Within the gay community, individuals are looking at ways to reduce the risk of contracting the disease, focusing on prevention and education, in the hope that
practicing safer sex will contribute to the reduction in AIDS cases (Goulden et al., 1984). As medical research has hypothesized, AIDS is transmitted sexually and, consequently, changes in sexual behavior could alter the spread of this disease (Martin & Vance, 1984). For many gay men, suggestions that they need to change their sexual behavior have been met with anger and denial, understanding these suggestions to be disguised rejection and hostility on "core components of their sexual identity" (Goulden et al., 1984, p. 584). Goulden et al., make reference to Cass (1979), who believes: "The gay identity of many men is accompanied by a reservoir of anger at and alienation by perceived or real rejection by families and friends during the identity formation process" (p. 584). Many gay men have stated that before they ever consider changing their sexual behavior, they want definitive answers to medical questions (Joseph, et al., 1984).

Morin and Charles (1983) believe that traditional psychotherapy with gay men focuses on the working through of "internalized negative" feelings associated with being homosexual (Morin et al., p. 1291). At the present time, as a result of this disease, therapists are in a precarious position; on one hand, there is the need to convey to their client that having sex and being gay are okay, while on the other hand, directing and assisting the individual toward safer sexual practices (Malyon & Pinka, 1983; Morin et al., 1984). For many gay men, practicing safe sex involves
being assertive and learning certain social skills that were unnecessary before the AIDS crisis (Morin et al., 1984). Morin and Batchelor (1984) and Morin et al. (1984) have suggested that therapists need to be attuned to their clients' individual reactions to these various, rather new suggestions. Additionally, they believe that therapists must be able to deal with their own feelings of frustration when they observe clients involved in behavior that is potentially dangerous.

Many therapists are seeing clients who have a need for compulsive sex (the need for continuous anonymous sexual encounters). Morin et al. believe that these individuals can be assisted by techniques which have been used to treat other compulsive problems. In making these suggestions, they point to the effectiveness of groups such as Sex and Love Anonymous, which follows the basic guidelines of Alcoholics Anonymous and Overeaters Anonymous. Hausman (1983), referring to these specialized groups, notes that having a group of individuals with a similar background discussing common issues, giving advice to one another and being supportive, has dramatically assisted in decreasing the need for compulsive sexual behavior (Morin et al., 1984).

Morin et al. (1984) believe that in addition to compulsive sexuality, another crucial therapeutic issue is intimacy. Presently, as a result of this crisis, these writers have observed that members of the gay community are
beginning to move away from anonymous sexual contacts, moving more in the direction to couple. They have classified three groups of gay men where conflicts have surfaced involving the issues of intimacy and sexuality.

The first group are those individuals who have never been in a relationship. These men are faced with several issues: principally, learning how to live with another person, and more importantly, learning how to be intimate. In this regard they believe that therapy should focus on teaching relationship-oriented skills as well as helping the individual overcome those fears regarding intimacy.

The second group are those men that have a history of intimate relationships but are currently single. Men in this situation experience conflicts associated with wanting a relationship but at the same time confronted with the frustration of meeting a healthy and compatible partner. For men in this situation, the bars and baths were the primary setting for both socialization and sex; now, however, these men are having to find other ways to meet potential partners.

The third group concerned with intimacy issues are those individuals who are presently in a relationship. Some individuals in this group have used sex outside of the relationship as a means of coping with stress or "sexual boredom" within the relationship. Consequently, conflicts in the relationship have been avoided through sexual outlets. As these authors note, when open relationships
are closed, problems and conflicts which have been other­wise repressed begin to surface. The relationship takes on a different perspective, needs that were satisfied outside of the relationship must be satisfied within the relationship.

In closing, AIDS panic observed in the worried well is another area that needs to be focused on in therapy (Deuchar, 1984). As Deuchar suggests, the physician can help assuage the person's fears by providing accurate information pointing out the unlikely probability of contracting the disease. He states, "'Reframing' is an important concept when dealing with these people. This involves helping the patient to slow down their thought processes and emotions, so they are able to sort out and present certain fears and anxieties in the form of questions which can be answered" (p. 616).

Malyon and Pinka (1984) and Morin et al. (1984) have suggested that stress-reducing exercises such as biofeedback, hypnosis training and cognitive techniques, focusing on taking control over anxiety, could be utilized in helping those men who suffer from AIDS panic. Malyon and Pinka suggest these techniques as they have been successfully used in other cases of stress reduction (Derogatis, Abeloff & Melisaratos, 1979, Locke, 1982), particularly with stress associated with illness. These researchers working with women who had breast cancer (but survived) were fearful of its return. With the application of
biofeedback and cognitive techniques they were able to reduce the stress and fear associated with developing the illness again.

As Malyon and Pinka (1983) state, "Traditional uncovering approaches to psychotherapy, however, are frequently desired in order to resolve the conflicts that have been constellated by the threat of AIDS" (p. 6). For those individuals in the "gray zone" group therapy which provides a caring and supportive environment has proven to be effective in reducing stress. Support groups for gay men focusing on a variety of issues (developing a positive gay identity, social skills and cultivating and maintaining relationships) have been utilized as a therapeutic intervention for years. For the worried well, group therapy has also been beneficial. These groups tend to focus on a variety of topics including obsessional thinking about AIDS, modifications in their social life, health related issues, loneliness, and bereavement and death (Morin et al., 1984).

Various gay organizations have implemented programs providing services for gay men during this crisis. Several communities have AIDS phone hotlines giving out information and providing an outlet for gay men to talk about their fears (Deuchar, 1984).

Coping Strategies

Goulden et al. (1984) constructed seven steps to assist people in learning to cope during this stressful
period. These writers applied some of the principles of Jemmnot and Locke (1984), who believe that "disorders having an immunologic component are affected by stress" (p. 80). The research by these men indicate individuals in stressful situations have decreased immune systems. Jemmnot and Locke cite various research which correlates an individual's illness with stress-related experiences.

In constructing these seven steps they applied stress-reducing exercises (exercises that have been found to help in reducing stress) to common psychological reactions to the AIDS crisis. The more common stress-related reactions to AIDS have been anger, fear of contracting the disease and depression (Deuchar, 1984, Malyon and Pinka, 1983, Morin et al., 1984, Morin and Batchelor, 1984), while common stress-provoking factors include lack of sleep, poor diet, drug use and interpersonal conflicts (Jemmott and Locke, 1984, Todd, 1984). These steps are:

1. Regain control by adopting stress-reducing activities such as exercise, modifying diet and sleep patterns.

2. Join support groups to acquire information to share feeling to learn habits of emotional freedom and expression.

3. Channel anger constructively, join social and political groups concerned with education and fund raising for AIDS.

4. Seek professional help if suffering from depression.

5. Resolve interpersonal conflicts.

6. Enhance communication skills and improve quality of relationships.
7. Avoid the abuse of drugs and alcohol.  
(p. 584)

Treatment Perspectives for People with AIDS

People with AIDS have a variety of psychological needs related to the fear of death, the stigma attached to the disease, concerns about exposure of their homosexuality, guilt feelings, and loss of lovers or friends (Deuchar, 1984).

Many people diagnosed with AIDS have mentioned that although their medical needs were being met, their emotional and psychological needs were not (Morin & Batchelor, 1984; Morin et al., 1984). At this time, so much of the emphasis has been on the medical aspects of this illness that the more global, psychological aspects have been virtually ignored (Martin & Vance, 1984; Joseph et al., 1984; Morin & Batchelor, 1984; Morin et al., 1984). Because of the nature and severity of this illness, mental health intervention needs to be considered an integral part of treatment (Coates et al., 1984). As Malyon and Pinka suggest, "At the point of diagnosis for instance, the practitioner's awareness of emotional factors can help prevent the patient's natural fear and anger from being transformed into self-destructive expression" (p. 5). Because this illness carries with it such catastrophic implications, Deuchar (1984) and Batchelor (1984) have pointed out that individuals with AIDS are going to need as
much assistance and help overcoming their feelings of frustrations and anguish that can be offered.

Several writers suggest that professionals in the mental health field who are going to have AIDS patients for clients need to become acquainted with all facets of the homosexual lifestyle as well as the inherent problems and conflicts associated with it (Nichols, 1983; Deuchar, 1984; Morin & Batchelor, 1984).

The central goal of therapy, similar to therapy with the terminally ill, is to assist the patient towards acceptance of their illness and instilling in them the belief that they can take care of themselves (Deuchar, 1984). This quite often requires the therapist to help in "restructuring" the individual's "meaning in life" as well as learning ways to adapt to the "limitations of the illness" (Deuchar, p. 617). As Deuchar states, "Patients must face their fear of death and, even more distressing for some, their fear of losing the ability to care for themselves" (p. 617).

Anger is a normal reaction observed in individuals with AIDS. Deuchar suggests that therapists focus on allowing the individual to express and vent this anger. He sees anger as measured by the degree of denial that is present. When the individual is able to release this anger, denial becomes diminished and movement towards acceptance is facilitated.
Support Groups

At this time one of the most useful tools in the treatment of the psychological aspects of AIDS are groups. Support groups are a vital component of the treatment of people with AIDS (Deuchar, 1984). These groups concentrate on decreasing isolation, planning outings and social get-togethers (Morin and Batchelor, 1984). In addition, the physical contact (touching/hugging) in support groups is particularly needed by people with AIDS who do not get much physical comfort elsewhere. Therapy groups also help people express their anger and resentment as a result of having lost friends, lovers and homes.

Organizations

Within the last several years, two cities have implemented special therapy programs to assist in the treatment of AIDS patients. In San Francisco, the Shanti project offers therapeutic services that are essential to AIDS victims and their families. Many of the people who utilize these services are referred by physicians. During the initial visit, the individual is assigned a counselor and asked to join one of the support groups. The use of support groups has proven to be an important tool in assisting the AIDS patient in coping with the various debilitating and psychological effects of this disease (Morin & Batchelor, 1984).

In New York, the Metropolitan Hospital Centre offers similar therapeutic services for people with AIDS. The
philosophy of the program is "to develop a bio-psycho-social approach, which maintains the view that each individual is a member of a family and community and deserves a coordinated approach to medical care and treatment with dignity" (Deuchar, 1984, p. 618). The program includes maintenance of a multidisciplinary treatment team, provisions of on-going psychological support for patients and families and education and supports for hospital staff (Deuchar, 1984).

Psychotherapeutic Indications with Lovers, Family and Friends

As mentioned throughout this paper, mental health considerations are desperately needed by people with AIDS and, to a larger extent, gay men. In addition, those people closest to them -- friends, lovers, and families -- will also be in need of therapy.

Several writers see those issues which are at the core of death and dying (grief, sadness and depression) as being not only restricted to the AIDS patient, but can also be found in the families, lovers and friends of the AIDS victims. Consequently, these people are going to be in need of mental health services (Morin & Batchelor, 1984; Morin et al., 1984; Goulden et al., 1984; Deucher, 1984; Nichols, 1983).

The families of AIDS victims are confronted with two devastating revelations: one involves the issue of death while the other involves learning that their son or sibling
is homosexual. For those families not knowing of the patient's homosexuality, there can be considerable distress, particularly at the same time finding out that their loved one is dying (Malyon & Pinka, 1984). Feelings of guilt and anger are superimposed on the family's attempts to reconcile the patient's homosexuality and also pending death. Anger might be expressed at the patient's homosexuality, which is seen as the reason for his developing AIDS (Goulden, Todd & Hay, 1984).

For the friends of AIDS victims, the issue of death is particularly frightening since most AIDS victims as well as their friends are fairly young (Morin & Batchelor, 1984). Friends are confronted with a variety of distressing issues (Morin et al., 1984). Knowing someone with AIDS brings to mind one's own vulnerability as well as mortality. Goulden et al. (1984) have described some of the issues friends of AIDS victims are confronted with, focusing on: fear of contracting AIDS, possible overidentification, awkwardness in discussing the illness, misgivings about their homosexuality as well as questions pertaining to the meaning of their own lives.

The lovers of people with AIDS are confronted with similar issues while at the same time can experience further psychological distress (Morin & Batchelor, 1984; Deuchar, 1984; Malyon & Pinka, 1983). Although AIDS is sexually transmitted, there has been no indication that the lovers of AIDS victims contract the disease. As Morin
and Batchelor (1984) state: "Lovers of people with AIDS have more reasons for developing emotional problems than concern over their own health. They are almost certain to face self-righteous discrimination, fear and legal impediments, as they help their lovers through the last months or years of his life" (p. 6).

Issues for lovers include intense loneliness, fear of rejection, isolation, and fear of becoming intimately involved with another person. He may lack the family recognition of a grief which is regarded as normal for heterosexual relations. Many lovers feel the need to be secretive, even within their own community, fearing the rejection of his infected lover by friends (Malyon & Pinka, 1984). After the death of his lover, the individual faces conflicts associated with reinvesting themselves emotionally and sexually in new relationships. For many men, this issue leads to apprehension and misgivings about repeating the whole experience with someone new (Morin & Batchelor, 1984).

As mentioned throughout, anger is a normal aspect of the bereavement process. For the surviving lover, anger can be triggered off not only in relation to the death of his lover, but also can be expressed in relation to other losses (Morin et al., 1984). The intensity of the loss of a loved one to AIDS may trigger off this anger and hostility which is then usually expressed against the closest and most vulnerable people. It can be directed at
the hospital, nurses, doctors, and family and close friends of the deceased. New losses reawaken feelings and memories associated with past losses such as loss of family, jobs and friendships because of being gay (McKusick & Horstman, 1983). Some express the wish to commit suicide which seems related to guilt, "Why did I survive? We both had the same lifestyle. We shared experiences together and now he is dead and I am alive and healthy" (Deuchar, 1984).

In respect to the treatment of lovers, friends and family of AIDS victims, the Shanti project in San Francisco has reported that 632 lovers and family members had been given individual counseling. Thus AIDS not only affects the person with the illness, but is having devastating effects on those closest to them. Consequently, mental health services that are AIDS-related are vital (Morin & Batchelor, 1984).

**Summary**

With regards to the literature, psychological issues pertaining to AIDS is an area that needs more research. After examination and review of the literature, several psychological issues are clear: the AIDS crises has had a profound impact on the gay community; as a result of AIDS, through interviews and observations, various psychological reactions abound, the most common of which are fear, depression, anger, anxiety and denial; and in addition, there are feelings of rejection, hostility from an unknow-
ing society, negative attitudes on their own sexuality and obsessional worry regarding contracting the disease.

Any serious effort to study the impact of AIDS on gay men must attempt to understand it from the perspective of those exposed to it. This includes not only those men who contracted the illness but to the larger number of men whose lives have been touched by the threat of AIDS.

It is the purpose of this thesis to take a closer look at this issue focusing on gay men with AIDS and those who are healthy.

How has this illness affected AIDS patients and gay men's attitudes on their sexuality and feelings about themselves as homosexual? Is there a significant difference on these issues between AIDS patients and healthy gay men? In order to answer this question it is important to fully understand homosexual identity development. The next section of the proposal examines this.
REVIEW OF THE LITERATURE - HOMOSEXUAL IDENTITY

Mapou, Ayers and Cole (1983) stated: "Gay people have problems unique to being gay" (p. 323). Using this premise, they attempted to assess the psychotherapeutic needs of a gay community in a large southern city. A questionnaire which covered a variety of topics (the length of time one had been aware of homosexual desires, had first homosexual experience, had taken a gay identity, relationship problems, alcoholism and family matters) was administered to 96 members of a gay organization. The items were scaled from 1 to 4, 1 being "not a real issue" to 4 "a problem area". The results of this study indicate the most severe problems encountered in terms of the scale rating tended to be those related to coming out or accepting one's homosexuality. This is not surprising when one considers the inherent problems gay people face living in a society which quite often labels them as "sick" or "perverted". Studies assessing homosexual's attitudes toward their homosexuality have shown that "it is a psychological and social burden for some but an energizing influence for others" (Bell & Weinberg, 1978, p. 122). Due to the AIDS crisis, the issue of a possible homosexual identity conflict has surfaced (Deuchar, 1984; Nichols, 1983). As Deuchar (1984)
states, "Homosexual men are experiencing a resurgence of anti-homosexual feelings (homophobia), no matter how well adjusted they have been to their sexuality" (p. 615). To have a better understanding of what is involved for gay men who have AIDS in relation to this potential sexual identity conflict, it is essential that there is a clear picture of just how homosexual identity evolves and what conditions facilitate a positive or negative identity. This section of the literature review examines this.

There are various theories that seek to explore the process which facilitates homosexual identity. This process is quite often labeled "coming out". DeMonteflores and Schultz (1978) state, "The term coming out is used by homosexuals to refer to the identity change to homosexual. Crucial to identity development are integrating adult sexuality into one's personality and fitting into society with its norms and values (including those regarding sexuality) exactly, the developing challenges of the coming out process. In a sense coming out is an adolescent phenomenon at whatever age it occurs" (p. 64). Coming out can be viewed as the individual's means of resolving differences between himself and society, differences associated with conforming to society's norms and values, while at the same time maintaining one's individuality (Plummer, 1981).

Researchers in this field tend to see homosexual identity formation in two distinct ways. There are those who take a process-oriented or developmental approach,
A definition of Homosexuality
Components of Sexual Identity

Morin (1977) defines homosexuality as comprised of three components: "a. presence of homosexual behavior, b. same-sex erotic preference, c. self-reported homosexual identity" (Morin & Schultz, 1978, p. 139). Morin and Schultz (1978) have added a fourth definition based on research conducted by Lehne (1974), labeling oneself gay rather than homosexual.

Demonteflores and Schultz believe that choice is an important aspect in the coming out process. They point out that the issue of choice invariably raises the question "does one choose to be gay?" They contend that an individual chooses to express same sex feelings, to refer to
oneself as homosexual and to be publicly open, however an individual does not choose to be homosexual, instead he or she chooses to be gay. Morin and Schultz believe that "A gay identity is healthy and a homosexual identity is not," referring to a homosexual identity as "Internalizing negative stereotypes" (p. 139).

These authors refer to Weinberg's (1972) distinction between being gay and homosexual. Weinberg sees a homosexual as having a sexual and "erotic" preference for the same sex, while a gay individual is attracted to the same sex he or she has been able to repudiate the "negative societal stereotypes" associated with being homosexual (p. 139).

Morin and Schultz studied the difference in homosexual men who labeled themselves "gay" as opposed to those who use the label "homosexual." In assessing this difference, they administered a questionnaire to a group of 75 homosexual men. Part of the questionnaire asked what label they prefer to use in describing their sexual orientation, followed by statements which are often associated with negative attitudes about homosexuality. The statements were ranked 1 (strongly agree) to 5 (strongly disagree). The results show those men who prefer the label "gay" tend to disagree to strongly disagree with negative societal images of homosexual men, while those who label themselves as "homosexual" tend to agree to mildly disagree with the societal negative statements.
DeMonteflores and Schultz make reference to a statement by Goffman (1963) focusing on the difference between the "discredited" and the "discreditable", which is appropriate to the issue of choice. Goffman states, "The 'discredited' have a visible mark of their stigma, blacks and women are in this group. The 'discreditable' on the other hand are not different by virtue of their appearance, but rather due to some failing which is not readily noticed until the subject reveals it. Homosexuals are included in this group. For the discreditable the main task is that of managing information about their failing, to display or not to display, to tell or not to tell, to let on or not to let on, to lie or not to lie, in each case to whom, how, when and where" (p. 67).

Components of Sexual Identity

Larson (1981) and Shively and DeCecco (1977) have written papers describing the components of sexual identity which is pertinent to this study. Larson (1981) stated: "Sexual identity can be conceived of as a set of self-referential attitudes, thoughts and feelings about sexuality that, taken together, is a subset of the overall self-concept. This identity and other areas of self concept function as intervening variables to produce human behavior" (p. 15). Referring to a paper by Green (1974), Larson added, "A person's sexual identity is composed of gender identity (the sense of being female or male), social
sex roles (culturally defined femininity or masculinity) and sexual orientation (the choice of sex partners)" (p. 16). Shively and DeCecco (1977) have adopted that basic framework but add biological sex as another component distinct from gender identity.

Biological Sex

As birth each individual is classified by biological sex. Most often it is an easy process to ascertain the biological sex, simply by looking. In more difficult cases there are seven criteria used in determining the biological sex of a newborn child.

Gender Identity

Shively and DeCecco believe the first psychological aspect of sexual identity to develop is gender identity. They make reference to several writers who have explored the formation of gender identity. Green (1974) defines this component as, "the individual basic conviction of being either male or female. When there is a conflict between identity and physical gender the person is referred to as a transsexual" (p. 41). Green, Money and Tucker (1975) believe gender identification develops between birth and three years of age. Maccoby and Jacklin (1974) and Money and Tucker (1975) see gender identification as a result of male infants being socialized as boys and female infants socialized as girls.
Social Sex-Roles

Larson (1981) refers to social sex roles as, "The behavioral attitudes, values and so on that are generally held to be typical of men or women by a particular culture" (p. 16). Shively and DeCecco (1977) refer to Kagan (1958) who believes that sexual formation occurs between the ages of 3 and 7. Quoting from Kagan (1958), "Social sex roles are acquired by: a) children wanting approval, b) adult caretakers giving children approval for developing stereotype behavior and c) males learning to behave like boys and females like girls" (p. 43).

Larson makes reference to studies by Block (1973), and Heilbrun, Spence and Helmreich (1978), who have challenged the assumption that "Social sex roles were mutually exclusive; an individual was either feminine or masculine" (p. 16). These writers believe that femininity and masculinity are 'independent dimensions' and that a person can "exhibit greater or lesser amounts of either or both sets of characteristics" (p. 16).

Sexual Orientation

Larson sees sexual orientation as that component of sexual identity which refers to one's choice of sex partners. It can be conceptualized as being composed of two separate facets, one is physical preference and one is affectional preference. The physical preference can be viewed as an individual's sexual attraction to either males
or females, while affectional preference is related to one's emotional attraction to males or females. Larson refers to studies by Kinsey (1948, 1953) who views sexual orientation as measured on a continuum. This continuum can be viewed on a seven-point scale ranging from exclusive heterosexuality to exclusive homosexuality.

Shively and DeCecco see physical and affectional preference composed of "two independent continua of heterosexuality and homosexuality" (p. 45). They believe that every individual has one continua for physical and affectional heterosexuality and physical affectional homosexuality. These authors refer to another theory that explains sexual orientation, the "physical affectional theory". This theory includes both the physical and affectional expression of sexual orientation, however, as these writers suggest, "it allows an examination of a greater variety of ways of expressing sexuality" (p. 46).

Several conflicts can occur in the physical affectional theory. These conflicts may be resolved on two levels: behavior and fantasy. Shively and DeCecco believe that an individual's sexual orientation consists of both behavior and fantasy, any investigation into one's sexual orientation needs to include these components. The behavioral level is one that is observable and quite often used to identify sexual orientation. The fantasy level, while not open to observation, has been used by therapists to identify sexual orientation.
A study by McDonald and Moore (1978), which looked at the relationship between homosexual men and their attitudes toward women, is appropriate in this section. The purpose of this study was to "challenge" a long-held misconception that male homosexuals lack masculinity and have a dislike for women. This study is significant to this review due to one of the hypothesized statements, "homosexual men with positive attitudes toward their own sexual orientation will have a more positive attitude toward women" (p. 4).

To measure this, the Sex Role Survey (MacDonald, 1975) and the Survey of Attitudes toward Deviance - Homosexual Men were utilized (May 1974). The SRS is a 53-statement questionnaire which measures attitude towards women. The subject either agrees or disagrees with these statements. Each item is followed by +3 to -3 (strongly agree to strongly disagree). The SAD$_H$ scale measures positive-negative attitudes about male homosexuality. The scale consists of 50 statements with each statement followed by a +3 to -3 (strongly agree to strongly disagree). The SAD$_H$ has been used previously to measure how gay men feel about their homosexuality (May, 1974).

Respondents' scores on the SRS and SAD$_H$ were inter-related and found to correlate significantly. The results of their study indicate that homosexual men who have a positive view of homosexuality also tend to agree with equality for women.
Homosexual Identity Formation
As a Single Event

Initial studies of homosexual identity formation tended to conceptualize coming out as a single event. Hooker (1967) sees coming out related to an individual's first public appearance as a homosexual. She believes this is quite often accomplished by an individual attending a gay bar. In her research she was able to assess through interviews the point that respondents saw themselves as homosexual. Her data show that a significant number of respondents claim homosexual identity when first associating with other homosexuals. Gagnon and Simon (1967), in their book "Sexual Deviance," refer to coming out as "that point in time where there is self-recognition by the individual of his identity as a homosexual and the first major exploration of the homosexual community" (p. 115). In their book, a section of a questionnaire was addressing the issue of coming out, and asked -- at what point in time between same sex feelings and behavior did the individual see themselves homosexual? Supporting Hooker's study, a significant number of respondents tied their being homosexual with contact within the gay community, whether it be through bars, organizations and so on.

Dank (1971) sees coming out as a single event. He viewed coming out as identifying oneself as being homosexual as a function of association with other homosexual individuals and institutions. In his study he was corre-
lating the age at which an individual initially began having homosexual feelings and thoughts, with the age the individual began associating with other gay people and institutions, as an indication of a positive homosexual identity. In addition he studied the setting that this association took place, and also examined the psychological differences between those who interacted with gay individuals and institutions and those who did not. He hypothesized that those who identify themselves as homosexual without association are more likely to have guilt feelings than those homosexuals who do.

He states, "in order for a person to identify themselves as homosexual he must be placed in a new social context in which knowledge of homosexuality and homosexuals can be found, in such a context he learns a new 'vocabulary of motives'. A vocabulary that will allow him to identify himself as being homosexual" (p. 184). In addition to this new knowledge, Dank believes individuals must alter their conception of what it means to be homosexual. He refers to this as altering one's "cognitive category". This cognitive category needs to be modified, replacing the negative stereotypes often associated with being homosexual with more accurate, positive views. Consequently, through contact, the negative views of homosexuals held by society no longer seem valid and the individual is now in a position to alter his cognitive category of what it means to be a homosexual. As Beane (1981) noted, "The person who is
coming out and developing a positive gay identity has most likely introjected many negative myths and stereotypes about gay men. He must differentiate himself from the homosexual image that straight society has presented to him, and this is accomplished through association" (p. 223). Supporting Dank's beliefs he adds, contact with the gay subculture "whether directly or indirectly" enables an individual to confront the stereotypes that society has of homosexuals. Jacobs and Tedford (1980) also agree that contact with other gay men who have positive gay identities helps in countering or reversing the negative identification he has experienced. In their study they compared a group of homosexual men who interact with other homosexuals, to a group who do not. By using a survey instrument measuring self-concept, they found those who interacted with other homosexuals tended to have a higher self-concept, which they attributed to interaction.

In order to test his hypothesis, Dank used a survey instrument consisting of questions he devised, focusing on the age of initial homosexual feelings, labeling oneself homosexual, the degree of association with other homosexuals and the setting where this took place. To measure psychological functioning, questions were asked as to how the individual was functioning at the present time. These responses were ranked along a 5 scale continuum, from 1, no effect to 5, a significant effect.
The results of this study show that there was an average of six years from initial homosexual feelings to association with other gay men. Sixty-eight percent of his respondents claim that they labeled themselves homosexual when they began contact within the gay community. In addition 50% came out while associating with gay people that had been met at work or through friends. The other 50% came out in what Dank labels "one-sex institutions" such as hospital wards, prisons, military settings, gay bars, baths and gay organizations. Within this category, 39% came out while going to gay bars. This supports the findings of Hooker (1967) that gay bars are the most widespread and well-known gay institution and therefore a likely place to come out. In measuring psychological states, guilt and depression are seen to be at a higher level with those who have contact with other gays as opposed to those who do not.

Weinberg and Williams (1974) also believe the individual's association with other homosexuals who accept their homosexuality in a positive manner often contributes to a decrease in psychological problems. Beane (1981) sees socializing and cultivating friendships with other gay men who accept their homosexuality positively greatly assists in facilitating the acceptance of a homosexual identity. As Beane (1981) states, "When a man grows up realizing he is homosexual but never sees any other homosexual with whom to identify he usually develops a negative
homosexual identity" (p. 223). Beane looked at the difference between homosexual men who had some prior contact (before coming out) with other homosexuals to homosexual men who had no contact. Using a survey instrument he devised assessing the differences, he was able to conclude that those men who had some contact with other homosexuals prior to coming out tended to have better images of homosexuals compared to those who did not. Those men who had no contact tended to agree with negative statements about homosexuals. This study supports the findings of Morin and Schultz (1978).

The Weinberg and Williams study focused on how homosexuals who socialize with other homosexuals affects not only psychological adjustment but also acceptance or rejection of themselves because of their homosexuality. They believe "those more involved with other homosexuals live with less fear of exposure, due to a supportive environment that has altered the way in which they conceive of their homosexuality" (p. 201).

To assess this relationship, several areas which they considered indicators of homosexual acceptance were measured and compared to the degree of social involvement with other gay men. The indicators of acceptance include: having had a homosexual relationship, acculturation (the degree of socialization with common homosexual practices) and commitment (the unwillingness to give up their homosexuality). These areas were compared with social involve-
ment with other homosexuals. The results of the study indicate that social involvement is correlated positively with acceptance of one's sexuality. This study as well as the others cited supports the contention that association with other homosexuals is a very significant factor in facilitating a gay man's positive sexual identity. This study and its further implications will be examined in another section of this paper.

In summation, positive homosexual identity is seen as facilitated by a single event, association or contact with other gay men. It is these researchers' belief that, through interaction with other gay men, one develops a positive sexual identity. Consequently an individual goes from same-sex feelings to homosexual identity in one step although, as Dank points out, this can take six years.

**The Process Oriented Perspective to Coming Out**

In this section of the review, researchers who take a process-oriented perspective are examined. These models postulate that individuals who are homosexual to varying degrees and in various ways move through similar stages of development. It is the belief of these researchers that homosexual identity is an evolving process beginning with feelings and culminating in a positive identity.

"Coming out is the process through which gay men and women recognize their sexual preferences and choose to integrate this knowledge into their personal and social
lives" (DeMonteflores & Schultz, 1978, p. 60). Beane sees the process of coming out and the subsequent development of a positive gay identity as "a lifelong endeavor" (p. 222). As Morin and Miller (1977) state: "It begins even before there is a realization that one is a homosexual and continues long after that realization of differences becomes integrated into the personality and is gradually shared with significant others" (p. 63). Coleman (1981) and Plummer (1981) refer to an initial period of "ambiguity" as "pre-coming out", it is seen as the time when the individual is not consciously aware of same sex feelings. The individual is aware that something is wrong but he is not able to describe it. During this time the individual is confused and frustrated but not sure why. From this initial confusion other stages follow and different models have been used to organize and interpret these.

One of the largest groups of process investigators believe in the ordering of coming out along a covert-overt dimension from the most private to the most public. These covert-overt models contend that private coming out experiences occur before public experiences.

Process investigators begin with the individual's awareness of feelings. Morin and Miller (1977) and DeMonteflores and Schultz (1978) refer to this as becoming "aware of same-sex feelings". Plummer (1981) and Lee (1977) refer to this as "signification", "a starting point that the individual uses to see differences between himself and
most peers, that, he is physically attracted to men and not to women" (Lee, 1977, p. 56). O'Dowd and Hencken (1977) call this initial stage "awareness", Grace (1981) refers to this as "acknowledgement" and Coleman (1981) labels this awareness of sexual feelings as "coming out". In this period the individual moves from ambiguity of feelings to a more clear picture of his feelings. The individual is aware of his feelings and may or may not act them out. For many getting in touch with what was bothering them is relieving, while at the same time can create further discomfort.

From this awareness of same-sex feelings the individual moves to what Coleman (1981) refers to as an "exploration" or "experimenting with this new sexual identity. He states, "It is during this time that the individual faces several developmental tasks. The first is to develop interpersonal skills in order to meet and socialize with others with similar interests, the second is the need to develop a sense of personal attractiveness" (p. 35). Lee (1977) sees this time as "coming out" or involvement with the gay community. This can be seen for instance as having more confidence in entering a gay bar. Plummer (1981) labels this as "coming out to the gay world", meeting and associating with other gay men. At this time the individual acknowledges and may act out his homosexuality. Morin and Miller (1977) tend to see this as "homosexual behavior stage" and O'Dowd and Hencken (1977) as "behavior
acceptance". Thus the individual is acting on sexual feelings and is arriving at a more clear picture of himself as a homosexual.

Two of these writers add another level which coincides with the level previously mentioned. Lee (1977) and Coleman (1981) add the gay person's contact with heterosexuals, whether they be friends or family. Lee (1977) includes this in what he calls "coming out", "the individual tells a few heterosexual friends and allows one's sexual orientation to become known within a restricted social network" (p. 53). Coleman (1981) refers to this period as a time cultivating a first relationship, and learning how to function in a same sex relationship.

Several writers believe before an individual is publicly able to disclose his sexual identity to the straight world, the individual must first accept himself as gay. DeMonteflores and Schultz, 1978) and Morin and Miller (1977) add homosexual identification to this period. They believe an individual first must begin to feel good about himself as a homosexual before publicly coming out. DeMonteflores (1979) refers to this as "a change in self-labeling" (p. 64). This new label "homosexual" integrates experiences by synthesizing events and aspects of self which had seemed disparate at one time.

When the individual publicly comes out, there is a sense of exhilaration and personal satisfaction. Morin and Miller (1977) refer to this as "gay identity," DeMonte-
Flores and Schultz (1978) as "coming out publicly," Plummer (1981) refers to this as coming out to the "straight world" and Coleman (1981) as "integration". This period is described as one's increased association with all facets of society both homosexual and heterosexual. Lee (1977) adds a further distinction in this category by adding being identified as gay in the media.

DeMonteflores and Schultz (1978), following up on the overt-covert model, have suggested that coming out can be looked at as a "feedback loop". In this respect, an individual's actions provoke societal reactions and these reactions subsequently affect the individual's future actions.

Riddle and Morin (1977) believe that in addition to the overt-covert model, the coming out process can be conceptualized along a timeframe. These writers studied coming out as well as a variety of other issues in a sample of 282 gay psychologists. To assess these areas, a questionnaire consisting of 24 categories, was placed in the 1976 APA Monitor. The results of their study indicated that within their sample, individuals came out over a 19-year period, ranging from as early as age 19 to age 32. Several factors were associated with the degree of openness including personal, social and professional. Based on their results, these authors were able to conclude that private coming out events are a prelude to public coming-out events.
Several writers disagree with the simplistic nature of the overt-covert model of coming out. Weinberg and Williams (1974) believe that the intricate aspects of the homosexual lifestyle cannot be viewed as following any prescribed model. Schultz (1980) believes that conceptualizing coming out related to a prescribed model is related to societal views on homosexuality. He states, "the more negative those attitudes the more likely it is that an individual must become secure in his or her identity as a gay person and have found a support group within the gay community before coming out to the heterosexual world" (DeMonteflores & Schultz, 1978, p. 62).

There is another group of process-oriented researchers who also follow the principles of the covert-overt model. These proponents of process development rely on the theory of Symbolic interaction which is derived from the Interpersonal Congruency Theory.

Interpersonal Congruency Theory is based on the assumption that "stability and change in human behavior are dependent on the congruency or incongruency that exists within an individual's interpersonal environment" (Cass, 1979, p. 220). Hammersmith and Weinberg (1973) make reference to research by Schwartz and Stryker (1977) and Cohen (1965) who believe that the basis of the symbolic interactionist perspective is derived from the idea that through socialization with others, individuals strive toward "establishing and evaluating themselves positively"
(p. 56). Weinberg and Williams (1974) see the symbolic interaction theory related to what they call the "looking glass self". This suggests that an individual's self-concept is based on how others regard him. Consequently, an individual's evaluation and image of himself, in addition to "psychological state", are a function of other people's reaction to him. In this section a closer look at these researchers who utilized the principles of symbolic interaction theory and interpersonal congruency theory to investigate homosexual identity.

Cass (1979) proposed six stages of development that an individual passes through to arrive at a homosexual identity, which will essentially become an integral aspect of the individual's self-concept. Movement from one stage to another is individualistic. In this regard, how an individual perceives societal responses as a result of one's actions ultimately determines future movement or action.

Cass believes there is a distinction between private and public components of identity. The development of these two different components of identity are separate entities, and yet in some ways are related to one another. Consequently, one might privately have a homosexual identity, and yet to the outside world have a heterosexual identity. As identity development progresses, there is a synthesizing of these two identities (private and public) culminating in "overall integrated homosexual identity" (p. 221).
Cass (1979) hypothesized that "movement from one stage of homosexual identity to another is motivated by the incongruency that exists in the individual's environment, the result of assigning homosexual meaning to the individual's own feelings, thoughts or behavior" (p. 221).

**Cass's Stages**

1. **Identity confusion** - this is conceptualized as the immediate personal identity crisis of 'who am I'.

2. **Identity comparison** - as a result of stage 1 the individual begins to feel alienated from society at large and thus the task in stage 2 is handling this societal alienation.

3. **Identity tolerance** - by the end of stage 2 the individual has turned the self image further away from heterosexuality and more toward homosexuality. As a result the individual has greater sense of identity while at the same time there is greater incongruency between the way the individual sees himself and the way others see him. The task is to try to resolve this. This stage results in greater contact with both other homosexuals and the homosexual subculture.

4. **Subculture acceptance** - this stage is seen as the time period when the individual accepts rather than tolerates a homosexual self image. This is accomplished
with increasing contact with other homosexuals and allows the individual to evaluate other homosexuals more positively and giving them more significance in the persons' life.

5. Identity pride - at this point the individual is more aware of the differences between his own self-concept and society's rejection of this. Consequently at this stage the individual devalues the importance of heterosexual others and revalues homosexual others.

6. Identity synthesis - during this final stage the individual is able to integrate in his life both heterosexuals and homosexuals. Instead of being seen as the identity (homosexual) it is now given the status of being merely one aspect of self.

(p. 223)

Hammersmith and Weinberg (1973) conducted research utilizing the ideas of Schwartz, Fearn and Stryker (1966), who studied "deviant identities" and the role commitment plays in their developing "stable identities." These writers concluded from their research that, "individuals establish and maintain stable identities and evaluate them positively and that this is accomplished by commitment" (p. 57). In their study Schwartz, and Fearn and Stryker (1966) tested a sample of emotionally disturbed children to assess the relationship between identity, self-concept and commitment to that identity. To assess the child's commit-
ment to the emotional disturbance identity, therapeutic prognosis for cure was utilized. The results of their study indicate that those children more committed to the emotional disturbance role had "1) the most stable positive self-concepts and 2) seemed primarily influenced in their self-concept by those most supportive of their deviance" (p. 56).

Hammersmith and Weinberg (1973) wanted to evaluate homosexual commitment (an unwillingness to give up their homosexuality) in relation to psychological adjustment and how support from significant others determines one's commitment or adjustment. They believe "the person who defines himself as homosexual may still regret the identity" (p. 58). These writers suggest that it is important to look at how an individual feels about being a homosexual, not only in the present but in the future as well. The sense of having a future homosexual identity has been referred to as one's 'commitment' to that identity. They believe that a committed homosexual would choose to stay homosexual if given a choice between homosexuality and heterosexuality. They hypothesized that homosexual commitment would be positively correlated with self-esteem and stability of self-concept. In addition, homosexual commitment would be negatively correlated with psychological maladjustment.

To measure this hypothesis a 145-item questionnaire was mailed out to various homosexual organizations, social
clubs, and bars to assess both commitment to homosexuality and psychological adjustment. Five areas were broken down followed by statements that the subject was instructed to check off if applicable. These areas were: homosexual commitment, stability of self-concept, self-esteem, anxiety symptoms and depression. All items had responses ranging from strongly agree to strongly disagree. The values of 1 to 5 were attached to each statement so a higher score was indicative of higher homosexual commitment, stability of self-concept, self-esteem and anxiety symptoms or depression. Based on the results of this study, they constructed six models showing the relationship between commitment, adjustment and support, which are listed below.

Hammersmith and Weinberg Models

1. This model suggested that a homosexual commitment positively influences adjustment and that adjustment influences the choice of significant others who are supportive.

2. The second model suggests that commitment increases psychological adjustment, irrespective of any outside support.

3. This model proposed that a person derives his self-support from others' reaction to him. If others support him he becomes highly committed.

4. If significant others support one's homosexuality then his adjustment will increase which will lead to a stronger commitment.

5. This model indicates that neither is commitment the result of adjustment nor adjustment the result of commitment. It suggests that one's adjustment and commitment both follow support.
6. Proposes the more committed homosexual is better adjusted because he has settled into an identity with which he is satisfied.

(p. 64)

The results of this study indicate as hypothesized that those individuals who are more committed also have higher self-concepts and are not maladjusted. In addition they found that support and adjustment are not related. As these authors state, "support seems to influence adjustment only through the variables of commitment. Thus support from significant others enhances the individual's adjustment not only to the extent that it increases the homosexual commitment to his identity" (p. 73).

Weinberg and Williams (1974) utilizing the symbolic interaction theory looked at the relationship between a homosexual's psychological problems and 1) heterosexual appraisal or acceptance of homosexuality and 2) the degree the individual accepts his homosexuality. To assess this, a questionnaire was mailed to 2,700 members of the Mattachine Society (a gay social and political organization) in both New York and San Francisco.

To measure psychological adjustment eight areas which they considered common psychological problems were assessed: self acceptance, stability of self concept, depression, anxiety, interpersonal awkwardness, faith in others, loneliness and psychiatric experiences. Weinberg and Williams believe that homosexuals are frequently confronted with negative sentiment from society. They note at times societal reaction to homosexuality is tolerant;
however, most of the time societal reaction is one of rejection. In this respect, they believe, "Fears of sanctions often inhibit persons from more fully embracing a homosexual identity" (p. 154). This is sometimes seen in the term "passing" (this will be looked at in the next section). To assess how a homosexual individual perceives heterosexual appraisal and acceptance, three questions were asked: 1) How do you think most people feel about homosexuality? 2) What sanctions would accompany discovery of your homosexuality? 3) At the present time, how popular are you in heterosexual circles? Finally in measuring a gay person's acceptance of being gay, three areas which the authors believe assess this were examined: 1) acculturation - which focuses on the individual's adjustment to "common homosexual practices" such as necking with other men or slow dancing. In constructing the items in this category, the authors included those behaviors which homosexuals regard as taking time to get used to. These behaviors are considered practiced by individuals who have frequent contact with the homosexual world. In their opinion, acculturation is a good indicator of one's acceptance of being gay. 2) Normalization - believing that homosexuality is normal and not a psychological disturbance or mental illness. 3) Commitment - the individual's unwillingness to give up homosexuality.

The results of this study indicate those respondents who believe most people have negative opinions about
homosexuals also tend to have more psychological problems. Respondents who anticipated discrimination in regard to their homosexuality tended to have more psychological problems. Finally, those homosexuals who feel more accepted by heterosexuals report less psychological problems.

In Section II the questions measuring acculturation indicate that homosexuals who score higher in this area report less depression, interpersonal awkwardness, loneliness and guilt feelings. The results of normalization indicate once again homosexuals who see homosexuality as normal report greater psychological well being. The section measuring commitment indicates those individuals who are unwilling to give up their homosexuality tend to also report greater psychological well being.

Further Studies and their Implications

In this section I look at some related studies which involve homosexual identity development. These studies include Weinberg and Williams' (1974) looking at passing or concealment of one's homosexuality, Bell and Weinberg's (1978) study on acceptance of homosexuality, and a study by Greenberg (1973) looking at self-esteem and alienation of male homosexuals.

In the previous section Weinberg and Williams stated 'fear of sanctions often inhibit persons from more fully embracing a homosexual identity.' This situation is most
clearly observed in individuals who "pass" or cover up their homosexuality. They hypothesized that there are two factors which contribute to passing: 1) worrying about exposure and 2) anticipating sanctions. It is believed that worrying associated with the disclosure of one's homosexuality is related to a "free-floating fear" that this disclosure would "destroy familiar patterns of societal relations" (p. 58). In this study, it was hypothesized that worry about exposure and anticipated discrimination would be correlated to passing.

To assess the relationship between psychological problems and passing, a questionnaire was mailed to members of the Mattachine Society (a gay social and political organization) in both New York and San Francisco. In measuring this area, two parts of the questionnaire were examined, those questions related to passing and those related to psychological functioning. The passing section was comprised of three statements and one question, while psychological functioning was broken into eight areas. The responses for most of the statements were ranked from strongly agree to strongly disagree.

The results of this study indicated that passing was significantly correlated to only three of the eight psychological measures: depression, interpersonal awkwardness and guilt, shame or anxiety regarding one's homosexuality. These authors believe that depression and interpersonal awkwardness are more closely related to worrying about
disclosure and subsequent discrimination than to passing. Those problem areas believed to be more associated with passing are guilt, shame, or anxiety in connection to one's homosexuality. As Weinberg and Williams state, "It is feelings such as these which are partially responsible for motivating the homosexual to mask in the first place" (p. 178).

Bell and Weinberg (1978), looking into the area of homosexual acceptance, wanted to assess how homosexuals differ in their acceptance of their homosexuality. This particular study was a part of their extensive investigation found in their book, "Homosexualities."

In conducting this research, Bell and Weinberg spent time in the San Francisco Bay area recruiting hundreds of participants. To assess numerous areas of interest, from cruising patterns to relationships, they constructed questionnaires which were specifically addressing each area. In this specific section (acceptance of homosexuality), 11 questions were organized into three sections -- regret of homosexuality, attempts to discontinue homosexuality, and negative feelings about homosexuality. Most responses were ranked from a "0" response (strongly disagree) to a "3" response (strongly agree).

The results of this investigation show that 50% of the white males and slightly over 50% of the black had "no regret" about being homosexual. About 25% of the white respondents and a slightly smaller number of the blacks
indicated that they had "some" or "a great deal" of regret over their homosexuality. Within the group that mentioned having regrets over their homosexuality, this was related to factors such as: negative societal views on homosexuality, not being able to have children, and at times feeling lonely.

Those items which measured an individual's attempts to discontinue their homosexuality showed that a small percentage considered it. Those respondents who did say they had made attempts indicated this occurred no more than twice. In addition, those who had made attempts did so by withdrawing from other gays.

In regards to other measures focusing on attitudes towards homosexuality, the results indicated that there were a variety of negative responses. Twenty-eight percent of the white males and almost 50% of the black males reported some guilt over their homosexual activities. About 25% of both white and black males agreed that homosexuality is an emotional disorder. Twenty-five percent of both groups wanted a "magic pill" at birth which would have insured their becoming heterosexual. Twenty-four percent said that "if possible" they would "give up" their homosexuality if it were possible.

Greenberg (1973) wanted to determine the differences in self-esteem and alienation between homosexual and heterosexual American males and the differences in self esteem and alienation in homosexual males. As this study
relates to the present study (AIDS - the effect on gay men's sexual identity), one particular hypothesis of Greenberg's deserves attention, "No significant difference exists in satisfaction with homosexual status for homosexuals" (p. 138).

To measure this area a questionnaire, which the author devised, was mailed out and 86 male homosexuals responded. The questionnaire consisted of a self-esteem scale with a range of 0 to 6, and an alienation scale with a range of 0 to 76.

Briefly, it should be mentioned that in this study there was a significant difference in alienation between the homosexual and heterosexual males, with the homosexual sample feeling more alienated. In reference to self-esteem there was not a significant difference noted.

The results of Greenberg's hypothesis regarding homosexual status indicates that homosexuals were satisfied with their homosexuality based on similar self esteem scores with the heterosexual sample. In answer to a question about ingesting a pill that would make them heterosexual, only 8 out of 85 replied yes.
RELATED STUDIES

In this final section I will present related studies associated with the research hypothesis. These are the psychological indications associated with sexually transmitted diseases and the effects terminal illness or cancer has on sexual identity and functioning. As a prelude to each section there will be a general overview presented on the topic. Part I will be broken into an overview section focusing on the sexual behavior pattern in both gay men who contract a STD and AIDS. This will be followed by risk factors which are attributed to the high incidence of STDs in gay men. The second section in Part I will present studies on the psychological indications in STDs with the emphasis on fear of VD and the psychiatric profile of people who have this fear. Part II, looking at terminal illness and cancer, its affect on sexual identity and functioning, will have an overview section focusing on a brief discussion on death and dying followed by terminal illness and sexuality with the focus on two studies on testicular cancer.
Overview on Sexual Behavior

At the present time medical researchers are classifying AIDS as a sexually transmitted disease (Dowdle, 1983; Curran, 1983; Brandt, 1983). This seems to be not only based on the viral theory of causation but also on indications that it is sexually transmitted in a similar fashion to hepatitis-B, which is transmitted from one person to another. Similar to AIDS, hepatitis-B is transmitted through intimate sexual contact and not through casual contact (Szmumess et al., 1975). Because of the close association between AIDS and other STDs it is important to understand the mechanism in which this occurs in homosexual men.

Studies that have been conducted with AIDS patients assessing their sexual behavior and studies on gay men with a history of STDs show similar behavior patterns (C.D.C., 1981). The CDC in 1981 attempted to assess these patterns. Interviews were carried out with homosexual AIDS patients and with healthy male homosexual controls who were located through private physicians or VD clinics. The sample consisted of fifty patients with AIDS and 120 homosexual men without AIDS. A subgroup of homosexual men was identified; these men were characterized as more likely to have
many anonymous sexual partners, to have a history of variety of STDs, and to participate in those sexual practices which increased the risk of contact with blood, semen and feces. In this study the most distinguishing factor was that the patients in the subgroup had more sexual partners than the controls. In fact the subgroup, while at the same time were healthy, had similar sexual behavior patterns as the AIDS group (Dowdle, 1983).

Judson (1983) makes reference to the decline in the number of cases of gonorrhea in homosexual men, which is attributed to behavior changes reflecting concern about AIDS (Curran, 1983). He analyzed the infection rates of Neisseria Gonorrhea (a common sexually transmitted disease in homosexual men), which is believed to be a reliable measure of changing sexual behavior, because it is easy to detect and the incubation period is short. To assess this, Judson cited figures from the Denver Metro Health Clinic which treats over 26,000 patients a year and includes 60% of reported cases of gonorrhea from Denver. In comparing the gonorrhea rates in homosexual men and the rates in heterosexual men and women, the analysis of the data showed a substantial decline in the infection rate and number of cases in homosexual men but not in heterosexual men and women.
Risk Factors

"Sexual behavior is often conceptualized as consisting of several distinct but correlated dimensions, each of which can be measured separately" (Martin & Vance, 1984, p. 1304). Researchers in this field label these dimensions risk factors. By definition these are various factors that contribute to the vulnerability of homosexual men in contracting a STD. The most prevalent of these are: multiple anonymous sex partners, years as a practicing homosexual and the specific sex practices used.

Multiple Sex Partners

Most studies examining the incidence of STDs in gay men point to the large number of sexual contacts as a strong indicator of increased susceptibility. Similarly, studies focusing on the sexual behavior of gay men repeatedly refer to the large numbers of established sexual contacts. Thin and Smith (1976) refer to the high proportion of homosexuals among men with syphilis and gonorrhea as related to "the promiscuous behavior of homosexuals" (p. 164). Gebhard and Johnson (1953) found the median number of lifetime sexual partners in gay men to be 20, while 8.4% reported having had over 500 different sexual partners (Darrow, Barrett, Jay & Young, 1981). Bell and Weinberg (1978), interviewing 575 gay men in the San Francisco area, found the average to be much higher.
Forty-three percent of their respondents said they had had at least 500 different lifetime sexual partners.

In addition to the numbers of sexual contacts, researchers refer to "furtive sexual behavior" in homosexual men (Darrow et al., p. 1006) which is described as establishing sexual contact in bathhouses, backrooms of bars, bookstores, and restrooms (Darrow et al., 1981; Ebbeson, Melybe & Biggar, 1984; Good & Troiden, 1980; Judson, Miller & Schaffint, 1977). The sexual contact observed in these settings is highly correlated with STD transmission. Consequently, when researchers speak of multiple sex partners as a risk factor, they associate "furtive sexual behavior" as a key component in facilitating contraction of an STD. It is not necessarily the numbers but rather the anonymity of such contacts that are prevalent in these settings (Owens, 1980; Henderson, 1976; Ostrow, 1984).

Darrow et al. (1981), in an extensive investigation of STDs in gay men, indicated that the self-reports of syphilis, gonorrhea and hepatitis-B were related to the number of sexual partners and furtive sexual activities, particularly among those who visited gay baths. Contrary to the belief that numbers influence susceptibility, Henderson (1976) believes an individual who has multiple sex partners is not necessarily at risk for contracting an STD. Rather he believes, "A person with a large number of sex partners will usually be at a higher risk for acquiring a STD. than a person with a smaller number, but the risk is
not related to the number so much as it is to the nature of those partners" (p. 62). He adds that sexual partners who are anonymous are those that pose the greatest risk. He believes that anonymity is primarily responsible for the high incidence of syphilis and gonorrhea, since the infected person is not usually in a position to contact the person they have exposed. Owens (1980) also believes that homosexual men with multiple sex partners are at an increased risk of STDs. He states, "This increased risk is not so much tied to numbers but rather it is related to anonymity" (p. 805).

Years as a Practicing Homosexual

This risk factor is seen as the length of time from initial homosexual identity to the present. It is distinct from the age of first homosexual sexual experience. By practicing it is meant those men who identify themselves as homosexual and establish sexual contact on a regular basis. Darrow et al. (1981) examined years as a practicing homosexual as a risk factor for syphilis, gonorrhea, hepatitis and other STDs. In the cases of syphilis and gonorrhea there was a strong correlation between disease and years as a practicing homosexual. Ostrow (1984) also examined years as a practicing homosexual as a risk factor. His data show that years of engaging in homosexual activities was related to contracting STDs. In hepatitis, syphilis and gonorrhea, those men who reported more years
as a practicing homosexual also tended to have more cases of these STDs. Ebbesen et al. (1984) indicates that men with "greater longevity of homosexual contact" (p. 299) tend to live in larger cities and have more incidents of STDs than those in smaller towns and less years as a practicing homosexual.

Sex Practices

Researchers have been able to correlate certain sexual practices to the risks of contracting an STD. As Ostrow (1984) states, "For each sexual practice the number and type of partners (anonymous or known) and the setting in which the practice occurred will significantly affect the actual risk" (p. 102). Those sex practices which have been implicated the most in transmission of STDs are: anal intercourse, analingus and fellatio. Merino and Richards (1977) found the anal canal to be the area most commonly infected with gonorrhea. The Denver Metro Health Clinic reported that 15.2% of positive cultures are in the anal canal compared to 12.7% in the urethra and 2.5% in the pharynx (Judson et al., 1977). Saghir, Robbins and Walbrand (1969) reported that "at any one time after the age of 19 fellatio is the most frequent behavior practiced, while anal intercourse was the second" (p. 223). Ostrow (1984) correlated sexual practices with medical consequence to that practice. For example, analingus (mouth to anus) has been associated with hepatitis-B, syphilis, oral gonorrhea
and oral infection. Fellatio has been associated with oral gonorrhea, syphilis, hepatitis-B and oral herpes. Anal intercourse is associated with gonococcal urethritis, syphilis, fungal infections and hepatitis-B. In an extensive study on the role of sexual behavior in the transmission of hepatitis-B, Szumuness et al. (1975) reported that of their sample 42% practiced oral-genital contact, 26% anal-genital and the remaining 32% equal use of both.

Psychological Indications

Researchers studying the psychological indications in S.T.D.'s quite often look at the irrational fear of contracting VD. In addition, studies have shown that a substantial number of patients who attend VD clinics present with a variety of psychiatric disturbances, primarily personality disorders, anxiety-related conditions and various forms of depression. In many of these patients there is a history of promiscuity and hypochondriasis as well as underlying feelings of guilt, shame and inadequacy. For many of these individuals, there are conflicts associated with marital and relationship difficulties.

In this section studies will be presented exploring the relationship between the STDs and psychological disturbance as well as one study looking into the personality of VD patients. Kite and Grimble (1963) explored venereophobia and its psychiatric correlates and causes; Mayou (1975), Bhanji and Mahony (1978) and Pedder (1970) examined
patients with psychiatric problems in relation to a fear of contracting VD. The last study by Wells (1970) focuses on three personality traits found in patients attending a VD clinic.

Kite and Grimble (1963) studied the fear of venereal disease and psychiatric problems associated with it. Abnormal anxiety associated with VD is referred to as venereophobia -- this is both a fear of VD as well as an obsession with contracting it. The purpose of this study was to assess the "incidence, psychogenesis, and diagnosis of those individuals who have a fear of VD" (p. 173).

Kite and Grimble make reference to studies which have shown that the fear of V.D. is associated with medical symptoms. Macalpine (1957), who studied patients in a VD clinic, stated "although figures for the incidence of VD may have declined the number of patients attending with psychiatric disorders had not" (p. 173). Wessel and Dinck (1947) reported that 50% of urological patients and 30% of neuropsychiatric patients had cases of VD anxiety.

In this study individuals who were considered having a psychiatric disturbance were given interviews and based on these interviews 76 people were classified as psychiatric cases. In order to determine a specific diagnosis, further psychiatric interviews were conducted. Within the sample, there were 44 new patients and 32 with previous visits to the clinic.
Kite and Grimble divided the 76 patients into three groups: non-venereal, gonorrhea, and syphilis. Eighty-six percent were placed in a non-venereal group, with slightly over half showing no indication of any physical VD symptom. The authors used two factors which they believed contributed to psychiatric problems: incapacity for work and poor social relationships. The criteria that seemed the most reliable indicator of disturbance was the persistence of anxiety or depression without any basis.

The results of this study indicated that anxiety syndromes and depressive illnesses were the most prevalent psychiatric disturbance. In addition, the authors noted several symptoms associated with these psychiatric conditions. They were: anxiety, venereophobia, genital pain or itching without organic cause, depression, delusions or false beliefs about infection, hallucinations, suicidal ideations, and impotence and frigidity.

Additional results show, in 66 cases, it was the fear of VD which caused mental disturbance before any breakdown. The authors attributed this to societal opinion about VD, particularly the belief that V.D. is a "sin" or a "disgrace". In this group, 97% believed that VD was something to be ashamed about. They were able to assess through interviews that the negative beliefs about VD were associated with a variety of conflicts, primarily social, physical, religious, marital or sexual. Additionally, the
patients were classified into two groups: venereal and non-venereal.

In the venereal group significant factors which contributed to the fear of VD were: individuals who had extra-marital affairs or who were promiscuous, previous VD infection, misinterpreting physical signs on their body as VD, and the role of anti-VD propaganda. It was the last factor which proved the most significant. In this study, anti-VD propaganda affected 78% of the sample and was considered the main source of fear. In addition, this was particularly significant for individuals who had previous VD infections or who were promiscuous. For individuals with a previous history of VD, the average period of time since the last infection was 12 years. Individuals in this group believed that VD could last for years based on information that they interpreted in the media.

Individuals in the non-venereal group did not disclose their fear of VD primarily due to "social stigma and that fears of VD had remained unresolved" (p. 178). While others in this group did not disclose previous psychiatric problems due to the "stigma still attached to mental illness, or because the fear that their fears of VD would be regarded as madness" (p. 178).

Mayou (1975) studied whether there was a need for psychiatric services for individuals who attend VD Clinics. To assess psychological problems, the author administered to 100 new patients an interview schedule which had been
used previously to assess psychiatric disturbance in VD patients.

The results of this testing indicated that out of the initial 100 patients, 20 were considered psychiatric cases. However, a larger number were characterized as having some disturbance. Mayou classified this larger group as follows: anxiety 25, depression 5, and mixed anxiety and depression 15. While individuals in this larger group did not have a significant psychiatric disturbance, there were indications that all but 26 had some degree of anxiety. In 44 of these individuals, anxiety was related to sexual intercourse. Mayou believes among those individuals who were considered having a significant psychological disturbance, concern over VD or other long-term problems contributed to this.

In comparing those patients with and without an STD, Mayou found little difference between the groups. However, he did note that individuals without VD tended to be female, were more likely to have had a casual sexual partner, to feel guilt and did not complain of specific genital symptoms. In this respect, these individuals were not typical cases of venereophobia and were thus placed in a variety of clinical groups: one group consisted of sexually inexperienced young men who were part of a "promiscuous peer group", another group consisted of older married men who were experiencing guilt over a sexual affair which was believed to be contributing to their
feelings of fear and shame. Additionally, there were three men with considerable fear of VD, so much so they curtailed their social and sexual lives for more than a year.

Bhanji and Mahony (1978), in a similar study, attempted to look at the need for psychiatric services in a VD clinic. Three hundred and sixty-eight male and 358 female patients with possible indications of infection were studied. Most of this group had genital infections other than syphilis and gonorrhea, however, approximately 20% had no evidence of genital infections. Within this smaller group 15 men and 2 women were referred for psychiatric interviews based on the staff's opinion that they were psychologically disturbed. The reason for referral was divided into four categories:

1. promiscuity associated with a psychological disorder
2. psychogenic physical complaints
3. psychogenic sexual dysfunction
4. depression (p. 266)

The results within this group indicated that four patients had never contracted VD; eight had been infected twice, two of the patients were already receiving psychiatric treatment, and five had previously seen psychiatrists but not necessarily for their current problems. Based on psychiatric opinion the following diagnoses were observed: personality disorder 5, depressive illness 5, primary
hypochondriasis 4, psychogenic sexual dysfunction 1, obsessive neurosis 1, and adolescent behavior disorder 1.

In regards to social problems, three individuals who had been married were now divorced or separated, 10 were unemployed, three drank heavily and three had problems with the police.

Bhanji and Mahoney also found that promiscuity and hypochondriasis were related to the fear of VD and psychiatric disturbances. Venereophobia was the most common hypochondriacal complaint.

Pedder (1970) attempted to survey the degree of psychiatric disturbance in patients attending a VD clinic. In this study, 40 patients were referred for psychiatric services, due to a fear of VD. Within this group, 11 did not have a STD, while 12 had non-specific urethritis, 7 with gonorrhea and 10 with genital infections. Through psychiatric interviews and observations, these patients were placed in eight separate diagnostic categories. These were: personality disorder 21, affective disorder 6, isolated sexual problems 5, hypochondriasis 3, post-coital sexual problems 2, schizophrenia 1, and drug addiction 2.

Pedder explains that a number of these cases fit into five "descriptive categories." The first was isolated sexual problems which includes those individuals who complained of "varying problems of potency" (p. 55), while at the same time denying other problem areas. Pedder believes that isolated sexual problems are primarily
psychological in origin. The second category, hypochondriasis, was believed to be related to a depressive condition. The third, post-coital symptoms, which was observed in two married men, was described as problems associated with sexual intercourse. Pedder indicates that there were marital conflicts associated with these symptoms. The fourth category, personality disorders, and the fifth, anxiety states, were found in homosexual men, although there was no explanation as to why homosexuals fit into these areas.

Wells (1970) examined the personality traits of patients in a VD clinic. In 1969, Wells conducted a similar study using the Eysenck personality inventory and was able to show that a subgroup had significant scores for the introversion and neuroticism scales. In this present study it was hypothesized that VD patients would show higher scores on an additional scale, psychoticism "which is not completely independent of neuroticism but somewhat correlated" (p. 498). It was believed that scores for psychoticism would be higher than of normal controls. In addition, it was hypothesized that this "P scale would be higher as a reflection of the disturbed interpersonal adjustments which frequently accompany venereal infection" (p. 498). This was expected to be noticeable in promiscuous women who the authors sees is "ignoring or defying much stronger social and moral taboos than men who live promiscuously" (p. 498).
To assess this, Wells administered the Eysenck Pen inventory to patients newly admitted to VD clinics. The results of this study show that male VD patients were significantly extroverted, female patients tended to be more introverted and neurotic, and had elevated scores on the psychoticism scale. Results showed female subjects having higher scores than the male subjects.

Wells also looked at social class and age in relation to these scales. The results indicate that regardless of sex, all three scales were elevated in the lower social group. The findings related to the age factor indicated that extroversion decreases with age. In addition, women in this sample who were infected by their husbands tended to have significantly higher scores on all three scales. Wells points out that this finding was interesting because promiscuous women also tend to have high psychoticism scores.
The subject of death and dying, until recently, has been an area that received little attention. With the advent of thanatology (the study of death and dying) a more precise understanding of the death process and how it affects both individuals and loved ones has evolved (Hacket, 1976). Hacket believes that communication -- particularly being open and truthful -- is a very crucial factors in dealing with the terminally ill. Through his work as a physician, through observation and interviews, he postulated four corrolories that encompass the dying experience.

1. Despite what has been told and what withheld, most dying patients know the truth about their illness.

2. Familiarity with the unpleasant facts of a terminal illness need not destroy hope and breed despair.

3. Fear of death itself is seldom expressed. It is fear of the process of dying that produces distress.
4. Most patients do not ask directly about their prognosis, they do so indirectly.  (p. 372)

In her extensive study of death and dying, Kubler-Ross (1969) describes five stages which she believes an individual passes through upon learning an illness is fatal, which is appropriate here. She sees these stages or responses fluctuating during the course of an illness. The first stage is denial and isolation. This is often characterized by the patient disbelieving that he is terminally ill. During the second stage, the patient will begin to experience anger. This anger can be focused on any number of people, including friends and family. Anger is followed by the third stage -- depression. During this time the patient begins to feel hopeless, withdraws and isolates and loses interest in everything and everybody. Kubler-Ross refers to the fourth stage as bargaining. The patient seeks an exchange of something for additional time. The final stage is referred to as acceptance. During this time the patient is neither depressed nor angry. Kubler-Ross points out that acceptance is not a "permanent state of mind"; rather it is a "goal to achieve". It is not unusual for a person to reach acceptance and suddenly swing back to depression.

Hacket (1976) believes that the fear of death is not as powerful as the fear of dying. He states, "the paradox of death is that we cannot imagine our own death even while certain that it will overtake us. On the other hand, the
process of dying entails a number of unpleasant things such as pain, discomforts and separation from loved ones" (p. 374). In addition to the fear associated with dying, isolation and loneliness are two very significant issues.

Gluck (1976) sees isolation as a result of family members and loved ones fearful of death, preferring to avoid the topic with the individual. Physicians and nurses, either due to pressure or stress, also avoid dealing with this issue of dying. She states, "Isolation might also arise within the patient as a result of feeling hopeless or as a result of feeling guilty about burdening others with their dependency on them" (p. 927). Hacket, referring to loneliness, believes "this adds to the anguish of dying" (p. 375) and consequently stresses the importance of maintaining not only communication but contact. In her work with the terminally ill, Kubler-Ross (1969) believes the most important thing the terminally ill want is to be able to talk with someone, particularly once the person has been given a diagnosis.

In closing, Hacket believes being truthful and honest is very crucial in the dying process, not only in letting the individual know he is dying, but in regards to loved ones expressing their feelings about this. Hacket, referring to a study by Gerle, Lunden and Sandblom (1980), in which 101 patients with inoperable cancer were divided into two groups. One half were told all the facts of their illness, and the other half told nothing. During the year
of the study it was found that those not told had more anxiety and depression and their overall management was more difficult than for those patients who were told.

**Terminal Illness - the Effects on Sexual Functioning and Identity**

Recently individuals in the medical community as well as in the psychology community have begun to look at sexual issues involving the terminally ill. Rausher (1981) speaks of the importance of preventing "the ultimate trauma (cancer) from depriving patients of the ultimate joy (of sex)" (Gunby, 1981, p. 1902). Leviton (1978), looking into the sexual needs of the terminally ill, stated "most people need and greatly benefit from an intimate/sexual relationship. Where such a relationship has been lost, a deprivation condition can be expected to arise that, in itself, serves as a stressor increasing the probability of maladaptation. The terminally ill are seen as high risks for maladaptation, depression, feeling poorly, contracting disease, suicide and dying prematurely" (p. 262). Derogatis (1981) believes that cancer can significantly affect sexual functioning, "with cancer many patients must experience mutilating surgery, or unpleasant cosmetic side effects of other treatments. If the patient feels repulsive or unattractive physically there is little chance that he or she will be effectively functional in sexual relations" (Gunby, 1981, p. 1903). For many women, breast cancer can
prove to be not only a tremendous threat to life but also a threat to a sense of femininity and sexual identity (Bransfield, 1982; Holland & Mastrovito, 1980; Lewis & Bloom, 1978).

Holland and Mastrovito (1980), focused on the effect breast cancer has on a woman's self-esteem and femininity. They believe that the age a woman develops breast cancer is a primary factor related to adjustment. They state, "For young women the meaning of breast cancer can be quite different than for older women and particularly women who are single and without a close male relationship" (p. 1046). In addition the husband's or sexual partner's reaction can significantly affect the woman's sense of security of being loved. They further observe that the patient tends to have a low self-esteem and this consequently affects sexual drive.

Lewis and Bloom (1978), referring to women who have had a mastectomy, see this as a threat to a woman's sense of femininity and sexual desirability. In an extensive review of the literature, they point to several studies that indicate that "women have specific notions of what they like or dislike about their bodies and that breast removal has a highly significant effect on body image, femininity and self-esteem" (p. 3). In addition, breast removal alters their view of themselves as being sexually desirable.
Bransfield (1982) believes that "body image or the self-perception, satisfaction and comfort with one's own body is closely related to sexual identity and functioning in women" (p. 203). Bransfield, referring to a study by Derogatis, Abeloff and Melistratos (1979), which suggests that for women, a poor body image can be related to the loss of an important body part and impaired sexual identity. Derogatis, Abeloff and Melistratos (1979), using the Derogatis Sexual Functioning Inventory which includes a body image subsection, assessed body image as it relates to sexual functioning. The inventory was administered to a group of sexually dysfunctional and sexually functional women. The results of this study indicate that a woman with poor body image tends to be in the dysfunctional group.

Testicular Cancer

Testicular cancer occurs primarily in men between the ages of 20 and 40, a period when most men are at the height of sexual activity. This form of cancer not only has psychological effects due to the death implications involved, but has been found to affect sexual functioning and masculinity. In this section a look at two studies on how testicular cancer affects sexuality. Gorzynski and Holland (1979), through clinical interviews and observations, reviewed the emotional and psychological problems in patients with testicular cancer. Shover and Eschenbach
(1985), through the use of a questionnaire, assessed various issues central to sexual functioning in men with testicular cancer. In addition, they wanted to know how this could affect marital relationships.

Gorzynski and Holland (1979) in their paper "Psychological Aspects of Testicular Cancer," examined three time intervals during treatment of testicular cancer which can be stress-provoking and, consequently, will need assistance in adjustment. The authors noted that in some individuals it is necessary to have all three treatment procedures, while for some only one or two are needed. This review discusses all three possible psychological aspects of treatment.

The discovery of a testicular mass usually induces feeling of fear and confusion. If the mass proves to be malignant, the individual is confronted with two significant issues. The first issue concerns anxiety over possible death and the second relates to anxiety about sexual functioning. These writers believe that the physician can help lower the patient's anxiety level by reassuring him that the prognosis for testicular cancer is very good. However, they note for the individual, the issue of sexual functioning is one that is not as easy to overcome. They state, "emotionally some patients or their partners view genital cancers as punishment for some real or imagined sexual thoughts or acts or retribution for excessive or aberrant sexual activities" (p. 126). It is
during this time that there are expressions of shame, guilt, and fear, particularly of transmitting the disease. Many of these thoughts and feelings contribute to sexual dysfunction, lowered libido and erectile difficulties.

If the patient has to undergo a further surgical procedure called retroperitoneal lymphadenectomy, loss of ejaculation can be expected. As these writers indicate, patients can adjust to the loss of ejaculation as long as there are no problems in sexual functioning. However, in addition to the loss of ejaculation, this procedure "may decrease libido, produce erectile difficulties and affect sexual performance" (p. 127). These problems can be further exacerbated by the patient believing he is "no longer normal" or "desirable" (p. 127). During this period the patient might feel guilt because he cannot meet his partner's sexual needs and fears that he might lose her affection. In addition, the authors observe that the sexual partners might be fearful of contracting cancer through sexual contact and this can add to the patient's feelings of rejection, inadequacy and guilt.

During the final stage of treatment, radiotherapy and chemotherapy are needed. This aspect of treatment has not been found to affect sexual functioning; however, radiotherapy might reduce semen volume. This is quite often remedied by protecting the healthy testicle during radiotherapy.
Shover and Eschenbach (1985) studied the effects testicular cancer had on sexual functioning and marital relationships. To assess this they administered a questionnaire to 121 patients who had been treated for testicular cancer and 92 married, healthy men who were similar in age and socioeconomic background. The questionnaire was divided into a variety of areas: sexual activity, sexual desire, erectile problems, difficulty achieving orgasm, and marital-related areas.

The results of this study indicate these patients have lower sexual desire, less sexual activity, more difficulty reaching orgasm and more erectile difficulties than the healthy control group. In this study, men who reported anxiety about sexual issues suggest that this might be due to infertility and lack of semen. Sexual anxiety was found to be correlated with actual sexual functioning. Anxiety about sexuality and cancer might affect or reduce the pleasure of orgasm. Both orgasmic difficulties and erectile dysfunction were more common in men who worried about sexuality.

The ability to function sexually was a crucial factor in marital happiness. Seventeen point eight percent of married couples separated or divorced after the diagnosis. In fact, sexual satisfaction was significantly reduced in those men who were divorced or separated. However, the authors believe that the stress associated with cancer treatment was a crucial factor in facilitating this. Men
who believed cancer had interfered with their relationship also had more sexual problems.
INTRODUCTION

At the present time the research on AIDS has primarily focused on the medical etiology of this disease, ignoring the more global psychological implication. As Coates, Temoshok and Mandel (1984) state, "Psychosocial research is essential to understanding and treating AIDS" (p. 1309). Several writers have suggested psychologists begin implementing studies focusing on the psychological ramifications of this illness with particular emphasis on the gay community (Martin & Vance, 1984; Joseph et al., 1984; Coates, Temoshock & Mandel, 1984).

Martin and Vance (1984) have suggested the psychological research look into "disease transmission, vulnerability factors, and the impact on the gay community" (p. 1303). Joseph et al. (1984) believed that "research on AIDS should not only assess individuals who have AIDS but also those whose lives have been touched by the threat of AIDS, those who lost someone, feel personally at risk, and experience the AIDS crisis as an historic occurrence with profound personal and community-wide implications" (p. 1297). Coates et al. (1984) suggest that, "Research is needed to determine the effects of specific interventions on medical status, psychological status, and specific health promoting and health damaging behaviors" (p. 1309).
Additionally, these authors have suggested that research into the psychosocial impact of AIDS take into account the literature on the related areas of cancer research and sexually transmitted diseases. Coates, Temoshock and Mandel (1984) point to the literature on how cancer affects psychological adjustment and quality of life. Martin and Vance (1984), following up on the "germ model" and "overload model" of AIDS, suggest that a third model, an "interactive model," should focus on sexual behavior and functioning as well as lifestyle factors in the gay community.

It is the purpose of this study to explore one aspect of the psychological effects AIDS is having on gay men. This study will take a closer look at how AIDS has affected gay men's attitudes toward their homosexuality. As Deuchar (1984) states, "AIDS is producing a resurgence of anti-homosexual feelings no matter how well adjusted the individual has been to their sexuality" (p. 615). For gay men with AIDS it would be reasonably apparent that they might believe if they were not gay this would not have happened to them. Feelings of regret and anguish over being homosexual would be expected to surface. Literature in the areas of sexually transmitted diseases, homosexual identity formation, terminal illness and the psychological reactions observed in AIDS will be presented, to arrive at a clear understanding of how AIDS might potentially affect sexual identity.
Since 1979 more than 80% of those diagnosed with AIDS have died within two years of diagnosis (Dowdle, 1983). Research conducted by members of the medical community have suggested that AIDS is caused by a virus and transmitted sexually (Brandt, 1983; Vierra, Frank, Spira & Landsman, 1983; Curran et al., 1984; Levy & Ziegler, 1983; Witte & Goldberg, 1983). Due to the high proportion of gay men with AIDS (71% of the total) it had been suggested that certain aspects of gay male behavior were responsible (Batchelor, 1984; Brandt, 1983). Sonnabend, Witkin, and Pertilo (1984) proposed the "immunologic overload theory" which contends that the characteristic lifestyle of gay men causes AIDS. They believe such factors as poor health habits, use of drugs, frequent exposure to semen and exposure to viruses such as cytomegalovirus and the Epstein-Barr virus are responsible. Additionally, researchers in the field of psychoneuroimmunology (which studies the relationship between psychosocial factors and predisposition to disease) have proposed additional theories to explain the etiology of AIDS (Jemmnot & Locke, 1984; Adder & Cohen, 1975; Bartrop & Lazarus, 1977). These scientists have looked at stress (Jemmnot & Locke; 1984; Bartrop & Lazarus, 1977), psychosocial factors (Kaplan, in press), conditioned learning (Adder & Cohen, 1975), and genetic and environmental factors (Coates et al., 1984) to explain the cause of AIDS.
In a review of the literature in sexually transmitted diseases in gay men, studies have shown that there are similar sexual behavior patterns in AIDS patients and men who contract STDs. The CDC in 1981 reported that gay men who have anonymous sexual contacts, have a history of STDs and engage in sex practices which expose the individual to blood, semen and feces, have similar sexual behavior patterns as AIDS patients. Additionally, those men who had more sexual partners were also similar to the AIDS patients. Valdeserri, Brandon and Lyter (1984) indicated that gay men with a large number of sex partners and a history of STDs resembled the pattern observed in AIDS patients. Certain sexual practices, particularly anal intercourse and analingus, have been implicated in the contraction of AIDS (Batchelor, 1983). The CDC (1983) reports that AIDS patients have more partners insert penises into their rectums than private practice or public controls. Several researchers have shown that this sexual practice is also found in large segments of the gay population who contract STDs as well as the population as a whole (Marino & Richards, 1977; Darrow, Barrett, Jay & Young, 1981; Ebbeson, Melybe & Biggar, 1984; Szumuness et al., 1975; Saghir, Robbins & Walbran, 1969; Judson, Miller & Schaffnit, 1977). Another factor in disease transmission is the years of being a practicing homosexual. While there does not seem to be any data in this area in regards to AIDS, researchers in STDs report this as significant
(Ostrow, 1984; Ebbeson et al., 1984; Darrow et al., 1981). Darrow et al (1981) reports that as the years increase in homosexual practice so does reporting the incidence of STDs. Ebbeson et al (1984), in a study comparing disease frequency in two groups of gay men, also indicates that as the years increase so does reporting of STDs.

Studies into the psychological indications of STDs suggest that there can be an irrational fear associated with contraction of disease. A review of the literature in this area indicates that this fear, often referred to as "venereophobia", is found in individuals who display a variety of psychiatric disturbances (Kite & Grimble, 1963). Individuals have presented with anxiety syndromes, depressive illnesses (Kite & Grimble, 1963), personality disorders (Bhanji & Mahoney, 1978) and hypochondraisis (Pedder, 1970) as well as other disturbances. Additionally there are indications that promiscuity, anti-VD propaganda and society's negative opinion about VD contribute to this (Kite & Grimble, 1963; Bhanji & Mahoney, 1978).

Research into the psychological implication of AIDS is just now beginning to be carried out. A review of the literature suggests that AIDS is having a significant psychological effect on the AIDS victim as well as the gay community. Relying primarily on observations and interviews, various investigators have reported the full scope of how this fatal illness is affecting the gay population.
For the AIDS victim, just hearing the diagnosis can be overwhelming (Morin & Batchelor, 1984), reacting in similar ways observed in the terminally ill (Deuchar, 1984). Researchers have observed these individuals experiencing a variety of problems particularly anger, depression and anxiety (Deuchar, 1984; Nichols, 1983; Malyon & Pinka, 1984; Morin & Batchelor, 1984; Morin, Charles & Malyon, 1984). Additionally, this is complicated by the stigma attached to this disease and involves issues of isolation, fear or death, loss of self-esteem, increased dependency, and at times issues dealing with coming out to friends and family who did not know the individual was gay prior to the illness.

Reactions in the gay community indicate that some individuals are experiencing an obsessional fear of contracting the disease, referred to as "AIDS panic" (Deuchar, 1984; Morin et al., 1984; Paroski, 1983; Schwartz, 1983). There are reports that individuals are feeling angry, helpless and at times depressed (Morin & Batchelor, 1984; Morin et al., 1984). Hausman (1983) reports that a survey in San Francisco indicates that 75% of respondents are feeling increased anxiety since they found out about AIDS. Powell (1984) identified fear, worry and increased anticipated discrimination as a result of AIDS in a group of healthy gay men. Morin and Batchelor (1984), referring to individuals who have symptoms of AIDS, observed feelings of isolation, loss of initiative and frustration of achieve-
Goulden, Todd, Hay and Dykes (1984), Morin et al. (1984) and Deucher (1984) have reported the devastating effects AIDS is having on the friends, families and lovers of AIDS victims. AIDS is also having an effect on sexual behavior. Studies by Golubjatnikov (1983) and Schechter and Jeffries (1984) reveal that there has been a steady decrease in sexual contact among gay men, possibly due to fear of contracting AIDS.

As the CDC (1981) has indicated, individuals who have AIDS report a higher number of sexual contacts than healthy controls. This is seen as a significant variable in the contraction of AIDS. For a significant number of gay men, numerous sexual encounters are part of an accepted aspect of homosexual life. Bell and Weinberg (1978) report that 43% of their sample of gay men reported having over 500 different lifetime sexual partners. Goode and Troiden (1980) reported in their study on gay promiscuity, that 42% of respondents reported between 100-499 sexual partners and 23% reported over 500. It is not surprising that the most common setting that gay men come out, is the gay bar (Dank, 1971; Achilles, 1967; Hooker, 1967), a setting which is also quite conducive to sexual "pick-ups" and encounters. Bell and Weinberg (1978) indicated that of their respondents, 42% of white homosexual males and 39% of black homosexual males reported cruising in gay bars once or twice a week. This tends to be the most widely used setting for establishing sexual contact. As Martin and
Vance (1984) state, "Sexual contact and interaction are deeply embedded in a range of gay social institutions as well as personal and community networks. The non-sexual dimensions of spaces typically thought of 'sexual', for example, bars and baths, constitute an important social arena for information exchange, friendship formation and the development of a sense of community and self-identity" (p. 1305).

In a sense there is an association between sexual expression and sexual identity in gay men. The literature on the development of homosexual identity indicates that association or contact with other gay men is the most important factor in facilitating a positive homosexual identity (Jacobs & Tedford, 1980; Dank, 1981; Beane, 1981; Hooker, 1967; Weinberg & Williams, 1974; Hammersmith & Weinberg, 1973). They believe that through association, gay men learn that the negative stereotypes about homosexuality do not hold up and consequently are reversed. Many researchers believe that to achieve a positive gay identity involves a process where the individual moves from same-sex feelings toward acceptance of their homosexual identity (Coleman, 1981; Plummer, 1981; Morin & Miller, 1977; Grace, 1981; Cass, 1979; DeMonteflores & Schultz, 1978; Lee, 1977; O'Dowd & Hencken, 1977). A study by Hammersmith and Weinberg (1982) indicates that achieving a homosexual identity is assisted by significant others who support that individuals' identity as homosexual. Weinberg
and Williams (1974) believe that socialization with other gay men and seeing homosexuality as normal is conducive to a positive gay identity. In addition, the way both homosexuals and heterosexuals accept that individual also affects identity.

Finally, literature on the psychological implications of cancer, particularly testicular cancer and breast cancer, suggest that this affects sexual functioning and sexual identity. Studies conducted by Holland and Mastrovito (1980) and Lewis and Bloom (1978) reveal that breast cancer in women tends to affect self esteem, feminity and sexual desirability. Bransfield (1982) believes that "body image or the self-perception, satisfaction and comfort with one's own body is related to sexual identity and sexual functioning" (p. 198). In men, testicular cancer has been found to affect sexual identity and sexual functioning. Gorzynski and Holland (1979) report that "emotionally some patients or their partners view genital cancers as punishment for some real or imagined sexual thoughts or acts of retribution for excessive or aberrant sexual activities" (p. 126). Additionally, for many men there are feelings of guilt, shame and fear, particularly of transmitting the disease. For the sexual partner of men with testicular cancer, there might be fear of contracting cancer through sexual intercourse. These factors, they believe, contribute to feelings of inadequacy, rejection, and sexual dysfunctioning. In another study by Shover and Eschenbach
(1985) it was reported that testicular cancer has had an effect on sexual functioning and marital happiness. This is contributed by anxiety related to sexual functioning, infertility and lack of semen.

Summary

In summation, one can see a potential conflict arising out of various overlapping areas. Literature on the development of a positive homosexual identity suggests that a positive identity is accomplished through contact with other gay men. The most widely available and accessible setting for this has traditionally been the gay bar. The gay bar serves as not only a setting for socialization, but is also conducive to the establishment of sexual contact. Consequently, for the individual just coming out, there is a sense that sexual contact and expression is a very integral part of what it means to be a homosexual. Medical research has postulated that AIDS is most probably a virus, transmitted through sexual contact and is found primarily in men who have had a history of multiple sexual partners. On this level, a potential identity conflict would be expected to arise. On one hand, AIDS is transmitted sexually and found in men with multiple sex partners, while on the other hand, positive homosexual identity has often been rooted in sexual expression.

In addition to association with other gay men, homosexual identity is facilitated by being accepted and supported by others, particularly other gay men. Presently
literature on the psychological reactions of AIDS indicates that many healthy gay men are fearful of contracting the disease. Consequently within the gay community, individuals are withdrawing from AIDS victims. For the person with AIDS, association, acceptance, and support that was previously accessible and available is now diminished. Thus the feelings of rejection and isolation have been observed. On this second level of potential conflict, positive identity is facilitated by support and contact, with its absence, homosexual identity might be affected.

Due to the fact that AIDS is a potentially terminal illness, another area of overlap is the possible sexual identity conflicts observed in cancer patients. Literature on the psychological implications of testicular cancer and breast cancer indicate that this form of cancer can affect sexual identity. For men with testicular cancer, there are indications that there are feelings of rejection, inadequacy and guilt. These feelings are often associated with the view that genital cancer is punishment for "excessive or aberrant sexual activities". In addition, rejection can be observed when a sexual partner believes cancer can be sexually transmitted. For women with breast cancer, changes in body image have been found to affect sexual identity.

It has also been shown that sexual, and at times affectional rejection, stem from concern that any physical contact with AIDS patients can result in contraction of the
disease itself. There can also be feelings of guilt, similar to the cancer victim, associated with the possible belief that AIDS is due to punishment for their excessive or aberrant sexual activities. Additionally, there are significant body changes during the course of the illness which, as in the case of breast cancer, potentially affect sexual identity. Studies have indicated that individuals with testicular cancer and breast cancer share similar experiences with AIDS victims, particularly related to sexual identity. Thus on this level one could expect a sexual identity conflict to also arise in AIDS patients.

Finally, literature in the area of STDs point to a fourth level of overlap. Studies have shown that the sexual behavior of gay men who contract STDs and AIDS victims have similar patterns. For example, the literature on both disease processes make particular note of anonymous sexual encounters and certain sexual practices (e.g., anal intercourse). Research on the psychological indications of VD indicate that individuals suffering from venereophobia (an irrational fear of VD) have several psychiatric disturbances and the basis for this tends to be related to guilt feelings over promiscuity and shame associated with the stigma society attaches to sexually contracted diseases. Within the gay community there has been a generalized fear of AIDS (AIDS panic) and for the AIDS patient, possible shame over the stigma that society attaches to this disease, as well as to homosexuality, in addition to the
guilt over promiscuous behavior associated with its contraction.

Thus, research has shown that STDs can result in psychological conflict related to promiscuity and stigma. In similar ways, AIDS victims are feeling stigmatized. On this level an identity conflict might result from promiscuous behavior leading to the contraction of AIDS as well as the stigma associated with the illness.

The above review of research into homosexual identity formation, the psychological reactions observed in AIDS, and the adjacent areas of cancer and STDs support the belief that AIDS has the potential for producing a homosexual identity conflict. In review of these facts and findings, I propose several hypotheses to test this:

Principal Hypothesis:

General Statement: AIDS in homosexual men will be negatively related to gay identity.

Operationalized Statement: Homosexual men without AIDS will have significantly higher scores on a measure of gay identity than will homosexual men with AIDS. Gay identity will be measured by the total sum scores on the following scales: 4, Anticipated Discrimination; 5, Putative Attitudes towards Homosexuals; 6, Passing; 7, Social Involvement; 8, Acculturation; 10 Ex-
inclusive Homosexual Relationships; 11, Homosexual Commitment; 12, Conception of Homosexuality; and 20, Anxiety Regarding Homosexuality. (From Weinberg and Williams [1974], see Appendix.) High scores mean more positive identity as gay, with the total possible score of 41.

Rationale: This principal hypothesis has been proposed based on the assumption that gay men with AIDS will see their homosexuality as responsible for contracting this disease. Subsequently, a gay man with AIDS will believe that if he were not homosexual, he would not be dying. Thus, homosexuality and death are synonymous and a poor homosexual identity will be expected.

Secondary Hypotheses:

1. General Statement: The length of time since labelling oneself homosexual will be positively related to gay identity.

Operationalized Statement: The length of time in years since AIDS patients as well as healthy gay men initially labelled themselves homosexual as assessed by question 83 of the questionnaire (see Appendix A) will be significantly and positively
correlated with gay identity. Gay identity will be assessed as defined above.

Rationale: This hypothesis has been proposed based on the belief that the longer an individual has been able to accept himself as homosexual, the more integrated this identity is to the self-concept. Thus, over time, an individual is more in a position to resolve conflicts regarding his homosexuality than an individual just coming to terms with his homosexuality.

2. General Statement: The length of time since diagnosis of AIDS will be negatively related to gay identity.

Operationalized Statement: The length of time in weeks since initial diagnosis of AIDS as assessed by question 94 on the questionnaire will be significantly and negatively correlated with gay identity. Gay identity will be assessed as defined above.

Rationale: This hypothesis has been proposed based on the belief that the passage of time enables an individual to resolve on some level the initial shock and depression resulting from
having a terminal illness. Thus, over time, it is expected an individual with AIDS has to some degree resolved the conflicts between being homosexual and contracting AIDS.

3. General Statement: The frequency of sexual contact will be negatively related to gay identity.

Operationalized Statement: The frequency of sexual contacts per month in numbers prior to the diagnosis of AIDS as assessed by scale 9 (Weinberg and Williams, 1974) measuring sexual frequency will be significantly and negatively correlated with gay identity while sexual frequency (monthly) will be significantly and positively correlated to gay identity in healthy gay men utilizing the 9 core scales as defined above.

Rationale: This hypothesis has been proposed on the belief that because AIDS has been found in men who primarily engage in a high frequency of sexual contact and promiscuous behavior is a component of a homosexual identity, a conflict between the two might arise. Thus AIDS patients who report a high frequency of sexual contact
might have regrets over their homosexuality and therefore lower scores on the measure of homosexual identity.

4. General Statement: Support and contact will be positively related to gay identity.

Operationalized Statement: The present frequency on a weekly basis of contact with other gay men and report of support from other gay men as assessed by questions 95 and 96 will be significantly and positively correlated with gay identity in gay men with AIDS as assessed by the 9 core scales.

Rationale: This hypothesis has been proposed based on studies by various researchers who claim that support and contact with other homosexuals is essential to a positive homosexual identity. Because AIDS patients have been isolated and stigmatized, it is expected that support and contact has been diminished and thus may contribute to a poor homosexual identity.
METHODS

Subjects

To test these hypotheses, two groups of gay men were sampled: (a) AIDS patients and (b) a healthy gay comparison group. To get as broad a sample as possible, participation and cooperation of various gay organizations, as well as a hospital which treats AIDS patients and a doctor's office which caters to homosexual men were obtained. By meeting with representatives of each location, an explanation was given as to the purpose and necessity of this study. Those individuals wishing to participate were handed a questionnaire packet, either through the representative or myself.

Other than the subject's age and years since labelling themselves homosexual, no additional criteria for inclusion in this study was utilized. The size of the sample consisted of 42 AIDS patients and 102 healthy controls. Participants ranged in age from 20 to 50, and labelled themselves homosexual for a period of one year or longer. The non-AIDS subjects were asked a question (#94) determining their health status. In order to get as large and varied a sample as possible within the AIDS population, the following targeted locations were selected: (1) the Montrose Counseling Center -- an out-patient counseling center
that caters to gay clients and offers therapeutic services to AIDS patients, and (2) the Macadory House -- a halfway house for AIDS patients and the administrative offices for the K.S./AIDS Foundation in Houston, Texas.

To get a varied comparison sample of non-AIDS individuals within the gay community, the targeted locations chosen were: a sports organization, gym, church, bath-house, bar, a political organization, a doctor's office, Houston Gay Health Advocates, and Lambda Center for Alcoholics.

b. Instrumentation

To assess homosexual identity in a sample of AIDS and non-AIDS homosexual men, a survey questionnaire devised by Weinberg and Williams (1974) will be utilized. This questionnaire was originally implemented to measure homosexual identity as it relates to psychological adjustment. The authors divided the questionnaire into two sections, measuring how the homosexual relates to (1) the heterosexual world and (2) the homosexual world. There are eight scales measuring psychological adjustment and 15 scales, each of which measures various aspects of homosexuality identity. For example, scale 8, "Acculturation", assesses the degree to which the individual is accustomed to common homosexual practices. Weinberg and Williams believe that acculturation is an integral component of homosexual identity and a good indicator of one's acceptance of their
homosexuality. Scale 6 measures "Passing", which is the extent to which one hides their homosexuality from others. It is believed that an individual who is more open regarding their homosexuality is also more accepting.

Each scale has been tested for reliability based on the coefficients alpha, which provides a measure of internal consistency taking into account the number of items. Its computation is derived from the Kuder and Richardson formulas 20 and 21. The reliabilities reported on these scales range from .22 to .91 (Cronback, 1951).

In scoring these scales, many have the following response categories: "strongly agree", "agree", "not sure", "disagree", and "strongly disagree". Values of 1 through 5 are attached to these categories according to the direction of the item. A higher value indicates more positive homosexual identity. Other items found in various scales are ranked from scores 1 through 4, 1 through 6, 1 through 7; once again the higher the value of the response, the more positive the identity. In order to arrive at an overall composite score, the values assigned for each scale will be totalled.

c. Procedures

For the purposes of this study, 8 scales of the 15 measuring homosexual identity and one scale (anxiety regarding homosexuality) of the 8 measuring psychological adjustment have been selected which best appear to reflect
the concept of a gay identity in this research. Thus the total of 9 core scales will be utilized to assess gay identity. In order to measure length of time since labeling oneself homosexual, length of time since AIDS diagnosis, sexual frequency, and support and contact, scale 9 measuring sexual frequency and responses to four original questions will be utilized. The core scales and questions are listed below.

Scale 4 -- Anticipated Discrimination measures the anticipated negative sanctions that would accompany disclosure of one's homosexuality.

Scale 5 -- Putative Attitudes Towards Homosexuals measures the respondent's beliefs regarding societal views on homosexuality.

Scale 6 -- Passing measures the extent the respondent covers up their homosexuality in the straight world.

In utilizing scales 4, 5 and 6 to measure homosexual identity, it is believed that fear of sanctions or the anticipated negative reactions that would accompany disclosure of one's homosexuality inhibit persons from more fully accepting a homosexual identity. Thus lower scores on these scales are indicative of an individual with a poor homosexual identity.
Scale 7 -- Social Involvement measures the degree of socialization with other homosexuals. Scale 7 has been chosen as a measure of homosexual identity because it is believed that by socializing with other homosexuals an individual is able to challenge the negative stereotypes of homosexuality and develop a more positive identity. Thus social involvement facilitates positive identity. Lower scores on this scale would indicate poor identity.

Scale 8 -- Acculturation measures the extent the respondent is accustomed to common homosexual practices. This scale has been selected based on the belief that an individual who has not accepted his homosexuality enough to engage in these practices may experience conflicts regarding his homosexuality.

Scale 10 -- Exclusive Homosexual Relationship measures whether the respondent is not or has ever been in a homosexual relationship. In utilizing this scale, an exclusive homosexual relationship indicates to the homosexual that other homosexuals appraise him positively. Its absence may lead a homosexual to regard himself as inadequate. In these respect a gay man who has had a relationship is seen as more accepting of himself as homosexual. Thus, lower scores on this scale indicate poor homosexual identity.
Scale 11 -- Homosexual Commitment measures the respondent's unwillingness to give up their homosexuality. This scale has been selected as an overall indicator of an individuals' regret about being homosexual. A higher score reflects greater acceptance of a homosexual identity.

Scale 12 -- Conception of Homosexuality

(a) Normalization measures the respondent's attitudes on whether homosexuality is regarded as normal or abnormal.

(b) Responsibility measures the respondent's beliefs whether homosexuality is something that is innate or chosen.

In selecting this scale it is believed that normalization is a way an individual adapts to his homosexuality. Additionally, for normalization, an individual has been able to repudiate the negative beliefs about homosexuality and consequently, sees it as "normal". In this respect a higher score is indicative of a more positive homosexual identity.

Scale 20 -- Anxiety Regarding Homosexuality measures the respondent's feelings being homosexual and participating in homosexual sexual relations. This scale has been selected based on indications that an individual who has more fully accepted himself as
homosexual also reports less feelings of guilt or shame about being homosexual. Thus lower scores on this scale suggest more negative identity.

**Questions**

83 "For how long have you thought of yourself as homosexual?"

94 "How long has it been (in weeks) since you received the AIDS diagnosis?"

95 "How often per week are you in contact with other gay individuals?"

96 "On a scale of 1 to 5 (little or no support to close or frequent), how much emotional support do you feel you receive from other gay men?"

In order to determine if there is a difference between AIDS and non-AIDS groups (principal hypothesis), a T-test procedure will be conducted to compare the total scale analysis between groups, as well as paired scales. In order to test the secondary hypotheses, Pearson Correlation Coefficients will be computed. For example, the length of time since labelling oneself homosexual will be correlated with the total gay identity score.
RESULTS

Description of the Respondents

The total sample consisted of 42 gay men with an active AIDS diagnosis and 102 healthy gay men. A comparison of the subjects on race, age, education, Kinsey scale ranking, and length of time labelling oneself homosexual, revealed that subjects in both groups were quite similar (see Table 1). For example, both groups were almost exclusively white, with 98 percent in the AIDS sample and 96% in the healthy. Slightly more than 45% and 46.1% of the healthy subjects were between the ages of 21 to 30 years, while 35.7% of the AIDS sample and 30.4% of the healthy were between 31 to 35 years. Both groups were well educated, with 57.1% of the AIDS subjects and 55.9% of the healthy subjects having at least a college degree. An adaptation of the Kinsey scale, 0=Exclusive homosexuality to 6=Exclusive heterosexuality was utilized to assess the subject's placement of their sexual orientation (1=Exclusive homosexuality, to 7=Exclusive heterosexuality). Based on the data, virtually all subjects considered themselves exclusively homosexual (AIDS, 93.2%; healthy, 91.3%). The last measurement, years of labelling self as homosexual (1=Never, to 7=10 years or longer) revealed that 81% of the AIDS sample and 83.3% of the healthy sample reported labelling themselves homosexual for 6 years or longer.
### TABLE 1
DEMOGRAPHICS OF SUBJECTS

<table>
<thead>
<tr>
<th></th>
<th>AGE</th>
<th></th>
<th></th>
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<th></th>
</tr>
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<tbody>
<tr>
<td></td>
<td>n 21-25 26-30 31-35 36-40 41&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AIDS</td>
<td>42 2.4% 42.9% 35.7% 14.3% 4.8%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy</td>
<td>102 20.6% 27.5% 18.6% 11.8% 21.5%</td>
<td></td>
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<table>
<thead>
<tr>
<th></th>
<th>EDUCATION</th>
<th></th>
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<tbody>
<tr>
<td></td>
<td>n High School Some College College Grad. Degree</td>
<td></td>
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<td></td>
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<tr>
<td>AIDS</td>
<td>42 14.2% 28.5% 46.5% 10.6%</td>
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</tr>
<tr>
<td>Healthy</td>
<td>102 4.9% 39.2% 34.3% 21.6%</td>
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<table>
<thead>
<tr>
<th></th>
<th>LENGTH OF LABELLING ONESELF HOMOSEXUAL</th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n &lt; 3 3-5yrs. 6-9yrs. 10yrs.&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AIDS</td>
<td>42 0 19.0% 23.8% 57.1%</td>
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</tr>
<tr>
<td>Healthy</td>
<td>102 4.0% 12.7% 20.6% 62.7%</td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>KINSEY SCALE</th>
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<tbody>
<tr>
<td></td>
<td>n Exclusive Homosexual</td>
<td>Predominantly Homosexual Insignificantly Heterosexual</td>
<td>Predominantly Homosexual Significantly Heterosexual</td>
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<tr>
<td>AIDS</td>
<td>42 93.2% 6.8% 0%</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Healthy</td>
<td>102 91.3% 4.9% 3.8%</td>
<td></td>
<td></td>
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</tbody>
</table>
I. The Effect of AIDS on Homosexual Identity

The principle research hypothesis postulated that the diagnosis of AIDS in homosexual men would be negatively related to gay identity. Thus it was predicted that healthy gay men would have significantly higher scores on a measure of gay identity than gay men with AIDS.

To test the first hypothesis, a t-test procedure was conducted based on total mean scores from the homosexual identity scale as well as separate scale comparisons. Table 2 includes both mean and standard deviations for individual scales and totals for each subject group (see Figure 1). The results indicate that both groups had similar mean scores (AIDS, $M=30.07$; Healthy, $M=30.55$; Maximum Possible=41) and appear to have positive homosexual identities as measured collectively by these scales. A comparison of the total score revealed no significant difference between groups, $t (142) = -.82, p < .41$. Thus the principle hypothesis, that AIDS in homosexual men would be negatively related to gay identity, cannot be supported.

Utilizing a t-test procedure, a comparison of paired scales between groups yielded six scales with significant differences between AIDS and healthy groups. On the scale assessing feelings regarding being homosexual (scale 20=anxiety regarding homosexuality) a significant difference was demonstrated ($t (142) = -5.62, p \leq .0001$). Healthy men had significantly higher scores indicating less anxiety
TABLE 2

A COMPARISON OF MEAN SCORES AND STANDARD DEVIATIONS ON HOMOSEXUAL IDENTITY SCALES

<table>
<thead>
<tr>
<th></th>
<th>Anticipated Discrimination 4 (max.=4)</th>
<th>Putative Attitudes 5 (max.=4)</th>
<th>Passing 6 (max.=5.5)</th>
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<tr>
<td></td>
<td>n=42</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>AIDS</td>
<td></td>
<td>2.46</td>
<td>.499</td>
</tr>
<tr>
<td>Healthy</td>
<td></td>
<td>2.83</td>
<td>.577</td>
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<table>
<thead>
<tr>
<th></th>
<th>Social Involvement 7 (max.=6.5)</th>
<th>Acculturation 8 (max.=5)</th>
<th>Exclusive Homosexual Relationship 10 (max.=5)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>n=42</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>AIDS</td>
<td></td>
<td>3.80</td>
<td>.427</td>
</tr>
<tr>
<td>Healthy</td>
<td></td>
<td>3.54</td>
<td>.381</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Homosexual Commitment 11(max=5)</th>
<th>Conception Homosexuality 12(max=4.6)</th>
<th>Anxiety Regarding Homosexuality 20 (max=4)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=42</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>AIDS</td>
<td></td>
<td>3.46</td>
<td>.675</td>
</tr>
<tr>
<td>Healthy</td>
<td></td>
<td>3.75</td>
<td>.675</td>
</tr>
</tbody>
</table>
Figure 1: A COMPARISON OF MEAN SCORES ON HOMOSEXUAL IDENTITY SCALES
than the AIDS sample (Healthy: $M=3.52$, $SD=.5$; AIDS: $M=2.89$, $SD=.703$, Maximum Score=4).

In examining the results on those scaled labelled "Relating to the Homosexual World" three scales provided evidence that the AIDS subjects tended to be slightly more socially involved with other homosexuals, had homosexual relationships of longer duration and were somewhat more accustomed to common homosexual practices than the healthy subjects. These differences were reflected by differences in scores on Scale 7, Social Involvement, $t(141) = 3.65$, $p<.0004$ (AIDS: $M=3.8$, $SD=.4$; Healthy: $M=3.54$, $SD=3.81$, Maximum Score=6.5); Scale 10, Exclusive Homosexual Relationship, $t(142) = 4.86$, $p<.0001$ (AIDS: $M=4.12$, $SD=.761$; Healthy: $M=3.44$, $SD=.7$, Maximum Score=5) and Scale 8, Acculturation, $t(142) = 2.75$, $p=.0067$ (AIDS: $M=3.75$, $SD=.335$; Healthy: $M=3.51$, $SD=.598$, Maximum Score=5).

Scales which assess "Relating to the Heterosexual World" indicated significant differences between groups with the AIDS sample showing evidence of greater expectations of discrimination and societal intolerance towards homosexuals; Scale 4, Anticipated Discrimination, $t(142) = -3.65$, $p<.0004$ (AIDS: $M=2.46$, $SD=.499$; Healthy: $M=2.84$, $SD=.577$, Maximum Score=4); and Scale 5, Putative Attitudes, $t(140) = -2.52$, $p=.0126$ (AIDS: $M=2.07$, $SD=.639$, Healthy: $M=2.43$, $SD=.819$, Maximum Score=4). In examining these differences Scale 20, Anxiety Regarding Homosexuality, provided evidence consistent with the hypothesis that AIDS
in gay men is to some degree negatively influencing homosexual identity. While Scales, 8, Acculturation, 10, Exclusive Homosexual Relationship, and 7, Social Involvement, revealed that, inconsistent with what is expected, men with AIDS have stronger relationships with other homosexuals as compared to the healthy subjects.

Pearson Correlation Coefficients were used to examine the relationship between age and education with homosexual identity. The analysis revealed no evidence that the age of respondents was significantly related to homosexual identity. AIDS: \( r = 0.0839 \); Healthy: \( r = 0.525 \), \( r = -0.06 \). However age was positively related to homosexual identity in the AIDS sample, \( r = 0.26 \). There was no relationship between education and homosexual identity for both groups. AIDS: \( r = 0.86 \), \( r = -0.02 \), Healthy: \( r = 0.40 \), \( r = -0.08 \). A \( t \)-test was conducted for age and education and the results show an insignificant negative association (age: \( t (142) = -0.6 \), \( p = 0.54 \); Healthy: \( t (142) = -1.3 \), \( p = 1.9 \)).

II. The Relationship between Length of Time Labelling Oneself Homosexual and Identity

Hypothesis: The length of time since labelling oneself homosexual will be positively related to gay identity in both healthy gay men and men with AIDS. A \( t \)-test revealed no significant differences between groups on time since labelling oneself homosexual. Subjects in
both groups labelled themselves homosexual for approximately the same length of time (AIDS: $M=6.21$ (Scale: 1=Never to 7=10 years or longer); Healthy: $M=6.38$).

Pearson Correlations were utilized to assess the relationship between the scores on the "Length of Time" and scale total homosexual identity scores. Within the AIDS sample there was an observed significant positive correlation ($r=.373$, $p=.014$) between length of time since labelling oneself homosexual and homosexual identity. Similarly within the healthy sample, a significant positive correlation was observed, $r=.19$, $p=.047$. Based on the data analysis that there is evidence that allows for supporting the hypothesis. Thus there appears to be a significant, positive relationship between length of time and identity.

An examination of the relationships between scores on "Length of Time Since Labelling Oneself Homosexual" and specific homosexual identity scales revealed significant correlations for scale 6 (Putative Attitudes) $r=.38$, $p=.01$; scale 20 (Anxiety Regarding Homosexuality) $r=.37$, $p=.02$; and scale 11 (Homosexual Commitment) $r=.33$, $p=.01$. Thus the length of time since labelling oneself homosexual has an effect on the perceived societal attitudes towards homosexuality, affects the feelings associated with being homosexual as well as commitment to a homosexual identity.
The Relationship Between Length of Time Since AIDS Diagnosis and Homosexual Identity

Hypothesis: The length of time since the diagnosis of AIDS will be negatively related to homosexual identity. The length of time since diagnosis was conceptualized as a time frame (in weeks) from initial diagnosis to the present and was rated on a scale, 1 = 1-4 weeks, to 5 = 24 weeks or longer. Within the sample, 40.5% were diagnosed 8-16 weeks ago, while 35.7% were diagnosed 16-24 weeks ago.

A Pearson Correlation procedure was utilized to compare the relationship between length and identity. The analysis of the data revealed a non-significant, weak negative relationship (r = -.03, p = .84). Similar non-significant low level correlations between length and the individual identity scales were found, -.24 < r's < .19. Based on this data there was no association between length of time since AIDS diagnosis and homosexual identity.

The Relationship Between Sexual Frequency and Homosexual Identity

Hypothesis: The frequency of sexual contact by gay men with AIDS will be negatively related to homosexual identity. Additionally, increased sexual frequency will be significantly and positively correlated to homosexual identity in healthy gay men.
The reported sexual frequency data between healthy gay men and gay men with AIDS revealed differences, indicating that the AIDS subjects have reported more sexual contacts than the healthy sample. The AIDS sample $M=7.73$ sexual contacts (per month) prior to contracting AIDS, with 63.7% of the subjects reporting between 5-12 sexual contacts a month, while the healthy sample reported $M=5.66$ contacts, with 63.2% of the respondents reporting 0-4 contacts per month, $t(137) = 1.88, p=.06$.

Pearson Correlation Coefficients were utilized to examine the relationship between sexual frequency and homosexual identity. The results revealed a weak, non-significant correlation for the AIDS sample, $r=-.20, p=.21$. However, within the healthy sample a significant positive correlation was observed ($r=.231, p=.02$).

The Relationship Between Emotional Support and Contact with Other Gay Men to Homosexual Identity

Hypothesis: Emotional support and contact with other gay men will be positively related to gay identity in men with AIDS. Specifically, the frequency of contacts with other gay men and reported level of emotional support will be significantly and positively correlated to homosexual identity.

In order to assess this relationship, contact and support were treated separately. The respondent was asked
to rank support on a scale from 1=No Support to 5=Frequent, High Support. In looking at the distribution, it appears that emotional support was somewhat divided with 38% of the AIDS respondents reporting receiving some emotional support (rank 2), 28.6% rank support on a level of "3", compared with 35.7% choosing "4" or "5". Contact (weekly) with other gay men was ranked on a scale from 1=Seldom to 5=3X/week. Results suggested that over half of the AIDS respondents were in contact with other gay men at least once a week, while a smaller percentage reported contact more frequently. Thus, 61.2% of the AIDS subjects reported contact with other gay men at least once a week, while 26.2% reported contact at twice or three times a week.

To test this hypothesis Pearson Correlations were conducted for both "Support" and "Contact" in relation to homosexual identity (see Table 3). The results provide evidence that emotional support is significantly and positively related to homosexual identity (r=.49, p=.009). Similarly contact with other gay men is significantly and positively related to homosexual identity (r=.63, p=.0001). Thus the hypothesis is accepted that there is a significant relationship between homosexual identity and emotional support and contact with other gay men.

There were significant positive associations between support and contact with several of the specific identity scales; scale 4; Anticipated Discrimination (Support,
### Table 3
PEARSON CORRELATION COEFFICIENTS FOR CONTACT AND EMOTIONAL SUPPORT TO IDENTITY SCALES

<table>
<thead>
<tr>
<th>Scale</th>
<th>Contact</th>
<th>Emotional Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>$r = 0.57, p = 0.0001$</td>
<td>$r = 0.47, p = 0.0015$</td>
</tr>
<tr>
<td>5</td>
<td>$r = 0.53, p = 0.0003$</td>
<td>$r = 0.37, p = 0.013$</td>
</tr>
<tr>
<td>6</td>
<td>$r = 0.36, p = 0.019$</td>
<td>$r = 0.29, p = 0.060$</td>
</tr>
<tr>
<td>7</td>
<td>$r = -0.08, p = 0.613$</td>
<td>$r = -0.27, p = 0.08$</td>
</tr>
<tr>
<td>8</td>
<td>$r = 0.56, p = 0.0001$</td>
<td>$r = 0.13, p = 0.37$</td>
</tr>
<tr>
<td>10</td>
<td>$r = 0.16, p = 0.29$</td>
<td>$r = -0.05, p = 0.73$</td>
</tr>
<tr>
<td>11</td>
<td>$r = 0.56, p = 0.0001$</td>
<td>$r = 0.57, p = 0.0001$</td>
</tr>
<tr>
<td>12</td>
<td>$r = -0.12, p = 0.41$</td>
<td>$r = 0.026, p = 0.86$</td>
</tr>
<tr>
<td>20</td>
<td>$r = 0.65, p = 0.0001$</td>
<td>$r = 0.65, p = 0.0001$</td>
</tr>
</tbody>
</table>
$r = .47^1, p = .0021$; Contact, $r = .57, p = .0001$); scale 5: Putative Attitudes (Support, $r = .37, p = .013$; Contact, $r = .54, p = .0003$); and Scale 20: Anxiety Regarding Homosexuality (Support, $r = .65, p = .0001$; Contact, $r = .65, p = .0001$). Additionally, contact with other gay men was found to be correlated with passive ($p = .0192$) and to homosexual commitment ($p = .0001$).

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$^1$The SAS computer analysis output provides only $r$ and $p$ values. The $t$ statistic is not provided.
DISCUSSION

The purpose of this study was to test the relationship between having been diagnosed with AIDS and homosexual identity. The principle hypothesis predicted that AIDS in homosexual men would be negatively related to gay identity whereas healthy gay men would score higher on a measure of homosexual identity than men with AIDS.

The findings indicated that, in terms of an overall measure of homosexual identity, there was virtually no difference between samples of healthy gay men and men with AIDS. The results supported the conclusion that both groups had positive attitudes regarding their homosexuality. However, an examination of the specific subscales which comprised homosexual identity in this study revealed that six significantly discriminated between groups.

The AIDS subjects scored significantly higher than the healthy subjects on those scales measuring the respondents' relations to the homosexual world (Scale 8 - Acculturation; Scale 10 - Exclusive Homosexual Relationship; and Scale 7 - Social Involvement) while the healthy subjects scored significantly higher on two of the three scales measuring the respondents' relations to the heterosexual world, (Scale 4 - Anticipated Discrimination; and Scale 5 -
Putative Attitude towards Homosexuals). The last indication of differences between groups was noted on Scale 20, Anxiety Regarding Homosexuality, on which the AIDS subjects scored significantly lower than the healthy subjects.

A Discussion of the Differences Found on Scales and the Implications on Homosexual Identity

While the overall findings did not support the principle hypothesis regarding a negative relationship between AIDS and homosexual identity, there was some data consistent with the initial expectations. The most important finding in terms of the central question of this investigation was observed on Scale 20 which assessed anxiety regarding homosexuality. The lower scores as reported by the AIDS subjects on this scale which assesses both present feelings about being homosexual and past feelings regarding participating in homosexual sexual relations, suggests that consistent with the conclusion men with AIDS are experiencing increased conflict associated with being homosexual. In speculating on this difference between groups, an explanation might be found within the lower scores on those scales measuring the subject's relations to the heterosexual world, suggesting an increased conflict being homosexual and relating to society.
Relating to the Heterosexual World

The lowest scores observed for both groups of gay men were found on those scales which measured the subjects' views on societal attitudes towards homosexuality: Scale 4, Anticipated Discrimination, and Scale 5, Putative Attitudes. Based on the data analysis, the majority of gay men in this study, both healthy and AIDS, see society on some level as unaccepting and intolerant of homosexuality and believe that disclosure of their homosexuality would result in negative sanctions against them. This finding supports the results of Weinberg and Williams (1974), who found that 86.7% of a sample of gay men anticipated "some" discrimination resulting from the disclosure of their homosexuality and 66.7% thought most people "dislike" or are "disgusted" with homosexuals. The AIDS subjects in the present study, however, scored significantly lower and thus to a greater extent tended to view society as less accepting and tolerant of homosexuals than their healthy counterparts. Differences on this measure lend support to various writers who have observed that men with AIDS are feeling increased sensitivity in dealing with heterosexual society. This appears to result from their perception of being both shunned and isolated.

Thus, it appears that how a gay man with AIDS feels about his homosexuality is affected by and related to the rejection and ostracism he is experiencing from society.
Additionally, as Powell (1985) notes, "At the same time AIDS has influenced societal influence towards homosexuals adding to the already established stereotypes and discrimination" (p. 56). Consequently men with AIDS appear to be experiencing increased conflicts with society in two distinct but overlapping ways: first, as it relates to their homosexuality, and secondly, having an illness that has resulted in being stigmatized and rejected, thus becoming members of two stigmatized groups. It is believed therefore, that because AIDS victims have often been treated like pariahs and objects of fear, societal attitudes have contributed to conflicts and reinforced anxiety regarding how a gay man with AIDS feels about being homosexual.

Weinberg and Williams (1974) referring to societal influence on homosexual identity stated, "A person's evaluation and image of himself as well as his general psychological state are affected by how he imagines other people react to him, regardless of whether these imputations are accurate or not" (p. 152).

Relating to the Homosexual World

Scales which were utilized to assess how the subject relates to the homosexual world picked up some unexpected differences. For example, the AIDS subjects scored significantly higher on Acculturation, Exclusive Homosexual
Relationships, and Social Involvement. It appears that the higher scores on these scales counterbalance the lower scores on scales relating to the heterosexual world and suggest that increased conflicts exists primarily with heterosexual society. Thus, while the majority of AIDS subjects feel increased alienation from heterosexual society, the results on these scales indicate a high degree of association and involvement with other homosexuals. Data based on Scale 10: Exclusive Homosexual Relationships, appear to challenge a misconception concerning men with AIDS. Because the contraction of AIDS has often been associated with frequent anonymous sexual activity, it might be expected that individuals who develop the illness would not be particularly interested in the establishment of relationships. The results surprisingly show that men with AIDS tended to be relationship oriented. In fact, the AIDS subjects report an involvement in homosexual relationships to a greater degree than healthy subjects. Additionally, 38% of the AIDS subjects reported being presently involved in a homosexual relationship as compared to 31% of the non-AIDS healthy subjects.

On a second measure, Social Involvement, the AIDS subjects reported a higher degree of socializing with other homosexuals. Eighty-three point three percent of the AIDS sample compared to 73.5% of the healthy subjects reported spending "most" to "more than half" of their leisure time with other homosexuals. Additionally the AIDS subjects
indicated that 73.8% of their friends were homosexual while the healthy subjects reported that 47% of their friends were homosexual. This finding was higher than reported in the Weinberg and Williams sample of gay men where 49.1% of respondents spend "most" to "more than half" socializing with other homosexuals and mentioned that 45.5% of their friends were homosexual. This higher level of social involvement might be related to: (1) the increased distance men with AIDS feel from heterosexual society and thus are restricting themselves to other homosexuals who are less likely to reject them as well as helping them adapt to the rejection experienced from society, and (2) a need to socialize with other gay men with AIDS. As Powell (1985) mentioned, "Stigmatized individuals gain support from others who share the stigma" (p. 57).

The Effects of: Years of Labelling Oneself Homosexual, the Length of Diagnosis, Sexual Frequency and Emotional Support and Contact on Homosexual Identity

Several additional areas were examined to see if they were related to homosexual identity. The first of these looked at the relationship between length of time since labelling oneself homosexual and homosexual identity. It was predicted that the years of labelling would be positively related to homosexual identity; i.e., the longer one
has considered oneself homosexual, the more stable and positive would be one's homosexual identity.

Research into the development of a positive homosexual identity has suggested that it is accomplished in stages. It is believed that before an individual is able to commit to a homosexual identity, he/she or they must be able to repudiate the negative societal stereotypes of homosexuals. This is often accomplished through socialization with other homosexuals. Thus the development of a positive homosexual identity is conceptualized within a time frame in which the individual moves through different stages before arriving at a fully integrated concept of self as homosexual. Cass (1979) provided a model suggesting that the attainment of a positive homosexual identity was a developmental process wherein the individual moves through various stages before he/she is able to label oneself homosexual. These stages are: identity confusion, identity comparison, identity tolerance, subculture acceptance, identity pride, and identity synthesis.

It was predicted that the length of time since labelling oneself homosexual would be positively related to homosexual identity. A majority of the subjects in both groups (AIDS; 81%; Healthy; 83.3%) had labelled themselves homosexual between 6-10 years. The results on this measure thus supported the hypothesis of a positive relationship between length of time since labelling oneself homosexual and homosexual identity. The AIDS subjects indicated that
length, in particular, influenced their perception of societal views towards homosexuals as well as commitment to a homosexual identity. These findings appear to support the research on the development of a positive homosexual identity.

The Length of Diagnosis

It was predicted that the length of time since the diagnosis of AIDS would be negatively related to homosexual identity. The results on this measure failed to support the predicted negative relationship (r=-.03). It is not clear based on this analysis whether the "length of diagnosis" has any influence on homosexual identity. It is possible that because the majority of subjects had been diagnosed within close proximity of one another (54.2% were diagnosed 16 weeks or longer), the question could not be adequately answered.

Sexual Frequency

The third area examined sexual frequency as it relates to homosexual identity. Increased sexual frequency is seen as an indication of positive homosexual identity by Weinberg and Williams (1974) who stated, "A high frequency of homosexual sex indicates to the homosexual that other homosexuals appraise them positively" (p. 199). However,
due to the association between high sexual frequency and the contraction of AIDS it was predicted that sexual frequency would be negatively related to homosexual identity in men with AIDS and at the same time be positively related to identity in the healthy subjects.

Examining the self-reports of sexual contact in both groups of gay men, differences revealed that AIDS subjects reported a higher sexual frequency than the healthy subjects. The analysis of the data did show a negative correlation between sexual frequency and homosexual identity in the AIDS sample ($r = -.20$) and a positive one in the healthy sample ($r = .231$). However, this negative relationship was considered to be so insignificant that no conclusions could be adequately made. One possible explanation for this finding could be, that when subjects were asked why they felt they had contracted AIDS, 64% attributed this to "having sex with the wrong person", while only 23% believe this was due to frequent, anonymous sex.

**Emotional Support and Contact**

The last area focused on the relationship between emotional support and contact with other gay men with homosexual identity. As previously stated, societal reaction to AIDS has contributed to some extent in how men with AIDS regard their homosexuality. Although other homosexuals have not rejected or isolated AIDS victims in
the same way as heterosexual society, there have been indications that many gay men are reluctant to associate with AIDS victims. To determine in fact if there had been a change in socializing patterns with AIDS victims, the AIDS subjects were asked if their illness had affected their friends' desire to socialize with them. Seventy point seven percent responded, "to some degree".

Weinberg and Williams (1974) were able to show that social involvement with other homosexuals was crucial to the development of a positive homosexual identity, it was similarly predicted that contact and support would be positively related to gay identity. It is important that a distinction is made between social involvement and frequency of contact. In constructing the social involvement scale, Weinberg and Williams asked two questions which assessed the percentage of leisure time spent with other homosexuals, and the number of close friends who are homosexual. As reported previously, the AIDS subjects socialize to a large extent with other homosexuals. Utilizing the measurement of contact help provide a closer look at the degree and frequency of social involvement with other homosexuals.

The results as predicted reveal that a positive relationship exists between contact, emotional support and homosexual identity. Contact with other gay men was found to be related to feelings associated with being homosexual and the commitment to a homosexual identity. It is sug-
gested that contact with other gay men in a similar fashion to social involvement contributes to strengthening the individual's homosexual identity and thus reduce the influence of an unaccepting society.

The emotional support received by men with AIDS similarly influenced the subject's concerns over societal attitudes and feelings regarding being homosexual.

**Sampling Issues**

Several factors might have influenced the results in this study; these are: age, length of diagnosis, and years of labelling oneself homosexual. A high proportion of the subjects in both groups tended to be older (Healthy: 54.8% between the ages of 31-50, AIDS: 49.2% between 31-50) and had labelled themselves homosexual for ten years or longer (Healthy: 62.7%, AIDS: 47.3%). Additionally, there was a high proportion of men with AIDS that had been diagnosed 16 weeks or longer (54%). Due to the upward distribution of these factors subjects tended to represent a limited segment of the total gay and AIDS population. Consequently it is believed that these factors might have skewed homosexual identity in a more positive direction.

In addition to these factors it appears that the sources for recruitment of the AIDS subjects tended to yield gay men who might have been more adjusted to their illness compared to the general population of victims.
Most of the AIDS respondents (83.3%) in this study were obtained either through the "buddy system" of the K.S./AIDS Foundation (a multi-purpose organization in Houston, Texas that handles all aspects of the psycho-social treatment for men with AIDS) or by responding to an ad placed in a weekly gay periodical. The buddy system is a widely used volunteer program in which healthy gay men befriend men with AIDS. Thus, many of the subjects who participated were in weekly contact with another gay man (the buddy) who offered support and guidance as well as providing the outlet for dialogue focusing on fears and concerns. Those subjects who were recruited from the gay periodical were interested in participating to the extent that they responded to an ad. Many of these individuals expressed a high level of interest and seemed quite willing to take part in this study. In this regard it appears that those men who participated had, on some level, worked through issues (the shock and depression) pertaining to having AIDS and may have been atypical of the total AIDS population.

Recommendations/Conclusion

Due to the sensitive nature involved in doing research on people with AIDS, it might be difficult to adequately sample this population. However, there are several important areas which need to be focused on in more depth. It is felt that research should begin taking a closer look at
the relationship between adjustment of AIDS and the role
society plays in this. Traditionally terminal illness is
met by others with trepidation and awkwardness and thus
those who are terminally ill are treated as outcasts.
However, with AIDS, due to the nature of this illness there
is a great deal of rejection by society. It is therefore,
important to assess the effects that this disease process
is having not only on gay men and women, but on all per-
sons. Additionally, research might focus on the role of
family in adjustment. In particular, it is suggested that
future research examine how AIDS affects family members and
how family support or non-support assists in the coping
process. In closing, research should investigate ways
that AIDS is changing how gay men relate to heterosexual
society.
APPENDIX A

WEINBERG AND WILLIAMS QUESTIONNAIRE
Weinberg-Williams Questionnaire

INSTRUCTIONS

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

1. I feel that I have a number of good qualities........................... SA A ? D SD
2. Being a homosexual is something that is completely beyond one's control........ SA A ? D SD
3. Homosexuals are usually superior in many ways to nonhomosexuals............... SA A ? D SD
4. I take a positive attitude toward myself.. SA A ? D SD
5. No one is going to care much what happens to you when you get right down to it...... SA A ? D SD
6. What consenting adults do in private is nobody's business as long as they do not hurt other people......................... SA A ? D SD
7. If you don't watch out for yourself, people will take advantage of you........... SA A ? D SD
8. Human nature is really cooperative........... SA A ? D SD
9. I look effeminate........................ SA A ? D SD
10. Most people can be trusted..................... SA A ? D SD
11. Homosexuality may be best described as an illness.

12. On the whole, I am satisfied with myself.

13. I am not as happy as others seem to be.

14. I prefer to pass by friends or people I know but have not seen for a long time unless they speak to me first.

15. I feel that I'm a person of worth, at least on an equal plane with others.

16. I find that it is easier for me to talk to male homosexuals than to male heterosexuals.

17. I find it easier for me to talk to male heterosexuals than to female heterosexuals.

18. I tend to behave effeminately when in the heterosexual world.

19. All in all, I am inclined to feel that I am a failure.

20. I do not care who knows about my homosexuality.

21. I do not like to associate socially with a person who has a reputation (among heterosexuals) of being homosexual.

22. I have a harder time than other people in gaining friends.

23. When I was a teenager I was unpopular with girls.

24. I wish I were not homosexuals.

25. I would not want to give up my homosexuality even if I could.

26. I certainly feel useless at times.

27. I have a harder time than other people in making conversation.

28. I often find myself "putting on an act" to impress people.
29. People have made fun of me because I am homosexual. SA A ? D SD

30. Homosexuals and heterosexuals are basically different in more ways than simply sexual preference. SA A ? D SD

31. I am able to do things as well as most others. SA A ? D SD

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

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

34. Usually it is the most unethical, immoral or hypocritical members of heterosexual society that are most likely to condemn homosexuals. SA A ? D SD

35. I feel "closer" to a heterosexual of my own social class than to a homosexual who is of a much lower social class. SA A ? D SD

36. It would not bother me if I had children who were homosexual. SA A ? D SD

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

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

39. I am easily embarrassed. SA A ? D SD

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

41. There have been times when I felt as though I were going to have a nervous breakdown. SA A ? D SD

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

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

44. There is nothing immoral about being a homosexual. SA A ? D SD

45. A person is born homosexual or heterosexual. SA A ? D SD
46. I often feel downcast and dejected........ SA A ? D SD
47. I am probably responsible for the fact that I am homosexual.................. SA A ? D SD
48. On the whole, I think I am quite a happy person.......................... SA A ? D SD
49. Homosexuality may be best described as a mental illness............... SA A ? D SD
50. Homosexuality tends to have a negative effect on the society at large........ SA A ? D SD
51. I would not mind being seen in public with a person who has the reputation (among heterosexuals) of being homosexuals....................... SA A ? D SD
52. I wish I could have more respect for myself.............................. SA A ? D SD
53. I often feel very self-conscious............. SA A ? D SD
54. I tend to have effeminately when I'm with other homosexuals............... SA A ? D SD
55. I feel I do not have much to be proud of.. SA A ? D SD
56. At times I think I am no good at all....... SA A ? D SD
57. I often feel ill at ease when I'm in the presence of others............... SA A ? D SD
58. I tend to be a rather shy person........... SA A ? D SD
Weinberg-Williams Questionnaire II

INSTRUCTIONS

After Reading Each Statement Circle That Number Which Corresponds With Your Response

59. From how many heterosexuals do you try to conceal your homosexuality?

All...................1
Most..................2
More than half.......3
About half............4
Less than half........5
Only a few............6
None..................7

60. Do you think people are likely to break off social relationships with someone if they suspect he is homosexual?

Yes, most people would.......1
Yes, many would.............2
Yes, a few would............3
No...........................4

61. Do you feel societal reaction to AIDS affected your response in item #60?

No.................................................1
Yes, but only to a very small degree....2
Yes, to some degree....................3
Yes, very much so.....................4

62. Do you think people are likely to make life difficult for persons they suspect are homosexual?

Yes, most people would.......1
Yes, many would.............2
Yes, a few would............3
No..........................4
63. How do you think most people feel about homosexuals?

- They feel disgusted or repelled by homosexuals...1
- They dislike homosexuals..............................2
- They have a "live and let live" attitude toward homosexuals..............................3
- They have some liking for homosexuals.....................4

64. Do you feel societal reaction to AIDS affected your response in item #63?

- No.................................................1
- Yes, but only to a very small degree...2
- Yes, to some degree...............................3
- Yes, very much so.................................4

65. What proportion of your leisure time socializing is with homosexuals?

- Most..............................1
- More than half..............................2
- About half.................................3
- Less than half..............................4
- Only a small amount........................5
- None.................................6

66. Would there be problems at work if people found out (that you were gay)?

- No.................................................1
- Yes, but only to a very small degree...2
- Yes, to some degree...............................3
- Yes, very much so.................................4

67. How many of your friends are homosexual?

- All..............................................1
- Most.............................................2
- More than half..............................3
- About half.................................4
- Less than half..............................5
- Only a small amount........................5
- None.....................................7

68. How often do you ordinarily frequent bars or clubs?

- More than once a week..............1
- About once a week......................2
- About once every other week........3
- About once a month....................4
- About once every few months........5
- Less often.................................6
- Never......................................7
69. Have you ever danced "slow" dances with another male?

   Yes, often.............1
   Yes, a few times......2
   Yes, once...............3
   No, never...............4

70. Has "necking" (kissing) been a part of your sexual practices?

   Yes, often.............1
   Yes, a few times......2
   Yes, once...............3
   No, never...............4

71. At the present time, are another homosexual and yourself limited your sexual relationships primarily to each other?

   No..........................1
   Yes, we have been for less than a month....2
   Yes, we have been for one to six months....3
   Yes, we have been for more than a year......4

72. At some time in the past, did another homosexual and yourself limit your sexual relationships primarily to each other? (This should refer to a different relationship than the one considered in the previous question.)

   No..........................1
   Yes, for less than a month...........2
   Yes, for between one to six months....3
   Yes, for more than a year............4

73. What do you think most homosexuals that know you think of you?

   Think very well of me.............1
   Think fairly well of me.............2
   Do not really accept or reject me.....3
   Think fairly poorly of me.............4
   Think very poorly of me.............5
   Do not associate enough with homosexuals to answer this question....6

74. Even though it may be difficult please specify the exact number of people who you consider to be your close friends (e.g., 1, 2, 3, ...)
75. Even though it may be difficult, in your answers to these questions provide numbers:

   In the last 6 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 first have a homosexual experience? ...........

76. Has the concern over AIDS affected sexual frequency?

   No ................................................. 1
   Yes, but only to a very small degree .... 2
   Yes, to some degree ....................... 3
   Yes, very much so ........................... 4

77. Does the opinion you have of yourself tend to change a great deal?

   Changes a great deal ...................... 1
   Changes somewhat .......................... 2
   Changes very little ....................... 3
   Does not change at all .................... 4

78. Do you ever find that on one day you have one opinion of yourself and on another day you have a different opinion?

   Yes, this happens often ............... 1
   Yes, this happens sometimes ........... 2
   Yes, but this rarely happens ......... 3
   No, this never happens ................. 4

79. Does knowing that you are homosexual "weight on your mind? (make you feel guilty, depressed, anxious or ashamed)?

   A great deal ......................... 1
   Somewhat .............................. 2
   Not very much ......................... 3
   Not at all .............................. 4

80. At the present time do you ever experience shame, guilty, or anxiety after having sexual (homosexual) relations?

   Nearly always ...................... 1
   Pretty often ......................... 2
   Not very often ....................... 3
   Never ................................. 4
81. Did you feel guilt or shame after your first homosexual experience?

Yes, a great deal........1
Yes, some..................2
Yes, but very little......3
No..........................4

82. Do you feel lonely?

Never..................1
Seldom....................2
Often..........................3
Very often..................4

83. Taking all things together, how would you say things are these days -- would you say you are:

Very happy...............1
Pretty happy..............2
Not too happy...........3
Very unhappy..............4

84. For how long have you thought of yourself as being homosexual?

Never..........................1
Only at some time in the past......2
For less than a year.............3
For less than 3 years............4
For between 3 and 5 years.........5
For between 6 and 9 years........6
For 10 years or more.............7

85. Do you presently worry about the possible exposure of your homosexuality?

A great deal...............1
Somewhat...................2
Very little .................3
Not at all....................4

86. If you answered with a 1 or 2 response in item #85, is this associated with the societal backlash related to AIDS?

No................................1
Yes, but only to a very small degree....2
Yes, to some degree..................3
Yes, very much so....................4
87. Do you think of yourself as:

- Exclusively homosexual .................. 1
- Predominantly homosexual, only insignificantly heterosexual .......... 2
- Predominantly homosexual, but significantly heterosexual ............ 3
- Equally heterosexual, but significantly homosexual .................. 4
- Predominantly heterosexual, but insignificantly homosexual ............ 5
- Predominantly heterosexual, only insignificantly homosexual ........... 6
- Exclusively heterosexual ................ 7

88. With whom do you live?

- Both parents ...................... 1
- Father ............................ 2
- Mother ................................ 3
- Alone ............................. 4
- Male (homosexual) roomate(s)........ 5
- Male (heterosexual) roomate(s) ...... 6
- Wife .............................. 7
- Other (specify: ____________________) 8

89. If you live with roomate is roomate also your lover?

__________________________

90. How old are you?

- Under 21 ...................... 1
- 21-25 .......................... 2
- 26-30 .......................... 3
- 31-35 .......................... 4
- 36-40 .......................... 5
- 41-45 .......................... 6
- 46-50 .......................... 7
- 51-60 .......................... 8
- Over 60 ...................... 9

91. Are you employed in?

- White collar work .......... 1
- Blue collar work .......... 2

92. How far have you gone in your education?

- 8th grade or less .......... 1
- Some high school .......... 2
- High school diploma ...... 3
- Some college ............... 4
- College graduate .......... 5
- Graduate degree .......... 6
93. What is your race?
   Black ................ 1
   White ................ 2
   Other ................ 3

94. What is your religious background?
   Catholic ............. 1
   Protestant .......... 2
   Jewish .............. 3
   Other ................ 4

95. To the best of your knowledge are you in good health?
   No ................... 1
   Yes ................... 2
Weinberg-Williams Questionnaire

INSTRUCTIONS

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

1. I feel that I have a number of good qualities..................... SA A ? D SD
2. Being a homosexual is something that is completely beyond one's control........ SA A ? D SD
3. Homosexuals are usually superior in many ways to nonhomosexuals.................. SA A ? D SD
4. I take a positive attitude toward myself.. SA A ? D SD
5. No one is going to care much what happens to you when you get right down to it... SA A ? D SD
6. What consenting adults do in private is nobody's business as long as they do not hurt other people......................... SA A ? D SD
7. If you don't watch out for yourself, people will take advantage of you........ SA A ? D SD
8. Human nature is really cooperative........ SA A ? D SD
9. I look effeminate.......................... SA A ? D SD
10. Most people can be trusted......................... SA A ? D SD
11. Homosexuality may be best described as an illness................................ SA A ? D SD
12. On the whole, I am satisfied with myself.. SA A ? D SD
13. I am not as happy as others seem to be.... SA A ? D SD
14. I prefer to pass by friends or people I know but have not seen for a long time unless they speak to me first .......... SA A ? D SD
15. I feel that I'm a person of worth, at least on an equal plane with others....... SA A ? D SD
16. I find that it is easier for me to talk to male homosexuals than to male heterosexuals........................ SA A ? D SD
17. I find it easier for me to talk to male heterosexuals than to female heterosexuals................................. SA A ? D SD
18. I tend to behave effeminately when in the heterosexual world ..................... SA A ? D SD
19. All in all, I am inclined to feel that I am a failure........................................ SA A ? D SD
20. I do not care who knows about my homosexuality......................................... SA A ? D SD
21. I do not like to associate socially with a person who has a reputation (among heterosexuals) of being homosexual....... SA A ? D SD
22. I have a harder time than other people in gaining friends................................. SA A ? D SD
23. When I was a teenager I was unpopular with girls........................................ SA A ? D SD
24. I wish I were not homosexuals............... SA A ? D SD
25. I would not want to give up my homosexuality even if I could.................. SA A ? D SD
26. I certainly feel useless at times........ SA A ? D SD
27. I have a harder time than other people in making conversation......................... SA A ? D SD
28. I often find myself "putting on an act" to impress people................................. SA A ? D SD
29. People have made fun of me because I am homosexual.......................... SA A ? D SD
30. Homosexuals and heterosexuals are basically different in more ways than simply sexual preference.................. SA A ? D SD
31. I am able to do things as well as most others................................. SA A ? D SD
32. Most people are inclined to look out for themselves.......................... SA A ? D SD
33. I feel that I don't have enough friends... SA A ? D SD
34. Usually it is the most unethical, immoral or hypocritical members of heterosexual society that are most likely to condemn homosexuals.................. SA A ? D SD
35. I feel "closer" to a heterosexual of my own social class than to a homosexual who is of a much lower social class........... SA A ? D SD
36. It would not bother me if I had children who were homosexual.................. SA A ? D SD
37. I have noticed that my ideas about myself seem to change very quickly........ SA A ? D SD
38. I feel that nothing, or almost nothing, can change the opinion I currently hold of myself................................SA A ? D SD
39. I am easily embarrassed.....................SA A ? D SD
40. Some days I have a very good opinion of myself; other days I have a very poor opinion of myself.................. SA A ? D SD
41. There have been times when I felt as though I were going to have a nervous breakdown.................. SA A ? D SD
42. In general, I feel in low spirits most of the time............................ SA A ? D SD
43. I get a lot of fun out of life....................... SA A ? D SD
44. There is nothing immoral about being a homosexual....................... SA A ? D SD
45. A person is born homosexual or heterosexual................................. SA A ? D SD
46. I often feel downcast and dejected ........ SA A ? D SD
47. I am probably responsible for the fact that I am homosexual ....................... SA A ? D SD
48. On the whole, I think I am quite a happy person .................................. SA A ? D SD
49. Homosexuality may be best described as a mental illness ........................... SA A ? D SD
50. Homosexuality tends to have a negative effect on the society at large ............. SA A ? D SD
51. I would not mind being seen in public with a person who has the reputation (among heterosexuals) of being homosexuals ........................................... SA A ? D SD
52. I wish I could have more respect for myself .............................................. SA A ? D SD
53. I often feel very self-conscious .......... SA A ? D SD
54. I tend to have effeminately when I'm with other homosexuals ..................... SA A ? D SD
55. I feel I do not have much to be proud of.. SA A ? D SD
56. At times I think I am no good at all...... SA A ? D SD
57. I often feel ill at ease when I'm in the presence of others.......................... SA A ? D SD
58. I tend to be a rather shy person ........ SA A ? D SD
Weinberg-Williams Questionnaire II

INSTRUCTIONS

After Reading Each Statement Circle That Number Which Corresponds With Your Response

59. From how many heterosexuals do you try to conceal your homosexuality?

   A 11••••••••••••••••••••• 1
   Most..........................2
   More than half..............3
   About half....................4
   Less than half..............5
   Only a few...................6
   None..........................7

60. Do you think people are likely to break off social relationships with someone if they suspect he is homosexual?

   Yes, most people would.......1
   Yes, many would................2
   Yes, a few would................3
   No..............................4

61. Do you feel societal reaction to AIDS affected your response in item #60?

   No..................................................1
   Yes, but only to a very small degree....2
   Yes, to some degree.....................3
   Yes, very much so.....................4

62. Would there be problems at work if people found out (that you were gay)?

   No..................................................1
   Yes, but only to a very small degree....2
   Yes, to some degree.....................3
   Yes, very much so.....................4
63. How do you think most people feel about homosexuals?

- They feel disgusted or repelled by homosexuals... 1
- They dislike homosexuals................................. 2
- They have a "live and let live" attitude toward homosexuals................................. 3
- They have some liking for homosexuals.................. 4

64. Do you feel societal reaction to AIDS affected your response in item #63?

- No......................................................... 1
- Yes, but only to a very small degree.... 2
- Yes, to some degree................................. 3
- Yes, very much so................................ 4

65. Do you think people are likely to make life difficult for persons they suspect are homosexual?

- Yes, most people would....... 1
- Yes, many would......................... 2
- Yes, a few would....................... 3
- No................................................. 4

66. What proportion of your leisure time socializing is with homosexuals?

- Most...................... 1
- More than half........ 2
- About half......... 3
- Less than half..... 4
- Only a small amount.. 5
- None.................. 6

67. Since you contracted AIDS has this affected your friends' desire to socialize with you?

- No......................................................... 1
- Yes, but only to a very small degree.... 2
- Yes, to some degree................................. 3
- Yes, very much so................................ 4

68. How many of your friends are homosexual?

- All......................... 1
- Most.......................... 2
- More than half........ 3
- About half......... 4
- Less than half..... 5
- Only a small amount.. 6
- None.................. 7
69. How often do you ordinarily frequent bars or clubs?
   More than once a week............1
   About once a week...................2
   About once every other week.....3
   About once a month...............4
   About once every few months....5
   Less often..........................6
   Never..............................7

70. Have you ever danced "slow" dances with another male?
   Yes, often...............1
   Yes, a few times...........2
   Yes, once................3
   No, never...............4

71. Has "necking" (kissing) been a part of your sexual practices?
   Yes, often...............1
   Yes, a few times...........2
   Yes, once................3
   No, never...............4

72. At the present time, are another homosexual and yourself limited your sexual relationships primarily to each other?
   No........................................1
   Yes, we have been for less than a month....2
   Yes, we have been for one to six months...3
   Yes, we have been for more than a year....4

73. At some time in the past, did another homosexual and yourself limit your sexual relationships primarily to each other? (This should refer to a different relationship than the one considered in the previous question.)
   No........................................1
   Yes, for less than a month...........2
   Yes, for between one to six months....3
   Yes, for more than a year............4

74. What do you think most homosexuals that know you think of you?
   Think very well of me................1
   Think fairly well of me.............2
   Do not really accept or reject me.....3
   Think fairly poorly of me...........4
   Think very poorly of me............5
   Do not associate enough with
   homosexuals to answer this question....6
75. Has there been a change (in a negative direction) in their opinion of you since you have been diagnosed with AIDS?

No.............................................1
Yes, but only to a very small degree.....2
Yes, to some degree......................3
Yes, very much so......................4

76. EVEN THOUGH IT MAY BE DIFFICULT IN YOUR ANSWERS TO THESE QUESTIONS PROVIDE NUMBERS:

Prior to contracting AIDS how many times per month did you have sexual relations with males?.....

At what age did you first have a homosexual experience?..............................

77. Does the opinion you have of yourself tend to change a great deal?

Changes a great deal.............1
Changes somewhat.................2
Changes very little..............3
Does not change at all.........4

78. Do you ever find that on one day you have one opinion of yourself and on another day you have a different opinion?

Yes, this happens often.........1
Yes, this happens sometimes....2
Yes, but this rarely happens....3
No, this never happens.........4

79. Does knowing that you are homosexual "weight on your mind? (make you feel guilty, depressed, anxious or ashamed)?

A great deal.................1
Somewhat.......................2
Not very much.................3
Not at all......................4

80. At the present time do you ever experience shame, guilty, or anxiety after having sexual (homosexual) relations?

Nearly always.............1
Pretty often...................2
Not very often................3
Never.........................4
81. Did you feel guilt or shame after your first homosexual experience?

Yes, a great deal.........1
Yes, some..................2
Yes, but very little.......3
No.........................4

82. Do you feel lonely?

Never......................1
Seldom......................2
Often.......................3
Very often..................4

83. For how long have you thought of yourself as being homosexual?

Never........................................1
Only at some time in the past...........2
For less than a year......................3
For less than 3 years....................4
For between 3 and 5 years..............5
For between 6 and 9 years..............6
For 10 years or more....................7

84. Do you presently worry about the possible exposure of your homosexuality?

A great deal.....................1
Somewhat..........................2
Very little .......................3
Not at all...........................4

85. If you answered with a 1 or 2 response in item #84, is this associated with the societal backlash related to AIDS?

No........................................1
Yes, but only to a very small degree....2
Yes, to some degree....................3
Yes, very much so.....................4

86. Do you think of yourself as:

Exclusively homosexual................1
Predominantly homosexual, only insignificantly heterosexual............2
Predominantly homosexual, but significantly heterosexual.............3
Equally heterosexual, but significantly homosexual....................4
Predominantly heterosexual, but significantly homosexual.............5
Predominantly heterosexual, only insignificantly homosexual.........6
Exclusively heterosexual...............7
87. With whom do you live?

Both parents...................... 1
Father............................. 2
Mother............................. 3
Alone............................. 4
Male (homosexual) roommate(s)... 5
Male (heterosexual) roommate(s)... 6
Wife................................ 7
Other (specify: _________________) 8

If you live with roommate is roommate also your lover?

88. How old are you?

Under 21......................... 1
21-25................................ 2
26-30................................ 3
31-35................................ 4
36-40................................ 5
41-45................................ 6
46-50................................ 7
51-60................................ 8
Over 60............................. 9

89. Are you employed in?

White collar work.............. 1
Blue collar work............ 2

90. How far have you gone in your education?

8th grade or less.............. 1
Some high school............ 2
High school diploma......... 3
Some college................... 4
College graduate.............. 5
Graduate degree............... 6

91. What is your race?

Black....................... 1
White....................... 2
Other....................... 3

92. What is your religious background?

Catholic...................... 1
Protestant................... 2
Jewish...................... 3
Other...................... 4
93. Even though this may be a rather difficult question to answer, please attempt an answer. Why do you feel you have contracted AIDS?

- Heavy drug use: 1
- Frequent, anonymous sexual activity: 2
- Was sexual with the wrong person: 3
- I was already in poor health: 4
- Other (please specify):  

94. How long has it been (in weeks) since you received the AIDS diagnosis?

- 1-4 Wks: 1
- 4-8 Wks: 2
- 8-16 Wks: 3
- 16-24 Wks: 4
- 24 Wks or longer: 5

95. How often per week are you in contact with other gay men?

- Seldom: 1
- Once a week: 2
- Twice a week: 3
- 3 times or more: 4

96. On a scale of 1 to 5 how much emotional support do you feel you receive from other gay men? (1 equal to little support, 5 equal to frequent support)

97. At the present time are you in therapy or receiving counseling of some type?

- Yes: 1
- No: 2
APPENDIX B

THE INFORMED CONSENT FORM
Informed Consent Form

You are being asked to participate in research conducted by Robert Schulman, a graduate student in clinical psychology at the University of Central Florida (U.C.F.) in Orlando, Florida. This research will be incorporated into a masters thesis, and is being supervised by Drs. Jack McGuire and Sandra Guest-Houston. The purpose of this study is to look at some of the psychological effects of AIDS on gay men. You will be asked to respond to a questionnaire consisting of questions regarding: 1) Your attitudes on being gay, 2) relationships, sexuality and socialization with other gay men, 3) how you feel about yourself, 4) how you feel AIDS has personally affected you, and 5) general questions such as your age, race and religion. Most statements are responded to by a 'strongly disagree' to 'strongly agree' ranking, while a few items will ask you to respond with either a yes or no, or a numerical response. Please try to respond to every question. However, if you are unable to respond to a given item you may leave it blank. It is estimated the questionnaire will take half-hour to an hour to complete.

Results from this research will help psychologists as well as other providers of mental health services understand more precisely how this devastating illness has affected various segments of the gay community, and will assist psychotherapists in treating gay men with AIDS. Your participation in this study is strictly voluntary and you are free at anytime to discontinue participation. The results of this study are likely to be published and possibly presented to various gay organizations and to members of the medical and mental health professions. In addition, the completed thesis will be available through the U.C.F. library.

At no time will your name appear on the questionnaire, nor will there be anyway of personal identification through your responses. Thus, the strictest confidential procedures will be utilized to safeguard anonymity. Your completed questionnaire will be scored by Robert Schulman with the assistance of Drs. McGuire and Guest-Houston. When you have completed the questionnaire you will be asked to place it in a sealed envelope with an address and stamp already in place and requested to mail to R. Schulman.

By taking part in this research you are greatly contributing to an area that is in vital need of more knowledge. Thank you.
My signature below indicates that I have been informed and understand that:

1. My participation in this research is voluntary.
2. I will be asked to fill in a questionnaire with 94 statements measuring:
   a. my attitudes on being gay
   b. relationships, sexuality and socialization
   c. how Aids has personally effected me
   d. my feelings about myself
   e. demographic questions
3. I may discontinue participation at anytime and may refuse to respond to any question if I choose.
4. I understand the results of this research will be retained as a masters thesis by U.C.F. and placed in the school library and maybe published in a professional journal.
5. I understand the questionnaire I complete will in no way be linked to me personally and my name will not be found on the questionnaire.
6. This consent to participate form, which acknowledges my participation in this study via my signature, will be retained by Dr. McGuire at U.C.F. in Orlando, Florida and will be subsequently destroyed.

Being fully aware of the above, I freely consent to participate in this research and allow the use of my responses in data analysis.

Signature: ______________________________

Date: ______________________________
REFERENCES


