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PSYCHOLOGICAL ADJUSTMENT TO AGING AMONG GAY MEN OVER AGE FIFTY

By

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ABSTRACT

PSYCHOLOGICAL ADJUSTMENT TO AGING AMONG GAY MEN OVER AGE FIFTY

By

Scott Berlin

This study examined psychological adjustment to aging in men who identified themselves as gay, bisexual, or men who have sex with men. The study considered the relationship between five dependent variables indicative of psychological adjustment to aging—loneliness, hope, depression, life satisfaction, and self-esteem—and the independent variables of social support, internalized homophobia, perceived health, perceived financial status, and perceptions of ageism. Additionally, the study looked at the relationship between the five dependent variables and the demographic variables of race/ethnicity, income, education, work status, relationship status, and living situation. A specific focus was placed on HIV status among participants, and both HIV-positive and HIV-negative individuals participated in the study.

It was unclear whether, in terms of HIV status, there would be differences in the five dependent variables between the men who were HIV-positive and those who were HIV-negative. Additionally it was unclear whether there would be a relationship between loneliness, hope, depression, life satisfaction, self-esteem, internalized homophobia, and social support. Finally, it was unclear whether variables such as perceived health, financial status, and life expectancy also would be related to the five dependent variables.

The results indicated that HIV status, income, race/ethnicity, living situation, work status, and relationship status did not have significant relationship to the dependent variables indicative of psychological adjustment to aging. However, perceptions of health, finances, and ageism were significantly correlated with the dependent variables. Poor perceived health, finances, and social support, as well as high levels of perceived ageism and internalized homophobia, were nonfavorably correlated with the dependent variables.

This study illustrates the importance of perceptions, as opposed to objective measures, of constructs such as health, wealth, and age. Specifically, the results indicated that respondents' perceptions of their reality generally had a stronger relationship to the variables that measured their psychological adjustment to aging. These findings inform services targeting older gay men, in terms of developing interventions that affect individuals' perceptions of, rather than just objective indicators of, aging.

DEDICATION

This dissertation is dedicated to the loving memory of my dearly departed nephew, Evan Turner, and dearly departed friend, Thomas Buckingham. I love and miss you both.

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CHAPTER 1

INTRODUCTION AND LITERATURE REVIEW

It has been estimated that there are over 85 million individuals who are age 50 or older in the United States (U.S. Census Bureau, 2003). This accounts for nearly 29% of the country's population. With a current median age of 36 that is increasing each year, there is an ever-increasing focus on older adults. Concerns such as Social Security solvency, Medicare coverage, and other policy issues, as well as the social support and care giving needs of this population, are becoming more prominent.

A National Gay and Lesbian Task Force study states that one to three million Americans over age 65, are lesbian, gay, bisexual or transgender (LGBT; Cahill, South, & Spade, 2001). The number and proportion of LGBT older adults is expected to grow significantly in the coming years. Based on the immense arrival of the baby-boomers into older age, it is expected that, within 30 years, twenty percent of Americans will be over age 65. Approximately four million of these seniors will be LGBT.

LGBT older adults will face many challenges as they move into older age. Older LGBT people often do not access health care, housing, or other social services, sometimes because of institutionalized heterosexism and homophobia (Cahill et al., 2001). In this context, heterosexism is defined as "a belief or argument that male-female sexuality is the only natural, normal, or moral mode of sexual behavior, and is also used to refer to the effects of that cultural ideology" (Corsini, 2001, p. 344). Homophobia is defined as "the fear of, aversion to, or discrimination against homosexuality or homosexuals" (O'Donahue & Casselles, 1993, p. 177). In relationship to this

"institutionalized heterosexism and homophobia", policies and delivery systems often do not consider the LGBT community (Cahill et al., 2001).

In addition to baby boomers transitioning into older adulthood, there is increased visibility of LGBT individuals in our communities and society. Moreover, due to the Stonewall Riots of 1969 and the beginnings of a large, organized LGBT political effort, acceptance of LGBT people has become much more common.

Background

In June of 1969, the famous Stonewall Riots took place in New York City at a gay bar, focusing national attention on the LGBT community. Patrons at the Stonewall Bar fought back against the police harassment and brutality that was often directed at them. Many see these riots as the beginning a "new age" for LGBT advocacy (Herdt & de Vries, 2004). Possibly as a result of this these events, in 1973, the American Psychiatric Association (APA) eliminated homosexuality from its listing of mental illnesses, creating another step toward equal rights and treatment for LGBT people (Berger, 1980).

During the 1970s, researchers in the social sciences began to recognize that LGBT seniors might have distinct characteristics and needs, and thus the research in this area continued to grow. Berger (1980) and others (Friend, 1980, 1987; Francher & Henkin., 1973; Kimmel, 1977, 1979) began to illuminate some of the realities of aging among these individuals. Although research has grown in this area, there continues to be an important need for additional research, particularly in regard to continuing social justice as well as social change and the development of more social services (Berger, 1980; Kimmel, 1977; Kooden, 1997).

This population of individuals who has witnessed epic change, including being one of the first generations to live as openly LGBT people, are now in middle and older adulthood. As such, research is needed in regard to how this generation of older LGBT adults negotiates its way into older age.

Overview of the Study

This exploratory study utilized a correlational research design. It specifically examined the outcomes associated with psychological adjustment to aging among gay and bisexual men, as well as men who have sex with men in metropolitan Chicago. These outcomes were measured by various established quantitative mental health and attitude measures. Additionally, the study assessed other descriptive and demographic information. While men who identified as gay, bisexual, and/or as men who have sex with men were eligible for this study, the sample will be identified simply as gay men for the remainder of this document.

Statement of the Problem

The problem that this study addressed is the lack of research on the ways in which gay men over 50 years of age cope with the stresses of aging, as well as the possible influence that various factors may have on their coping skills.

Research Questions

Based on the statement of the problem, the research questions are:

1. What are the demographic and descriptive characteristics of the sample?

2. Are there differences between HIV-positive and HIV-negative participants in terms of psychological adjustment to aging measures?

3. Do variables such as perceived health, income, finances, social supports, race/ethnicity, education, employment status, and internalized homophobia affect the psychological adjustment aging measures?

4. Are the variables associated with psychological adjustment to aging (self-esteem, loneliness, hopelessness, depression, and life satisfaction) correlated with one another?

5. Do the variables and the psychological aging measures have a relationship with participants' life expectancy?

6. Do study participants perceive LGBT community ageism?

7. Do study participants perceive or experience accelerated aging?

Definition of Terms

It is important to have a clear understanding of the following terms when considering the research.

Accelerated aging is the notion that gay men consider themselves as old (or at least past their prime) at a younger age than their heterosexual counterparts (Bennett & Thompson, 1991).

Ageism is "a prejudice against a certain individual or group because of their age. This includes any assumption of familiarity or sameness due to one's age. Age discrimination can refer to prejudice against any age group solely on the grounds of age" (Butler, 1968).

Gay refers to people who share affectional and/or sexual attractions to others of the same sex and to identities and the culture and communities that have developed among people who share those identities (American Psychological Association [APA],

1998). In terms of this study, gay men, bisexual men, and men who have sex with men were all considered eligible for the study. In some cases, "gay" is used to refer to the collective sample throughout this document.

Heterosexism is defined by Herek (1996) as a system of ideology that "devalues and stigmatizes" non-heterosexual behavior, identity, relationships, and community.

Homophobia is the "irrational fear, hatred and intolerance of gay, lesbian, and bisexual persons" (Gelberg & Chojnacki, 1995 p. 268).

Internalized homophobia is "a set of negative attitudes and affects toward homosexuality in other persons and towards homosexual features in oneself" (Shidlo, 1994, p. 178).

Older, for the purpose of this study, refers to individuals 50 years of age or older. While "older"generally refers to those 65 and older, this study utilizes participants in midlife and older age, and the participation criteria included being aged 50 years or older. Bennett and Thompson's work (1991) discusses that there is a belief among some gay men, that their old age begins at a younger age.

Psychological adjustment to aging is the measurement or assessment of mental health, attitudes, personality, affect, and other outcomes among older adults (Havighurst & Orr, 1955). For the purpose of this study, psychological adjustment to aging will be assessed through five constructs: depression, hopelessness, loneliness, life-satisfaction, and self-esteem.

Theoretical Framework

Psychological Adjustment to Aging

Psychological adjustment to aging is a concept that has been discussed in the aging literature since the 1950s (Havighurst & Orr, 1955), and various specific indicators have been used to measure psychological adjustment to aging. Psychological adjustment to aging concerns general well being and quality of life in terms of social and psychological outcomes for individuals during their years of older adulthood.

In the context of this study, psychological adjustment to aging was evaluated through various scales cited in the research (Berger, 1984; & Kimmel, 1977; Kooden, 1997) and was broken down into the dependent variables of hope, life satisfaction, loneliness, depression, and self-esteem. Factors that may affect these measures of psychological adjustment included the descriptive variables of HIV status, income, education, relationship status, and employment status, as well as various independent variables such as perceived health, internalized homophobia, perceived financial stability, and social support. HIV status is a key variable in terms of adjustment to aging. The variables and measures will be described in detail in Chapter 2 (Methods).

When discussing psychological adjustment to aging, a broad theoretical view can be utilized to explain the phenomenon. This study is based on five theories: (1) social construction theory, (2) homosexual identity theory, (3) sociocultural perspective, (4) activity theory, and (5) disengagement theory. These theoretical bases will assist in exploring psychological adjustment to aging and are discussed below.

Social Construction Theory

The central concept of social construction theory is the idea that people and social groups that interact collectively in a social system, produce, over time, representations of each other's actions and that these beliefs eventually become tailored into societal roles relative to one another. Thus, knowledge and people's concept of reality becomes combined into the structure of society. Therefore, "social reality" is thought to be socially constructed and is a function of a person's unique reality as well as society's vision of what is real (Berger & Luckmann, 1966).

Friend (1987) discussed aging among gay and lesbian people in the context of social construction theory. He presented the notion that gay people who are dealing with sexual identity, generally have two types of responses to the social construction of homosexuality as a negative identity. Some internalize the negativity related to homosexuality, while others reconstruct its meaning in positive ways. Friend believes that an individual's capability to reconstruct his homosexuality in a positive manner is a significant indicator of a positive psychological adjustment to aging. Although Friend discussed two distinct responses to the construction of homosexuality, he sees them as two extremes or opposing endpoints of a continuum. He identified three groups in the above-mentioned continua that reflect three possible styles of identity formation. Each is discussed below.

Stereotypical older LGBT people. This group consists of those who have completely internalized their homosexual identity. They are characterized by low or no associations with other LGBT people, isolation, low sexual intimacy, self-hatred, guilt anxiety, and low self-esteem.

Passing older LGBT people. This group is characterized by marginal acceptance of their sexual orientation. Generally, this group takes great pains in hiding their sexual orientation through activities such as heterosexual marriages and distancing themselves from other aspects of "stereotypical" LGBT people. Common emotional components include anxiety, self-consciousness, fear of being exposed, conditioned self-acceptance, and absence of support during crises. While the construct of a passing older LGBT person represents a midpoint in the continuum of self-acceptance, it becomes clear that the idea of passing and continuing to hide one's self-identity is not a great deal more desirable than being completely closeted.

Affirmative older LGBT people. The affirmative group is characterized by reconstructing homosexuality as something positive. The literature states that this is the largest group (Berger, 1984; Friend, 1987). Vibrancy, activity, and independence characterize this group. They have maintained a high level of self-acceptance and healthy adjustment even in non-accepting environments (Friend, 1987).

In terms of this study, variables assessing perceptions of health and illness, as well as perceptions of financial well being, are assessed. These socially constructed meanings were analyzed in terms of their impact on dependent variables that measure psychological adjustment to aging.

Homosexual Identity Formation and Development Theory

Cass's (1979) work presented the first theoretical model of homosexual identity formation and expanded our knowledge of gay and lesbian persons. The six-stage model that Cass presented has developed into a foundation for the study of homosexual identity formation (McCarn & Fassinger, 1996).

Friend (1987) and Kooden (1997) utilized Cass's model and applied it to older gay men in the 1980s and 1990s. Kooden's (1997) paper builds on Friend's (1987) discussion regarding the necessity of dealing with one's internalized homophobia as a first step to the "successful" psychological adjustment to the aging process. The second step is the need to address one's ageism, both internally and externally. Kooden stated that creating (reconstructing) a positive notion regarding one's age is as important as creating an affirmative image of oneself as a gay person. In this regard, he created a list of developmental tasks for successful aging, based on his work with gay male clients. They are as follows:

1. Resolving negative attitudes toward homosexuality.
2. Finding a positive gay/lesbian role model.
3. Renegotiating a "new body image" in which one feels attractive and comfortable with the body.
4. Creating and developing a personalized value system.
5. Developing high self-esteem and empowerment.
6. Developing a positive sense of peership and family of choice in the context of interpersonal relationships.
7. Finding joy in work and play.
8. Taking charge of one's life.
9. Taking control of physical health.
10. Positive visualization of the future as an older gay person.
11. Acceptance of mortality and development of spirituality/meaning of life.
12. Positive acceptance of being an older gay person (Kooden, 1997, p. 26).

In terms of this study, the variables measuring internalized homophobia and perceived ageism were used to address the theoretical perspective of homosexual identity formation theory. The data were analyzed to assess how these factors affected the dependent variables of psychological adjustment to aging. Both internalized homophobia and perceived ageism had a non-favorable relationship with psychological adjustment to aging measures (Kooden, 1997)

Sociocultural Perspective

The fundamental concept of the sociocultural perspective view of human development is idea that people develop predominantly through social interaction. The sociocultural perspective theorizes that behavior and emotions are shaped not only by previous learning and unconscious influences, but also essentially through the social and cultural context. Current sociocultural theory has its foundation in Vygotsky's (1986) work as well as other social scientists (Wertsch, 1991; Wertsch, 1998). The sociocultural perspective has major implications various social science discipline, including education, psychology, and sociology.

When considering the sociocultural perspective among gay men, it is vital to be aware of minority status, marginalization, and stigmatization among this group. Historical events play a key role in influencing the experiences of LGBT people.

Although the Stonewall Riots and the 1973 decision of the American Psychiatric Association to remove homosexuality as a mental illness from the Diagnostic and Statistical Manual of Mental Disorders (DSM) both positively affected the LGBT community, homophobia still strongly exists in our society. On the interpersonal level, gay people internalize the homophobia that they experience from individuals,

organizations, and the larger society. "To be a sinner in the eyes of God, criminal in the eyes of the law and sick in the eyes of psychiatrists, leads to low self-esteem and lack of self worth" (Kochman, 1997, p. 12).

While, historically, the helping professions have not been particularly supportive of gay/lesbian people, recent self-advocacy and social change has brought social workers and other social scientists to more progressive views. However, full acceptance and nurturing are still not prevalent (Kochman, 1997). For the current study, descriptive data that addressed the sociocultural perspective of gay men over 50 years of age were collected and analyzed.

Activity Theory and Disengagement Theory

Research on aging has traditionally focused on the older individual's participation in life, and aging theories generally include biological, physical, psychological, and social aspects of the aging process. Two predominant theories, activity theory and disengagement theory, have been studied by Havighurst (1968). They have been used widely to explain the psychological well being of older adults.

Activity theory is a notion of aging that holds that, the greater an older adult's level of activity, the more likely he or she will do better in terms of psychological well being. When considering activity theory, the emphasis is placed on the external actions of the person. Havighurst (1968) stated that activity theory is the foundation for interventions that most helping professionals use when working with seniors. The accepted belief is that older adults should attempt to maintain activities and attitudes of middle age as long as possible. When they cannot continue certain activities, they are encouraged to find alternatives for those activities.

An opposing theory to activity theory is disengagement theory. Disengagement theory posits that disengagement with various social systems is a normal and appropriate step as an individual moves into older age. This theory regards lessened social activity as a process characterized by mutual withdrawal of both the individual and society. The older individual both accepts and desires this lessened activity (Havighurst, 1968).

Cumming and Henry (1961), in their discussion of disengagement theory, posited that this disengagement can be initiated by the older individual or by other people in his or her life. The older person may remove themselves, more distinctly from some people, while continuing to be close to others. Furthermore, systems in society, such as employers and Social Security may make this withdrawal easy for the older person. Disengagement theory also posits that, when a person has entered into older age, the balance that existed in middle age between the person and society is replaced with a new balanced that often includes a greater distance and a different relationship with one's environment.

These two theoretical frameworks provide different views of older age. To date, research has been inconclusive in support of one theory over the other. It has been argued, and supported by extensive research (Havens, 1968; Reichard, 1962), that some aging persons find disengagement more satisfying, while others gain greater satisfaction from higher levels of activity.

In terms of this study, variables that assess the factors of engagement with life were collected and correlated with variables that measure psychological adjustment to aging. Examples of variables that help assess engagement with life include work status, hobbies, relationship status, and socialization activities.

Literature Review

Historical Research on Older Gay Men

One of the first pieces that discussed the topic of older gay men in the context of social science research was a passage in a book, *The Third Sex* (Allen, 1961). In the 1970s, a few empirical studies were conducted (Fenwick, 1978; Kelly, 1977; Kimmel, 1977), and in the 1980s, while the amount of research increased on older gay men, its prevalence was still small (Wahler & Gabbay, 1997). During the 1990s, there was a sizable addition of empirical articles on older gay men. Two full issues of the *Journal of Gay and Lesbian Social Services* (1997, 2001) were dedicated to the LGBT older adult population.

Sampling and research model problems. Research has almost always occurred among middle class, Caucasian, urban-dwelling men who are active in the community (Wahler, 1997). Additionally, sample sizes usually have been quite small, less than 20 (Francher & Henken, 1973; Friend, 1987; Kimmel, 1977, 1979; Minnegrove & Adelman, 1978). These small samples probably occurred due to invisibility of LGBT seniors and other community members at the time of the research. In addition, much of the research contained statistically insignificant findings; the research simply served as an informational base, with small samples and anecdotal information (Allen, 1961; Fenwick, 1978; Kimmel, 1977, 1979-1980).

Research design. The knowledge base on aging gay men has been generated through a combination of both quantitative and qualitative research (Wahler & Gabbay, 1997). Later 1980s articles that assessed psychological adjustment to aging have embraced a more positivist approach, utilizing depression and anxiety scales to compare

gay people to heterosexuals (Berger, 1984; Friend, 1987; Kehoe, 1988). The late 1990s articles concerned needed services and contained qualitative needs assessments and discussions of services generally developed through practice wisdom (Beeler, Rawls, Herdt, & Cohler, 1999; Jacobs, Rasmussen, & Hohman, 1999). Such research has been based on the increased needs for these services (Beeler et al., 1999).

Evolution of the research. The research on older gay men has followed a course from a essentially pathological and negative emphasis, to a much more functional discussion and, finally, to a development of theory about the unique strengths and competencies of older gay men (Berger, 1980, 1982, 1984; Friend, 1980; Lee, 1987). More recent research has concentrated on the identification of programming and interventions for older gay men (Beeler et al., 1999; Jacobs et al., 1999). Additionally, there has been a change in language used, from a deviance perspective (Francher & Henkin, 1973; Weinberg, 1970) to one that recognizes and respects LGBT people (Kimmel, 1977). This parallels the historical changes and increasing acceptance of LGBT people.

Stereotypes of older gay men. Berger (1980, 1982, 1984) looked at older gay men through a series of semi-structured interviews. This research helped to dispel many commonly held stereotypes that older gay men were sad and alone. He noted, with few exceptions, that gay men were at least as well adjusted to aging as were their heterosexual counterparts.

Numerous later studies found that gay men may, in fact, adjust more easily to aging than do their heterosexual counterparts (Kooden, 1997; Whitford, 1997). The literature, however, is inconsistent. Some research found no significant differences in

psychological adjustment among gay men, compared to their heterosexual counterparts (Adelman, 1991; Berger, 1982), while other research found smooth transitions into older age for gay men, as compared to their heterosexual counterparts (Kooden, 1997; Whitford, 1997).

Psychological Adjustment to Aging

There is a fair amount of literature that explores how gay men adjust to the aging process, including an examination of the social context of aging among gay men from the standpoint of what is known and how it is known. The issues that will be discussed below include successful aging, self-acceptance, crisis competency, expectations of aging "family" relationships, intimate relationships, gender role flexibility, friendship, and generativity. These issues were chosen not only to represent the social domain of aging in general, but also to represent the critical gaps and issues for the 21st century in research and policy.

Successful aging. Early aging research had historically looked at on aging, using the constructs of decline and loss (Williams & Wirths, 1965). Then, older individuals began to experience better health and longevity, which created a new area of study. This area of study grew to include a new focus on healthy older adults (Heckhausen & Schulz, 1996; Rowe & Kahn, 1998). This broadened focus led to comparisons between the two groups of older adults, the healthy and the ill. In addition, research highlighting the distinctions among the healthy group of older adults began to be a part of the framework of aging research (Rowe & Kahn, 1998). This research was intended to learn more about the two groups of healthy older persons, those without illness, but at risk (the usual agers), and those without illness and not at risk (the successful agers).

The concept of "successful aging" has been broadly studied using constructs of physical, cognitive, and psychological and social functioning (Herdt & de Vries, 2004). Some have stated that the use of terms such as successful aging suggests "the capitalist takeover of aging" (Herdt & de Vries, 2004). The critical evaluation of "successful aging" is the notion that, when aging is studied in terms of "objective" outcomes, these outcomes are assessed within a given historical and cultural period and in a given gender and class context, without proper recognition of the social construction of aging (Herdt & de Vries, 2004). However, if research looks at aging and successful aging in only subjective terms, this also would not be appropriate (Herdt & de Vries, 2004).

The previously mentioned concepts produce concerns in terms of how to measure successful aging. If all the criteria for successful aging was considered, it would be difficult to assess who is a successful ager and who is not (Baltes & Carstensen, 1996). Rowe and Kahn (1998) propose one set of possible criteria of successful aging. Their model includes three constructs: avoidance of disease, maintenance of high cognitive and physical functioning, and engagement with life. These measures are most commonly utilized by researchers from various disciplines (Herdt & de Vries, 2004).

Self-acceptance. A central theme in the research reviewed was the notion that a key determinant of success in aging among gay people is a high level of self-acceptance as a gay person and as an older person. This can be a high expectation because of continuing widespread non-acceptance of ones gay identity, by American culture coupled with widespread ageism in the gay community and in the larger society (Friend 1987; Kooden, 1997).

Crisis competency. Berger (1982), Friend (1991), and Kooden (1997) discussed the concept of crisis competency. This concept is the notion that gay men may have had a history of addressing crises more often than their heterosexual counterparts and therefore may have an easier time handling the crises that accompany old age. Dealing with issues such as coming out, discrimination, isolation, and HIV/AIDS has perhaps better prepared gay men for the issues of older age, such as death, loss, and loneliness. Many gay men have already cut off relationships with family members due to non-acceptance of their sexual orientation. Still many others have lived through the deaths of a significant proportion of close friends and peers. Many living with HIV/AIDS have had to make the emotional adjustment of having chronic compromised health. This "crisis competency" may help gay men in this situation (Kooden, 1997).

Expectations of aging. Berger (1984) stated that expectations of aging may be different and perhaps more realistic among gay men. Many of their heterosexual counterparts have perceptions about receiving assistance and care from their children and spouses. Most gay men studied did not possess this notion and tended to independently plan for their retirement and older age. These gay men were more likely to be alone during older age. Although this may manifest as an isolating factor, this independence may assist in the facilitation of transition to older age (Friend, 1987).

"Family" relationships. While gay men report less contact with their families, they also generally report larger close friendship networks (Kosberg & Kaye, 1997). In the absence of close family ties, some gay men establish friendship networks that serve as family equivalents. The research points out that gay/lesbian people generally have a larger network of friends, as compared to their straight counterparts, who have more

family ties. Dorfman (1995) measured the quality and quantity of informal support among a group of homosexual and heterosexual respondents and found no statistically significant differences in the two groups.

Many studies cite the concept of "chosen families" for older gay people. Beeler et al. (1999) stated that two-thirds of their sample of middle-aged and older gay men and lesbians stated that they had created a family of choice. Weinstock (1998) discussed the notion of friends as family by categorizing three possible groups: (a) friends as substitute family members; (b) friends as a challenge to the core structure of the family; and (c) friends as in-laws. A recent qualitative study of 20 gay men and lesbians over the age of 65 found that all but one considered their friends to be their family in some manner (Herdt & de Vries, 2004)

Friendship. Many studies have illustrated several positive impacts of friendship that are associated with a person's emotional well being in their later years. Therefore, it should be even more important in the lives of older gay men and lesbians. Unfortunately, there have been few studies is addressing the role and meaning of friends in the lives of LGBT seniors. Most of the studies in this area are anecdotal and inferential and consist of compilations of personal narratives of lesbian and gay seniors (Adelman, 1990; Berger, 1982; Vacha, 1985). The few empirical studies that assess friendship among gay men and lesbians, particularly in later life, include Nardi's (1999) study of gay men representing a broad age range, Dorfman et al.'s (1995) exploration of lesbians and gay men over 60, Quam and Whitford's (1992) study of gay men and lesbians over 50, and Beeler et al.'s (1999) study of mid- and later life gay men and lesbians. In all of these

studies, the importance of friendship for the health and psychological well being of older gay men and lesbians has been highlighted.

Gender role flexibility. Gender role flexibility is often more common among gay and lesbian couples than it is among heterosexuals. Often, in same sex relationships, particular responsibilities and roles are not clearly defined. For example, if a straight man's partner/wife dies, he is probably more likely to have to learn her responsibilities, such as managing the household. In gay/lesbian relationships, it is more likely that both partners complete many common tasks (Friend, 1987). This may allow the other to adjust more easily if a partner dies. The role of "head of household" or "breadwinner" is less defined among gay couples. This may help to make the transition to living alone and managing a household less severe among LGBT seniors (Berger, 1980; Lee, 1987)

Generativity. The concept of generativity was coined by Erikson (1978). Erikson's generativity versus stagnation stage stresses the notion of "achieving a sense of commitment and love" and prepares an individual for creating a legacy to leave for later generations. This notion of commitment and legacy as Erikson viewed it, in terms of generativity, has often been interpreted by social scientists in terms of having and raising children. Erikson never limited his conceptualization of generativity to parenthood and did not believe that parenthood and generativity are one in the same (Herdt & DeVries, 2004).

Generativity can be accomplished through numerous varied life choices, beliefs, and commitments, ranging from child-bearing and child-rearing to vocation/occupation, professional activities, volunteer activities, social group memberships, friendships, and leisure pursuits. These areas of generativity remain unexplored, although some

preliminary study in this area has occurred (McAdams, 1993). Having and raising children continues to be the primary focal point of research with middle-aged and older heterosexuals, there are many ways of achieving generativity among midlife and older gay people that have been studied by a few researchers (Cohler, 1998; Cornett & Hudson, 1987; Herdt & DeVries, 2004; Isay, 1996). Generativity for LGBT individuals may be achieved in many ways, including parenting, mentoring, pet ownership, real estate preservation, and various career pursuits such as teaching, the arts, and community service (Herdt & DeVries, 2004).

Contextual Issues

Many contextual issues affect older gay men and their lives. This section will present some of these contextual issues.

Historical experiences of discrimination. A large portion of existing social service research on gay people confirms that gay seniors often mistrust social services and health care agencies due to life long experiences of marginalization and oppression within those organizations and within their community. The older gay people who were out and seeking services prior to Stonewall, and before homosexuality was removed from the American Psychological Association's (APA) list of mental disorders in 1973, are even more likely to be guarded in terms of social service organizations. Before these changes, LGBT individuals were disempowered, assumed to be mentally ill, and were often sent of these organizations to "fix" their problem of homosexuality (Herdt, et al.,1997).

The damage from being marginalized and stigmatized from past experiences reminds older LGBTs that it may be risky to place their trust in individuals and social

systems that have historically harmed them. In terms of accessing systems, the historical experience has had a lasting impact on this group (Herdt, et al.,1997).

Homophobia and heterosexism. Many LGBT seniors have been significantly affected by their past history of accessing social services. Further, poor treatment of these individuals continues today. Currently, civil rights for LGBT people are not recognized based on sexual orientation, gay marriage or domestic partnership is not legal in the majority of states, and many states have enacted bans on gay marriage. LGBT seniors continue to report homophobia in the community and in helping agencies. Research among social workers in recent years has cited a significant rate of homophobia and heterosexism that is reflected in community settings and among social workers themselves (Herdt & de Vries, 2004).

When older gay and lesbian people consider that, one day, they may have to rely on systems such as nursing homes, home care agencies, and senior centers, they are concerned and anxious. Numerous gay seniors fear being mistreated and may avoid getting needed services, even when their health and safety may depend on it (Herdt & DeVries, 2004).

The meaning of aging among LGBT people is not understood well in the United States. For the first time in history, a generation of self-identified gay people is entering retirement and still there is minimal information about their physical health, mental health, and special social service needs. We understand even less about what well being, successful aging, and psychological adjustment to aging in later life mean among this group. Additionally, the aging processes among LGBT people who are already in their

retirement years, many of whom are still "closeted," remain invisible (Herdt & DeVries, 2004).

HIV/AIDS and youth focus of social services. The HIV epidemic has dominated research efforts in the LGBT community during the past 25 years. Most current and predominant areas of social science study relate to risk and prevention in the community (Levine, Gagnon, & Nardi, 1997). Additionally, a focused effort of HIV prevention among young gay men is the area in which most money and effort is dedicated (Boxer, 1997; Cohler, 1998). Additional social services that assist youth in coming out and in adjustment, while important, have obscured from view older gay people, many of whom remain isolated from the community (Herdt, Beeler, & Rawls, 1997).

Ageism and age cohorts. It is important to discuss the greater culture when considering the study of midlife and senior gay men in the US. In a recent report, the Henry J. Kaiser Foundation found that the experiences of older gay men and lesbians is vastly different than those of younger lesbians and gay men when it comes to interacting with their heterosexual peers. As the research presents, a large number of young people are increasingly open and accepting of LGBT people in their schools, churches, and workplaces. However, individuals, age 65 and older, are least likely to have accepting attitudes toward LGBT people. Additionally, young people and seniors, according to the report, hold very different views about policy. The great majority of young people, aged 18 to 29, support lesbian and gay unions, marriage, and adoptions for LGBT people, while, for people over 65, only about 25% support these policies. This is a huge gulf that defines the problems of each cohort as it adapts to society and finds a foothold in this new century (Herdt & de Vries, 2004).

In addition to vastly different perceptions about LGBT people among age cohorts, there are also high levels of ageism that are perceived in the gay community, according to some of the current research. Further, research shows that gay men have more ageist beliefs than do lesbians, and gay men perceive more ageism in society than do lesbians (Schope, 2005).

Accelerated aging. The term accelerated aging was coined by Bennett and Thompson (1990). It refers to the notion that gay men consider themselves as old (or at least past their prime) at a younger age than do their heterosexual counterparts. This issue has been the subject a few studies during the past few decades. The findings of studies looking at accelerated aging among gay men are inconclusive, however (Jones & Pugh, 2005).

Mental health needs and access. In general, gay and lesbian older adults are considered to be more cautious to use mental health services than are heterosexual older adults, even though many concerns of the two groups are similar. LGBT seniors often see a counselor for common reasons such as, relationship difficulties, bereavement issues, work worries, and financial stress. Concerns about discrimination, marginalization and homophobia prevent LGBT seniors from getting help when they need it (Quam, 1997).

Mental health providers and other helping professionals should be cognizant of internalized homophobia and create a setting responsive to their LGBT clients (Quam, 1997). It is also important that mental health providers do not assume that clients' presenting problems are automatically related to their sexual orientation. Further, helping professionals should be aware of their personal perceptions and assumptions about gay and lesbian seniors and learn about differences among the group (Quam, 1997).

Study Variables

The following section presents the study variables in terms of the literature available on these constructs. The review will include a discussion of findings to date on these measures and how they relate to mental health, aging, and gay identity.

Life satisfaction. Life satisfaction is a construct usually assessed through self-rating and is looked at in combination with other variables to create an extensive view of well being (Andrews & Whitney, 1976; Diener et al., 1999). In the literature, life satisfaction has been associated with variables such as job satisfaction, interpersonal relationships, socioeconomic status, education, and family background, in addition to various others. All these associations highlight the idea that life satisfaction is a multidimensional construct.

Larson (1978) reviewed historical studies and noted that assessments of overall psychological well being varied widely among research efforts. Larson expressed concern about these studies based on their dependence on respondents' self-assessment. He coined the term, "subjective well-being" to define social psychological factors measured by self-reports. Larson stated that several measures should be used to assess the construct of life satisfaction among seniors. Specifically, he looked at early measures of subjective well being or life satisfaction among individuals in areas of adjustment in various aspects of life including work, health, and religion.

Larson (1978) assessed that health, socioeconomic level, and activity level were significantly related to life satisfaction among the older adults that he studied. Also, Larson discovered that, among people over 60 years of age, assessments of life satisfaction declined. However, when other variables were considered, such as poor

health, financial issues, lower activity, fewer friends, and widowhood, the relationship between age and life satisfaction was not significant.

Loneliness. Townsend's (1973) work emphasizes the difference between social isolation and loneliness in later adulthood. Social isolation implies having less contact with family and community. Loneliness is defined as having an undesirable feeling of loss of companionship.

There are inconsistent results in terms of assessing whether loneliness increases or decreases as one ages Several studies that look at age trends in loneliness indicate that loneliness tends to be highest among adolescents, and then continues to decrease across the lifespan (Berger, 1999; Kooden, 1997), while some of the literature indicates that loneliness increases among older adults (Herdt & DeVries, 2004). When discussing the relationships between age and loneliness, researchers stress the need to take into consideration background variables such as available social contacts with family, friends, and partners (Yoakum, 1994).

Self-esteem. Rosenberg and associates (1995) postulated that self-esteem is created and maintained by way of three social processes: "(a) reflected appraisals, which are the evaluations and responses of others toward us; (b) social comparison, which involves evaluating ourselves in comparison to a reference group or individual; and (c) self-attribution, which involves observations of our own behaviors and outcomes and subsequent attributing of characteristics to ourselves". All three processes contribute to self-esteem.

Brandstadter and Greve (1994) studied self-esteem among seniors in terms of their "view of self". "The self is maintained and enhanced through a continual process of

regulation throughout the life cycle, involving psychological processes that aid in the achievement of and consistency between actual and intended courses of personal development" (p. 152.). This framework centers heavily on the psychological adjustment to social circumstances that allows for maintaining self-esteem.

Depression. Research indicates that older adults suffer from depression at a rate of 17%, as observed in medical setteings and that there is an even higher rate among those older adults who are hospitalized or in nursing homes (Beekman et al., 1995; Borson, 1998). Seniors have the highest rate of suicide among all age groups, as well as other physical issues that are related to their depression. Estimates of the incidence of depression in later life vary from about 10% for older persons living on their own, to about 25% among individuals with a chronic illness (Beekman et al., 1995; Blazer, 1989; Borson, 1998; Callahan, Hendrie, Dittus, Brater, Hui & Tierney, 1994). These results stress the connection between mental and physical health among seniors.

An intersesting aspect of depression in later years is greater likelihood of physical illness and suicide. The high suicide rate is predominately accounted for by Caucasian men. Caucasian males, age 85 and older have suicide rates of up to 67.6 suicides per 100,000, more than five times the overall national suicide rate of 12 per 100,000 (Advance Report of Final Mortality Statistics, 1992). Depression represents the most frequent cause of suicide among these individuals (Conwell, et al., 1996). The relationship between depression and nonsuicidal death among older adults is supported for heart attack and other illnesses, where depression increases mortality significantly (Frasure-Smith & Lesperance, 1993).

Numerous seniors are widowed annually. Bereavement after the death of a significant other is a major risk factor for depression. Approximately 10-20% of widows and widowers experience depression during the first year of bereavement (Zisook & Schuchter, 1991). Although this research did not address older gay men, the notion of depression due to loss of a partner should hold true for this group as well. Untreated, this depression may continue, become chronic, and lead to increased disability and problems with health (Latham & Prigerson, 2004).

Hopelessness. Although the construct of hopelessness has been somewhat difficult to define, historically, hopelessness may be viewed as the level to which a person has a negative expectancy about events in his or her future and is one of Beck's (1967) "cognitive triad of negative condition, which includes the depressed person's view of the self, the world and the future. Hopelessness is closely related to depression, and assessment of hopelessness is often utilized to assess the threat of suicide or of suicidal ideation. (Beck, Steer & Ranieri, 1988).

HIV/AIDS. HIV/AIDS is an important concern in many populations; however, it has major importance when discussing communities of both gay men and the elderly. The Centers for Disease Control and Prevention (CDC) provides various statistics in regard to HIV/AIDS. As of December 2004, there were 462,792 persons living with HIV/AIDS in the US. With regard to prevalence, 72% of cases occurred among men (CDC, 2006). The number of persons in the 55 and older age group living with HIV was 51,602 at the end of 2004 (CDC, 2006).

Moss and Miles (1987) examined HIV infection rates in older adults and found that 10% of AIDS cases occurred in the age group of 50 years and older, with 25%

occurring in the population aged 65 and older and 4% in persons who are 70 years of age and older. Noting the statistics reported by the CDC as well as Moss and Miles' statistics, an argument can be made for the need to educate older populations about HIV transmission and safe-sex/intravenous (IV) drug use tactics. In addition, several researchers have noted that elderly persons are frequently left out of the HIV/AIDS prevention education agenda, based on misconceptions regarding their lack of sexual activity or drug use (Emlet, 1997).

Such misconceptions regarding the aging population (and specifically the aging gay male population) are problematic because the result is that these persons are not being targeted with HIV prevention education nor are they being tested for HIV/AIDS when they present themselves in medical settings with symptoms. Emlet (1997) indicated that men having sex with men (among the population aged 50 and over) still account for most AIDS cases (Scharnhorst, 1992). Gordon and Thompson (1995) also indicates that 38% of respondents in their study contracted HIV via male to male sex. This information is important for the medical community, so that persons are targeted for HIV prevention education or tested for HIV when presenting themselves for medical attention; for the social services community, who presumably counsel and deal with the emotional/psychological needs of those affected; and for members of the community at large—gays, straights, and HIV-positive and HIV-negative individuals.

Kowalewski (1988) stated that gay men are often ambivalent towards persons living with AIDS, so that, "although they cannot forget or overlook them, they fail to get involved in any meaningful sense in advocating for those dealing with the disease". Mental health issues among HIV-positive persons is an key factor in providing optimal

HIV care. Mental health information from clients with HIV can be an key source to supplement the research knowledge base on HIV and mental health. Intake information can supply a helpful snapshot of significant patient concerns in terms of psychosocial issues associated with HIV/AIDS (Berg, Mimiaga, & Safren, 2004).

In recent study, that analyzed intake information from HIV positive men who have sex with men (MSM), depression was cited as the most common issue (58.1% of clients), followed by anxiety (38.2%),(Berg, et al., 2004). Depression (96.3%) and low energy (78.2%) top two symptoms on a self-administered patient checklist, followed by anxiety (69.2%). HIV-specific problems was often discussed by patients as a presenting problem in their lives, and indirectly as HIV impacted their interpersonal relationships The discussion above emphasizes the mental health issues that are common among HIV-positive men who have sex with men. Mental health is a key component of overall quality of life. Helping professionals, who work with gay men, can use this information to broaden their awareness of mental health issues that impact this population (Berg, et al., 2004).

Health. To address the needs of LGBT community members, the American Medical Association (AMA) formally outlines medical provider responsibilities for assisting individuals in this community (AMA Council on Scientific Affairs, 1996). For example, gay men may be at increased risk for health issues such as HIV, Hepatitis, cancer, and certain sexually transmitted diseases. It is critical that gay men receive particular treatments, such as a Hepatitis B vaccine and colo-rectal cancer screenings. Research has shown that physicians often do not ask patients about their sexual orientation and that patients often do not divulge it. When this lack of communication

occurs, the result is inevitably a health care situation in which the needs of a gay/lesbian person cannot possibly be fully met. In fact, almost one-half of patients in one study did not tell physicians their sexual orientation. Further, many did not communicate their HIV status to their health providers (AMA Council on Scientific Affairs, 1996). This lack of communication generally enables the physician to assume that the patient is heterosexual and potentially not investigate, diagnose, or treat ailments that are more likely to affect the homosexual community. However, "taking a sexual history in a nonjudgmental and attentive manner with open ended questions can help the patient feel comfortable and willing to confide in the physician" (AMA Council on Scientific Affairs, 1996, p. 188). This nonjudgmental attitude reminds physicians that it is certain behaviors that put gay men at risk for particular ailments, rather than sexual orientation, per se.

A major breakthrough relating to the physical health of gay and lesbian persons is found in the health initiative recently released by the federal government, called Healthy People 2010 (Gay and Lesbian Medical Association and LGBT Health Experts [GLMA], 2001). This is a national agenda with two main goals: "(a) increase quality and years of healthy life and (b) eliminate health disparities." The initiative also addresses ten leading health indicators and has several areas of focus. Among the leading health indicators are responsible sexual behavior and access to health care. HIV is included in one of the focus areas. The Gay and Lesbian Medical Association has also released a document supporting this report, which specifies health care needs that are specific to the LGBT community. This is the first time in the history of the federal government that such a document has been offered in conjunction with the nation's ten-year health initiative plans. The document aims to educate the medical community (and the LGBT

community) about issues specifically related to health maintenance of persons in this community. For example, the document asserts the importance of regular immunizations, in addition to being immunized for Hepatitis A and B and influenza (Gay and Lesbian Medical Association and LGBT Health Experts, 2001).

Internalized homophobia. Disclosure of homosexuality is now generally viewed in the professional literature as more desirable than secrecy. Disclosure is often seen as evidence of a healthy gay identity, whereas secrecy has come to be viewed as socially and psychologically problematic (Cain, 1991).

Social support. Social support is an important component of one's ability to cope and function across the life course (Kooden, 1997). The perception that one can obtain assistance or empathy when needed has been shown to influence well being, as well as rates of morbidity and mortality. However, while perceived social support has been shown to influence psychological and biopsychosocial adaptation across the life course, several qualifications need to be made. The perception of social support may be just one of several social factors influencing these processes. As posited by Svenson (1981), the interaction of the person with the environment is a functionally complex phenomenon. Thus, she suggests that assessment of social support requires the acknowledgement of individual differences in conjunction with a wide variety of social factors that may moderate psychological and biopsychosocial practices. (Friend, 1987)

Financial stability. A key factor of successful aging is found in the interface among financial stability and good health. Disagreement about the direction and causation of these two variables has been difficult to pin down. It has been shown in the literature that healthier households are more financially stable ones. It is unclear whether

higher incomes lead to better health, or poor health limits ones ability to build up assets There is also a possibility that neither direction of causation is key, and the association simply reflects other factors that make some healthier and wealthier. A great deal of further research is required to understand the complexities of health, wealth and aging (Older Americans, 2004).

The preceding paragraphs have outlined the research literature regarding aging issues among gay men. The Introduction should help to set the stage for this study. Informed by the research to date, the next chapter will outline the study of psychological adjustment to aging among a sample of gay men over 50 years of age in Chicago.

CHAPTER 2

METHODOLOGY

This study examined psychological adjustment to aging in men who identified themselves as gay, bisexual, or men who have sex with men, who are over 50 years of age and who reside in metropolitan Chicago. This was an exploratory study that utilized a cross-sectional one-phase research design. Because of its exploratory nature, the study did not call for formal hypothesis testing. Participants were recruited to complete a 305-item questionnaire and were paid a stipend of $15 for their participation. There were 75 participants who met the criteria for study and completed the questionnaire. Questionnaires were collected from May 2005 through September 2006. Human Subjects Review Board Approval from Michigan State University and Howard Brown Health Center were obtained (Appendix A).

This chapter presents the methodology used to assess psychological adjustment to aging outcomes. It begins with a restatement of the research questions, followed by a discussion of participant recruitment and procedures, participant characteristics, instrumentation and variables, risks and benefits to participants, institutional review board (IRB) review and informed consent, and data analysis. The chapter concludes with a summary.

Research Questions

This study was guided by six research questions, which is an appropriate way to conduct descriptive social research (Lofland & Lofland, 1995). The goal was to examine psychological adjustment to aging, as well as to assess the impact of HIV/AIDS on the study sample. The research questions pertain to life experiences of gay men as they age

and were designed to collect data on the physical, mental, and social attributes of the respondents. The research questions guiding this study are as follows:

1. What are the demographic and descriptive characteristics of the sample?

2. Are there differences between HIV-positive and HIV-negative participants in terms of psychological adjustment to aging measures?

3. Do variables such as perceived health, income, finances, social supports, race/ethnicity, education, employment, and acceptance of gay identity affect the psychological adjustment aging measures?

4. Are the variables associated with psychological adjustment to aging (self-esteem, loneliness, acceptance of gay identity, hopelessness, depression, and life satisfaction) correlated with one another?

5. Do the variables and the psychological aging measures have a relationship with participants' life expectancy?

6. Do study participants perceive LGBT community ageism?

7. Do study participants perceive or experience accelerated aging?

Participant Recruitment and Procedures

Procedure

The procedure involves the administration of the questionnaire, described below, to 75 men who identified themselves as gay, bisexual, and/or as a man who has sex with men (MSM), and who were 50 years of age and older. Participants were recruited for the study at agency locations (Howard Brown Health Center and Test Positive Aware Network) and community social venues, as well as through various existing studies at

Howard Brown Health Center. All participants resided in metropolitan Chicago during their participation in the study.

Stratification

The sample was stratified into two groups: those who were HIV-positive and those who were HIV-negative. If a participant self-reported as HIV-positive, he was asked to complete additional questions about health and HIV status. These questions included T-cell counts and viral load assessments, as indicators of HIV/AIDS progression and health. Other questions included year of diagnosis, whether the participant had been hospitalized, and whether they had had an HIV-related illness.

Sampling Design

Men who identified themselves as gay, bisexual, or MSM were recruited for the study. The reason for including men who have sex with men with gay and bisexual men is that a significant group of men who have sexual activity and relationships with same sex partners do not identify themselves as gay or bisexual. While sexual identity is important to the study, inclusion of men who have sex with men but do not identify as age or bisexual includes a different aspect of the gay community. Because gay men are a complex, heterogeneous population, obtaining a representative or random sample would be difficult. Thus, convenience sampling methods were utilized through referrals from and recruitment in LGBT community venues. These venues included organizations that offer social services to LGBT people in the metropolitan Chicago LGBT community, organizations that offer health services to the LGBT community, organizations that offer HIV/AIDS specific services to those who are HIV-positive, and bars, businesses, and community activities that serve LGBT individuals.

Participant Inclusion Criteria

As noted above, the researcher recruited men who identified themselves as gay, bisexual, or MSM, who were over 50 years of age and who resided in metropolitan Chicago. More specifically, individuals were required to identify as a male, but this self-reporting may or may not have excluded transgender individuals. Individuals were considered eligible to participate in the study based on the criteria detailed below, which also appeared on the consent form (Appendix A).

Inclusion criteria were: (a) aged 50 years and older, defined as 50 years, 0 months, 0 days, and older; (b) self-identification as a man; and (c) self-identification as gay, bisexual, or a man who has had sex with men. Exclusion criteria were: (a) not meeting the three criteria above; (b) not willing to sign a consent form; or (c) identified by study staff as cognitively impaired such that the individual would not be able to understand the consent process.

Recruitment

Recruitment began in May 2005, and data collection was completed in September 2006. As noted above, convenience sampling techniques were utilized to recruit individuals into the study. A broad-based recruitment plan was utilized to obtain participants who varied in terms of race/ethnicity, socioeconomic status, and experiences of aging.

Community-based agency recruitment. The majority of respondents were recruited by networking with community-based agencies that offer services for LGBT individuals and for those who are living with HIV/AIDS. The organizations were contacted and an appointment was made to discuss the study and present it to potential

participants. Participants had the option of filling out the questionnaire immediately at the agency or to taking the questionnaire home and returning it via US mail. Approximately 67 participants completed the questionnaire and mailed it in while approximately 8 participants filled the survey out, on site. Stipends in the amount of $15 were given in cash to those participants who filled out the surveys at the agencies. Those who mailed in the survey were sent their stipend by return mail. A brief description of the agencies from which participants were recruited is presented below.

Howard Brown Health Center (HBHC) is a health center and social service organization that addresses the health care needs of the LGBT community. HBHC's multi-site operation includes a main health center in an uptown neighborhood in Chicago, Triad Health Practice at Illinois Masonic Hospital, and the Broadway Youth Center in the Lakeview neighborhood of northern Chicago. HBHC offers a large network of programs and services, provided by a diverse and qualified staff of licensed doctors, nurses, health care practitioners, research professionals, and prominent community leaders.

The Multicenter AIDS Cohort Study (MACS) at Howard Brown is a longitudinal study of the natural and treated histories of HIV/AIDS among gay and bisexual men, conducted at sites located in Baltimore, Chicago, Pittsburgh, and Los Angeles. A total of 6,973 men have been enrolled during the past 23 years. From April 1984 through March 1985, a total of 4,954 men were enrolled; an additional 668 enrolled from April 1987 through September 1991. A third enrollment of 1,351 men took place between October 2001 and August 2003. This third cohort augments research efforts in regard to the long-term benefits and adverse effects of medical treatment.

Some participants for this study were enrolled through MACS. Permission was obtained from the lead principal investigator of the MACS to mail survey packets to all MACS participants living in Chicago, who were 50 years of age and older. Additionally, all service providers at HBHC were asked to refer their clients who met the criteria for the study to the researcher for follow-up. Some employees at HBHC who met the criteria for the study also completed surveys.

Test Positive Aware Network (TPAN) in Chicago is an HIV/AIDS service organization that empowers people living with HIV through peer-led programming, support services, information dissemination, and advocacy. The organization also provides services to the broader community to increase HIV knowledge and sensitivity, and to reduce the risk of infection.

The researcher attended and recruited participants in TPAN groups that were designed for and attended by older gay men living with HIV/AIDS. In most cases, group members completed the questionnaire during group time, although, in some cases, they took the survey packet home and mailed it back later. Additionally, the researcher asked group members to take extra survey packets if they knew other gay or bisexual men or men who have sex with men who would be willing to complete a survey.

Bar/club community recruitment. Recruiting participants at bar/club venues and other public venues was important to capture those who do not access services in the community. These venues were identified based on the age of customers who go to the venue. For example, there are bars that cater to an older gay male crowd in the Chicago metropolitan area. The researcher took questionnaires to local gay bars in Chicago. Eligible individuals who agreed to participate in the study were given a packet that

included a cover letter, an informed consent form, a copy of the questionnaire, and a self-addressed stamped envelope. Participants were given the option to fill out the questionnaire at the venue or to take the packet home and to return it through U.S. mail. Participants who mailed in their surveys were sent a $15 stipend when their questionnaire and consent form were returned by mail. The participants who filled out the questionnaire on site were each given $15 in cash.

Consent Procedures

Prior to participating in the study, individuals were oriented to the activities involved in participation. The individual was given a consent form to read, review, and sign if he was interested in participating. Further, participants were told that they could refrain from answering any question that they wanted to and that they would incur no penalty should they choose not to answer a question or to discontinue the survey.

Participant Characteristics

A total of 102 surveys were distributed, and 75 were returned either in person or through U.S. mail, resulting in a return rate of 73.5%. The majority of those who commented stated that the questionnaire was interesting and enjoyed filling it out. The typical participant in the study was 51 years old, HIV-negative, Caucasian, had earned a bachelor's degree or better, was working full-time, earned more than $41,000 per year, was not in a relationship, and was living alone. However, there was a great deal of variance among the participants in regard to these attributes. Detailed characteristics of the sample will be presented in Chapter 3, which contains the results of the study.

Instrumentation and Variables

In developing the questionnaire, the researcher relied heavily on the review of the literature on social and psychological adjustment to aging among gay men. The literature suggested utilizing a combination of existing scales that assess various attitudes and mental health status. Thus, the questionnaire was developed utilizing established instruments that, historically, have been used to measure aspects of psychological adjustment to aging, including hope, depression, life satisfaction, social support, and loneliness. In addition to selecting and combining existing scales that measure attitudes and mental health, the researcher included items that were relevant to the study of older gay, bisexual and MSM, such as perceptions of ageism in the LGBT community, the impact of HIV/AIDS on their lives, parenthood, and life expectancy, among others.

Participants responded to a questionnaire (Appendix B) designed specifically for this study to solicit reactions about the experience of aging as a gay male. The questions were arranged into sections as follows: (a) Hopelessness; (b) Life Satisfaction; (c) Depression; (d) Loneliness; (e) Perceived Health; (f) HIV Status; (g) Social Support; (h) Internalized Homophobia; and (i) Demographics.

Responses to these questions were answered by means of a Likert-type scale, multiple choice questions, and numerical responses, resulting in quantitative data. Existing scales were utilized and new questions were constructed to assess the experiences of the participants and to answer the research questions guiding the study. A pilot test of the survey instrument was conducted with five staff members at HBHC, three of whom were gay men over 50 years of age. Based on their responses, minor changes were made to the questionnaire.

Table 1 presents the variables measured in the questionnaire, broken down by descriptive and demographic, independent, and dependent. The numbers in parentheses correspond to the item numbers on the questionnaire. A discussion of each set of variables follows the table.

Table 1: Independent, Dependent, and Descriptive Variables

Descriptive and Demographic Variables	Independent Variables	Dependent Variables
HIV Status (No. 18)	Social Support (Nos. 82-93)	Loneliness (Nos. 19-38)
Income (No. 8)	Internalized Homophobia (Nos. 39-61)	Depression (Nos. 193-212)
Race/Ethnicity (No. 3)	Perceived Financial Status (Nos. 9-11)	Hopelessness (Nos. 62-81)
Education (No. 4)	Perceived Health (Nos. 185-187)	Life Satisfaction (Nos. 213-232)
Employment Status (No. 5)	Perceptions of Ageism (Nos. 244-246)	Self-esteem (Nos. 161-184)
Living Arrangement (No. 12)	Life Expectancy (No. 251)	
Relationship Status (No. 13)	Perception of Gay Old Age (No. 240)	

Descriptive and Demographic Variables

The questionnaire contained a section designed to obtain demographic data from the participants, including age, race/ethnicity, sexual orientation, living situation, relationship status, income and financial status, educational attainment, employment status, HIV status, and health status, among other items. Participants' date of birth was collected to verify age. Race/ethnicity was determined with one multiple choice question with seven options, one of which was "other." Participants could identify their sexual orientation as gay, bisexual, heterosexual, or other. Income was determined by one multiple choice question that presented different ranges of annual income, while financial status was collected with three questions that asked participants to judge their ability to

meet present and future financial needs. Relationship status and living situation were determined through one multiple question each, as were education and employment level.

Dependent Variables

Hope: Beck Hopelessness Scale (BHS). Hopelessness was measured by the Beck Hopelessness Scale (Beck et al., 1974). This self-report instrument "assesses the degree to which an individual holds negative expectations towards his or her future. Each statement is scored on a 4-point Likert-type scale (1 = definitely false, 2 = mostly false, 3 = mostly true, 4 = definitely true)." (Beck et al., 1974) The primary notion is that hopelessness can be objectively measured by characterizing it as a system of constructs with a common set of negative expectations (Beck et al., 1974). BHS has been utilized extensively with older adults and in studies of gay men. Below are three sample items contained from the Beck Hopelessness Scale (see Appendix B for the entire scale).

I look forward to the future.

I can't imagine what life will be like 10 years.

All I can see ahead of me is unpleasantness rather than pleasantness

Reliability and Validity for the Beck Hopelessness Scale (BHS)

When discussing reliability of the BHS, the scale has been shown to be a reliable measure of hopelessness reflecting a negative expectation of future outcomes. Beck et al. (1974) examined the reliability of the BHS in a population of 294 hospitalized patients who had attempted suicide, and Hill et al (1988) tested the scale on depressed elderly persons and acceptable coefficient alphas were obtained (.76 and .84). An alpha was also completed on the sample in this study and it was reported to be .940.

In terms of validity of the scale, the BHS has a strong association with suicidal intent and actual suicide completion (Beck et al., 1985). Further the scale was found to have a moderately high correlation with Beck Depression Inventory which addresses issues of content validity.

Life satisfaction: Life Satisfaction Index-A (LSIA). Life satisfaction was measured using the Life Satisfaction Index A, which assesses well being using a subjective evaluation of one's own present and/or past life (Fischer & Corcoran, 2000). "Life Satisfaction Index-A measures five components of well being: (a) zest versus apathy; (b) resolution and fortitude; (c) congruence between desired and achieved goals; (d) self-concept; and (e) positive mood tone" (Fischer & Corcoran, 2000, p. 223). The index generally is used to measure happiness among respondents (Neugarten et al., 1961). Each statement is scored on a 4-point Likert-type scale (1 = definitely false, 2 = mostly false, 3 = mostly true, 4 = definitely true). Three sample items are presented below:

As I look back on my life, I am fairly well satisfied.

When I think back over my life, I didn't get most of the important things I wanted.

Most of the things I do are boring and monotonous.

Reliability and Validity for Life Satisfaction Index-A (LSIA)

In terms of reliability for the Life Satisfaction Index-A (LSIA) There have been numerous studies testing the reliability of items (Rao & Rao, 1983). Acceptable coefficient alphas of .76 and above have been reported on studies utilizing the scale. An alpha was run for the scale items with this sample and the alpha was .899. When discussing validity of the LSIA, the scale showed a relationship to other scale measuring

life satisfaction and happiness demonstrating concurrent validity (Fischer & Corcoran, 2000).

Self-esteem: Index of Self Esteem (ISE). The Index of Self-Esteem is intended to measure the "degree, severity, or magnitude" of a client's issues with self-esteem. Self-esteem is regarded as the evaluative measure of self-concept. The ISE is written in straightforward language and easily administered and scored. Each statement is scored on a 7-point Likert-type scale (1 = none of the time, 2 = very rarely, 3 = a little of the time, 4 = some of the time, 5 = a good part of the time, 6 = most of the time, 7 = all of the time). Oftentimes, issues with self-esteem are central to social and psychological problems. Therefore the instrument has a wide range of uses for a number of clinical problems (Fischer & Corcoran, 2000).

The index was established through testing of 1,745 respondents, including single and married individuals, clinical and nonclinical populations, and college students and non-students. Respondents included Caucasians, Japanese and Chinese Americans, and a smaller number of members of other ethnic groups. Below are three sample items.

I feel that I am likely to fail at things I do.

I feel that people have a good time when they are with me.

I wish that I were someone else.

Reliability and Validity for Index of Self Esteem (ISE)

When discussing validity, the ISE has good known-groups validity, significantly distinguishing between clients judged by clinicians as having self-esteem issues compared to those judged as having no problems. In terms of construct validity the ISE

has been shown to correlate highly with measures that it should be related to such as depression, happiness and sense of identity scales (Fischer & Corcoran, 1994).

Loneliness: Revised UCLA Loneliness Scale (RULS). Loneliness was measured utilizing the Revised UCLA Loneliness Scale, which, based on research citations, has become the most commonly used measure of loneliness. Items on the RULS are scored on a 4-point Likert-type scale (1 = never, 2 = rarely, 3 = sometimes, 4 = often). The revised scale was developed to correct for "issues of bias, socially desirable responses, and distinctiveness from related constructs." The scale has been utilized to assess a varied range of mental and physical health outcomes among diverse populations (Berger, 1984). Loneliness is related to a variety of other problems, including personality disorders, substance abuse, suicide, and physical ailments. The Revised UCLA Loneliness Scale has several uses for practice in identifying lonely clients, whose loneliness is a problem in and of itself, or is connected to other problems (Fischer & Corcoran, 2000).

Three sample items are presented below:

I lack companionship.

There are people I can talk to

I can find companionship when I want it.

Reliability and Validity for Revised UCLA Loneliness Scale (RULS)

In terms of reliability the RULS has an established internal consistency that is excellent, with an alpha of .94 (Fischer & Corcoran, 2000). An alpha was run for the study sample and it was respectively .902.

When considering validity, the RULS offers good concurrent validity, correlating with several emotional and personality measures, such as depression and social support (Fischer & Corcoran, 2000).

Depression: Beck Depression Inventory (BDI). The Beck Depression Inventory (Beck, 1974) is a 21-question multiple choice self-report inventory that is one of the most widely utilized instruments for measuring depression. Items of the BDI are self-rated by the respondent on a 4-point Likert-type scale (1 = often, 2 = sometimes, 3 = rarely, 4 = never). The BDI is intended for adults, ages 17 to 80, and consists of items that relate to depressive symptoms such as, irritability, hopelessness, guilt or feelings of being punished, as well as physical symptoms such as fatigue, weight loss, and lack of interest in sex. The BDI is commonly utilized as an assessment tool by a variety of helping professionals and researchers in various venues.

The Beck Depression Inventory experiences the similar issues as other self-report scales, in that scores can be overstated or understated by the respondent. Similar to other inventories, the way in which the test is administered can impact the final score. For example, if a respondent is asked to complete the scale in the presence of others in a clinical environment, social pressure might elicit a different response, compared to a survey that is mailed (Beck, 1988). Presented below are three sample items:

During the past week, I felt like I could not shake off the blues even with the help from family and friends.

During the past week, I was happy.

During the past week, I did not feel like eating; my appetite was poor.

Reliability and Validity for the Beck Depression Inventory (BDI)

In terms of reliability for the BDI, Beck, et al. examined reliability of the scale through a meta-analysis of 25 studies. The samples represented a diverse sampling of many different groups such as substance abusers, college students and older adults. The internal consistency of the scale was high regardless of the group. Alphas ranged from .73 to .95. An alpha was run on this sample and it was .945.

As far as validity with the scale, the scale shows strenghth in content, concurrent and discriminant validity (Maruish, 1998).

Independent Variables

Social support: Multidimensional Scale of Perceived Social Support (MSPSS).

The Multidimensional Scale of Perceived Social Supports was created in 1988 and piloted on young adults. It is an scale designed to assess social support in three construct areas: family, friends, and significant other (Fischer & Corcoran, 2000). Each statement of the MSPSS is scored on a 7-point Likert-type scale (1 = very strongly disagree, 2 = strongly disagree, 3 = mildly disagree, 4 = neutral, 5 = mildly agree, 6 = strongly agree, 7 = very strongly agree). The scale, which was determined to be a reliable measure, assesses the extent to which respondents receive support form each of these sources. Sample items are presented below:

There is a special person with whom I can share my joys and sorrows.

My family really tries to help me.

I can talk about my problems with my friends.

Reliability and Validity for the Multidimensional Scale of Perceived Social Support (MSPSS).

The MSPSS has excellent internal consistency, with alphas of .91 for the total scale and .90 to .95 for the subscales. The entire scale was utilized for this study. An alpha was run on this sample and it was .945. In terms of validity the MSPSS has good concurrent validity correlating with depression and loneliness (Fischer and Corcoran, 2000).

Internalized homophobia: Internalized Homophobia Scale (IHS). The Internalized Homophobia Scale is intended to assess internalized homophobia, which is thought to be an important construct in the symptoms and treatment of gay men and lesbians. The scale was initially piloted on 184 men who directly or indirectly identified as being gay (Fischer & Corcoran, 2000).

Internalized homophobia can be viewed as a reaction to the stigma associated with being gay or lesbian. Many psychological characteristics are linked to internalized homophobia, such as "low self-acceptance, low ability to self-disclose, low self-esteem, self-hatred, self-doubt, belief in one's inferiority, and acceptance of popular myths about homosexuality" (Fischer & Corcoran, 2000). This measure is extremely useful in assisting providers in identifying internalized homophobia among clients and identifying areas for intervention. Each statement of the IHS is scored on a 7-point Likert-type scale (1 = strongly agree, 2 = moderately agree, 3 = slightly agree, 4 = neither agree nor disagree, 5 = mildly disagree, 6 = moderately disagree, 7 = strongly disagree). Below are three sample items:

Most of my friends are gay.

It is important to me to control who knows about my being gay.

Even if I could change my sexual orientation, I wouldn't.

Reliability and Validity for Internalized Homophobia Scale (IHS)

There was little information on reliability and validity for the HIS. However to tested reliability an alpha was run on the study sample and it was .789.

Other Independent Variables

Additional independent variables were analyzed for their relationship to the dependent variables that assess psychological adjustment to aging. They included: perceived financial status, perceived health, perceptions of ageism, life expectancy, and perception of gay old age. Perceived financial status was measured by three questions in which participants were asked to assess their subjective current and future financial situation, and perceived health was measured by asking participants to rate their current health and their health compared to one year ago. Perceptions of ageism were assessed by four questions in which participants were asked to comment on their perceptions of the prevalence of ageism in the gay community. Life expectancy was measured by simply asking participants the age to which they thought they would live. Perception of gay old age was measured by asking participants, "At what age is a gay man old?" as compared to "At what age is a person old?" These questions were generated by the researcher.

Risks and Benefits to Participants

Risks of participating in the study were thought to be minimal, but may have included increased anxiety or depression as a result of discussing difficult experiences in participants' lives, as well as anxiety about disclosure and discussion of HIV status.

Benefits of participating in the study may have included acquiring a level of support in regard to sharing feelings about their life experiences. Another potential benefit may have included resource referrals, available to individuals seeking other social service support. The study's researcher is a social worker and has expertise and knowledge in regard to resource referrals. Finally, it was anticipated that some participants may have felt good about participating in that their information and stories would be helpful for others who may have had similar experiences. Upon completion of the survey, participants were compensated with $15 in cash, which may have provided a small incentive to participate, or an acknowledgement of the time people took to participate in the study.

Institutional Review Board (IRB) Review and Informed Consent

This protocol, the informed consent documents, and any subsequent modifications were reviewed and approved by the IRB at Howard Brown Health Center and at Michigan State University. The informed consent described the purpose of the study, the procedures to be followed, and the risks and benefits of participation. A copy of the consent form was given to each participant. A sample informed consent form is included in the supporting documents section (See Appendix A)

Data Processing and Analysis

The informed consent forms and questionnaires for individual participants were filed separately in locked files in the researcher's office. Data from source documents were entered on Statistical Package for the Social Sciences 14.0 (SPSS, 2005) software, with secured access fields. Names and any other identifying information were not entered on SPSS files or on the questionnaires. Unique confidential numbers were

assigned to each participant. Participant numbers and identifying information are being kept under double locks, separate from all other study files and accessible only to the researcher.

Data were derived from the 75 completed surveys. As noted above, the surveys were coded with a number and entered into SPSS for data analysis. Demographic data were reported in terms of frequencies and percentages. Cross-tabulation tables were generated as a means to determine possible associations, and correlations were determined.

Summary

This chapter described the methodology utilized in collecting the data. The primary source for data collection was the Multicenter AIDS Cohort Study at Howard Brown Health Center, followed by the clients of Test Positive Aware Network and the individuals contacted in community venues, including social organizations, churches, and local bars.

The next chapter presents the results of the data analysis. The results are used to address each research question and to provide a better understanding of the aging gay male experience.

CHAPTER 3

RESULTS

This chapter presents the results of the data analysis from this exploratory study of 75 gay men over 50 years of age, in metropolitan Chicago. The chapter begins by addressing the first research question, using descriptive data from the study participants, to describe the sample. The descriptive variables are organized by HIV status group, i.e., positive or negative. Following the descriptive data, the results of the data analysis are presented, with a focus on significant relationships and group differences. The rest of the results are organized in terms of the remaining six research questions. The chapter concludes with a summary.

Participant Characteristics

HIV Status

For HIV Status, 32 participants (42.7%) reported being HIV positive, 41 (54.7%) reported being HIV negative, and two (2.7%) did not answer the question. Of the HIV-positive participants, 28 participants (83.9%) reported being HIV positive for greater than ten years (1994 or before). Of the 32 participants who reported being HIV positive, only two (2.7%) reported having an HIV-related illness in the past six months (lymphoma and wasting syndrome) and one participant reported a hospitalization in the past six months.

This section creates a descriptive picture of the study sample both in terms of demographic characteristics and HIV Status.

Sexual Orientation

As noted above, this study consisted of 75 participants. All participants signed the consent form stating that they were gay, bisexual, or a man who has sex with men

(MSM). In terms of sexual orientation, 66 participants identified as gay, four identified as bisexual, and two identified as "other," while three did not report sexual orientation. Due to the participants' signing of the consent form, it was assumed that the two respondents who identified as "other" and the three who did not report their sexual orientation still fit the criteria of the study. It can possibly be assumed that some of these participants are men who have sex with men but do not identify as gay or bisexual. Table 2 provides information on sexual orientation by the men's reported HIV status. .

Note for Tables 2-19). When total N is less than 75, this indicates that some participants did not respond to a given question.

Table 2: Sexual Orientation by HIV Status

	HIV Positive		HIV Negative	
Sexual Orientation	N	Percentage	N	Percentage
Gay	28	40.0	36	51.4
Bisexual	1	1.4	3	4.3
Other	2	2.9	0	0
Total	30	43.4	39	55.7

Age

Of the 75 participants, 66 reported their age. The mean age of participants was 56.39, with a median of 55.5 and a mode of 51. As can be seen, the age distribution was skewed toward the early 50s. Compared to other studies on aging and psychological adjustment to aging, the sample is somewhat younger. Additionally, the HIV positive participants were slightly younger, but not significantly so (Table 3).

Table 3: *Age by HIV Status*

HIV Status	N	Mean	Median	Standard Deviation	Minimum	Maximum
HIV Positive	30	55.47	54.00	4.73	51	73
HIV Negative	34	57.56	58.00	5.69	50	73
Total	64	56.58	56.00	5.32	50	73

Race/Ethnicity

The sample was largely Caucasian (N = 62, 82.7%). However there was sizeable representation of African American participants (N = 11, 14.7%), one participant identified as Hispanic and one as Native American. Compared to the US population, in this sample, Caucasians are over-represented (82.7% vs. 69.1%). African Americans are also slightly over represented (14.7% vs. 12.3%). Native Americans represent 1% of the population and had a representation of one participant in this study. Persons of Hispanic or Latino origin were notably underrepresented, with one participant (1.4%) as compared to 12.5% of the national population, and Asian American and others were not represented, as compared to 3.6% of the population (United States Census Bureau, 2001). Table 4 presents the results for race/ethnicity by HIV status.

Table 4: Race/Ethnicity by HIV Status

	HIV Positive		HIV Negative	
Race/Ethnicity	N	Percentage	N	Percentage
White/Caucasian	24	32.9	36	49.2
African American	8	11.0	3	4.1
Hispanic/Latino	0	0	1	1.4
Native American	0	0	1	1.4
Total	32	43.9	41	56.1

Education, Employment, and Income

All of the 75 participants reported completing high school. Further, 97.2% had completed some college, compared to 58.5% of the general population of those 50-54 years of age, 77.3% had an associates degree or greater, and 73.3% had completed a bachelor's degree or greater, compared to 29% of the general population of those 50-54 years of age. Of the participants, 42% reported having earned an advanced degree (master's or doctorate), compared to 12.7% of the general population of those 50-54 years of age). Overall, the sample reported a much higher level of education than did the general population of the same ages (United States Census Bureau, 2000). Table 5 presents the results for education by HIV status.

Table 5: Education by HIV Status

	HIV Positive		HIV Negative	
Education	N	Percentage	N	Percentage
High School	0	0	2	2.7
Some College	11	15.1	4	5.5
Associate's Degree	3	4.1	0	0
Bachelor's Degree	3	4.1	19	26.0
Master's Degree	12	16.4	15	20.5
Doctoral Degree	3	4.1	1	1.4
Total	32	43.8	41	56.2

In terms of employment status, 46.4% of participants worked full-time, 24.6% had retired, 15.9% were disabled, 7.2% worked part time, and 5.8% were unemployed. Overall, this group reports lower participation in the labor force than do the general population their age. The general population reports 76.3% employment for those aged 45-54 and 64.7% for those aged 55-59, compared to 53.6% employment among the study

participants. Additionally, employment disability status is higher among this group, at 15.9%, as compared to 11.9% of the general population (United States Census Bureau, 2000). Both lower work force participation and greater prevalence of employment disability can be explained by the impact of HIV/AIDS on this group. Table 6 presents the results for employment by HIV status.

Table 6: Employment by HIV Status

	HIV Positive		HIV Negative	
Employment	N	Percentage	N	Percentage
Full-time	11	16.4	19	28.4
Part-time	2	3.0	3	4.5
Unemployed	3	4.5	1	1.5
Retired	5	7.5	12	17.9
Disabled	8	11.9	3	4.5
Total	29	43.3	38	56.7

As seen in Table 7, in regard to income, 38% of the sample reported having incomes of over $61,000 annually, 26.8% reported incomes of less than $20,000, while 28.3% fell in the middle three categories, representing $31,000 to $50,999, which is the range in which most US citizens report their earnings (United States Census Bureau, 2000). It is difficult to assess how this sample compares to national incomes, except to say that higher than average incomes and lower than average incomes are disproportionately represented among this group. The lower than average incomes among the sample could be accounted for by the disproportionate retirement and disability status among the group. Further, the higher than average incomes could be accounted for by the disproportionately high education levels among participants.

Table 7: Income by HIV Status

	HIV Positive		HIV Negative	
Income (in dollars)	N	Percentage	N	Percentage
< 11,000	5	7.2	4	5.8
11,000-20,999	7	10.1	3	4.3
21,000-30,999	4	5.8	2	2.9
31,000-40,999	3	4.3	4	5.8
41,000-50,999	4	5.8	3	4.3
51,000-60,999	1	1.4	4	5.8
61,000-70,999	4	5.8	5	7.2
>71,000	4	5.8	12	17.4
Total	32	46.4	37	53.6

Relationship Status and Living Situation

As seen in Table 8, for relationship status, 58.9% of the sample reported not being in a relationship, separated, or widowed from a same sex relationship, 41.1% reported being in a relationship with a man, and no respondents reported being in, separated from, or widowed from an opposite sex relationship. The sample reported a disproportionate percentage of single individuals, although the statistics are difficult to interpret. The major reason for this is the statutes that ban or do not allow gay people to marry in most states. Currently, in the US, 51% of the general population is unmarried (USA Today, 2006). This only accounts for legally married and coupled, so for the general population in the US, it can be assumed that the percentage of persons in a relationship is somewhat higher than 51%. This would create an even greater disparity of individuals not in a relationship compared to the general population. The HIV positive participants were significantly less likely to be in a relationship (Pearson Chi Square Value: 11.77; $p<.001$)

Table 8: Relationship Status by HIV Status

	HIV Positive		HIV Negative	
Relationship Status	N	Percentage	N	Percentage
Relationship with male	6	8.5	23	32.4
Not in a relationship	20	28.2	13	18.3
Separated from male	1	1.4	2	2.9
Widowed from male	5	7.0	1	1.4
Total	32	45.1	39	54.9

As seen in Table 9, in terms of living situation, 58.3% of the group reported living alone, while 41.7% reported living with someone, of whom, 31.9% reported living with a partner. The number of individuals living alone is significantly different from the general population, for whom 9.7% live alone (United States Census Bureau, 2000). Further, significantly more of the HIV positive participants were living alone compared to their HIV negative counterparts. (Pearson Chi Square Value: 10.32; p value< .035)

Table 9: Living Situation by HIV Status

	HIV Positive		HIV Negative	
Living Situation	N	Percentage	N	Percentage
Lives with partner	5	7.1	17	24.3
Lives alone	22	31.4	19	27.1
Lives with roommate	1	1.4	2	2.9
Lives with friend(s)	0	0	1	1.4
Lives with relatives	3	3	0	0
Total	31	44.3	39	55.7

Addressing of the Research Questions

Research Question 1 (What are the demographic and descriptive characteristics of the sample?) was addressed above. The results presented in this section are organized in terms of each of the remaining research questions.

Research Question 2

Are there differences between HIV-positive and HIV-negative participants in terms of psychological adjustment to aging measures?

When analyzing HIV status and its relationship to psychological adjustment to aging, the results indicated that there were no significant differences between the groups. Perhaps surprisingly, when using ANOVA to look at the dependent variables of loneliness, hopelessness, self-esteem, depression, and life satisfaction, there were no significant differences between the HIV-positive and HIV-negative groups.

Research Question 3

Do variables such as perceived health, income, finances, social supports, race/ethnicity, education, employment, and internalized homophobia affect the psychological adjustment aging measures?

The following section contains a presentation of the findings for each independent variable (perceived health status, income, perceived financial status, race/ethnicity, education, employment, social supports, and internalized homophobia) and its relationship with the dependent variables related to psychological adjustment to aging.

Perceived health. As discussed above, HIV status did not significantly affect any of the dependent variables. Participants were asked to report their current health status (excellent, very good, good, fair, poor). Interestingly, even among the HIV-positive

group, there were no participants who rated their current health as "poor." The analysis (Spearman's rho) showed significant correlations between health status and hopelessness, -.421 (p = .000); self-esteem, .454 (p = .000); depression, -.409 (p = .000); and life satisfaction, .458 (p = .000). Participants who reported higher current health ratings also reported better psychological adjustment to aging. The correlational analysis (Spearman's Rho) also showed no significant relationships between perceived current health ratings and the dependent variable of loneliness (Table 10).

Table 10: *Relationship between Perceived Health and Psychological Adjustment to Aging*

Variable	Rho	Significance	N
Hopelessness	-.421	.000	73
Self-Esteem	.454	.000	72
Depression	-.409	.000	74
Life Satisfaction	.483	.000	75
Loneliness	-.095	.419	75

Income and perceived financial status. In regard to the relationship between income and psychological adjustment to aging, there were no significant correlations Table 11 shows the statistics regarding income and psychological adjustment to aging.

In addition to income, the survey collected data on perceived financial status, as well as perceived adequacy of current finances and future finances through three questions;

Question 9: How would you characterize your current financial status? (excellent, good, average , below average, poor).

Question 10: Do you believe you have adequate finances to meet your current needs? (yes, no, maybe , don't know).

Question 11: Do you believe you have adequate finances to see you through the rest of your life? (yes, no, maybe , don't know)

When rating the of adequacy of finances to cover current and future needs, participants who answered more positively showed significantly more favorable scores on the variables used to assess psychological adjustment to aging, followed by those who answered "maybe," "don't know," or "no." The results for the three categories are presented in Table 12.

Table 11: *Relationship between Income and Psychological Adjustment to Aging*

Variable	F	df	Significance
Hopelessness	1.66	68	.136
Self-Esteem	0.95	60	.478
Depression	1.21	69	.311
Life Satisfaction	1.94	70	.078
Loneliness	1.61	70	.140

Table 12: *Relationship between Perceived Financial Status and Psychological Adjustment to Aging*

	Q19 Current Fin.			Q10Adeq.-Current			Q11Adeq.-Future		
Variable	Rho	Sig.	N	Rho	Sig.	N	Rho	Sig.	N
Hopelessness	-.335	.004	72	-.313	.008	72	-.374	.001	73
Self-Esteem	.290	.014	71	.299	.011	71	.393	.001	72
Depression	-.363	.002	73	-.305	.009	73	-.394	.001	74
Life Satisfaction	.453	.000	74	.423	.000	74	.494	.000	75
Loneliness	-.268	.021	74	-.296	.011	74	-.462	.000	75

Race/ethnicity. In regard to the relationship between race/ethnicity and psychological adjustment to aging, the results indicated that there were no significant findings, either in terms of the differences between groups or for the various dependent variables.

Education. The analysis of the relationship between education and psychological adjustment to aging also yielded no significant differences between the groups or for the variables.

Employment status. In regard to the relationship between education and psychological adjustment to aging, there were no significant findings in regard to the differences between groups or for the variables.

Relationship status. The analysis for the relationship between relationship status and psychological adjustment to aging yielded no significant findings.

Living situation. In regard to living situation (living with someone versus living alone), the results indicated that life satisfaction was significantly higher (*Anova* .4311 ; p <.042) among participants who were living with someone. Otherwise, the results showed that there were no significant differences between the groups or for the other psychological variables, based on living situation.

Social support. The results demonstrated a statistically significant relationship between social support and all the variables indicative of psychological adjustment to aging. Hopelessness, self-esteem, life satisfaction, and loneliness were all correlated with social support at the p = .01 level (2-tailed), while depression had a correlation to social support that at the p = .05 level (2-tailed). This means that social support was related to all measures of psychological adjustment to aging among study participants.

Self-esteem and life satisfaction are both positive measures of emotional outcomes and were positively correlated with social support, meaning that higher social support was related to higher scores for self-esteem and life satisfaction. Hopelessness, depression, and loneliness are all negative measures of emotional outcomes (higher

scores mean more negative outcomes). The correlations with social support among the dependent variables are as follows: hopelessness, -.381(p = .001, 2-tailed); self-esteem, .330 (p = .005, 2-tailed); depression, -.278 (p = .017, 2-tailed); life satisfaction, .494 (p = .000, 2-tailed); and loneliness, -.328 (p = .004, 2-tailed). The strongest correlation was between social support and life satisfaction (Table 13).

Table 13: *Relationship between Social Support and Psychological Adjustment to Aging*

Variable	Pearson r	Significance	N
Hopelessness	-.381	.001	72
Self-Esteem	.330	.005	71
Depression	-.278	.017	73
Life Satisfaction	.494	.000	74
Loneliness	-.328	.004	74

Internalized homophobia. The data showed a statistically significant relationship between internalized homophobia and all the dependent variables that measure psychological adjustment to aging. Each variable, hopelessness, self-esteem, depression, life satisfaction, and loneliness, showed a correlation with social support that was significant at the p =.01 level (2-tailed). Self-esteem and life satisfaction are both positive measures of emotional outcomes and were negatively correlated with internalized homophobia, meaning that, as internalized homophobia increased, scores rating self-esteem and life satisfaction declined. Hopelessness, depression, and loneliness are all negative measures of emotion outcomes (higher scores mean more negative outcomes). These items were positively correlated with internalized homophobia, meaning that, as internalized homophobia increased, scores rating hopelessness, depression, and loneliness increased. The correlations with internalized homophobia

among the variables are presented in Table 14. The strongest correlation was between internalized homophobia and loneliness (Table 14).

Table 14: *Relationship between Internalized Homophobia and Psychological Adjustment to Aging*

Variable	Pearson r	Significance	N
Hopelessness	.392	.001	73
Self-Esteem	-.384	.001	72
Depression	.385	.001	74
Life Satisfaction	-.447	.000	74
Loneliness	.534	.000	74

Research Question 4

Are the variables associated with psychological adjustment to aging (self-esteem, loneliness, acceptance of gay identity, hopelessness, depression, and life satisfaction) correlated with one another?

As seen in Table 15, the dependent variables of hopelessness, self-esteem, depression, life satisfaction, and loneliness were all correlated with each other. Hopelessness, depression, and loneliness, which indicate negative emotional outcomes, were all correlated positively with each other at the $p = .01$ level (2-tailed). Self-esteem and life satisfaction, variables that measure positive emotional outcomes also correlated positively with each other at the $p = .01$ level (2-tailed). Further, the variables that indicate negative emotional outcomes (hopelessness, depression, and loneliness) were negatively correlated with the variables that measured positive emotional outcomes at the $p = .01$ level (2-tailed).

Table 15: *Correlations between the Variables of Psychological Adjustment to Aging*

		Hopeless-ness	Self-Esteem	Depression	Life Satis.	Loneliness
Hopelessness	Pearson	1	-.774	.753	-.769	.638
	Sig.		.000	.000	.000	.000
	N	73	71	73	73	73
Self-Esteem	Pearson		1	-.790	.731	-.632
	Sig.			.000	.000	.000
	N		72	72	72	72
Depression	Pearson			1	-.740	.646
	Sig.				.000	.000
	N			74	74	74
Life Satis.	Pearson				1	-.585
	Sig.					.000
	N				75	75
Loneliness	Pearson					1
	Sig.					
	N					75

Research Question 5

Do the variables and the psychological aging measures have a relationship with participants' life expectancy?

Life expectancy was determined with one survey question that asked participants to estimate until what age they would live. For the 65 participants who responded to this question, life expectancy ranged from 58 to 106 years, with a mean of 80.98 and a median and mode of 80.

The results for the relationship of the independent variables with life expectancy showed a significant relationship between life expectancy and HIV status, perceived

current health status, social support, and internalized homophobia. As presented in Table 16, HIV-positive participants had significantly lower mean life expectancy, at 77.28, than did HIV-negative participants, with a mean of 83.58 (p = .018, 2-tailed).

Table 16: *Life Expectancy by HIV Status*

HIV Status	N	Mean	Standard Deviation	Minimum	Maximum
HIV Positive	25	77.28	11.40	58	97
HIV Negative	38	83.58	9.16	70	106
Total	63	81.08	10.49	58	106

Current Health, Life Expectancy and Psychological Adjustment to Aging. There were no significant differences between the two groups (HIV positive and HIV negative) for current health rating (excellent, very good, good, and fair). However current health rating had a significant relationship to life expectancy (.265, p = .033, 2-tailed), while other variables, including income, finances, race/ethnicity, education, employment, social support, and internalized homophobia, had no relationship. There was also a significant relationship ($p < .05$, 2-tailed) between life expectancy and hopelessness, self-esteem, depression, and life satisfaction, but no relationship between life expectancy and loneliness (Table 17).

Table 17: Relationship between Life Expectancy & Psychological Adjustment to Aging

Variable	Pearson r	Significance	N
Hopelessness	-.410	.001	64
Self-Esteem	.297	.019	62
Depression	-.302	.015	64
Life Satisfaction	.307	.013	65
Loneliness	-.190	.131	65

Research Question 6

Do study participants perceive LGBT community ageism?

For perceived ageism, there was one item on the questionnaire, "There is a lot of ageism in the gay community," to which participants indicated their degree of agreement (or disagreement). As presented in Table 18, 80% of respondents stated that they either strongly agreed or agreed.

Table 18: *Perceptions of Ageism*

Response	Frequency	Percentage
Strongly Agree	24	32.0
Agree	36	48.0
Disagree	9	12.0
Strongly Disagree	4	5.3
Missing	2	2.7
Total	75	100.0

Research Question 7:

Do study participants perceive or experience accelerated aging?

The idea of accelerated aging is the notion that individuals feel that they reach older age more quickly than does the general population. To assess a perception of accelerated again, participants were asked: "At what age do you consider a person old?" and "At what age do you consider a gay man old?" The results, as presented in Table 19, indicated a significant difference in the answers to the two questions. The mean old age rating for people in general was 71.7, compared to a mean old age for gay men of 64.33. This difference was significant at the $p = .00$ level (2 tailed) t-test = .5478. Further, those participants reporting a lower gay old age scored less favorably on all the

dependent variables that measure psychological adjustment to aging. This means that those who reported a lower age of when they consider a gay man old, also scored significant worse on all measures of psychological adjustment to aging. Hopelessness, self-esteem, depression, and life satisfaction were all significant at the $p = .01$ level (2-tailed) and loneliness was significant at the $p = .05$ level (2-tailed).

Table 19: *Perceptions of Accelerated Aging*

Question	N	Mean	Standard Deviation	Std. Error of the Mean
At what age do you consider a person old?	73	71.78	13.03	1.53
At what age do you consider a gay man old?	73	64.33	12.81	1.50

Summary

This section included a comprehensive discussion of the study results, answering all seven research questions. It was observed that HIV/AIDS status, income, relationship status, living situation and employment status, had no significant relationship to psychological adjustment to aging measures. However subjective views of health and finances had significant associations with participants' psychological adjustment to aging. Additionally, it was observed that participants who scored unfavorably in the area of internalized homophobia and social supports were also more likely to score unfavorably on measures of psychological adjustment to aging. The following chapter will relate these findings to the research to date as well as suggesting future directions for research.

CHAPTER 4

DISCUSSION

This exploratory research, utilizing a survey questionnaire, was designed to investigate differences in psychological adjustment to aging among a sample of 75 self-identified gay men over 50 years old. The study considered the relationship between five dependent variables indicative of psychological adjustment to aging: hopelessness, self-esteem, depression, life satisfaction, and loneliness. These constructs have been historically utilized in past studies to assess psychological adjustment to aging and successful aging (Berger, 1984; Kooden, 1997; Quam & Whitford, 1992). The independent variables assessed in this study included social support, internalized homophobia, perceived health, perceived financial status, and perceptions of ageism. These constructs have been assessed in other studies, and relationships have been found among them, with psychological adjustment and mental health (Kooden, 1997; Kimmel, 1979; Kaplan & Camacho, 1983; Calahan et al., 1994; Umberson, Wortman & Kessler, 1992). Additionally, the study looked at the relationship between the five dependent variables and the demographic and descriptive variables of race/ethnicity, income, education, work status, relationship status, and living situation. HIV status was also considered as a factor possibly associated with psychological adjustment to aging.

The study was conducted in metropolitan Chicago. Generally speaking, participants were professional and educated, as well as having perceptions of a favorable psychological adjustment to aging and were in good physical health. These characteristics are not surprising, as the research documents the fact that a select group of people is typically included in studies such as this (Berger & Kelly, 1996).

Unfortunately, a representative group of older gay men is not available for study in most cases. Those who are closeted, isolated or not accessing the LGBT community are increasingly hard to find and even more difficult to recruit into a study. Additionally, there is less access to gay communities of color. There are not as many venues in Chicago where older gay men of color can be found. The researcher is a Caucasian gay man, so accessing gay white men was easier than other groups. The literature discusses these difficulties in obtaining diverse and representative samples among LGBT people (Meyer, 1999; Sell & Petrulio, 1996; Harry, 1986)

This chapter begins with a review of the findings, followed by a discussion of the study's strengths and limitations, as well as recommendations for future research and for the field of social work. The chapter ends with the conclusion and other recommendations for the field of social work in serving older gay men.

Review of the Findings

Demographic and Descriptive Characteristics

As stated above, in general, the sample was educated, professional, and fairly affluent. Other demographic components included higher singlehood status, greater likelihood to be retired or disabled, and greater likelihood of living alone. Although the research of Berger (1984) and others (Friend, 1987; Kimmel, 1977, 1979; Quam, 1997) dispelled stereotypes about older gay men being sad and alone, this study highlighted a higher likelihood of their living alone and being single in older age. This did not, however, equate to being unhappy or lonely. The sample of single or living alone respondents reported no significant differences in psychological adjustment measures from their counterparts in the study and most reported strong social support networks.

These findings have important implications for services and interventions for this population. When serving this group, it is important to be aware that many may be living on their own and services should be designed to meet those needs, in addition to meeting the needs of couples and families. Services such as meals, chore services and day to day living support will become much more important for someone who is single and living alone. Isolation may increase among individuals who are living alone if they become ill and homebound. Programs such as "Friendly Visitors", originally offered to LGBT seniors by Senior Action in a Gay Environment (SAGE) in New York City is a practical way to provide additional support for those seniors who are living alone. Further, support services including groups and individual counseling could assist single gay seniors in nurturing their experiences and identities as singles. Social workers should be creative in development of innovative programs that target specific needs of the group they serve whether single or coupled.

In terms of singlehood, living alone and disability status, HIV positive participants were significantly more likely to be single, to live alone and to be on disability. These findings have not been highlighted in other studies, with the exception of higher likelihood of disability status among HIV positive people (Cruz, 2003). However, these findings highlight important issues that may be impacting HIV positive, gay clients in older age. If, in fact, HIV positive older gay men are more likely to be living alone and single in older age, social workers and other service providers may need to factor this into care giving and other services as HIV positive individuals face compromised health.

Social Supports

The study finds that social support impacts positively on the dependent variables that measure psychological adjustment to aging. This finding supports various other studies in the literature stating that social supports result in positive impacts on individuals' experiences with and perceptions of older age (Berger, 1984; Kooden, 1997; Friend, 1987).

Social workers and other service providers can continue to offer and create interventions that allow older gay men to find, access and create stronger and larger support networks. This can be done by increasing services specifically designed for older gay men such as social outings, friendship groups, dating resources, theatre field trips and group travel. Also, services can be designed to encourage group participation such as social events, support groups, performing arts, group vacations and group living. The possibilities for creating strong and large support networks, are endless.

Internalized Homophobia

Several authors have noted the manner in which one can accomplish a "successful" aging process. As discussed in chapter one, for example, Friend (1987) asserted the need for one to accept his or her homosexuality as part of the successful aging process. Friend's work not only highlighted and discussed the concept of successful aging, but also elaborated on the concept of homosexual identity formation theory. In combining and discussing these two concepts, he developed a conceptual model whereby gay people fit into one of three identities: stereotypical older gay person, passing older gay person, or affirming older gay person. He believed that, regardless of which of these three identities one assumes, one's self-acceptance is important. He did

however encourage clients to move toward an affirming identity. This idea was illustrated with the internalized homophobia scale. Those with higher scores (less favorable) in the construct of internalized homophobia also scored less favorably on scales measuring adjustment to aging including hopelessness, self-esteem, depression, life satisfaction, and loneliness. Further, the findings in this study support earlier findings on self-acceptance and successful aging (Berger, 1984; Kimmel, 1979; Kooden, 1997)

These findings create some interesting notions about programming that will better help older gay men as well as others in the community to accept their sexual orientation and identity. When proposing interventions to address internalized homophobia, micro, mezzo and macro interventions must all be considered.

On the micro level, interventions with older gay men take many possible forms. Innovative programs that include education, counseling and role modeling can assist individuals to move along Friends' suggested continuum toward being an affirming older gay person. In addition to psycho-social support programs for LGBT seniors, macro efforts in the area of public policy could have great impacts on internalized homophobia. Legalizing gay marriage, including sexual orientation as a protected class from discrimination, allowing LGBT people to be "out" as they serve in the military, mandating domestic partner benefits in the workplace and community, are all areas where policies would validate and empower LGBT people in their identity. On the mezzo level of intervention many existing programs developed for the mainstream older adult population could be revised to provide services in a LGBT-inclusive manner. When assessing community programs for seniors, there were almost no programs that had specialized programs for older LGBT individuals. It is necessary for social workers to

advocate for their older LGBT clients, and to create interventions to address internalized homophobia, at all systems levels.

Differences Between HIV-Positive and HIV-Negative Participants

The findings of this study create a narrative of a changing environment for those individuals who are HIV infected. Numerous studies cite a relationship between chronic illness and mental health issues, especially depression (Katon & Sullivan, 1990; Katon & Schulberg, 1992). This study found no relationship between chronic illness (HIV/AIDS) and poorer mental health outcomes. Specifically, there were no significant differences between the HIV-positive and HIV-negative participants. This finding may be related to the technological advances in the treatment of HIV/AIDS. At the beginning of the disease (1980s and early 1990s), ineffective and toxic treatments were utilized with AIDS patients. After the mid-1990s, there were dramatic advances and survival and quality of life increased. Today, although still a major health issue, HIV/AIDS, in many cases, can be managed through a medication regimen. If this study had been conducted prior to these technological advances, the relationship between HIV and mental health would likely have been dramatically different.

This finding creates an interesting discussion about how to better provide services to HIV positive individuals. Quite possibly, efforts could be redirected for HIV positive older gay men. Instead of concentrating on mental health issues, perhaps service programs can be diversified that are more comprehensive and include reintegration services such as getting people back to work, health and educational programs and others.

Crisis competency

As previously discussed in chapter one, Berger (1982), Friend (1991), and Kooden (1997) discussed the concept of crisis competency. This concept is the notion that gay men may have had a history of addressing crises more often than their heterosexual counterparts and therefore may have an easier time handling the crises that accompany old age. Dealing with issues such as coming out, discrimination, isolation, and HIV/AIDS has perhaps better prepared gay men for the issues of older age, such as death, loss, and loneliness. Many living with HIV/AIDS have had to make the emotional adjustment of having chronic compromised health. This "crisis competency" may, in fact, help gay men in this situation (Kooden, 1997).

This consideration of crisis competency may help explain the results discussed above regarding no significant differences between the HIV positive participants and the HIV negative participants in terms of measures of psychological adjustment to aging. While the literature highlights a relationship between chronic illness and worse mental health outcomes such as depression (Katon & Sullivan, 1990; Katon & Schulberg, 1992), this study did not have similar findings. The idea that HIV positive men in the study may have developed a high level of resilience or crisis competency and thus reduced any psychological impacts of living with HIV/AIDS to a negligible level.

Perceived Health, Income, and Finances

In terms of perceived health, participants who reported worse perceived health also significantly reported poorer mental health outcomes. Although HIV status was not related to worse mental health outcomes, participants' personal evaluation of their health was an important variable. These findings support earlier findings that relate health

perceptions to mental health outcomes (Kaplan & Camacho, 1994; Calahan et al., 1994). The findings also support the theoretical framework or "social construction theory," that individuals create their own reality and that perceived reality is more powerful than objectively measured outcomes.

In this study, social construction theory also was relevant to income and financial status. Although participants showed no significant differences in mental health/adjustment to aging scores in terms of objective income differences, they did report differences when they were asked about whether they had adequate finances for current and future needs. This finding supports past studies of perceived financial status and its impact on mental health (Umberson, et al., 1992).

Overall Outcomes of Psychological Adjustment

The findings of this study also support the findings of others in regard to the majority of participants reporting favorable outcomes on scales measuring psychological adjustment to aging, including hopelessness, self-esteem, depression, life satisfaction, and loneliness (Berger, 1980, 1982, 1984; Friend, 1991; Kelly, 1974, 1977, 1980; Kimmel, 1979; Weinberg, 1970). As found in these studies, the present study found that there were no significant differences in measures of psychological adjustment to aging among those who were coupled versus those who were not. Further race/ethnicity, income, education, living situation, and relationship status also had no impact on psychological adjustment to aging.

Additionally the study found a relationship among all of the dependent variables: hopelessness, depression, self-esteem, loneliness and life satisfaction. This finding speaks to concurrent validity. In other words the scales hung together as they were

expected to (See Table 15). This should help to add on to the discussion and development of a scale that comprehensively measures psychological adjustment to aging.

LGBT Community Ageism

Ageism and invisibility have been cited in many articles as an ongoing and serious issues among older gay men as well as other members of the LGBT community (Harrison, 2002; Brotman, Ryan, & Cormier, 2003; Cahill et. al, 2000). In terms of LGBT organizational priorities, programs focusing on younger LGBT people have often been on the top of the list of agency funding and operation. This creates few programs designed for LGBT seniors that are housed at LGBT community organizations. In Chicago, there are three organizations that offer programs specific to older LGBT individuals. This lack of services will become increasingly evident as LGBT baby boomers move into retirement. In addition to this invisibility in social service provision, older gay men cite ageism and invisibility in social venues such as bars, health clubs and social events (Harrison, 2002). This issue is related to societal and community norms about aging in American culture and specific norms about age and attractiveness in gay culture.

When questioned about ageism in the gay community, the sample reported high levels of perceived ageism in the community. Seventy percent of the sample agreed or strongly agreed that there is a lot of ageism in the gay community. This finding supports previous literature (Kaufman & Phua, 2003; Garnets & D'Augelli, 1994). Such results suggest that work needs to be done among gay men to reduce both ageism and perceptions of ageism in the community. These efforts must take place on many levels.

First, LGBT organizations must factor in programs into the array of programs developed and offered to community members. This can be done by including older LGBT people in planning groups, on board positions and in leadership positions at community agencies. Additionally efforts to reframe gay culture to find value and desirability in older LGBT people should be a priority. This can be accomplished through intergenerational programs that facilitate cooperation, mentorship and exposure of all age groups to each other in the community. There are a few intergenerational groups in major U.S. cities that are facilitating this exposure of the generations to one another. Work with both young and old must be a part of changing attitudes about age.

Accelerated Aging

As discussed in previous chapters, the idea of accelerated aging is the notion that individuals feel that they reach older age more quickly than the general population does. To assess a perception of accelerated again, participants were asked: "At what age do you consider a person old?" and "At what age do you consider a gay man old?" There have been just a few studies that look at accelerated aging among gay men (Bennett & Thompson, 1990; Adelman, 1991; Schope, 2005; Friend, 1991). In Bennett and Thompson's work (1990), accelerated aging or the onset of middle and old age was perceived to be earlier for gay men compared to their heterosexual counterparts. Also, in Schope's work (2005), both younger and older gay men perceived accelerated aging in their personal community experiences. Schope's study contrasted gay men and lesbians and found that gay men in his study were significantly more ageist and experienced accelerated aging, than lesbians.

There were a relatively high number of participants who reported accelerated aging in this study. This is in comparison to the existing research on "accelerated aging" These findings reflect most studies' findings of accelerated aging (Bennett & Thompson, 1990; Adelman, 1991; Schope, 2005; Friend, 1991). In terms of interventions, accelerated aging can be addressed and reframed much in the same way that ageism issues can be dealt with. These two concepts are interrelated. When gay culture can successfully address ageism, accelerated aging will dissipate.

Study Strengths

The study possessed at least four strengths. First, the study incorporated established measures that have been utilized for many years on different populations, including gay people, older adults and, in some cases, older LGBT adults (Berger, 1984; Friend, 1987; Cruz, 2003). These established and frequently used scales enabled the questionnaire to have a high level of reliability and validity.

Second, this study was one of the first of its kind to analyze and discuss differences that exist as a result of HIV status. Information about how HIV/AIDS may affect individuals socially, psychologically, and interpersonally is important information. In this study, a lack of difference in measures based on HIV/AIDS status was interesting and important with implications for changing attitudes and programs.

Third, this study had a good sample size. Although, in some ways, 75 participants represent a small, limited sample, a sample of 75 gay men over 50 years of age represents a fairly sizable sample, compared to the majority of studies with this population (Friend, 1987; Kimmel, 1979, Berger 1984). While a bigger, more diverse sample would have

been ideal, this study represents a move in the direction of greater access to this population that was perhaps not as possible or likely before.

Fourth, this study included more persons of color, especially African Americans, than have similar studies (Berger, 1984; Herdt, et al., 1997; Weinberg, 1970). The study sample included 11 African American participants (14.7%). While Caucasians were still over-represented in the sample, African Americans had reasonably good representation.

Study Limitations

There were at least four limitations to this study. The first and most important is the sampling methods. Participants were recruited via two social services organizations serving the LGBT community, as well as through local gay bars in metropolitan Chicago. This convenience sampling did not allow for random sampling and, consequently, the persons in this study were not representative of aging gay men, in general. Additionally, this method restricted the recruitment of persons to those who were connected to the LGBT community in one way or another and also biased the sample toward middle class, educated, and professional participants. Sampling issues were the greatest threat to external validity in this study.

The second is that participants were largely well educated, largely Caucasian men with high incomes, a typical problem in sampling this community of older gay men (Quam & Whitford, 1992). This is a problem as a sample of well educated, Caucasian men with higher socioeconomic status may have differential access to the physical and mental health care systems than do than less educated, poorer men and possibly those of minority status, thus more positive results, i.e. positive adjustment to aging, may be indicative of this sample.

The third is that, although the study recruited gay man over 50 years old, the sample was skewed toward individuals 55 years and under. This group accounted for approximately 50% of the sample. While this lack of diversity in age was a weakness, it did allow the research to target those gay men that were hardest hit by the HIV/AIDS epidemic, providing greater access to a cohort that experienced the greatest health impacts and loss of loved ones to the disease.

A fourth area in which the study was limited was in its cross-sectional survey design. The study involved primarily quantitative research, collected at one time period. Although this method allowed the researcher to collect data from 75 respondents, representing a good sample size, and an interesting "snapshot" of their circumstances, other studies (Berger, 1984; Kimmel, 1977; Cruz, 2003) used a mixed method approach, which, if used in this study, would have provided greater depth to the data. The addition of qualitative methods, such as interviews, would allow for triangulation of the data and, as noted above, provide more depth. Further, longitudinal data would also allow for looking at the participants over time and perhaps exploring some causal relationships between independent and dependent variables.

Recommendations for Future Research

Studies that draw participants from a wider range of gay men would be useful in presenting the diversity of experience among gay men in later life. Underrepresented groups such as ethnic minorities, those who are less educated or less wealthy, and gay men living rural areas also need be given a voice. Future research efforts should stress greater priority and creativity in terms of finding a diverse sample. Researchers must find nontraditional places where diverse gay men gather. For ethnic minorities this may

include ethnic neighborhoods, community settings, festivals and business establishments. Researchers could make contacts with health department representatives to establish where HIV incidence as well as testing and counseling is done for given ethnic groups. Community leaders from Latino, Native American and Asian American gay constituencies could be contacted to better locate and reach out to community members. More collaboration with groups and community organizations can further broaden the scope of diverse individuals recruited for studies.

When considering rural gay men and gay men who are not "out", creative methods and new technologies could be utilized to access this group. The internet is a powerful networking tool in which gay men who are otherwise not connected to large gay communities could be accessed. Doing outreach through websites, online publications and chat rooms would open up areas that previously remained untapped.

As people live longer lives, research that contributes to further understanding of adult development, particularly to development in later life, would enrich our body of knowledge about adulthood, as well as about old age. Investigators of human development should look at the lives of gay people and incorporate their experiences into traditional models of development, expanding their utility. This notion is important because often models of development are applied to gay men as well as other marginalized groups. These models may not be appropriate to apply to individuals with different history and experiences. Gay men and other marginalized groups must be included in adult development research.

Another area of future research is in the area of mixed research modalities. This study was completely quantitative in nature, which provided significant contributions to

the knowledge of gay men and aging. By using qualitative measures with this group a level of triangulation could occur. Future research could use mixed modalities to provide an understanding, not only of trends among this group but could further assess meanings of aging, HIV/AIDS and ageism from a narrative perspective, giving voice to this population.

This study found no significant differences between HIV positive and HIV negative participants in terms of their adjustment to aging measures. This highlights the probable strong resilience and crisis competency among the HIV positive respondents. Further research could explore sources of resilience among HIV positive gay men. Answering questions about resilience and protective social factors among these individuals could feasibly inform social work interventions for newly HIV diagnosed individuals as well as others experiencing difficult adjustment to life events.

Finally, findings from this study highlight high levels of perceived ageism among the sample and a high level of accelerated aging. These findings are interesting and disturbing because they implicate a high level of prejudice in the gay community as well as creating perceived stigma about age among older gay men. Future research could look at meanings of aging and ageism as well as sources of prejudice about age among gay men of all age groups. Further, testing interventions that attempt to lower levels of ageism would be a formidable research agenda around this area of interest.

The previous paragraphs discussed a few possible areas for future research. The area of aging among gay men is a largely untapped area of study. Possibilities for research remain unexplored.

Recommendations for the Field of Social Work

The findings of this study, as well as the literature reviewed, have implications for services and programs for older LGBT seniors. In this regard, four areas, social services, health care, housing, and awareness/acceptance (Herdt et al., 1997), are discussed below.

Social Services

Many of the participants reported not utilizing agencies for LGBT people. In some cases, they reported using aging organizations of the mainstream society more often than those designed for older LGBT individuals. This may speak to the provision of inappropriate services and or a lack of services for older LGBT individuals. As such, it is fitting to establish more LGBT-specific senior centers in certain geographic locations. These centers could house accessible advocacy, referral, and case management services. Ideally, outreach activities would be provided that would include support programs for seniors who are homebound, such as friendly visitor programs and telephone support. In addition to services, the center should offer social outlets for LGBT seniors that include social/romantic and intellectual venues for seniors (Quam, 1997).

Based on some of this study's findings, social service efforts should include programs that target ageism. Such programs could include mentorship and reverse mentorship programs that include all ages of LGBT people. Intergenerational support, discussion and social groups may also address some of the ageism in the LGBT community.

This study highlighted the importance of and individual's perceptions of their emotional well-being. Programs are needed that help change individuals' perceptions of their lives including accelerated aging, perceived health and finances may facilitate better

perceived experiences among LGBT clients. These programs could include Cognitive Behavioral Therapy (CBT) to help clients reframe their experiences and realities.

Health Care

In terms of health care for LGBT seniors, it has been suggested that training be provided for healthcare providers and staff to ensure that they are aware of and open to LGBT issues. These issues include health risks specific to LGBT patients, senior sexuality, and recognition of partners and families of choice in terms of medical care and decision-making. In the area of access, communities should offer access to affordable LGBT-sensitive health care providers, as well as to preventative health care services (Herdt et al., 1997). Also, legal paperwork and contracts should be completed to help protect the rights of partners and other caregivers in healthcare settings. Power of attorney, guardianship rights and living wills are important documents to include in assisting LGBT clients.

Housing

Housing has been cited as one of the key unmet needs of LGBT seniors. Seniors need support services that will allow them to remain in their homes for as long as they can. When remaining in the home is no longer an option, LGBT seniors desire comfortable, safe, affordable, and LGBT-friendly retirement housing. Additionally, support services and resources for caregivers were cited as a desire of these seniors (Herdt et al., 1997).

Awareness and Acceptance

A major theme present among many LGBT seniors researched is a sense of being invisible in their communities. This invisibility happens in the LGBT community as well

as in the senior community and society at large (Herdt & DeVries, 2004; Berger, 1984; Cruz, 2003). It is, therefore, an important first step in providing needed services that we, as service providers, recognize that LGBT seniors exist. Additionally, service providers need to accept their experiences and appreciate their histories when providing services (Herdt et al., 1997). There is a great deal of work to be done at the community level in both mainstream aging organizations as well as agencies providing LGBT services to included older LGBT people in their service planning.

Conclusion

As discussed above, recent studies have shown that some aging gay men and lesbians face unique challenges, including limited access to gay-friendly health care, feelings of invisibility, confrontations with ageism within gay and lesbian communities, denial of hospital and nursing home visitation rights for their partners, loneliness and social isolation, internalized homophobia, and accelerated aging (Quam, 1997; Cruz, 2003). Nevertheless, some research suggests that gay men and lesbians age with the advantage of crisis competence and mastery of stigma, having weathered the trials of coming out and having developed positive self-identities within a homophobic society (Herdt & DeVries, 2004).

Unprecedented demographic changes in the United States associated with the "elder boom" are placing enormous demands on private and governmental social service agencies and health care providers. These demands are particularly acute for those attempting to address the special needs of LGBT elders, and additional research to guide their efforts is sorely needed. Agencies and policymakers are currently scrambling to

meet these special needs. The time is ripe for the development of a research agenda to address the needs of this population in the 21st century (Herdt & DeVries, 2004).

Many of the needs of older LGBT people have little to do with their sexual orientation and a great deal to do with their age. It is important not to assume that problems are necessarily tied to one's sexual orientation. LGBT clients face many of the same issues that their heterosexual counterparts do in terms of isolation and loneliness. Heterosexual seniors at least have the option to rely on the local senior center for support. LGBT older adults often have no such services available that are "gay friendly" or sensitive to their needs. For those who have not come out, this isolation becomes even more severe (Kooden, 1997).

Being cared for when ill is often an issue faced by LGBT seniors. It is estimated that one to three million gay men are parents (Patterson, 1992). No data were found on the number of gay seniors with children. In this study, 15 percent of the participants reported having children. LGBT seniors often do not have children or other family support, upon which their heterosexual counterparts can rely. This lack of an available network of younger, healthier caregivers offers challenges for aging LGBT people and their social workers.

Bereavement creates still other issues. Participants in this study reported disproportionately high levels of loss to HIV/AIDS, of friends and partners, especially among those HIV positive respondents. While the loss of a partner carries the same issues for LGBT people as for straight people, both legal and emotional barriers make the grieving process more difficult for LGBTs (Quam, 1997). Most states do not offer complete legal protection for partners of LGBT people. In many cases the partner can be

left out of decision making around hospital care, advanced directives and power of attorney. Survivor benefits are nonexistent and the federal level and in most states. There are no legal guarantees around will and inheritance for partners of LGBT people. Social workers must be aware of the unsure and unpredictable legal landscape and must help their LGBT clients to document their wishes in a clear and comprehensive manner.

There is a great deal of work that needs to be done for the aging LGBT population. At the 1995 White House Conference on Aging, the Lesbian and Gay Aging Interest Network (LGAIN) made the following recommendations to better serve gay and lesbian elders: (1) ensuring access to aging services; (2) developing health care prevention and education policies that address particular risk factors of gay and lesbian elders such as AIDS, breast cancer, and substance abuse; (3) addressing homophobia and eliminating presumption of heterosexuality among health, mental health, housing, and social services providers; and (4) eliminating legal and social barriers facing caregivers and survivors. These issues are still present a decade later. Further, many more goals must be met to appropriately provide for our LGBT seniors (Kochman, 1997).

This dissertation has continued the discussion of aging among gay men. The study highlighted that HIV status was not related to psychological adjustment to aging. This finding paints a different picture of the social impacts of HIV/AIDS in the U.S in the twenty-first century. Although still a serious and chronic illness, perceptions of living with the disease have changed. Further, the study highlights the importance of perceptions and social construction in the participants' lives and emotional well-being. Finally, the prevalence of perceived ageism and accelerated aging among this group signals a serious concern about how the LGBT community views older gay men and how

older gay men view themselves. Social workers working with this population must consider these findings when developing programs and interventions to improve the lives and experiences for the older LGBT clients.

APPENDIX A:

CONSENT FORM

HOWARD BROWN HEALTH CENTER

MICHIGAN STATE UNIVERSITY

Consent Form

Attitude and Impression Survey for Gay Men Over 50

Project Investigators: Scott Berlin, MSW and Rena Harold, PhD

A. Purpose of the Study

You are being asked to participate in a study of gay men who are over 50 years of age. The goal of the study is to assess participants' understandings and perceptions about aging. We hope to learn about coping skills that gay men possess in regard to aging. You are invited to participate in this study. Participation in this study is completely voluntary. If you decide not to participate, this will not affect your relationship with Howard Brown Health Center or Michigan State University or your receipt of services from these organizations in any way.

B. Procedures

If you decide to participate, you will complete a questionnaire that will take you approximately 30 minutes. This study consists of a one-time survey and there will be no follow-up. In this questionnaire we are asking you to reflect on thoughts and experiences about aging and related issues.

C. Eligibilty

While many men in this study will consider themselves gay, participation in the study is open to all men who have had sex with men, regardless of their sexual orientation or identity. To be in this study, you need to:

- **Be 50 years and older** -- This is defined as 50 years, 0 months, 0 days and older.
- **Identify as a man (male)** – This is based on self-identification
- **Identify as a gay man or as a man who has had sex with men** This is based on self-identification.

D. Voluntary Nature of the Study

Your decision to take part in the study is voluntary. You are free to choose not to take part in the study or to stop taking part at any time. If you choose not to take part or to stop at any time, Your decision whether or not to participate will not influence your future relations with Howard Brown Health Center or Michigan State University.

You can refrain from answering any question on the survey that you choose.

E. Risks/Discomforts

While completing the survey, you will be asked questions on topics such as HIV issues, mental/physical health status and substance use. Some people may feel uncomfortable or embarrassed by these topics. While we need to ask these questions in order to complete the study, you do not have to answer any questions that make you feel uncomfortable, that you find unacceptable, or that you feel do not apply to you.

There may be unforseeable risks associated with the study.

F. Confidentiality Statement

Everything we learn about you in the study will be confidential. If we publish the results of the study, you will not be identified in any way. Your service providers and other people working in the agency will not be given any of the information that you give us.

Your privacy will be protected to the maximum extent allowable by law (See the following section F for exceptions of confidentiality). Your name and identifier information will be kept in a locked cabinet. All study data will be labeled with unique codes assigned to each participant and kept separate from identifier information. The study code and identifying information will be joined in one list locked securely away from other study records. The information collected for the study will be archived for no longer that three (3) years at which time all documents will be shredded. The project investigators and study staff will be the only individuals who will have direct access to the participant study data and identifier information.

G. Exceptions to Confidentiality

We must make exceptions to confidentiality in some cases. We do this to help assure safety of participants and the public. According to the law our staff must report some things to proper authorities. Specifically we must report if you tell us that:

- You intend to harm yourself or others
- A child (someone under age 18) is being physically or sexually abused
- An elder or dependent adult is being physically or sexually abused.

H. Contacts and Questions

If you have questions or concerns regarding your rights as a study participant, or are dissatisfied at any time with any aspect of this study you may contact the Human Subjects Protection Administrator at Howard Brown Health Center (773-388-8880). You may also contact – anonymously if you wish- Peter Vasilenko, Ph.D., Chair of the University Committee on Research Involving Human Subjects (UCRIHS) at Michigan State University by phone: (517) 355-2180, email ucrihs@msu.edu, or regular mail: 204b Olds Hall, East Lansing, Michigan 48823.

If you have any additional questions about this study, please contact the project investigators (Scott Berlin, M.S.W., phone: 773-388-8863, email: scottb@howardbrown.org, or regular mail: 4025 N. Sheridan Road; and/or Rena Harold, Ph.D., phone: 517-432-3733, email: haroldr@msu.edu or regular mail: 254 Baker Hall, East Lansing, MI 48824

I. Financial Information
You will receive a $15 incentive upon completion of your questionnaire. This will be given to you in person or mailed to you in the event that mailed in your questionnaire.

J. Injury Statement
If you are injured while participating in the study and need medical treatment, we will refer you to get care. However, we do not pay for this treatment. Signing this form does not mean that you are giving up any legal rights to be compensated for harm that results from being in this study. For more information about this, you may contact Project Investigator, at 773-388-8863.

K. Statement of Consent
1. I have read the above information. I know I may withdraw from the study at anytime without any consequences after signing this form.

My signature indicates all of the following:

- I consent to participate in the study.
- I have asked any questions I have and they have been answered to my satisfaction.

_____
Signature of participant Date

_____
Printed Name of Participant:

_____
Street Address to Send Stipend

_____
City, State, Zip

APPENDIX B

QUESTIONNAIRE

Attitude and Impression Survey

For Men

Mental health professionals are becoming more aware of both psychological/social needs of older people, the needs of gay men. While more is known than in the past, relatively little is known about the experiences of gay men who are over 50 years old. In order to understand and more sensitively meet the needs of gay men over 50, we would like you to fill out the following questionnaire. There are no right or wrong answers.

For each question, please check/circle the correct answer or fill in the blank.

SECTION A: PERSONAL INFORMATION

1. Please enter today's date _____
   (mo./day/ year)

2. What is you date of birth? _____

3. What is your race/ethnicity. Check all that apply.
   ____African American/Black (not Hispanic)
   ____Hispanic/Latino
   ____Caribbean Islander
   ____Asian or Pacific Islander
   ____Native American
   ____White/Caucasian (not Hispanic)
   ____Other (please specify)_____

4. What is your highest educational level?
   ____Less than High School
   ____High school or equivalent
   ____Some college
   ____Associate's degree
   ____Bachelor's degree
   ____Master's degree
   ____Doctoral degree

5. What is your employment status?
   ____Employed Full-time
   ____Employed Part-time
   ____Unemployed
   ____Retired
   ____Other (Please Explain) _____

6. What is (was) your most recent (last) occupation? (Please describe what kind of work you do (did) including daily responsibilities, supervisory duties, your job title and the type of business or workplace).

7. Do you have hobbies?
   ___ Yes
   (What Types?)_____
   ____ No

8. What is your income?
   ____Below $11,000 per year
   ____$11,000 –20,999
   ____$21,000-30,999
   ____$31,000-40,999
   ____$41,000-50,999
   ____$51,000- 60,999
   ____$61,000- 70,999
   ____OVER $71,000

9. How would you characterize your financial status?
   ____ Excellent
   ____ Good
   ____ Average
   ____ Below Average
   ____ Poor

10. Do you believe you will have adequate finances to meet your current needs?
    ____ Yes
    ____ No
    ____ Maybe
    ____ Don't know

11. Do you believe you will have adequate finances to see you through the rest of your life?
    ____ Yes
    ____ No
    ____ Maybe
    ____ Don't know

12. What is your living situation?
____ Live with partner
____ Live alone
____ Live with roommate(s)
____ Live with friend(s)
____ Live with relative(s)
____ Other _____

13. What is your present relationship status?
____ In a relationship with a male
____ In a relationship with a female
____ Not in a relationship
____ Separated from a relationship with a male
____ Separated from relationship with a female
____ Widowed from a same-sex relationship
____ Widowed from a heterosexual relationship
____ Other _____ (please explain)

14. Check all of the following Lesbian, Gay, Bisexual, Transgender (LGBT) community activities that you have participated in within the past 2 months.
____ LGBT bars
____ LGBT social groups
____ LGBT service organizations
____ LGBT political organizations
____ LGBT religious organizations
____ Other (Please specify) _____

15. Have you fathered or adopted children?
____ Yes
____ No

If yes how many? _____
What are their current ages _____

IF YOU HAVE FATHERED OR ADOPTED CHILDREN ANSWER THE NEXT 3 QUESTIONS
OTHERWISE SKIP TO QUESTION 16

15a. How would you classify your emotional relationships with your children?
____ Excellent
____ Good
____ Average
____ Below Average
____ Poor

15b Do you think your children will provide care to you, if and when you may need it?
____ Yes
____ No
____ Maybe
____ Don't know
____ No children

15c Are you willing to accept help from your children, if and when you need it?

____ Yes
____ No
____ Maybe
____ Don't know

16. What is your zip code _____

17a. What is your sexual orientation

____ Gay
____ Bisexual
____ Heterosexual
____ Other _____

17b. Are you transgender?

____Yes
____ No

18. What is your HIV status?

____ HIV Positive
____ HIV Negative
____ Do not know HIV status
____ Unwilling to disclose HIV status

IF YOU ARE HIV POSITIVE PLEASE ANSWER THE NEXT 4 QUESTIONS.
OTHERWISE SKIP TO QUESTION 19

18a. What year did you first test positive for HIV? _____

18b. Have you had HIV specific blood work done in the past 12 months?

____ no
____ yes
If yes, do you know approximate levels of:
___ T-Cell Count
___ Viral Load

18c. Have you had an HIV related illness in the past 12 months?

____ no
____ yes
If yes, what illness did you have? _____

18d. Have you been hospitalized in the past 12 months with an HIV related illness.

____ no
____ yes
If yes what illness did you have? _____

Section B:

Respond to the following statements by circling the number that best describes you. Give your first response and don't spend too much time on any item.	**Often**	**Sometimes**	**Rarely**	**Never**
19. I feel in tune with people around me.	1	2	3	4
20. I lack companionship.	1	2	3	4
21. There is no one I can turn to.	1	2	3	4
22. I feel alone.	1	2	3	4
23. I feel part of a group of friends.	1	2	3	4
24. I have a lot in common with the people around me.	1	2	3	4
25. I am no longer close to anyone.	1	2	3	4
26. My interests and ideas are not shared by those around me.	1	2	3	4
27. I am an out going person.	1	2	3	4
28. There are people I feel close to.	1	2	3	4
29. I feel left out.	1	2	3	4
30. My social relationships are superficial.	1	2	3	4
31. No one really knows me well.	1	2	3	4

Respond to the following statements by circling the number that best describes you. Give your first response and don't spend too much time on any item	**Often**	**Sometimes**	**Rarely**	**Never**
32. I feel isolated from others.	1	2	3	4
33. I can find companionship when I want it.	1	2	3	4
34. There are people who really understand me.	1	2	3	4
35. I am unhappy being so withdrawn.	1	2	3	4
36. People are around me but not with me	1	2	3	4
37. There are people I can talk to.	1	2	3	4
38. There are people I can turn to.	1	2	3	4

CONTINUE ON TO THE NEXT PAGE

Respond to the following statements by circling the number that best describes you. Give your first response and don't spend too much time on any item.	**Strongly Agree**	**Moderately Agree**	**Slightly Agree**	**Neither Agree Or Disagree**	**Slightly Disagree**	**Moderately Disagree**	**Strongly Disagree**
39. Obviously effeminate gay men make me feel uncomfortable.	1	2	3	4	5	6	7
40. I prefer to have anonymous sexual partners.	1	2	3	4	5	6	7
41. It would be easier to be heterosexual.	1	2	3	4	5	6	7
42. Most of my friends are gay.	1	2	3	4	5	6	7
43. I do not feel confident about making an advance at another man.	1	2	3	4	5	6	7
44. I am comfortable in gay bars.	1	2	3	4	5	6	7
45. Social situations with gay men make me feel uncomfortable.	1	2	3	4	5	6	7
46. I don't like thinking about being gay.	1	2	3	4	5	6	7
47. When I think about other gay men, I think of negative situations.	1	2	3	4	5	6	7
48. I feel comfortable being seen in public with an obviously gay person.	1	2	3	4	5	6	7
48.I feel comfortable being gay.	1	2	3	4	5	6	7
49. Being gay is morally acceptable.	1	2	3	4	5	6	7

Respond to the following statements by circling the number that best describes you. Give your first response and don't spend too much time on any item.	**Strongly Agree**	**Moderately Agree**	**Slightly Agree**	**Neither Agree or Disagree**	**Slightly Disagree**	**Moderately Disagree**	**Strongly Disagree**
50. I am not worried about anyone finding out if I am gay.	1	2	3	4	5	6	7
51.Discrimination against gay people is still common.	1	2	3	4	5	6	7
52. Even if I could change my sexual orientation, I wouldn't.	1	2	3	4	5	6	7
53.Homosexuality is as natural as heterosexuality	1	2	3	4	5	6	7
54. I feel comfortable discussing homosexuality in a public situation.	1	2	3	4	5	6	7
55. It is important to me to control who knows about my being gay.	1	2	3	4	5	6	7
56. Being gay is not against the will of God.	1	2	3	4	5	6	7
57. Society still punishes people for being gay.	1	2	3	4	5	6	7
58. I object if an anti-gay joke is told in my presence.	1	2	3	4	5	6	7
59. I worry about becoming old and gay.	1	2	3	4	5	6	7
60. I worry about becoming unattractive.	1	2	3	4	5	6	7
61. Most people don't discriminate against gays.	1	2	3	4	5	6	7

Respond to the following statements by circling the number that best describes you. Give your first response and don't spend too much time on any item.	**definitely false**	**mostly false**	**mostly true**	**definitely true**
62. I look forward to the future	1	2	3	4
63. I might as well give up because I can't make things better for myself	1	2	3	4
64. When things are going badly, I am helped by knowing they can't stay that way forever	1	2	3	4
65. I can't imagine what life will be like in10 years.	1	2	3	4
66. I have enough time to accomplish the things I most want to do.	1	2	3	4
67. In the future, I expect to succeed in what concerns me most.	1	2	3	4
68. My future seems dark to me.	1	2	3	4
69. I expect to get more of the good things in my life than the average person.	1	2	3	4
70. I just don't get the breaks, and there's no reason to believe I will in the future.	1	2	3	4
71. My past experiences have prepared me well for my future.	1	2	3	4
72. All I can see ahead of me is unpleasantness rather than pleasantness	1	2	3	4
73. I don't expect to get what I really want.	1	2	3	4

Respond to the following statements by circling the number that best describes you. Give your first response and don't spend too much time on any item.	**definitely false**	**mostly false**	**mostly true**	**definitely true**
74. When I look ahead to the future, I expect to be happier than I am now.	1	2	3	4
75. Things just won't work out the way I want them to.	1	2	3	4
76. I have great faith in the future.	1	2	3	4
77. I never get what I want so it's foolish to want anything.	1	2	3	4
78. It is very unlikely that I will get any real satisfaction in the future.	1	2	3	4
79. The future seems vague and uncertain to me.	1	2	3	4
80. I can look forward to more good times than bad times.	1	2	3	4
81. There's no use in really trying to get something I want because I probably won't get it.	1	2	3	4

CONTINUE ON TO THE NEXT PAGE

SECTION E:

Respond to the following statements by circling the number that best describes you. Give your first response and don't spend too much time on any item.	**Very Strongly disagree**	**Strongly disagree**	**Mildly disagree**	**Neutral**	**Mildly Agree**	**Strongly Agree**	**Very Strongly Agree**
82. There is a special person around when I am in need.	1	2	3	4	5	6	7
83. There is a special person with whom I can share my joys and sorrows.	1	2	3	4	5	6	7
84. My family really tries to help me.	1	2	3	4	5	6	7
85. I get the emotional help and support I need from my family.	1	2	3	4	5	6	7
86. I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7
87. My friends really try to help me.	1	2	3	4	5	6	7
88. I can count on my friends when things go wrong.	1	2	3	4	5	6	7
89. I can talk about problems with my family	1	2	3	4	5	6	7
90. I have friends with whom I can share my joys and sorrows.	1	2	3	4	5	6	7

Respond to the following statements by circling the number that best describes you. Give your first response and don't spend too much time on any item.	**Very Strongly disagree**	**Strongly disagree**	**Mildly disagree**	**Neutral**	**Mildly Agree**	**Strongly Agree**	**Very Strongly Agree**
91. There is a special person in my life who cares about my feelings	1	2	3	4	5	6	7
92. My family is willing to help me make decisions.	1	2	3	4	5	6	7
93. I can talk about my problems with my friends.	1	2	3	4	5	6	7

CONTINUE ON TO THE NEXT PAGE

Respond to the following statements by circling the number that best describes you. Give your first response and don't spend too much time on any item.	**Definitely disagree**	**Mostly disagree**	**Neither agree nor disagree**	**Mostly agree**	**Definitely agree**
94. Before going out in public, I always notice how I look.	1	2	3	4	5
95. I am careful to buy clothes that will make me look my best.	1	2	3	4	5
96. I would pass most physical fitness tests.	1	2	3	4	5
97. It is important that I have superior physical strength.	1	2	3	4	5
98. My body is sexually appealing.	1	2	3	4	5
99. I am not involved in a regular exercise program.	1	2	3	4	5
100. I am in control of my health.	1	2	3	4	5
101. I know a lot about things that affect my physical health.	1	2	3	4	5
102. I have deliberately developed a healthy life-style.	1	2	3	4	5
103. I constantly worry about being or becoming fat.	1	2	3	4	5
104. I like my looks just the way they are.	1	2	3	4	5
105. I check my appearance in the mirror.	1	2	3	4	5
106. Before going out, I usually spend a lot of time getting ready.	1	2	3	4	5
107. My physical endurance is good.	1	2	3	4	5
108. Participating in sports is unimportant to me.	1	2	3	4	5

Section F

Respond to the following statements by circling the number that best describes you. Give your first response and don't spend too much time on any item.	**Definitely disagree**	**Mostly disagree**	**Neither agree nor disagree**	**Mostly agree**	**Definitely agree**
109. My health is a matter of unexpected ups and downs.	1	2	3	4	5
110. Good health is one of the most important things in my life.	1	2	3	4	5
111. I don't do anything that I know might threaten my health	1	2	3	4	5
112. I am very conscious of even small changes in my weight.	1	2	3	4	5
113. Most people would consider me good looking.	1	2	3	4	5
114. It is important to me that always look good.	1	2	3	4	5
115. I use very few grooming products.	1	2	3	4	5
116. I easily learn physical skills easily.	1	2	3	4	5
117. Being physically fit is not a strong priority in my life.	1	2	3	4	5
118. I do things to increase my physical strength.	1	2	3	4	5
119. I am seldom physically ill.	1	2	3	4	5
120. I take my health for granted.	1	2	3	4	5
121. I often read books that pertain to health.	1	2	3	4	5
122. I like the way I look without my clothes.	1	2	3	4	5
123. I am self-conscious if my grooming isn't right.	1	2	3	4	5

Respond to the following statements by circling the number that best describes you. Give your first response and don't spend too much time on any item.	**Definitely disagree**	**Mostly disagree**	**Neither agree nor disagree**	**Mostly agree**	**Definitely agree**
124. I usually wear whatever is handy without caring how it looks.	1	2	3	4	5
125. I do poorly in physical sports or games.	1	2	3	4	5
126. I work hard to improve my physical stamina.	1	2	3	4	5
127. From day to day, I never know how my body will feel.	1	2	3	4	5
128. If I am sick, I don't pay too much attention to my symptoms.	1	2	3	4	5
129. I make no special effort to eat a balanced and nutritious diet.	1	2	3	4	5
130. I like the way my clothes fit me.	1	2	3	4	5
131. I don't care what people think about my appearance.	1	2	3	4	5
132. I take special care with my hair grooming.	1	2	3	4	5
133. I dislike my physique.	1	2	3	4	5
134. I don't care to improve my abilities in physical activities.	1	2	3	4	5
135. I try to be physically active.	1	2	3	4	5
136. I often feel vulnerable to sickness.	1	2	3	4	5
137. I pay close attention to my body for any signs of illness.	1	2	3	4	5

Respond to the following statements by circling the number that best describes you. Give your first response and don't spend too much time on any item.	**Definitely disagree**	**Mostly disagree**	**Neither agree nor disagree**	**Mostly agree**	**Definitely agree**
138. If I'm coming down with a cold or flu, I just go on and ignore it as usual.	1	2	3	4	5
139. I am physically unattractive.	1	2	3	4	5
140. I am always trying to improve my physical appearance.	1	2	3	4	5
141. I am very well coordinated.	1	2	3	4	5
142. I know a lot about physical fitness.	1	2	3	4	5
143. I play a sport regularly throughout the year.	1	2	3	4	5
144. I am a physically healthy person.	1	2	3	4	5
145. I am very aware of small changes in my physical health.	1	2	3	4	5
146. At the first sign of illness, I seek medical advice.	1	2	3	4	5
147. I am on a weight-loss diet.	1	2	3	4	5
148. I do not actively do things to keep physically fit.	1	2	3	4	5

CONTINUE ON TO THE NEXT PAGE

FOR THE REMAINDER OF THE ITEMS IN THIS SECTION, USE THE RESPONSE SCALE GIVEN WITH THE ITEM, AND ENTER YOUR ANSWER IN THE SPACE BESIDE THE ITEM.

____149. I have tried to lose weight by fasting or going on crash diets.
1. Never
2. Rarely
3. Sometimes
4. Often
5. Very Often

____ 150. I think I am:
1. Very underweight
2. Somewhat underweight
3. Normal weight
4. Somewhat overweight
5. Very overweight

____ 151. From looking at me, most other people would think I am:
1. Very underweight
2. Somewhat underweight
3. Normal weight
4. Somewhat overweight
5. Very overweight

152-160. Use this 1-5 scale to indicate how satisfied you are with each of the following areas of your body.

1	2	3	4	5
Very dissatisfied	Mostly dissatisfied	Neither satisfied nor dissatisfied	Mostly satisfied	Very satisfied

____152. Face (facial features, complexion)

____ 153. Hair (color, thickness, texture)

____ 154. Lower torso (buttocks, hips, thighs, legs)

____ 155. Mid torso (waist, stomach)

____ 156. Upper torso (chest, shoulders arms)

____ 157. Muscle tone

____ 158. Weight

____159. Height

____ 160. Overall appearance

Respond to the following statements by circling the number that best describes you. Give your first response and don't spend too much time on any item.	**None of the Time**	**Very Rarely**	**A Little of the Time**	**Some of the Time**	**A Good Part of the Time**	**Most of the Time**	**All of the Time**
161. I feel that people would NOT like me if they really knew me well.	1	2	3	4	5	6	7
162. I feel that others do things much better than I do.	1	2	3	4	5	6	7
163. I feel that I am an attractive person.	1	2	3	4	5	6	7
164. I feel confident in my ability to deal with other people.	1	2	3	4	5	6	7
165. I feel that I am likely to fail at things I do.	1	2	3	4	5	6	7
166. I feel that people really like to talk with me.	1	2	3	4	5	6	7
167. I feel that I am a very competent person.	1	2	3	4	5	6	7
168. When I am with other people I feel that they are glad I am with them.	1	2	3	4	5	6	7
169. I feel that I make a good impression on others.	1	2	3	4	5	6	7
170. I feel confident that I can begin new relationships if I want to.	1	2	3	4	5	6	7
171. I feel that I am ugly.	1	2	3	4	5	6	7
172. I feel that I am a boring person.	1	2	3	4	5	6	7

Respond to the following statements by circling the number that best describes you. Give your first response and don't spend too much time on any item.	**None of the Time**	**Very Rarely**	**A Little of the Time**	**Some of the Time**	**A Good Part of the Time**	**Most of the Time**	**All of the Time**
173. I feel very nervous when I am with strangers.	1	2	3	4	5	6	7
174. I feel confident in my ability to learn new things.	1	2	3	4	5	6	7
175. I feel good about myself.	1	2	3	4	5	6	7
176. I feel ashamed about myself.	1	2	3	4	5	6	7
177. I feel that if I could be more like other people then I would feel *better* about myself.	1	2	3	4	5	6	7
178. I feel that I get pushed around more than others.	1	2	3	4	5	6	7
179. I feel that people like me.	1	2	3	4	5	6	7
180. I feel that people have a good time when they are with me.	1	2	3	4	5	6	7
181. I feel confident that I can do well in whatever I do.	1	2	3	4	5	6	7
182. I trust the competence of others more than I trust my own abilities.	1	2	3	4	5	6	7
183. I feel that I mess things up.	1	2	3	4	5	6	7
184. I wish that I were someone else.	1	2	3	4	5	6	7

SECTION H:

185. In general, would you say your health is:
____Excellent
____Very Good
____Good
____Fair
____Poor

186. Compared to one year ago, how would you rate your health?
____Much better now than 1 year ago
____Somewhat better now than 1 year ago
____About the same as 1 year ago
____Somewhat worse than 1 year ago
____Much worse better now than 1 year ago

187. How many hours per day do you generally sleep? _____

188. Do you take regular naps?
___ Yes
___ No

During the *past 4 weeks*, have you had any of the following problems with your work or other regular daily activities *as a result of your physical health?*	Yes	No
189. Cut down the amount of time you spent on work or other activities.	1	2
190. Accomplished less than you would like.	1	2
191. Were limited in the kind of work or other activities.	1	2
192. Had difficulty performing the work or other activities.	1	2

CONTINUE ON TO THE NEXT PAGE

SECTION I:

Respond to the following statements by circling the number that best describes you. Give your first response and don't spend too much time on any item.	**Often**	**Sometimes**	**Rarely**	**Never**
193. During the past week, I was bothered by things that usually don't bother me.	1	2	3	4
194. During the past week, I did not feel like eating; my appetite was poor.	1	2	3	4
195. During the past week, I felt like I could not shake off the blues even with the help from family and friends.	1	2	3	4
196. During the past week, I felt that I was just as good as other people.	1	2	3	4
197. During the past week, I had trouble keeping my mind on what I was doing.	1	2	3	4
198. During the past week, I felt depressed.	1	2	3	4
199. During the past week, I felt that everything I did was an effort.	1	2	3	4
200. During the past week, I felt hopeful about the future.	1	2	3	4
201. During the past week, I thought my life had been a failure.	1	2	3	4
202. During the past week, I felt fearful.	1	2	3	4
203. During the past week, my sleep was restless.	1	2	3	4
204. During the past week, I was happy.	1	2	3	4

Respond to the following statements by circling the number that best describes you. Give your first response and don't spend too much time on any item.	**Often**	**Sometimes**	**Rarely**	**Never**
205. During the past week, I talked less than usual.	1	2	3	4
206. During the past week, I felt lonely.	1	2	3	4
207. During the past week, people were unfriendly.	1	2	3	4
208. During the past week, I enjoyed life.	1	2	3	4
209. During the past week, I had crying spells.	1	2	3	4
210. During the past week, I felt sad.	1	2	3	4
211. During the past week, I felt that people disliked me.	1	2	3	4
212. During the past week, I could not "get going."	1	2	3	4

CONTINUE ON TO THE NEXT PAGE

SECTION J:

Respond to the following statements by circling the number that best describes you. Give your first response and don't spend too much time on any item.	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**
213. As I grow older, things seem better than I thought they would be.	1	2	3	4
214. I have gotten more breaks in life than most of the people I know.	1	2	3	4
215. This is the dreariest time in my life.	1	2	3	4
216. I am just as happy as when I was younger.	1	2	3	4
217. My life could be happier than it is now.	1	2	3	4
218. These are the best years of my life	1	2	3	4
219. Most of the things I do are boring and monotonous.	1	2	3	4
220. I expect some interesting and pleasant things to happen to me in the near future.	1	2	3	4
221. The things I do are as interesting to me now as they ever were.	1	2	3	4
222. I feel old and somewhat tired.	1	2	3	4
223. I feel my age but it does not bother me.	1	2	3	4
224. As I look back on my life, I am fairly well satisfied.	1	2	3	4
225. I would not change past life even if I could.	1	2	3	4

Respond to the following statements by circling the number that best describes you. Give your first response and don't spend too much time on any item.	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**
226. Compared to other people my age, I have made a lot of foolish decisions in my life.	1	2	3	4
227. Compared to other people my age, I make a good appearance.	1	2	3	4
228. I have made plans for things I'll be doing a month or a year from now.	1	2	3	4
229. When I think back over my life, I didn't get most of the important things I wanted.	1	2	3	4
230. Compared to other people, I get down in the dumps too often.	1	2	3	4
231. I've gotten pretty much what I expected out of life.	1	2	3	4
232. In spite of what people say, the lot of the average person is getting worse, not better.	1	2	3	4

CONTINUE ON TO THE NEXT PAGE

SECTION K:

CHECK THE ANSWER THAT BEST APPLIES TO YOU

233. Does the thought of growing old occur to you?

____Never
____Very infrequently
____Sometimes
____ Often
____Constantly

234. Do you worry about growing old?

___Never
___Very infrequently
___Sometimes
___Often
___Constantly

235. Does the thought of dying occur to you?

___Never
___Very infrequently
___Sometimes
___Often
___Constantly

236. Do you worry about dying?

___Never
___Very infrequently
___Sometimes
___Often
___Constantly

237. How much has HIV/AIDS had an impact on your outlook about getting older?

___Not at all
___A little
___Some
___A great deal

238. How has HIV/AIDS impacted your outlook about getting older?

___Positively
___Negatively

___Neither positively or negatively
___Not at all

239. At what age do you consider a person as being "old? _____

240. At what age do you consider a gay man as being "old"? _____

241. About how many people have you known whom have died from HIV/AIDS?_____

242. How many of your close friends or relatives have died from HIV/AIDS?____

243. How many of your partners have died from HIV/AIDS?_____

244. Most young gay men think that older gay men are pretty dull.

____Strongly Disagree
____Disagree
____Agree
____Strongly Agree

245. In the gay/lesbian community most young people do not want to make friends with an older lesbian/ gay person.

____Strongly Disagree
____Disagree
____Agree
____Strongly Agree

246. There is a lot of ageism in the gay/lesbian community.

____Strongly Disagree
____Disagree
____Agree
____Strongly Agree

247..Do you currently participate in Gay/Lesbian organizations?

____Yes
____No

248. Do you receive social services provided for older Gay/Lesbian adults.

___Yes
___No

249. Do you receive social services provided the general population of older adults?

___Yes
___No

250. What age are most of your friends?

___50 and older
___30-40
___30 and younger

251. Until what age do you think you will live to be? ____

CONTINUE TO THE NEXT PAGE

Section L:

Respond to the following statements by circling the number that best describes you. Give your first response and don't spend too much time on any item.	Very Strongly disagree	Strongly disagree	Mildly disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree
252. When I make plans I follow through with them.	1	2	3	4	5	6	7
253. I usually manage one way or another.	1	2	3	4	5	6	7
254. I am able to depend on myself more than anyone else.	1	2	3	4	5	6	7
255. Keeping interested in things is important to me.	1	2	3	4	5	6	7
256. I can be on my own if I have to.	1	2	3	4	5	6	7
257. I feel proud that I have accomplished things in my life.	1	2	3	4	5	6	7
258. I usually take things in stride.	1	2	3	4	5	6	7
259. I am friends with myself.	1	2	3	4	5	6	7
260. I feel I can handle many things at a time.	1	2	3	4	5	6	7
261. I am determined.	1	2	3	4	5	6	7
262. I seldom wonder what the point of it all is.	1	2	3	4	5	6	7
263. I take things one day at a time.	1	2	3	4	5	6	7

Respond to the following statements by circling the number that best describes you. Give your first response and don't spend too much time on any item.	**Very Strongly disagree**	**Strongly disagree**	**Mildly disagree**	**Neutral**	**Mildly Agree**	**Strongly Agree**	**Very Strongly Agree**
264. I can get through tough times because I've experienced difficulty before.	1	2	3	4	5	6	7
265. I have self-discipline. I keep interested in things.	1	2	3	4	5	6	7
266. I can usually find something to laugh about.	1	2	3	4	5	6	7
267. My belief in myself gets me through hard times.	1	2	3	4	5	6	7
268. In an emergency, I'm someone people can generally rely on.	1	2	3	4	5	6	7
269. I can usually look at a situation in a number of ways.	1	2	3	4	5	6	7
270. Sometimes I make myself do things whether I want to or not.	1	2	3	4	5	6	7
271. My life has meaning.	1	2	3	4	5	6	7
272. I do not dwell on things that I can't do anything about.	1	2	3	4	5	6	7
273. When I'm in a difficult situation, I can usually find my way out of it.	1	2	3	4	5	6	7
274. I have enough energy to do what I have to do.	1	2	3	4	5	6	7
275. It's okay if there are people who don't like me.	1	2	3	4	5	6	7

Section M:

Respond to the following statements by circling the number that best describes you. Give your first response and don't spend too much time on any item.	**Almost always True**	**Often Is True**	**Sometimes True**	**Seldom True**	**Almost Never True**
276. I get embarrassed when someone begins to tell me personal things.	1	2	3	4	5
277. I am warm and friendly.	1	2	3	4	5
278. It's important to me to be completely open with my friends.	1	2	3	4	5
279. I keep what I really think and feel to myself.	1	2	3	4	5
280. I think it's crazy to get too involved with people.	1	2	3	4	5
281. I care deeply for others.	1	2	3	4	5
282. I'm basically a loner.	1	2	3	4	5
283. I have (have had) a close physical and emotional relationship with another person.	1	2	3	4	5
284. I prefer not to show too much of myself to others.	1	2	3	4	5
285. I find it easy to make close friends.	1	2	3	4	5
286. I feel that I have left my mark on the world through my influence on others.	1	2	3	4	5
287. I spend a great deal of time thinking about myself.	1	2	3	4	5
288. I have a sense that there is a purpose in my life.	1	2	3	4	5

Respond to the following statements by circling the number that best describes you. Give your first response and don't spend too much time on any item.	**Almost always True**	**Often Is True**	**Sometimes True**	**Seldom True**	**Almost Never True**
289. I feel inadequate in my interactions with others.	1	2	3	4	5
290. It's important to me to feel that I have made a contribution in life.	1	2	3	4	5
291. I have difficulty relating to people different than me.	1	2	3	4	5
292. I have discovered no mission or purpose in life.	1	2	3	4	5
293. I worry how others perceive me.	1	2	3	4	5
294. It's more important to work on behalf of those I care about than to work just for myself.	1	2	3	4	5
295. I am proud of what I have accomplished in my life.	1	2	3	4	5
296. As I look over my life, I feel the need to make up for lost time.	1	2	3	4	5
297. I feel that I have the wisdom an experience to be a help to others.	1	2	3	4	5
298. I have many regrets about what I might have become.	1	2	3	4	5
299. I am afraid of growing old.	1	2	3	4	5
300. My achievements and failures are largely a consequence of my own actions.	1	2	3	4	5
301. There's a lot about my life that I am sorry about.	1	2	3	4	5

Respond to the following statements by circling the number that best describes you. Give your first response and don't spend too much time on any item.	**Almost always True**	**Often Is True**	**Sometimes True**	**Seldom True**	**Almost Never True**
302. I am disgusted by other people.	1	2	3	4	5
303. I feel at peace with myself.	1	2	3	4	5
304. If I could live my life over, there is little I would change.	1	2	3	4	5
305. As I look back over my life, I realize my parents did the best they could do for me.	1	2	3	4	5

306. Are there any additional comments you would like to add to this questionnaire?

THANK YOU FOR YOUR PARTICIPATION!

APPENDIX C

HUMAN SUBJECTS APPROVAL

MICHIGAN STATE
UNIVERSITY

Renewal Application Approval

February 6, 2007

To: Rena HAROLD
232 Baker Hall

Re: **IRB # 05-184** Category: EXPEDITED 2-8
Renewal Approval Date: **February 5, 2007**
Project Expiration Date: **February 4, 2008**

Title: ATTITUDES AND IMPRESSIONS OF GAY MEN AND MEN WHO HAVE SEX WITH MEN OVER 50 YEARS OF AGE

The Institutional Review Board has completed their review of your project. I am pleased to advise you that **the renewal has been approved.**

This protocol has been bumped down to 2-8 expedited.

This letter notes approval for data analysis only (contact with subjects and data collection is complete). Any further recruitment, data collection or contact with subjects will require IRB review and approval via a revision before implementation.

The review by the committee has found that your renewal is consistent with the continued protection of the rights and welfare of human subjects, and meets the requirements of MSU's Federal Wide Assurance and the Federal Guidelines (45 CFR 46 and 21 CFR Part 50). The protection of human subjects in research is a partnership between the IRB and the investigators. We look forward to working with you as we both fulfill our responsibilities.

Renewals: IRB approval is valid until the expiration date listed above. If you are continuing your project, you must submit an ***Application for Renewal*** application at least one month before expiration. If the project is completed, please submit an ***Application for Permanent Closure.***

Revisions: The IRB must review any changes in the project, prior to initiation of the change. Please submit an ***Application for Revision*** to have your changes reviewed. If changes are made at the time of renewal, please include an ***Application for Revision*** with the renewal application.

Problems: If issues should arise during the conduct of the research, such as unanticipated problems, adverse events, or any problem that may increase the risk to the human subjects, notify the IRB office promptly. Forms are available to report these issues.

Please use the IRB number listed above on any forms submitted which relate to this project, or on any correspondence with the IRB office.

Good luck in your research. If we can be of further assistance, please contact us at 517-355-2180 or via email at IRB@msu.edu. Thank you for your cooperation.

Sincerely,

Peter Vasilenko, Ph.D.
SIRB Chair

c: Scott Berlin

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