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# Aging Gay Men: An Examination of the Life Satisfaction and Well-Being between Younger and Older Gay Males

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## Abstract

Very little research exists on the process of aging among gay men. The number of men self-identifying as gay over the age of 65 will be close to a million and a half by 2030. However, what is known about how these men have aged, what they experience, and will experience is mostly unknown. This study examined the relationship among internalized homophobia, life satisfaction, and attitudes toward aging in 209 gay men between the ages of 18 to 77 (M = 42.86; SD = 14.83). Participants completed online versions of the Internalized Homophobia Scale, Satisfaction with Life Scale, and the Aging Attitudes toward Gay Men Scale, which was constructed for this study. The Aging Attitudes scale consisted of two vignettes that differed only in the age of the character (25 or 65 years), and 10 questions designed to evaluate the well-being of the character. Covariates were identified for the scales, and the scores for each scale were found to be normally distributed. As expected, a significant one-tailed partial correlation between internalized homophobia and age emerged. Contrary to expectation, the 156 White/Caucasians had a significantly higher internalized homophobia score than the 50 non-White/Caucasians. Consistent with the expectation that the participants would exhibit some ageist attitudes, the 25-year-old vignette was rated significantly more positively than the 65-year-old vignette. As hypothesized, both vignettes of the Aging Attitudes scale showed significant positive partial correlations with satisfaction with life, but the expected negative correlation between the Aging Attitudes scale and internalized homophobia did not emerge. This study is one of the first in the literature to examine attitudes about aging among gay men, and describe how those attitudes are associated with their level of life satisfaction, but not their level of internalized homophobia. The clinical implications are wide as it is important to understand the challenges of aging that gay men experience throughout their development. The finding that gay men can have a high level of internalized homophobia and still acknowledge a generally satisfactory attitude toward aging deserves further exploration.



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# CHAPTER I

# Literature Review

## Introduction

The field of gerontology is less than 75 years old. The Gerontological Society of America was founded in 1945 (https://www.geron.org/) [1]. This creation seemed to foresee the Baby Boomer generation, which is defined by those born between 1946 and 1964. Baby Boomers started turning 65 as of January 1, 2011, and, as of that date, approximately 10,000 Boomers began hitting that age each day [2]. By 2030, it is expected that 20 percent of all Americans will be age 65 years or older [3]. It is clear in our society— where life expectancy has risen dramatically over the last century [4]—that addressing the needs of the aging population is paramount.

For one group, however, this demand falls far short in the literature. The older members of the Lesbian, Gay, Bisexual, and Transgender (LGBT) population have received relatively little attention. It has been shown that not only are the needs distinctive and varying for the LGBT community, but there is a lack of empirical research on specific desires and concerns for older LGBT adults [5]. Unfortunately, the lack of research, empirical or otherwise, will become a constant refrain in this review. One example of neglect is reflected in health disparities for LGBT adults, which will be discussed in the next section. Health disparities for LGBT adults were recognized by the U.S. Department of Health and Human Services in 2011 as significant [5]. By extension, it is expected that the health disparities for older LGBT adults are at least as concerning. Other forms of discrimination and oppression, such as workplace and housing discrimination, are also problematic for the LGBT community.

Strong statements by researchers reflect the lack of attention paid to aging LGBT adults. Price [6] described older gay men and lesbians as "all but invisible" (p.16). Price argued that few studies looked at research and realities of older LGBT individuals. Blando [7] referred to older gay men and lesbians as being "twice hidden" (p. 87), meaning that gays and lesbians are already an unseen minority group, and aging makes them doubly so. Thus while the information on the LGBT population is limited, what is shown proves to be negative and in need of change.

### Statement of the Problem

The current study was designed to promote our scientific understanding of attitudes toward aging, specifically within gay men. Returning to the statistic that by 2030, one in five Americans will be age 65 years of age or older, it is estimated that 4 million of that number will self-identify as gay or lesbian. Even by a conservative estimate, that would result in 1.2 to 1.4 million older gay men [8]. We know that both homophobia and ageism negatively impact the investigation of how older gay men age, and both forces will be discussed in the next section. The current study explored attitudes toward health and wellness among gay men by examining their reactions to two versions of a vignette describing "Topher," a gay man who has some mild to moderate struggles with relationships, health, employment, and his general outlook on life. In one version, Topher is 25 years old, and in the other he is 65 years old. Gay male participants were asked various questions about Topher, and their attitudes toward him were expected to differ based on the age they believe him to be. The nature of potentially ageist attitudes toward the vignette character were expected to vary according to different characteristics of the participants, such as their own internalized homophobia and satisfaction with life.

The goal of the current study is to identify differences in attitudes toward the well-being of younger and older gay men among a diverse sample of gay men, with the hope that the results will enrich the scientific literature on aging in gay men. The results of the current study are also expected to inform clinical practice by helping clinicians appreciate the wide array of attitudes toward aging among their gay male clients. This can aid clinicians in treating different clients based on how they might see themselves as they age.

### Review of the Literature

The following sections offer an overview of the literature that guided the development of this study. The following literature review sets the foundation for the need to investigate the attitudes and beliefs that gay men have toward the aging process among those in their community.

The first ever of its kind—a federal study on LGBT health and aging—was done in 2011. It was called the Caring and Aging with Pride (CAP) study (http://caringandaging.org). Using a database of 2,560 LGBT adults (ages 50-95) from 11 U.S. community-based aging agencies, the study highlighted some unfortunate truths, as well as underscored the need for further research on this population [9]. For example,


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CAP found that 82% of the sample had experienced at least one incident of discrimination or victimization due to their sexual orientation; over 60% of the sample reported three or more such incidents [10]. Fredriksen-Goldsen et al. [11] found that roughly 30% of LGBT individuals were at 200% of the poverty level or below. It was also found that some of the aging LGBT population had higher chronic conditions on average than their heterosexual counterparts, including high blood pressure and HIV [11].

In addition to the health disparities, the CAP study found discrepancies in access to health care [11]. About 13% of the older gay adults reported being denied health care, and 15% feared finding health care that was outside the LGBT community [11]. Finally, the researchers called for further research on older LGBT adults.

Other researchers have found findings similar to those of CAP. Conron, Mimiaga, and Landers [12] discovered that a variable to consider when looking at some of the poor physical and mental health among LGBT older adults is their lack of access to aging health services and care. Discrimination based on a person's age and/or sexual orientation can impede an LGBT person's access to care and perhaps lower their ability to obtain adequate health care [13]. Finally many older LGBT adults will participate less in modern geriatric care because they anticipate homophobic and discriminatory practices among staff and administrators [14]. These reports cement the negative picture associated with growing older as an LGBT person.

Besides mental and physical issues, financial strife has been shown in the research as well. A pilot study conducted by McFarland and Sanders [15] with 59 participants found that 51% of those reporting, ages 49 to 86, identified a lack of financial resources for meeting their aging needs. Crisp, Wayland, and Gordon [16] reviewed literature on the financial status of older gay and lesbian adults. They found that 7% reported housing discrimination. Such findings underscore the precarious situations that threaten the well-being of older LGBT adults.

It has been shown that it is inappropriate to take principles based on the dominant group—heterosexuals—and apply them to the more nuanced minority of homosexuals. Depending on when, why and how aging gay adults have come to terms with their sexuality provides varying and unique risks that are different from those faced by aging heterosexual adults [11]. These are sexual orientation-based issues to which only LGBT people are subjected. In a *New York Times* article online, Gross [17] found that older gay adults who receive out-of-home care or in-home care report being "disrespected, shunned, or mistreated in ways that range from hurtful to deadly" (http://www.nytimes.com/2007/10/09/us).

In fact, Gross [17] described the case of an openly gay 79 year-old man who had to be moved off his floor of his peers due to complaints by other residents about his being the sole out gay person. After being placed in a unit with residents with serious physical and cognitive limitations, the man hung himself. Homophobia and discrimination are often faced throughout the aging care system, and these burdens differentiate older sexual minority adults from their heterosexual counterparts [16]. Tolley and Ranzijn [18] described the perils of *heteronormativity,* or "the general, often silent, assumption and acceptance of heterosexuality as normal" (p. 211).

Given the long history of discrimination and oppression, many older LGBT adults view their past as negative. Homophobia and heterosexism have shaped many aspects of older LGBT adults' life. These mostly negative experiences have adversely affected gay individuals' willingness to share their authentic selves, may have cause strained relations with family, along with the limited resources regarding health, legal, financial and housing that were described earlier [19].

Loneliness is a major theme for LGBT individuals. For Baby Boomers, AIDS has contributed to the loss of friendships and relationships within the survivor's support network. Finally, LGBT individuals can find it difficult to share interests and supportive activities in the broader community where they live [20]. D'Augelli, Grossman, Hershberger, and O'Connell [21] reported on the general well-being of a sample of 416 older GLB adults ages 60 to 91 years who attended social and recreational programs. With respect to social rejection, the authors found that incidents of verbal abuse were reported by 63% of the recreational attendees, and threats of violence due to their being gay were reported by 29% [21].

To summarize, the information on the growing aging population is relatively limited.

The knowledge concerning the growing LGBT population is even smaller. Yet, two conclusions are clear: (1) it is inaccurate and unfair to apply information about the dominant group to minority group, as the issues that LGBT people face are typically more complex than those faced by heterosexuals, and (2) serious improvements need to be made to improve the quality of life for those growing older as an LGBT person in this country.

Clearly, many studies have shown that the need to address the growing LGBT population and its unique issues is paramount. However, the LGBT acronym consists of four separate subcultures; each group needs investigations of its


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own. Generalizations about the totality of LGBT people do not necessarily apply to each subgroup.

In the earlier literature on gay aging it was assumed that being homosexual made gay men and women more alike than did their being male or female. Quam and Whitford [22], for example, grouped 39 females and 41 males over the age of 50 into one group. This study was conducted at a time when the literature on gay men and lesbians was not only very limited but also still in line with the notion that being gay meant one was depressed and negative. Quam and Whitford [22] attempted to dispel that notion. However, what was discovered was that there were significant differences between lesbians and gay men in a wide array of life variables: living situations, housing, friendship, community participation, and interest in LGBT organizations.

As a result of this discovery, Quam and Whitford [22] argued that critical information is lost if differences in the gay male versus lesbian population are not acknowledged. They proposed that the differences between gay men and lesbians are significant enough that they should not be put together into one investigative cohort. This finding was reiterated by D'Augelli, et al. [21]: "Compared to [lesbian] women, [gay] men reported significantly more internalized homophobia, alcohol abuse, and suicidality related to their sexual orientation" (p. 149).

Similarly, another recent study noted that older gay men self-reported higher levels of discrimination and internalized stigma than older lesbians [9,10].

Such findings demonstrate that just as research on heterosexuals should not be applied to homosexuals, studies on lesbians should not be applied to gay men, or vice versa.

For the purposes of this literature review, the *G*, gay men, will be the focus. However, if there is a dearth of literature for LGBT aging as a group, there are even fewer investigations of aging gay men specifically: A total of 124 articles were published between 1975 and 2011 [8]. Moreover, articles even from 20 years ago are already becoming outdated by the huge transformation the country has seen in shifting of gay rights, coming out earlier, and HIV/AIDS longevity.

**A Look Backward: Where we've Been**

The year 1969 is considered a watershed in the creation of the gay right's movement [24]. It was the night of Judy Garland's memorial in New York City when a police raid at a local West Village Bar, the Stonewall Inn, became the scene of a riot [25]. Ms. Garland was beloved by the gay male community for her legendary performance in *The Wizard of Oz*. Many a gay man identified with a kid from Kansas who was thrust into a Technicolor world where dreams could magically materialize [25]. What was supposed to be a night of mourning and celebration for an icon became a riot when the patrons of Stonewall Inn fought back against the police raid. Before that night, homosexuality was pathology; after that evening, it became a group identity [26]. Thus, 1969 and the term *Stonewall* are considered by most to be the start of the gay rights movement.

A few years later, another milestone came in 1973, when the American Psychiatric Association removed homosexuality as a diagnosis from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), thus removing the stigma of mental illness from homosexuality [27]. The group identity formed from the Stonewall riots was moving forward toward a legitimate, positive force.

Despite the removal of homosexuality from the DSM as a mental disorder, a myth about what being an aging gay man meant still resonated as *self-loathing* among many gay men themselves. Tim Bergling in his book, *Reeling in the Years: Gay Men's Perspectives on Age and Ageism* [28], illustrated this point by a quote from an interview of a young gay man on the aging process:

I never knew his name. He lived somewhere on the floor above us, rather anonymously…I only know a few things about him. He wore too many rings. He liked cats and Mozart. He was gentle-mannered and fastidious, and he scared me half to death. That was because he was everything I was afraid I was going to be: an 'auntie.' (p. 25)

The stereotype of a gay man, especially an aging one, was fraught with fear and negativity. The idea of being effeminate and aging alone was deemed very negative and still continues on to this day.

In 1982, a seminal book on aging gay men was released, which changed how growing older was perceived. This book, entitled *Gay and Gray: The Older Homosexual Man*, was written by Raymond M Berger [29]. According to Bergling [28], this book "was notable in that it was one of the first widely distributed research reports to suggest that older gay men might not be the lonely and self-tortured lot described by earlier writers on homosexuality" (p. 1). The book was revolutionary because it offered a different prism through which to view aging gay men. It helped to start the movement of research that dismantled all the negative stereotypes on homosexuality. It helped to highlight the positive aspects of being homosexual and, more specifically, an aging gay male. Finally, it suggested that aging as a gay man did not have to entail maladjustment, as had previously assumed [30].

Unfortunately, something far more serious replaced the


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myth of the dreaded *auntie*. A year before Berger's book was released, a mysterious and deadly disease called Gay-Related Immune Deficiency (GRID) was identified. It caused healthy gay men to die in awful ways that were stigmatized and discriminatory [24]. GRID became known as AIDS and it was not until 1996 that a diagnosis of HIV (the virus that is believed to cause the disease) was considered manageable and not a death sentence [24]. A few years later, the U.S. Supreme Court ruled in 2003 that consensual homosexual behavior in private was not a crime [24]. It had not even been 15 years since being homosexual was no longer a mental illness: Now being gay was no longer a violation of the law. However, AIDS was still largely known as a gay disease.

By 2015, 1.2 million Americans will be living with HIV, of which 50% will be 50 and over [31]. A report by Brown, Alley, Sarosy, Quarto, and Cook [32] presented findings from four ethnographic studies of older gay men. There were a total of 69 participants ranging in age from 36 to 79 years, most of whom were 50 to 65 years of age. The study's purpose to ascertain how these gay men had adjusted both psychologically and socially to being gay and aging [32]. One outcome from the report was that participants felt HIV/AIDS "has had a devastating impact on older gay men, interrupting the normal aging process for those who have contracted it and prematurely aging those who care for them" (p. 42). The AIDS epidemic is a crucial aspect in understanding the aging process for gay men. Here was a marginalized, stigmatized group that was beginning to move from a negative status to an optimistic one when it was hit with an epidemic that still has no cure.

According to Brown, et al. [32], HIV/AIDS left none of these men untouched, whether it was losing a friend, loved one, or acquaintance to AIDS. They also reported that for all of their 69 participants, HIV/AIDS disrupted the normal aging process. It prematurely aged the caregivers for those with AIDS, as well as those afflicted with the disease. This created a unique issue that affects both the gay and straight populations, specifically, the awareness of how living with HIV/AIDS affects the aging process, both for those infected and those affected (the care-takers). Studying these variables are outside the scope of the current study. Yet, for future research, studying how being HIV-positive or having AIDS affects the aging process for any population seems valid and timely.

The AIDS epidemic contributed to the further isolation of many gay men and resulted in primary care coming mostly from friends and partners [33]. A study, cited by Fenkl [5], underscored how many domains in an individual's life that an HIV or AIDS diagnosis affected, e.g., identity development, social support, health, psychosocial adjustment to aging, aging-related community needs [34]. Being a gay male living with HIV/AIDS is filled with discrimination that can affect the normal aging process.

In addition to HIV/AIDS, growing older for gay men has been shown to have negative social consequences. In a MetLife study of LGBT aging, almost half of the 1,200 sample of respondents stated that being gay made aging more difficult [35]. *Outing Age* (as cited by Bergling, [28]) reported a first-ever of its kind analysis by the National Gay and Lesbian Task Force's Aging Initiative that surveyed aging gay men and the issues that they faced. In New York City, two-thirds of older gay men lived alone, while in Los Angeles that number was closer to 75% [28]. Further, the study reviewed economic issues and found that senior gay men are more likely to face economic uncertainty than their heterosexual counterparts, and that living alone typically equates more with poverty than not [28].

Gay men are twice more likely to be single and live alone than their heterosexual peers. They are four times more likely to have no children which can often offer significant elements of comfort and care in later life for parents. Finally, gay men are less likely to have access to adequate health care and social care services due to the fear of discrimination and need to hide their sexual orientation [36].

No discussion of gay men would be complete without talking about homophobia. It's an obstacle all gay men, especially older gay men, face. The U.S. Department of Health and Human Services' Administration on Aging (AOA) suggests that older gay seniors face the *double whammy* of dual discrimination of both ageism and homophobia [28]. They therefore may not seek assistance that usually accommodates older people. The AOA also suggest that these gay individuals came of age before Stonewall and before a time when being gay was beginning to be accepted in society. These individuals may still be deeply closeted or only have a few close confidants [28].

**Youth and the Aging Process**

Since the advent of the gay rights movement, the gay community has been hit with many pros and some devastating cons. Maybe not surprising is the idea that youth and beauty seemed to be the pinnacle when looking at the results of the few studies done on gay men during this time. As if a prophecy when he wrote his novel, *The Picture of Dorian Gray*, Oscar Wilde seemed to know that generations of gay men would hope the picture would grow old, fade and die—not themselves.

Maybe in part because of what was happening within the community due to the ravages of AIDS or maybe because our culture celebrates youth so much, the aging gay man is



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highly drawn to staying young. Pela [37] reiterates the theme of *Dorian Gray* about gay culture: "growing old is a gay man's nightmare. Somewhere, somehow, someone told us that the moment we turn 40, the world as we know it will end" (p. 268). The quest to stay young is still with the aging gay male; it's a reference back to the *auntie* that was described earlier. Scott Capurro, an American gay comedian, has a funny, albeit unfortunate, joke that still resonates: "Thirty equals eighty in gay years" (p. 163) [38]. Again, whatever the rationale, staying young as a gay man has been found to be an imperative. Gay male culture overvalues youth and good looks.

It is a powerful internal reality of gay men that shapes their inner lives. And, as they age, they become more invisible and feel that the less they exist [38]. This desire to stay young can even have a life or death consequence.

In his book, *The Velvet Rage* [39], Alan Downs found that some gay men assume that aging means no sex. Simply put, they would rather be dead than old. He showed some attention- grabbing research that a sizeable minority of younger men would rather die young than get older; hence, they practiced unprotected, high-risk sexual acts.

This focus on youth is called *ageism*. Ageist attitudes elevate youth with privilege, while minimizing and overlooking those who are getting older [16]. Due to this emphasis on youth, gay men consider themselves middle aged and elderly at a younger age than their heterosexual counterparts [40]. In fact, ageism is so powerful that a phrase for it has been defined in the gay male community: *accelerated aging*. Some men define themselves as being washed up with no hope for the future by their mid-40s [40]. Combining Bennett and Thompson's [40] work with Down's *Velvet Rage*, there appears to be a dangerous paradigm in the gay community in relation to a young gay male's perceived movement through adult life. Yet, it has been suggested that accelerated aging may play a survival role, too.

Having an accelerated feeling about aging may prompt many older gay men to develop skills to prepare for their future [41]. Having anticipated the possible discrimination they will face, many gay men (and lesbians) are better prepared for variables like employment, housing, health care and long-term care as they get older [22]. For some, then, the prospects of aging can be adaptive and cause men to focus more thoughtfully on their future.

In a meta-analysis done by Fredriksen-Goldsen and Muraco [30], 58 articles on LGBT aging published between 1984 and 2008 were reviewed. The researchers were attempting to summarize the existing knowledge from the 58 studies in order to guide future research on aging. As has been noted earlier, the first and most common stereotype was that aging was a lonely and negative experience. However, these beliefs were discovered to be unfounded by the meta-analysis review of the literature [30].

Bergling [28] found this also to be the case in his research. Asked if they were "happy" with their ages, gay men within every age group, from young to old, responded positively; and many of those 40 and above responded quite enthusiastically. It was a novel idea that being over 40 and happy could be possible. Unfortunately, some gay men still see 40 as delineation between life and death. One explanation is that the zeitgeist for American culture is youth-based and gay men don't escape that message. Another possible explanation is that HIV/AIDS made a very strong impact on the process of earlier aging issues for those afflicted with the disease and then the caretaking of these individuals by HIV-negative gay men.

One interesting concept about why many gay men may flourish in aging was summarized by Joel Frost [42]. He reiterated what has been noted before and had been called *adaptation theory*. It states that having lived in a society that is biased against them, gay men have developed adaptive capacities that aid them in growing older [42]. Berger and Kelly [43] citing a study done by Berger in the late 1970s on 112 gay men over the age of 40, call successful aging for gay men "crisis competence". This is a variation of Frost's (1997) idea.

Berger and Kelly [43] propose that gay men are better suited to aging due to strengths they learned while being stigmatized, having learned better coping skills due to crisis management and having developed better flexibility during the vicissitudes of life [43]. So, a substantial amount of research supports the idea that the struggle gay men face as they develop their identities and sexuality as they age can actually make them resilient and happy—despite the unique challenges of gay aging that were described earlier.

Coming out is one first substantial event that can buffer persons against later in life crises [44]. Stating one's sexual orientation to oneself and the world shows a strong sense of ego strength that bodes well for moving into a healthy development identity. Also, flexible gender roles may enable a sense of independence that allows some gay men to be more malleable as they age, which can help with the adjustment to old age [22]. These are strong arguments for the idea that at least some aging gay men can mold themselves into their later years more easily than previously thought.

Thus, for gay men, the perceptions of what it's like to age have been shown to possibly be successful and far from the myth of the *auntie* who lived alone. For some, being gay has even helped prepare them for aging. A study by DeVries [35]


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asked LGBT individuals what prepared them for growing older. The respondents stated that having to forge their own unique path in life, forming their own communities and families, and learning strategies to cope with discrimination were activities that aided their own successful aging [35]. So the myth that gay men would move into the mid-point of life and beyond in a tragic way was shown not to be as valid as previously believed.

Returning to what was discussed earlier: Gay men have specific life paths that separate them from the other letters in the LGBT acronym and from their heterosexual male peers. These unique characteristics are caused by destructive myths and stereotypes about older gay men, the lack of positive role models, and discrimination in a heterosexist society that provides no clear model for how gay men should age [8]. This presents a dilemma as there is no specific conceptualization of aging as it relates to gay men. Price [6] cautioned that this gap in the literature presents a tough challenge about responding appropriately to aging gay men.

However, a few researchers have proposed some notable theories about gay aging that will be briefly presented. One such theory is the cohort model of aging [24]. The birth cohort is the period in which one is born, i.e., the Baby Boomer generation. In this way, it is expected that individuals from the same birth cohort share certain characteristics because they experience historical events at the same age [24]. But there are other types of cohorts, such as the age cohort when a man discloses his sexual identity [45]. Two 60-year-old gay men—one who came out at 21 and one who came out at 55—share a birth cohort but they may have radically different aging experiences due to the difference in their coming out age. So grouping men not by age, like the birth cohort, but by their coming out cohort instead, might be a better way to examine how a gay male ages [46].

**Aging Gay Male Minorities**

If the literature is sparse in discussing aging gay males, it is even more meager in addressing aging gay male minorities. The term "*double whammy*" was coined by Bergling [28] to refer to the dual discrimination of ageism and heterosexism in studying older gay males. The term "*triple whammy*" can be applied to the experience of older gay male minorities, who face the triple discrimination of ageism, heterosexism and racism. However, this is really a colloquialism for research that was done after Bergling [28]. Elizabeth R Cole [47] postulated a rubic of "*intersectionality*" which was developed to "consider the meaning and consequences of multiple categories of social group membership" (p.170). This term of intersectionality concretely states that gender, race, class and sexuality all simultaneously mesh together which affect perceptions, experiences, and opportunities of all that are germane to these definitions [47].

The experience of intersectionality has been historically associated with oppression and discrimination which can create significant hardship for an individual. For example, Croom [48] identifies the main conflict for LGB people of color is a constant intrapsychic struggle between two identities. LGB minorities not only grapple with their sexual identity but with their ethnic one as well: "LGB people of color must negotiate the realities of racial and ethnic discrimination as well as homophobia" [48].

A qualitative study done by Stokes and Peterson [49] investigated the attitudes that gay African American men expressed toward homosexuality. This study will be reviewed in detail, as it reveals many important themes that recur in the literature on minority gay men. Individual interviews lasting 60 to 90 minutes with 18-29 year old African men who have sex with men were conducted in Atlanta and Chicago. The Community Identification Process, a qualitative assessment strategy for hard-to-reach populations was utilized; as a result, participants were recruited from public parks where men cruise for male sexual partners, clubs with largely gay populations, gay community organizations, and private parties. Participants expressed many negative attitudes toward homosexuality, self-esteem, and risk for HIV [49]. Due to negative attitudes toward homosexuality in the Black community and the oppression of racism, most respondents expressed a feeling that their identity was dichotomized.

The troubling result was that many felt they had no sense of community or place they were comfortable or freely able to be themselves [49]. Further, they felt the "gay community" was mostly white and racist while the Black community was homophobic [49]. That, ironically, leaves an individual with two identities without a clear sense of belonging to either. As noted by Stokes and Peterson [49], rates of suicide attempts among gay youth are significantly greater than rates of suicide attempts among high school students in general. Also, there was a correlation between participants having unprotected anal sex with high levels of anxiety and depression and, also, with having low self- esteem. The idea of having to live two lives also was showed to make men conform to something they are not, namely straight; maintaining a heterosexual appearance was frequently used as a mask to ward off physical violence [49].

A significant constant in creating virulent homophobia in the Black community is the church [49]. The Black church's strict, anti-gay views will become a constant refrain in most of the articles about gay African Americans (e.g., Jones & Hill [50]). On the positive side, Stokes and Peterson [49] found that the church helped men cope with oppression and feel better about their sinful behavior (although the belief that


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their behavior is "sinful" only recapitulates the internalized homophobia these men feel). On the negative side, the church helped to hide the participants' homosexuality and was a good place to meet other men on the *down low*, i.e., the pretense that one is heterosexual but still engages in homosexual behavior.

Finally, apathy towards HIV emerges with the negative coping that being caught between two identities can create. One of Stokes and Peterson's [49] participants said: [Having unprotected sex is] like committing suicide slowly. "I got nothing to live for anyway, why should I bother protecting myself from this?...Why should I worry about getting sick ten years from now?" … Sex is an escape from stress and aversive realities…People are under so much pressure and hopelessness that there's a tendency to throw all [they know about HIV and AIDS] out the window (p. 288).

Having low self-esteem and having internalized homophobia can influence many young men into making choices not to protect themselves from contracting HIV. The sexual encounter may provide a man with validation because the act feels good and someone finds him attractive.

These perceived benefits might outweigh the decision to have safe sex. It is also worth noting that when HIV and AIDS was viewed as a gay disease, ignoring the list of safer sex practices can be a way of not admitting one's own same-sex attraction [49].

Finally, many participants in the Stokes and Peterson [49] study experienced racism from the larger society and from the white gay community. They also experienced homophobia from the larger African American community and were told that they could not be both gay and a strong black man [49].

Echoing the distress expressed by many of Stokes and Peterson's [49] participants, Crawford, Allison, Zamboni, and Soto [51] reported some startling statistics about African American gay and bisexual men (AAGBM). First, in comparison to their heterosexual counterparts, AAGBM had higher rates of heavy substance. Second, between the years of 1980 and 1995, the suicide rate among African-American boys and young men increased 105%.

Third, in comparison to European-American homosexuals or heterosexual African- American men, AAGBM have elevated levels of depression, mood and anxiety disorders [51]. Clearly these studies show that maladaptive coping strategies have been integrated into the lives of many AAGBM, possibly as a result of poor integration of the racial-ethnic and sexual identity among AAGBM [51]. This echoes some of what Croom [48] postulated, and what Stokes and Peterson [49] found in their qualitative study.

Crawford, et al.'s [51] review of the literature on identity, ethnicity and race came to the conclusion that individuals for whom these issues are integrated possess higher levels of self- esteem and life satisfaction. The goal of their study was to see if this conclusion was *also* valid for AAGBM.

Crawford, et al. [51] recruited 174 participants from Chicago, IL and Richmond, VA using print ads, outreach by recruiters and snowball sampling. The requirements for participants were that they had to be 18 years of age or older, self-identify as having sex with men, finished 8 years of formal education and be in fair to good medical condition. Participants completed a battery of 11 instruments in one sitting [51]. The results indicate that AAGBM who possessed a more integrated self-identification as being gay and African-American also reported higher levels of self-esteem, HIV prevention self-efficacy, stronger social support networks, greater levels of life satisfaction and lower levels of male gender role and psychological distress than their counterparts. They reported less positive (i.e. less well-integrated) African American and gay identity development [51].

The importance of feeling validated and integrating identities from both the gay community and African American community was confirmed in a study by Adams and Kimmel [52]. Their sample was 17 African American gay men from New York City. The respondents ranged in age from 39 to 73 years of age with the mean age of 56. The sample was divided to form a middle-aged group (ages 39-57) and an older group (ages 58-73).

Participants completed a 41-item survey that included questions about self-acceptance (10 items), depression (5 items), concealment of sexual orientation (3 items), and global happiness (1 item) [52]. Further, an open-ended life-history interview was the major source of information for this study. The results illuminated several issues about race, homophobia, and age.

Out of fear of anyone in the African American community learning of their sexual orientation, many respondents commented that they only had sexual contact with White men [52]. About 75% said they did not have role models and many noted that the gay men in their neighborhoods they did know were used to illustrate what *not* to become, i.e., *sissies* (p. 139, Adams & Kimmel, 1997). This term harkens back to the dreaded *auntie* that was brought up about being gay earlier in this literature review. Along those same lines, many felt that because gay sex does not lead to procreation, being gay meant that they were traitors to their families and race [50,52].


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Finally, the older gay male cohort felt isolated from the younger gay men, both by cohort and age discrimination [52]. As one 45 year-old participant said, “Thirty-year-olds treat me like I’m their father. Perhaps it’s the gay movement; perhaps it’s AIDS—they want to hold on to someone who has lasted longer than they have” (p. 146). This comment is fascinating as a 15 year age difference does not seem to warrant such a strong dichotomy of roles. It seems to reiterate that there may be serious gaps in how homosexual development is understood. Also, although it was a small sample and results were obtained about 20 years ago, this study illustrates that even in a highly progressive and forward-thinking metropolis like Manhattan, insidious forms of racism, homophobia and ageism exist.

Jones and Hill [50] further described the Afrocentric theory that white slave owners imposed homosexual practices on male slaves. This theory further postulates that being gay as an African American means to identify with the white oppressor. Jones and Hill [50] suggested that racial discrimination was not just felt outside the gay community but within it as well: White gay men could be just as racist as the African American community. Thus, gay- identified social groups, political organizations, and social services often marginalized or hindered the full participation of African Americans.

One fundamental tenet of racism is that White people’s behavior, values and attitudes are the behaviors and values that persons of color should not only ascribe to but integrate into their own identities [48]. When persons of color are told in some way that they need to assimilate into the dominant culture to be accepted, an innate part of them may be negated.

Until recently, research on gay minorities has virtually excluded discussion of aging gay minorities. A notable exception was the study by Woody [53], which offered a qualitative investigation using in-depth interviews. The sample, 11 females and 4 males of African descent, ranged in age from 58 to 72 years of age, who were recruited from a national health organization and a midsized, Christian-based church. The participants self-identified as middle class with their median age being 64 years old. The sample skewed to highly educated participants: two had doctoral degrees, six had master’s degrees, and seven received advanced technical training.

A sense of alienation in the African community was one of the main findings from Woody’s [53] sample. One male participant, aged 58 stated:

Well it hurts of course, but again being African American you hurt on two levels at the same time. You hurt because you are Black and you hurt, sometimes you hurt because you are black and gay; you can’t separate the two [53].

This idea that a gay minority male has two separate identities is once again reiterated in this study and shows that the integration that is needed is still present with the persons of color as they age; the need to integrate one’s identities is not just experienced by youth. Woody [53] suggested that as a result of real or perceived racism, homophobia, heterosexism, and ageism, many gay African Americans are unable to find support services. Along these lines, the possible risk of losing support from the African American community because of perceived or actually being gay can be devastating with significant social and health implications [53].

Finally, aging LGBT African Americans face unique challenges regarding discrimination on all fronts of life: access to health care, community resources, housing, familial, financial and legal support and security [53]. Whereas the implications of a non-integrated identity caused tremendous detriment to youths, as one ages it also seems to add several other adverse variables to one’s life.

David and Knight [54] investigated outcomes between gay Black and White younger, middle-aged and older adults in their coping styles, perceived stigmatization, and mental and physical health. The final sample size was 383 participants for a 3 (age group) X 2 (ethnic group) design. This resulted in 3 groups: younger (age 18-34) Black and White men; middle aged (age 35-54) Black and White men; and older (age 55+) Black and White men. At this time, their study was the first to have samples of this size including Black older adult gay men. It was also the first to look at Black and White gay men across younger and older adult age groups [54].

Gay men in Southern California were recruited as participants using convenience sampling. In a 6-month period, nine questionnaires were given. Results showed that older gay adult Black men perceived significantly higher levels of ageism than their White counterparts. These gay older adult Black men also perceived significantly higher levels of racism than the younger Black men, and, finally, these men perceived significantly higher levels of homonegativity and lower levels of sexual identity disclosure than all other groups. Notably, gay older adult Black men did not experience significantly higher levels of negative mental health outcomes [54].

David and Knight’s [54] study provided a unique investigation of young vs. older gay Black males. Their results further support what Woody [53] suggested, that life becomes more stressful for gay Black men as they age. It seems that not only the dissonance of identity can disrupt the lives of these aging gay Black men but a plethora of negative


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experiences can be present, as well.

Turning to other gay minorities, it is important not to lump all sexual minorities together. The issues of Black gay men are not the same as those of other gay male minorities. For instance, Asian Americans have been observed to have lower rates of cancer, diabetes, and hypertension than white Americans, whereas African Americans have a higher rate than either Asian Americans or white Americans [48]. Just as there are group differences in medical conditions, there may well be differences in other aspects of adjustment and wellbeing.

Gay men of Asian descent will be discussed next. As with most ethnic groups, little is known about the dating preferences of Asian American gay men [55]. Nehl, et al. described some damaging stereotypes that have been ascribed to gay Asian Americans, e.g., they only prefer White partners, they are passive and submissive, effeminate, smooth, boyish and dependent in relationships. The consequences of these detrimental views make many gay Asian Americans feel undesirable as a partner, have internalized negative feelings and experience lower self-esteem, emasculation and social exclusion. Moreover, Nehl, et al. [55] found that Asian American gay men, like African American gay men, struggle to integrate their two identities, although the two groups experience some differences in acculturation and other social obstacles.

To confront one of the stereotypes of gay Asian Americans, Nehl, et al. [55] examined whether gay men of Asian descent truly preferred to date White men. The research used two federally funded cross-sectional datasets with a combined sample of 731 participants who self- identified as Asian and predominately gay [55]. Descriptive results revealed that only 17% preferred dating White men and, in fact, a majority 61.9% had no racial/ethnic dating preference [55]. This study contributes to the literature by dispelling a stereotype. However, research on minority gay men is in its infancy as the research on White gay men was about 20-30 years ago, when efforts were aimed at eliminating the stereotype that most gay men were unhappy, dreaded *aunties*.

**Well-Being**

When Martin Seligman gave the Presidential speech at the 1998 American Psychological Association (APA) convention, the construct of positive psychology was birthed [56]. In his address he challenged the field to turn the construct of psychology toward a more positive, affirmative one. He defined his approach toward positive psychology as "exploring what makes life worth living and building the enabling conditions of a life worth living" (pp. 1-2) [56]. Since his speech, Seligman's contribution to the field has created a significant movement and shift in how psychologists view happiness and well-being [56]. Of course, these constructs have also been scrutinized at how they also apply to the growing aging population in general as well. However, as Seligman acknowledges in his book, *Flourish*, the definitions of happiness, well-being, and positive psychology all mesh together and are used interchangeably.

Therefore, given the need for a well-being definition, the PERMA model promulgated by Seligman [56] was chosen in order to provide a framework for this research study. The PERMA model is an acronym that stands for: *p*ositive emotion, *e*ngagement, positive *r*elationships, *m*eaning, and *a*ccomplishment [56]. PERMA does not provide a definitive definition for well-being, nor was it designed specifically for a specific age group.

Yet, it offers a solid framework to look at well-being.

The elements of PERMA share three properties: well-being contributions, people pursuing it for its own sake, not just to get out of any of the elements, and it being defined and measured independently of the other elements (p. 16). According to Seligman, these five elements collectively show what people will choose for their own sake [56]. So it's not a single definitive monism, instead its five elements are wide ranging and eliminate the assumption of one operationalized definition of happiness [56]. So, the definition of each letter are as follows:

**P - Positive Emotion:** This first element of this construct of measures life satisfaction or happiness as a positive emotion, and as part of a pleasant life. For one to experience well-being, an individual needs to experience positive emotion. These emotions, like connectedness, happiness, love, renew one's energy and help to rejuvenate a person [56].

**E – Engagement:** This second element to well-being refers to a person being absorbed in activity. People who are engaged are not aware of what they are thinking and feeling as their attention is focused on what they are doing. Only in retrospect do they identify the experience, and recognize that they were in *flow*, which is the sense that time stood still during that engagement of activity. Individuals meet the highest challenges they encounter when they go into flow with their greatest strengths [56].

**R – Positive Relationships:** Humans are social beings and good relationships are core to well-being. People who have meaningful and positive relationships with others are happier than those who do not. As Seligman wrote, "other people are the best antidote to the downs of life and the single most reliable up" (p. 20).


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**M – Meaning:** This element of well-being is characterized by serving something perceived to be greater than the self. There is a subjective component to the question of what is meaningful. A sense of belonging, involvement in religion, and political activity typically lend meaning and purpose to life [56].

**A - Accomplishment:** The final element, accomplishment, refers to the pursuit of something better, i.e., an achievement that reflects winning or mastery. A central way people seek accomplishment is through their work. Also, people just strive to better themselves in some way [56].

As stated at the beginning of this section, PERMA is just one conceptualization of well- being, although it is the primary model used for this study. However, the concept of well-being is a multifaceted idea that can have many different definitions in the literature.

Bowling [57] notes there is confusion and interchangeable use of concepts like happiness, quality of life (QoL), well-being and life satisfaction. In fact, in her 2011 article, Bowling [57] looked at this question of what is well-being to older and younger people in Britain with interesting results.

Bowling's [57] study was conducted by the Office for National Statistics (ONS) for the Omnibus Survey in Britain. This is a monthly survey that is conducted through the postal service and allows researchers to ask questions to a national random sample. At random, responses were selected to set up an interview in the house of individuals 16 years of age or greater [57].

Interviews from 1,049 adults were obtained; the mean age was 49 years, and the majority were White. Well-being was measured by asking an unprompted, open-ended survey question on the perception of well-being. A 5-point Likert self-rating scale was then used to code responses from *very good* to *very bad* [57].

When asked what constitutes well-being, the most common response was good health (67%), life satisfaction (21%), positive outlook (19%), financial security (19%), and mental functioning (13%). People 65 years of age and older defined well-being "as being able to continue to do the things they had always done" (p. 148). This answer differed from younger people who responded to that definition in low numbers (4%). This dichotomy underscores an important age-related difference in how adults conceptualize well-being.

The next open-ended question was what could be done to improve well-being for older people. The most popular answers were: having better access to services (28%), more social support (22%), more social activities (17%), and having more money (14%) [57]. This is interesting as has been shown for aging gay males that the need for these services is similar; however, the accessibility to those services are significantly lacking.

Overall, the respondents rated their well-being as very good or bad (78%). This included their mental well-being, life satisfaction, happiness, and QoL. However, mean health and functioning by age and sex there were differences, with women and older people having worse scores [57]. Additionally, men were more likely than women to have someone available for comfort, as were younger people, people were likely to have available practical help, and women were most likely to report anxiety/nerves/depression [57]. These findings are relevant to the proposed study as it's not clear how many aging gay men have in terms of someone for comfort. With marriage just recently being declared a right to all same-sex couples in the United States, the number of same-sex married couples is yet to be determined.

Also, with the AIDS epidemic having decimated a huge demographic portion of the aging gay male Baby Boomers, many friends and lovers may no longer be alive. So the availability of a meaningful social support system for aging gay men is unknown. And, as stated above, aging gay men may not have ready access to the practical help that they need, either.

Finally, Bowling [57] found that individuals who ranked health more negatively also had problems with mobility, issues with anxiety, nerves and depression, and lower likelihood of rating their well-being as good. Illness also changed a person's perspective with those reporting no long-standing illness having a four times the odds of those with a long-standing illness of rating *good* rather than *not good* for overall well-being [57]. This is important because there may be a significant portion of aging gay males who are HIV+ or have AIDS, so how an aging gay male ranks his health is likely to be an important determinant of his overall sense of well-being.

Bowling's [57] study points to some key issues. Older adults and younger adults differed significantly in the way they conceptualized and experienced well-being. Unfortunately, Bowling's conclusions may not be generalizable to aging gay men. In fact, many of the issues she reported have been contradicted in the literature for aging gay men. So, while acknowledging the importance of her article, one strong criticism is that it did not include sexual orientation in its variables.

It's important to reiterate that many researchers have


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concluded that the definition of well-being is quite fluid. In fact, a study by the National Institutes of Health (NIH; the National Institute on Aging; the National Institute of Mental Health; and, the National Institutes of Neurological Disorders and Stroke) synthesized 96 papers on how many of the ideas already put forth applied to the aging population and they came to the same conclusions. There was no universally definitive definition of emotional and cognitive health, nor consensus on how these terms might apply to older adults [58].

The committee did adopt a working guideline to understand this amalgam of concepts, though. In an older adult, cognitive health should be defined not as just the absence of disease but also:

As the development and preservation of the multidimensional cognitive structure that allows the older adult to maintain social connectedness, an ongoing sense of purpose and the abilities to function independently, to permit functional recovery from illness or injury, and to cope with residual functional deficits" (p.13) [58].

Underlying the NIH committee's recommendations is the premise that successful aging is not just the absence of illness. Instead, it means a presence of other variables, including a cognitive structure that allows an aging individual to participate in intellectual, social, and physical activities. The results of such activities include social connectedness with others and a sense of purpose, as well as a sense of self-actualization [58]. Much of what the NIH reported is captured in Seligman's [56] PERMA construct. So, while acknowledging that the definition of well-being is inexact, a general set of guidelines seem to be developing from the literature.

Not accounted for in the NIH evaluation were faith and religion, though. Cohen and Hall [59] surveyed over 1,000 older adults with varying religious affiliations. They discovered that religiousness, spirituality and existential beliefs were important sources of well-being, yet neither their specific effects nor their group variation could be totally understood.

Implied but not overtly stated in the NIH definition was physical health. In general, to avoid illness and poor health, one needs physical activity. In a small sample of 28 community dwelling, retired older adults, 62 to 81 years, it was shown that physical activity led to self- reported positive subjective well-being [60]. So, while health is not one of the elements of PERMA, it seems to be a relevant variable to include in the conceptualization of well-being, especially for aging gay men given the health disparities described earlier in this review. Hence, a description of current health concerns were included in the vignettes about the older/younger gay man that were used in this study.

Finally, another variable not included in PERMA—but commonsense seems to suggest— is financial. In their book, *Well Being: The Five Essential Elements* [61], Tom Rath and Jim Harter included financial status as one of the five tenets to their definition of well-being. As part of their research, Gallup scientists conducted a global study of more than 150 countries. Gallup designed an assessment composed of questions that became the Wellbeing Finder, which includes hundreds of questions [61]. They concluded that not only is financial well-being an important component of the definition but wealthier countries having individuals with higher well-being. Financial status were also included in the vignettes about the older/younger gay man.

**Long Term Care for Aging LGBT Population**

The Equal Rights Center was formed in 1983. It is a national non-profit civil rights organization whose mission statement is dedicated to equal opportunity in housing, employment and access to public accommodations and government services. In 2014 they investigated adverse and differential treatment against a senior who is seeking housing for oneself and their same sex partner. While, currently, federal law does not "expressly prohibit housing discrimination based on sexual orientation or gender identity in the private housing market" (p. 9); they discovered that housing discrimination is all too distressingly common.

Of 96 out of 200 tests (48%) a LGB tester experienced at least one type of adverse, differential treatment. The LGB tester experienced multiple forms of adverse, differential treatment in 25 of the 200 tests (12.5%). The treatments ranged from housing providers quoting higher fees and rental prices to LGB testers; being provided fewer options than their heterosexual testers; not providing the LGB tester with financial incentives that the heterosexual tester was provided; finally, the LGB tester was asked to partake in additional requirements like background checks, proof of income, credit checks or having a waitlist process while the heterosexual tester was streamlined through this process (http://www.equalrightscenter.org/site/DocServer/LGBT_Senior_Toolkit.pdf).

This Equal Rights Center study best illuminates the need for better laws concerning housing for aging LGBT folks. A solution has been to make gay-only retirement communities. However, a web search for how many of these communities exist in the United States revealed a paltry sum, 24 of them, in 11 states (www.gayretirementguide.com). Completing the issue brought to the fore with the previous study, this miniscule number of gay-based retirement communities show the much needed attention to be paid to the aging


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LGBT population.

### Summary and Hypotheses

In summary, the literature review has shown that there are significant issues affecting older gay men. These include health disparities, financial and housing discrimination, as well as successful aging role models due to the devastation caused by the AIDS epidemic. While some research indicates that life as an aging gay man can be well-adjusted and happy [28], there is still much evidence that supports what Scott Capuro said, “30 equals 80 in gay years” (p. 163) [38]. It has been suggested that accelerated aging my actually facilitate the adjustment to old age for gay men [43]; however, other research shows a dimmer view for the future [16]. Regardless of which pole of research one looks at the realities of both homophobia and ageism still exist [8] and for gay aging minorities that stress is compounded by racial discrimination [48]. It’s important for clinicians and researchers to understand more about the aging gay male population, even though the definition of well-being may be vague [58]. Seligman’s [56] PERMA was used as a starting point for describing well-being, but this study also included information about the vignette character’s health and financial status in order to provide a more comprehensive view of well-being.

The study explored how gay men view the well-being of a vignette character that is described as a gay man with some difficulties in the areas of health, financial status, and social relationships. The vignette character was described as either 25 or 65 years old in order to compare attitudes toward the character based on his age. I constructed a scale to assess the participants’ attitudes toward the well-being of the vignette character. Participants were asked to fill out questionnaires about internalized homophobia and satisfaction with life in order to provide additional information about the association of these constructs with attitudes toward the younger and older vignette characters.

The following hypotheses were tested:

1. There will be a positive correlation between level of internalized homophobia and age of participants.
2. White Men of European ancestry will score lower on the internalized homophobia scale than others.
3. The well-being of the young vignette character will be rated higher than the well-being of the old vignette character.
4. There will be a positive correlation between the attitudes toward aging score and satisfaction with life.
5. There will be a negative correlation between the attitudes toward aging score and the level of internalized homophobia.
6. The negative correlation between attitudes toward aging score and internalized homophobia will be greater in magnitude for the old vignette character than the young vignette character.


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# CHAPTER II

# Methods

### Participants and Recruitment

A total of 210 participants were recruited for this study. This number exceeds the number of participants required to detect a medium effect size using t-tests (two-tailed) for independent samples with a power of .80. Participants needed to meet the following inclusion criteria: be 18 years of age or over, currently reside in the U.S., self-identify as a gay man, and have access to a computer and sufficient computer literacy to take an online survey.

Participants were recruited through Qualtrics, which has a participant data service that obtained a sample of gay men throughout the U.S. Participant recruitment was designed to achieve ethnic and racial diversity, as well as a wide age.

Frequency charts were run on all scores obtained by the 210 participants. One participant (#135) had the lowest possible score (10) on the Aging Attitudes toward Gay Men scale (the next lowest score was 15). The score of 10 on the Aging Attitudes toward Gay Men scale was 3 *SD*s below the mean. Examination of the other scores obtained by Participant #135 revealed a pattern of extreme scores, so he was deleted from the data set. All descriptive statistics and all statistical tests were performed on $N = 209$.

### Design

The current study utilized an exploratory analysis design. Participants were randomly assigned to read one of two vignettes that differed only on the age of the main character.

The independent variable was the age of the character in the vignette (25 years old versus 65 years old). The dependent variable was the participants' attitudes about the vignette character's well-being, as measured by the Aging Attitudes toward Gay Men scale that was constructed for this study. Level of internalized homophobia and satisfaction with life were assessed by the Internalized Homophobia Scale [62] and the Satisfaction with Life Scale [63], respectively.

### Instrumentation

**Aging Attitudes toward Gay Men Scale:** To assess attitudes toward the well-being of gay men, participants were randomly assigned to read one of two vignettes, and then complete a 10- item questionnaire. The vignettes and the scale were created for this study.

The vignettes were created based on a review of the literature that revealed several areas that are considered aspects of well-being, specifically social relationships, intimate connectedness, financial status, health status, and emotional status. The two vignettes were identical except for the age of the character in the vignette:
Topher is a 25/65 year old gay man. He recently ended a 6-month relationship that he thought was "the one." He's had a string of "the one" liaisons and is feeling depressed over the failure of this last man. In addition, Topher has lost his job and is currently seeking employment in the field he finds the most exciting and satisfying. He exists on some savings but that will run out if he does not find work soon. And employment prospects have not yielded anything on the horizon. Topher feels a little isolated from friends and family and is thinking of entering therapy for help. Also, despite being in good shape, Topher has had a persistent cough and flu-like symptoms for about a month that his roommate has been urging him to see a doctor.

Items for the Aging Attitudes toward Gay Men scale were written based on a review of well-being and successful aging among older adults, and older gay men in particular. An extensive literature search revealed no published scale that assesses attitudes toward aging. The Aging Attitudes toward Gay Men scale assesses a variety of aspects of successful aging.

Participants completed the Aging Attitudes scale after they read one of the two vignettes. Participants were asked to respond to each item using a likert-type scale from 1 *Strongly Disagree* to 5 *Strongly Agree*. Half of the items were worded in a positive direction (e.g., "Topher is likely to find a job in his field of passion and expertise") and half of the items were worded in a negative direction (e.g., "Topher can look at his life and see failure"). Items 1, 6, 7 and 10 are negatively worded, and were reverse coded before the total score was tallied. The total score was the sum of the 10 items; scores ranged from 10 to 50, with higher scores reflecting more positive views of the character's well-being. The Aging Attitudes toward Gay Men was developed for the study so its psychometric properties are reported here for the first time.


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| Topher is likely to experience serious financial setbacks and uncertainty in the near future. |
|---|
| Topher is likely to find a job in his field of passion and expertise. |
| Topher will soon find a circle of friends who support and encourage him. |
| Topher will find a partner in the near future. |
| Topher has reason to be happy. |
| Topher has reason to be concerned with his life. |
| Topher is likely to regain his health and engage in enjoyable physical activities. |
| Topher is on his way to being self-actualized (i.e., fulfilled and a life with meaning). |
| ****The 2 items deleted**** |
| Topher should be worried about his not feeling well. |
| Topher can look at his life and see failure. |

**Table 1:** 8-Item Scale.

Cronbach's alpha for the entire sample (*N* = 209) for the 25-year-old and 65-year-old vignettes combined was .73, which is generally considered acceptable [23]. Results indicated that if Item 7 ("Topher should be worried about his not feeling well") and Item 10 ("Topher can look at his life and see failure") were deleted, the Cronbach's alpha would increase. The decision was made to delete these two items in order to increase the reliability of the scale. The Cronbach's alpha for the revised 8-item scale with both vignettes combined (*N* = 209) was .79, and the Spearman-Brown split-half reliability coefficient was .76. Althoughitem #7 was the only item that addressed the important aspect of physical well-being, its deletion improved the reliability of the scale. The 8-item scale was used in all analyses reported in the remainder of this report.

To summarize, the same 8-item Aging Attitudes toward Gay Men scale was used for the 25-year-old Topher vignette and the 65-year-old Topher vignette. For the sake of simplicity, the scale used with the 25-year-old vignette will be called the Aging Attitudes-25, and the scale used with the 65-year-old vignette will be called the Aging Attitudes-65. When the Aging Attitudes- 25 and the Aging Attitudes-65 are combined, the scale will be referred to as Aging Attitudes-Combined.

Cronbach's alpha for the Aging Attitudes-25 scale was .80; the Cronbach's alpha for the Aging Attitudes-65 scale was .77. The scores on each version (Aging Attitudes-Combined, Aging Attitudes-25, and Aging Attitudes-65) ranged from 8 to 40, and each version approximated a normal distribution.

**Internalized Homophobia Scale (IHS)**

Developed by Wagner, et al. [62], the IHS consists of 20 items scored on a 5-point Likert-type scale where 1 = *strongly disagree* and 5 = *strongly agree*. The scale takes approximately 5 minutes to complete. Ten items are positively keyed, and 10 are negatively keyed. The range for the total score is 20 to 100, with higher scores representing greater internalized homophobia. Research using the IHS has revealed the construct to be positively correlated with mental health measures including demoralization ($r$ = .49), global psychological distress ($r$ = .37), and depression ($r$ = .36). Other correlates include age at which one first accepted being gay ($r$ = .46) and degree of integration into the gay community ($r$ = -.54) [62]. In the current study, Cronbach's alpha was .92 for the IHS, which replicates the originally reported internal reliability coefficient (Wagner, 1994).

**Satisfaction with Life (SWLS)**

The SWLS [63] is a 5-item self-report scale that uses a 7-point Likert-type scale in which 1 = *strongly disagree* and 7 = *strongly agree* (example: "In most ways, my life is close to my ideal"). The possible range of scores is from 5 (low satisfaction) to 35 (high satisfaction). The SWLS correlated .02 with the Marlowe-Crowne measure, indicating that the SWLS was not evoking a social desirability response set [63]. The SWLS showed moderately strong correlations with all the subjective well-being scales: self-esteem, .54; symptom checklist, -.41; neuroticism, -.48; emotionality, -.25; activity, .08; sociability, .20; and impulsivity, -.03 [63].

In a study looking at the value of positive emotion associated with life satisfaction [64], 9,874 participants from 47 nations were recruited. The mean score of the SWLS was $M$ = 4.49 ($SD$ = 1.12). The within-country internal consistency reliabilities (Cronbach's alpha) for the scale averaged .78 ($SD$ = .09). The results also showed when experiencing positive emotions people on average reported increased life satisfaction ($B$ = .29, $SE$ = .01, $p$ < .001) [64].

Siedlecki, Tucker-Drob, Oishi and Salthouse [65] administered the SWLS to 818 adults, age 18 to 94. They reported a significant positive correlation between the SWLS


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and age of $r$ = .12. In contrast, Darbonne, Uchino, and Ong [66] reported a non-significant correlation of $r$ = .05 between the SWLS and age in their study of 67 men and 77 women between the ages of 30 and 70. Their careful exploration of this non-significant correlation revealed a curvilinear relationship such that participants in their 30s and 60s had the highest SWLS, and those in their mid-40s to mid-50s had the lowest SWLS. This curvilinear relationship is consistent with other reports that both young adults and older adults typically have higher SWLS scores than middle- aged adults, possibly due to the additional stressors experienced by those in middle age [66].

In the current study, Cronbach's alpha was .92 for the SWLS. Compared to other studies, the Cronbach's alpha in six previous studies ranged from a low of .79 to a high of .89 [67].

**Demographic questionnaire**

A 10-item demographic questionnaire was used to assess basic information about the participants.

**Procedure**

After receiving IRB approval, Qualtrics was used to collect data. After entering the study, participants saw an informed consent; if they clicked on agreement, they were randomly assigned to one of the two vignettes. To control for order of administration effects, a counterbalancing technique was used. Half of the participants were randomly assigned to complete the questionnaires one order (Aging Attitudes toward Gay Men, IHS, SWLS, Demographic Questionnaire), while the other half were randomly assigned to complete the questionnaires in a different order (Aging Attitudes toward Gay Men, SWLS, IHS, Demographic Questionnaire).

Participants could exit the survey at any time. Participants were permitted to request a copy of their results when they agreed to participate.

| Measure | Mean | SD | Median | Min. Score | Max. Score | Skewness | Kurtosis |
|---|---|---|---|---|---|---|---|
| Attitudes Toward Aging Scale | | | | | | | |
| Aging Attitudes Toward Gay Men | 27.92 | 5 | 28 | 15 | 42 | -0.08 | -0.02 |
| 25 Year-Old (N=105) | 28.54 | 5.24 | 29 | 17 | 42 | 0.05 | -0.13 |
| 65 Year-Old (N=104) | 27.29 | 4.69 | 28 | 15 | 37 | -0.38 | -0.12 |
| Internalized Homophobia Scale | 83.92 | 12.65 | 87 | 37 | 100 | -0.83 | 0.33 |
| Satisfaction with Life Scale | 23.05 | 7.76 | 23 | 5 | 35 | -0.46 | -0.68 |

**Table 2:** Summary Statistics for Study Measures (N = 209).

| **Variable** | **Minimum** | **Maximum** | ***M*** | ***SD*** |
|---|---|---|---|---|
| **Age** | 18 | 77 | 42.86 | 14.83 |
| **Age of Coming Out** | | | | |
| **Employment** | | | **N** | **% of Sample** |
| Full Time | | | 101 | 48.3 |
| Half Time | | | 26 | 12.4 |
| Unemployed | | | 31 | 14.8 |
| Retired | | | 30 | 14.4 |
| Disabled | | | 21 | 10 |
| **Income** | | | | |
| $0 to $10,000 | | | 12 | 5.7 |
| $10,001 to $30,000 | | | 49 | 23.4 |
| $30,001 to $50,000 | | | 40 | 19.1 |
| $50,001 to $70,000 | | | 37 | 17.7 |
| $70,001 to $90,000 | | | 31 | 14.8 |


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| | | | | |
|---|---|---|---|---|
| $90,001 to $110,000 | | | 15 | 7.2 |
| $110,001 to 130,000 | | | 8 | 3.8 |
| $130,001 or more | | | 17 | 8.1 |
| **Marital Status** | | | | |
| Married | | | 32 | 15.1 |
| Divorced | | | 5 | 2.3 |
| Separated | | | 3 | 1.4 |
| Single | | | 96 | 46 |
| In a Relationship | | | 34 | 34 |
| Widowed | | | 2 | 0.1 |
| **Self-Identification** | | | | |
| Gay | | | 192 | 91.9 |
| Homosexual | | | 15 | 7.2 |
| None of the Above | | | 2 | 1 |
| **Education Level** | | | | |
| High School | | | 23 | 11.01 |
| Some College | | | 86 | 41.1 |
| Bachelor’s Degree | | | 50 | 23.9 |
| Graduate Degree | | | 46 | 22 |
| Technical Certificate | | | 4 | 1.9 |
| **Race / Ethnicity** | | | | |
| Angelo-American/Caucasian | | | 156 | 74.6 |
| African-American/Black | | | 11 | 5.3 |
| Asian American | | | 6 | 2.9 |
| Middle Eastern | | | 1 | 0.5 |
| Latino/Hispanic American | | | 23 | 11 |
| Native American | | | 2 | 1 |
| Pacific Islander | | | 0 | 0 |
| I don’t Know | | | 1 | 0.5 |
| Multi-Ethnic | | | 7 | 3.3 |
| Other | | | 2 | 1 |
| **Religion** | | | | |
| Catholic | | | 42 | 20 |
| Jewish | | | 7 | 3.3 |
| Muslim | | | 0 | 0 |
| Hindu | | | 2 | 1 |
| Christian | | | 48 | 22.9 |
| Buddhist | | | 1 | 0.5 |
| Spiritual but not Religious | | | 44 | 21 |
| None | | | 65 | 31.1 |

**Table 3:** Demographic Variables (N = 209).


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# CHAPTER III

# Results

### Counterbalancing Effect

Participants were randomly assigned to take the two versions of the Aging Attitudes toward Gay Men scale: the Aging Attitudes-25, $n$ = 105, and the Aging Attitudes-65, $n$ = 104. To see if there was a priming effect on how participants answered the next two questionnaires, participants were again randomly assigned to take the IHS followed by the SWLS, $n$ = 103, or the reverse order, $n$ = 106.

A one-way ANOVA comparing the order of administration (standard vs. reversed) was conducted separately on the dependent variables of IHS total score and SWLS total score. The 103 participants receiving the standard order had a mean IHS total score of 82.78 ($SD$ = 14.01), and the 106 participants receiving the reverse order had a mean IHS total score of 85.05 ($SD$=11.15). The two means were not significantly different, $F(1, 207) = 1.9$, $p > .05$. Thus, counterbalancing the order of administering the IHS and SWLS had no effect on the mean total scores of the IHS, so the IHS scores were combined for all remaining analyses.

Similarly for the SWLS, the 103 participants receiving standard order had a mean SWLS score of 22.18 ($SD$ = 7.94), and the 106 participants receiving the reverse order had a mean SWLS score of 23.90 ($SD$ = 7.52). The two means were not significantly different, $F(2.586) =.11$, $p > .05$. Again, counterbalancing the order of SWLS and IHS had no effect on the mean total scores of the SWLS, so the SWLS scores were combined for all remaining analyses.

### Outcome Scores

Summary statistics are provided in Table 2. The SWLS scores obtained in the current study ($M$= 23.05; $SD$ =7.76) were very similar to SWLS scores obtained on older American adults in previous studies ($M$ = 24.2; $SD$ = 6.9) [67]. Gay college students ($M$= 46.26; $SD$ = 15.65; White & Murrell, 2012) and Australian gay men with a mean age of about 36 years ($M$ = 38.56; $SD$ = 13.38; McLaren [68]) had much lower IHS scores than those obtained in the current study ($M$ = 83.92; $SD$ = 12.65). The distribution of the current IHS scores suggested a ceiling effect, as 11 participants (5.3% of the sample) obtained the modal score of 98 out of a possible 100. In fact, 51 participants (24.4% of the sample) had scores between 95 and 100. It is possible that the current participants may have even higher internalized homophobia than the IHS measured.

### Identification of Covariates

**Age:** Age was not explored as a covariate for the IHS scale because the relationship between age and internalized homophobia was explored in Hypothesis 1. Age was not significantly correlated with SWLS total score, $r(N=209) = .11$, $p > .05$, so age was not controlled for in hypothesis testing involving SWLS. Age was significantly correlated with the Aging Attitudes-Combined, $r(N = 105) = -.25$, p=.047, and the Aging Attitudes-65, $r(N = 104) =-.31$, p = .001. As a result, age was controlled for in hypothesis testing involving the Aging Attitude scales.

**Coming out age:** Coming out age was not significantly correlated with IHS total score, $r(N = 209) = -.02$, $p > .05$, nor SWLS total score, $r(N = 209) = .05$, $p > .05$, so coming out age was not controlled for in hypothesis testing involving either IHS or SWLS.

Coming out age was not significantly correlated with the Aging Attitudes-Combined, $r(N= 209) = .04$, $p > .05$, the Aging Attitudes-25, $r(N = 105) = .10$, $p > .05$, or the Aging Attitudes- 65, $r(N = 104) = -.03$, $p > .05$. Coming out age was not controlled for in any hypothesis testing involving any of the Aging Attitude scales.

**Education level:** A one-way ANOVA was conducted with education level as the independent variable (with five different education levels) and IHS total scores as the dependent variable. There was no significant effect of education on level on IHS total score, $F(4, 204) = 1.45$, $p > .05$, so education level was not confounded with IHS total score.

A one-way ANOVA was conducted with education level as the independent variable (with five different education levels) and SWLS total score as the dependent variable. There was a significant effect of education level on SWLS total score, $F(4, 204) = 3.32$, $p = .01$, partial eta$^2$= .06. Education level was confounded with SWLS total score, so education was controlled for in hypothesis testing involving SWLS total score.



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A one-way ANOVA was conducted with education as the independent variable (with five different education levels) and Aging Attitudes-Combined total score as the dependent variable. There was no significant effect of education levels on Aging Attitudes-Combined total score, $F(4, 204) = 1.37$, $p > .05$. Education levels was not confounded with Aging Attitudes-Combined total score.

A one-way ANOVA was conducted with education level as the independent variable (with five different education levels) and Aging Attitudes-25 total score as the dependent variable. There was no significant effect of education levels on Aging Attitudes-25 total score, $F(4, 100) = 1.82$, $p > .05$. Education level was not confounded with Aging Attitudes-25 total score.

A one-way ANOVA was conducted with education level as the independent variable (with five different education levels) and Aging Attitudes-65 total score as the dependent variable. There was no significant effect of education levels on Aging Attitudes-65 total score, $F(4, 99) = 0.34$, $p > .05$. Education levels was not confounded with Aging Attitudes-65 total score.

**Employment:** A one-way ANOVA was conducted with employment status as the independent variable (with five different employment status categories) and IHS total score as the dependent variable. There was a significant effect of employment status on IHS total score $F(4, 204) = 2.94$, $p = .02$, partial eta$^2$ = .06. Employment status was confounded with IHS total score, so employment status was controlled for in hypothesis testing involving IHS.

A one-way ANOVA was conducted with employment status as the independent variable (with five different employment categories) and SWLS total score as the dependent variable.

There was no significant effect of employment on SWLS total score, $F(4, 204) = 2.29$, $p > .05$. Employment status was not confounded with SWLS total score.

A one-way ANOVA was conducted with employment as the independent variable (with five different employment categories) and Aging Attitudes-Combined total score as the dependent variable. There was no significant effect of employment on Aging Attitudes- Combined total score, $F(4, 204) = 2.39$, $p = .052$. Employment was not significantly confounded with Aging Attitudes-Combined total score.

A one-way ANOVA was conducted with employment as the independent variable (with five different employment categories) and Aging Attitudes-25 total score as the dependent variable. There was no significant effect of employment on Aging Attitudes-25 total score, $F(4,100) = 1.04$, $p > .05$. Employment was not confounded with Aging Attitudes-25 score.

A one-way ANOVA was conducted with employment as the independent variable (with five different employment categories) and Aging Attitudes-65 total score as the dependent variable. There was a significant effect of employment on Aging Attitudes-65 total score, $F(4,99) = 2.63$, $p < .05$, partial eta$^2$ = .1. Employment was confounded with Aging Attitudes-65 total score, so employment was controlled for in hypothesis testing involving Aging Attitudes-65.

**Income level:** Income level was originally grouped into eight categories. Because the lowest category (<$10,000) and highest category (>$130,000) did not have discrete boundaries, they were deleted from the analysis. The remaining six categories of income level were used in the analysis.

A one-way ANOVA was conducted with income level as the independent variable (with six different income categories) and IHS total score as the dependent variable. There was no significant effect of employment on IHS total score, $F(5, 174) = .42$ $p > .05$. Income level was not confounded with IHS total score.

A one-way ANOVA was conducted with income level as the independent variable (with six different income level status categories) and SWLS total score as the dependent variable.

There was a significant effect of income level on SWLS total score $F(5,174) = 2.48$, $p = .03$, partial eta$^2$ = .07. Income level was confounded with SWLS total score, so income level was controlled for in hypothesis testing involving SWLS.

A one-way ANOVA was conducted with income level as the independent variable (with six different income categories) and Aging Attitudes-Combined total score as the dependent variable. There was a significant effect of income level on Aging Attitudes-Combined total score $F(5,174) = 2.75$, $p = .02$, partial eta$^2$= .07. Income level was confounded with Aging Attitudes- Combined total score, so income level was controlled for in hypothesis testing involving Aging Attitudes-Combined.

A one-way ANOVA was conducted with income as the independent variable (with six different income categories) and Aging Attitudes-25 total score as the dependent variable. There was a significant effect of income on Aging Attitudes-25 total score $F(5, 87) = 3.43$, $p = .007$, partial eta$^2$= .17. Income was confounded with Aging Attitudes-25 total score, so


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income was controlled for in hypothesis testing involving Aging Attitudes-25.

A one-way ANOVA was conducted with income as the independent variable (with six different income categories) and Aging Attitudes-65 total score as the dependent variable. There was no significant effect of income on Aging Attitudes-65 total score, $F(5, 81) = .81$, $p > .05$. Income was not confounded with Aging Attitudes-65 total score.

**Marital status:** A one-way ANOVA was conducted with marital status as the independent variable (with six different marital status categories) and IHS total score as the dependent variable. There was a significant effect of marriage status on IHS total score $F(5, 203) = 3.71$, $p = .003$, partial eta$^2$ = .08. Marital status was confounded with IHS total score, so marriage status was controlled for in hypothesis testing involving IHS.

A one-way ANOVA was conducted with marriage status as the independent variable (with six different marital status categories) and SWLS total score as the dependent variable. There was a significant effect of marital status on SWLS total score, $F(5, 203) = 7.95$, $p < .001$, partial eta$^2$= .16. Marital status was confounded with SWLS total score, so marital status was controlled for in hypothesis testing involving SWLS.

A one-way ANOVA was conducted with marriage status as the independent variable (with five different marital status categories) and Aging Attitudes-Combined total score as the dependent variable. There was no significant effect of marital status on Aging Attitudes- Combined total score, $F(5, 203) = 0.61$, $p > .05$. Marital status was not confounded with Aging Attitudes-Combined total score.

A one-way ANOVA was conducted with marriage status as the independent variable (with five different marital status categories) and Aging Attitudes-25 total score as the dependent variable. There was no significant effect of marital status on Aging Attitudes-25 total score, $F(5, 99) = .36$, $p > .05$. Marital status was not confounded with Aging Attitudes-25 total score.

A one-way ANOVA was conducted with marriage status as the independent variable (with five different marital status categories) and Aging Attitudes-65 total score as the dependent variable. There was no significant effect of marital status on Aging Attitudes-65 total score, $F(5, 98) = 0.59$, $p > .05$. Marital status was not confounded with Aging Attitudes-65 total score.

**Race/Ethnicity:** Although participants self-identified as belonging to nine different categories of race/ethnicity, there were only one or two participants in four of the categories, so they were not included in the exploration of race/ethnicity as a possible covariate.

A one-way ANOVA was conducted with race/ethnicity as the independent variable (with five different race/ethnicity categories) and IHS total score as the dependent variable. There was a significant effect of race/ethnicity on IHS total score $F(4, 198) = 3.94$, $p = .01$, partial eta$^2$ =.07. Race/ethnicity was confounded with IHS total score, so race/ethnicity was controlled for in hypothesis testing involving IHS.

A one-way ANOVA was conducted with race/ethnicity as the independent variable (with five different race/ethnicity categories) and SWLS total score as the dependent variable. There was no significant effect of race/ethnicity on SWLS total score, $F(4, 198) = 0.77$, $p > .05$.

Race/ethnicity was not confounded with SWLS total score.

A one-way ANOVA was conducted with race/ethnicity as the independent variable (with five different race/ethnicity categories) and Aging Attitudes-Combined total score as the dependent variable. There was no significant effect of race/ethnicity on Aging Attitudes- Combined total score, $F(4, 198) = 0.73$, $p > .05$. Race/ethnicity was not confounded with Aging Attitudes-Combined total score.

A one-way ANOVA was conducted with race/ethnicity as the independent variable (with five different race/ethnicity categories) and Aging Attitudes-25 total score as the dependent variable. There was no significant effect of race/ethnicity on Aging Attitudes-25 total score, $F(4,97) = 0.37$, $p > .05$. Race/ethnicity was not confounded with Aging Attitudes-25 total score.

A one-way ANOVA was conducted with race/ethnicity as the independent variable (with five different race/ethnicity categories) and Aging Attitudes-65 total score as the dependent variable. There was no significant effect of race/ethnicity on Aging Attitudes-65 total score, $F(4, 96) = 1.32$, $p > .05$. Race/ethnicity was not confounded with Aging Attitudes-65 total score.

**Religion:** Although participants self-identified as belonging to seven different categories, there were only one or two participants in two of the categories, so they were not included in the exploration of possible covariates.

A one-way ANOVA was conducted with religion as the independent variable (with five different religion categories) and IHS total score as the dependent variable. There was a significant effect of religion on IHS total score, $F(4, 201) =$


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2.63, $p$ = .04, partial eta$^2$ = .05.

Religion was confounded with IHS total score, so religion was controlled for in hypothesis testing involving IHS.

A one-way ANOVA was conducted with religion as the independent variable (with five different religion categories) and SWLS total score as the dependent variable. There was no significant effect of religion on SWLS total score, $F(4, 201) = 1.12$, $p > .05$. Religion was not confounded with SWLS total score.

A one-way ANOVA was conducted with religion as the independent variable (with five different religion categories) and Aging Attitudes-Combined total score as the dependent variable. There was no significant effect of religion on Aging-Attitudes total score, $F(4,201) = 1.05$, $p > .05$. Religion was not confounded with Aging Attitudes-Combined total score.

A one-way ANOVA was conducted with religion as the independent variable (with five different religion categories) and Aging Attitudes-25 total score as the dependent variable. There was no significant effect of religion on Aging Attitudes-25 total score, $F(3, 100) = 1.72$, $p > .05$. Religion was not confounded with Aging Attitudes-25 total score.

A one-way ANOVA was conducted with religion independent variable (with five different religion categories) and Aging Attitudes-65 total score as the dependent variable. There was no significant effect of religion on Aging Attitudes-65 total score, $F(4, 97) = .72$, $p > .05$. Religion was not confounded with Aging Attitudes-65 total score.

**Summary of covariates:** The following is a list of covariates for each dependent variable:
IHS: Age, ethnicity/race, religion, employment, marital status. SWLS: Education, income, marital status.
Aging Attitudes-Combined: Age, income. Aging Attitudes-25: Age, income.
Aging Attitudes-65: Age, employment.

**Hypothesis Testing**

**Hypothesis 1:** There will be a positive correlation between level of internalized homophobia and age. A partial Pearson correlation between IHS total score and age (controlling for ethnicity/race, religion, employment status, and marital status) was significant, $r(\text{df} = 203) = .13$, $p = .03$, one-tailed. Hypothesis 1 was supported: There was a positive correlation between level of internalized homophobia and age, although the magnitude of the correlation is modest. As noted earlier, the sample's mean IHS score was very high, indicating that the sample had, on average, a high degree of internalized homophobia. It is possible that a ceiling effect, which restricts the range of scores, may have reduced the magnitude of the positive correlation.

**Hypothesis 2:** White men of European ancestry will score lower on the internalized homophobia scale than others. A one-way ANCOVA was used to compare the mean IHS score of White men of European ancestry to the mean IHS score of the other participants, controlling for religion, employment status, and marital status. Race/ethnicity was already identified as a covariate for IHS total score. Of the 209 participants, one indicated, "I don't know" for his race/ethnicity, and two indicated, "Other." These three participants were deleted from the sample used to test this hypothesis. Of the remaining 206 participants, the majority (75.70%) was White/Caucasian.

Although the result of the ANCOVA was significant, it was opposite to what was expected, $F(1, 201) = 5.70$, $p = .02$, partial eta$^2$ = .03. The 156 White/Caucasians ($M = 85.71$; $SD = 11.95$) had a significantly higher mean IHS score than the 50 non-White/Caucasians ($M = 78.72$; $SD = 13.45$). Hypothesis 2 was not supported; the results were significant in the opposite direction.

**Hypothesis 3:** The well-being of the young vignette character will be rated higher than the well-being of the old vignette character. A one-way ANCOVA (controlling for age, income, and employment status) revealed that the 25-year-old vignette (Aging Attitudes-25 $M = 23.71$; $SD = 4.67$) was rated significantly more positive than the 65-year-old vignette (Aging Attitudes- 65 $M = 22.26$; $SD = 4.40$), $F(1, 205) = 4.49$, $p = .04$, partial eta$^2$ = .02. Hypothesis 3 was supported; however, the very small effect size (.02) indicated that the difference between the means, while statistically significant, is negligible. As the scores range from 8 (minimum) to 40 (maximum), the means of 22.26 and 23.71 both indicate moderately positive attitudes toward aging.

**Hypothesis 4:** There will be a positive correlation between the attitudes toward aging score and satisfaction with life. This hypothesis was tested separately for the young and old vignette characters. For the Aging Attitudes-25, a significant positive partial correlation (controlling for age, education level, income level, and marital status) emerged with SWLS, $r(\text{df}= 99) = .21$, $p = .02$, one-tailed. For the Aging Attitudes-65, a significant positive partial correlation (controlling for age, employment status, education level, income level, and marital status) emerged with SWLS, $r(\text{df} = 97) = .30$, $p = .002$, one-tailed. Hypothesis 4 was supported for both the young and old vignette characters.

**Hypothesis 5:** There will be a negative correlation between the attitudes toward aging score and the level of internalized homophobia. This hypothesis was not supported. The


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correlation (controlling for marital status, age, employment, ethnicity, religion, and income) for the Aging Attitudes-25 was not significant, $r(\text{df} = 97) = .11$, $p > .05$, one-tailed. It was also in the unexpected direction. The correlation (controlling for marital status, age, employment, ethnicity, and religion) for the Aging Attitudes-65 was not significant, $r(\text{df} = 96) = -.16$, $p = .06$, one-tailed, although it was in the expected direction. Contrary to expectation, no significant relationship emerged between the participants' attitudes toward aging score on either the 25- or 65-year-old vignette and their level of internalized homophobia. It should be noted that there was a non-significant trend ($p = .06$) for participants' attitudes toward aging score on the 65- year-old vignette to be negatively correlated with their level of internalized homophobia, as predicted.

**Hypothesis 5a:** The negative correlation between internalized homophobia and attitude toward aging score will be greater in magnitude for the old vignette character than the young vignette character. This hypothesis could not be tested as neither partial correlation was significant in the previous analysis.


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# CHAPTER IV

# Discussion

Investigations about the study of aging in gay men are still in their initial stages. To date, there has not been any quantitative examination of aging gay men, their wellness and life satisfaction. This analysis is the first to explore a wide age range of adult gay men, and see how their views of aging are related to their own age, as well as their level of homophobia and their personal sense of life satisfaction. The findings of the current study will be discussed with reference to the extant literature, and the implications clinical treatment of gay men and future research will be discussed.

**Study Results and Clinical Implications**

**Characteristics of the study participants:** The sample consisted of 209 participants whose ages ranged from 18 to 77. The mean age was 43 (*SD* = 15). The age range from the youngest to the oldest participant was nearly 60 years. About 50% of the sample was between 31 and 55 years old, with 25% between 18 and 31, and 25% between 56 and 77. Although few participants had reached the age of the older vignette character, 65 was probably not an unimaginable age for many participants. Although there was a wide age range, the ethnic distribution was less impressive. The ethnicity was mostly Caucasian (156 participants); the next largest group was Latino/Hispanic Americans (23 participants), followed by African- American/Black individuals (11 participants). The remaining 19 individuals self-identified as belonging to five different ethnic groups. The following discussion of the results is therefore based on a predominantly Caucasian sample.

The participants showed a much higher degree of internalized homophobia than anticipated. Out of a maximum score on the Internalized Homophobia Scale of 100, the mean score of this sample was 83.92 (*SD* = 12.65). The unexpectedly high level of internalized homophobia among the participants prompts a few initial observations. Ageism may be partly responsible. Ratigan [38] found gay men felt as though they became more invisible as they aged. Members of the Baby Boomer generation survived through a time when 1) consensual gay intercourse was criminalized; 2) the stereotype of the dreaded older *auntie* prevailed; 3) the psychological and psychiatric communities viewed being gay as a disorder; and 4) the AIDS epidemic decimated the gay population. Even if most of the participants did not experience all of these events first-hand, they were undoubtedly affected by them. It is possible that high levels of homophobia found in this sample reflect the long-lasting effects of oppression and discrimination against gay men, and the message that being gay was not acceptable. Internalized homophobia was the focus of the first two hypotheses, and will be discussed below.

Turning to life satisfaction, the mean SWLS score of this sample was 23.05 (*SD* = 7.76), with 35 was the maximum and 5 was the minimum. Although the overall level of internalized homophobia was quite high, the general life satisfaction of the participants seemed to be unrelated to the negative experience of internalized homophobia. Ergo, one could experience a solid sense of life satisfaction while still experiencing a high level of internalized homophobia. Findings involving life satisfaction will be discussed below.

**Level of internalized homophobia and age:** Hypothesis 1 posited a positive correlation between level of internalized homophobia and age. As noted above, there are several reasons why today's older gay cohort would have more internalized homophobia than their younger counterpart. A trifecta appeared in which mental, physical and financial strife among older LGBT individuals were expected to contribute to higher internalized homophobia in the present sample. The results from this study confirmed the expectation, with a correlation of $r$(df = 203) =.13, $p$ = .03. While significant, the correlation was much lower than expected, possibly due to the apparent ceiling effect in the scores. In his dissertation, White [69] examined attitudes and internalized homophobia in 79 gay and lesbian college students. In White's sample, the mean IHS score was 46.26 (*SD* = 15), which is much lower than the mean score found in this study. Even in the original article about the IHS [62] the mean IHS scores were 32.6 (*SD* = 10.6), 37.4 (*SD* = 12.8), and 36.3 (*SD* = 11.6) in three samples of gay men. It is not clear why the participants in this study had much higher levels of internalized homophobia than other samples.

The hypothesis was created, and supported, based on the expectation that the younger generation would be flourishing relative to the older generation of gay men. Gay men are now able to come out at a younger age, marriage equality is the rule of the land, and acceptance of being gay is more the norm, especially among the younger generation.


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Yet, the sample of this study showed that internalized homophobia was quite high overall. Young or old, the participants' high IHS scores suggested that they felt a sense of shame. Recently, an article by Jan Hoffman [70] ran in the *New York Times* showing a possibility for the high level of internalized homophobia. In the federal government's biennial Youth Risk Behavior Survey, considered to be the gold standard of health data collected for adolescents, 1.3 million high school students identified themselves as LGB. These students were three times more likely than their straight counterparts to have been raped. Due to not feeling safe, they skipped school more often than straight students. At least of a third of the participants had been bullied and were twice as likely as their straight counterparts to have been threatened with a weapon. Almost half, 40%, had considered suicide, and 29% had made attempts in the previous year. In terms of drugs, straight participants, 1.3%, reported heroin use while 6% of LGB respondents had tried the narcotic. Although the Hoffman [70] report was based on adolescents, it suggests some reasons for internalized homophobia in samples of gay men. In any case, the significant positive (although very low) correlation between IHS and age supported the notion that internalized homophobia would be greater in older gay men compared to younger gay men.

**Level of internalized homophobia and ethnicity/race:** Hypothesis 2 predicted that White men of European ancestry would score lower on internalized homophobia than other races. Very few examples of studies done on ethnic minorities have been completed up until this date; however, what has been examined showed the reason for this hypothesis. Woody [53] did a qualitative study of ages ranging from 58 to 72 years of age. The possible risk of losing support from the African American community because of being gay can be devastating with significant social and health implications [53]. Although Woody didn't discuss internalized homophobia directly, it is plausible that alienation from one's racial community could result in internalized homophobia.

Finally, aging LGBT African Americans face unique challenges regarding discrimination on all fronts of life: access to health care, community resources, housing, familial, financial and legal support and security [53]. Similarly, David and Knight [54] compared outcomes of gay Black and White younger, middle-aged and older adults coping styles, perceived stigmatization and mental and physical health. At that time, their study was the first to include older Black gay men. Their results showed that old gay Black men perceived significantly higher levels of ageism than their White counterparts and perceived higher levels of homonegativity than their White counterparts [54]. Again, while homonegativity is not exactly the same as the internalized homophobia assessed in the current study, the results of David and Knight's study suggest that older gay Black men may be at risk for higher levels of internalized homophobia.

Based on the literature, it was thought that White men would have lower levels of internalized homophobia than other ethnic minorities. But, in fact, Hypothesis 2 was not supported. The opposite was true. Of the 206 participants with complete data on the measures used to analyze this hypothesis, 156 were white while 50 were non-whites. It is unfortunate that the numbers of minorities was not high enough to compare the distinct groups. It is a serious limitation of this study to have such a high number of whites comparing to such a low number of minorities. Because the level of internalized homophobia was so high in this study, there may not be much of a meaningful difference in terms of internalized homophobia between groups, as indicated by the very small effect size of .03.

**Attitudes toward aging:** A significant problem for this study was that a psychometrically sound instrument measuring attitudes for adults towards aging could not be found after a thorough search of the literature. Two vignettes were generated, and the only difference between them was the age of the character. One was aged 25 and the other aged 65. Questions for the scale were constructed primarily from Seligman's [56] PERMA model, which does not provide an exhaustive definition for well-being but it offers a solid framework. PERMA stands for Positive emotion, Engagement, positive Relationships, Meaning, and Accomplishments. Two additional questions were also created that were not based on the PERMA model, one about physical health, and the other about financial stability. Initial psychometric analyses revealed that deletion of these two items improved the overall internal consistency of the scale, resulting in a Cronbach's alpha of .80 for the Aging Attitudes-25 and a Cronbach's alpha of .77 for the Aging Attitudes-65, with notably normal distributions.

Hypothesis 3 predicted that the well-being of the younger character would be rated higher than the older character, primarily because the review of the literature revealed a significant amount of ageism among gay men. This hypothesis was supported; however, the effect size of .02 was very small. So, while statistically significant, the difference between the means for the Aging Attitudes-25 ($M$ = 23.71) and the Aging Attitudes-65 ($M$ = 22.26) was negligible. As the Aging Attitudes scale was developed for this study, there are no other data with which to compare these findings. The younger character was rated significantly more positively than the older character, which is consistent with the presence of at least mildly ageist attitudes toward older adults.

Hypothesis 4 stated that there would be a positive


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correlation between participants' scores on the Aging Attitudes Scale and their scores on the SWLS. It was expected that the attitudes participants held toward the somewhat struggling vignette character would vary in the same direction as their overall satisfaction with life. This was analyzed separately for both the 25-year-old vignette and the 65-year-old vignette. The hypothesis was supported for the 25 year- old vignette, $r(df = 99) = .21$, $p = .02$, and for the 65 year-old vignette, $r(df = 97) = .30$, $p = .002$. It appears that general satisfaction with life correlated positively with participants' attitudes toward the well-being of the vignette characters.

Some gay men define themselves as being washed up with no hope for the future by their mid-40s [40]. But, as the participants' scores revealed that was not the case in this study. The participants' overall sense of well-being, as assessed by the SWLS, was positively correlated with the overall ratings of the vignette characters' well-being, and this effect occurred for both the 25- and 65-year-old character. This is useful evidence of convergent validity of the Aging Attitudes Scale, as personal sense of well-being correlated positively with the ratings of well-being of the vignette characters.

To further explore the response to the Aging Attitudes Scale, Hypothesis 5 predicted that internalized homophobia would be negatively correlated with participants' views about the vignette characters. Results showed that the hypothesis was not supported for either Aging Attitudes scale. The correlation between IHS and the Aging Attitudes-25 was $r(df = 97) = .11$, $p > .05$ and between IHS and the Aging Attitude-65 was $r(df = 96) = -.16$, $p = .06$. The apparent ceiling effect of the IHS scores may have restricted the range of this scale's scores, which may have limited its correlation with the Aging Attitudes Scale. It appears that the level of internalized homophobia endorsed by the participants was unrelated to their ratings of either the 25- or 65-year-old vignette characters. The participants rated the vignette characters' level of well-being independently of their own level of internalized homophobia. Again, this indicates that ratings on the Aging Attitudes scales are unrelated to levels of internalized homophobia, although as seen above, ratings on the Aging Attitudes scales were directly related to the participants' sense of life satisfaction.

**Limitations and Suggestions for Future Research**

Upon reflection, a few limitations revealed themselves. The first limitation concerned the participants. This examination hoped to capture a snapshot of a wide variety, ethnically diverse and big age differences. However, this was not the case. The majority of the sample was Caucasian men, 159 participants, to 53 other participants who were dispersed over seven different so the generalizability of the study may not be particularly wide. The lack of racial/ethnic diversity poses a threat to external validity in that the population validity was not representative of the true population. Greater participant diversity is recommended in future investigations. This is an important fact because as the literature review showed ethnic minorities had their own needs and variations as did the fact that this study separated the G from the LGBT acronym. A more ethnically diverse sample may have shown different results.

Next, a ceiling effect was detected in which the internalized homophobia score was much higher than expected. As introduced earlier, the federal government's biennial Youth Risk Behavior Survey reported some shocking results. For instance, over one million self-identified LGBT adolescents identified being three times more likely than their heterosexual counterparts to have been raped. They missed school far more often than their straight counterparts due to not feeling safe; about a third of them had been bullied on school property. And they were twice as likely to have been threatened or injured by a weapon on their school property [70]. This strongly suggests that the younger generations are still internalizing some hatred and loathing about their identity which would easily lead to them acquiring high levels of internalized homophobia.

The next limitation was that this study does not have any comparison to heterosexual men or lesbians. So the findings, while interesting, are not generalizable beyond a sample of predominantly white gay men. It is not known whether these findings are unique to gay men.

Clearly, a comparison group, as well as replication with other samples of gay men, are needed in the future.

Another limitation to this study is a theoretical one: the definition of "coming out." While coming out age was expected to be a useful way to characterize the sample or serve as a covariate in statistical analyses, it was not clearly defined for the participants. In other words, what does coming out actually mean? In this study, men indicated when they came out; however, there was no clear rubic as to what that date represented. Did it mean coming out to family? Or did it mean coming out to friends or even to oneself? Perhaps participants responded to one of those scenarios or perhaps they created an average age of multiple coming out experiences. This sensitivity to precision is imperative as it may have affected the internalized homophobia scores, but the instructions about the coming out age were not clear.

Finally, this study was designed to assess attitudes toward aging in gay men, but no well- validated measure was found to assess the construct. The Aging Attitudes Scale


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was created for this study, and while it showed promising psychometric properties, it needs to be explored further. The vignettes can be easily edited to reflect different ages, ethnicities, and sexual orientations. The Aging Attitudes Scale showed no relationship with internalized homophobia, and direct associations with satisfaction with life ratings in the current study. The relationship between the Aging Attitudes scales and additional constructs need to be investigated in the future.

**Clinical Implications**

"Homophobia whether internalized or externalized is really fear; it's not hatred, it's fear. It's fear of the truth about ourselves" (http://www.brainyquote.com/quotes/authors/a/andrew_sullivan.html) [71]. Mr. Sullivan makes a salient point about internalized homophobia, one that revolves around fear. This study, then, found a great deal of fear among gay men: There was an unexpectedly high level of internalized homophobia, and it was higher in the older participants than the younger participants. The white gay men in the sample had a small but significantly higher degree of internalized homophobia than the minority men. The high degree of internalized homophobia was distressing but not that surprising after reflecting upon the published literature. Fear is a main motivator for gay men. For too many years the fear of being found out that one was gay characterized the community. Fear of continued oppression sparked the Stonewall riots. Fear of dying drove the AIDS activism in the 80s and early 90s. Fear of being pathologized fueled the removal of homosexuality from the *DSM*. Fear of growing older and being alone created the dreaded *auntie* stereotype. *Fear = Internalized Homophobia*, just like the famous AIDS slogan *Silence = Death*. One doesn't exist without the other.

While the implications for this examination were, at first, disheartening, an idea begin to flourish. How does one help with the rampant internalized homophobia from a clinical standpoint? It seems logical to turn to fear about combating this insidious self-hatred. Perhaps looking at internalized homophobia as a broad, all-encompassing umbrella label is just that—too broad. To begin to dismantle internalized homophobia, clinicians need to meet clients where they are, and the construct of intersectionality mandates that we consider multiple starting points, e.g., how the client identifies in terms of sex, age, race/ethnicity, etc. These are just a few of the many identities that need to be examined in relationship to one another.

To work with internalized homophobia in the future, clinicians may need to dismantle the broad definition and look solely at the individual in front of them. Clinicians need to work only with the client in the room and explore the fears that he harbors. Then, and only then, can growth and a freedom from the plight of self-hatred give both clinician and client a rebirth into acceptance.

The Attitudes toward Aging Scale was created for this study because nothing similar could be found in the published literature. Besides demonstrating some impressive psychometric characteristics that suggest its utility for future investigations of attitudes toward aging, it proved to be very useful for the current investigation. Specifically, as expected, the 25-year-old character was rated at a significantly higher level of well-being than the 65-year-old character.

Also, participants' attitudes toward both the 25- and 65-year old characters were positively associated with their own well-being: As their SWLS scores increased, so did their ratings regarding the well-being of both vignette characters. Interestingly, the participants' level of internalized homophobia was unrelated to the way they viewed either the 25- or 65-year-old character.

Ergo, the Attitudes toward Aging Instrument may be a useful instrument in future research. The vignette allowed the researcher to explore attitudes toward aging, which had not been previously explored quantitatively in gay men. And, as ageism would predict, it was found that the older character was rated more poorly than the younger character. Even without further research on the instrument, it could be used clinically to assess a person's attitudes toward growing old, by giving the client both vignettes to read and respond to.

Unfortunately, the gay community has a bias toward youth, as reflected in the literature and in this study. Although ways to age successfully have been discussed in the literature, the predisposition is toward youth. When gay men are feeling old and put out to pasture at age 40 what does that mean clinically? It means that gay men have a problem of their own making.

They want to live forever, they want to stay fledgling, in a state where everything is new. This is because many gay men are still grappling with HIV/AIDS and their mortality is a constant presence; this means that growing older without children and a family can create a panic and realism of loneliness; this means that growing older alone (it was shown gay men are more likely to be single as they age than heterosexuals) and the fear of life's transitions are too unbearable to deal with by oneself. So, to be young, vibrant, and carefree is a much more viable alternative to choose to look at.

The Attitudes Toward Aging Scale showed that life satisfaction was positively correlated with the ratings of the vignette characters. This is significant as it shows that


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the instrument appears to measure what it intended and suggests a powerful point: Gay men need a paradigm of how to age. Erickson offered psychosocial stages of development for people that arguably do not apply to gay men and their specific needs. If the 25-year-old vignette character's well-being was positively correlated with gay men's life satisfaction, the question becomes why? What connects the two? Why were well-being ratings of the 65-year-old vignette character positively correlated with gay men's life satisfaction? It's been shown how much ageism is at work in the gay community. But these findings suggested that overall life satisfaction can create a positive outlook—even about vignette characters. This is valuable information for clinicians as they work with gay men who have concerns about their own aging process. Perhaps a model of how gay men age could be developed that respects the sensitive needs of this population.

Among those men who have yet to come out, there may be tremendous fear about the coming out process as well as the implications for their identities as gay men and, eventually, older gay men. Being gay entails many hardships, which typically increase with age. Clinicians should consider age-related factors and developmental processes as they work with gay men.

It is important to note that internalized homophobia did not affect the participants' attitudes toward the well-being of the vignette characters. Clinically, it may be that gay men may be skilled at compartmentalizing their internalized homophobia. Clinicians may not see a client's internalized homophobia affecting every aspect of his life. Results from this study suggest that internalized homophobia may co-exist with some positive and some negative attitudes toward other aspects of life, and this is important for clinicians to understand. So, instead of blanketing the whole population with labels or making unwarranted assumptions, what a clinician needs to do is meet the client where he is. It sounds perfunctory but sometimes the simplest ideas are the most profound [72].

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