HEALTH CARE AND COMING OUT:

GAY AND BISEXUAL MEN'S

HEALTH CARE

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CHAPTER I

INTRODUCTION

Since the publication of Alfred Kinsey's book *Sexual Behavior in the Human Male* (1948) the scientific and healthcare communities have been aware that a portion of the male population engages in sexual activities with other males. Actually knowledge of same sex (i.e. male/male, female/female) sexual activity and intimate relationships has been documented since antiquity. Although this knowledge exists, it is frequently marginalized and/or outright ignored by many individuals for various reasons (e.g. religious/spiritual, societal disapproval, embarrassment, etc.). This marginalization and disregard has resulted in a lack of awareness and understanding of individuals who engage in same sex sexual activity and/or intimate relationships by society at large. As with any group that is marginalized, disregarded, and/or seen as not being "normal" and/or "desirable" a cloud of mystery and disinformation tends to form around them.

People often view things and others that are mysterious and/or unfamiliar to them as being potentially dangerous, untrustworthy, or perhaps undesirable (Cook, Fine, & House, 1995; Gladding, 2003; Myers, 1999; Yalom & Leszcz, 2005). This tendency along with negative propaganda can and often does leads individuals to dislike or even outright fear a mysterious and/or unfamiliar object, person, or group of people. When this occurs a person is said to have a prejudice towards a specific object, person, or group. Gay men, lesbians, bisexual men and women have endured and continue to endure discrimination due to the prejudices of others.

Health Care Services

Strides have been made since the mid 1960s in acknowledging and addressing the discrimination and prejudices that negatively impact the lives of gay men, lesbians, and bisexual men and women. With that said, there remain areas in which some of their needs continue to be ignored, denied, and/or inadequately addressed. One such area is competent and comprehensive healthcare services. Professionals within the medical, legal, and psychological communities have been outspoken concerning the healthcare needs of the gay, lesbian, and bisexual (GLB) community, however progress towards adequately addressing their needs has been slow and often met with opposition. O'Hanlan, Cabaj, Schatz, Lock, and Nemrow (1997) stated that "the gay and lesbian community needs medical care that recognizes its unique medical demographic profile and is provided with the same degree of knowledge, sensitivity, and respect afforded other segments of our large and diverse society" (p. 26). This is consistent with the American Medical Association's H-160.991 policy, which states that the:

> AMA: (1) believes that the physician's nonjudgmental recognition of sexual orientation and behavior enhances the ability to render optimal patient care in health as well as in illness. In the case of the homosexual patient this is especially true, since unrecognized homosexuality by the physician or the patient's reluctance to report his or her sexual orientation and behavior can lead to failure to screen, diagnose, or treat important medical problems…. [The AMA] is committed to taking a leadership role in: … educating physicians to recognize the physical and psychological needs of their homosexual patients… [as well as] encouraging physicians to seek out local or national experts in the health care needs of gay men and lesbians so that all physicians will achieve a better understanding of the medical needs of this population…(American Medical Association., 2005, p. 1)

There are undoubtedly many reasons for the disparity between the quality of healthcare provided to GLB individuals and that of heterosexual individuals, but nonetheless disparities exist which need to be addressed.

There have been several studies that have sought to explore the health care experiences of lesbian and bisexual women, but very few have been conducted that specifically look at the health care experiences of gay and bisexual men (Brotman, Ryan, Jalbert, & Rowe, 2002; Klitzman & Greenberg, 2002). Thus, the emphasis of this research study was to examine the health care experiences of gay and bisexual men, paying special attention to factors influencing their decision to disclose their sexual orientation to health care providers. Due to the lack of research with gay and bisexual men in this specific area of focus, it was determined that a survey based approach was the most appropriate to utilize.

Gay and Bisexual Men's Health

Prejudice, stigmatization, and discrimination can negatively impact the health care of gay and bisexual men. For instance homophobia and heterosexism can result in health care environments which can be unwelcoming and potentially threatening to non-heterosexual individuals. Additionally, there are some health issues that gay and bisexual men experience at higher rates from their heterosexual male peers. For example, gay and bisexual men are considered a higher risk group for some sexually transmitted diseases such as HIV/AIDS, hepatitis A & B, human papillomavirus, genital herpes, chlamydia, and syphilis. Gay and bisexual men also are considered at higher risk of struggling with anxiety, depression, suicidal ideation and attempts, drug and alcohol dependence and abuse, and tobacco. These facts highlights the importance for health care providers to have knowledge about their client's sexual orientation and sexual behaviors, as well as knowledge about what factors can impact the wellbeing of gay and bisexual men.

Coming Out

The disclosing of one's sexual orientation is often referred to as "coming out" and according to multiple psychological theories of gay, lesbian, and bisexual identity development, coming out occurs in multiple stages/steps (Taylor, 1999). For instance, the first step in the coming out process tends to focus on an individual's recognition and acceptance of their same sex sexual attractions. Thus the first person an individual "comes out" to is their selves. One interesting aspect of the "coming out process" is that it is never truly over. Unlike some other minority populations, it is not always evident to others that a person is gay, lesbian, or bisexual and thus it places them into a situation of having to choose whether or not to disclose their minority status to each individual to whom they come into contact.

The decision to come out is rarely a simple one and often multiple considerations are taken into account by individuals when they are deciding to disclose to a specific person or group of persons (Savin-Williams, 2001). Furthermore, a GLB individual may have to come out to the same person on multiple occasions before that person accepts their sexual orientation. Some individuals within the GLB community decide to live an "out" life (i.e. they communicate to those they come into contact with that they are gay, lesbian, or bisexual). Others, however, live a "closeted" life (i.e. they conceal their sexual orientation from all or a select few individuals).

The decision of when and to whom to come out to is often a hotly debated issue within the GLB community and within society in general. There are some individuals within the community that are steadfastly insistent that all GLB individuals owe it to themselves and the community to live openly "out" lives. Often times their argument for their stance is that until members of the GLB community commit to living "out" lives, the remainder of society will be resistant to acknowledging the existence of gay, lesbian, and bisexual individuals and their civil rights (Human Rights Campaign., 2008). On the other hand, there is a segment of society that claims to hold no bias against GLB individuals but ask that they avoid public disclosure of their sexual orientation and displays of non-heterosexual behaviors (Otjen, Redd, DaVitte, Loy, &

Miller, 1993). Another stance held by some people is that GLB individuals are abominable and that they have no place in civilized cultures and societies. One way to view the issue of "outness" is on a continuum, with one end of it representing those who openly support GLB individuals and rally for them to live as "out" individuals, and the other end representing those who oppose GLB individuals living an "out" existence.

As with many minority groups, the level at which GLB individuals are seen as a valued part of society is often hotly debated and sadly sometimes this debate has led to GLB individuals being persecuted or killed for simply being themselves (Mathew Shepard Foundation., 2006). Regardless of the stance one takes on GLB individuals and their place in societies, one can argue that all individuals deserve adequate, comprehensive, and compassionate health care. Unfortunately, a significant portion of the GLB community cannot claim to have access to such health care for various reasons (Eliason, 1996; Mail & Lear, 2006; Turner, Wilson, & Shirah, 2006).

Goals of the Study

One goal of this study was to explore if a participant's age group, education level, global outness level, years with health care provider (HCP), personal importance rating of discussing sexual behaviors with their HCP, personal importance rating of disclosing sexual orientation to HCP, and personal knowledge rating of heath concerns and issues for gay and bisexual men could be used to predict whether or not a participant has disclosed their sexual orientation to their HCP. A second goal of this study was to explore if there were significant differences between participants who have disclosed their sexual orientation to their HCP and those who have not on importance survey items.

The reasons for conducting this study were to explore what factors may be helpful in creating a more welcoming health care environment for gay and bisexual men. Additionally, this study examined what factors can help predict which gay and bisexual men are more and less likely to disclose their sexual orientation to their health care providers.

CHAPTER II

REVIEW OF LITERATURE

Research and literature pertaining to gay men, lesbians, and bisexual (GLB) individuals has increased vastly since the early 1970s (Garnets & Kimmel, 2003). For instance there are currently at least 8 journals that focus primarily on issues pertaining to GLB individuals (see appendix A for a listing of the aforementioned journals). In addition to these journals many more journals routinely publish research and scholarly articles pertaining to GLB individuals. With that said there continues to be aspects about GLB individuals and their lives that continue to be enigmatic and under-researched (Harcourt, 2006).

One difficulty individuals often experience when reviewing literature or research pertaining to GLB individuals is the vast (and sometimes confusing) terminology used to describe and identify GLB individuals, their communities, and sub-communities. Since the focus of this study is on gay and bisexual men and their health care a brief discussion of terminology often associated with these two groups is needed.

Terminology Pertaining to Gay and Bisexual Men

It is not uncommon to come across the term *sexual orientation* when reviewing literature pertaining to gay and bisexual men. Sexual orientation is defined as "an enduring emotional, romantic, sexual, or affectional attraction toward others.… [It] exists along a continuum

that ranges from exclusive heterosexuality to exclusive homosexuality and includes various forms of bisexuality" (American Psychological Association., 2010b). It is important to note that sexual orientation and sexual preference are not interchangeable with each other. The term sexual preference implies that a person chooses his or her sexual attractions, whereas sexual orientation does not emphasize that choice is a factor in their attractions.

The term homosexual is occasionally used in research pertaining to gay and bisexual men. *Homosexual* is used as a label for individuals "who are attracted to their same gender" (Herek, 2003, p. 274). It is a general term which is often used to describe all individuals (i.e. gay men, lesbians, and bisexual men and women) who possess same-sex attractions. It is important to note that the use of "blanket terms" such as homosexual should be avoided when possible because these terms often do not address the uniqueness of the members for which they are used to represent. In addition to its nonspecificity, the term homosexual is viewed by some in a negative light due to its historical association with the pathologization of same-sex attraction predominant prior to the early 1970s (American Psychological Association., 2010a).

A term that has been gaining acceptance in academic and health related fields is *men who have sex with men* (MSM). This term surfaced in the medical and public health fields as a means of addressing the issue that not all men who engage in sex with other men identify as being a gay or bisexual man, but rather self-identify as heterosexual. Thus the focus of the MSM term is not on one's self-identity but rather on one's sexual behaviors.

Another term sometimes used when describing or discussing gay and bisexual men is the term *queer*. Prior to the 1980s, queer was often seen as a derogatory name for GLB individuals. Although some individuals continue to view it as derogatory others have reclaimed the term and see it as a symbol of GLB pride and an alternative to other terms used for self-identification.

> Queer is a decidedly political term that, for many people, symbolizes a challenge to traditional category boundaries. Any person with same-gender desires can be queer

> because they challenge traditional heterosexual notions of gendered sexuality…. For many people who adopt queer identity, it symbolizes not only their sexuality but also the challenge their sexuality poses to socially constructed sexuality, gender, or both. Yet, for other people, the term queer retains its pejorative connotations; for these people a queer identity would not reflect a positive self-image" (Rust, 2003, p. 244).

Some bisexual individuals prefer to identify as queer due to the stigma associated with the term bisexual within some gay male, lesbian, and heterosexual communities.

Stigmatization and discrimination towards GLB individuals is a reality for many gay and bisexual men. Sadly, stigmatization and discrimination are so prevalent that there have been terms developed to describe and label their occurrence. For instance, the term *homophobia* is commonly defined as "an irrational, persistent fear or dread of homosexuals [and/or homosexuality]" (Kite & Whitley, 2003, p. 167; MacDonald, 1976).

It is important to note that the terms homophobia, homophobe, and homophobic are often misused in the press and in casual conversations to describe anyone who has a bias against GLB individuals. The more accurate term to describe the practice of holding a bias against GLB individuals is *heterosexism*, which is defined as "the belief that heterosexuality is the only normal or natural option for human relationships and/or that heterosexuality is superior to homosexuality" (Eliason, 1996, p. 33). The key difference between homophobia and heterosexism is that homophobia is indicative of an "irrational fear, or aversion to" GLB individuals, whereas heterosexism is not characterized by fear of GLB individuals but rather a prejudice against them because of their sexual orientation or sexual practices.

On a similar line with homophobia, bisexual individuals are sometimes subjected to *biphobia*, which is defined as "the fear of intimacy and closeness to people who don't identify with either the hetero- or same-sex orientation…" (Hutchins & Kaahumanu, 1991, p. 369; Potoczniak, 2007, p. 124). Thus bisexual individuals can and sometimes do experience biphobia from heterosexuals, gay men, and lesbians.

Gay and Bisexual Male Identity Development

Several identity development models have been theorized to address the issue of gay male, lesbian, and bisexual individual's identity formation and consolidation. One of the earlier models was developed in 1979 by Cass.

The Cass model of gay male / lesbian identity formation. Cass's (1979, 1984) model suggests that an individual's gay or lesbian identity develops in a six stage linear fashion consisting of: Identity Confusion, Identity Comparison, Identity Tolerance, Identity Acceptance, Identity Pride, and Identity Synthesis. This model was developed to address the formation of a gay male or lesbian (GL) sexual identity. In this model bisexuality is viewed as an individual's inability to successfully reconcile their sexual identity as either gay/lesbian or heterosexual.

Cass's model can be classified as being a "choice model". In choice models, it is suggested that individuals can cognitively choose to assume a heterosexual or gay/lesbian identity. For example, Cass (1984, p. 150) wrote that "in each stage, identity foreclosure [i.e. the reconciliation of personal behaviors with a heterosexual identity] in which individuals may *choose* not to proceed any further in the development of a [GL] identity is possible".

Stage 1: Identity Confusion. Cass (1984) theorized that in *identity confusion* an individual notices that some of their behaviors (i.e. feelings, thoughts, and/or actions) could be defined as being same-sex oriented. This realization marks the individual's entry into the process of GL identity formation. Stage 1 is identified as "confusion" because of the bewilderment individuals experience when they realize that some of their behaviors could be considered as being same-sex oriented. Cass (1979, p. 223) suggested that this "confusion" leads people to ask themselves the question "If my behavior may be called [same-sex oriented], does this mean that I am a [gay man / lesbian]?"

According to Cass's model this leads individuals to utilize one of three approaches (A, B, or C) to reconcile their sexual identity with their behaviors (1979). In *approach A* an individual finds that some of their behaviors are same-sex oriented and that they view this as being

acceptable and congruent with their self-perception. Individuals who utilize *approach A* advance to stage 2 of the identity development model.

An individual utilizing *approach B* find that some of their behaviors are same-sex oriented but view the behaviors to be inconsistent with their self-perception (i.e. behaviors are seen as negative and incongruent with who they see themselves as). The feelings of incongruence felt by the person results in them seeking to correct the incongruence via the use of three strategies: 1) attempting to stop all behaviors that are deemed same-sex oriented, 2) actively avoiding or ignoring all information of or relating to homosexuality, 3) denial that information pertaining to homosexuality has relevance to them.

In essence individuals who utilize *approach B* attempt to limit their knowledge of homosexuality and to distance themselves from their behaviors that are suggestive of a potential GL identity. According to Cass (1979) the effectiveness of *approach B* depends on the individual's ability to distance themselves from their past same-sex behaviors while avoiding engaging in future same-sex behaviors. Successful implementation of *approach B* allows the individual to deny their same-sex attractions and thus they are able to maintain a heterosexual (or perhaps an asexual) identity. Failure to successfully implement *approach B* leads the individual to enter into stage 2 in spite of their not wanting to accept a GL identity.

Approach C is utilized by those who view their same-sex behaviors negatively and also incongruent with their self identity. Often individuals who utilize *approach C* do not view their same-sex behaviors as being indicative of a GL sexual orientation. For many of these individuals they view their behaviors as being situationally dependent (i.e. inaccessibility to other sex partners) and thus once their situation changes they fully expect not to continue to engage in behaviors that are considered same-sex oriented. Those who utilize *approach C*, continue to maintain their heterosexual identity, in spite of engaging in behaviors that are often associated with homosexuality.

Stage 2: Identity Comparison. In *identity comparison* an individual has accepted the possibility that they may indeed be a gay male or lesbian. This stage is marked by feelings of alienation upon the realization that they may indeed be different from people who identify as heterosexual. The feelings of alienation lead the individual to feel as if they are not a part of society at large as well as from family and other social groups (Cass, 1979). An overwhelming sense of isolation is not uncommon for individuals to experience during this stage of Cass's model.

During this stage individuals begin to realize that social guidelines and life trajectories which they were taught to strive towards and adhere to may no longer be relevant or applicable to them. This realization can potentially destabilize one's sense of self and purpose. For some the sense of alienation and isolation will lead them to seek out help (e.g. counseling, pastoral consultation, etc.) in reconciling their feelings and behaviors so that they may restore their confidence in having a heterosexual identity and thus maintain their standing in heterosexual society and other social groups. Others will attempt to seek out others who are also "different" in an attempt to reduce their sense of isolation and alienation. Cass theorized that individuals in the *identity comparison* stage have four approaches (A, B, C, and D) to choose from in order to reduce their feelings of alienation felt during this stage.

Approach A is utilized by those who react positively to the idea of being different from society at large. Cass suggests that three categories of individuals make up the individuals that utilize *approach A*. The first group is made up of individuals who "feel that they have 'always been different' by virtue of having had what were later labeled [same-sex oriented] feelings, thoughts, or behavior[s]" (Cass, 1979, p. 226). For this group of individuals they are able to apply a label (i.e. gay or lesbian) that helps to explain their long felt feelings of differentness. The ability to now categorize themselves provides them with a since of belonging which they previously had not had.

The second group is made up of individuals who "have felt 'different' throughout their lives on the basis of nonconformity to the heterosexual role…" (Cass, 1979, p. 226). Cass suggested that some individuals will assume a GL identity as a means of justifying their nontraditional feelings or beliefs (e.g. non-desire to marry or have children, desire to pursue a nontraditional occupation). For these people the assumption of a GL identity provides them with a means of legitimizing their beliefs and desires. The third group who tend to utilize *approach A* are those who "find 'being different' exciting, out of the ordinary, as adding something special or extra to their lives"(Cass, 1979, p. 226). Those who utilize *approach A* will move onto stage 3.

Approach B for reducing incongruency occurs when an individual acknowledges and accepts that some of their behaviors are same-sex oriented, but considers taking on a GL identity as undesirable (Cass, 1979). Individuals utilizing this approach tend to use one of four coping strategies: special case, ambisexual, temporary identity, or personal innocence. The *special case* strategy is used when an individual accounts their same-sex oriented behaviors/feelings to the presence of a specific person (e.g. a man states that if it were not for his boyfriend he would be heterosexual), thus if that person did not exist they would be GL. This strategy places the responsibility for an individual's GL identity on a specific person rather than on themselves.

Cass (1979, p. 227) states that the *ambisexual* strategy is utilized by individuals who "perceive [themselves] as both [GL] and heterosexual". Cass's *ambisexual strategy* suggests that sexual identity is dichotomous (i.e. GL or heterosexual) and that bisexuality is a coping strategy for individuals who engage in same-sex behaviors, while at the same time holding negative views towards taking on an exclusively GL identity. The *temporary identity* strategy is utilized by individuals who view their GL identity as temporary. This approach allows individuals who presently identify as GL the option of choosing a heterosexual identity at a later time.

The fourth strategy that individuals using *approach B* can utilize is the *personal innocence* strategy. Those who utilize this strategy acknowledge that they possess a GL self-image however they deny having control of it (e.g. They may claim they were born same-sex

orientated or that it is because of how they were raised). Cass (1979) suggests that individuals who utilize *approach B* may increase their efforts to pass as heterosexual as a means of hiding their GL identity from heterosexuals. Additionally, others may attempt to live two separate lives, one as a GL and the other as a heterosexual. Those who are unable to effectively utilize *approach B* to reduce their feelings of alienation will proceed to stage 3 of identity formation.

Approach C is utilized by those who accept that they are possibly GL but because of strong negative social ramifications they view being GL negatively. Individuals utilizing *approach C* attempt to stop themselves from engaging in same-sex oriented behaviors and may attempt to engage in behaviors that they deem opposite to same-sex oriented behaviors. Those who are unable to arrest their same-sex behaviors may attempt to modify their environments so that their behaviors are less likely to impact their social relationships. For example, an individual may move to a city where none of their family members live to reduce the likelihood of their GL identity being discovered. Those who are unable to effectively utilize *approach C* will proceed to stage 3 of identity formation.

The fourth approach used by individuals during stage 2 is *approach D*. This approach is utilized by individuals who view both their same-sex behaviors and possible GL identity negatively. Individuals who utilize this approach are likely to attempt to arrest all of their same-sex oriented behaviors in addition to taking on a negative stance against GLs and idealizing heterosexuality. Utilization of *approach D* may lead individuals to adopt an extremely negative self-view and an aversion to all things representative of homosexuality.

Effective use of this approach allows an individual to reject the possibility that they may be GL. Ineffective use of the approach may lead the person to self-loathing. Cass suggested that those who view their behaviors and a possible GL identity with extreme negativity may be vulnerable to suicidal thoughts or attempts if they are unable to adopt a heterosexual identity and heterosexual behaviors. For this group of individuals the possibility that they may be GL is so unacceptable they are willing to go to extremes to avoid taking on the identity.

Stage 3: Identity Tolerance. The *identity tolerance* stage is marked by an increased tolerance of one's same-sex oriented behaviors and the possibility that they are GL. During this stage individuals begin to seek out others who are GL in an attempt to fulfill their needs (i.e. social, emotional, and/or sexual). Cass (1979, 1984) emphasized that the perceived quality of the interactions people have will other GLs has a significant impact on their identity formation. For instance if an individual finds their interactions with other GLs to be satisfying then they are more likely to seek out more GL contacts and feel that they belong in the homosexual community.

However, if their experiences with other homosexuals are viewed negatively then it is likely that they will continue to feel isolated and as not belonging in either of the GL or heterosexual societies. A feeling of not fitting in with other GLs may lead a person in stage 3 to either outright reject the possibility that they are GL or may lead them to continue to utilize stage 2's approaches (*B, C, and/or D*) as a means of coping with their possible GL identity. For those who find themselves fitting in and making friends with other GLs are able to confirm that they are indeed GL. These individuals move on to stage 4.

Stage 4: Identity Acceptance. The most prominent aspect of stage 4 is that the individual has come to accept that they are indeed GL. This realization leads them to seek out other GL people and to attempt to construct social support networks that are affirming of their newfound GL identity. It is during this stage that people first start to selectively disclose their GL identity to others. Prior to stage 4 many individuals are reluctant to discuss their uncertainty of their sexual identity. Rather than discuss their concerns or doubts individuals in stages 1 threw 3 let others continue to assume that they are heterosexual.

Stage 4 marks a shift for individuals in their desire to tell their secret to others. No longer do they wish to completely conceal their GL identity. For some individuals this is the first time that they are able to answer the questions "who am I?" and "where they belong?" With the acceptance of "who they are" comes the realization that some people in their lives may not understand or approve of their new GL identity. This realization places individuals in the position

of having to decide whether or not to disclose their GL identity to others and to assess when and if disclosure would be safe.

Stage 5: Identity Pride. Cass (1984, p. 152)stated that the *identity pride* stage is "characterized by feelings of pride towards one's GL identity and fierce loyalty to GLs as a group, who are seen as important and creditable while heterosexuals have become discredited and devalued". Another aspect of stage 5 is anger towards those who stigmatize GLs and a need to confront those who express negative opinions of GLs and homosexuality. The goals of this stage are to promote the validity of homosexuality and to press for GL equality in society at large.

During this stage an "us against you" mentality develops, where "us" represents the individual and other GLs and "you" representing heterosexuals. It is suggested that some individuals will not proceed to stage 6 in identity formation, and thus they will perpetually retain a dichotomous view of the world (i.e. GL or heterosexual, us or them, etc.). Others however will proceed to stage 6.

Stage 6: Identity Synthesis. Individuals who advance to the *identity synthesis* stage become aware that there is more to individuals than their sexual identity. Although these individuals continue to be open about their sexuality with others it becomes less of a central focus and more of an aspect of who they are. During stage 6 alliances and friendships are made or strengthened with heterosexuals and the mentality of "us versus them" gives way to a sense of "we," which includes both GLs and heterosexuals. Cass (1984, p. 153) suggested that successful completion of this stage "gives rise to feelings of peace and stability" and thus identity formation is complete.

Critique of Cass' model. Cass' model of GL identity formation has proved popular since its inception and publication (Diamond, 2006; Eliason, 1996; Grossman, D'Augelli, & O'Connell, 2003; Herdt, 1990; Meyer, 2003; Rust, 2003; Savin-Williams, 2001; Wright & Perry, 2006). The model's emphasis on a linear progression of identity development plays nicely into peoples'

desires for a clear cut means of identifying and tracking of a gay man's or lesbian's progress in solidifying their sexual orientation.

Unfortunately like all models seeking to classify human behavior and human identity development Cass' model is unable to account for those who do not experience or progress through the theorized stages. A study conducted by Cass (1984) provided support for six distinct groupings of participants (each grouping representing one of the six stages), however the study revealed that not all individuals proceed thru the stages in a linear fashion (i.e. a person may skip from stage 1 to stage 3 without going through stage 2 or a person can be classified as belonging in stage 4 on one occasion and at a later date may be experiencing aspects consistent with stage 2).

Thus what can be concluded from Cass' study is that people can be classified into six distinct groupings of individuals, but that their current grouping (i.e. stage placement) cannot accurately be used to predict their future stages of identity formation. Furthermore, Cass' model suggests that being in a later stage is a sign of identity maturity, whereas placement in an earlier stage is indicative of identity immaturity. By placing sexual identity formation on a linear scale it leads individuals to assume that identity development ceases to occur once one has entered into the "final stage".

A longitudinal study which examined women's sexual identity self-labeling showed that some individuals who at one time labeled themselves as a sexual minority later resist classifying themselves with any sexual identity label (i.e. gay, lesbian, bisexual, heterosexual, etc) (Diamond, 2006). Under Cass' model these individuals would be described as experiencing identity turmoil, however Diamond stated that instead of experiencing identity confusion or turmoil the women in the study were very comfortable with their current sexual behaviors and intimate relationships.

According to Diamond (2006, p. 83) these women resisted self-labeling due to a "sophisticated understanding of the inherent limitations of sexual categorization." Diamond (2006, p. 84) suggests that "traditional sexual identity models may have erred in placing so much emphasis on the adoption of a lesbian, gay, or bisexual identity rather than focusing on the

multiple ways in which individuals might manifest a deep acceptance and integration of their same-sex sexuality".

In addition to the questions raised about the appropriateness of stage based linear models of identity development Cass' model also casts doubts on the legitimacy of bisexual sexual identities. According to Cass' model an individual who identifies as bisexual is struggling with coming to terms with their same-sex oriented behaviors and their desires to maintain their connections with the heterosexual predominant culture. Thus their claim of bisexuality is seen as a sign of the individual's inability to come to terms with their same-sex oriented behaviors and their potential GL identity, which in turn suggests immaturity on the part of the individual and their identity development. Cass' model attempts to divide the world's people into dichotomous populations (i.e. heterosexuals and GLs).

This attempt is unrealistic and lacking in appropriateness. For instance even the use of three categories (bisexuals, heterosexuals, and gays/lesbians) is incapable of addressing all of the variations in human sexual identity. Although still lacking in complete coverage at least the three categories are able to account for the majority of people and their sexual identifications and behaviors. Under the dichotomous identity structure suggested by Cass, one has to ask "to which group (i.e. heterosexual or GL) does a person belong to if they do not engage in exclusively same-sex or heterosexual behaviors?" Failure to exclusively identify with either group essentially leaves an individual's identity in limbo under Cass' model.

In reality some individuals do find that they are attracted to both women and men and thus dichotomous models place a demand on them to make a decision. Essentially these people are asked to choose sides when in reality they possess aspects that make them similar to each group while also possessing aspects that make them different from either. In essence individuals who identify as bisexual are neither GL nor heterosexual; rather they are a hybrid of the two. Thus asking them to choose sides is like asking them to disown an aspect of themselves. Research has suggested that there may be far more individuals who could be classified as bisexual than

there are those who could be considered exclusively heterosexual or GL (Ford & Beach, 1951; Kinsey, et al., 1948).

Whether or not an individual could be classified as bisexual verses GL or heterosexual often depends on the criteria used to distinguish between the three groups. For instance, if ever having felt sexually attracted to an opposite-sex person is a disqualifier for an individual being classified as GL then it is possible that many people who consider themselves to be GL would not meet the criteria regardless of their self identification. Likewise, if having ever felt sexually attracted to a same-sex person is a disqualifier for an individual being classified as heterosexual then it is likely that the number of exclusive heterosexuals would noticeably decline.

Some researchers have attempted to sidestep the issues of self-identification by focusing on sexual behaviors. Although this provides them with a more concrete means of categorizing individuals into groups it also is problematic because it does not take into count individuals who are not sexually active and thus making them ineligible for categorization.

If sexual behaviors (i.e. engaging in specific sexual acts with people of specific sexes) were the only means of categorizing individuals into sexual orientations then it could be argued that a person's sexual orientation could not be determined until they have become sexually active. One would be in serious error to believe that behavior alone is an adequate representation of a person or their beliefs. For instance, a man may experience significant sexual attraction to another man without ever acting on his feelings and desires. Thus we must take into considerations peoples' feelings and thoughts and not just their behaviors.

This leads us to the hotly debated issue of "choice" concerning homosexuality and same-sex behavior. Some argue that homosexuality is a choice in which gay men, lesbians, and bisexual individuals choose to engage in, while others argue that homosexuality is innate and thus it is not about choice but about being (Money, 1987). Cass' model is considered to be a *choice model*, in which individuals go thru an identity formation process during which they evaluate

their same-sex behaviors and their perceived self-identity resulting in decisions to either reject or pursue the development of a GL identity.

Choice based models of sexual identity development often aim to empower individuals, by emphasizing that they have control over who they are and what they do. The problem with *choice based models* is that they place a huge amount of unwarranted stress and strain on the individual and they often fail to take into account factors not under the direct control of an individual (e.g. biological and societal influences). Thus, choice models of GL identity development pin the formation of a GL identity solely on the decisions of GL individuals.

One huge problem associated with choice models is that people sometimes use them as an argument for engaging in discriminatory practices against gay men, lesbians, and bisexual individuals. Some individuals argue that since a GLB individual has "chosen" to be GBL then they deserve to be treated with hostility for going against what society at large have deemed appropriate.

Within the literature pertaining to GLB individuals and homosexuality one often comes across the term *sexual preference*. As discussed earlier, this term is often used to imply that sexual identity is based on conscious choices made by GLB individuals. With that said, it would be wise for those reviewing GLB literature to evaluate the underlying contextual assumptions and the potential bias that such assumptions may cast on the literature. The origins of homosexuality and same-sex attraction remain under debate with some individuals claiming that it is an inborn quality, where others believe that it is a learned behavior.

The intent of this research is not to take sides in this debate, but rather to acknowledge that homosexuality does exist and that GLB individuals have health concerns which need to be addressed within the health care system. With that said, the focus will now shift onto the coming out process of GLB individuals.

Disclosure of GLB Identity

Coming out (i.e. disclosure of one's sexual orientation to one's self or others) is often a central aspect of GLB identity formation models. Disclosure of sexual orientation is considered important in GLB identity formation because it is thought to be a sign that an individual is becoming more comfortable with their same-sex attractions and thus wishing to form intimate bonds with others (Cass, 1979; Savin-Williams, 2001) . With that said *coming out* is often a very difficult and anxiety provoking experience for many GLB individuals.

GLB individuals make up a unique minority population. Unlike some minority groups, GLB individuals are not always easily identifiable and often go unrecognized within society. The GLB community is sometimes referred to as an *invisible minority* or a *hidden minority* group (Anderson, 1997; Mathison, 1998; Matthews, 2007). The reason that they are considered an *invisible minority* group is because there is not a single defining visible feature which can be used to identify GLB individuals and thus people often make the false assumption that GLB individuals are not present in their environments (e.g. workplace, school, churches, etc).

Diversity is another aspect that adds to the invisibility of GLB individuals and the GLB community. GLB individuals come from every culture, ethnicity, race, gender, nationality, religion, and socioeconomic class (Eliason, 1996; Perez, 2007). This diversity within the GLB community can make it difficult for others to recognize members of this community, especially for heterosexual individuals who may not be overly familiar with the community, its customs, and symbols. The diverse backgrounds from which many GLB individuals come from often do not adhere to the predominant stereotypes society ascribes to GLB individuals, further hindering others' abilities to recognize the presence and existence of GLB individuals in their everyday settings.

There are some individuals within the GLB community whose sexual orientation is fairly evident because of their appearance and/or behaviors (e.g. highly effeminate gay men, highly masculine lesbians); however for a large portion of the GLB community their sexual orientation

is not easily identifiable (Turner, et al., 2006). For the GLB individual whose sexual orientation is not easily identifiable by others, they are often confronted with the decision of whether or not to disclose it (i.e. *come out*) to others. Due to the stigma often associated with homosexuality and GLB individuals, the decision of whether or not to disclose one's GLB sexual orientation can be an extremely hard decision to make (Cole, 2006; Savin-Williams, 2001, 2003; Turner, et al., 2006).

When a GLB individual "comes out" to someone they are taking a risk, and with all risk come potential gains and/or hazards. William Shakespeare once wrote that "what's done is done" (i.e. once something has been done it cannot be undone), which rings true concerning coming out (1979, p. 2019). Once someone comes out to a person they cannot return the relationship back to its pre-disclosure state. Even if the relationship only slightly changes from the disclosure it has indeed changed (Savin-Williams, 2001).

Within the GLB community it is not uncommon to hear coming-out stories that depict negative reactions from those who are told (Herek, 2003; Savin-Williams, 2001). Sadly, some GLB individuals do indeed experience negative reactions from others, ranging from arguments and verbal abuse to physical assaults and occasionally even murder. Others however, are greeted with compassion, empathy, and sometimes even understanding and acceptance. It is this uncertainty in how others will respond that creates so much internal turmoil for GLB individuals (Heron, 1994; Savin-Williams, 2001).

Some GLB individuals choose to conceal their sexual orientation in order to avoid having potentially negative interactions with friends, family members, co-workers, or others they interact with somewhat regularly. The decision to conceal one's sexual orientation (a.k.a. *closeting* or *passing*) or to *come-out* is often a very complicated one, and one in which each GLB individual at some point is faced with (Cole, 2006). It is important to note that occasionally, the choice concerning disclosure is taken away from a GLB individual, by someone else (Savin-Williams, 2001). For example, someone may take it upon themselves to disclose the sexual orientation of

another person to other individuals. This is often referred to as *outing* someone and it is done for a number of reasons, some well intentioned while others more sinister (Savin-Williams, 2001). Other times GLB individuals are *outed* by shear accident, or unintentionally by another.

One may ask, "why is it important to know about: *closeting*, *coming-out*, and *outing*?" and "what kinds of impact can these things and experiences have on GLB individuals and their health care?" One of the hallmarks of good healthcare is honesty and openness between the client and their health care provider (Beehler, 2001; Eliason, 1996; Eliason & Schope, 2001; Hunter, Cohall, Mallon, Moyer, & Riddle, 2006).

As mentioned previously some may choose to remain *closeted* in order to avoid potentially negative interactions with others (Savin-Williams, 2001). Whereas, others may decide to remain *closeted*, because the environments (socially and/or physically) in which they find themselves are thought to be unsafe to disclose in (Heron, 1994). Still, some may decide to remain *closeted* for no other reason than it being a private matter which they do not desire to discuss with others.

Whatever, the reason for deciding to conceal one's GLB sexual orientation doing so often comes with some foreseen and perhaps unforeseen consequences. One such potential consequence is that of restricting pertinent information in health care settings. GLB individuals may avoid discussing their sexual orientation and/or behaviors with their health care providers in an attempt to protect themselves from negative reactions from their health care providers (Eliason & Schope, 2001). This self-protective strategy holds the potential of actually undermining the health of a GLB individual and/or delaying the diagnosis and treatment of ailments/medical conditions.

Within the health care system, the typical approach to patient care and ailment diagnosis is to rule out the common causes first before exploring alternative explanations for illnesses/disease. This can prove problematic when it comes to GLB individuals because the general patient care strategies and assumptions are not always appropriate or pertinent to GLB

individuals. A case in point would be when a physician questions a lesbian client about birth control use, when the woman does not engage in sexual activities with men and does not require the medications for hormone regulation. When a GLB individual maintains a closeted stance with their health care provider, it is likely that their provider will treat them utilizing the same assumptions that they would use when caring for heterosexual individuals.

In many circumstances such an approach may not prove problematic (e.g. cases of the common cold, bacterial infections), however utilizing such a health care approach may result in delayed treatment or misdiagnosis in other situations. With this in mind it becomes important for both GLB individuals and their health care providers to realize that being candid with each other will increase the likelihood that the GLB individual will receive optimal care and may even help them to avoid some illnesses.

As stated previously, the decision to come out as a GLB individual can be a very difficult and complex decision to make. For some GLB individuals the desire to maintain or perhaps strengthen relationships is one reason they may decide to come-out to their friends, family, health care providers, and others (Heron, 1994; Savin-Williams, 2001). With that said it is important to point out that being *out* and *closeted* is rarely an all or none issue; rather, more commonly people are *out* to some and remain *closeted* to others. Often those who are closeted live in fear of being *outed* to individuals or groups of people they do not think will respond well to their GLB sexual orientation. Sadly, the fear of being *outed* is sometimes justified due to the prejudices some individuals hold against GLB individuals.

Studies have been conducted that provide support to the idea that coming out can have positive influences on the lives of GLB individuals and their physical and/or psychological health (Cole, 2006; Cole, Kemeny, Taylor, & Visscher, 1996; Herek, 2003). It is thought that the positive influences of *coming out* may be due to the stress reduction brought about by the GLB individual sharing their concerns and forming bonds with others. Stress reduction may occur because the GLB individual no longer has to shoulder the stresses associated with their GLB

identity alone (i.e. their support group can help them cope with the negative effects of homophobia, heterosexism, and isolation).

However, disclosure alone is no guarantee of stress reduction. In order for the GLB individual's stress levels to reduce the disclosure would need to be a positive experience for them (i.e. those who they disclose to would need to respond in a supportive fashion). A negative disclosure experience would likely increase the amount of stress experienced by the GLB individual and further add to their stress loads instead of decrease them. With that said, the emphasis will now be turned to the health care issues and concerns of GLB individuals.

GLB Health Barriers and Concerns

Heterosexist health care is by far the largest barrier GLB individuals are confronted with when it comes to receiving comprehensive and compassionate health care. Oftentimes health care providers and health care facilities are unaware of their heterosexism. For instance, it is rare for health care providers to actually ask their clients about their sexual orientation, either directly or indirectly. This is because many health care providers assume that their clients are heterosexual (Harrison, 1996; Keogh et al., 2004).

In a journal article published in *Family Medicine*, it was suggested that "physicians should avoid assuming that all patients are heterosexual and accept the fact that many of their patients are gay. Physicians also should be aware of their own views and assumptions about homosexuality and consider their impact on clinical interaction and judgment" (Harrison, 1996, p. 16). Statements such as these serve as indicators that some within the health care industry are indeed aware of the heterosexist assumptions that have permeated throughout the health care industry.

Another assumption which is often held within the health care community is that a client's sexual orientation has little bearing in how one should be cared for. However, people are more than a collection of tissues, bones, and fluids. People are beings capable of complex thoughts, emotional expression, and self-awareness. As much as our anatomy and physiology

make us similar to one another, our personalities, experiences, environmental exposures and thoughts make each of us unique. Therefore, a simple "one-size-fits-all" approach to health care takes into consideration the anatomical and physiological similarities, but fails to address each person's uniqueness and how this can impact their health.

Like all people, GLB individuals need comprehensive and compassionate health care. Unfortunately, not all GLB individuals have access to health care facilities and providers who are knowledgeable about the GLB community and the unique health care needs and concerns of GLB individuals. It is important to mention that most major health care issues faced by GLB individuals are also faced by heterosexual individuals. However, there are health issues which impact the GLB community in larger proportions than they do the heterosexual population.

Sexually transmitted diseases. Sexually transmitted diseases are a significant problem in the GLB community, especially among gay and bisexual men. Two of the most researched and discussed sexually transmitted infections impacting the GLB community are the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS). According to the Centers for Disease Control and Prevention (2009) in 2007 men who have sex with men (MSM) made up 53% of overall diagnoses and 71% of men living with HIV/AIDS.

In the early 1980's health care providers started to see an increase in rare forms of cancer and diseases linked with immune system complications among gay men (Mail & Lear, 2006). Often times the health care providers of the ailing men focused on treating the cancers and other illnesses, but failed to realize that these ailments were the complications of an unidentified viral infection (i.e. HIV). Only after it became apparent that a new pandemic (i.e. AIDS) had cropped up did health care providers realize that they were going to have to look outside of the proverbial box to care for and properly diagnose these ailing people. By the time that it was discovered that AIDS was caused by HIV, multitudes of people (many of whom were gay and bisexual men) had become infected with HIV and were dying from AIDS complications (Mail & Lear, 2006). In hind sight it is easy to criticize the health care system for its initial slow recognition and response

to the AIDS pandemic; however the point is not to criticize but to emphasize that GLB community needs health care providers who are willing to step up and provide sensitive and comprehensive care to GLB individuals.

HIV and AIDS are not the only sexually transmitted infections (STIs) plaguing the GLB community. Some of the other STIs impacting the GLB community are: hepatitis A & B, human papillomavirus, genital herpes, chlamydia, and syphilis. Unbeknownst to many gay and bisexual men, the CDC has issued guidelines and recommendations for MSM concerning STIs. For instance, the CDC (2006) recommends that all MSM receive hepatitis A & B vaccinations.

One of the largest dangers to the GLB community is a lack of awareness of their vulnerabilities to STIs and related diseases and the appropriate protective measures and testing procedures needed to combat the spread of them. For example, According to the CDC (2008) "gay and bisexual men are 17 times more likely to develop anal cancer than heterosexual men", which is often associated with rectal infection with human papillomavirus (HPV). The stark difference in rates of anal cancer in gay and bisexual men when compared to heterosexual men highlights why it is so important for health care providers to know about their patients' sexual orientation and sexual behaviors.

Since health care providers are seen as the authorities on health care related issues they are the people who are in the best position to educate GLB individuals about. Unfortunately, if health care providers are uneducated about the GLB community and their health care needs the likelihood of them discussing such issues with GLB patients is quite low.

Mental health and substance use issues. Sociological and environmental stressors (e.g. prejudice, stigmatization, discrimination, and victimization) experienced by GLB individuals may result in adverse mental health issues for some GLB individuals (American Psychological Association, 2003; Meyer, 2003). According to the Gay and Lesbian Medical Association (2006) GLB individuals experience higher rates of the following: anxiety, depression, suicidal ideation

and attempts, drug and alcohol dependence and abuse, and tobacco use in comparison to their heterosexual peers.

With higher rates of anxiety, depression, and substance use the risk of suicide among GLB individuals is an area of significant concern. Exact statistics concerning completed suicides and suicidal attempts concerning the GLB population are nonexistent because sexual orientation is not a demographic variable collected during the reporting of suicides or suicidal attempts (American Foundation for Suicide Prevention, 2010). However, a review of empirical literature conducted by Anhalt and Morris (2003, p. 586) reported that research studies conducted with GLB youths have reported that between "11 to 42 percent" of the GLB youth who participated in the studies reported attempting suicide.

Furthermore it is rational to conclude that with higher rates of drug, alcohol, and tobacco use reported among the GLB population then it is probable that the occurrence of health complications related to the use of these substances is also higher within the GLB community. Findings such as these emphasize the importance of health care providers knowing about the GLB orientation of their GLB patients.

It is important to note that these higher rates of occurrence should not be interpreted as being evidence that a gay, lesbian, or bisexual sexual orientation is indicative of mental illness or defects in character. Rather these higher rates of occurrence help to highlight the negative impact that sociological and environmental stressors can have on GLB individuals' mental health.

Historical pathologization of homosexuality and bisexuality. Prior to the early 1970s homosexuality and bisexuality were viewed by the medical and mental health communities as mental illnesses. In 1973 the American Psychiatric Association removed homosexuality form its list of known mental health disorders and issued the following statement:

> Whereas homosexuality per se implies no impairment in judgment, stability, reliability, or general social or vocational capabilities, therefore, be it resolved that the American Psychiatric Association deplores all public and private discrimination against

> homosexuals … and declares that no burden of proof of such judgment, capacity, or reliability shall be placed upon homosexuals greater than that imposed on any other persons. Further, the American Psychiatric Association supports and urges the enactment of civil rights legislation at the local, state, and federal level that would offer homosexual citizens the same protections now guaranteed to others on the basis of race, creed, color, etc. (1973).

Two years later in 1975 the American Psychological Association followed suit by adopting the following resolutions:

> [Resolution 1] Homosexuality, per se, implies no impairment in judgment, stability, reliability, or general social or vocational capabilities: Further, the American Psychological Association urges all mental health professionals to take the lead in removing the stigma of mental illness that has long been associated with homosexual orientations….[Resolution 2] The American Psychological Association deplores all public and private discrimination … against those who engage in or who have engaged in homosexual activities …. Further, the American Psychological Association supports and urges the enactment of civil rights legislation at the local, state, and federal level that would offer citizens who engage in acts of homosexuality the same protections now guaranteed to others on the basis of race, creed, color, etc. (Conger, 1975, p. 633).

These public statements marked significant changes within the medical and psychological professions; unfortunately, many GLB individuals continue to frequently experience discrimination and stigmatization due to homophobia/biphobia and societal/personal prejudices in their everyday lives and their health care.

Prevalence of GLB Individuals

Some may argue that since GLB individuals make up a relatively small percentage of the overall population the resources that it would take to educate and train health care professional to

provide comprehensive and compassionate care to GLB individuals is unjustified. However, it is important to note that the prevalence of same-sex attraction is a highly debated issue, and one that often depends on how same-sex orientation is defined and assessed.

For instance in research conducted by Alfred Kinsey (1948), it was reported that up to 37 percent of the American male population has engaged in physical contact with another male to the point of orgasm. In addition to this finding, it was also reported that up to ten percent of the American male population was for the most part exclusively homosexual. Other studies have resulted in findings that estimate that between 1 to 25 percent of males have engaged in same-sex sexual behaviors at some point since the onset of adolescence (Gagnon & Simon, 1973; Hunt, 1974; Sell, Wells, & Wypij, 1995; Smith, 1991).

In addition to the variation in means of defining and assessing same-sex attraction one should keep in mind that within many communities and societies it is still considered taboo to harbor same-sex attractions. Due to this it is likely that some people who do experience same-sex attractions may decide not to share this information with others, or perhaps limit their disclosures, and thus the prevalence of same-sex attractions may be more common than previously reported (Cole, 2006). Taking into consideration that up to roughly 1/3 of the American population may have experimented with or perhaps identify as having some amount of same-sex attraction, then the cost in resources become much more justifiable.

CHAPTER III

METHODS

Participants

A total of 95 participants responded to the research participation requests. Thirteen participants dropped out before completing the internet based survey. One participant was excluded from analysis because they reported their sex as female-to-male transsexual, which did not meet the biological male participant selection criteria. This resulted in a total of 81 participants for this study. The following eligibility criteria were used to select participants for this study: 1) participants needed to be 18 years of age or older, 2) be a biological male, 3) identify as being gay or bisexual, 4) and reside in the United States of America (or one of its territories). Table 1 lists the frequency distributions of the demographic characteristics for the total sample and the two disclosure groups.

Table 1

Frequency Distribution of the Demographic Characteristics of Disclosers, Non-disclosers, and the Total Sample

Demographic Category	Subcategories	Disclosers		Non-disclosers		Total Sample	
		n	%	n	%	n	%
Age Group*	18-20	0	0.0	2	8.7	2	2.5
	21-30	7	12.1	6	26.1	13	16.0
	31-40	12	20.7	9	39.1	21	25.9
	41-50	12	20.7	2	8.7	14	17.3
	51-60	15	25.9	4	17.4	19	23.5

	61-70	11	19.0	0	0.0	11	13.6
	71-80	1	1.7	0	0.0	1	1.2
	Total	58	100	23	100	81	100
Sexual Orientation	Gay	57	98.3	22	95.7	79	97.5
	Bisexual	1	1.7	1	4.3	2	2.5
	Total	58		23	100	81	100
Racial and Ethnic Group	African American	0	0.0	1	4.3	1	1.2
	Caucasian	52	89.7	19	82.6	71	87.7
	Mexican American	3	5.2	1	4.3	4	4.9
	Native American	0	0.0	1	4.3	1	1.2
	Pacific Islander	1	1.7	0	0.0	1	1.2
	Multiracial	2	3.4	1	4.3	3	3.7
	Total	58	100	23	100	81	100
Highest Education Level	High School/GED	0	0.0	2	8.7	2	2.5
	Some College	1	1.7	1	4.3	2	2.5
	Associate/Certification	1	1.7	2	8.7	3	3.7
	Bachelors	6	10.3	3	13.0	9	11.1
	Graduate	42	72.4	13	56.5	55	67.9
	Professional	8	13.8	2	8.7	10	12.3
	Total	58	100	23	100	81	100
U.S. Region of Residence	Mid-Atlantic	14	24.1	4	17.4	18	22.2
	Midwest	19	32.8	6	26.1	25	30.9
	New England	5	8.6	0	0.0	5	6.2
	South	6	10.3	1	4.3	7	8.6
	Southwest	5	8.6	11	47.8	16	19.8
	West	9	15.5	1	4.3	10	12.3
	Total	58	100	23	100	81	100
Religious Affiliation	Atheism	2	3.4	1	4.3	3	3.7
	Agnosticism	12	20.7	5	21.7	17	21.0
	Christianity	18	31.0	14	60.9	32	39.5
	Judaism	8	13.8	0	0.0	8	9.9
	Other	7	12.1	1	4.3	8	9.9
	Not Applicable	11	19.0	2	8.7	13	16.0
	Total	58	100	23	100	81	100
Years with HCP	< 1 Year	11	19.0	10	43.5	21	25.9
	1 Year	3	5.2	1	4.3	4	4.9
	2 Years	8	13.8	6	26.1	14	17.3
	3+ Years	36	62.0	6	26.1	42	51.9
	Total	58	100	23	100	81	100

Health Care Setting	Private Practice Office	49	84.5	16	69.9	65	80.2
	Community Health Clinic	3	5.2	3	13.0	6	7.4
	Minor Emergency Clinic	0	0.0	1	4.3	1	1.2
	Other**	6	10.3	1	4.3	7	8.6
	Not Applicable	0	0.0	2	8.7	2	2.5
	Total	58	100	23	100	81	100
*Participants' ages ranged from 18-74 years (m = 44.95, sd = 13.86) **University student health clinic, Veterans Administration clinic, Primary Care Clinic							

Sampling Procedure

Each participant completed an internet based survey which consisted of four sections: the Outness Inventory, an importance survey, a health care questionnaire, and a demographics questionnaire. A copy of the survey is located in appendix B. Participants' responses to questions on the demographics questionnaire (i.e. age, sex, sexual orientation, and state/territory of residence) were used to verify participant eligibility.

This study utilized snowballing and email forwarding requests to obtain the 81 participants. Informed consent was obtained utilizing an informed consent page attached to the internet based survey. By clicking on the agree button, on the informed consent page, the participant were directed to the first page of the survey. Prospective participants who indicated that they did not agree with the informed consent requirements were direct to a thank you page. A copy of the informed consent page is located in appendix B. Examples of the recruiting literature utilized in this study are located in appendix C.

Measures

As previously stated this study consisted of a survey with four sections: an Outness Inventory (OI), a health care questionnaire (HCQ), an importance survey (IS), and a demographics questionnaire (DQ).

Outness inventory (OI). The first section consisted of a modified version of Mohr and Fassinger's Outness Inventory (OI). Copies of the original OI and the modified version used in this study are located in appendix B. Mohr and Fassinger's original inventory consists of eleven

questions, each aimed at assessing an individual's level of outness to a specific individual or groups of individuals. For each of the eleven questions respondents are asked to rank their level of outness to an individual or group of people, utilizing a rating scale of 0 to 7, where zero indicates that there is no such person or group of people in one's life and seven indicates that the person or group definitely knows about their (i.e. the respondent's) sexual orientation status, and it is openly talked about. A number of studies have been conducted utilizing the OI or a modified version of it to assess individuals' levels of outness (Balsam, Beauchaine, Rothblum, & Solomon, 2008; Mohr & Fassinger, 2003; Rothblum, Balsam, & Solomon, 2008; Todosijevic, 2003; van Eeden-Moorefield., 2005).

As previously stated a modified version of the OI was used in this study. The modifications and additions to the OI were made in order to gain a clearer and more accurate picture of participants' levels of outness to specific individuals or groups of people. The modifications resulted in a total of 26 total questions. It is important to note that new categories were not added to the modified version of the OI; rather, the modifications are expansions of categories in the original version of the OI.

The OI and the modified version of it consist of three subscales: Out to Family, Out to World, and Out to Religion. To obtain the outness rating score for each subscale the associated questions for each subscale are averaged together. A "global outness" rating score is obtained by averaging the scores from each of the subscales into a single score, which is referred to by Mohr and Fassinger as "Overall Outness" (2000).

Modifications made to the original outness inventory (OI). The family section of the OI was modified to obtain a more in depth reporting of participant's disclosure status to family members. Mohr and Fassinger's original inventory asked participants to rate their level of outness to family members via four rating questions: mother, father, siblings, and extended family/relatives. Literature pertaining to "coming out" indicates that GLB individuals often come out to people differently (and to varying degrees) based on their relationship with them

(D'Augelli, 2006; Rust, 2003; Savin-Williams, 2001, 2003). Thus it was decided to expand Mohr and Fassinger's four family questions into 16 questions.

The modifications allowed the researcher to more accurately record participant's disclosure status to specific individuals or groups within their family, which logically strengthens the accuracy of the averaged OI global outness score. The modifications were not thought to violate Mohr and Fassinger's original four family questions, because outness scores for the four questions could be calculated by averaging new questions together to consolidate scores into the original four questions. For example, the sister and brother questions from the modified IO can be averaged together to produce a single average rating score for siblings. Table 2 compares the original and modified versions of the OI family subscale questions.

Table 2

Original OI and Modified OI Family Questions.

Original Family Questions	Modified Family Questions	
Mother	Mother	Mother
		Stepmother
Father	Father	Father
		Stepfather
Siblings	Siblings	Sister
		Brother
Extended Family	Maternal Family	Grandmother
		Grandfather
		Aunt
		Uncle
	Paternal Family	Grandmother
		Grandfather
		Aunt
		Uncle
	Other Family	Niece(s)/Nephew(s)
		Cousin(s)

Questions are highlighted in the white colored cells.

The out to world subscale of the original OI consisted of 5 questions. In the modified version of the OI the number of questions was increased to 8. The three additional questions were added to assess for participant outness with school peers, teachers/professors, and LGBT friends.

On the original OI two questions asked participants to rate their level of outness to their "work" peers and supervisors. After heavy consideration two additional questions (one focused

on assessing outness to school peers and the other outness to teachers/professors) were added to the modified inventory to go along with the two questions concerning outness in work relationships. These questions were added because some participants may have been students and thus they could provide outness information about an important aspect of participants' lives.

The out to world subscale in the original OI included two questions about heterosexual friends. After discussing the original world subscale questions with colleagues an additional question was added to assess participants' outness to LGBT friends. The new question sought to assess outness to LGBT friends and to address an implied assumption in the original OI that participants are out to their LGBT friends.

The two school questions and the LGBT friends question were included in the world subscale because of their similarity to original OI questions pertaining to work and friends. To obtain the "Out to World" subscale rating on the modified OI the eight world subscale questions were averaged together to produce a single average score. Table 3 compares the original and modified versions of the OI world subscale questions.

Table 3

Original OI and Modified OI World Questions.

Original World Questions	Modified World Questions
New Straight Friends	New Heterosexual Friends
Old Heterosexual Friends	Old Heterosexual Friends
Work Peers	Work Peers
Work Supervisors	Work Supervisors
Strangers/ New Acquaintances	Acquaintances/Strangers
	School Peers*
	Teachers/ Professors*
	LGBT Friends*

*Indicates new questions

No modifications were made to the out to religion subscale questions, thus the religion subscale questions of the modified OI were the same as the original OI religion questions. In Mohr and Fassinger's original OI the terms "straight" and "heterosexual" were used in questions to refer to participants friends. A consolidation in terminology was made in the modified version

of the OI to eliminate the use of slang from the inventory and to form a consensus concerning terminology used. Thus on the modified OI the term heterosexual was used in place of "straight".

Validity and reliability of the outness inventory (OI). According to an article written by Mohr and Fassinger (2000), "preliminary validity evidence [was] provided through correlations of the [Outness Inventory] with measures of self-esteem, identification with lesbian and gay male communities, interaction with heterosexual individuals, stage of lesbian/gay male identity…" The measures used to assess validity of the OI were: the Rosenberg Self-Esteem Scale, the Lesbian Identity Scale, the Gay Identity Scale, and the Multigroup Ethnic Identity Measure. Mohr and Fassinger (2000, p. 86) reported that "estimated internal consistency reliabilities of the subscales were sufficiently high for research purposes….Researchers may use either the full scale or individual subscales when analyzing data… ".

It is important to note that the modifications and additions made to the original OI for this study were expected to have little impact on its validity or reliability. This expectation was based on the rationale that the subscales of the original OI remain intact and that the modifications and additions serve only to increase the clarity and accuracy of participants' ratings of groups of individuals covered by each of the subscales.

Since the OI was modified for this study, internal consistency coefficients (i.e. Cronbach's alphas) were computed to verify its reliability. Although the modified OI maintains the three subscales utilized in the original version the reliability of the family subscale was assessed by separating the family questions into two categories (core and extended family) for analysis purposes. Four internal consistency coefficients were calculated, two for the family subscale and one each for the religion and world subscales. The internal consistency coefficients confirmed that internal consistency was acceptable. Table 4 displays the internal consistency coefficients for the modified OI and the number questions included in the calculations of the coefficients.

Table 4

Reliability Statistics for Modified OI

Categories		Questions	N	Cronbach's alpha
Family	Core Family	Mother	6	.87*
		Stepmother		
		Father		
		Stepfather		
		Sister		
		Brother		
	Extended Family	Maternal Grandmother	9	.98*
		Maternal Grandfather		
		Paternal Grandmother		
		Paternal Grandfather		
		Maternal Aunt		
		Maternal Uncle		
		Paternal Aunt		
		Paternal Uncle		
		Niece(s)/Nephew(s)		
		Cousin(s)**		
World		New Heterosexual Friends	8	.90*
		Old Heterosexual Friends		
		Work Peers		
		Work Supervisors		
		Acquaintances/Strangers		
		School Peers		
		Teachers/ Professors		
		LGBT Friends		
Religion***		Members of religious/spiritual community	2	.83*
		Leaders of religious/spiritual community		

*Exceeds acceptable internal consistency coefficients reliability of .70
**Component variable Cousin(s) had zero variance and was removed from the scale
***No modifications were made to the religion subscale

Health care questionnaire (HCQ). The second section of the online survey consisted of an eight question health care questionnaire (HCQ), which was designed for the purpose of gathering the following information: where participants receive their health care services from, whether or not a participant has a health care provider (HCP), how long participants have been seen by their HCP, the type of HCP seen, and whether or not they have disclosed their sexual orientation to their HCP. Additionally, participants were asked to rank the level of importance of the following: disclosing their sexual orientation to their HCP and discussing their sexual behaviors with their HCP using a rating scale. The last question of the HCQ asked participants to

rank their knowledge about health concerns and issues important to the health and wellbeing of gay and bisexual men by having them rank their knowledge level on a rating scale. See appendix B for a copy of the HCQ.

Importance survey (IS). The third section of the online survey consisted of a 24 item importance survey (IS). It was designed to assess the importance level each item could have on the participants' decision of whether or not to disclose their sexual orientation to their HCP. Participants were asked to rate the importance of each of the 24 items using a four point rating scale (no, slight, moderate, or high importance).

Items were selected for inclusion in the IS based on previous research and literature pertaining to LGB individuals and their health care (Dardick & Grady, 1980; Eliason & Schope, 2001; Fogel, 2005; Harrison & Silenzio, 1996; Harvey, Carr, & Bernheine, 1989). The 24 items were grouped into three categories (relationship with HCP, environmental factors, and personal factors) for ease of analysis. Groupings were based on whether items were examining the patient/provider relationship, the environment in which disclosure may occur, or personal reasons concerning disclosure. See appendix B to view a copy of the IS.

Validity and reliability of the importance survey (IS). Validity of the IS was considered to be acceptable based on content validity. Literature pertaining to LGB individuals and health care identified patient/provider relationship factors, health care environment factors, and personal beliefs factors as key factors in disclosure of sexual orientation by LGB to health care providers (Dardick & Grady, 1980; Eliason & Schope, 2001; Fogel, 2005; Harrison & Silenzio, 1996; Harvey, et al., 1989). Thus the IS questions were designed to evaluate these three areas. Due to the exploratory nature of this study criterion-related validity was unachievable because of the lack of established measures for use in comparisons.

Reliability of the IS was assessed using four internal consistency coefficients (i.e. Cronbach's alphas). The first internal consistency coefficient assessed the reliability of all 24 IS items, where as the other three internal consistency coefficients assessed the reliability of the

items that make up each of the three IS item categories. All four internal consistency coefficients confirmed that internal consistency was acceptable. Table 5 displays the internal consistency coefficients for the IS.

Table 5

IS Internal Consistency Coefficients

Importance Items	N	Cronbach's alpha
All Items	24	.91*
Relationship Items	8	.80*
Environmental Items	9	.88*
Personal Items	7	.79*

*Exceeds acceptable internal consistency coefficients reliability of .70

Demographics questionnaire (DQ). The fourth and final section of the online survey consisted of a demographics questionnaire (DQ). The DQ consisted of seven demographic questions (sex, age, sexual orientation, racial and ethnic identity, religious affiliation, state/territory of residence, and highest education level). Four of the seven questions (sex, age, sexual orientation, and location of residence) were used to verify participant eligibility. Participant responses on the DQ were used to separate the sample into groups and subgroups (i.e. gay men/bisexual men; ages, racial and ethnic identity, location of residence, and education) for data analysis purposes. A copy of the DQ is located in appendix B.

Design

This study utilized a multivariate between participants survey design. The variables consisted of participant's scores on the modified OI, responses to the HCQ, rating scores on the IS, and responses to the DQ. The study sought to answer two distinct research questions. The first question asked, "Can seven variables (age group, education level, global outness, years with HCP, personal importance rating of disclosing to HCP, personal importance rating of discussing sexual behaviors with HCP, and personal knowledge of health concerns and issues of GB men) be used to predict whether or not a participant is "out" to their health care provider? The second question asked, "is there a significant difference between participants who have disclosed their

sexual orientation to their health care provider and those who have not and importance survey items?"

For the first research question a discriminant function analysis was conducted to examine if seven variables (age group, education level, global outness, years with HCP, personal importance rating of disclosing to HCP, personal importance rating of discussing sexual behaviors with HCP, and personal knowledge of health concerns and issues of GB men) could be utilized as predictors of participant disclosure status (i.e. whether or not they are "out") to their HCP.

For the second research question a multivariate analysis of variance (MANOVA) was conducted to examine if there were relationships among participants' disclosure status to their HCP and their importance ratings on the importance survey (IS).

CHAPTER IV

RESULTS

Recruitment

Data collection for this study was conducted over a 90 day span starting in April 2009 and concluding in July 2009. Participants were obtained utilizing email solicitation and snow ball sampling techniques.

Statistics and Data Analysis

First research question. For the first research question a discriminant analysis was conducted to determine whether seven predictors (age group, education level, global outness, years with HCP, personal importance rating of disclosing sexual orientation to HCP, personal importance rating of discussing sexual behaviors with HCP, and personal knowledge of health concerns and issues of GB men) could predict disclosure status to HCP. The overall Wilk's lambda was significant, Wilks' $\Lambda = .465$, $X^2(7, N = 81) = 57.744$, $p = .000$, indicating that overall the predictors differentiated among the two disclosure status groups. The analysis resulted in one discriminant function being identified.

Table 6 presents the structure matrix (i.e. the pooled within-groups correlations between the predictors and the standardized weights on the lone discriminant function). Based on these coefficients the personal importance rating of disclosing sexual orientation to HCP demonstrated the strongest relationship with the discriminant

function, while personal importance rating of discussing sexual behaviors with HCP was second strongest, and age group was third strongest. Based on the pooled within-groups correlations the discriminant function was labeled importance of disclosure.

Table 6

Structure Matrix and Standardized Canonical Discriminant Function Coefficients

Predictor	Structure Matrix*	Standardized canonical discriminant function coefficients
Personal Importance Rating of Disclosing Sexual Orientation to HCP	.89	.78
Personal Importance Rating of Discussing Sexual Behaviors with HCP	.52	.06
Age Group	.40	.01
Global Outness	.39	.29
Personal Knowledge of Health Concerns & Issues of GB Men	.30	.05
Years with HCP	.29	.34
Education Level	.29	.16

*Pooled within-groups correlations between discriminating variables and standardized canonical discriminant functions. Variables ordered by absolute size of correlation within function.

Table 7 presents the means and standard deviations for the discriminant function variables.

Table 7

Means & Standard Deviations for the Discriminant Function Analysis Variables

Item	Disclosure Status	*M*	*SD*
Personal Importance Rating of Disclosing Sexual Orientation to HCP	Yes	2.78	.53
	No	1.30	1.02
	Total	2.36	.97
Personal Importance Rating of Discussing Sexual Behaviors with HCP	Yes	2.45	.65
	No	1.52	.99
	Total	2.19	.87
Age Group	Yes	4.24	1.36
	No	3.00	1.21
	Total	3.89	1.42
Global Outness	Yes	5.68	1.01
	No	4.65	1.36
	Total	5.38	1.21
Personal Knowledge of Health Concerns & Issues of GB Men	Yes	4.33	.85
	No	3.70	1.02
	Total	4.15	.94
Years with HCP	Yes	3.19	1.19
	No	2.35	1.30
	Total	2.95	1.27

Education Level	Yes	5.95	.69
	No	5.30	1.40
	Total	5.77	.98

Post-hoc frequency analyses were conducted to evaluate the distribution of participants within and between the two disclosure groups on the top four predictors (personal importance rating of disclosing sexual orientation to HCP, personal importance rating of discussing sexual behaviors with HCP, age group, and global outness). Figure 1 displays the frequency of participants' importance rating responses on the predictor *personal importance rating of disclosing sexual orientation to HCP* by disclosure group status. The vast majority of participants who reported having disclosed their sexual orientation to their HCP ranked doing so as being high in importance to them, whereas participants who reported not disclosing ranked importance to disclose from high to no importance.

Figure 1. Frequency of Participants' Personal Importance Ratings of Disclosing Sexual Orientation to HCP Predictor by Disclosure Group Status.

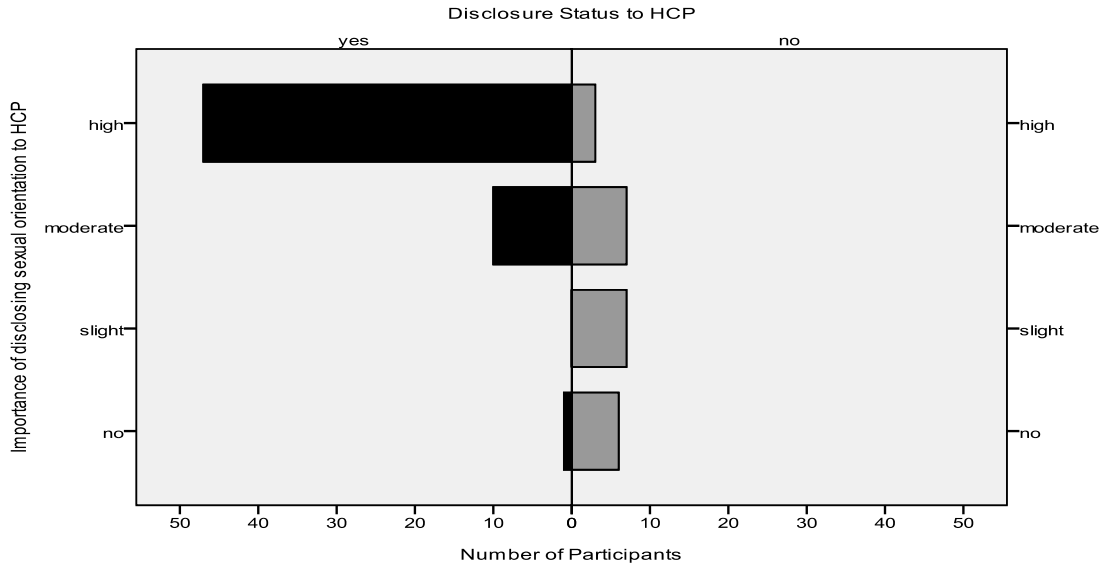

Figure 1. Frequency of participants' importance ratings on the Personal Importance Rating of Disclosing to HCP predictor variable. Participants are grouped according to their disclosure status to their HCP: yes = has disclosed; no = has not disclosed.

Figure 2 displays the frequency of participants' importance rating responses on the predictor *personal importance rating of discussing sexual behaviors with HCP* by disclosure group status. Participants who reported having disclosed their sexual orientation to their HCP all reported that discussing their sexual behaviors to the HCP was important to them to varying degrees, whereas some of the non-disclosing participants reported that it was not important to them.

Figure 2. Frequency of Participant's Personal Importance Ratings of Discussing Sexual Behaviors with their HCP Predictory by Disclosure Group Status.

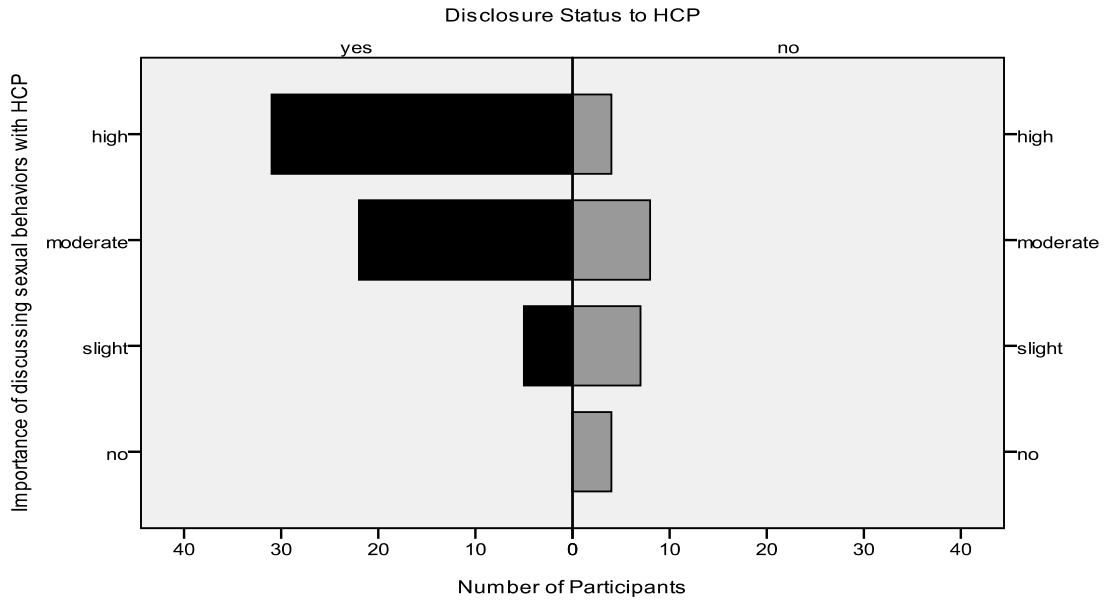

Figure 2. Frequency of participants' importance ratings on the Personal Importance Rating of Discussing their Sexual Behaviors with their HCP. Participants are grouped according to their disclosure status to their HCP: yes = has disclosed; no = has not disclosed.

Figure 3 displays the frequency of participants' ages on the predictor *age group* by disclosure group status. The age group with the most participants who have disclosed their sexual orientation to the HCP was the 51-60 year old age group, whereas for non-disclosers the age group with the most participants was the 31-40 year old age group.

Figure 3. Frequency of Participants' Ages on the Age Group Predictor by Disclosure Group Status.

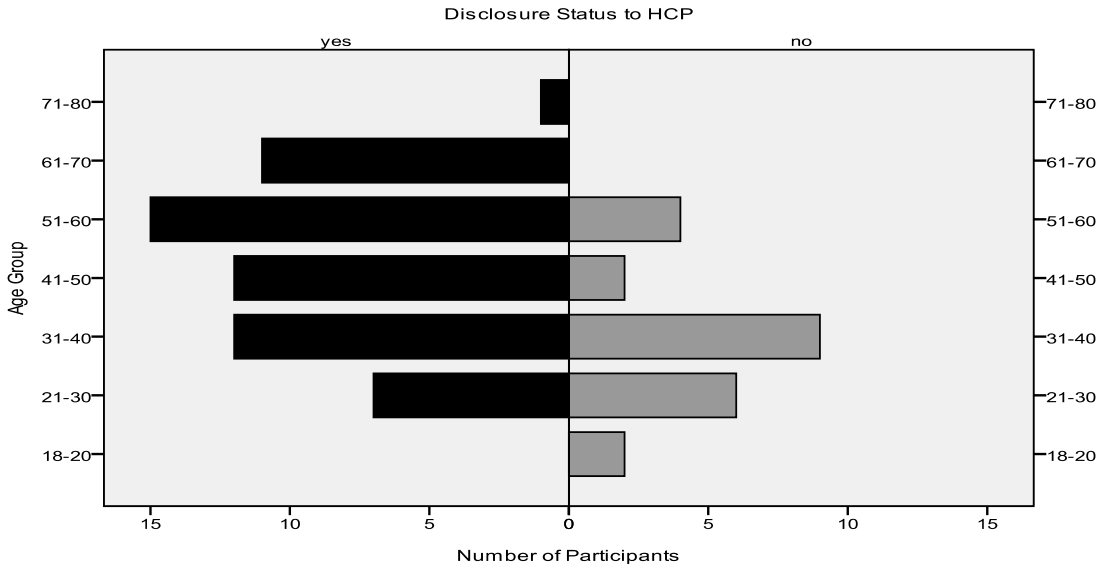

Figure 3. Frequency of participants' ages on the Age Group predictor variable. Participants are grouped according to their disclosure status to their HCP (yes = has disclosed; no = has not disclosed) and their age groupings. Age groupings are based on ten year increments, with the exeption of 18-20 which is a two year increment.

Figure 4 displays the frequency of participants' outness levels on the predictor *global outness* by disclosure group status. For both disclosure groups the majority of participants' global outness scores were categorized as being high; however, in the non-disclosing group there were some participants who's global outness scores were categorized as being low.

Figure 4. Frequency of Participants' Scores on the Global Outness Predictor by Disclosure Group Status.

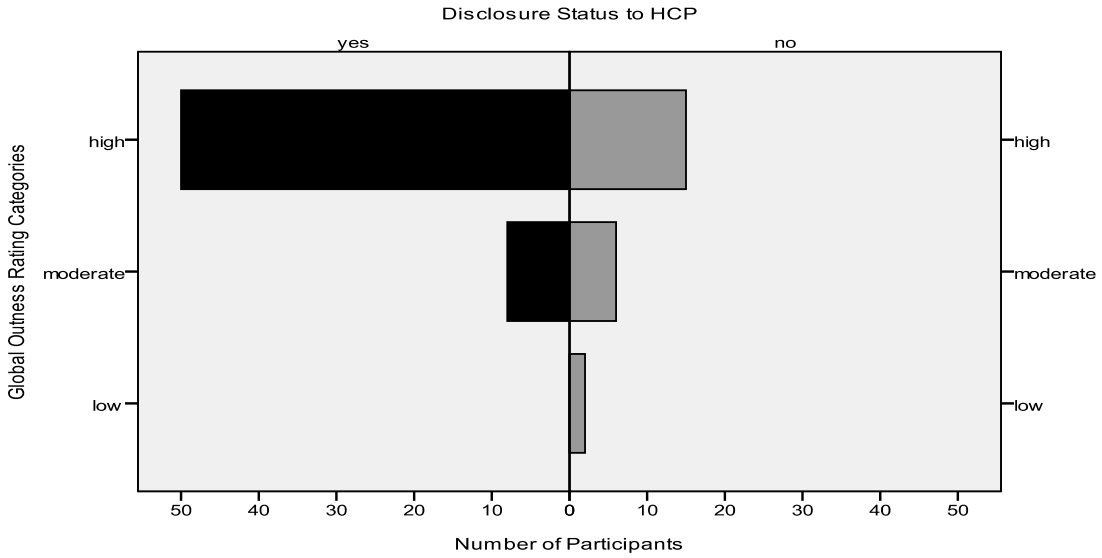

Figure 4. Frequency of participts' outness scores on the Global Outness Rating predictor variable. Participants are grouped according to their disclosure status to their HCP (yes = has disclosed; no = has not disclosed) and their global outness rating category. Global outness categorization was based on participants' global outness scores (low = 1-2.33; moderate = 2.34-4.66; high = 4.67-7).

When prediction of disclosure group membership was attempted, 73 cases (90.1%) of the total sample (N = 81) were classified correctly. Of the 58 cases in the disclosed group, 56 (96.6%) were predicted correctly. In the not disclosed group 17 of 23 cases (73.9%) were classified correctly. In order to take into account chance agreement, the kappa coefficient was calculated which resulted in a value of .744, a strong value. To assess how well the classification procedure would predict disclosure status in a new sample the leave-one-out technique (a.k.a. cross-validation) was utilized which resulted in an estimate of 85.2% correct classification. Table 8 presents the classification results of the original and cross-validated group cases.

Table 8

Classification Results of the Discriminant Function Analysis

	Disclosure Status	Predicted Group Membership		Total	% Correctly Predicted
		Yes	No		
Original	Yes	56	2	58	56/58 = 96.6
	No	6	17	23	17/23 = 73.9
	% Yes	96.6	3.4	100	-
	% No	26.1	73.9	100	-
Cross-	Yes	55	3	58	55/58 = 94.8

validated	No	9	14	23	14/23 = 60.9
	% Yes	94.8	5.2	100	-
	% No	39.1	60.9	100	-
90.1% of original grouped cases correctly classified ((56+17)/81)					
85.2% of cross-validated grouped cases correctly classified ((55+14)/81)					

Second research question. The second research question asked "is there a significant difference between disclosure status and importance survey items?" For analysis purposes the 24 importance survey items were divided into three categories (relationship, environmental, and personal) and category scores were calculated. Category scores were obtained by averaging the scores of the importance survey items placed within each group (8 items for the relationship group, 9 items for the environmental group, and 7 items for the personal group). Categorization of importance survey items was conducted in order to provide macro analysis of the data, which would have been difficult to discern from conducting analysis solely on the individual items.

A one-way MANOVA was conducted to determine the effect of disclosure status (disclosed, not disclosed) on the three importance survey categories (relationship, environmental, and personal). The analysis revealed that significant differences were found between those who had disclosed and those who had not on the dependent measures, Wilks' $\Lambda = .813$, $F(3, 77) = 5.898$, $p = .001$, $\eta_p^2 = .187$. Table 9 presents the MANOVA significance test results for the importance survey categories.

Table 9

MANOVA Table for the Importance Survey Categories

	Value	*F*	*df*	*p*
Wilks' Lambda	.81	5.90	3, 77	.001*
Pillai's Trace	.19	5.90	3, 77	.001*
Hotelling's Trace	.23	5.90	3, 77	.001*
Roy's Largest Root	.23	5.90	3, 77	.001*
* indicates significance at .05 alpha level				

Post-hoc analyses utilizing ANOVAs were conducted on each of the three categories. The post-hoc analyses revealed that there was a significant difference between those who had disclosed and those who had not on the personal category, $F(1, 79) = 7.735$, $p = .007$, $\eta_p^2 = .089$.

No significant differences were detected between those who had disclosed and those who had not on the relationship, $F(1, 79) = .139$, $p = .710$, $\eta_p^2 = .002$, and environmental, $F(1, 79) = .036$, $p = .850$, $\eta_p^2 = .000$, categories. Table 10 presents the post-hoc ANOVA significance results for the importance survey categories.

Table 10
Post-hoc ANOVA Table
Importance Survey Categories

Item	*F*	*df*	*p*
Personal	7.74	1, 79	.007*
Relationship	.14	1, 79	.710
Environmental	.04	1, 79	.850

* indicates significance at .05 alpha level

In order to see which of the personal items were significant additional post-hoc analyses utilizing Bonferroni corrected ANOVAs were conducted on each of the seven items. As can be seen in Table 11, significant differences were detected on two items: desire to share, $F(1, 79) = 14.528$, $p = .000$, $\eta_p^2 = .155$ and previous experience, $F(1, 79) = 8.161$, $p = .005$, $\eta_p^2 = .094$. No significant differences were detected between those who had disclosed and those who had not on five of the seven items (personal knowledge, HCP knowledge and reputation, nature of visit, encouragement to disclose, and recommendation of HCP). Table 11 presents the ANOVA significance results for the personal importance items from the IS.

Table 11
ANOVA Table for the Personal Importance Items

Item	*F*	*df*	*p*
Desire to Share	14.53	1, 79	< .001*
Previous Experience	8.16	1, 79	.005*
Personal Knowledge	5.17	1, 79	.026
HCP Knowledge & Reputation	2.80	1, 79	.098
Nature of Visit	1.14	1, 79	.289
Encouragement to Disclose	.89	1, 79	.348
Recommendation of HCP	.18	1, 79	.677

Note. Bonferroni correction was applied to the ANOVAs (.05/7)
* indicates significance at .007 alpha level

Table 12 presents the means and the standard deviation for the personal importance items.

Table 12			
Means & Standard Deviations for the Personal Importance Items			
Item	Disclosure Status	*M*	*SD*
Desire to Share	Yes	2.09	.88
	No	1.26	.86
	Total	1.85	.95
Previous Experience	Yes	2.02	.81
	No	1.39	1.08
	Total	1.84	.93
Personal Knowledge	Yes	2.26	.79
	No	1.78	1.00
	Total	2.12	.87
HCP Knowledge & Reputation	Yes	2.05	.98
	No	1.65	.94
	Total	1.94	.98
Nature of Visit	Yes	2.02	.81
	No	1.78	1.09
	Total	1.95	.89
Encouragement to Disclose	Yes	1.33	1.08
	No	1.09	.90
	Total	1.26	1.03
Recommendation of HCP	Yes	2.02	.98
	No	1.91	1.08
	Total	1.99	1.01

Even though the relationship and environmental categories were not statistically significant ANOVAs were conducted on the 17 importance survey items from these two categories. This was done to see if any of the individual items were statistically significant even if the category was not. ANOVA analyses of the remaining 17 importance survey items revealed that there were no significant differences between those who had disclosed and those who had not on the aforementioned items. Tables 13 and 14 present the ANOVA significance results for the relationship importance and the environmental importance items.

Table 13			
ANOVA Table for the Relationship Importance Items			
Item	*F*	*df*	*p**
Age of HCP	5.18	1, 79	.026
Level of trust	4.21	1, 79	.043
Gender of HCP	1.07	1, 79	.303
Friendliness of HCP	.53	1, 79	.469

HCP asks	.43	1, 79	.516
HCP discusses reasons for needing to know	.41	1, 79	.525
Recording and protecting of sensitive info	.08	1, 79	.775
Sharing of sensitive info	.04	1, 79	.836
Note. Bonferroni correction was applied to the ANOVAs (.05/8) * no items were significant at the .006 alpha level			

Table 14

ANOVA Table for the Environmental Importance Items

Item	*F*	*df*	*p**
Location of office	1.52	1, 79	.221
Presence of non-discrimination statement	1.12	1, 79	.293
Display of GLBT symbols	.73	1, 79	.396
HCP advertisements in GLBT publications	.37	1, 79	.546
Friendliness of staff	.12	1, 79	.736
Use of inclusive language	.02	1, 79	.882
Presence of GLBT publications	.01	1, 79	.919
Presence of political or religious materials	.01	1, 79	.938
Presence of GLBT info	.002	1, 79	.965
Note. Bonferroni correction was applied to the ANOVAs (.05/9) * no items were significance at .006 alpha level			

Tables 15 and 16 present the means and standard deviations for the relationship and the environmental importance items.

Table 15

Means & Standard Deviation Table for the Relationship Importance Items

Item	Disclosure Status	*M*	*SD*
Age of HCP	Yes	.84	.93
	No	1.39	1.08
	Total	1.00	1.00
Level of trust	Yes	2.81	.44
	No	2.57	.59
	Total	2.74	.49
Gender of HCP	Yes	1.02	1.10
	No	1.30	1.19
	Total	1.10	1.13
Friendliness of HCP	Yes	2.33	.83
	No	2.17	.94
	Total	2.28	.86
HCP asks	Yes	2.16	.91
	No	2.00	1.09
	Total	2.11	.96
HCP discusses reasons for needing to know	Yes	2.02	1.00
	No	2.17	.98
	Total	2.06	.99

Recording and protecting of sensitive info	Yes	1.79	1.02
	No	1.87	1.22
	Total	1.81	1.07
Sharing of sensitive info	Yes	1.88	.99
	No	1.83	1.15
	Total	1.86	1.03

Table 16

Means & Standard Deviation Table for the Environmental Importance Items

Item	Disclosure Status	*M*	*SD*
Location of office	Yes	1.38	1.14
	No	1.04	1.02
	Total	1.28	1.11
Presence of non-discrimination statement	Yes	1.86	1.05
	No	2.13	.97
	Total	1.94	1.03
Display of GLBT symbols	Yes	1.36	1.12
	No	1.61	1.31
	Total	1.43	1.17
HCP advertisements in GLBT publications	Yes	1.43	1.17
	No	1.61	1.23
	Total	1.48	1.18
Friendliness of staff	Yes	2.03	.94
	No	1.96	.93
	Total	2.01	.93
Use of inclusive language	Yes	2.14	.96
	No	2.17	1.03
	Total	2.15	.98
Presence of GLBT publications	Yes	1.36	1.14
	No	1.39	1.23
	Total	1.37	1.16
Presence of political or religious materials	Yes	1.41	1.14
	No	1.39	1.23
	Total	1.41	1.16
Presence of GLBT info	Yes	1.47	1.13
	No	1.48	1.24
	Total	1.47	1.15

Additional post-hoc analyses. Frequency distribution post-hoc analyses were conducted on six demographic variables (*age group, sexual orientation, racial and ethnic group, highest education level, region of residence and religious affiliation*) from the DQ and two items from the HCQ: *years with HCP, health care setting* (see table 1). For the *age group* variable it was

revealed that 88 percent of the disclosers were 31 years of age or older; whereas for the non-disclosers 34.8 percent were 18-30 years old. Analysis of the *sexual orientation* variable revealed that 72.2 percent of the gay participants reported that they have disclosed their sexual orientation to their HCP. For the *racial and ethnic group* variable it was revealed that 10.3 percent of the disclosers identified as being non-Caucasian and that 17.2 percent of the non-disclosers identified as being non-Caucasian. Caucasian identifying participants made up 87.7 percent of the total sample; out of which 73.2 percent reported having disclosed their sexual orientation to their HCP.

The frequency analysis of the *highest education level* variable revealed that 86.2 percent of the disclosers had a graduate or a professional degree; whereas 65.2 percent of the non-disclosers had a graduate or a professional degree. For the *region of residence* variable the largest percentage of participants (30.9%) reported being from the Midwest region of the U.S. Analysis of the *religious affiliation* variable revealed that 56.3 percent of the Christian identified participants had disclosed; whereas, 66.7 percent of the Atheist, 70.6 percent of the Agnostics, and 100 percent of the Jewish identified participants reported disclosing to their HCP.

For the *years with HCP* variable 62 percent of the disclosers had been with their provider for 3+ years; whereas 43.5 percent of the non-disclosers have been with their provider for less than one year. Analysis of the *health care setting* variable revealed that 84.5 percent of disclosers received their health care services in private practice settings; whereas 69.9 percent of non-disclosers received their health care services in private practice settings (see table 1).

CHAPTER V

DISCUSSION

When it comes to health care few would argue that honest and direct communication about health care issues between patients and their health care providers is essential for optimal care. Unfortunately sometimes personal and societal issues can complicate and undermine communication between patients and their health care providers (HCP). This is especially true for gay and bisexual (GB) men who are frequently subjected to discrimination, stigmatization, and marginalization due to their sexual orientations and/or sexual behaviors. Thus it is not uncommon for GB men to conceal their sexual orientation or sexual behaviors from their HCPs, which can negatively impact their health and the quality of their health care. This exploratory study was conducted to answer two research questions pertaining to GB men and the disclosure of their sexual orientation to their health care providers.

First Research Question

It was hypothesized that seven variables could be used to predict whether or not a GB man had disclosed their sexual orientation to their health care provider. Via discriminant function analysis it was confirmed that the seven predictor variables do serve as reliable predictors of disclosure status. Of particular interest are the four strongest predictor variables: personal importance rating of disclosing sexual orientation to HCP, personal importance rating of discussing sexual behaviors with HCP, age group, and global outness score.

The strongest predictor of whether or not a participant had disclosed to their sexual orientation to their HCP was their rating level of how important they felt it was to disclose their sexual orientation to their health care provider. This finding is not surprising because rationally if an individual feels it is important to disclose then they are more likely to disclose. With that said, the desire to share personal information with one's HCP could be interpreted as an attempt to form a closer relationship with their provider. A strong relationship between a patient and their HCP can help in the development of trust, which can increase one's personal sense of security and their willingness to discuss sensitive topics. It is important to note that some participants rated disclosure importance as high and moderate but have not disclosed their sexual orientation to their HCP (see figure 1).

The second strongest predictor of whether or not a participant had disclosed their sexual orientation to their HCP was their rating level of how important they felt it was to discuss their sexual behaviors with their HCP. Since discussing sexual behaviors with a HCP would likely include discussing with whom sexual behaviors are engaged in with it makes sense that participants who felt that it was important to discuss their sexual behaviors are also likely to disclose their sexual orientation to their HCP. Frequency analysis revealed that participants who felt it was not important to discuss their sexual behaviors were less likely to have disclosed their sexual orientation with their HCP (see figure 2).

The third strongest predictor of whether or not a participant had disclosed their sexual orientation to their HCP was their age group. Frequency analysis revealed that for disclosers (i.e. those who had disclosed their sexual orientation to their HCP) and non-disclosers (i.e. those who have not disclosed their sexual orientation to their HCP) age appeared to play a role in their decisions to disclose (see Figure 3). For example, every participant 61 years of age or older (n = 12) reported that they have disclosed their sexual orientation to their HCP, whereas the two participants in the 18-20 years old group reported that they have not disclosed their sexual

orientation. Based on the findings of this study it appears that as GB men age their comfort with disclosing their sexual orientation to their HCP increases.

The forth strongest predictor of whether or not a participant had disclosed their sexual orientation to their HCP was their global outness score. All of the participants who reported that they had disclosed their sexual orientation to their HCP scored in the moderate or high global outness categories, whereas non-disclosers' global outness scores ranged from high to low (see figure 4). It is likely that global outness and desire to share personal information with one's HCP are associated. One's own personal comfort with their sexual orientation is likely to influence their decision to disclose their sexual orientation to others, including their HCP. For example, it is thought to be unlikely for someone who is highly closeted about their sexual orientation to openly discuss their sexual orientation with the HCP. Dardick and Grady (1980) identified that openness about sexual orientation with family and peers as a factor that contributed to disclosure of sexual orientation to HCPs (p. 118).

Overall the seven predictor variables were able to correctly classify 90.1 percent of the participants, and it was estimated, using cross-validation, that the seven predictors could correctly classify 85.2 percent of participants in a new sample.

Second Research Question

It was hypothesized that there would be significant differences between participants' disclosure status (i.e. those who had disclosed and those who had not disclosed to their HCP) and their importance ratings on the 24 importance survey (IS) items. A one-way MANOVA confirmed that there were significant differences between disclosers and non-disclosers on the IS items, which were categorized into three groups (relationship, environmental, and personal).

IS items were categorized into these groups based on whether items pertained to one of the following: the relationship between the participant and their HCP; environmental factors; or personal factors. It is important to note that the IS was constructed for this study and that an internal consistency coefficient (i.e. Cronbach's alpha) for all 24 items was extremely high (see

Table 5), which suggest that the items measured approximately the same underlying dimension (i.e. importance for disclosure).

Post-hoc analyses utilizing Bonferroni corrected ANOVAs were ran on the items making up the three categories. The analyses revealed that out of the 24 IS items two were found to have significant differences between those who had disclosed and those who had not to their HCP. The two significant items were d*esire to share* (i.e. desire for their HCP to know more about them and their personal life) and *previous experience* (i.e. experience with previous HCPs), which were both from the IS personal category. These two items suggest that personal factors (i.e. personal feelings, beliefs, or perceptions) play a very important role in whether or not a GB man decides to disclose their sexual orientation to their HCP.

It was not surprising that *desire to share* was found to be a statistically significant between disclosers and non-disclosers because rationally individuals who have a higher desire for their HCP to know more about them and their personal lives are more likely to disclose. Stein and Bonuck (2001) reported that desire for honest and improved understanding was found to be a reason for disclosure in a study that they conducted. Their finding is consistent with the *desire to share* item significance in this study.

The significance of *previous experience* is supported by prior research on sexual orientation disclosure to health care providers in which it was found that negative health care experiences adversely impacted willingness to disclose. Fogel (2005) listed “previous bad experience with disclosure to HCP” as a barrier to disclosure of sexual orientation for gay men and lesbians (p. 3). Dardick and Grady (1980) stated that they found a “clear association between what a respondent thought [their] primary health professional felt about homosexuality and whether or not [they] had been open about [their] homosexuality” (p. 116).

Of the three groups that the 24 IS items were categorized into only the personal category contained items of significance. The remaining two groups (i.e. relationship and environmental) did not contain significant items. This was somewhat surprising considering previous research

has reported that relationship and environmental factors could increase the comfort level of lesbian, gay, and bisexual individuals and thus potentially influence their decisions to disclose their sexual orientation (Makadon, Mayer, & Garofalo, 2006; Meckler, Elliott, Kanouse, Beals, & Schuster, 2006; Mulligan & Heath, 2007).

Limitations

Due to the sampling techniques utilized in this exploratory study the participant sample did not result in a widely diverse sample. Although it was hoped that a diverse sample of participants could be recruited for the study the study's sample was fairly homogeneous. Thus the generalizeability of the findings may be limited. It is recommended that caution be used when attempting to generalize the study's findings to bisexual men because the vast majority of the sample identified as being gay (97.5%). Additionally, the majority of the study's participants (87.7%) reported that they identify as Caucasian. Thus it is recommended that caution be used when attempting to generalize the findings to non-Caucasian identified GB men. Furthermore the majority of the sample (80.2%) reported having earned a graduate or professional degree, which calls into question whether or not the findings can be generalized to GB men who have fewer years of formal education.

An additional limitation of this study is that data collection was based solely online and thus it is possible that sample diversity may have been negatively impacted due to unforeseen factors such as socioeconomic factors and access to internet accessible technology. The decision to collect data using an online based survey was done out of convenience and as a means of limiting researcher bias; however, this decision may have had unforeseen or undetected influences on the study's findings. Another limitation of the study is that it did not assess the reasons or rational behind non-disclosers' decisions not to disclose to their HCPs. It is possible that some non-disclosers have not formally discussed their sexual orientation with their HCPs because they believe or assume that the HCP already is aware of their sexual orientation.

Conclusions and Recommendations

The findings of this study add to the small but growing body of research pertaining GB men and their health care experiences. This study was able to detect differences in GB men who disclose their sexual orientation to their health care providers and those who do not, which could be utilized by HCPs to help them create welcoming and affirming health care environments for GB men. Additionally, the study's findings revealed that although environmental and relationship factors have the potential to influence GB men's decisions to disclose their sexual orientation, the strongest predictor of disclosure is how important GB men feel it is to disclose their sexual orientation to their HCP. Thus in order to significantly increase the number of GB men who disclose steps could be taken to inform GB men of the unique health care issues that they face and the importance of disclosing their sexual orientation to their HCPs.

Educational programs, similar to those designed to promote condom use among GB men, may prove helpful in increasing GB men's knowledge about health care issues and to help influence them to disclose to their HCPs. Furthermore, this study's findings could be used in health care training programs to help inform new HCPs of the factors that influence disclosure rates in GB men and to aid them in developing health care environments that are welcoming and conducive for disclosure. HCPs often serve as the primary source of health care information for their patients, which means that they are in a unique position to aid in improving the health care of GB men by encouraging all of their clients to discuss their sexual behaviors and their sexual orientations. By including such a dialog into their dialogues with their patients HCPs can help set the stage for honest and direct conversations about sexuality and possible health care issues.

In future studies it is recommended that steps be taken to increase sample diversity by additionally collecting data using hard copy surveys in locations such as health care facilities, LGBT bars/clubs, college campuses, LGBT community events, and other locations. Furthermore, the use of qualitative research methods could provide an alternative and rich source of information on GB men and their health care experiences which quantitative methods may not be

able to assess fully. Lastly, future research may want to explore how stigma and discriminatory experiences may impact the personal beliefs and health care perceptions of GB men.

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APPPENDICES

APPENDIX A

Journals which focus on GLBT issues:

1. Journal of Homosexuality
2. Journal of Gay & Lesbian Social Services
3. Journal of Gay, Lesbian, and Bisexual Identity
4. Journal of Lesbian Studies
5. Journal of the Gay & Lesbian Medical Association
6. Journal of Bisexuality
7. Journal of Gay & Lesbian Psychotherapy
8. Journal of LGBT Youth

APPENDIX B

Health Care and Coming Out: Gay and Bisexual Men's Health Care

1. Consent Page

Project Title:
Health Care and Coming Out: Gay and Bisexual Men's Health Care

Investigator:
Steven T. Hubbard, M.S.

Advisor:
Don Boswell, Ph.D.

Purpose:
The purpose for conducting this research study is to explore what factors may be helpful in creating a more welcoming health care environment for gay and bisexual (GB) men. This study will examine what factors may help predict which GB men are most and least likely to disclose their sexual orientation to their health care provider (HCP). As a gay or bisexual male 18 years of age or older, who is a resident of the United States of American (or one of its territories), you are hereby invited to participate in this study.

Procedures:
You will be asked to complete an internet based survey consisting of four sections: an Outness Inventory, a health care questionnaire, an importance survey, and a demographics questionnaire. Participation in this study should take between 10 to 20 minutes to complete.

Risks of Participation:
There are no anticipated risks associated with this research study which are greater than those ordinarily encountered in daily life.

Benefits of Participation:
You may gain an increased understanding of factors that influence your decisions of whether or not to disclose your sexual orientation to health care physicians. This research study may help health care providers create a more welcoming health care environment for gay and bisexual men.

Anonymity:
The internet based survey has been designed so that you can submit responses anonymously (i.e. the researcher will not know the identity of those participating in the research study) via Secure Sockets Layer (SSL) 128 bit encryption. It is recommended that participants utilize private computers (i.e. computers not accessible by the general public), instead of public computers, to complete the survey due to the sensitivity of some of the information being sought. Use of public computers could potentially result in unintended disclosure of participant responses to others not involved with the study. Participant data will be stored on a secured computer server which is password protected. Only the researcher (Steven T. Hubbard, M.S.) and individuals responsible for research oversight will have access to participant data. Survey responses will only be reported using group descriptive techniques (i.e. individual participant data will not be separately used for reporting purposes). The researcher will retain participant data for 2 years after which the data will be deleted.

Compensation:
No compensation is being offered for participation in this research study.

Contacts:
For questions concerning this research study, contact Steven T. Hubbard, M.S., principal investigator, via e-mail at steven.hubbard@okstate.edu or Don Boswell, Ph.D., research advisor, at don.boswell@okstate.edu or (405)744-9454. If you have questions about your rights as a research volunteer, you may contact Dr. Shelia Kennison, IRB Chair, 219 Cordell North, Stillwater, OK 74078, 405-

Health Care and Coming Out: Gay and Bisexual Men's Health Care

744-1676 or irb@okstate.edu.

Participant Rights:
Your participation in this research study is strictly voluntary and you have the right to withdraw from the study at any time without penalty or explanation.

This research study has been approved by the Institutional Review Board (IRB) of Oklahoma State University. (IRB# ED0969)

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1. Do you agree to participate in this study under the above mentioned conditions.

- ◯ Agree
- ◯ Disagree

Health Care and Coming Out: Gay and Bisexual Men's Health Care

2. Outness Inventory

Use the following rating scale to indicate how open you are about your sexual orientation to the people or groups listed below. Respond to all of the items, mark items that do not apply to you by clicking on the N/A option.

NOTE: For some of the questions you may have more than one person for which the question may apply, in such cases please provide an average rating for the question. For example, if you have two sisters, one of which you would rate your level of outness to as being a 7 and the other your rated level of outness to as being a 5, then the averaged response to the sister question would be 6.

1 = person definitely does NOT know about your sexual orientation status
2 = person might know about your sexual orientation status, but it is NEVER talked about
3 = person probably knows about your sexual orientation status, but it is NEVER talked about
4 = person probably knows about your sexual orientation status, but it is RARELY talked about
5 = person definitely knows about your sexual orientation status, but it is NEVER or RARELY talked about
6 = person definitely knows about your sexual orientation status, and it is SOMETIMES talked about
7 = person definitely knows about your sexual orientation status, and it is OPENLY talked about
N/A = not applicable to your situation; there is no such person or group of people in your life

Family/Relatives:

1. Mother

	1	2	3	4	5	6	7	N/A
Mother	○	○	○	○	○	○	○	○

2. Father

	1	2	3	4	5	6	7	N/A
Father	○	○	○	○	○	○	○	○

3. Stepmother

	1	2	3	4	5	6	7	N/A
Stepmother	○	○	○	○	○	○	○	○

4. Stepfather

	1	2	3	4	5	6	7	N/A
Stepfather	○	○	○	○	○	○	○	○

5. Sister

	1	2	3	4	5	6	7	N/A
Sister	○	○	○	○	○	○	○	○

6. Brother

	1	2	3	4	5	6	7	N/A
Brother	○	○	○	○	○	○	○	○

Health Care and Coming Out: Gay and Bisexual Men's Health Care

3. Outness Inventory (continued)

Use the following rating scale to indicate how open you are about your sexual orientation to the people or groups listed below. Respond to all of the items, mark items that do not apply to you by clicking on the N/A option.

NOTE: For some of the questions you may have more than one person for which the question may apply, in such cases please provide an average rating for the question. For example, if you have two sisters, one of which you would rate your level of outness to as being a 7 and the other your rated level of outness to as being a 5, then the averaged response to the sister question would be 6.

1 = person definitely does NOT know about your sexual orientation status
2 = person might know about your sexual orientation status, but it is NEVER talked about
3 = person probably knows about your sexual orientation status, but it is NEVER talked about
4 = person probably knows about your sexual orientation status, but it is RARELY talked about
5 = person definitely knows about your sexual orientation status, but it is NEVER or RARELY talked about
6 = person definitely knows about your sexual orientation status, and it is SOMETIMES talked about
7 = person definitely knows about your sexual orientation status, and it is OPENLY talked about
N/A = not applicable to your situation; there is no such person or group of people in your life

Extended Family/Relatives:

1. Maternal Grandmother (Mother's mother)

	1	2	3	4	5	6	7	N/A
Maternal Grandmother	○	○	○	○	○	○	○	○

2. Maternal Grandfather (Mother's father)

	1	2	3	4	5	6	7	N/A
Maternal Grandfather	○	○	○	○	○	○	○	○

3. Paternal Grandmother (Father's mother)

	1	2	3	4	5	6	7	N/A
Paternal Grandmother	○	○	○	○	○	○	○	○

4. Paternal Grandfather (Father's father)

	1	2	3	4	5	6	7	N/A
Paternal Grandfather	○	○	○	○	○	○	○	○

5. Maternal Aunt (Mother's Sister)

	1	2	3	4	5	6	7	N/A
Maternal Aunt	○	○	○	○	○	○	○	○

6. Paternal Aunt (Father's sister)

	1	2	3	4	5	6	7	N/A
Paternal Aunt	○	○	○	○	○	○	○	○

Health Care and Coming Out: Gay and Bisexual Men's Health Care

7. Maternal Uncle (Mother's brother)

	1	2	3	4	5	6	7	N/A
Maternal Uncle	◯	◯	◯	◯	◯	◯	◯	◯

8. Paternal Uncle (Father's brother)

	1	2	3	4	5	6	7	N/A
Paternal Uncle	◯	◯	◯	◯	◯	◯	◯	◯

9. Niece(s)/Nephew(s)

	1	2	3	4	5	6	7	N/A
Nieces(s)/Nephew(s)	◯	◯	◯	◯	◯	◯	◯	◯

10. Cousin(s)

	1	2	3	4	5	6	7	N/A
Cousin(s)	◯	◯	◯	◯	◯	◯	◯	◯

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4. Outness Inventory (continued)

Use the following rating scale to indicate how open you are about your sexual orientation to the people or groups listed below. Respond to all of the items, mark items that do not apply to you by clicking on the N/A option.

NOTE: For some of the questions you may have more than one person for which the question may apply, in such cases please provide an average rating for the question. For example, if you have two sisters, one of which you would rate your level of outness to as being a 7 and the other your rated level of outness to as being a 5, then the averaged response to the sister question would be 6.

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7 = person definitely knows about your sexual orientation status, and it is OPENLY talked about
N/A = not applicable to your situation; there is no such person or group of people in your life

Friends/Acquaintances/Others:

1. Gay, Lesbian, Bisexual, Transgender Friends

	1	2	3	4	5	6	7	N/A
Gay, Lesbian, Bisexual, Transgender Friends	◯	◯	◯	◯	◯	◯	◯	◯

2. New heterosexual friends (i.e. those you met since you became aware of your sexual orientation)

	1	2	3	4	5	6	7	N/A
New heterosexual friends	◯	◯	◯	◯	◯	◯	◯	◯

3. Old heterosexual friends (i.e. those you met before you became aware of your sexual orientation)

	1	2	3	4	5	6	7	N/A
Old heterosexual friends	◯	◯	◯	◯	◯	◯	◯	◯

4. Acquaintances/Strangers

	1	2	3	4	5	6	7	N/A
Acquaintances/Strangers	◯	◯	◯	◯	◯	◯	◯	◯

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5. Outness Inventory (continued)

Use the following rating scale to indicate how open you are about your sexual orientation to the people or groups listed below. Respond to all of the items, mark items that do not apply to you by clicking on the N/A option.

NOTE: For some of the questions you may have more than one person for which the question may apply, in such cases please provide an average rating for the question. For example, if you have two sisters, one of which you would rate your level of outness to as being a 7 and the other your rated level of outness to as being a 5, then the averaged response to the sister question would be 6.

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7 = person definitely knows about your sexual orientation status, and it is OPENLY talked about
N/A = not applicable to your situation; there is no such person or group of people in your life

School/Work:

1. School Peers

	1	2	3	4	5	6	7	N/A
School Peers	○	○	○	○	○	○	○	○

2. Teacher(s)/Professor(s)

	1	2	3	4	5	6	7	N/A
Teacher(s)/Professor (s)	○	○	○	○	○	○	○	○

3. Work Peers

	1	2	3	4	5	6	7	N/A
Work Peers	○	○	○	○	○	○	○	○

4. Work Supervisor(s)

	1	2	3	4	5	6	7	N/A
Work Supervisor(s)	○	○	○	○	○	○	○	○

Health Care and Coming Out: Gay and Bisexual Men's Health Care

6. Outness Inventory (continued)

Use the following rating scale to indicate how open you are about your sexual orientation to the people or groups listed below. Respond to all of the items, mark items that do not apply to you by clicking on the N/A option.

NOTE: For some of the questions you may have more than one person for which the question may apply, in such cases please provide an average rating for the question. For example, if you have two sisters, one of which you would rate your level of outness to as being a 7 and the other your rated level of outness to as being a 5, then the averaged response to the sister question would be 6.

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6 = person definitely knows about your sexual orientation status, and it is SOMETIMES talked about
7 = person definitely knows about your sexual orientation status, and it is OPENLY talked about
N/A = not applicable to your situation; there is no such person or group of people in your life

Religious/Spiritual Community:

1. Members of my religious/spiritual community

	1	2	3	4	5	6	7	N/A
Members of my religious/spiritual community	◯	◯	◯	◯	◯	◯	◯	◯

2. Leaders of my religious/spiritual community

	1	2	3	4	5	6	7	N/A
Leaders of my religious/spiritual community	◯	◯	◯	◯	◯	◯	◯	◯

Health Care and Coming Out: Gay and Bisexual Men's Health Care

7. Health Care Questionnaire

In this section you will be asked about your past and current use of health care services.

1. Where do you receive your health care services from?

- ◯ Private practice doctor's office
- ◯ Community health center
- ◯ Minor emergency clinic
- ◯ Hospital emergency room
- ◯ Specialty clinic
- ◯ Not Applicable (N/A)
- ◯ Other (please specify)

2. Do you have a health care provider?
(i.e. someone that you receive health care services from)

- ◯ Yes
- ◯ No

3. How long have you been seen by your health care provider?

- ◯ less than 1 year
- ◯ 1 year
- ◯ 2 years
- ◯ 3 or more years

4. Type of health care provider seen?

- ◯ Medical Doctor (M.D.)/Osteopathic Physician (D.O.)
- ◯ Nurse Practitioner (NP)
- ◯ Physician's Assistant (PA)
- ◯ Unknown
- ◯ Other (please specify)

Health Care and Coming Out: Gay and Bisexual Men's Health Care

5. Have you disclosed your sexual orientation to your health care provider?

- ◯ Yes
- ◯ No

6. Please rate how important you feel it is to disclose your sexual orientation to your health care provider.

	No	Slight	Moderate	High
Level of importance	◯	◯	◯	◯

7. Please rate how important you feel it is to discuss your sexual behaviors with your health care provider.

	No	Slight	Moderate	High
Level of importance	◯	◯	◯	◯

8. Using the following scale, please rate your level of personal knowledge about health concerns and issues that are important to the health and wellbeing of gay and bisexual men.

1 = I am not aware of any important health concerns or issues that are different from those experienced by heterosexual men
2 = There are some health concerns and issues that are different, but I have little or no specific knowledge of them
3 = I am aware that there are health concerns and issues that are different, and have some knowledge about them
4 = I am aware that there are health concerns and issues that are different, and I have a good understanding of them
5 = I am extremely knowledgeable about the health concerns and issues that are different for gay and bisexual men

	1	2	3	4	5
Level of personal knowledge	◯	◯	◯	◯	◯

Health Care and Coming Out: Gay and Bisexual Men's Health Care

8. Importance Survey

Please rate each of the following items on how much importance each would have on your decision of whether or not to disclose your gay or bisexual orientation to your health care provider.

1. Your health care provider directly asks you about your sexual orientation and/or sexual behaviors.

	No	Slight	Moderate	High
Level of importance	◯	◯	◯	◯

2. The level of trust you have with your health care provider.

	No	Slight	Moderate	High
Level of importance	◯	◯	◯	◯

3. The gender of your health care provider.

	No	Slight	Moderate	High
Level of importance	◯	◯	◯	◯

4. The age of your health care provider.

	No	Slight	Moderate	High
Level of importance	◯	◯	◯	◯

5. Your health care provider discusses with you the way in which sensitive information is recorded and protected.

	No	Slight	Moderate	High
Level of importance	◯	◯	◯	◯

6. Your health care provider discusses to whom and under what circumstances your sensitive information will be shared.

	No	Slight	Moderate	High
Level of importance	◯	◯	◯	◯

7. The friendliness of your health care provider.

	No	Slight	Moderate	High
Level of importance	◯	◯	◯	◯

8. Your health care provider discusses with you the reasons they need to know about your sexual orientation and/or sexual behaviors.

	No	Slight	Moderate	High
Level of importance	◯	◯	◯	◯

Health Care and Coming Out: Gay and Bisexual Men's Health Care

9. The presence of GLBT informational health care pamphlets in the health care provider's office (i.e. waiting and/or exam rooms).

	No	Slight	Moderate	High
Level of importance	◯	◯	◯	◯

10. The presence of a non-discrimination statement which states that the health care provider and his/her staff do not discriminate against GLBT individuals.

	No	Slight	Moderate	High
Level of importance	◯	◯	◯	◯

11. The presence of GLBT magazines/publications in the health care provider's office (i.e. waiting and/or exam rooms).

	No	Slight	Moderate	High
Level of importance	◯	◯	◯	◯

12. The dispaly of a GLBT symbol in the health care provider's office (ex. rainbow flag, Human Rights Campaign emblem, pink triangle, etc.)

	No	Slight	Moderate	High
Level of importance	◯	◯	◯	◯

13. The friendliness of the health care provider's staff.

	No	Slight	Moderate	High
Level of importance	◯	◯	◯	◯

14. The use of inclusive language and/or questions on the health care provider's intake forms and paperwork.

	No	Slight	Moderate	High
Level of importance	◯	◯	◯	◯

15. Advertisements by your health care provider in GLBT publications and/or their affiliation with a GLBT health care providers' network.

	No	Slight	Moderate	High
Level of importance	◯	◯	◯	◯

16. The location of the health care provider's office.

	No	Slight	Moderate	High
Level of importance	◯	◯	◯	◯

17. The presence of affirming/unaffirming political or religious materials in the health care provider's office.

	No	Slight	Moderate	High
Level of importance	◯	◯	◯	◯

Health Care and Coming Out: Gay and Bisexual Men's Health Care

18. Your personal knowledge of health issues and concerns which are specific to gay and bisexual men.

	No	Slight	Moderate	High
Level of importance	◯	◯	◯	◯

19. The nature of your visit to your health care provider. (Examples: acute illness, chronic illness, preventative health checks, vaccinations, etc.)

	No	Slight	Moderate	High
Level of importance	◯	◯	◯	◯

20. Your personal knowledge of the health care provider and their reputation and/or knowledge pertaining to caring for GLBT individuals.

	No	Slight	Moderate	High
Level of importance	◯	◯	◯	◯

21. Recommendation of your health care provider by other GLBT individuals, friends, or relatives.

	No	Slight	Moderate	High
Level of importance	◯	◯	◯	◯

22. Encouragement from a significant other, friend, or relative to disclose your sexual orientation to your health care provider.

	No	Slight	Moderate	High
Level of importance	◯	◯	◯	◯

23. A desire for your health care provider to know more about you and your personal life.

	No	Slight	Moderate	High
Level of importance	◯	◯	◯	◯

24. Experience with previous health care providers.

	No	Slight	Moderate	High
Level of importance	◯	◯	◯	◯

Health Care and Coming Out: Gay and Bisexual Men's Health Care

9. Demographics Questionnaire

1. Sex:

- ◯ Male
- ◯ Female-to-Male Transsexual
- ◯ Intersexual

2. Age:
(Please type in your current age in years)

3. Sexual Orientation:

- ◯ Gay
- ◯ Bisexual

4. Racial and Ethnic Identity:

- ☐ African American
- ☐ Asian
- ☐ Caucasian
- ☐ Latin American
- ☐ Mexican American
- ☐ Native American
- ☐ Multiracial
- ☐ Other (please specify)

Health Care and Coming Out: Gay and Bisexual Men's Health Care

5. Religious Affiliation:

- ◯ Atheism
- ◯ Agnosticism
- ◯ Buddhism
- ◯ Christianity
- ◯ Hinduism
- ◯ Islam
- ◯ Judaism
- ◯ Not Applicable
- ◯ Other (please specify)

6. State (or US territory) of Residence:

7. Highest Education Level Achieved:

- ◯ Some schooling
- ◯ High School Diploma or GED
- ◯ Some college
- ◯ Associate Degree or Certification
- ◯ Bachelor's Degree
- ◯ Graduate Degree (Master's Degree or Doctorate)
- ◯ Professional Degree (JD, MD, OD, MBA, etc.)

Health Care and Coming Out: Gay and Bisexual Men's Health Care

10. Thank you.

I would like to personally thank your for your time. If you would like to receive a summary of the results of this study feel free to send me a blank e-mail at steven.hubbard@okstate.edu with "Study Summary" as the subject.

Sincerely,

Steven T. Hubbard, M.S.
Counseling Psychology
Doctoral Candidate
Oklahoma State University

APPENDIX C

Solicitation Letter

You are invited to participate in an internet based research study titled "Health Care and Coming Out: Gay and Bisexual Men's Health Care" This study is being conducted by Steven Hubbard, M.S., a counseling psychology doctoral candidate at Oklahoma State University, as partial fulfillment of the requirements for a Ph.D. in educational psychology.

Purpose:
The purpose of this research study is to explore what factors may be helpful in creating a more welcoming health care environment for gay and bisexual (GB) men. This study will examine what factors may help predict which GB men are most and least likely to disclose their sexual orientation to their health care provider.

Participant Requirements:
For the study you will be asked to complete an internet based survey consisting of four sections: an Outness Inventory, a health care questionnaire, an importance survey, and a demographics questionnaire. Participation in this study should take between 10 to 20 minutes to complete. Your participation in the research study is strictly voluntary and you have the right to withdraw from the study at any time without penalty or explanation. Your participation will be anonymous.

Eligibility:
You are eligible to participate in this research study if you are a male resident of the United States of America (or one of its territories) who is 18 years of age or older that identifies as being gay or bisexual. Participants will need to be able to read and comprehend written English.

Study Web Link:
If you are interested in participating in the internet based survey study it can be reached by visiting the following web link:
http://www.surveymonkey.com/s.aspx?sm=NpwpufWB5gk0OvKjE5xxyw_3d_3d

Please feel free to forward this letter to any individuals who may be eligible to participate in this study.

If you have any questions concerning this study, please feel free to contact Steven Hubbard, M.S. or Don Boswell, Ph.D.

Steven Hubbard, M.S.
Primary Investigator
Counseling Psychology Doctoral Candidate
Oklahoma State University
steven.hubbard@okstate.edu

Don Boswell, Ph.D.
Research Advisor
Associate Professor
Oklahoma State University
don.boswell@okstate.edu
(405)744-9454

APPENDIX D

Oklahoma State University Institutional Review Board

Date:	Friday, April 10, 2009
IRB Application No	ED0969
Proposal Title:	Health Care and Coming Out: Gay and Bisexual Men's Health Care
Reviewed and Processed as:	Exempt

Status Recommended by Reviewer(s): Approved Protocol Expires: 4/9/2010

Principal Investigator(s):

Steven T. Hubbard
P.O. Box 825
Stillwater, OK 74076

Donald Boswell
406 Willard
Stillwater, OK 74078

The IRB application referenced above has been approved. It is the judgment of the reviewers that the rights and welfare of individuals who may be asked to participate in this study will be respected, and that the research will be conducted in a manner consistent with the IRB requirements as outlined in section 45 CFR 46.

✓ The final versions of any printed recruitment, consent and assent documents bearing the IRB approval stamp are attached to this letter. These are the versions that must be used during the study.

As Principal Investigator, it is your responsibility to do the following:

1. Conduct this study exactly as it has been approved. Any modifications to the research protocol must be submitted with the appropriate signatures for IRB approval.
2. Submit a request for continuation if the study extends beyond the approval period of one calendar year. This continuation must receive IRB review and approval before the research can continue.
3. Report any adverse events to the IRB Chair promptly. Adverse events are those which are unanticipated and impact the subjects during the course of this research; and
4. Notify the IRB office in writing when your research project is complete.

Please note that approved protocols are subject to monitoring by the IRB and that the IRB office has the authority to inspect research records associated with this protocol at any time. If you have questions about the IRB procedures or need any assistance from the Board, please contact Beth McTernan in 219 Cordell North (phone: 405-744-5700, beth.mcternan@okstate.edu).

Sincerely,

Sheila Kennison, Chair
Institutional Review Board

VITA

Steven Taylor Hubbard

Candidate for the Degree of

Doctor of Philosophy

Thesis: HEALTH CARE AND COMING OUT: GAY AND BISEXUAL MEN'S HEALTH CARE

Major Field: Counseling Psychology

Biographical:

Education:
Completed the requirements for the Doctor of Philosophy in Educational Psychology, Option in Counseling Psychology at Oklahoma State University, Stillwater, Oklahoma in July, 2010.

Completed the requirements for the Master of Science in Educational Psychology at Oklahoma State University, Stillwater, Oklahoma in July, 2007.

Completed the requirements for the Bachelor of Science in Psychology at West Texas A&M University, Canyon, Texas in December, 2003.

Experience:
Predoctoral Psychology Internship at Ohio University's Counseling and Psychological Services (APPIC member), Athens, Ohio
APA-accredited PhD in Counseling Psychology at Oklahoma State University

Professional Memberships:
American Psychological Association, Student Affiliate

Society of Counseling Psychology, Student Affiliate

Society for the Psychological Study of Men and Masculinity, Student Affiliate

Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues, Student Affiliate

Name: Steven Taylor Hubbard Date of Degree: July, 2010

Institution: Oklahoma State University Location: Stillwater, Oklahoma

Title of Study: HEALTH CARE AND COMING OUT: GAY AND BISEXUAL MEN'S HEALTH CARE

Pages in Study: 87 Candidate for the Degree of Doctor of Philosophy

Major Field: Educational Psychology, Option Counseling Psychology

Scope and Method of Study: Exploratory Survey Research

Findings and Conclusions:

In this study a discriminant function analysis was conducted utilizing seven predictor variables to see if they could predict whether or not a gay or bisexual man had disclosed their sexual orientation to their health care providers. The discriminant function analysis confirmed that the predictor variables do serve as reliable predictors of disclosure status. Overall the seven predictor variables were able to correctly classify 90.1 percent of the participants. A one-way MANOVA was conducted to evaluate whether or not there were significant differences between participant's disclosure status to their health care providers and their importance ratings on a 24 item importance survey. The one-way MANOVA confirmed that there were significant differences between disclosers and non-disclosers. Post-hoc analyses utilizing Bonferroni corrected ANOVAs were ran on the 24 items which revealed that two items (desire to share and previous experience) were statistically significant between disclosers and non-disclosers. This study revealed that gay and bisexual men's disclosure status to their health care providers could be predicted using seven variables. Additionally this study revealed that a significant difference existed between participants who had disclosed their sexual orientation to their health care provider and those who had not based on their desire for their health care provider to know more about them and their previous experience with health care providers.

ADVISER'S APPROVAL: Dr. Donald L. Boswell