

**HIV Prevention in Colorado:
A Snapshot of
Men Who Have Sex with Men
Residing Outside of Denver**

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By

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TABLE OF CONTENTS

LIST OF TABLES.....	iii
LIST OF FIGURES	iv
LIST OF APPENDICES	v
ACKNOWLEDGEMENTS.....	vi
ABOUT THE AUTHORS.....	vii
INTRODUCTION	1
LITERATURE REVIEW	
The Non-Urban Context	
Social hostility	2
Violence.....	3
Assimilation.....	3
Social and sexual isolation	4
Looking for sex partners.....	4
Attitudes toward HIV prevention	5
Religion and MSM.....	6
Internalized Homophobia	7
Gender Role Conflict.....	8
METHODOLOGY.....	9
FINDINGS	
Basic Demographics.....	10
Health Insurance, Medical Usage, and Disabilities.....	12
Religion Related Variables.....	12
Openness and Feelings about Sexual Orientation and Gender	
Expression	
Openness about sexual orientation	15
Feelings about sexual orientation	15
Feelings about gender expression.....	16
Emotional Support, Connections, and Loneliness	
Emotional support.....	20
Connections with others	20
Loneliness.....	20
Mental Health Symptoms	
Depression	21
Dysthymia	22
Anxiety.....	22
Panic disorder	22
Post-traumatic stress disorder.....	22

Mania.....	22
Psychosocial Risks	23
Victimization	25
Alcohol and Drug-Related Behaviors	
Alcohol	25
Drugs other than alcohol.....	27
Sexuality and Sexual Behaviors.....	30
Relationships.....	34
Homophobia and Heterosexism	35
HIV Risk Behaviors	
Frequency of drug-use related behaviors	38
Frequency of sex-related behaviors.....	39
Reasons for risk behaviors.....	41
Helpfulness of HIV Prevention Activities.....	42
HIV Prevention Behaviors	
Injection drug prevention behaviors.....	45
Sex-related prevention behaviors	47
HIV and STI Testing Behaviors	
HIV Testing.....	51
STI/STDS.....	53
Hepatitis C.....	54
Preferred Contexts of HIV Prevention Services	54
Characteristics of HIV Prevention Services Providers	55
Supports Needed for HIV Prevention	56
Life Concerns	58
DISCUSSION AND CONCLUSION	
Limitations	60
Implications for HIV Prevention Services	62
Implications for Future Research.....	65
Conclusion	66
REFERENCES	67
APPENDICES	78

LIST OF TABLES

Table 1: Demographics of Sample.....	13
Table 2: Health Insurance, Recent Health Care Visits and Disabilities	14
Table 3: Religion Variables.....	15
Table 4: Comparison of Sample Means on the GRC	18
Table 5: Openness and Feelings about Sexual Orientation and Gender Express	19
Table 6: Comparison of Sample Means on the UCLA Loneliness Scale.....	20
Table 7: Emotional Support and Connections with Others.....	21
Table 8: Mental Health Symptoms	23
Table 9: Psychosocial Risks.....	26-27
Table 10: Thresholds for Substance Abuse Symptom Criteria	30
Table 11: Usage of Alcohol and Other Drugs	31
Table 12: Usage of Other Drugs.....	32
Table 13: Comparison of Sample Means on the PSC.....	34
Table 14: Gender of Sexual Partners.....	35
Table 15: Frequency of Drug-related HIV Risk Behaviors	39
Table 16: Frequency of Sexuality-related HIV Risk Behaviors	41
Table 17: Helpfulness of HIV Prevention Services and Information Sources (Last 12 Months)	46-47
Table 18: Helpfulness of Drug- and Sexuality-Related Prevention Services	48
Table 19: Perception of Cultural Norms of HIV Status Disclosure	48
Table 20: HIV Testing Patterns	52
Table 21: Life Concerns	60

LIST OF FIGURES

Figure 1: Mental Health Symptoms (Percentages)	24
Figure 2: Psychosocial Risks (Percentages)	28
Figure 3: Types of Victimization (Percentages)	29
Figure 4: Places for Meeting Sexual Partners (Percentages)	36
Figure 5: Types of Relationships Desired (Percentages)	37
Figure 6: Barriers to Relationships Desired (Percentages)	38
Figure 7: Reasons for Engaging in HIV Risk Behaviors (Percentages)	43
Figure 8: Factors Influencing Communications about HIV Status (Percentages)	49
Figure 9: Needs to Support HIV Status Disclosure (Percentages)	50
Figure 10: Reasons Reported for Not Being Tested in Prior Twelve Months (Percentages)	53
Figure 11: STI, Hepatitis C, and HIV Statuses (Percentages)	54
Figure 12: Preferred Context of Prevention Services (Percentages)	56
Figure 13: Preferred Characteristics of Service Providers (Percentages)	57
Figure 14: Supports Needed for HIV Prevention (Percentages)	58
Figure 15: Life Concerns (Percentages)	59

LIST OF APPENDICES

Appendix 1: Organizations through Which Surveys Were Distributed	78-79
Appendix 2: Questions from the Internalized Homophobia Scale	80
Appendix 3: Questions from the Gender Role Conflict Scale	81
Appendix 4: Questions from the UCLA Loneliness Scale	82
Appendix 5: Questions from the Perceived Sexual Control Scale.....	83
Appendix 6: Selected Responses of Ideas to Address Homophobia, Stigma, and Discrimination Based on Sexual Orientation	84
Appendix 7: Selected Responses of Ideas of What is Needed to Support Disclosure of HIV Status	85
Appendix 8: Selected Responses of Reasons Why Gay and Bisexual Men Have Unprotected Sex with Persons with Unknown HIV Status or Status Different from Their Own	86
Appendix 9: Selected Responses of Supports Needed to Avoid HIV Transmission	87-88
Appendix 10: Selected Responses of Life Concerns.....	89-90

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INTRODUCTION

HIV and AIDS remains a major health issue in the United States and within the state of Colorado (Centers for Disease Control and Prevention [CDC], 2008; Colorado Department of Public Health and Environment [CDPHE], 2005). Through 2007, 9,129 Coloradans have been diagnosed with AIDS, two-thirds of whom likely contracted HIV through male-to-male sexual behavior (CDC, 2009). Many more Coloradans are likely HIV-infected, some of whom are unaware of their HIV-status – a context that increases the likelihood of HIV risky behaviors (O’Leary & Wolitski, 2009; Pinkerton, Holtgrave, & Galletly, 2008).

Most studies on HIV prevention, particularly those that focus on men-who-have-sex-with-men (MSM), have focused on large metropolitan areas, resulting in a lack of knowledge of the effect of HIV/AIDS on MSM in smaller towns and rural areas (Preston, D’Augelli, Cain, & Schulze, 2002), something that is also documented in more general research about the lives of MSM (Neely, 2005). Preston and colleagues (2002) further suggest that this lack of knowledge about MSM outside of major metropolitan areas is highly problematic for HIV prevention efforts in rural areas as service models used in urban areas are not likely to work well in rural settings. D’Augelli, Preston, Cain, & Schluzze (2007) argue for the importance of more research with non-urban MSM to help providers understand “how living in rural community influences the behavior – social as well as sexual – of men who have sex with men, whether or not they identify as gay or bisexual” (p. 132).

Given that this pattern of research focusing primarily on urban MSM also exists in Colorado (Luerssen, Coombs, Voorhees, & Ware, 2006), CDPHE purposefully focused this survey on identifying HIV-related circumstances and needs of MSM living in areas of the state outside of the metropolitan Denver area.

In addition to its focus on populations of MSM outside of the Denver area, this study sought to examine a number of other sociological and psychosocial patterns that have not historically been included in HIV prevention surveys conducted in Colorado including religion and religiosity, internalized homophobia, and feelings about gender expression. The goal in gathering information on these topics was to seek greater understanding of how these potential areas influence HIV-related attitudes, behaviors, and beliefs, and to determine the unique challenges and opportunities they provide in assuring effective HIV prevention service delivery.

LITERATURE REVIEW

In this section, we explore what is currently known about HIV prevention with a particular focus on rural MSM. Because research is limited on MSM residing outside of major metropolitan areas, we have, at times, included information that does not focus solely on rural MSM which we believe might be helpful in contextualizing the findings of this study.

The Non-Urban Context

In research on the needs of MSM who live outside of metropolitan areas, Williams, Bowen, and Horvath (2005) conducted a qualitative study of 39 gay men living in the rural areas and small towns of Wyoming. Six themes emerged as particularly influential on the lives of their participants: social hostility, violence, assimilation, social and sexual isolation, looking for sex partners, and attitudes toward HIV prevention. These themes also emerge in the extant literature on the needs of rural MSM, and thus this section is organized by these themes.

Social Hostility

Social hostility refers to the culturally enforced social silence about being gay, heteronormative expectations, and the need to avoid any behaviors that might indicate a gay identity (Williams et al., 2005). Regardless of whether gay issues were discussed by local media or heterosexually-identified people, MSM in the Williams study viewed these discussions with suspicion and alarm, fearing that participating in the discussions may inadvertently out them as gay or bisexual. Likewise Neely's (2005) experience working with rural lesbian and gay communities suggests common struggles with negative feelings about being different, ambivalence about one's sexual identity, and fear of family rejection.

The stigma associated with being gay – from families, from health care providers, and from the general community – has been found to be correlated with low self-esteem among rural MSM which is then significantly related to engaging in high levels of risky sexual behavior (Preston et al., 2002). Additionally, in the same study, the authors concluded that “MSM in less tolerant communities were more likely to report higher sexual sensation seeking leading to higher levels of sexual risk-taking behaviors” (p. 227).

Educating rural health care providers and other reference groups in non-urban areas is one strategy that has been proposed to help address issues of social hostility and cultural heterosexism (Preston et al., 2002).

Violence

Experiences of violence and fear of violence play a significant role in the lives of rural MSM (Neely, 2005; Williams et al., 2005). Because of the fear of violence, rural MSM often police their behaviors to insure that they enact gender in such a way as to conform to societal expectations. Findings from scholarship suggest that violence against gay men and within the gay community are treated as normal by the larger society and as not something worthy of being addressed, even, at times, by the police (Williams et al., 2005).

Violence and threat of violence is not an uncommon experience for members of the adult LGBT community – whether rural or urban (Berrill, 1992; Herek, 2009; Herek, Gillis, & Cogan, 1999), and is likewise prevalent among LGBT youth and young adults (Bontempo & D’Augelli, 2002; Russell, Franz, & Driscoll, 2001; Saewyc et al., 2006). Victimization has been associated with numerous psychosocial risks among LGBT people including increased suicidality (Bontempo & D’Augelli, 2002; D’Augelli & Grossman, 2001; Walls, Freedenthal, & Wisneski, 2008), cutting and other self-injurious behaviors (Alexander & Clare, 2004; Hall, 1996; Hilt, Cha, & Nolen-Hoeksema, 2008; Walls, Laser, Nickels, & Wisneski, in press), drug and alcohol abuse (Brennan, Hellerstedt, Ross, & Welles, 2007; Doll et al., 1992; Houston & McKirnan, 2007), and mental health issues (Balsam & D’Augelli, 2006; D’Augelli, Pilkington, & Hershberger, 2002). Similarly, certain types of victimization have been linked to sexual risk-taking (Meade, Kershaw, Hansen, & Sikkema, 2009; Relf, Huang, Campbell, & Catania, 2004).

Assimilation

Assimilation into the heteronormative culture of small town and rural America is one strategy used by rural MSM to cope with the hostility they experience from the general community and their fear of violence (Smith, 1997; Williams et al., 2005). At times, this manifests itself in rural MSM compartmentalizing their lives as a way to keep their identity a secret in their work environment as well as in other social networks that may not be supportive (Boulden, 2001; D’Augelli & Hart, 1987). This can also emerge as an avoidance of other gay and bisexual people, including potential partners to whom they are attracted, making the development of community difficult.

Rural communities often emphasize conformity and sameness so that there are frequently social and interpersonal costs for appearing different (Neely, 2005). The degree of tolerance for difference and social constraints in various rural communities can influence the degree to which gay and lesbian people are open about their sexual orientation or HIV status (Leedy & Connolly, 2007; Ullrich, Lutgendorf, & Stapleton, 2002)

Social and Sexual Isolation

Rural MSM frequently describe themselves as isolated outsiders and have the perception that there is not a gay community to which they can relate (Neely, 2005; Williams et al., 2005). In addition to perceptions of a lack of community, members of the LGBT community may also self-isolate to protect themselves from victimization (Reis, Mendoza, & Takamura, 2003). Most often it is only in a very limited social network that others are aware of their sexual orientation, and within which opportunities exist to meet other gay and bisexual men for friendships, support, and romantic and sexual partners. The Internet frequently emerges as a mechanism through which MSM connect to the larger gay community that is not available to them geographically (Bowen, Williams, & Horvath, 2004; Bull, McFarlane, & Rietmeijer, 2001; Horvath, Bowen, & Williams, 2006).

The importance of developing a strong sense of a gay subculture within rural communities – whether through “strengthening MSM networks, gaining support through health care providers, and promoting gay pride” (Preston et al., 2002, pp. 206-207) or intentional community-building strategies (D’Augelli & Hart, 1987) – is one theme in recommended strategies to attempt to address the isolation experienced by rural MSM.

Looking for Sex Partners

The combination of the lack of a wide social network and cultural hostility frequently sends rural MSM into the closest urban areas to find romantic relationships and sex partners (Williams et al., 2005). This allows them to avoid being outted in their home communities and to find emotional and sexual connections with other MSM. Forays into urban areas are frequently to gay bars and/or bathhouses where there is the greatest likelihood of finding a romantic or sexual partner. The Internet is also frequently used to meet, socialize, and arrange face-to-face meetings with other MSM (Bowen, 2005; Horvath et al., 2006; Williams et al., 2005).

In their study of rural MSM in Pennsylvania, D’Augelli et al. (2007) found that 46 % of their respondents were in a relationship with a partner for at least the prior six

months. Of those in long-term relationships, 83% lived with their partners and the average length of relationship was ten years, with a range from one year to thirty years. Of those in steady relationships, 49% had more than one sexual partner and 56% indicated that their primary partner had other sexual partners (D'Augelli et al., 2007).

Attitudes toward HIV Prevention

Knowledge. Rural MSM, in general, are fairly knowledgeable about HIV, including risks, modes of transmissions, the mechanics of protected sex, etc. (Williams et al., 2005), although many in the same study could not name HIV prevention agencies or service providers in their area. Luerssen and colleagues (2006) found that HIV prevention services were not readily accessible in many areas of Colorado, and echoing the findings in the Williams study, that those that did exist were not well-advertised in rural areas.

Rural MSM rarely discuss HIV with other gay men, with straight friends, or even with their physicians because of fears of being outted as gay or fears that their HIV-status would not remain confidential (Luerssen et al., 2006; Williams et al., 2005). HIV-positive men in the Williams study indicated that they did not tend to reveal their status to anyone, and some of the HIV-negative men believed they were at low risk for contracting HIV because they resided in a rural area. D'Augelli et al. (2007) found that almost one-third of the rural respondents did not talk about condom use with their sexual partners, and about one quarter of the sample *never* talked with sexual partners about their HIV status.

Some researchers have recommended providing HIV prevention activities through the Internet because it is both cost-effective and respects individual privacy concerns (Bowen, Horvath, & Williams, 2007). Delivery of prevention services in this manner have been shown to improve knowledge and HIV self-efficacy (Bowen et al., 2007).

Behaviors. In their study of rural MSM in Pennsylvania, Preston and colleagues (2002) found that 47% of their sample reported moderate or high risk sexual behaviors (based on a classification system developed by Ostrow, DiFranceisco, & Wagstaff, 1998). Fifty percent of their sample had engaged in receptive anal intercourse in the prior six months, 37% of whom did not use a condom regularly and 56% of whom had multiple sex partners. Comparing across groups of rural MSM who were at different levels of HIV risk behavior for demographic differences, only age played a significant role with those in the modified high risk group being significantly younger than those in the no risk group (D'Augelli et al., 2007).

Rural MSM who had previously lived in an urban area had unprotected anal sex significantly less often and with significantly fewer partners than men who had always lived in rural areas (D'Augelli et al., 2007). Similarly, while 72% of the sample in the same study had been tested for HIV, significantly fewer men who had always lived in rural areas had been tested compared to men who had previously lived in urban areas. Rationales for not being tested included believing that they were at low risk for contracting HIV and fear of the results (D'Augelli et al., 2007).

One identified barrier to services in rural areas is the small number of organizations serving those areas, most of which are very small organizations with significantly limited capacity to provide services (Preston et al., 2002).

Religion and MSM

Little research exists on the relationship between religion variables (denomination, religiosity, etc.) and HIV-related risk behaviors (Galvan, Collins, Kanouse, Pantoja, & Golinelli, 2007), even though “a deeper understanding of the values-based motivation that complements self-interest can inform a next step in [HIV] prevention science and provide a dramatically new way of addressing the most deeply held values of those at risk” (Nimmons & Folkman, 1999, p. 323).

In a nationally representative probability sample of HIV-positive adults (over half of whom were gay or bisexual men), differences in religious affiliation and religiosity were found between gay and bisexual men, and those men and women who identified as heterosexual (Galvan et al., 2007). The largest affiliation group among gay and bisexual men was *no religious affiliation*, while the largest among heterosexual men and woman was *evangelical Christian. Catholics* were the second largest affiliation for both groups. In the same study, not only did religiosity predict sexual behaviors in the past six months while controlling for numerous other correlates, but so did religious affiliation. The findings of their study suggest that religious beliefs can have a significant influence on sexual behavior and should be considered in HIV prevention activities (Galvan et al., 2007).

In another study that examined motivations for engaging in protected sex, Nimmons and Folkman (1999) found that “ethical and moral concerns” were mentioned by 92% of their participants. Forty-three percent of the HIV-positive men and 31 % of the sample as a whole mentioned how spirituality influenced their desire to practice protected sex.

In a study of rural MSM, Preston et al. (2004) found that 62 % of their respondents reported that religion was either extremely or very important in their lives. Concern

about moral/religious acceptability of being gay has been shown to correlate with shorter relationship durations and being less open about one's sexual orientation in one's personal life among MSM (Ross & Rosser, 1996). And, in one study of rural and small town MSM, higher levels of religiosity were significantly related to higher scores on the Compulsive Sexual Behavior Inventory (Coleman et al., 2009).

Internalized Homophobia

Heterosexism – “an ideological system that denies, denigrates, stigmatizes, or segregates any nonheterosexual form of behavior, identity, relationship, or community” (Walls, 2008, pp. 26-27, adaptation of Herek's, 1992 definition) – is pervasive in the U.S., as it is in many other societies. As such, gay and bisexual men growing up in the U.S. internalize many of the negative messages, a process which has the potential to foster psychological issues such as low self-esteem and self-hatred and make the development of a positive sexual identity difficult (Gonsiorek, 1988; Malyon, 1982; Stein & Cabaj, 1996). This internalization is most often referred to in the literature as *internalized homophobia* (Herek, Cogan, Gillis, & Glunt, 1998).

Although the potential negative impacts of internalized homophobia on gay and bisexual men's psychological and physical well-being are widely acknowledged among social scientists and mental health practitioners (Barbara, 2002; Cornelson, 1998), much more research is needed to document the prevalence of consequent health problems (Herek et al., 1997; Shidlo, 1994). Existing literature suggests that higher levels of internalized homophobia are associated with decreased self-esteem, increased psychological distress and depression, increased perceptions of an anti-gay climate, and decreased social support (Herek et al., 1998; Lima, LoPresto, Sherman, & Sobelman, 1993; Ross & Rosser, 1996; Shidlo, 1994).

With regard to HIV risk, internalized homophobia has been associated with increased sexual risk taking across numerous subgroups of MSM, including Black MSM (Jerome & Halkitis, 2009), South Asian MSM (Ratti, Bakeman, & Peterson, 2000), bereaved gay men (Hatzenbuehler, Nolen-Hoeksema, & Erickson, 2008), and urban gay youth and young adults (Meyer & Dean, 1995). It has been found to correlate with increased levels of sexual compulsivity and decreased levels of sexual control (Dew & Chaney, 2005; Dupras, 1994).

Higher levels of internalized homophobia have been found to predict decreased awareness of HIV-related services and decreased feelings of connection and ability to relate well to other gay and bisexual men (Huebner, Davis, Nemeroff, & Aiken, 2002), and Nicholson & Long (1990) found higher levels of internalized homophobia to be correlated with avoidant styles of coping among a sample of HIV-positive gay men.

In contrast, Ross and Rosser (1996) found higher levels of internalized homophobia to be associated with *decreased* sexual risk taking in their sample. And, while higher levels were associated with psychological distress in their sample of mostly HIV-positive gay men, it was only weakly correlated with coping in a study conducted by Wagner, Brondolo, and Rabkin (1996).

While research on the impact of internalized homophobia on HIV-related behaviors has produced mixed results, scholars argue that understanding the role of internalized homophobia in HIV care and prevention services is critical (Huebner et al., 2002; Williamson, 2000). As with most of the research on HIV prevention, findings regarding internalized homophobia on MSM who live outside of major metropolitan areas are virtually non-existent.

Gender Role Conflict

Gender role conflict (GRC) – “a psychological state in which gender roles have negative consequences or impact on the individual or others” (O’Neil, 1990, p. 25) – has been identified as an important psychosocial construct to examine in health-related research because of its potential to influence psychosocial risks and physical well-being (Kimmel & Mahalik, 2005).

Higher levels of GRC have been found to associate with numerous difficulties in heterosexual male samples, including lower levels of psychological well-being (Blazina & Watkins, 1996; Good & Wood, 1995), higher levels of poor social intimacy (Sharpe & Heppner, 1991), depression (Good & Mintz, 1990, and sexual aggression (Good, Robertson, Fitzgerald, Stevens & Bartels, 1996). Among gay male samples, higher levels of GRC have been associated with increased levels of general distress (Blashill & Hughes, 2009; Simonsen, Blazina, & Watkins, 2000), lower levels of self-esteem (Szymanski & Carr, 2008) and lower levels of relationship satisfaction (Wester, Pionke, & Vogel, 2005). GRC has also been found to be both directly and indirectly related (through internalized homophobia) to self-esteem, with self-esteem in turn, being directly and indirectly related (through avoidant coping) to psychological distress (Szymanski & Carr, 2008).

Younger gay and bisexual males may be at greater risk for higher levels of GRC than older gay and bisexual males (Blashill & Vander Wal, 2009), and bisexual males have been shown to have higher levels of GRC than gay-identified males (Blashill & Vander Wal, 2009). Additionally, different aspects of GRC may function differently for single gay men than for partnered gay men. Sánchez, Bocklandt, and Vilain (2009), for example, found that while single gay men were more restrictive in their affectionate behavior with other men and more interested in casual sex than partnered

gay men, partnered gay men were more concerned with being successful, powerful, and competitive than single gay men.

Empirical evidence also suggests that those who are gender variant experience more negative societal reactions. In one study of adolescents, both LGB and heterosexual peers who were gender variant were rated as less acceptable than those who were gender conforming (Horn, 2007). Gender variant young people are subjected to substantial pressures during their development and commonly have experiences of violence, isolation, and rejection (Grossman, D'Augelli, Howell, & Hubbard, 2005). Increases in levels of gender nonconformity prior to the age of 13 have been found to be associated with increased likelihood of verbal and physical abuse by parents (Grossman et al., 2005).

While little research exists that directly examines gender role conflict and HIV, psychological factors that have been identified as a contributing risk factor for HIV infection are the “traditional gender roles that reinforce men's adherence to masculine images” (Operario, Smith, & Kegeles, 2008, p. 347). Given the evidence of the costs of gender variance due to negative societal reaction – many of which are potential correlates for HIV risk behaviors – scholars have argued for the importance of building and strengthening acceptance of gender expression in same-sex oriented clients (Levitt & Bridges, 2007).

METHODOLOGY

Because of the need to reach MSM who reside out of the metropolitan Denver area, a strategy was used to elicit the participation of organizations and groups that provide services to the LGBT community throughout the state. To develop the list of possible agencies, websites and numerous existing lists of LGBT community groups were examined to extract names of groups (and contact information) that have contact with MSM who are 18 years and older and reside outside of the city of Denver. The final list included community organizations serving the LGBT community, AIDS service organizations, gay-straight alliances and related organizations at colleges and universities, LGBT student services offices on campuses, multicultural student service offices on campuses, and online social network groups.

Each organization was contacted -- first by telephone, and if that was not successful, by email – to determine their willingness to distribute surveys on behalf of the project. An organizational incentive was provided whereby a \$250 gift card from an area grocery store was awarded to one participating organization through a random draw lottery. Each participating organization received one lottery ticket for agreeing to

participate and an additional lottery ticket for each completed survey on which respondents indicated that they received the survey from the organization.

Organizations had the option of receiving paper surveys, online surveys, or both formats. Organizations estimated how many paper surveys they could distribute by the study deadline and that number of paper surveys was mailed to them with self-addressed, stamped return envelopes for the survey and a second self-addressed, stamped return envelope for participants to return a ticket to enter into a lottery for drawings of five \$50 gift certificates. Data collection was open for the project from August 7, 2009 to October 5, 2009, at which point the online survey was closed. Paper surveys were distributed to 32 groups and information on the online survey was distributed to 34 groups. (Some groups received both). See Appendix 1 for a list of organizations that agreed to distribute surveys.

Once the deadline for return of the surveys had elapsed, data from the online survey and data from the paper-and-pen surveys were combined into one SPSS dataset. Data were cleaned, coded, and then analyzed using SPSS 17.0. A total of 153 surveys were returned, however four surveys were dropped because of incompleteness, and six additional surveys were removed from the dataset because respondents did not meet the criteria for participating in the study (i.e., three respondents were female, and three respondents were heterosexual males who had not had sex with men). The final usable sample size of completed surveys was 143, consisting of 66 online surveys and 77 paper-and-pen surveys.

Data collection and data analyses were approved under CDPHE's Institutional Review Board and the Institutional Review Board of the University of Denver.

FINDINGS

Basic Demographics

A total of 143 MSM residing outside Denver returned completed surveys, the vast majority of whom identified as *Male* (99.3%, $n=142$) with one person (0.7%) identifying as *Female-to-male transgender*. With regard to sexual orientation, 93.7% ($n=134$) identified as *Gay/homosexual*, 4.9% ($n=7$) as *Bisexual*, and 1.4% ($n=2$) as *Other*. Respondents ranged in age from 18 to 84 years old, with a mean age of 43.6 ($SD=15.8$) and a median age of 45.0.

Racially, 89.2% ($n=124$) identified as *White*, a percentage similar to that of the general Colorado population (89.7%, U.S. Census, 2009). Of the remaining respondents, 3.6%

($n=5$) identified as *African American/Black*, 1.4% ($n=2$) as *Asian/Pacific Islander*, 4.3% ($n=6$) as *Biracial/multiracial*, and 1.4% ($n=2$) as *Other*. In a separate question, 9.9% ($n=14$) reported a *Hispanic/Latino* ethnicity, of which 42.9% ($n=6$) identified racially as *White*, 14.3% ($n=2$) as *bi- or multi-racial*, 7.1% ($n=1$) as *African American/Black*, and 7.1% ($n=1$) as *Other*. The remainder, 28.6% ($n=4$), did not report a race in addition to their ethnicity.

Educationally, 0.7% ($n=1$) had *Less than a high school education*, 10.5% ($n=15$) had a *High school degree or GED*, 39.2% ($n=56$) had attended *Some college*, 24.5% ($n=35$) were *College graduates*, and 25.2% ($n=36$) had gone to *Graduate or professional school*.

Slightly more than half (50.4%, $n=71$) of the respondents were currently employed *Full-time*, 9.2% ($n=13$) were employed *Part-time*, 10.6% ($n=15$) were *Unemployed, but looking for work*, 9.9% ($n=14$) were *Out of the work force and not looking for employment*, 9.2% ($n=13$) were on *Disability or long-term sick leave*, 8.5% ($n=12$) were *Students*, and 2.1% ($n=3$) were in combinations of work situations (e.g., student and working part-time). Of the respondents, 12.8% ($n=18$) reported living in a household making *Less than \$10,000*, 23.4% ($n=33$) between *\$10,000 and \$29,999*, 20.6% ($n=29$) between *\$30,000 and \$49,999*, and 36.9% ($n=52$) *\$50,000 or more*. *Don't know* was given as an answer to the household income question by 6.4% ($n=9$) of the respondents, and 1.4% ($n=2$) did not provide an answer.

Converting the categorical income variable to an interval approximation by substituting the midpoint of the income category¹ yielded an estimated mean household income of \$36,288, with a median income between \$30,000 and \$49,000. Additionally, respondents were asked to provide information on the number of people residing in the household. Responses ranged from 1 to 5, with a mean of 1.7 ($SD=.95$, median=1.0). Dividing the derived interval income variable by the number of household members yields an annual income per capita ranging from \$1,250 to \$55,000 with a mean of \$26,595 ($SD=\1492.90), and a median of \$25,000.

This study specifically targeted MSM living outside the city of Denver since most HIV-related surveys in Colorado have focused on the Denver-based MSM population. Respondents were from rural areas of the state as well as smaller urbanized areas of Colorado (e.g., Colorado Springs, Pueblo, Grand Junction, Ft. Collins). Based on zip codes, geographic areas were classified as either *Urban* or *Rural* based on population. Respondents were classified as *Urban* if they resided in municipalities or geographic areas that had a population of 25,000 or more. Those who lived in areas with populations less than 25,000 were classified as *Rural*. Most of

¹ \$5000 was substituted for the “Less than \$10,000” category and \$55,000 for the “\$50,000 or more” category.

the respondents lived in urban areas (75.5%, $n=108$), with the remainder (24.5%, $n=35$) residing in more rural areas. A further breakdown of those classified as *Rural* indicated that 4.9% ($n=7$) of the sample resided in areas with populations between 10,000 and 25,000, and 19.6% ($n=28$) resided in areas with populations less than 10,000.

Basic demographic information regarding the sample can be found in Table 1.

Health Insurance, Medical Usage, and Disability

Respondents were asked to indicate their health insurance status. In the sample, 16.8% ($n=24$) indicated that they did not have any type of health insurance, with an additional 1.4% ($n=2$) indicating that they didn't know if they had health insurance. The largest group – 46.9% ($n=67$) – indicated that they had private health insurance through their employer or their school, with an additional 11.2% ($n=16$) having self-pay private insurance. Public-supported health insurance (Medicaid, Medicare, Colorado Indigent Care Program, VA) were reported as primary health insurance (either by themselves or in combination with private insurance) by 20.3% ($n=29$) of the respondents. Of the remaining respondents, 2.1% ($n=3$) reported being covered by their parents' insurance, and 1.4% ($n=2$) reported being covered under health insurance provided through their retirement packages.

Most of the respondents (82.5%, $n=118$) reported having visited a health care provider *Within the last year*, while 13.3% ($n=19$) reported their last visit as being *Between 1 and 2 years ago*. A small proportion of respondents (2.1%, $n=3$) reported visiting a health care provider *2 to 5 years ago* or *More than 5 years ago*.

Respondents were asked if they had experienced any type of disability and 76.9% ($n=110$) reported that they had not. However, 14.0% ($n=20$) reported a physical or neurological disability, 7.7% ($n=11$) a mental, emotional, or psychiatric disability, and 1.4% ($n=2$) a learning or cognitive disability.

Summary of the findings related to health insurance status, recent health care visits, and disabilities can be found in Table 2.

Religion Related Variables

Respondents were asked to indicate what religion they considered themselves with a response set that included nine options, one of which was *Other* that allowed them to write in their religious identification. Initially, 21.1% ($n=30$) identified as *Other*. Responses were examined and were re-classified as appropriate (e.g., Mormon and

Table 1: Demographics of Sample

	Male	Trans				
Gender (<i>n</i> =143)	142 (99.3%)	1 (0.7%)				
	Gay	Bisexual	Other			
Sexual orientation (<i>n</i> =143)	134 (93.7%)	7 (4.9%)	2 (1.4%)			
	White	African American	Asian/ Pacific Islander	Other	Bi/Multi-racial	
Race (<i>n</i> =139)	124 (89.2%)	5 (3.6%)	2 (1.4%)	2 (1.4%)	6 (4.3%)	
	Yes	No				
Latino ethnicity (<i>n</i> =142)	14 (9.9%)	128 (90.1%)				
	Less than high school	High school graduate	Some college	College graduate	Advanced degree	
Education (<i>n</i> =143)	1 (9.8%)	15 (10.5%)	56 (39.2%)	35 (24.5%)	36 (25.2%)	
	Employed, full-time	Employed, Part-time	Looking for work	On disability	Student	Other*
Work status (<i>n</i> =141)	71 (50.4%)	13 (9.2%)	15 (10.6%)	13 (9.2%)	12 (8.5%)	17 (12.0%)
	<\$10K	\$10K-\$30K	\$30K-\$50K	>\$50K	DK	
Income (<i>n</i> =141)	18 (12.8%)	33 (23.4%)	29 (20.6%)	52 (36.9%)	9 (6.4%)	

* Includes those who are out of the work force and those who indicated multiple work statuses.

Table 2: Health Insurance, Recent Health Care Visits, and Disabilities

	Private	Public Funded	Parents	Retirement	None	DK
Health Insurance (n=143)	67 (46.9%)	29 (20.3%)	3 (2.1%)	3 (2.1%)	24 (16.8%)	2 (1.4%)
	Within Last Year	1 to 2 Years Ago	2 to 5 Years Ago	>5 Years Ago		
Last health visit (n=143)	118 (82.5%)	19 (13.3%)	3 (2.1%)	3 (2.1%)		
	None	Physical/ Neurological	Mental/ Emotional/ Psychiatric	Learning/ Cognitive		
Disability*	110 (76.9%)	20 (14.0%)	11 (7.7%)	2 (1.4%)		

*Respondents could indicate more than one type of disability.

Unitarian were reclassified as *Christian*), resulting in the addition of two additional religious categories of *Spiritual/personal beliefs* and *Pagan/Wiccan/animist*.

Almost half (45.8%, n=65) identified as *Christian*, followed by 14.8% (n=21) identifying as *Agnostic*, 12.7% (n=18) as *No religious belief*, 9.2% (n=13) as having *Spiritual/personal beliefs*, and 7.8% (n=11) as *Atheist*. All remaining categories were indicated by less than 5% of the sample: 4.2% (n=6) as *Pagan/Wiccan/animist*, 2.8% (n=4) as *Buddhist*, 2.1% (n=3) as *Jewish*. One response was unclassifiable. One respondent did not respond to this question.

In addition to religious classification, respondents were also asked to indicate how much guidance religion provided in their day-to-day life. Of those responding, 11.4% (n=16) selected *A great deal*, 12.9% (n=18) selected *Quite a bit*, 26.4% (n=37) selected *Some*, 16.4% (n=23) selected *Little*, and 32.9% (n=46) selected *No guidance*.

A summary of the religion variables is included in Table 3.

Table 3: Religion Variables

	Christian	Agnostic	No belief	Spiritual/ Personal	Atheist
Religion (n=142)	65 (45.8%)	21 (14.8%)	18 (12.7%)	13 (9.2%)	11 (7.8%)
	Pagan/ Wiccan/ Animist	Buddhist	Jewish	Other	
	6 (4.2%)	4 (2.8%)	3 (2.1%)	1 (0.7%)	
	A great deal	Quite a bit	Some	Little	No guidance
Religious Guidance (n=140)	16 (11.4%)	18 (12.9%)	37 (26.4%)	23 (16.4%)	46 (32.9%)

Openness and Feelings about Sexual Orientation and Gender Expression

Openness about sexual orientation. To determine the level of openness about sexual orientation, respondents were asked, “In general, how open are you about your sexual orientation and/or gender identity?” with a Likert scale response set ranging from *Not at all open* to *Completely open*. Only 1.4% (n=2) reported that they were *Not at all open*, with 7.0% (n=10) reporting they were *Hardly open*, 15.4% (n=22) that they were *Somewhat open*, 28.0% (n=40) that they were *Mostly open*, and 48.3% (n=69) that they were *Completely open*.

Feelings about sexual orientation. Respondents’ feelings about their sexual orientation were examined utilizing questions from the Internalized Homophobia Scale (IHS; Ross & Rosser, 1996). The original IHS is a 26-item scale with four factors: *public identification as gay*, *perception of stigma associated with being gay*, *social comfort with gay men*, and *moral & religious acceptability of being gay*. In original psychometric testing, “the scales computed from these dimensions had internal reliabilities (coefficient alpha) of .85, .69, .64, and .62, respectively” (Ross & Rosser, 1996, p. 18).

Because of concerns about the length of the overall survey, only twelve items were included in the survey, consisting of the three questions that had the highest factor loadings on each of the four factors identified in the initial study examining the

psychometric qualities of the scale. See Appendix 2 for a list of IHS questions included on the survey.

For each of the four factors, a score was calculated by summing the three variables that were included for each of the factors and dividing that total by three, resulting in a possible range of scores from 1 to 5 on each of the factors where 5 indicates the highest level of internalized homophobia.

Scores on the *public identification as gay* factor ranged from 1 to 4.33, with a mean of 2.1 ($SD=.81$). The scores for the factor capturing *perception of stigma associated with being gay* ranged from 1 to 5 with a mean of 3.6 ($SD=.83$). Scores for the factor capturing *social comfort with gay men* ranged from 1 to 5 with a mean of 2.8 ($SD=.72$). Finally the *moral and religious acceptability of being gay* factor scores had the most truncated range – from 1 to 3.33 – with a mean of 1.5 ($SD=.61$). Combining the four additively in an overall internalized homophobia score, we find a range from 1.25 to 3.58 with a mean of 2.5 ($SD=.46$, median = 2.5) – less than the mean of 3.38 found in a recent sample of MSM (Rosser, Bockting, Ross, Miner, & Coleman, .2008).

Feelings about gender expression. Three approaches were utilized to determine respondents' feelings about their gender expression. First to capture respondents' self-concept about their gender expression, a series of three questions were asked. The questions were: (1) In terms of how I feel about myself, I would rate me as (2) Most people would rate my appearance as being and, (3) In terms of my interests, I would say they are. The response set for all three questions was a 7-point Likert scale ranging from *Extremely masculine* to *Extremely feminine*. Higher scores indicated higher degrees of femininity.

In terms of feelings about self, 10.0% ($n=14$) rated themselves as *Extremely masculine*, 52.8% ($n=74$) as *Somewhat masculine*, 19.3% ($n=27$) as *Slightly masculine*, 8.6% ($n=12$) as *Neither masculine nor feminine*, 7.9% ($n=11$) as *Slightly feminine*, and 1.4% ($n=2$) as *Somewhat feminine*. No respondents indicated that they rated themselves as being *Extremely feminine*. The mean for the scale was 2.6 – falling somewhere between *Slightly masculine* and *Somewhat masculine* – with a standard deviation of 1.13 and a median of 2.0.

Shifting now to how respondents' believed most people would rate their appearance, 12.8% ($n=18$) believed that most would rate their appearance as *Extremely masculine*, 54.3% ($n=76$) as *Somewhat masculine*, 17.1% ($n=24$) as *Slightly masculine*, 9.3% ($n=13$) as *Neither masculine nor feminine*, 5.7% ($n=8$) as *Slightly feminine*, and 0.7% ($n=1$) as *Extremely feminine*. No respondents indicated *Somewhat feminine*. The mean for the scale was 2.4,

again falling between *Slightly masculine* and *Somewhat masculine* – with a standard deviation of 1.08 and a median of 2.0.

Looking at the gendered nature of their interests, 5.1% ($n=7$) rated their interests as *Extremely masculine*, 37.0% ($n=51$) as *Somewhat masculine*, 18.8% ($n=26$) as *Slightly masculine*, 25.4% ($n=35$) as *Neither masculine nor feminine*, 12.3% ($n=17$) as *Slightly feminine*, and 1.5% ($n=2$) as *Somewhat feminine*. No one reported his interests as *Extremely feminine*. The mean for the scale capturing interests was 3.1 with a standard deviation of 1.2 and a median of 3.0, falling between *Slightly masculine* and *Neither masculine nor feminine*. Respondents viewed their interests as being slightly more feminine than either their self-rating of their gender expression or their rating of how they believe others see them.

An additional question was asked regarding how the respondents feel about their gender expression, with a five-point Likert scale ranging from *Strongly wish I were more feminine* to *Strongly wish I were more masculine*. None of the respondents indicated that they either *Strongly* or *Somewhat* wished that they were more feminine. The largest proportion of the sample at 68.8% ($n=97$) indicated that they were *Very happy with how I am*, 27.7% ($n=39$) indicated that they *Somewhat wish I were more masculine*, and 3.5% ($n=5$) indicated that they *Strongly wish I were more masculine*.

The final area explored in terms of feelings about sexual orientation and gender expression was gender role conflict using a scaled down version of the Gender Role Conflict scale (GRC; O'Neil, 1981, 1982; O'Neil, Helms, Gable, David, & Wrightsman, 1986). The original GRC is a 37-item scale and captures four factors: (a) *success, power, and competition*, (b) *restrictive emotionality*, (c) *restrictive affectionate behavior between men*, and (d) *conflict between work and family relations*. Internal consistency in initial psychometric testing of the subscales ranged from .75 to .85. Three questions from each of the four factors that had the highest loading factors in the initial psychometric testing of the scale were included in the survey. See Appendix 2 for a list of the questions that were included in the survey.

For each of the four factors, a score was calculated by summing the three variables that were included for each of the factors and dividing that total by three, resulting in a possible range of scores from 1 to 5 where 5 indicates the highest level of that factor of gender role conflict.

For the *success, power, and competition* factor, the full range of the scale is found in the sample with a mean of 3.0 ($SD=.97$) and median of 3.0. The *restrictive emotionality* factor finds a slightly more truncated representation in the sample – from 1 to 4.67 – and has a mean of 2.6 ($SD=.99$) and median of 2.7. Of all the factors, the *restrictive*

affectionate behavior between men factor had the most truncated representation in the sample – from 1 to 4.33, as well as the lowest mean at 1.7 ($SD=.62$) and median at 1.7. The final factor, *conflict between work and family relations* had scores across the full range and a mean of 2.8 ($n=1.12$) and a median of 3.0. Combining all four subscales into a comprehensive gender role conflict measure, we find a range from 1 to 4.08, and a mean of 2.5 ($SD=.64$) and a median of 2.6.

To put the mean scores found on the four GRC factors in this sample into context, we have listed comparisons found in the existing literature using the full GRC in Table 4. In the O’Neill et al. (1986) study, the sample consisted of 527 college-aged men, and the authors provided a range of means for four different subsamples in their study based on the masculinity and femininity of personal attributes. The second comparison figures come from a study of 117 gay men by Simonsen and colleagues (2000). Mean scores on the four factors for the gay men in Simonsen’s study were lower than their counterparts for the college-aged men in the O’Neill study. The mean scores in our sample are similar to those of the gay male sample by Simonsen et al.

Table 4: Comparison of Sample Means on the GRC²

	O’Neill et al. (1986)	Simonsen et al. (2000)	Current study
Success, power, and competition	3.9 – 4.4	3.3	3.0
Restrictive emotionality	2.6 – 3.4	2.6	2.6
Restrictive affectionate behavior between men	3.4 – 3.9	2.2	1.7
Conflict between work and family relations	3.5 – 3.7	3.5	2.8

A summary of the information presented in this section can be found in Table 5.

² Means from the O’Neill et al. (1996) and Simonsen et al. (2000) studies were recalibrated to be on the same metric used in this study to make comparisons easier.

Table 5: Openness and Feelings about Sexual Orientation and Gender Expression.

	Not at all	Hardly open	Somewhat open	Mostly open	Completely Open		
Openness (<i>n</i> =143)	2 (1.4%)	10 (7.0%)	22 (15.4%)	40 (28.0%)	69 (48.3%)		
Feelings about self (<i>n</i> =140)	Extremely masculine	Somewhat masculine	Slightly masculine	Neither masculine nor feminine	Slightly feminine	Somewhat feminine	Extremely feminine
	14 (10.0%)	74 (52.8%)	27 (19.3%)	12 (8.6%)	11 (7.9%)	2 (1.4%)	0 (0.0%)
Appear to others (<i>n</i> =140)	Extremely masculine	Somewhat masculine	Slightly masculine	Neither masculine nor feminine	Slightly feminine	Somewhat feminine	Extremely feminine
	18 (12.8%)	76 (54.3%)	24 (17.1%)	13 (9.3%)	8 (5.7%)	0 (0.0%)	1 (0.7%)
Interests (<i>n</i> =138)	Extremely masculine	Somewhat masculine	Slightly masculine	Neither masculine nor feminine	Slightly feminine	Somewhat feminine	Extremely feminine
	7 (5.1%)	51 (37.0%)	26 (18.8%)	35 (25.4%)	17 (12.3%)	2 (1.5%)	0 (0.0%)
Feelings about gender (<i>n</i> =141)	Strongly wish I were more masculine	Somewhat wish I were more masculine	Very happy with how I am	Somewhat wish I were more feminine	Strongly wish I were more feminine		
	5 (3.5%)	39 (27.7%)	97 (68.8%)	0 (0.0%)	0 (0.0%)		

Emotional Support, Connection, and Loneliness

Emotional Support. Respondents were asked to rate how much they agreed with the statement, “I have someone in my life that provides me with emotional support” on a five-point Likert scale ranging from *Strongly disagree* to *Strongly agree*. Most of the respondents (46.9%, $n=67$) indicated that they *Strongly agreed*, 33.6% ($n=48$) that they *Agreed*, 10.5% ($n=15$) that they *Neither agreed nor disagreed*, 3.5% ($n=5$) that they *Disagreed*, and 5.6% ($n=8$) that they *Strongly disagreed*.

Connection with Others. Additionally, respondents were asked how connected they feel to others on a five-point Likert scale ranging from *Very disconnected* to *Very connected*. *Very connected* was selected by 28.0% ($n=40$), while 46.9% ($n=67$) reported feeling *Connected*, 14.7% ($n=21$) reported being *Undecided*, 9.8% ($n=14$) feeling *Not connected*, and 0.7% ($n=1$) as feeling *Very disconnected*.

Loneliness. A modified version of the UCLA Loneliness Scale – Short Form (Hays & DiMatteo, 1987) was used to capture the level of loneliness experienced by the respondents. See Appendix 4 for the items included from the scale. The items were totaled and divided by the number of items to arrive at a score on a 1 to 5 scale, with higher scores indicating higher levels of loneliness. Scores ranged from 1 to 3.71 with a mean of 2.3 ($SD=.58$) and a median of 2.3, higher than the average range which falls between 1.5 and 2.0 (Russell, 1996)³.

To put the mean score found in this sample in context, Table 6 contains the current study mean as well as means found on the UCLA Loneliness Scale in two other study samples. The first is from the Hays and DiMatteo (1987) study of 199 college students while the second is from a subsample of 30 HIV-positive gay men recruited from the San Diego area (Semple, Patterson, Straits-Tröster, Atkinson, McCutchan, Grant & The San Diego HIV Neurobehavioral Research Center., 1996). The current study’s sample mean is similar to that found by Semple and colleagues.

See Table 7 for a summary of the findings related to emotional support, connection, and loneliness.

Mental Health Symptoms

In this section we examine various symptoms associated with mental health diagnoses using items from the Substance Abuse and Mental Illness Symptoms Screener (SAMISS; Whetten, Reif, Swartz, Stevens, Ostermann, Hanisch, & Eron, 2005).

Table 6: Comparison of Sample Means on the UCLA Loneliness Scale³

	Hays & DiMatteo (1987)	Semple et al. (1996)	Current study
UCLA Loneliness Scale	3.5	2.3	2.3

Table 7: Emotional Support and Connections with Others

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Emotional support (<i>n</i> =143)	8 (5.6%)	5 (3.5%)	15 (10.5%)	48 (33.6%)	67 (46.9%)
	Very disconnected	Not connected	Undecided	Connected	Very connected
Connection with others (<i>n</i> =143)	1 (0.7%)	14 (9.8%)	21 (14.7%)	67 (46.9%)	40 (28.0%)

Depression. Three questions were included in the survey to capture depression. The first asked whether, in the past year, the respondent had ever been on medication or anti-depressants for depression or nerve problems. Of the respondents who answered the question (*n*=141), 71.6% (*n*=101) indicated that they had not, while 28.4% (*n*=40) indicated that they had.

Two questions asked specifically about depression symptoms. Respondents were asked whether they had felt sad, blue, or depressed for more than two weeks in a row during the past year. Of the sample, 140 responded to the question with 56.4% (*n*=79) indicating that they had, and 43.6% (*n*=61) indicating that they had not. Next respondents were asked whether they had lost interest for more than two weeks in hobbies, work, or activities that usually gave them pleasure. Most (55.7%, *n*=78) indicated they had not, while 44.3% (*n*=62) indicated that they had.

³ Means from the Hays & DiMatteo (1987), Semple et al. (1996), and Russell (1996) studies were recalibrated to be on the same metric used in this study to make comparisons easier.

Dysthymia. To capture dysthymic mood disorder, respondents were asked if they experienced themselves as being depressed, sad, or in a “blah” mood most of the time for almost every day for at least two years. About one-fifth (17.9%, $n=25$) reported that they had, while the remainder (82.1%, $n=115$) reported they had not.

Anxiety. Respondents were asked to indicate if, in the past year, they experienced a period lasting more than one month when most of the time they were worried or anxious. Slightly more than one-third (34.3%, $n=48$) reported that they had, with 63.7% ($n=92$) reporting they had not.

Panic Disorder. Two questions were asked to ascertain whether respondents had experienced symptoms of panic disorder in the past year. The first asked if they had ever had a spell or attack when all of the sudden they felt frightened, anxious, or very uneasy in situations where most people would not be afraid or anxious. Of the responses, 29.8% ($n=42$) reported that they had, while 70.2% ($n=99$) reported that they had not. The second question asked whether, in the past year, the respondent had experienced a spell or attack for no reason when their heart suddenly started to race, they felt faint, or they could not catch their breath. A similar percentage, (24.8%, $n=35$) reported they experienced such an attack while 75.2% ($n=106$) reported they had not.

Post-traumatic Stress Disorder (PTSD). Two questions were asked about PTSD-related experiences and symptoms. First respondents were asked if they had experienced or witnessed traumatic events during their lifetime⁴, of which 63.1% ($n=89$) reported they had. Second, they were asked if, during the past year, they had been troubled by flashbacks, nightmares, or thoughts about some trauma they had experienced in their past, of which 27.0% ($n=38$) reported they did.

Mania. The final psychological symptomology question respondents were given, asked if – in the past year – when they were not high or intoxicated, they had felt extremely energetic, irritable, or more talkative than usual. Almost one-third (31.4%, $n=44$) reported they had.

Summary information for psychological symptoms can be found in Table 8 and Figure 1.

⁴ The question regarding witnessing traumatic events during their lifetime is not from the SAMISS.

Table 8: Mental Health Symptoms

	Yes	No
Anti-depressants (n=141)	40 (28.4%)	101 (71.6%)
Sad, blue, or depressed (n=140)	61 (43.6%)	79 (56.4%)
Loss of pleasure (n=140)	62 (44.3%)	78 (55.7%)
Dysthymia (n=140)	25 (17.9%)	115 (82.1%)
Anxiety (n=140)	48 (34.3%)	92 (65.7%)
Panic - emotional (n=141)	42 (29.8%)	99 (70.2%)
Panic - physical (n=141)	35 (24.8%)	106 (75.2%)
Trauma events (n=141)	89 (63.1%)	52 (36.9%)
Flashbacks (n=141)	38 (27.0%)	103 (73.0%)
Mania (n=140)	44 (31.4%)	96 (68.6%)

Psychosocial Risks

To provide an understanding of potential psychosocial risks that shape the lived experiences of the men responding to the survey, respondents were asked to indicate if they had experienced a series of different psychosocial risks. Respondents could indicate more than one of the risks listed. The risks are reported here in order of highest percentage indicated by respondents.

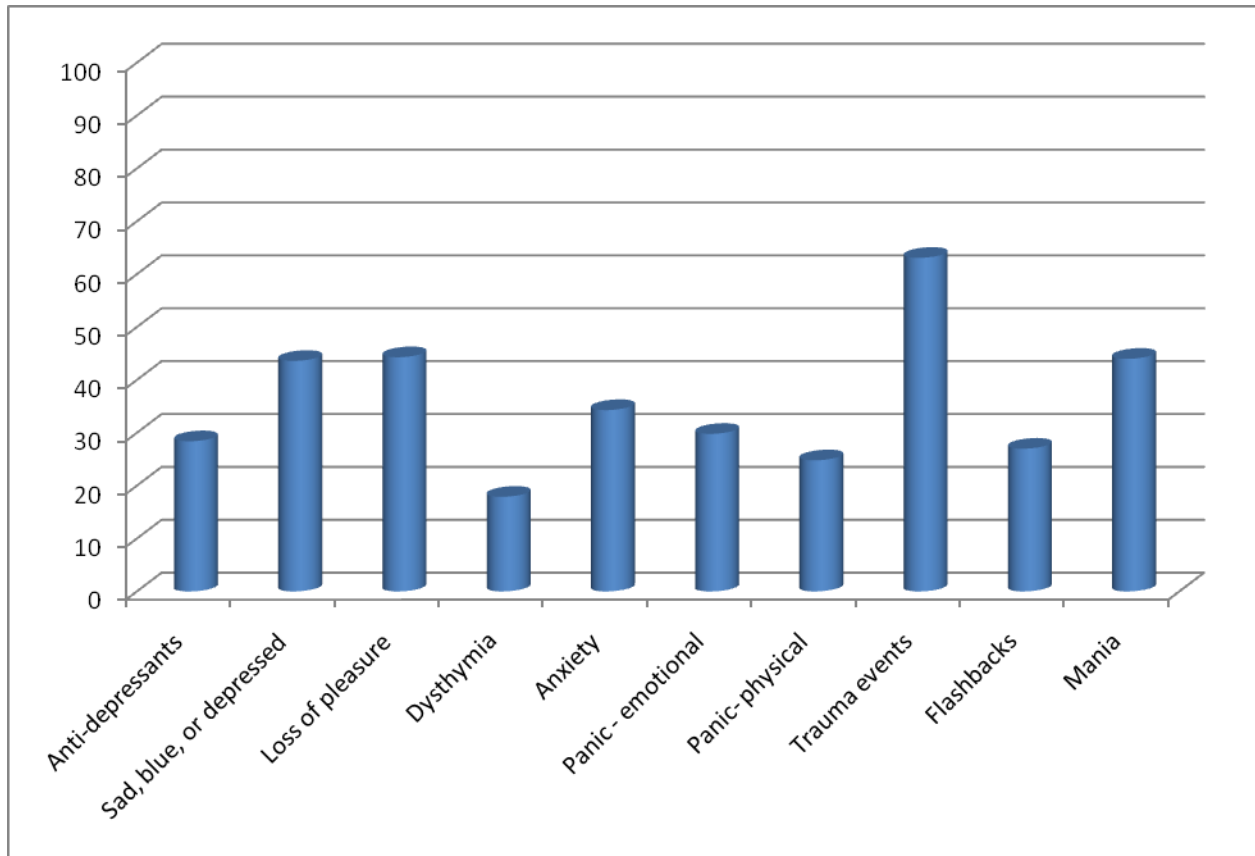


Figure 1: Mental Health Symptoms (Percentages)

Low self-esteem was indicated by 64.3% ($n=92$) of the sample, followed by feeling not accepted by others at 56.6% ($n=81$), experiencing isolation by 55.2% ($n=79$), and feeling shame about their sexual orientation at 53.8% ($n=77$). Almost half (45.5%, $n=65$) reported having been poor or living in poverty, and 44.8% ($n=64$) as experiencing hopelessness.

Slightly more than one quarter (27.3%, $n=39$) reporting having a chronic health problem or life-threatening illness, 25.9% ($n=37$) as feeling as if they do not have control over what happens to them, 23.8% ($n=34$) as experiencing sexual abuse or unwanted sexual experiences as a child, 21.7% ($n=31$) as feeling shame about their gender expression, and 21.0% ($n=30$) experiencing substance abuse or addiction.

Less than 1 in 5 reported experiencing the remainder of the listed psychosocial risks with 18.9% ($n=27$) reporting feeling like they would become infected with HIV sooner or later, 16.1% ($n=23$) reporting childhood physical abuse, 12.6% ($n=18$)

indicating sexual abuse, sexual assault, or unwanted sexual experiences as an adult, 11.9% ($n=17$) reporting physical abuse or assault as an adult, 11.9% ($n=17$) having a serious mental illness such as bipolar disorder or schizophrenia, and 11.2% ($n=16$) having experienced homelessness. Lower rates of prevalence were reported for trading sex for food, money, housing or other necessities (5.6%, $n=8$), and having been incarcerated (3.5%, $n=5$).

Summary information for psychosocial risks can be found in Table 9 and Figure 2.

Victimization

Because rates of victimization among LGBT community members are reported at significantly higher rates than victimization levels in the general community (D'Augelli et al., 2005; Ryan & Rivers, 2003; Herek, 2009; Herek, Gillis, & Cogan, 1999; Walls, Kane, & Wisneski, in press), respondents were asked to identify their experiences of victimization in the prior 12 months. Respondents were able to indicate more than one experience.

Approximately one-half (49.7%, $n=71$) reported none of the listed experiences of victimization had occurred to them in the past year. The most common type of victimization among respondents was being called names (28.7%, $n=41$), followed by receiving unwanted attention (22.4%, $n=32$), and equal numbers reporting having obscenities said to them and being excluded from groups (18.9%, $n=27$). Bullying was reported by 9.8% ($n=14$), 9.1% ($n=13$) reported being threatened, 7.7% ($n=11$) reported being touched in unwanted ways, and 2.1% ($n=3$) reported being physically assaulted. No one in the sample reported being sexually assaulted or having graffiti written on their property.

Figure 3 illustrates the types of victimization experienced by respondents.

Alcohol and Drug-related Behaviors

Alcohol. To ascertain the degree of alcohol use, respondents were asked how often, in the past 12 months, they drank alcohol. The smallest proportion of respondents (12.6%, $n=18$) reported *Never* using alcohol in the past year, with 26.6% ($n=38$) reporting *Monthly or less* usage, 27.3% ($n=39$) reporting *2-4 times per month*, 17.5% ($n=25$) reporting *2-3 times per week*, and 16.1% ($n=23$) reporting *4 or more times per week*.

In addition to frequency, respondents were asked how often they had 5 or more drinks in one sitting. More than half (51.7%, $n=74$) reported *Never* having had 5 or more alcoholic drinks in one sitting in the past year, 28.7% ($n=41$) reported doing so

Table 9: Psychosocial Risks

	Yes
Low self-esteem	92 (64.3%)
Feeling not accepted by others	81 (56.6%)
Feeling isolated	79 (55.2%)
Feeling shame about my sexual orientation	77 (53.8%)
Being poor or living in poverty	65 (45.5%)
Feeling hopeless	64 (44.8%)
Chronic health problems or life threatening illness	39 (27.3%)
Feeling as if I did not have control over what happened to me	37 (25.9%)
Sexual abuse or unwanted sexual experiences as a child	34 (23.8%)
Feeling shame about my gender expression (how masculine or feminine)	31 (21.7%)
Substance abuse/addiction	30 (21.0%)
Feeling that sooner or later I will become infected with HIV	27 (18.9%)
Physical abuse as a child	18 (12.6%)
Sexual abuse/assault or unwanted sexual experiences as an adult	17 (11.9%)

Table 9: Psychosocial Risks (continued)

	Yes
Physical abuse/assault as an adult	17 (11.9%)
Serious mental illness like bipolar disorder or schizophrenia	17 (11.9%)
Homelessness	16 (11.2%)
Trading sex for food, money, housing, other necessities	8 (5.6%)
History of incarceration	5 (3.5%)

Less than monthly, 9.1% ($n=13$) reported doing so *Monthly*, 8.4% ($n=12$) reported doing so *Weekly*, and 2.1% ($n=3$) reported doing so *Daily or almost daily*.

Drugs other than alcohol. Respondents were asked to indicate how often they used drugs to get high or to change the way they feel. More than two-thirds (67.4%, $n=95$) reported *Never* using drugs in the last 12 months, 14.9% ($n=21$) reported doing so *Less than monthly*, 5.7% ($n=8$) reported doing so *Monthly*, 7.8% ($n=11$) reported doing so *Weekly*, and 4.3% ($n=6$) reported doing so *Daily or almost daily*.

To gauge whether levels and frequency of drug and alcohol usage were of concern to respondents, they were asked, “In the past year, how often did you drink or use drugs more than you meant to?” and were given a five-point Likert scale ranging from *Never* to *Daily or almost daily*. Most (66.9%, $n=95$) indicated they *Never* used drugs or alcohol more than they meant to, 22.5% ($n=32$) indicated that they used drugs or alcohol more than they meant to *Less than monthly*, 5.6% ($n=8$) indicated they did so *Monthly*, 2.1% ($n=3$) reported they did so *Weekly*, and 2.8% ($n=4$) that they did so *Daily or almost daily*.

Similarly, respondents were asked how often in the past year they felt that they wanted or needed to cut down on their drinking or drug usage. In this case, 70.0% ($n=98$) indicated *Never*, 17.1% ($n=24$) indicated *Less than monthly*, 5.0% ($n=7$) indicated *Monthly*, 2.9% ($n=4$) indicated *Weekly*, and 5.0% ($n=7$) indicated *Daily or almost daily*.

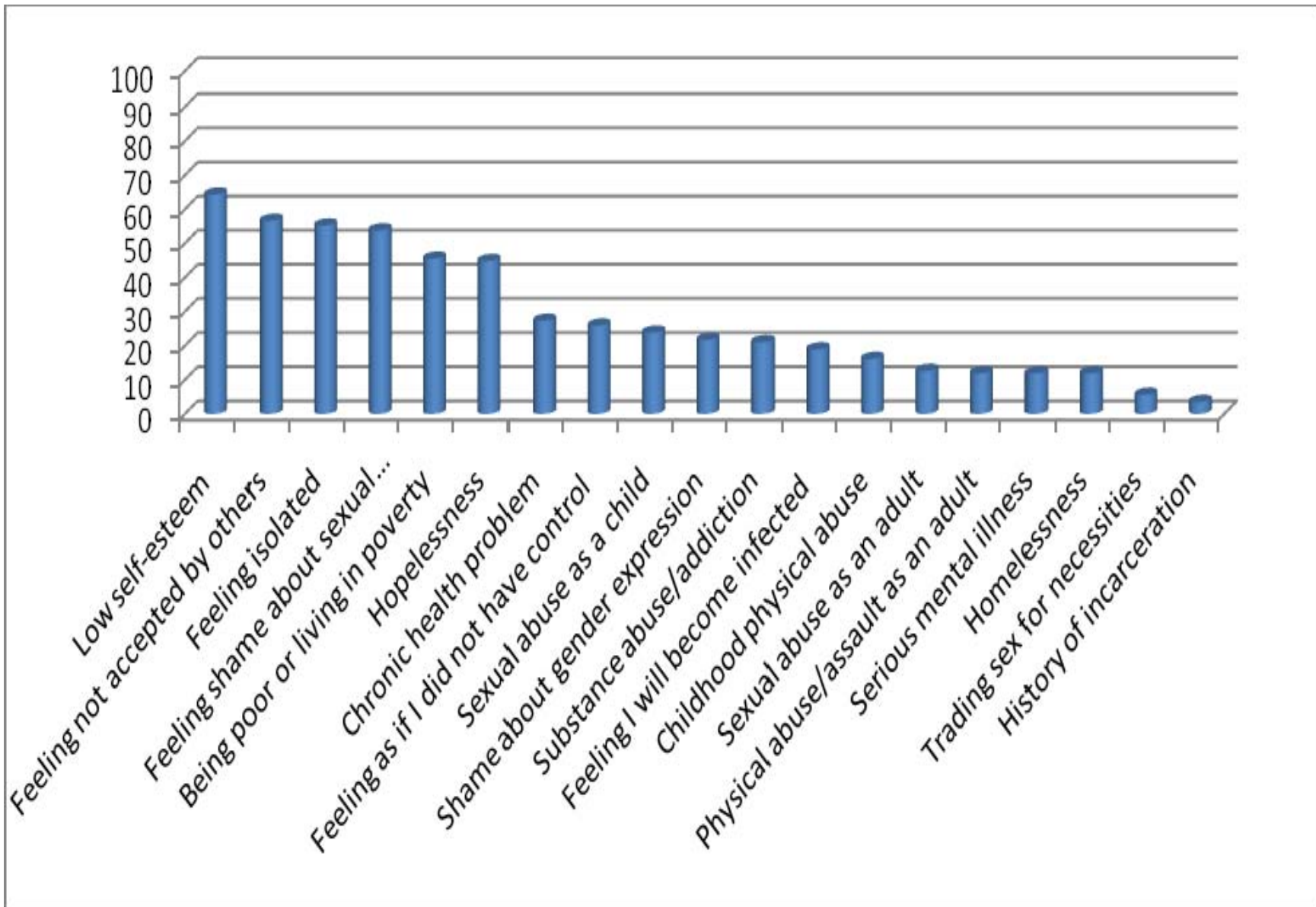


Figure 2: Psychosocial Risks (Percentages)

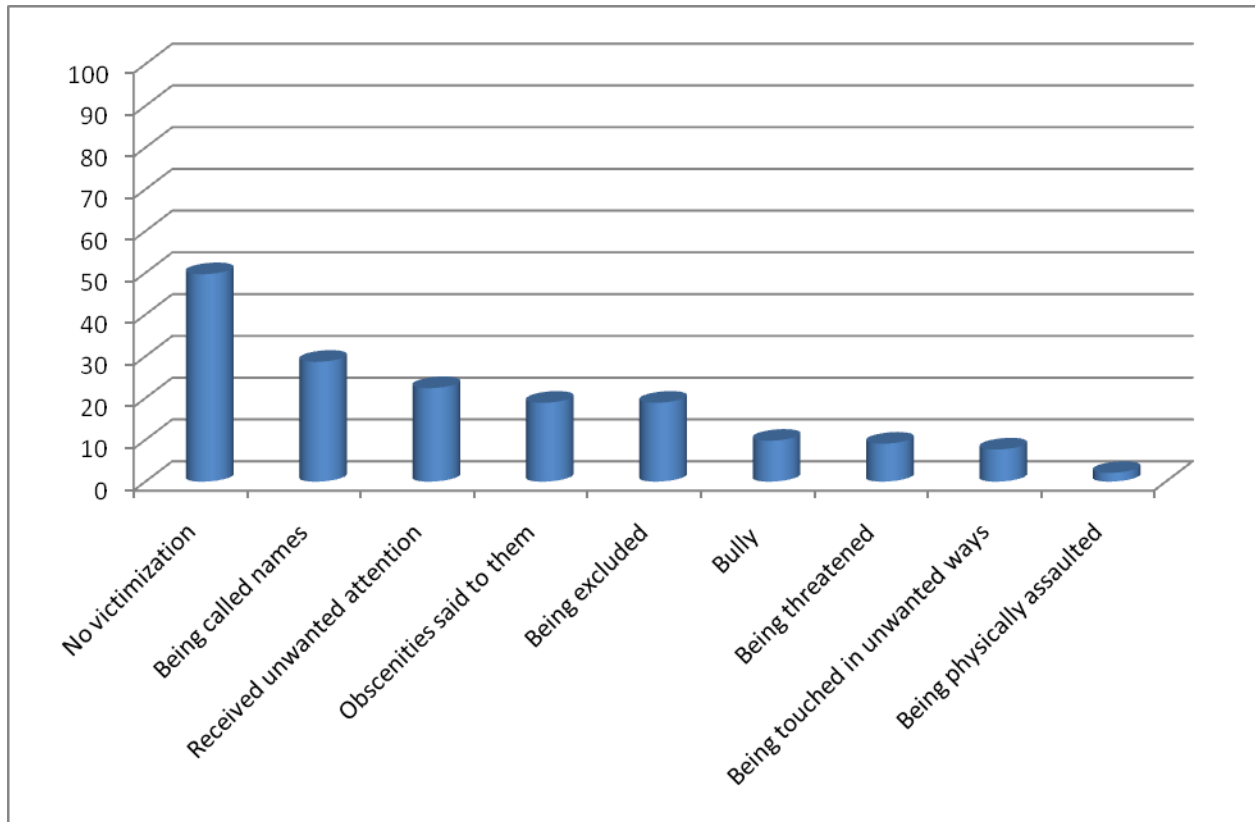


Figure 3: Types of Victimization (Percentages)

The above alcohol-related/substance use questions are part of the SAMISS (Whetten et al., 2005) and provide an indication, based on scoring, of which respondents would be considered positive for substance abuse symptoms. The outlined criteria⁵ measure three different areas – frequency and amount of use, use to get high, and concern about use. On the frequency and amount of use criteria, 35.0% ($n=50$) of the sample meets the criteria for being considered positive for substance abuse symptoms. On the use of substances to get high criteria, 17.7% ($n=25$) meet the threshold, and on the concern about use criteria, 37.1% ($n=52$) do so.

Examining all three criteria thresholds in conjunction with one another suggests that 7.2% ($n=10$) of the sample meets all three of the criteria, 24.5% ($n=34$) meet two of the three criteria, and 18.0% ($n=25$) equals one of the three criteria. Table 10 summarizes the findings related to the substance abuse symptom criteria.

⁵ The scoring criteria were modified according to the number of question included on the survey as not all questions were asked due to survey length.

Table 10: Thresholds for Substance Abuse Symptom Criteria

	Meets criteria
Frequency and amount of use	50 (35.0%)
Use to get high	25 (17.7%)
Concern about use	52 (37.1%)

The most commonly reported drug (after alcohol) used in the sample was marijuana/hash with 50.4% ($n=71$) reporting usage in the past 12 months. Almost one-third (32.4%, $n=46$) reported using painkillers such as Oxycontin, followed by 28.9% ($n=41$) reporting using poppers, and 14.2% ($n=20$) reporting using ecstasy, GHB, or similar drugs.

While 5.0% ($n=7$) reported using crack cocaine less often than *Once or twice in the past 12 months*, 15.6% ($n=22$) reported using powder cocaine less often than *About once a month*. Methamphetamines were reported to be used by 8.4% ($n=12$) of the sample at rates of *About once a month* or less, and 7.9% ($n=11$) reported using downers.

Respondents were asked if they had used injection drugs in the past five years and 3.5% ($n=5$) indicated that they had. Heroin use was reported by 1.4% ($n=2$) in its injectable form and 2.1% ($n=3$) in its non-injectable form.

Findings related to drug and alcohol usage are reported in Table 11 and Table 12.

Sexuality and Sexual Behaviors

Since sexual identity does not always align neatly with sexual behavior (Pathela et al., 2006; Remafedi, 1992; Smith, Rissel, Richters, Grulich, & Visser, 2003), particularly for younger people (Igartua, Thombs, Burgos, & Montoro, 2009; Savin-Williams, 2006), the survey inquired about the gender of people with whom the respondents had had sex with in the past five years. Most (90.2%, $n=129$) indicated they had only had sex with *Men*, no respondents indicated that they had only had sex with *Women*, and 8.4% ($n=12$) indicated that they had sex with *Both*. Two respondents (1.4%) indicated that they had sex with *No one* for the past 5 years.

Table 11: Usage of Alcohol and Other Drugs

	Never	Monthly or less	2-4 times per month	2-3 times per week	4 or more times per week
Frequency of alcohol use in last 12 months (n=143)	18 (12.6%)	38 (26.6%)	39 (27.3%)	25 (17.5%)	23 (16.1%)
	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Frequency of having 5 or more drinks in one sitting (n=143)	74 (51.7%)	41 (28.7%)	13 (9.1%)	12 (8.4%)	3 (2.1%)
	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Frequency of using drugs to get high or change mood (n=141)	95 (67.4%)	21 (14.9%)	8 (5.7%)	11 (7.8%)	6 (4.3%)
	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Frequency of drinking or using drugs more than meant to (n=142)	95 (66.9%)	32 (22.5%)	8 (5.6%)	3 (2.1%)	4 (2.8%)
	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Frequency of feeling like the need to cut down on drinking or using drugs (n=140)	98 (70.0%)	24 (17.1%)	7 (5.0%)	4 (2.9%)	7 (5.0%)

Table 12: Usage of Other Drugs

	Never	Not in past 12 months	Once or twice in past 12 months	About once a month	About once a week	Twice a week or more
Meth (<i>n</i> =142)	130 (91.5%)	5 (3.5%)	6 (4.2%)	1 (0.7%)	0 (0.0%)	0 (0.0%)
Crack (<i>n</i> =141)	134 (95.0%)	6 (4.3%)	1 (0.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Powder cocaine (<i>n</i> =141)	119 (84.4%)	8 (5.7%)	13 (9.2%)	1 (0.7%)	0 (0.0%)	0 (0.0%)
Injected heroin (<i>n</i> =142)	140 (98.6%)	2 (1.4%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Non-injected heroin (<i>n</i> =142)	130 (97.9%)	2 (1.4%)	1 (0.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Ecstasy, GHB, etc. (<i>n</i> =140)	120 (85.7%)	9 (6.4%)	9 (6.4%)	2 (1.4%)	0 (0.0%)	0 (0.0%)
Poppers, rush (<i>n</i> =142)	101 (71.1%)	13 (9.2%)	15 (10.6%)	5 (3.5%)	4 (2.8%)	4 (2.8%)
Marijuana, hash (<i>n</i> =141)	70 (49.6%)	14 (9.9%)	19 (13.5%)	11 (7.8%)	10 (7.1%)	17 (12.1%)
Painkillers (Oxycontin, etc.) (<i>n</i> =141)	96 (67.6%)	9 (6.3%)	17 (12.0%)	6 (4.2%)	2 (1.4%)	12 (8.5%)
Downers (<i>n</i> =138)	127 (92.0%)	4 (2.9%)	3 (2.2%)	1 (0.7%)	2 (1.4%)	1 (0.7%)

Respondents were asked to indicate the number of sexual partners they had in the past 12 months. The number of sex partners ranged from 0 to 52 with a mean of 5.25 sexual partners ($SD=8$), a median of 3 sexual partners, and a modal response of 1 sexual partner.

Next, respondents were asked where they met sexual partners and were provided with a series of ten responses plus an *Other* category that they could indicate. Respondents

could indicate more than one category. Responses from the *Other* category were examined and, when appropriate, reclassified into an appropriate existing category (e.g., “Craigslist” was recoded as *Internet*). Two additional categories emerged from the examination of *Other* responses: *Monogamous relationship* and *Celibacy*.

The most commonly indicated place for meeting sexual partners was the *Internet* at 51.8% ($n=74$), followed by *Parties or social events* at 43.4% ($n=62$). Introduction to sexual partners by *Friends* was 40.6% ($n=58$), followed by 35.7% ($n=51$) at *Bars*, 16.8% ($n=24$) at *Bathhouses or adult bookstores*, 11.9% ($n=17$) at *Classes or school*, 11.9% ($n=17$) indicating *Street/cruising or other public places*, 9.1% ($n=13$) at *Parks*, 7.7% ($n=11$) indicating *Being in a monogamous relationship*, 6.3% ($n=9$) at *Work*, 4.2% ($n=6$) at *Church/place of worship*, and 4.2% ($n=6$) indicating *Celibacy*.

Compulsive sexual behavior and sexual addiction have been shown to play a role in HIV-related sexual behaviors (Kalichman & Cain, 2004; Reece, 2003; Reece, Plate, & Daughtry, 2001; Satinsky et al., 2008) and, as such, a modified version of the measure of Perceived Sexual Control (PSC; Exner, Meyer-Bahlburg, & Ehrhardt, 1992) was included in the survey. See Appendix 5 for questions included in the survey. The PSC is a measure that was created specifically for use with gay men and was psychometrically tested with a sample composed of both HIV-positive and HIV-negative gay and bisexual men (Exner et al., 1992). The scale has two factors, perceived control over sex drive (PSC-SD) and perceived control over risk behavior (PSC-RB), both of which demonstrated more than adequate Cronbach’s alpha in initial psychometric testing. The three items from each subscale included in the survey were summed and then divided by three to give a scale ranging from one to five where higher numbers indicate greater levels of perceived sexual control.

For the PSC-SD, we found scores ranging from 1.3 to 5.0 in the sample, with a mean of 3.8, a standard deviation of .86, and a median of 4.0. For the PSC-RB, scores ranged from 1.3 to 5.0 with a mean of 3.9, a standard deviation of .86, and a median of 3.8. Combining the two subscales for an overall measure of PSC, we find a range from 2.0 to 5.0 in the sample, with a mean of 3.8, a standard deviation of .73, and a median of 3.8. The two subscales are significantly correlated with one another ($r=.48$, $p<.0001$).

Two existing studies using the PSC were identified in the existing literature to enable a comparison with the means of the current study. In Exner et al.’s (1992) study using a volunteer sample of 108 HIV-positive and 48 HIV-negative gay or bisexual men in New York City, the PSC-SD had a mean of 3.9, and the PSC-RB had a mean of 4.1. A more recent study by Mulry, Kalichman, Kelly, Ostrow, and Heckman (1997) used

hierarchical clustering to identify three groups of gay men based on various sexual behaviors and found means between 3.7 - 3.8 for the scale among all three groups.

Table 13 summarizes the comparison between the three samples.

Table 13: Comparison of Sample Means on the PSC

	Exner et al. (1992)	Mulry et al. (1997)	Current study
PSC-SD	3.9	--	3.8
PSC-RB	4.1	--	3.9
PSC-Total	--	3.7-3.8	3.8

Results related to sexuality and sexual behaviors are presented in Table 14 and Figure 4.

Relationships

Respondents were asked to indicate what types of relationships they want or prefer with other men, and were allowed to select more than one response. Some of the responses provided described qualities of relationships (e.g., *mutual trust*), while others described arrangements for sexual behavior (e.g., *monogamous*). The most commonly indicated response was *Relationships that involve honest communication*, with 79.7% ($n=114$) indicating this response. Following that, 78.3% ($n=112$) indicated *Relationships that involve mutual trust*, 76.2% ($n=109$) indicated *Relationships that are fun*, 64.3% ($n=92$) indicated *Long-term, steady monogamous relationships*, 55.2% ($n=79$) indicated *Relationships that involve total responsibility and commitment*. Fewer respondents indicated that they wanted *Long-term, steady relationships that are not monogamous* (17.5%, $n=25$), or *Casual short-term relationships* (11.9%, $n=17$). Less than 10% of the sample indicated short-term relationships free of any type of commitment with 9.1% ($n=13$) indicated *Anonymous sexual relationships*, and 8.4% ($n=12$) indicated *Relationships that involve no responsibility and commitment* (8.4%, $n=12$).

Table 14: Gender of Sexual Partners

	Male	Female	Both	No One
Gender of sexual partners (n=143)	129 (90.2%)	0 (0.0%)	12 (8.4%)	2 (1.4%)

Figure 5 summarizes the types of relationships respondents indicated that they wanted.

To determine what respondents view as barriers to creating the types of relationships they desire, they were asked, “What are the barriers you experience trying to create and maintain the types of relationships you most want?” Respondents could indicate more than one response.

The most frequently cited barrier was *There are no good places to meet men to establish these kinds of relationships* with 41.3% (n=59) respondents indicating this as a barrier. Following that were *Fear of rejection* at 39.9% (n=57), *Lack of support for same-sex relationships* at 37.8% (n=54), *Shyness* at 37.1% (n=53), *Discrimination within the gay community (based on age, race, class, HIV status, etc.)* at 35.0% (n=50), *Low self-esteem* at 29.4% (n=42), and *Difference in HIV status* at 11.2% (n=16). Twenty respondents (14.0%) indicated that *There are no barriers*.

A summary of the barriers identified by respondents can be found in Figure 6.

Homophobia and Heterosexism

Respondents were asked directly to indicate on a five-point Likert scale ranging from *Strongly agree* to *Strongly disagree* how much they agree with the statement, “Homophobia, stigma, and discrimination based on sexual orientation is widespread, making life difficult for gay and bisexual men.” The vast majority of respondents agreed with the statement to some degree with 25.5% (n=36) indicating that they *Strongly agree*, and 52.5% (n=74) indicating that they *Somewhat agree*. *Neither agree nor disagree* was selected by 9.2% (n=13), followed by *Somewhat disagree* at 9.2% (n=13), and *Strongly disagree* at 3.5% (n=5).

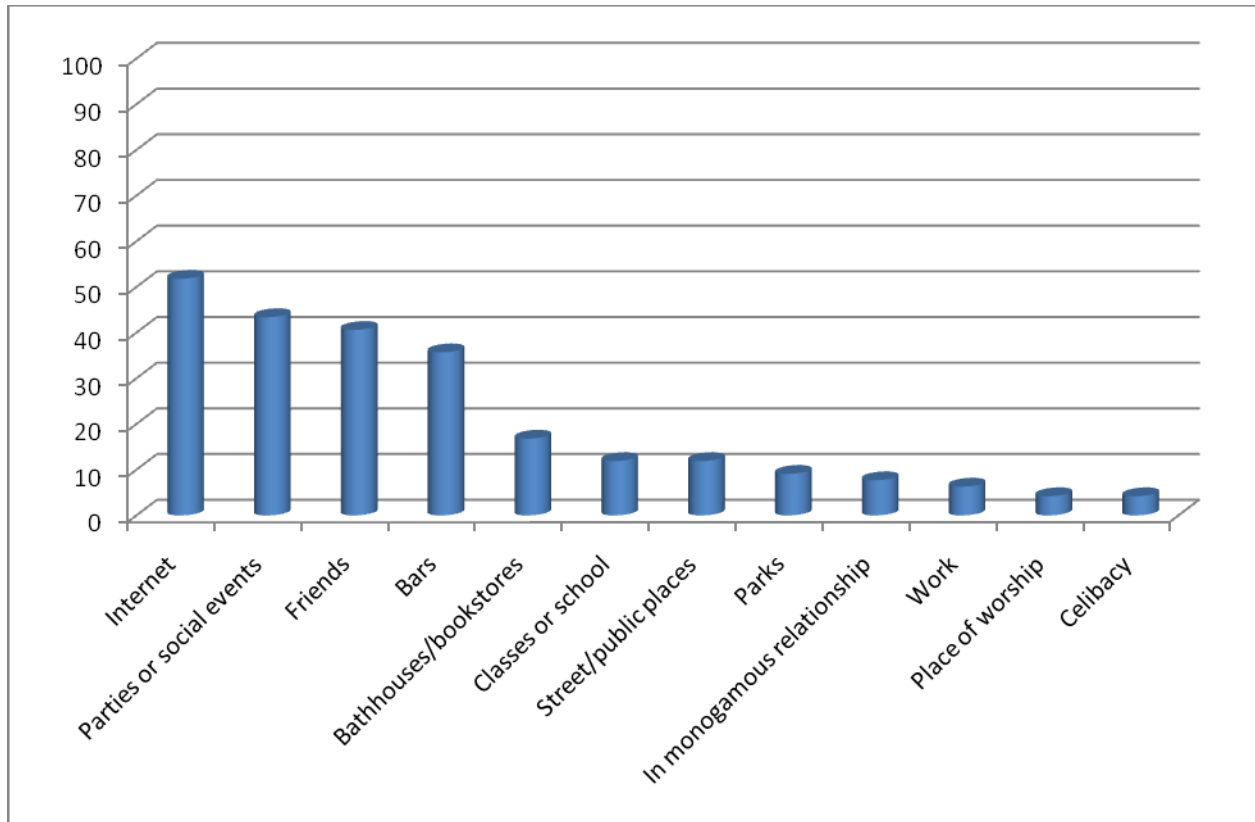


Figure 4: Places for Meeting Sexual Partners (Percentages)

A follow up, open-ended question was asked of respondents who either indicated that they either *Strongly agree* or *Somewhat agree* with the previous statement about homophobia, asking what they would recommend to improve the situation. Responses were reviewed and categorized, with most of the responses indicating some educational and/or legal approach.

Approximately half (44.6%, $n=49$) of those who indicated some level of agreement with the statement provided an answer. The most commonly indicated answer was educational in nature with 25.5% ($n=28$) making educational suggestions. In addition to directly indicating “education”, other responses in this category were more specific such as, “Bring people of all sexualities together and try to create understanding. Forums?” and “People understanding us, so more information on our sexuality.”

The second most commonly indicated category of ideas fell in the arena of legal suggestions with 11.8% ($n=13$) of the respondents recommending policy and legislative action. Examples of responses in this category include “More action by Congress to give GLBT folks equal rights,” and “Pass laws making it safer & better.”

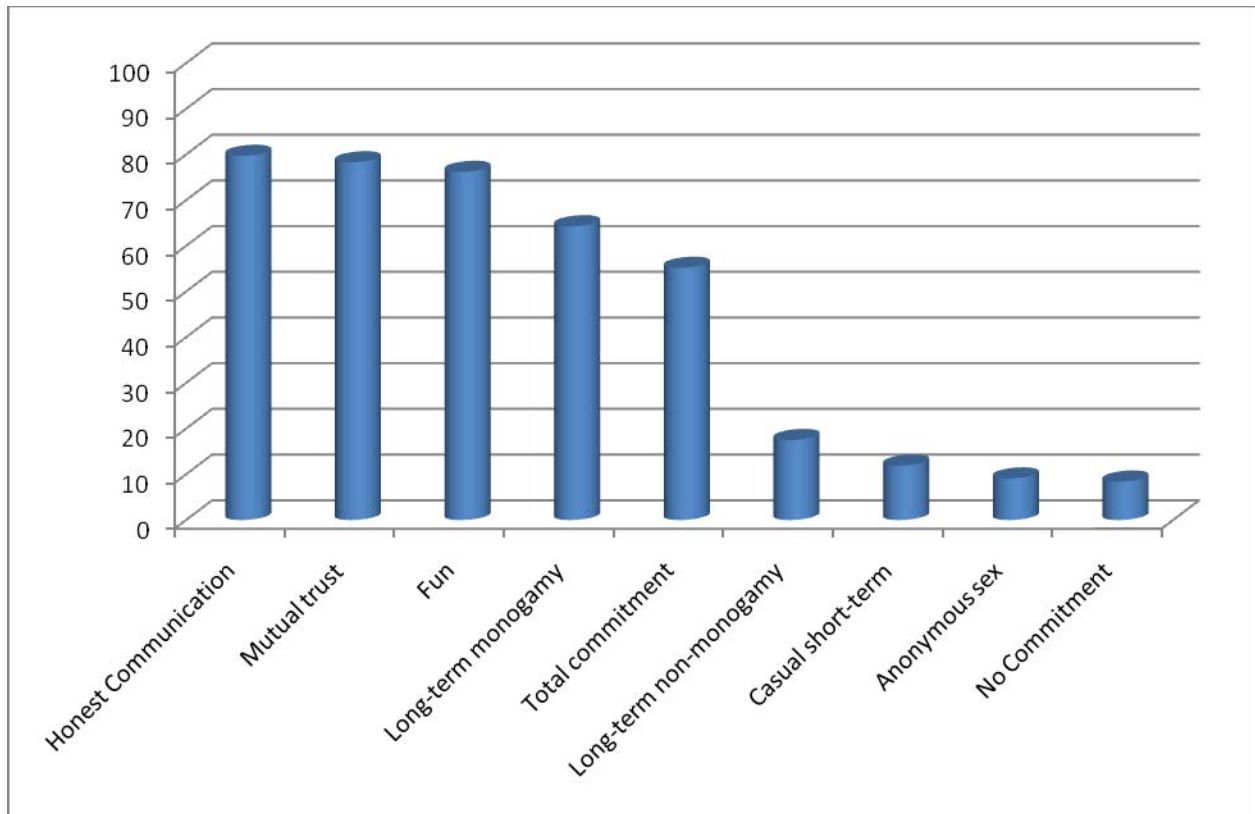


Figure 5: Types of Relationships Desired (Percentages)

Eight respondents (7.3%) made suggestions that target media and cultural representations of gay and bisexual men. Examples of responses in this category include, “Have more TV shows exemplifying it as ok,” and “More representation of gay & bisexual men in the media.”

The final category of suggestions focused on gay and bisexual men coming out to increase awareness and change attitudes, with 6.4% ($n=7$) recommending this strategy.

Additional examples of statements in each of the categories are provided in Appendix 6.

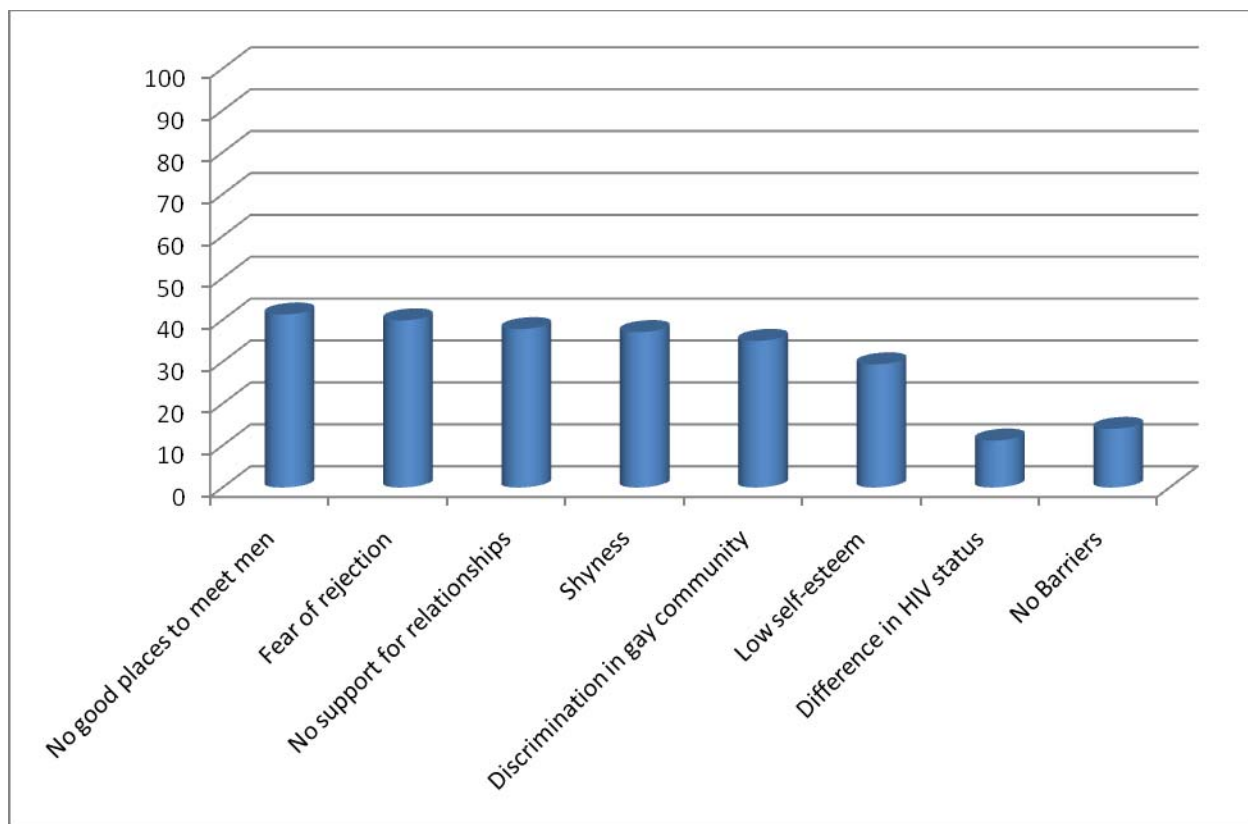


Figure 6: Barriers to Relationships Desired (Percentages)

HIV Risk Behaviors

Frequency of drug-use related behaviors.

Respondents were asked to indicate how frequently (*Never, Not in the past 12 months, Once or twice in the past 12 months, About once a month, About once a week, and Twice a week or more*) they engaged in four different risky behaviors related to injection drug use.

The first statement was “I shared needles without using bleach” and 99.3% ($n=134$) indicated that they had *Never* done this, with 0.7% ($n=1$) indicated that they had done this, but *Not in the past 12 months*. No respondents indicated any of the other frequencies.

The second statement, “I shared needles that had been cleaned with bleach,” was reported as having been done *Once or twice in the past 12 months* by one respondent (0.7%), and *Never* by 99.3% ($n=134$).

For the two remaining statements, “I shared other works (cooker, cotton)” and “I backloaded while sharing drugs with someone. (Backloading is when injecting drug users use their syringes to mix drugs and to give measured shares to other users by squirting drug solution in the syringes of other users),” 99.3% ($n=134$) reported *Never* and 0.7% ($n=1$) reported *Not in the past 12 months*.

Frequency of drug-related HIV risk behaviors are summarized in Table 15.

Table 15: Frequency of Drug-related HIV Risk Behaviors

	Never	Not in past 12 months	Once or twice in past 12 months	About once a month	About once a week	Twice a week or more
Shared needles without using bleach ($n=135$)	134 (99.3%)	1 (0.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Shared needles cleaned with bleach ($n=135$)	134 (99.3%)	0 (0.0%)	1 (0.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Shared other works ($n=135$)	134 (99.3%)	1 (0.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Backloaded while sharing drugs ($n=135$)	134 (99.3%)	1 (0.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)

Frequency of sex-related behaviors. Seven sex-related risky behaviors were inquired about on the survey and are presented in the order of those most frequently engaged in.

While 39.3% ($n=55$) of the respondents responded *Never* and 15.7% ($n=22$) of the respondents responded *Not in the past 12 months* to the statement, “I put my penis in someone’s anus (butt) without using a condom,” the remainder of the respondents (44.7%) responded that they had engaged in unprotected insertive anal sex at least once in the previous twelve months. Starting with the category representing the most frequent engagement in the behavior, 6.3% ($n=9$) indicated having done so *Twice a*

week or more, 4.3% ($n=6$) having done so *About once a week*, 9.8% ($n=14$) having done so *About once a month*, and 24.3% ($n=34$) having done so *Once or twice in the past 12 months*.

The next most commonly reported risky sexual behavior engaged in during the last 12 months was unprotected receptive anal sex, with 41.8% of the respondents reporting having engaged in this behavior at least once in the prior 12 months. Almost half (44.7%, $n=63$) responded *Never* and 13.5% ($n=19$) responded *Not in the past 12 months*. However, 2.1% ($n=3$) reported the behavior *Twice a week or more*, 5.7% ($n=8$) reported *About once a week*, 5.7% ($n=8$) reported *About once a month*, and 28.4% ($n=40$) reported *Once or twice in the past 12 months*

Third on the list of most commonly reported risky sexual behaviors was 36.0% reporting, “I had sex while I was high or drunk.” The frequency of this behavior was reported as *Twice a week or more* by 0.7% ($n=1$), *About once a week* by 2.2% ($n=3$), *About once a month* by 10.1% ($n=14$), and *Once or twice in the past 12 months* by 23.0% ($n=32$). The behavior was reported *Not in the past 12 months* by 10.8% ($n=15$) and *Never* by 53.2% ($n=74$).

The more general “I had unprotected sex with someone at high risk for HIV” was reported at *Twice a week or more* by 2.2% ($n=3$), *About once a week* by 1.5% ($n=2$), *About once a month* by 0.7% ($n=1$), and *Once or twice in the past 12 months* by 17.5% ($n=24$). Almost 14.0% ($n=19$) reported *Not in the past 12 months*, and 64.2% ($n=88$) reported *Never*.

“I had unprotected sex with someone whose HIV status was different than my own or whose HIV status I didn’t know” was reported as occurring *Twice a week or more* by 2.1% ($n=3$), *About once a week* by 0.7% ($n=1$), *About once a month* by 2.9% ($n=4$), and *Once or twice in the past 12 months* by 18.7% ($n=26$). The behavior was reported as occurring *Not in the past 12 months* by 10.8% ($n=15$) and *Never* by 64.7% ($n=90$).

The least frequently reported risky sexual behaviors reported by men in the sample were “I had unprotected sex by someone who shoots drugs,” and “I put my penis in someone’s vagina without using a condom.” Unprotected sex with a drug user was reported *Never* by 90.5% ($n=124$), *Not in the past 12 months* by 5.8% ($n=8$), *Once or twice in the past 12 months* by 2.9% ($n=4$), *About once a week* by 0.7% ($n=1$). No respondents reported the behavior as occurring either *About once a month* or *Twice a week or more*.

Frequency of unprotected vaginal intercourse was reported as *Never* by 90.5% ($n=124$), *Not in the past 12 months* by 7.3% ($n=10$), *Once or twice in the past 12 months* by 1.5% ($n=2$), and *Twice a week or more* by 0.7% ($n=1$). No respondents reported engaging in unprotected vaginal intercourse *About once a month*, or *About once a week*.

Frequency of sexuality-related HIV risk behaviors are summarized in Table 16.

Table 16: Frequency of Sexuality-related HIV Risk Behaviors

	Never	Not in past 12 months	Once or twice in past 12 months	About once a month	About once a week	Twice a week or more
Unprotected insertive anal intercourse (<i>n</i> =140)	55 (39.3%)	22 (15.7%)	34 (24.3%)	14 (9.8%)	6 (4.3%)	9 (6.3%)
Unprotected receptive anal intercourse (<i>n</i> =141)	63 (44.7%)	19 (13.5%)	40 (28.4%)	8 (5.7%)	8 (5.7%)	3 (2.1%)
Had sex while high or drunk (<i>n</i> =139)	74 (53.2%)	15 (10.8%)	32 (23.0%)	14 (10.1%)	3 (2.2%)	1 (0.7%)
Unprotected sex with someone at high risk for HIV (<i>n</i> =137)	88 (64.2%)	19 (14.0%)	24 (17.5%)	1 (0.7%)	2 (1.5%)	3 (2.2%)
Unprotected sex with someone with unknown or different HIV status (<i>n</i> =139)	90 (64.7%)	15 (10.8%)	26 (18.7%)	4 (2.9%)	1 (0.7%)	3 (2.1%)

Reasons for risk behaviors. To understand the reasons why respondents engage in behaviors that put them at increased risk for exposure to HIV infection, the respondents were asked, “What are some reasons why you might, at times, put yourself at risk for getting or spreading HIV? (You may check more than one.)” Almost one-third (30.1%, *n*=43) indicated that this question was *Not applicable* (*I do not do things that make it likely for me to catch HIV or give HIV to someone else*). The remainder of the results reported here, exclude those who indicate that they do not engage in behaviors that put them at risk for HIV transmission.

The most frequently cited reason for engaging in risk behavior, reported by 65.0% ($n=65$) of the sample, is *I get caught up in the heat of the moment*. The next two reasons reported (with less than half the number of respondents selecting the response as selected the previous) at 30.0% ($n=30$) are *I want to feel close to someone* and *I don't like condoms*. Following the top three reasons is *I get drunk or high* reported by 28.0% ($n=28$). Next, at 25.0% ($n=25$) is *I want to demonstrate love, affection, or trust* followed by 22.0% ($n=22$) reporting *I feel pressured or forced to have sex without condoms*.

The next three most frequently cited reasons all revolve around difficulties in communicating with partners. At 21.0% ($n=21$) is *I have trouble talking to my partner about sex*, at 13.0% ($n=13$) is *I don't feel comfortable asking my partner to use a condom*, and at 9.0% ($n=9$) is *I am afraid that my partner may think I have been unfaithful or that I don't trust him/her*. The remainder of reasons indicated by respondents were reported by 3.0% ($n=3$) and include *I don't have control over my life*, *I engage in less risky behaviors* (derived from other responses), *Condoms are not easily available to me*, *HIV is not important to me*, *Medication is available that makes HIV more manageable and easier to live with*, and *Medication is available that makes it harder to give HIV to someone else*. No respondents indicated either *Clean needles are not easily available to me*, or *I need food, housing, money, drugs*.

Summary of reasons for engaging in HIV risk behaviors is below in Figure 7.

Helpfulness of HIV Prevention Activities

Respondents were asked to review a list of HIV prevention activities and to indicate whether or not they had experienced the activity and, if so, how helpful the activity was for them on a 5-point Likert scale ranging from *Not helpful* to *Very helpful*. Respondents were instructed to indicate *Not applicable* if they had not experienced the activity in the past 12 months.

Regarding having read written information about HIV, 14.0% ($n=20$) reported they had not read written information about HIV in the past 12 months, 0.7% ($n=1$) found it *Not helpful*, 13.3% ($n=19$) found it *Mildly helpful*, 30.8% ($n=44$) found it *Somewhat helpful* and 41.3% ($n=59$) found it *Very helpful*.

The second most frequently indicated source of information was a pamphlet or brochure about HIV without designating a source for that material. In the sample, 31.9% ($n=45$) reported that it was *Not applicable*, 1.4% ($n=2$) reported it as *Not helpful*, 16.3% ($n=23$) reported it as *Mildly helpful*, 26.2% ($n=37$) reported it as *Somewhat helpful*, and 24.1% ($n=34$) reported it as *Very helpful*.

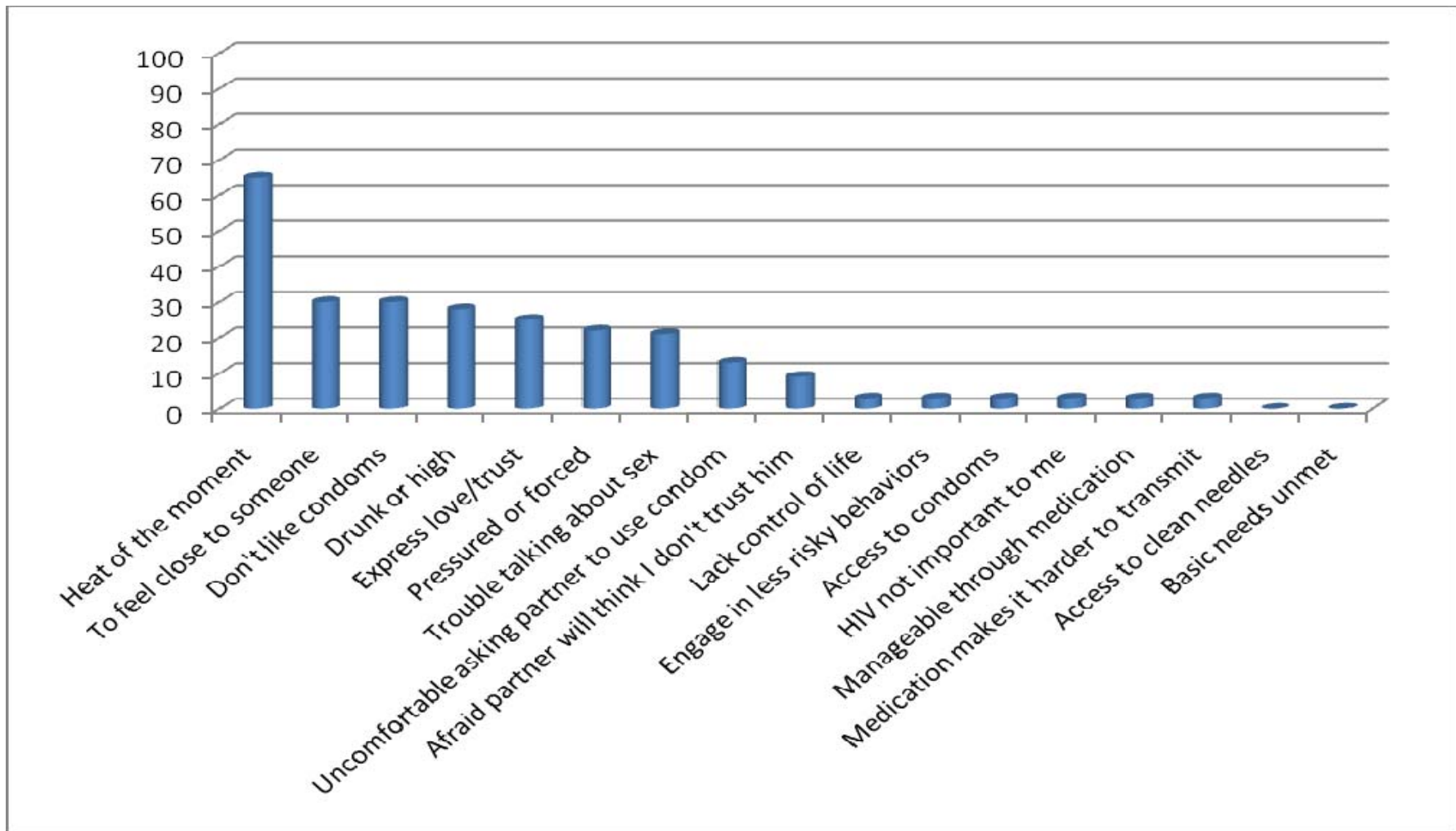


Figure 7: Reasons for Engaging in HIV Risk Behaviors (Percentages)

Information on HIV read from an Internet website was rated as *Not helpful* by 2.9% ($n=4$), as *Mildly helpful* by 11.4% ($n=16$), as *Somewhat helpful* by 20.0% ($n=28$), and as *Very helpful* by 30.7% ($n=43$). The remainder (35.0%, $n=49$) reported that they had not read such information from a website.

Respondents were then asked to rate information received at community events. Slightly more than one-third (35.2%, $n=50$) had not received HIV-related information at community events in the previous year, while 1.4% ($n=2$) rated the information as *Not helpful*, 13.5% ($n=19$) as *Mildly helpful*, 17.7% ($n=25$) as *Somewhat helpful*, and 36.9% ($n=52$) as *Very helpful*.

More than one-third (35.9%, $n=51$) of the respondents reported that they had not heard HIV-related information on the radio or television in the past year, 9.2% ($n=13$) had found it *Not helpful*, 21.1% ($n=30$) as *Mildly helpful*, 18.3% ($n=26$) as *Somewhat helpful*, and 15.5% ($n=22$) as *Very helpful*.

Talking with a medical doctor, nurse, or other medical worker about HIV was rated as *Not helpful* by 1.4% ($n=2$) of the respondents, as *Mildly helpful* by 9.2% ($n=13$), as *Somewhat helpful* by 15.6% ($n=22$), and as *Very helpful* by 36.9% ($n=52$). Slightly more than one-third (36.9%, $n=52$) reported they had not received HIV-related information from medical providers in the last 12 months.

Respondents were asked about participating in a group to help them gain skills related to HIV prevention. The largest proportion (48.6%, $n=69$) reported that was *Not applicable* for them in the past 12 months, while 1.4% ($n=2$) reported it was *Not helpful*, 9.9% ($n=14$) that it was *Mildly helpful*, 11.3% ($n=16$) that it was *Somewhat helpful*, and 28.9% ($n=41$) that it was *Very helpful*.

Next respondents were asked about receiving HIV information from a health department which 62.9% ($n=90$) reported as *Not applicable*. Information in this context was regarded as *Not helpful* by 4.9% ($n=7$), as *Mildly helpful* by 3.5% ($n=5$), as *Somewhat helpful* by 9.8% ($n=14$), and as *Very helpful* by 18.9% ($n=27$).

Most respondents (70.9%, $n=100$) did not receive HIV-related information in the past year in a school or college context, while 2.1% ($n=3$) found information in that context *Not helpful*, 7.1% ($n=10$) found it *Mildly helpful*, 12.1% ($n=17$) found it *Somewhat helpful*, and 7.8% ($n=11$) found it *Extremely helpful*.

In terms of someone approaching them in a public place to talk about HIV, 74.6% ($n=106$) reported that had not happened to them in the last year, 5.6% ($n=8$) that it

was *Not helpful*, 4.2% ($n=6$) that it was *Mildly helpful*, 8.5% ($n=12$) that it was *Somewhat helpful*, and 7.0% ($n=10$) that it was *Very helpful*.

HIV-related information from talking to mental health workers was rated as *Not helpful* by 3.5% ($n=5$), as *Mildly helpful* by 6.4% ($n=9$), as *Somewhat helpful* by 4.3% ($n=6$), and as *Very helpful* by 7.8% ($n=11$). Most of the sample (78.0%, $n=110$) reported they had not received HIV information from a mental health worker in the past year.

Receiving HIV information from a substance abuse counselor was reported even less frequently than from a mental health worker with 90.1% ($n=128$) reporting not having that experience in the past year. From that source, 2.1% ($n=3$) rated the information as *Not helpful*, 0.7% ($n=1$) as *Mildly helpful*, 2.8% ($n=4$) as *Somewhat helpful*, and 4.2% ($n=6$) as *Very helpful*.

Next respondents were asked about HIV information received in prison or jail. Most (94.3%, $n=133$) indicated that they had not received HIV information in this context in the last 12 months, while 2.8% ($n=4$) found it *Not helpful*, 1.4% ($n=2$) found it *Mildly helpful*, no one (0.0%, $n=0$) found it *Somewhat helpful*, and 1.4% ($n=2$) found it *Very helpful*.

Respondents were also allowed to enter a response to list other prevention activities that they had participated in. Slightly more than 10% (10.5%, $n=15$) listed programs and organizations that have programs for MSM that include HIV prevention information, fellowship, and social activities (e.g., ManReach, B-CAP, WestCap, etc.).

Table 17 lists helpfulness of sources of HIV prevention services and information accessed in the last 12 months by respondents in order of percentage reporting obtaining information from that source.

HIV Prevention Behaviors

In addition to obtaining information about HIV and rating that information according to its helpfulness, respondents were also asked about participation in a number of other HIV prevention activities and to rate those activities in terms of the activities helpfulness.

Injection Drug Prevention Behaviors. Respondents were asked to indicate whether or not they had picked up free, clean needles or used a needle exchange program. The vast majority (97.9%, $n=137$) indicated that this behavior was *Not applicable*, 0.7% ($n=1$) indicated that it was *Not helpful*, 0.7% ($n=1$) that it was *Somewhat helpful*, and 0.7% ($n=1$) that it was *Very helpful*.

Table 17: Helpfulness of HIV Prevention Services and Information Sources (Last 12 Months)

	Not applicable	Not helpful	Mildly helpful	Somewhat helpful	Very helpful
Written information (<i>n</i> =143)	20 (14.0%)	1 (0.7%)	19 (13.3%)	44 (30.8%)	59 (41.3%)
In a pamphlet or brochure (<i>n</i> =141)	45 (31.9%)	2 (1.4%)	23 (16.3%)	37 (26.2%)	34 (24.1%)
On the Internet (<i>n</i> =140)	49 (35.0%)	4 (2.9%)	16 (11.4%)	28 (20.0%)	43 (30.7%)
At community events (<i>n</i> =142)	50 (35.2%)	2 (1.4%)	19 (13.5%)	25 (17.7%)	52 (36.9%)
Information on radio or TV (<i>n</i> =142)	51 (35.9%)	13 (9.2%)	30 (21.1%)	26 (18.3%)	22 (15.5%)
Talking with medical worker (<i>n</i> =141)	52 (36.9%)	2 (1.4%)	13 (9.2%)	22 (15.6%)	52 (36.9%)
Participating in a group to gain skills (<i>n</i> =142)	69 (48.6%)	2 (1.4%)	14 (9.9%)	16 (11.3%)	41 (28.9%)
From health department (<i>n</i> =143)	90 (62.9%)	7 (4.9%)	5 (3.5%)	15 (9.8%)	27 (18.9%)
In school or college (<i>n</i> =141)	100 (70.9%)	3 (2.1%)	10 (7.1%)	17 (12.1%)	11 (7.8%)
Approached in public place (<i>n</i> =142)	106 (74.6%)	8 (5.6%)	6 (4.2%)	12 (8.5%)	10 (7.0%)

Table 17: Helpfulness of HIV Prevention Services and Information Sources (Last 12 Months, continued)

	Not applicable	Not helpful	Mildly helpful	Somewhat helpful	Very helpful
From a mental health worker (n=141)	110 (78.0%)	5 (3.5%)	9 (6.4%)	6 (4.3%)	11 (7.8%)
From a substance abuse counselor (n=142)	128 (90.1%)	3 (2.1%)	1 (0.7%)	4 (2.8%)	6 (4.2%)
HIV information in prison or jail (n=141)	133 (94.3%)	4 (2.8%)	2 (1.4%)	0 (0.0%)	2 (1.4%)

Ratings for picking up a bleach kit were similar. Most (97.9%, $n=137$) rated the behavior as *Not applicable*, 0.7% ($n=1$) as *Not helpful*, 0.7% ($n=1$) as *Somewhat helpful*, and 0.7% ($n=1$) as *Very helpful*.

Sexuality-related Prevention Behaviors. Respondents were asked to indicate if they had picked up condoms or safer sex kits at a bar or public place. The modal response, *Very helpful*, was provided by 36.9% ($n=52$) of the sample, 17.7% ($n=25$) reported *Somewhat helpful*, 13.5% ($n=19$) reported *Mildly helpful*, and 1.4% ($n=2$) reported *Not helpful*. *Not applicable* was the response of 30.5% ($n=43$) of the sample.

Table 18 summarizes the responses for ratings of helpfulness of HIV prevention behaviors.

Communication between sexual partners about HIV status and condom use has been cited as important in HIV prevention (Noar, Carlyle, & Cole, 2006; Noar, Morokoff, & Harlow, 2004; Prather et al., 2006; Sheeran, Abraham, & Orbell, 1999; Zamboni, Crawford, & Williams, 2000). To gauge cultural norms around discussing HIV status with sexual partners, respondents were asked, “How common is it for gay and bisexual men to discuss HIV status with their sexual partners?” with a response set ranging from *It never happens* to

Table 18: Helpfulness of Drug- and Sexuality-related Prevention Services (Last 12 Months)

	Not applicable	Not helpful	Mildly helpful	Somewhat helpful	Very helpful
Needle exchange (n=140)	137 (97.9%)	1 (0.7%)	0 (0.0%)	1 (0.7%)	1 (0.7%)
Bleach kit distribution (n=141)	137 (97.9%)	1 (0.7%)	0 (0.0%)	1 (0.7%)	1 (0.7%)
Condom Distribution (n=140)	43 (30.5%)	2 (1.4%)	19 (13.5%)	25 (17.7%)	52 (36.9%)

It's very common, and an additional response of *I don't know*. Only 2.1% (n=3) indicated that *It never happens*, while 18.3% (n=26) indicated that *It rarely happens*. Almost half (45.8%, n=65) indicated that *It happens occasionally*, and 25.4% (n=36) indicated that *It's pretty common*. Only 7.7% (n=11) indicated *It's very common* and 0.7% (n=1) indicated *I don't know*.

Perceptions of cultural norms regarding communication with sexual partners about HIV status is presented in Table 19.

Table 19: Perceptions of Cultural Norms of HIV Status Disclosure

	Never happens	Rarely happens	Happens occasionally	Pretty common	Very common
Frequency of HIV status discussion* (n=140)	3 (2.1%)	26 (18.3%)	65 (45.8%)	36 (25.4%)	11 (7.7%)

*One participant (0.7%) indicated that they did not know.

Following the question on the frequency of communication about HIV status was a list of factors that might influence whether or not communication occurs. Study respondents were asked to check all reasons that they believed influenced whether or not these discussions occur.

The most commonly selected factor was *The settings where men meet each other* with 70.6% ($n=101$) of the sample indicating this as a factor. Next was *Whether or not people are drunk or high* with 61.5% ($n=88$), followed by *The expectations for behavior in the places where men meet each other* with 52.4% ($n=75$). *Fear of rejection for those who are living with HIV* was indicated by 51.0% ($n=73$), *Assumptions about partners' HIV status* by 49.7% ($n=71$), *How partners feel about each other* by 44.8% ($n=64$), *Perceived potential for the relationship to move forward* by 42.0% ($n=60$), *Concerns about confidentiality* by 39.2% ($n=56$), and *Expectations of peers* by 30.1% ($n=43$).

Respondents selected from 0 factors (4.2%, $n=6$) to 9 factors (10.5%, $n=15$), with an average of 4.4 ($SD=2.6$) and a median of 4.0 factors selected as influencing whether or not communication occurs about HIV status between sexual partners.

Figure 8 lists the factors influencing communication about HIV status in the order of frequency selected.

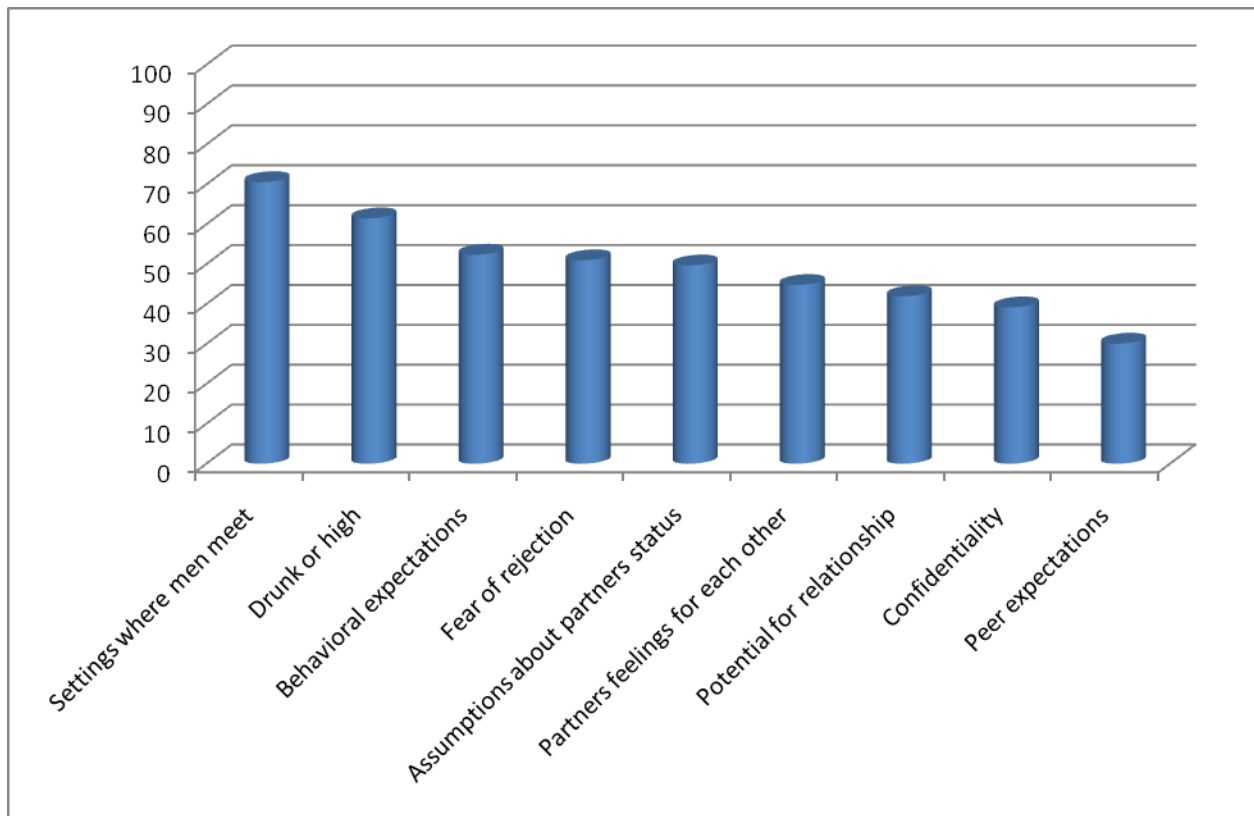


Figure 8: Factors Influencing Communication about HIV Status (Percentages)

Next respondents were asked an open-ended question, “What do gay and bisexual men need to help them disclose their status to their partners?” The answers were examined and classified into common themes.

Slightly more than one-third (36.4%, $n=52$) did not provide an answer. The most commonly provided answer was related to trust and confidentiality with 19.6% ($n=28$) responding in such a manner. Next was education with 14.7% ($n=21$) of the sample, followed by self-esteem and confidence at 9.8% ($n=14$) and community and social support at 9.8% ($n=14$). Decreasing or eliminating stigma related to HIV and/or homosexuality was mentioned by 6.3% ($n=9$), and changing cultural norms so that disclosure of HIV status is expected was mentioned by 4.9% ($n=7$). Courage was mentioned by 4.2% ($n=6$) and therapy, support groups, or counseling by 2.1% ($n=3$). Two respondents (1.4%) advocated for punitive legislation to punish those who do not disclose being HIV-positive.

Needs to support status disclosure to sexual partners are illustrated in Figure 9. Examples of responses falling into each category are provided in Appendix 7.

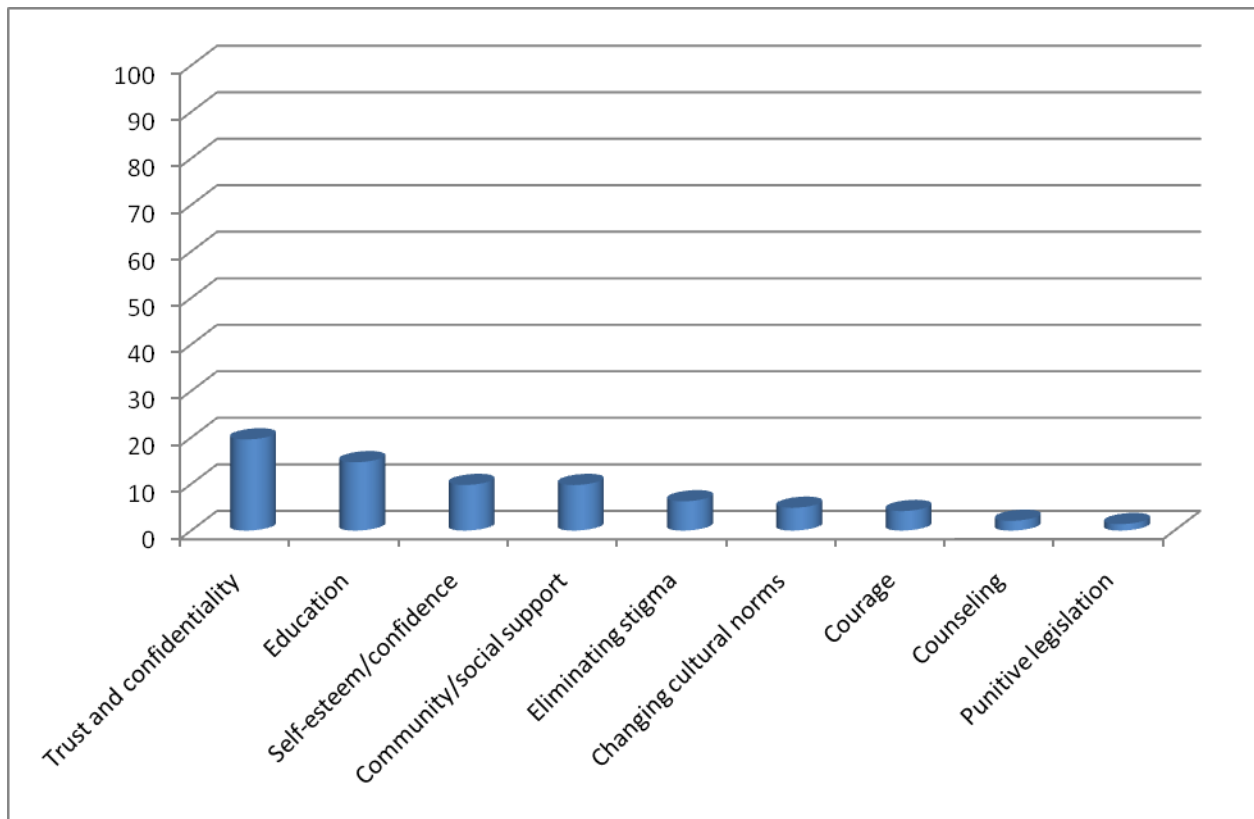


Figure 9: Needs to Support HIV Status Disclosure (Percentages)

Respondents were also asked an open-ended question, “What are some of the reasons that gay and bisexual men have unprotected sex with persons whose HIV status is unknown or different from their own?” Of the full sample, 106 (74.1%) respondents provided an answer to this question. Numerous respondents mentioned more than one reason, each of which was categorized and coded.

The most commonly reported reason was getting caught up in the *Heat of the moment* with 38.7% ($n=41$), followed by *Use of alcohol and drugs* at 22.6% ($n=24$), and *Lack of concern* at 22.6% ($n=24$). Mention in the lack of concern category ranged from general statements like, “People don’t care.” to more specific statements such as “Will worry about it when they get it.” *Self-esteem* issues were mentioned by 16.0% ($n=17$), as was *Lack of education about HIV*, and *Fear*. In the fear category, respondents reported unspecified fear as well as more specific examples such as fear of rejection.

Psychological reasons (other than low self-esteem) were mentioned by 13.2% ($n=14$) of the sample, including loneliness, the need to connect, demonstrating trust to one’s partner, and escape from life stresses. Ten (9.4%) respondents reported responses in both of the categories of *People liking the feel of unprotected sex* and *Believing that “it can’t happen to me.”*

Appendix 8 lists examples of responses from the various categories.

HIV and STI Testing Behaviors

HIV Testing. In the section asking respondents about their participation in HIV prevention activities, respondents were asked if they had been tested for HIV in the last twelve months. Slightly more than one-third (33.6%, $n=48$) indicated that they had not been tested in the last twelve months, 1.4% ($n=2$) reported that testing was *Not helpful*, 2.1% ($n=3$) reported that it was *Mildly helpful*, 6.3% ($n=9$) reported that it was *Somewhat helpful*, and 56.6% ($n=81$) reported that it was *Very helpful*.

In another question on testing, respondents were asked, “Have you ever been tested for HIV?” The overwhelming majority (93.6%, $n=132$) indicated that they had been tested and received the results from their last HIV test. Only 0.7% ($n=1$) indicated that they had been tested, but not received the results from their last HIV test, and 5.7% ($n=8$) indicated that they had never been tested.

In terms of the timing of the most recent HIV test, 40.6% ($n=58$) reported that their last test had been in the last six months, 11.2% ($n=16$) that it had been longer than six months, but less than a year, 16.1% ($n=23$) that it had been between 1 and 2 years

ago, 7.0% ($n=10$) that it had been between 2 and 5 years ago, and 5.6% ($n=8$) that they had never been tested.

HIV testing behavior responses are summarized in Table 20.

Table 20: HIV Testing Patterns

	Not applicable	Not helpful	Mildly helpful	Somewhat helpful	Very helpful	
Been tested for HIV (in past 12 months as prevention activity) ($n=143$)	48 (33.6%)	2 (1.4%)	3 (2.1%)	9 (6.3%)	81 (56.6%)	
	Yes and received results	Yes but did not get results	Never been tested			
Ever been tested for HIV ($n=141$)	132 (93.6%)	1 (0.7%)	8 (5.7%)			
	In last six months	Six months to a year	Between 1 and 2 years	Between 2 and 5 years	More than 5 years ago	Never been tested
Timing of most recent HIV test ($n=143$)	58 (40.6%)	16 (11.2%)	23 (16.1%)	10 (7.0%)	28 (19.6%)	8 (5.6%)

As a follow up question, respondents were asked to check all the reasons why they had not been tested in the past year. Respondents were able to check more than one reason or to leave each reason blank. Celibacy was indicated by 2.1% ($n=3$) as the rationale for not testing in the past year, while 13.3% ($n=19$) indicated that they have been in a monogamous relationship since their last HIV test, 14.0% ($n=20$) that they had only engaged in protected sex since their last test, 3.5% ($n=5$) that they were afraid to find out the results, 3.5% ($n=5$) that they “just know” that they are HIV negative, 3.5% ($n=5$) that they did not want to think about being HIV positive. Concerns about confidentiality were raised by a few of the respondents with 2.1% ($n=3$) indicating concern that their name would be released to the government, and

2.8% ($n=4$) indicating concern that their status would be shared by others. Only 0.7% ($n=1$) indicated that they did not have money to pay for the tests, and 4.2% ($n=6$) that they did not know where to be tested. A small percentage (2.8%, $n=4$) reported that they were embarrassed or felt ashamed, and 1.4% ($n=2$) reported that the results did not matter to them. Some respondents (11.9%, $n=17$) reported in the *Other* response that they had not been tested in the past year because they were HIV-positive.

Figure 10 charts the frequency of reasons listed by respondents for not being tested in the past 12 months.

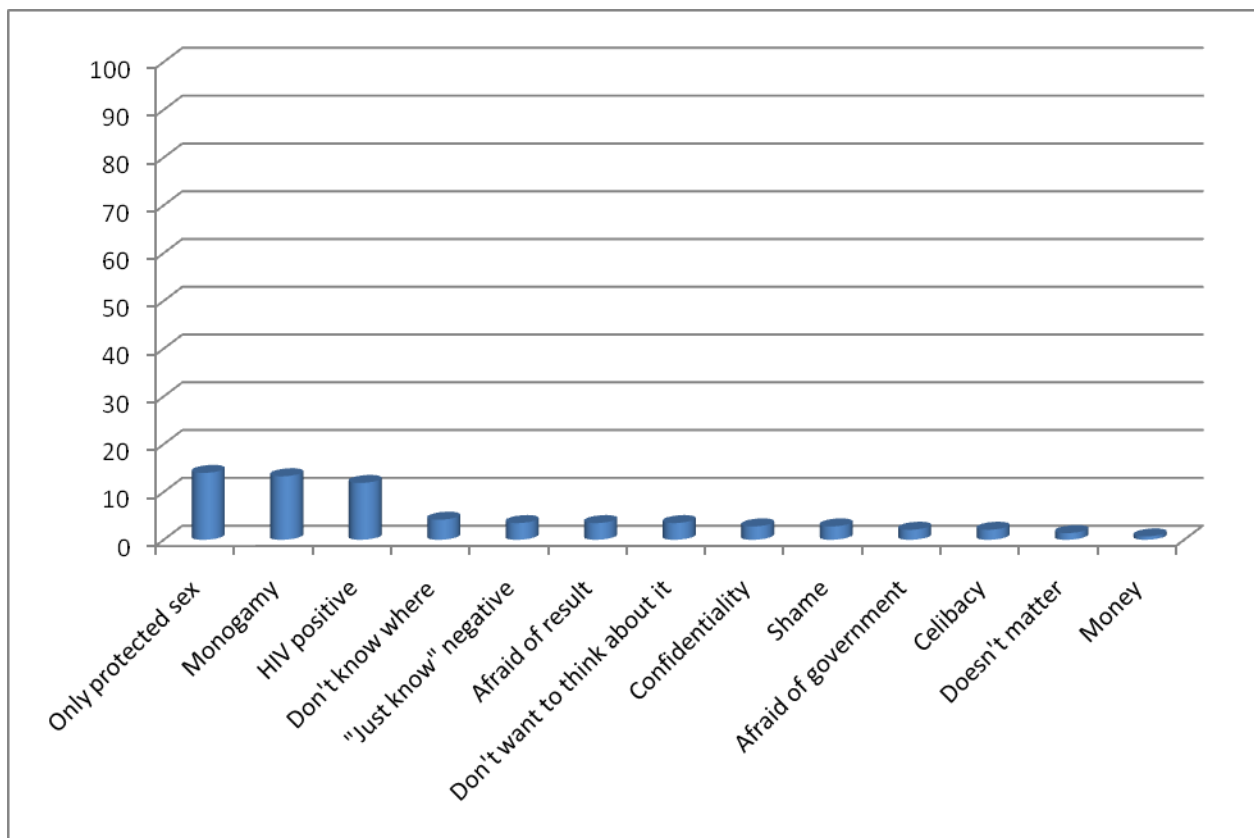


Figure 10: Reasons Reported for Not Being Tested in Prior 12 Months (Percentages)

STI/STDs. Respondents were also asked to indicate their HIV status directly. Only one respondent (0.7%) did not provide a response. Most (69.7%, $n=99$) reported that they do not have HIV, 25.4% ($n=36$) that they have HIV, and 4.9% ($n=7$) that they don't know whether or not they have HIV infection.

Respondents were asked if they had experienced a sexually transmitted disease in the past five years, and 16.2% ($n=23$) reported that they had, 1.4% reported that they didn't know, and the remaining 82.4% ($n=117$) reported that they had not.

Hepatitis C. Most respondents (93.0%, $n=132$) reported that they did not have hepatitis C, while 2.8% ($n=4$) did and 4.2% ($n=6$) did not know their hepatitis C status.

Prevalence of STIs, including HIV, is charted in Figure 11.

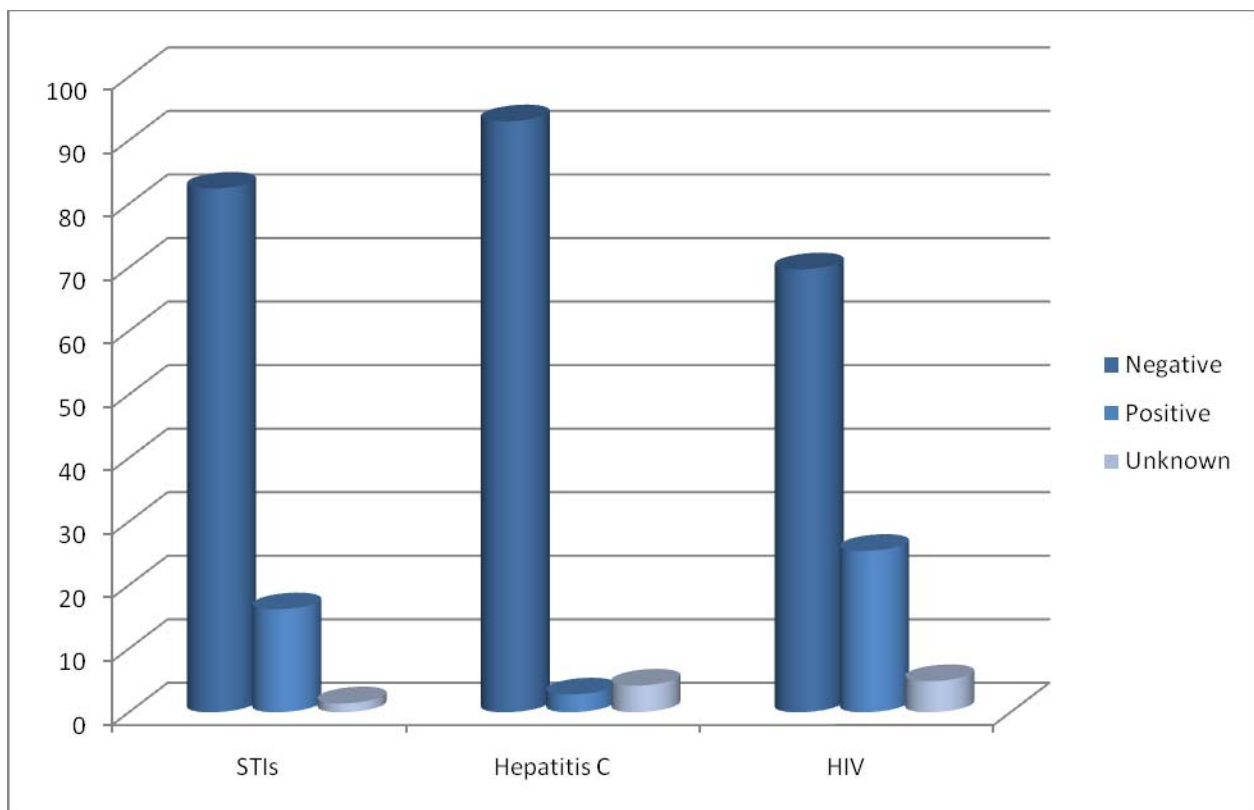


Figure 11: STI, Hepatitis C, and HIV Statuses (Percentages)

Preferred Context of HIV Prevention Services

To ascertain in what contexts respondents would prefer to receive HIV prevention information and services, respondents were asked, “Where or under what circumstances would you be most likely to use HIV prevention services if they were

available?” and were permitted to indicate more than one response. Responses are reported in the order of highest proportion selecting.

Healthcare clinics was the most frequently reported context where respondents would prefer to receive HIV prevention information and services with 57.3% ($n=82$) indicating this response, followed by *community-based organizations* at 51.0% ($n=73$).

The next most frequently selected responses were the *Internet* (46.9%, $n=67$), in a *Bar or nightclub* (34.3%, $n=49$), the *Health department* (34.3%, $n=49$), *School* (27.3%, $n=39$), a *Drop-in center* (26.6%, $n=38$), places where high-risk behaviors are likely to occur such as *Bathhouses or parks* (25.2%, $n=36$), *Radio or television* (22.4%, $n=32$), and *With mental health services* (16.1%, $n=23$).

Less than 15.0% indicated the remaining options including *In someone's home* (14.7%, $n=21$), *In their own neighborhood* (11.2%, $n=16$), *On the street or other public place* (10.5%, $n=15$), *With basic services* (10.5%, $n=15$), at a *Substance use treatment center* (9.8%, $n=14$), or their *Place of worship* (9.1%, $n=13$).

Figure 12 illustrates the preferences of the respondents on contexts in which they would prefer to receive HIV prevention information and services.

Characteristics of HIV prevention service provider.

In addition to the context preferred for HIV prevention information and services, respondents were also asked with whom they would most like to work to help them avoid catching or transmitting HIV infection. Again, respondents could indicate more than one characteristic.

The most frequently reported characteristic was someone who *Shared the respondent's sexual orientation* (73.4%, $n=105$), followed by *Someone easy to talk to who doesn't judge me* (69.9%, $n=100$). More than half indicated it would be preferred to work with *Another man* (58.7%, $n=84$), or a *Doctor, nurse, or other health care worker* (54.5%, $n=78$). Next was a *Health educator* (48.3%, $n=69$), *Someone in the same peer group* (42.0%, $n=60$), *Someone whose life situation was similar* (42.0%, $n=60$), *Someone similar in age* (41.3%, $n=59$), *Someone who is HIV-infected* (28.0%, $n=40$), and the least important was *Someone who was similar in regard to race or ethnicity* (14.0%, $n=20$). Among respondents of color in the sample, however, 33.3% ($n=7$) indicated that it was important to have *Someone who was similar in regard to race or ethnicity*.

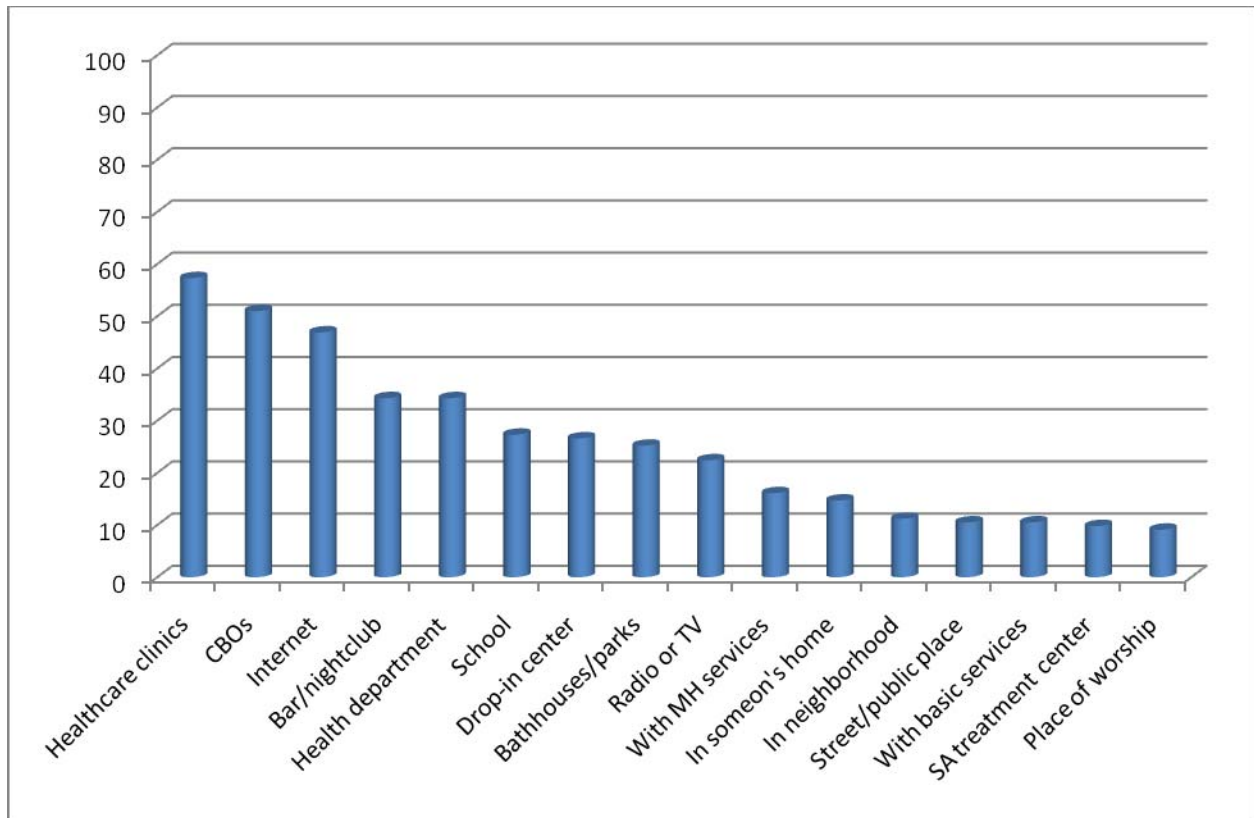


Figure 12: Preferred Context of Prevention Services (Percentages)

Preferred characteristics of HIV prevention service providers are summarized in Figure 13.

Supports Needed for HIV Prevention

An open-ended question asking respondents to indicate what supports would need to be in place to help the respondent avoid contracting HIV or giving HIV to someone else was responded to by 67.1% ($n=96$) of the sample. Responses were reviewed and categorized. Some responses contained answers that fit more than one category and were coded in multiple categories.

The most commonly provided answer was *HIV-related education*, referring either to information about HIV transmission, safer sex practices, reminders about the importance of safer sex practices, or behavioral education. Behavioral education includes support and practice in asking partner about HIV status, requesting condom usage, etc. In the sample, 20.3% ($n=29$) mention HIV-related education.

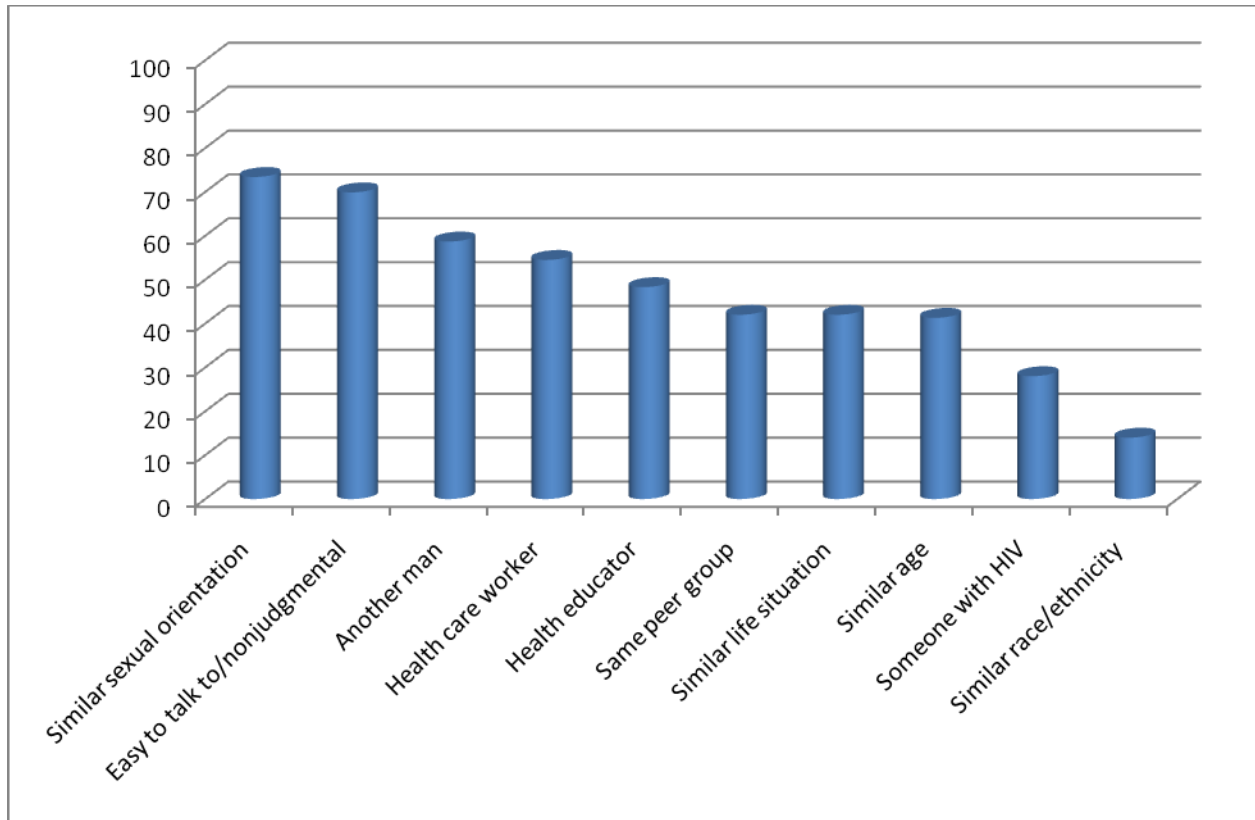


Figure 13: Preferred Characteristics of Service Providers (Percentages)

The second most commonly provided answer regarded *Access to free condoms*, which was mentioned by 19.6% ($n=28$) of the sample. Twenty-one individuals (14.7%) noted that they needed *No additional supports* to prevent them from transmitting or contracting HIV. Some in this category made comments indicating that they were knowledgeable about safer sex practices, that they were currently in long-term, monogamous relationships with HIV-negative partners, or that they consistently practice safe sex.

Supportive social networks, friends, or mentors were mentioned by 12.6% ($n=18$) respondents. Less than 10% of the sample mentioned the remaining needed supports: 6.3% ($n=9$) *Accessible testing*, 3.5% ($n=5$) *Formal organizations and programs*, and 1.4% ($n=2$) each of the three categories of *Relationship support*, *Addiction recovery programs and supports*, and *Access to medical services*.

Examples of responses from each category are provided in Appendix 9. Percentage of mentions of supports needed for HIV prevention is illustrated in Figure 14.

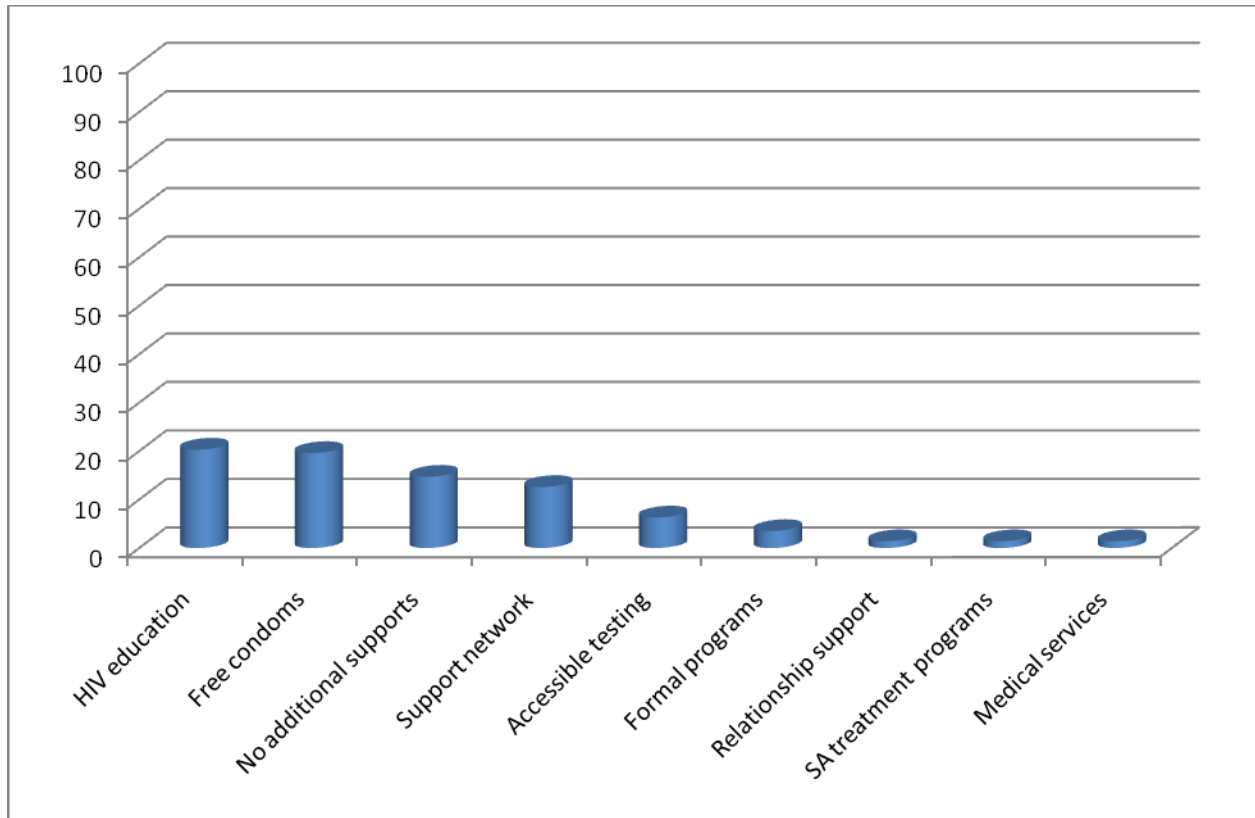


Figure 14: Supports Needed for HIV Prevention (Percentages)

Life Concerns

To better understand the more general life concerns of respondents, and how concerns about HIV fit into that larger picture, respondents were first asked the open-ended question, “As a gay or bisexual man living in Colorado, what are your biggest concerns?” Most (85.3%, $n=122$) of the respondents provided an answer. Some answers contained numerous responses that were all categorized as individual responses.

Of the respondents who provided an answer, the most commonly reported concern was *Isolation and the need for community* at 27.0% ($n=33$). This grouping of concerns included answers indicating the need to have more opportunities to socialize as gay and bisexual men, the difficulty of meeting an appropriate partner, and the isolation of living in a rural community. Almost as many respondents – 23.8% ($n=29$) – reported that *Anti-gay bigotry and prejudicial attitudes* were a primary concern.

The next most commonly mentioned concern was *Contracting HIV and other STIs* by 15.6% ($n=19$). Similar numbers of respondents at 14.8% ($n=18$) mentioned the need for *Legal protection and civil rights*, sometimes mentioning specific rights such as marriage equality and at other times more generally just noting civil rights. *Education on HIV* was mentioned by 13.1% ($n=16$), while *Financial concerns* including concerns about job loss were mentioned by 12.3% ($n=15$). *Health needs* – sometimes expressed as a general need for access to health-related services and sometimes more specifically around needed access to HIV-related health services – were mentioned by 11.5% ($n=14$). Seven (5.7%) respondents mentioned *Violence and fear of violence*. A small group of respondents (3.3%, $n=4$) reported that they did not have any concerns.

Appendix 10 includes examples from each category. Figure 15 summarizes the life concerns expressed by respondents.

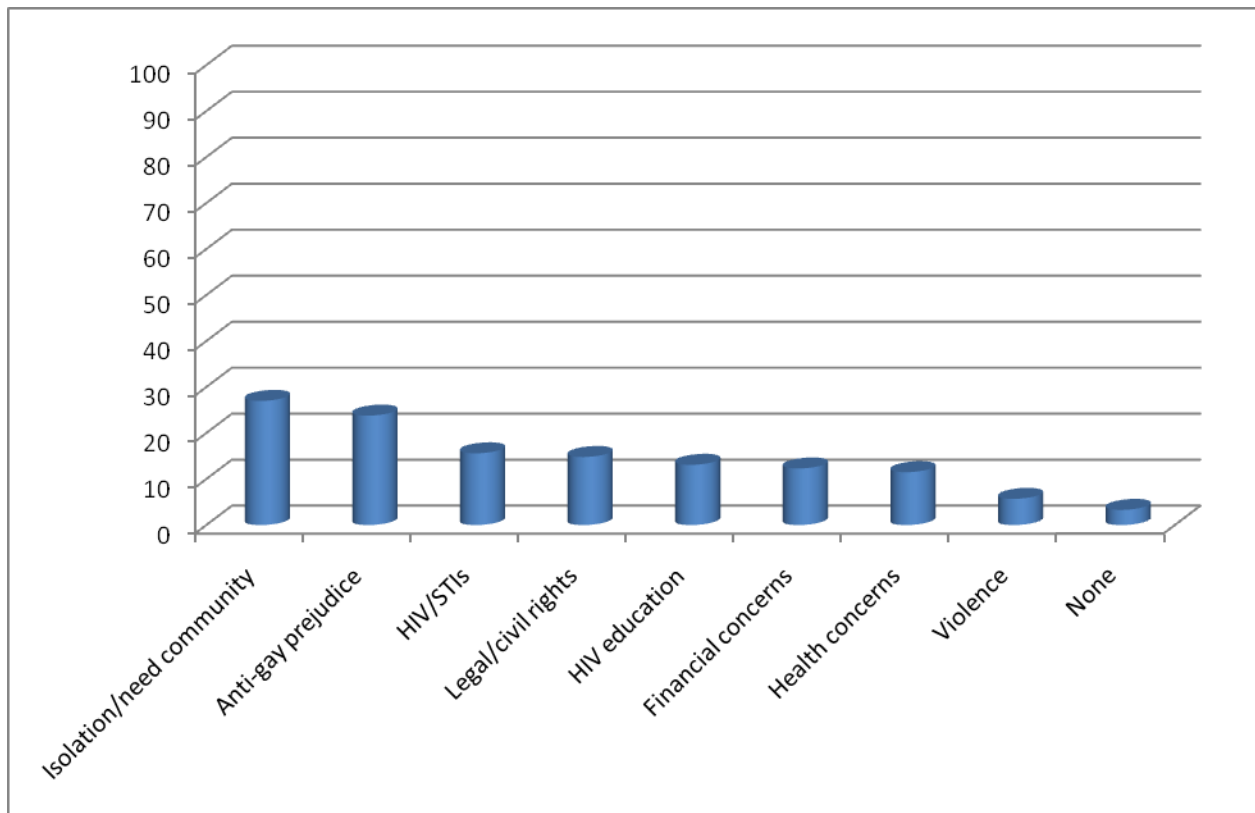


Figure 15: Life Concerns (Percentages)

To contextualize HIV as a concern, respondents were next asked, “How important is HIV to you personally compared with the concerns you listed above?” with a three-point Likert response set of *HIV is just as important*, *HIV is less important*, and *HIV is much less important*. Most of the respondents (77.9%, $n=109$) reported that HIV was just as important as their other life concerns, with 12.1% ($n=17$) reported that it was less important and 10.0% ($n=14$) reporting that it was much less important.

Finally, respondents were asked to indicate how much they agreed with the statement, “HIV has ‘fallen off the radar screen’ and I rarely hear people talk about HIV or see information on HIV” with a five-point Likert response set ranging from *Strongly agree* to *Strongly disagree*. More than half of the respondents indicated with the agree side of the response set, with 17.9% ($n=25$) indicating they *Strongly agree* with the statement and 43.6% ($n=61$) indicating that they *Somewhat agree*. Neither agree nor disagree was indicated by 12.1% ($n=17$), while 15.7% ($n=22$) indicated that they *Somewhat disagree*, and 10.7% ($n=15$) that they *Strongly disagree*.

Table 21 summarizes findings related to life concerns.

Table 21: Life Concerns

	Just as important	Less important	Much less important		
Relative importance of HIV ($n=140$)	109 (77.9%)	17 (12.1%)	14 (10.0%)		
	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
HIV has fallen off the radar screen ($n=140$)	25 (17.9%)	61 (43.6%)	17 (12.1%)	22 (15.7%)	15 (10.7%)

DISCUSSION AND CONCLUSION

Limitations

Prior to discussing the implications, it is important to point out the limitations of the report and its findings. First, while the sample represents MSM from a wide

geographical region across the State of Colorado, it should not be construed as representative of MSM in the state nor of MSM living outside the Denver metropolitan area. Men who were recruited into the study were in contact with organizations, groups, and clubs that provide services to or have significant contact with MSM. As such, men who are not involved or connected to organizations, groups, and clubs such as those engaged in the recruitment of respondents are most likely absent from the sample. Similarly, given the high degree of identification as *gay* found among respondents in the sample, MSM who identify as heterosexual, bisexual, or in other ways are likewise absent from the sample.

It is also likely – given the mean educational level and mean income level – that the sample is not representative of MSM in the state. We would suspect that low income men and men with lower educational levels are underrepresented, as well as subpopulations which are typically correlated with lower income and educational levels. Intravenous drug using MSM are also likely underrepresented.

Because both versions (online and paper-and-pen) of the survey were only made available in English, non-English speakers did not have the opportunity to participate in the study

Recruitment of rural MSM to participate in a research project is a difficult undertaking given the isolation and safety issues that have been documented as concerns among the population. While almost twenty percent of our sample resided in geographic areas with populations less than 25,000 (most of whom were from areas with populations less than 10,000), the remaining 80% of the sample were from more urbanized areas ranging in size from small towns to large cities such as Ft. Collins, Boulder, and Pueblo. It is likely that the more urban subsample may be, in many ways, more similar to a Denver-based sample of MSM than to their rural counterparts.

Another limitation is the use of significantly shortened versions of psychometrically-tested scales to measure the concepts of interest to the study. Given the length of the survey, inclusion of full scales was not possible. While care was taken to use items from scales that had the highest factor loadings in previous studies, the use of modified scales decreases the reliability of those measures. Similarly, the use of single-item questions to capture complex constructs may have inadvertently introduced measurement error that would have likely been absent had multiple item scales been used.

Given these limitations, however, the findings do suggest some implications for HIV prevention services for populations similar to that which responded to the survey.

Implications for HIV Prevention Services

A number of findings of the study stand out as particularly interesting and suggest important needs, challenges, and opportunities around HIV prevention services. These findings are discussed below.

First, in contrast to what may be expected, the men in the sample are, for the most part, open about their sexual orientation. Less than one in ten indicated that they were *not at all open* or *hardly open*. While this likely is an artifact of the sampling approach used in this study, it does suggest that MSM such as those represented in the study may have less aversion to associating with other gay and bisexual men or being associated (even if covertly) with organizations, groups, and clubs that serve MSM. This is further underscored by the overwhelming majority of the men in the sample identifying their sexual orientation as *gay*, as well as high percentages of men indicating that they prefer to work with men who share their sexual orientation in receiving HIV prevention services.

A second finding that echoes earlier research findings is the social isolation that many of the men experience, with more than half of the men indicating that they have felt isolated as one of the psychosocial risk factors in their lives. While most indicated that they agreed to some degree that they had someone in their life from whom they receive emotional support, slightly more than one in four indicated that they do not feel connected to others, and the mean score on the UCLA Loneliness Scale mirrors the degree of loneliness found in other samples of urban HIV-positive gay men at approximately the mid-point of the scale. In addition to the quantitative indications of social isolation, throughout the qualitative responses many of the men indicated that isolation, frustrations with what they perceive as the “lack of a gay community,” and not having supportive contexts in which to socialize with other MSM were serious concerns. HIV prevention services that support the building of community among MSM and strengthen existing social networks may be useful in decreasing the isolation of MSM and supporting healthier behaviors.

Another finding that indicates a significant unmet need is the disproportionate number of MSM who indicate experiencing mental health symptoms. While some were receiving medical care for mental health needs (as evidenced by the number of MSM on anti-depressants), the percentages of mental health symptoms in the sample were quite high. More information is needed about their service utilization, but it seems unlikely that their mental health needs are currently being adequately met. These needs also appear in the numbers of men who have experienced low self-esteem (64.3%), feeling hopeless (44.8%), sexual abuse or unwanted sexual

experiences as a child (23.8%), physical abuse as a child (12.6%), sexual abuse/assault or unwanted sexual experiences as an adult (11.9%), physical abuse/assault as an adult (11.9%), and/or serious mental illnesses like bipolar disorder or schizophrenia (11.9%). HIV prevention services that incorporate screenings for mental health issues and those that develop support services and provide referrals for those clients with mental health symptoms appear needed.

Related to the mental health needs, the numbers of MSM in the sample who meet the threshold of concern for substance use issues is similarly high, indicating that somewhere between 17% and 37% of the men in the sample may need support around issues of substance abuse. Almost one in five indicated substance abuse/addiction as an experience in their life. As with mental health issues, HIV prevention services that screen men for substance abuse issues, that provide substance abuse treatment and support for recovery, and that link MSM to existing substance abuse services in the community are critical. To be supportive of MSM, community-based services need to be culturally competent in providing services to both MSM and knowledgeable around HIV-related issues.

Potentially related to both mental health needs and substance abuse issues, more than half of the men indicated that at some point in their life they felt shame about their sexual orientation and slightly more than one in five indicated they felt shame about how masculine or feminine they are. While scores in the Internalized Homophobia Scale in the sample were lower than those found in a recent sample of MSM, scores on the Gender Role Conflict Scale were in the same range as other samples of MSM. Additionally, almost one in three of the men indicated a desire to be more masculine than they currently are. Support services that educate men on the socially constructed nature of gender, including how notions of gender are both historically and culturally bounded, may provide support for men who still struggle with internalized homophobia or gender shame.

In line with previous findings of rural MSM, a sizable portion of the respondents identify with a Christian religious tradition, and more than half indicate that religious beliefs provide guidance in their day-to-day life at least some of the time. This suggests that religious values may be one cultural resource that can be mobilized to support MSM in decreasing risk behaviors. Consideration should be given to exploring the roles that religious institutions might play in supporting MSM in reducing their risks for contracting HIV.

Also similar to other findings, the role of the Internet is ever present in the lives of the MSM in the study. It is reported as a potentially effective site for HIV prevention messaging, a site for building community for MSM who experience isolation, and a

common place to meet sexual partners. Given that the linkage between risky sexual behaviors and use of the Internet to find sexual partners has been noted in other studies, the Internet represents both an opportunity as well as a challenge for HIV prevention services.

The qualities that MSM in the study desire in their emotional and sexual relationships with other men suggest many of the men are seeking long-term, committed relationships. The top five characteristics were *honest communication*, *mutual trust*, *fun*, *long-term monogamy*, and *total commitment*. More fleeting and casual sexual relationships were much less likely to be indicated as desired characteristics of relationships. These findings suggest that services that support relationship-building skills are an important part of HIV prevention services.

Barriers to the desired types of relationships were both structural as well as individual. On the structural side, and related to the isolation mentioned above, the barrier most frequently indicated by respondents was not having good social outlets to meet men who are interested in relationships. Many of the men mentioned the lack of societal support for same-gender relationships, and the role of racism, ageism, and discrimination based on HIV status within the gay community. On the individual side, fear of rejection, shyness, and low self-esteem were common themes. There is a need for developing social contexts where men can be supported in meeting other men interested in relationships, as well as for educational work with the gay community that addresses issues of power, oppression, and privilege and how those function to create more isolation. Individual and group support to assist MSM in managing their fears of rejection and low self-esteem also appear critical.

Only one in three of the men indicated that disclosure of HIV status between sexual partners was common, with the remainder of the sample indicating that it happens occasionally, rarely, or never. Cultural norms of the settings where MSM meet others for sexual relationships were cited as the most common factor influencing failure to disclose, followed by having sex while under the influence of substances. Other reasons also included fear of rejection, assumptions about partners' statuses, partners' feelings for each other, and fears of HIV status being disclosed to others. Some of these barriers may be amenable to psychoeducational interventions that support individuals in learning to communicate about HIV status during sexual experiences, both in terms of addressing personal barriers as well as support in practicing such communications. Other barriers mentioned suggest the need for cultural level shifts both in particular subcultural contexts (where men meet others for sex) as well as within the gay community as a whole.

Healthcare clinics, community-based organizations, and the Internet were the most frequently indicated sites preferred for receiving HIV prevention services. This indicates the need to continue to provide financial support to community-based services and to develop and support Internet-based service provision. Similarly, the most frequently cited preferred characteristic of a service provider was someone with a similar sexual orientation, followed by someone who is easy to talk to and non-judgmental. This suggests MSM prefer to receive HIV prevention services from other MSM, or at least from service providers who embody a non-judgmental stance with regard to same-sex sexual identity and behavior.

Implications for Future Research

While this report provides a descriptive snapshot of the respondents of the study, it leaves many questions unanswered that inferential analyses with these data might be able to shed additional light on. Likewise, it raises questions that future research may wish to explore to continue to illuminate the HIV prevention needs of MSM outside of major metropolitan areas.

In terms of future analyses of the existing data, some potential research questions that might advance the understanding of HIV prevention needs of MSM and particular subgroups of MSM in Colorado include the following:

1. What differences emerge, in terms of experiences, needs, and recommendations, between the rural and urban subsamples? How do these differences influence the manner in which HIV prevention services need to be provided in rural areas?
2. Do differences emerge in behavior and attitudes based on religious tradition or religiosity? What are the implications of these differences on HIV prevention activities? How might religious ideologies and values be harnessed to support MSM in making changes to decrease risk behaviors?
3. How does gender role conflict and feelings about gender expression impact risk taking behaviors? Do these differences suggest specific types of intervention around feelings of gender role conflict and/or gender shame?
4. Are the HIV prevention needs of MSM with higher levels of internalized homophobia different than those with lower levels? Do differences emerge in what these different subsamples of men suggest would be helpful and supportive in decreasing risk behaviors?
5. Are there important differences in needs and behaviors between the men in the sample who report a fatalistic attitude toward contracting HIV (belief that contracting HIV will occur sooner or later) than those who don't? What types of interventions may increase the self-efficacy of this subgroup of respondents

so that they feel more in control of their risk behaviors if differences do emerge?

Conclusion

The findings in this study contribute to the existing literature on HIV prevention, both in terms of replicating findings from other research with MSM (particularly MSM outside of major metropolitan areas), and in exploring new areas that have not been examined in the state of Colorado. What emerges is a picture of significant unmet needs of MSM and the importance of addressing those needs in HIV prevention services. Contextualizing HIV prevention services so that they are culturally responsive to these needs and understanding the unique cultural context of MSM is critical if these services are to be effective.

While many of the needs and barriers can be met effectively through social and medical services, some of the barriers are cultural-level challenges that need a large-scale commitment, such as ending homophobia and discriminatory public policies, addressing social justice issues in the context of the gay community, and creating communities of support built on trust.

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Appendix 1: Organizations through Which Surveys Were Distributed

1. 4 Corners GLAD
2. Adams State College, Multicultural Center
3. Aims Community College, Gay Straight Alliance
4. Aims Community College, Student Life
5. Arapahoe Community College
6. Boulder County Aging Services
7. Boulder County AIDS Project
8. Boulder PFLAG
9. Colorado Anti-Violence Program
10. Colorado College, EQUAL
11. Colorado College, Office of Minority and International Students
12. Colorado Northwestern Community College
13. Colorado School of Mines, Student Health Center
14. Colorado School of Mines, Sigma Lambda
15. Colorado State University - Ft. Collins
16. Colorado State University - Pueblo, Prizm
17. CU Boulder, Delta Lambda Phi
18. CU Boulder, Gay Straight Alliance
19. CU Boulder, GLBT Resource Center
20. CU Boulder, Outlaw
21. Fort Lewis College, Prism
22. Front Range Community College, Student Life
23. Iliff School of Theology, FLAME
24. Inside/Out Youth Services
25. Lambda Community Center
26. ManReach
27. Mesa State College, A Voice of Reason
28. Morgan Community College, Student Center
29. Naropa University, Student Affairs
30. Naropa University, Doing Gender
31. Northeastern Junior College
32. Northern Colorado AIDS Project
33. OASOS Program
34. Otero Junior College
35. Our Sisters Keeper
36. PFLAG Boulder County
37. Pikes Peak Community College
38. Pikes Peak Gay & Lesbian Community Center

39. Pueblo PFLAG
40. Red Rocks Community College, Student Life
41. Red Rocks Community College, GLBT Resource Center
42. Rocky Mountain Rainbeaus
43. Southern Colorado AIDS Project
44. Southern Colorado Equality Alliance
45. University of Colorado - Colorado Springs, Spectrum
46. University of Northern Colorado, In & Out
47. Western Colorado AIDS Project
48. Western Equality
49. Western State College, Campus Life

Appendix 2: Questions from the Internalized Homophobia Scale (Ross & Rosser, 1996)

Public Identification as Gay

1. Even if I could change my sexual orientation, I wouldn't.
2. I feel comfortable discussing homosexuality in a public setting.
3. I am worried about people finding out I am gay.

Perception of Stigma Associated with Being Gay

1. I worry about becoming unattractive.
2. Society still punishes people for being gay.
3. I worry about becoming old and gay.

Social Comfort with Gay Men

1. I feel comfortable in gay bars.
2. I DO NOT feel confident approaching men I am interested in.
3. Most of my friends are gay (homosexual/bisexual).

Moral and Religious Acceptability of Being Gay

1. Homosexuality or bisexuality are just as natural as heterosexuality.
2. Homosexuality is against the will of God.
3. Homosexuality is morally acceptable.

Appendix 3: Questions from the Gender Role Conflict Scale (O'Neill 1981, 1982; O'Neil, Helms, Gable, David & Wrightman, 1986)

Success, Power, and Competition

1. Being smarter or physically stronger than other men is important to me.
2. Moving up the career ladder is important to me.
3. I strive to be more successful than others.

Restrictive Emotionality

1. I have difficulty expressing my tender feelings.
2. I have difficulty telling others that I care for them.
3. I have difficulty expressing my emotional needs to my partners.

Restrictive Affectionate Behavior between Men

1. Affection with other men makes me tense.
2. Men who touch each other make me uncomfortable.
3. Hugging other men is difficult for me.

Conflict between Work and Family Relations

1. My needs to work and study keep me from my family or leisure more than I would like.
2. My work or school often disrupts other parts of my life (home, health, leisure).
3. My career, job, or school affects the quality of my leisure or family life.

Appendix 4: Questions from the UCLA Loneliness Scale – Short Form (Hays & DiMatteo, 1987)

1. I lack companionship.
2. I am an outgoing person.
3. Even when people are around me, I often feel like they're not connecting with me.
4. I feel left out.
5. There is no one I can turn to.
6. I can find companionship when I want it.
7. I feel isolated from others.

Appendix 5: Questions from the Perceived Sexual Control Scale (Exner, Meyer-Bahlburg, & Ehrhardt, 1992)

Perceived Control over Sex Drive

1. My sex drive controls my life.
2. Once I get sex on my mind, I can't stop or relax until I've scored.
3. I've tried to cut down on casual sex, but I just can't do it.

Perceive Control over Risk Behaviors

1. I forget about safe sex when I am with a new sexual partner.
2. When I am sexually aroused, I will do anything sexual with anyone.
3. I don't take sexual risks with new sexual partners.

Appendix 6: Selected Responses of Ideas to Address Homophobia, Stigma, and Discrimination Based on Sexual Orientation

Educational

Incorporate sexuality into sex ed classes.

Bring people of all sexualities together and try to create understanding. Forums?

Education

Educate everyone

Educating in schools/work place

People understanding us so more information on our sexuality

Legal Suggestions

More action by Congress to give GLBT folks equal rights

Pass new laws to protect

We need to band together more as a community and change things legally

Pass laws making it safer and better

Have conversations with emerging leaders

Gay equality in civil rights, marriage equality

Media and Cultural Representations

Not only showing naked men as representations of “gay life”

More representation of gay & bisexual men in the media

Have more TV shows exemplifying it as ok

Coming Out

More gays coming out to their family members and friends

The more that people come out, the more that people realize they can put a face to
gay and it is someone they have loved or know

Need more good role models that are open

Appendix 7: Selected Responses of Ideas of what is Needed to Support Disclosure of HIV Status

Trust and Confidentiality

Confidence that their partner won't share the info w/ others
They need to feel safe for them to do so

Education

All around education of HIV and its transmission
Accurate information about transmission risks as information has been fear-based for over 20 years

Self-esteem and Confidence

Confidence and to be asked
Stronger self-esteem needed

Community and Social Support

A community where they get the support to be able to talk to others openly
The establishment of general love, concern & respect for one another

Decreasing or Eliminating Stigma

To get rid of social stigma
Less HIV stigma

Changing Cultural Norms

Constant reinforcement that it's okay and expected to ask
A culture where that is the norm and is expected

Courage

Courage
To get rid of the fear of rejection

Therapy, Support Groups, and Counseling

Therapy
Support groups

Punitive Legislation

Laws on attempted murder
Scarier laws

Appendix 8: Selected Responses of Reasons Why Gay and Bisexual Men Have Unprotected Sex with Persons with Unknown HIV Status or Status Different From Their Own

Caught Up in the Heat of the Moment

Caught in the moment. Don't want to spoil the moment and ask their status
Passion

Use of Alcohol and Drugs

Impaired judgment (drugs and alcohol)
Under the influence

Lack of Concern

They want instant gratification and don't care what happens
They see that people are living 20-30 years with the virus

Self-esteem Issues

Insecurity
Low self-esteem

Lack of Education

Lack of knowledge about contracting HIV
Uneducated on the severity of the disease

Fear

Rejection by HIV- men
Afraid the guy won't have sex with you if you insist he uses protection

Psychological Reasons

To feel loved and needed or attractive
Loneliness

Don't Like the Feel of Condoms

Don't like condoms, feels unnatural
Don't like using condoms

It Can't Happen to Me

A feeling of being invincible
They think if they only top they won't get HIV

Appendix 9: Selected Responses of Supports Needed to Avoid HIV Transmission

HIV-related Education

Free and open discussion about HIV, No abstinence only education!
Graphic reminders such as ads that pop up on connexion.org

Access to Free Condoms

Plentiful and free access to condoms & such
Free condoms in hotel rooms. Also, they should come in new pairs of pants from Old Navy

No Additional Supports

None are needed. I know how to prevent it and will never spread it.
None needed for me.

Supportive social networks, friends or mentors

Strong community of friends/gay men
Just a good support system

Accessible Testing

Simple, accurate testing (at home) or free testing any day of the week, regardless of sexual orientation.
Better availability of testing

Formal Organizations and Programs

A program for Senior/GLBTer's (50+)
Social programs unrelated to sex

Relationship Support

Promote long term relationship with open communication between couple
Allowing same sex marriage would help cut down the spread of HIV

Addiction Recovery Programs and Supports

Narcotics Anonymous
Sobriety, community support

Access to Medical Services

Updates and talking to doctor

Primary care physician, case manager well-informed about current developments in
HIV/AIDS

Appendix 10: Selected Responses of Life Concerns

Isolation/Need for Community

Rural isolation results in greater masking of others' HIV status (loneliness, etc.)
Finding appropriate social situations in which to meet people, safe/open locations to go on dates
No life here

Anti-gay Bigotry and Prejudicial Attitudes

People who hate gay people
A somewhat hostile environment for GLBT
Being fired from my job because I'm gay

Contracting HIV/STIs

Not to become infected with HIV
Getting in the heat of the moment and getting infected
STDs

Legal Protections/Civil Rights

Legal rights of marriage
Achieving equal civil rights
Lack of rights for a partner in medical & death situations

HIV Education

That people aren't learning all sides of HIV/AIDS awareness
Wish there were more published facts on chances of contracting HIV from pre-cum, saliva, unprotected oral sex
That younger gay men are not being thoughtful and protecting themselves and are having sex without condoms

Financial Concerns

The possibility of becoming no longer able to take care of myself...financially
Losing my job, the rising costs of everything
Losing funding that pays for my copays.

Medical Concerns

Losing drug assistance and CACP
Medication, health coverage
Getting medical help

Violence

It doesn't feel safe to be very out here
Getting bashed, verbally or physically
Fear of being hurt

No Concerns

None really
I don't really have any