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The relationship between internalized homophobia and gender roles in gay men

Alexander Levine

Pacific University

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The relationship between internalized homophobia and gender roles in gay men

Abstract
This study attempts to answer three questions. Is there a significant relationship between internalized homophobia and gender role in gay men? If there is a relationship, how does Gender Role Conflict moderate it? Do androgynous gay men have less internalized homophobia than gay men who are masculine, feminine, or undifferentiated? To answer these questions, 149 gay men were recruited to participate in an online survey with measures of internalized homophobia, gender role, and gender role conflict. The results suggest that there is not a significant relationship between internalized homophobia and gender roles and that gender role conflict does not mediate this relationship. In addition, androgynous gay men did not have significantly lower levels of internalized homophobia. Implications of these findings for clinicians are discussed as well as limitations to this study and future directions.

Degree Type
Thesis

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INTERNALIZED HOMOPHOBIA AND GENDER ROLES

THE RELATIONSHIP BETWEEN INTERNALIZED HOMOPHOBIA AND GENDER ROLES IN GAY MEN

A THESIS

SUBMITTED TO THE FACULTY

OF

SCHOOL OF PROFESSIONAL PSYCHOLOGY

PACIFIC UNIVERSITY

HILLSBORO, OREGON

BY

ALEXANDER LEVINE

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE

OF

MASTER OF SCIENCE IN CLINICAL PSYCHOLOGY

JULY 20, 2013

APPROVED:

Shawn E. Davis, Ph.D.

Committee Chair
Abstract

This study attempts to answer three questions. Is there a significant relationship between internalized homophobia and gender role in gay men? If there is a relationship, how does Gender Role Conflict moderate it? Do androgynous gay men have less internalized homophobia than gay men who are masculine, feminine, or undifferentiated? To answer these questions, 149 gay men were recruited to participate in an online survey with measures of internalized homophobia, gender role, and gender role conflict. The results suggest that there is not a significant relationship between internalized homophobia and gender roles and that gender role conflict does not mediate this relationship. In addition, androgynous gay men did not have significantly lower levels of internalized homophobia. Implications of these findings for clinicians are discussed as well as limitations to this study and future directions.
Acknowledgements

I would like acknowledge that the present study is funded by the Hersen Student Research Grant and I would like to thank the donors of this fund for their support. I would also like to thank Sandra Bem, Jim O’neil, and Ariel Shidlo for giving me permission to use their scales. Finally, I would like to express my gratitude toward Dr. Shawn Davis for his support and assistance throughout the entirety of this project.
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The Relationship Between Internalized Homophobia and Gender Roles in Gay Men

Introduction

When a client informs you during an intake interview or therapy that he identifies as a gay man, your initial instinct may be to assess for internalized homophobia. In other words, you are likely going to explore whether or not your client is at peace with being gay, and how this is affecting his sense of wellbeing. Another thing that may come up is that your client is cisgender, which means that they identify with the gender they were assigned at birth. This leaves out two important constructs, gender roles and gender role conflict.

The present study is an examination the interaction between psychological androgyny and internalized homophobia in gay men, and how gender role conflict moderates this interaction. The questions we ask are: is a gay man who identifies with androgynous traits less likely to experience internalized homophobia than a gay man who identifies with traditionally masculine or feminine traits? How does gender role conflict affect this likelihood?

Literature Review

Internalized Homophobia

Imagine growing up knowing that something about you, which you cannot control, will cause others to stigmatize you. You desperately try to hide this secret for most of your childhood and adolescence. For many sexual minorities, this experience is common. Sexual minorities are individuals who do not identify as heterosexual (e.g., lesbians, gay men, and bisexual individuals) or who do not identify with the gender assigned to them at birth (e.g., transgender individuals). This experience is not uncommon. In a representative samples of youth in high school 3% of individuals identified as lesbian, gay, bisexual, or transgender (LGBT; Garafolo, Wolf, Wissow, Woods, & Goodman, 1999).
What are the effects of internalized homophobia on this population? There have been reports of increased risk of suicide among LGBT individuals compared to heteronormative individuals for over 40 years, yet despite this risk relatively little attention has been given to the problem of suicide in the LGBT population (U.S. Department of Health and Human Services, 2001). LGBT individuals have also been found to be more likely than heterosexual individuals to experience depression, substance abuse, and low self-esteem (Gold, Feinstein, Skidmore, & Marx, 2011).

Many psychologists believe that internalized homophobia accounts for these findings. Internalized homophobia has been defined as having three components: disgust with one’s sexual orientation, a lack of comfort with being associated with other sexual minorities, and a purposeful avoidance of being identified as a sexual minority (Shidlo, 1994). In the following review, I examine studies looking at the relationship between internalized homophobia and health among sexual minorities.

Gold, Feinstein, Skidmore, and Marx (2011) conducted a study exploring the relationships between scores on measures assessing internalized homophobia, childhood physical abuse, experiential avoidance, and current psychological symptoms. The participants were 115 adult gay men and 122 adult lesbian women recruited from LGBT community events and organizations (the authors did not recruit bisexual or transgender individuals for the study because no validated measures were available to assess internalized homophobia for those populations). The authors found that childhood physical abuse predicted symptoms of depression and Posttraumatic Stress Disorder (PTSD). Internalized homophobia partially mediated the correlation between childhood physical abuse and PTSD symptoms among gay men, but experiential avoidance did not mediate the correlation; conversely, among lesbians,
internalized homophobia did not mediate this correlation but experiential avoidance did partially mediate the correlation. Internalized homophobia completely mediated the correlation between childhood physical abuse and depression symptoms among gay men, but not among lesbians. The authors concluded that internalized homophobia and experiential avoidance play different roles in predicting psychopathology among gay men and lesbians.

The effects of internalized homophobia on adolescent males (ages 14 to 19) were explored in a study by DeLonga et al. (2011). Specifically, the authors explored whether internalized homophobia had a role in the Loneliness and Sexual Risk Model (LSRM), which posits that sexual risk behaviors result in part from loneliness and compulsivity. The participants were a convenience sample of 49 adolescent males seeking services at an LGBT Community Center. The participants were asked to complete a cross-sectional survey that included measures of internalized homophobia, loneliness, and compulsive Internet use. Participants were also asked to report the number of sexual partners they had in the past year. The authors found that internalized homophobia was positively and significantly correlated with loneliness, compulsive Internet use, and reported number of sexual partners. The authors also found that greater feelings of loneliness and internalized homophobia correlated positively with the reported number of sexual partners in the last year, even in the absence of compulsive Internet use. The authors concluded that the results provided partial support for the LSRM in adolescents and internalized homophobia’s role in mediating the factors of the model.

In South Africa, Vu, Tun, Sheehy, and Nel (2012) looked at the levels and correlates of internalized homophobia among men who have sex with men (MSM). The authors used respondent-driven sampling to recruit 324 men who have sex with men (MSM); statistical adjustments were made to provide population-based estimates and compensate for the non-
random sample. The authors found high levels of internalized homophobia among South African MSM: 10-15% of participants reported having feelings of internalized homophobia often/very often and over 20% reported having these feelings sometimes. The authors also found that internalized homophobia was correlated negatively with education and positively with HIV misinformation, HIV-related conspiracy beliefs, and bisexual identity. The authors suggested that their findings indicated a need to empower the gay community of South Africa by promoting self-acceptance of a gay identity. In addition, they believed that it was critical to address HIV conspiracy beliefs among MSM in order to reduce internalized homophobia and increase access to HIV prevention interventions.

The aforementioned findings indicate that internalized homophobia is very prevalent and detrimental to both mental and physical health: higher levels of internalized homophobia were correlated with poorer responses to childhood physical abuse among adult gay men; loneliness, compulsivity, Internet use, and the number of reported sexual partners among adolescents; and lower levels of education and higher levels of HIV misinformation among South African MSM. With a better understanding of its correlates, causes, and effects psychologists can begin to study the prevention and reduction of internalized homophobia.

**Gender Role**

Gender Role, society’s sex-typed standards of desirable behavior for men and women, can be explored by looking at how strongly one identifies with stereotypically masculine and/or feminine traits (Bem, 1974). A masculine individual identifies primarily with stereotypically masculine traits, just as a feminine individual identifies with stereotypically feminine traits. Outside of this binary, an androgynous individual identifies with both masculine and feminine qualities and undifferentiated individual identifies with neither masculine nor feminine traits.
Psychological androgyny, a person’s possessing both masculine and feminine traits in equal measure, has been shown to be associated with optimal mental health (Lefkowitz, 2006). Bem (1974) found that dimensions of masculinity and femininity are empirically as well as logically independent, the concept of psychological androgyny is a reliable one, and that highly sex-typed scores do not merely represent a tendency to respond in a social desirable manner. Rather, sex-typed scores represent a tendency to describe oneself in accordance with societal stereotypes of what a man or woman is supposed to be. Stets and Burke (1988) have found that our concepts of gender and desirable traits for men and women are deeply rooted in our culture, and that over a lifetime a human being is socialized to develop a rigid gender identity that meets cultural expectations.

The Bem Sex Role Inventory (BSRI; Bem, 1974) is a 60-item scale; items address the participant’s gender role. Each item is a characteristic (e.g. “helpful”) and the participant is asked to indicate on a seven-point scale how well each of the sixty characteristics describes herself or himself. The scale ranges from 1 ("Never or almost never true") to 7 (Always or almost always true"). The participant’s scores can then be used to identify the participant as Masculine, Feminine, Androgynous, or Undifferentiated.

Previous research has shown that masculinity may be a key construct in the differentiation of individuals in self-efficacy, which is an important predictor of achievement (Choi, 2004). Recently, there have been studies attempting to test the original theory that psychological androgyny would predict optimal well-being. Choi (2004) examined group differences between individuals with different gender roles on three measures of self-efficacy: general, academic, and course specific. With a sample of 215 undergraduate students, she found that there was a multivariate significance among the gender role groups in the three levels of
self-efficacy. Specifically, she found that masculine and androgynous individuals had higher general and academic efficacy means than the undifferentiated or feminine groups. These results left it unclear if androgynous individuals benefitted from their masculinity, or if androgyny itself may have potential benefits. Woo and Oei (2006) believe that androgyny is only beneficial because it contains masculinity in that they found masculinity associated psychological wellbeing, while femininity was not. In contrast, Lefkowiz and Zeldow (2006) conducted a study looking at psychological androgyny and optimal health with a sample of 154 participants who were adults seeking career consultation and found that androgynous individuals, those who had high levels of both masculinity and femininity, experienced higher levels of optimal mental health. They suggested that further research, however, needs to be conducted to confirm the potential benefits of androgyny.

Cheng (2005) examined whether or not androgynous individuals have better coping skills. Specifically, she looked at gender-role flexibility across a variety of stressful events and tested two hypotheses that explicate the processes underlying gender-role flexibility. The first hypothesis predicted that androgynous individuals would have a broader knowledge of coping and the second hypothesis predicted that androgynous individuals are better at adapting to changing situational characteristics. By placing participants in real life and hypothetical stressful situations, she found that androgynous participants were characterized by cognitive astuteness in distinguishing among situational characteristics and deploying strategies to fit the specific situational demands. This supported the second hypothesis that androgynous individuals are better at adapting to stressful situations. She also found that androgynous participants were less depressed than others participants.
Shin, Yang, and Edwards (2010) looked at gender role identity among American and Korean college students and how it related to gender and academic achievement. First, they found that androgynous individuals represented the largest proportion in the American while feminine individuals represented the largest in the Korean sample. In the Korean sample, masculine students had higher levels of academic success followed by the androgynous sample. In contrast, feminine American students scored highest on an academic measure. Another interesting finding was that Americans students differed more by gender role, while Korean students differed more by socioeconomic status.

Uang, Hu, Heng, and Hang (2012) found that, in a sample of 434 Chinese undergraduates, the majority of participants were either androgynous or undifferentiated. They found that the androgynous students had the highest self-esteem level and tended to use positive coping strategies, and concluded that androgyne is an ideal gender role type relative to the other three.

Other research has focused on the correlates found in men who identify with the masculine gender role. Vogel, Heimerdinger-Edwards, Hammer, and Hubbard (2011) found more health problems and risks in individuals who identify with stereotypically masculine traits. Specifically, they found high levels of self-stigma and negative help-seeking attitudes. Sanchez, Bocklandt, and Vilain (2012) looked at monozygotic male twins discordant for sexual orientation and found that both straight and gay brothers were vulnerable to masculine norms preventing healthy health seeking behaviors. This led them to conclude that social environments influence attitudes and behaviors that are stereotypically masculine and possibly detrimental to health.
Gender Role Conflict

Gender role conflict in men is psychological distress about one’s sense of masculinity or being a man. It manifests as unhealthy aspects of the masculine stereotype, such as placing one’s sense of worth in one’s career or power, restricting the expression and feeling of emotionality, and being uncomfortable with intimacy. In other words, a man is at peace with his gender identity in the context of cultural stereotypes about what a man is “supposed” to be. Gender role conflict has also been correlated with a long list of mental and physical health problems (O’Neil, 2008).

The Gender Role Conflict Scale (GRCS; O’Neil, Helms, Gable, David, & Wrightsman, 1986) is often used to analyze the possible role of gender role conflict (GRC) as a covariate. All items are responded to using a Likert scale of strongly disagree (1) to strongly agree (6), with higher scores on the GRCS indicating greater degree of GRC. The experience of GRC is defined as a psychological state in which socialized gender roles have negative consequences for the person or others. GRC occurs when rigid, sexist, or restrictive gender roles result in restriction, devaluation, or violation of others or self. The ultimate outcome of GRC is the restriction of a person’s human potential or the restriction of another person’s potential (O’Neil, 2008, p. 362).

Gender role conflict has not been studied enough in gay men (O’Neil, 2008). One of the few studies on gender role conflict in gay men was conducted by Simonsen, Blazina, and Watkins (2000). They found that gay men with less gender role conflict had a more positive view of seeking help for mental health problems and reported fewer symptoms of depression and anxiety. They recommended that counselors be mindful of the importance of emotional and affection expression to well-being in gay men. They believe that gay men do indeed experience unique issues attending to their sexual orientation regarding gender. They also found that some
of the basic concerns of gay men, such as emotionality and work and family conflict, are similar to those of straight men vis-à-vis gender role conflict. In 2007, Simonsen found that attitude towards masculinity predicted psychological well-being and help-seeking behaviors in gay men.

Sanchez, Westefeld, Liu, and Vilain (2010) found that professional psychologists working with gay men believe that traditional masculine ideals play a prominent role in the gay community. They saw how this endorsement of traditional masculine ideals led to the stigmatization of effeminate behaviors by other gay men. They hypothesized that this behavior actually reflects negative feelings about being gay. With a sample of 622 self-identified gay men, they found that most participants valued the public appearance of masculinity and that they ideally wished to be more masculine than they felt they were. Further, a multiple regression analysis showed that the degree to which they valued masculinity and were concerned about violating masculine ideals, the more they felt negatively about being gay. Overall, they concluded that since negative feelings about being gay can negatively affect psychological wellbeing, these findings highlight the importance of exploring the role that masculine ideals play in gay client’s lives.

The Present Study

To date, no research has been done that looks at the relationship between psychological androgyny and internalized homophobia. This research is significant, as The William’s Institute estimates that 2.2% of the adult population in the United States identifies as gay men (Gates, 2011). This means that 2,491,034 individuals have the potential to benefit from the findings of this study. If there is a relationship between psychological androgyny and internalized homophobia, future research could explore this relationship and implications it may have for clinicians working with gay men.
Additionally, this research could help to increase competency in working with gay clients among clinicians. Garnets, Hancock, Cochran, Goodchilds, and Peplau (1991) found that 99% of psychologists had seen one or more LGBT clients in their practice. Murphy, Rawlings, and Howe (2002) found that 56% of a random sample of psychologists reported that they had seen an LGBT client in the past week, yet they also reported seeing LGBT clients “regardless of whether or not they had specialized training with this population.” In addition, LGBT clients were found to be more likely to report dissatisfaction with psychotherapy than their heterosexual peers; this was attributed mainly to psychologists’ lack of competence (Liddle, 1996). LGBT clients who also identified as People of Color reported being even less satisfied with psychotherapy than White LGBT clients (Avery, Hellman, & Sudderth, 2001). This suggests that a client’s sexual orientation could predict client satisfaction.

These findings are rather alarming, especially considering that The American Psychological Association’s (2002) Ethical Principles of Psychologists and Code of Conduct (Ethics Code) recognizes competence as both an enforceable standard and aspiration principle (Lyons, 2010). Specifically, the Ethics Code requires that:

(a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.

(b) Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or
research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services.

Despite this enforceable standard, 28% of psychologists surveyed reported no formal training in clinical work with LGBT clients (Murphy, Rawlings, & Howe, 2002).

The present study is meant to provide greater understanding into the relationship between internalized homophobia and gender roles in gay men, so that clinicians can develop greater competency in working with this population. The first hypothesis is that there will be a significant differences in internalized homophobia based on gender roles. If this relationship is found to be significant, it is also hypothesized that gender role conflict will positively moderate this relationship. Specifically, when gender role conflict increases, internalized homophobia will as well. Based on Bem’s original theory predicting that androgyny would be associated with optimal health (Bem, 1974), it is expected that androgynous gay men will have lower levels of internalized homophobia than masculine, feminine, or undifferentiated gay men.

**Method**

**Participants**

Participants included 149 gay male individuals. A total of four participants were dropped from the study due to incomplete or haphazard responding. An additional three participants were dropped from the study because they did not identify as a gay man.

A total of 149 participants were included in the final analysis. All participants reported identifying as gay men. The average age of participants was 36.34 (SD = 12.42). A breakdown of additional demographic information (i.e., ethnicity, education, and relationship status) is provided in Table 1.
Table 1

*Number of Participants in Each Demographic Variable (N=149)*

<table>
<thead>
<tr>
<th>Demographic Variable</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>122</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>8</td>
</tr>
<tr>
<td>Asian</td>
<td>5</td>
</tr>
<tr>
<td>African American</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
</tr>
<tr>
<td>American Indian/Alaskan Native</td>
<td>1</td>
</tr>
<tr>
<td>Hawaiian/Pacific Islander</td>
<td>1</td>
</tr>
<tr>
<td>Decline to Respond</td>
<td>1</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
</tr>
<tr>
<td>Doctoral Degree</td>
<td>37</td>
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<tr>
<td>College Degree</td>
<td>35</td>
</tr>
<tr>
<td>Masters Degree</td>
<td>28</td>
</tr>
<tr>
<td>Some College or Technical School</td>
<td>24</td>
</tr>
<tr>
<td>Some Graduate School</td>
<td>24</td>
</tr>
<tr>
<td>Completed High School</td>
<td>1</td>
</tr>
</tbody>
</table>
Relationship Status

Single 62
Married or Partnered 47
In a Relationship 40

Participants were recruited through digital fliers (Appendix E) sent to LGBT centers around the country, to LGBT departments at state Universities, and through LGBT academic listservs. Advertisements for the study were also posted on facebook.com. Additionally, participants were encouraged pass study information along to other individuals who identify as gay men. The participants in the final analysis reported living in a number of geographic locations including 33 U.S. states and two participants reported living in Canada.

Participants were provided a non-profit incentive for completing the study. For every study completed, one dollar was donated to the Trevor Project, a non-profit organization that works with LGBT youth to prevent suicide and bullying and to promote health (The Trevor Project Organization, 2010; Appendix G).

Materials

Materials included an informed consent document (Appendix A), a demographics questionnaire, the Bem Sex Role Inventory (Bem, 1974), the Multi-Axial Gay Inventory – Men’s Short Version (Theodore et al., 2013), and the Gender Role Conflict Scale (O’Neil, Helms, Gable, David, & Wrightsman, 1986). The materials and stimuli used are described in detail below.
The demographics questionnaire (Appendix B) consisted primarily of multiple-choice questions. Initially, participants needed to state that they are 18 or older in order to continue on to the rest of the items. Additionally, participants needed to state that they identify as a gay man to continue on to the rest of the items. Areas assessed included age, sexual orientation, gender identity, education, ethnicity, state and/or country of current residence, and relationship status.

The Bem Sex Role Inventory (BSRI; Bem, 1974; Appendix C) was used as a measure of gender role. The BSRI is a 60-item scale; items address the participant’s gender role. Each item is a characteristic (e.g. “helpful”) and the participant is asked to indicate on a seven-point scale how well each of the sixty characteristics describes herself or himself. The scale ranges from 1 ("Never or almost never true") to 7 (Always or almost always true"). The participant’s scores were used to identify the participant as Masculine, Feminine, Androgynous, or Undifferentiated.

The Multi-Axial Gay Inventory – Men’s Short Version (MAGI-MSV; Theodore, et al., 2013; Appendix D) was utilized in the present study. The MAGI-MSV is based on the Nungesser Homosexual Attitudes Inventory (NHAI; Nungesser, 1983) and is a 14-item scale assessing for Internalized Homophobia in gay men. Several revisions were made from the Nungesser inventory, including improving content validity by adding more extreme items such as items that address suicidality, improving grammatically awkward or unclear items, and omitting items that conceptually confound with other constructs too much (Shidlo, 1994, p. 201). Within the MAGI-MSV, respondents rated items on a four-point Likert-type scale. Agreement with any MAGI-MSV item by answering “strongly agree (1)” or “mainly agree (2),” indicates higher levels of internalized homophobia. Disagreement with any MAGI-MSV item by answering “mainly disagree (3)” or “strongly disagree (4),” indicates lower levels of internalized homophobia.
The Gender Role Conflict Scale (GRCS; O’Neil, Helms, Gable, David, & Wrightsman, 1986; Appendix E) was used to analyze the role of gender role conflict (GRC) as a possible covariate. All items are responded to using a Likert scale of *strongly disagree* (1) to *strongly agree* (6), with higher scores on the GRCS indicating greater degree of GRC. The experience of GRC is defined as a psychological state in which socialized gender roles have negative consequences for the person or others. GRC occurs when rigid, sexist, or restrictive gender roles result in restriction, devaluation, or violation of others or self. The ultimate outcome of GRC is the restriction of a person’s human potential or the restriction of another person’s potential (O’Neil, 2008, p. 362).

**Procedure**

Surveys were conducted through SurveyGizmo.com, a secure Internet-based survey program. Upon entering the study site, participants were presented with the informed consent document. Next, participants completed the demographics questionnaire followed by the BSRI, the MAGI-MSV, and the GRCS. The order of the items in these three scales was randomized to minimize order effects. After completing all of the measures, participants were thanked for their completion of the study.

**Results**

The purpose of the present study was to investigate the relationship between internalized homophobia and gender roles in gay men. Of particular interest was whether or not androgynous gay men would have lower levels of internalized homophobia than masculine, feminine, or undifferentiated gay men.

**Gender Roles**

Using the BSRI results, a median-split of this samples’ average masculinity (5.10) and
femininity (4.75) scores categorized participants as masculine, feminine, androgynous, or undifferentiated.

Table 2

*Number of Participants Categorized in Each Gender Role (N=149)*

<table>
<thead>
<tr>
<th>Gender Role</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feminine</td>
<td>40</td>
</tr>
<tr>
<td>Undifferentiated</td>
<td>39</td>
</tr>
<tr>
<td>Masculine</td>
<td>36</td>
</tr>
<tr>
<td>Androgynous</td>
<td>36</td>
</tr>
</tbody>
</table>

**Internalized Homophobia and Gender Roles**

A one-way within-subjects ANOVA was conducted with the grouping factor being gender role (masculine, feminine, androgynous, or undifferentiated) and the dependent variable being internalized homophobia. Prior to performing tests of the main effects and interactions, the data were evaluated to test the homogeneity of variance assumption. The assumption was met based on the result of Levene's Test of Equality of Variance ($F = .107; df = 3, 145; p = .956$).

Using an a priori p-value of .05, the results indicated a non-significant main effect for the gender role variable, $F (3, 145), = .83, p = .482, \bar{\chi}^2 = .017$. The means and standard deviations for internalized homophobia are presented in Table 3.

Table 3

*Means and Standard Deviations for Internalized Homophobia by Gender Role (Masculine, $N = 36$, Feminine, $N = 40$, Androgynous, $N = 36$, and Undifferentiated, $N = 39$).*
The results indicated that the participants with a masculine gender role, on average, did not have significantly different scores on a measure of internalized homophobia ($M = 50.94, SD = 4.97$) than those with a feminine gender role ($M = 50.83, SD = 4.82$). The 95% confidence interval for the difference in means ranged from -2.71 to 2.94. The results also indicated that the participants with a masculine gender role on average did not have significantly different scores on a measure of internalized homophobia ($M = 50.94, SD = 4.97$) than those with an androgynous gender role ($M = 52.06, SD = 4.84$). The 95% confidence interval for the difference in means ranged from -4.05 to 1.83. Further, the results indicated that the participants with a masculine gender role on average did not have significantly different scores on a measure of internalized homophobia ($M = 50.94, SD = 4.97$) than those with an undifferentiated gender role ($M = 50.36, SD = $). The 95% confidence interval for the difference in means ranged from -2.26 to 3.43.

The results indicated that the participants with a feminine gender role on average did not have significantly different scores on a measure of internalized homophobia ($M = 50.83, SD = 4.82$) than those with an androgynous gender role ($M = 52.06, SD = 4.84$). The 95% confidence interval for the difference in means ranged from -4.10 to 1.63. The results indicated also that the participants with a feminine gender role on average did not have significantly different scores on a measure of internalized homophobia ($M = 50.83, SD = 4.82$) than those with an undifferentiated
gender role (M= 50.36, SD= 4.29). The 95% confidence interval for the difference in means ranged from -2.30 to 3.23.

The results indicated that the participants with an androgynous gender role on average did not have significantly different scores on a measure of internalized homophobia (M= 52.06, SD= 4.84) than those with an undifferentiated gender role (M= 50.36, SD= 4.29). The 95% confidence interval for the difference in means ranged from -1.18 to 4.58.

Discussion

The present study was an investigation of the relationship between internalized homophobia and gender roles. It was hypothesized that there would be a significant differences in internalized homophobia based on gender roles. If such differences were found, it was hypothesized that gender role conflict would moderate this relationship. It was expected that androgynous individuals would have significantly lower levels of internalized homophobia,

Contrary to the first hypothesis, there were no significant differences found between internalized homophobia based on gender role. Since no significant differences in internalized homophobia based on gender role, gender role conflict could not have served as a significant moderator and this was not explored.

Contrary to expectation, androgynous individuals did not have significantly lower levels of internalized homophobia. In fact, androgynous individuals actually had the highest level of internalized homophobia, although not significantly so. Undifferentiated individuals had slightly lower levels than feminine individuals, who had slightly lower levels than masculine individuals, although none of these results were significant.

These results, while unexpected, still hold valuable insights into clinical work with gay male clients. Specifically, it can disconfirm stereotypes or preconceived notions clinicians may
have about the relationship between internalized homophobia and gender roles. For example, if a clinician assumes that a feminine gay male client is more likely to have internalized homophobia than a masculine gay male client, the results of this study would suggest that their assumption is incorrect. Further, if a clinician assumes that an androgynous client is less likely to have internalized homophobia, these results would suggest that their assumption is incorrect. Since internalized homophobia is a very real and dangerous threat to health in gay men, it is important that clinicians do not make assumptions about how clients’ gender roles may reduce internalized homophobia, as this could lead the clinician to overlook internalized homophobia that is present.

A limitation of the present study is the nature of the sample. The sample was not very ethnically diverse, as 122 of the 149 participants were white. Additionally, the sample was not very diverse vis-à-vis education, as only one participant completed high school without any further education and nearly 44% of the population had earned a masters or doctoral degree. Overall, this means that the results of this study can only be generalized to highly educated, white gay men. Future research should find participants that come from more diverse ethnic and educational backgrounds.

Another limitation of this study is the sampling method. Due to the nature of the population being sought, a snowball sampling method was used to recruit self-identified gay men. This means that the sample was not randomly selected. In addition, there could not be random assignment into the independent variable because participants’ responses to the BSRI led to their categorization as masculine, feminine, androgynous, or undifferentiated.

An additional limitation of this study was the use of the BSRI. The items on this scale were selected over thirty years ago based on what traits participants described as desirable in
men and women (Bem, 1974). Although these traits feel very relevant to modern stereotypes of desirable traits in men and women, it would be ideal if this scale were updated with a modern sample.

In conclusion, the results of the present study suggest that there is not a significant relationship between internalized homophobia and gender roles. Further, it does not provide any evidence supporting Bem’s hypothesis about the benefits of androgyny.
References


Appendix A

Informed Consent

1. Study title

The relationship between gender roles and internalized homophobia.

2. Study personnel

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<th>Alexander Levine</th>
<th>Shawn Davis</th>
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<tr>
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<td>503-352-7319</td>
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3. Study invitation, purpose, location, and dates

You are invited to participate in this examination of the potential relationships that exist between gender roles and internalized homophobia.

The study is expected to begin after IRB approval and to be completed by July 2013. All study information will be collected via the Internet and stored on a secure account owned by a student of the Pacific University School of Professional Psychology, within the College of Health Professions.

4. Participant characteristics and exclusionary criteria

To participate in this study, you must be at least 18 years of age and identify as a gay man. If you are below the age of 18 or do not identify as a gay man, please exit this survey immediately by closing the browser window.

5. Study materials and procedures

In this study, you will be asked to complete a brief demographic survey. Once this is complete, you will be presented two brief questionnaires with items regarding the ways you characterize yourself and relate to your sexual orientation.

Your participation is completely anonymous. There is no means of associating any information that you provide with you personally.
You may opt out of the study at any time by closing the browser window. If you choose to close the window before completing the study none of your information can or will be used.

It should only take about 15 minutes to complete your participation in the study.

### 6. Risks, risk reduction steps and clinical alternatives

#### a. Unknown risks

Your participation in this project involves no foreseeable risks.

#### b. Anticipated risks and strategies to minimize/avoid

Any risks involved in participation in this study are minimal and are not greater that those ordinarily experienced in daily life or during the performance of any routine computer operation.

All data collected will be strictly anonymous. While SurveyGizmo allows the survey administer to determine whether or not to collect IP addresses as part of the survey data, IP addresses will not be collected during any phase of this study to insure anonymity.

#### c. Advantageous clinical alternatives

This study does not involve experimental clinical trials.

### 7. Adverse event handling and reporting plan

If you experience discomfort during the study procedure you should stop your participation immediately and Shawn Davis, Ph.D. at (503) 352-7319.

The Institutional Review Board office will be notified by Dr. Davis on or before the next normal business day if minor adverse events occur. Study investigators will consult with the IRB about changes that may need to be made to the protocol or other changes deemed necessary to minimize any minor adverse events.

The Institutional Review Board office will be notified by Dr. Davis within 24 hours if major adverse events occur. In such a situation, the study investigators will immediately discontinue recruitment and discuss with the IRB office the best solution in order to minimize any and all adverse events.

### 8. Direct benefits and/or payment to participants

#### a. Benefit(s)

There are no direct benefits to you as a participant in this study.
b. Payment(s) or reward(s)

Your participation will help to support the Trevor Project, a non-profit organization that’s mission is to prevent suicide in and empower LGBT youth. Learn more at [www.trevorproject.org](http://www.trevorproject.org). Upon your completion of the study, $1 will be donated to the Trevor Project.

9. Promise of privacy

Your participation is completely anonymous. There is no means of associating any information that you provide with you personally.

Results from participants will be available only to the experimenters. If a publication or conference presentation results from this experiment and findings are presented, all information will be presented in terms of group data; no responses for a single individual will be presented. There is no means of associating your responses with your identity.

10. Voluntary nature of the study

Your decision whether or not to participate will not affect your current or future relations with Pacific University. There are no costs to you for your participation other than the time involved in completing the surveys. If you choose not to participate, you are free to withdraw at any time; withdrawal will not result in penalty.

If you withdraw (by closing your browser window) from the study at any point prior to completing the survey, your participation will be ended. In this situation, all data collected to that point will be erased and not used in any analyses. It will not be possible to withdraw from the study after completing the entire study survey, due to its anonymous nature. However, all data will be erased (and not used in any analyses) for any individual that does not complete the entire study survey (defined as not reaching the final page of questions and answering any questions on that page).

Participation in this project is voluntary and the only other alternative to this project is non-participation. If you decide to participate, you are free to not answer any question or withdraw at any time without prejudice or negative consequences.

11. Contacts and questions

The researcher(s) will be happy to answer any questions you may have at any time during the course of the study. If you are not satisfied with the answers you receive, please call Pacific University’s Institutional Review Board, at (503) 352-1478 to discuss your questions or concerns further. If you have questions about your rights as a research subject or become injured in some
way and feel it is related to your participation in this study, please contact the investigators and/or the IRB office. All concerns and questions will be kept in confidence.

12. Statement of consent

Since this is an on-line survey, signatures cannot be obtained. By clicking “NEXT” I understand I will be taken to the study and that my continued participation in the survey denotes my consent to the following:

I have read and understand the above. All my questions have been answered. I am 18 years of age or over, identify as a gay man, and agree to participate in the study. I have read and understand the description of my participation duties and I understand that I can print a copy of this form to keep for my records.

Remember that if you choose not to participate or to withdraw from participation, you can close your web browser at any time.
Appendix B

Demographic Questionnaire

What is your age? ____

Do you identify as a gay man?
- yes
- no

What is your racial identity? (Check all that apply)
- American Indian / Alaska Native
- Asian
- Black or African American
- Hawaiian Native / Pacific Islander
- White
- Other

What is your ethnicity?
- Hispanic or Latino
- Not Hispanic or Latino

What country do you live in? (Drop box of all countries)

What state do you live in? (Drop box list of all US states)

What is your level of education?
- Some high school
- Completed high school
- Some college or technical school?
- 2 year degree
- 4 year degree
- Some graduate school
- Masters degree
- Doctoral degree

I am:
- Married or Partnered
- In a relationship
- Single
Appendix C

**Bem Sex Role Inventory**

*Rate yourself on each item, on a scale from 1 (never or almost never true) to 7 (almost always true).*

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Appendix D

**Multi-Axial Gay Inventory – Men’s Short Version**

Please respond to each of the following: (1) Strongly Agree (2) Mainly Agree (3) Mainly Disagree (4) Strongly Disagree

- Whenever I think about being gay, I feel depressed.
- My homosexuality makes me unhappy.
- I feel alienated from myself specifically because I am gay.
- Homosexuality is a hellish life.
- I wish I were heterosexual.
- Most gay men end up lonely and isolated.
- I wish I weren't gay.
- Some gay men are too effeminate.
- Some homosexual women and men flaunt their homosexuality too much.
- I don’t like people who behave like fags (femme) or dykes (butch).

- Over the past 2 years, I have actually attempted suicide because I could not accept my homosexuality.
- Over the past 2 years, I have considered getting professional help to change my sexual orientation from gay to straight.
- Because of the fear of AIDS, I find myself wishing that I were heterosexual.
- Occasionally, when I think about AIDS, I start wishing that I weren’t gay.
Appendix E

**Gender Role Conflict Scale**

Instructions: In the space to the left of each sentence below, write the number that most closely represents the degree that you **Agree** or **Disagree** with the statement. There is no right or wrong answer to each statement; your own reaction is what is asked for.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

1. ____ Moving up the career ladder is important to me.
2. ____ I have difficulty telling others I care about them.
3. ____ Verbally expressing my love to another man is difficult for me.
4. ____ I feel torn between my hectic work schedule and caring for my health.
5. ____ Making money is part of my idea of being a successful man.
6. ____ Strong emotions are difficult for me to understand.
7. ____ Affection with other men makes me tense.
8. ____ I sometimes define my personal value by my career success.
9. ____ Expressing feelings makes me feel open to attack by other people.
10. ____ Expressing my emotions to other men is risky.
11. ____ My career, job, or school affects the quality of my leisure or family life.
12. ____ I evaluate other people’s value by their level of achievement and success.
<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

13. ____ Talking about my feelings during sexual relations is difficult for me.
14. ____ I worry about failing and how it affects my doing well as a man.
15. ____ I have difficulty expressing my emotional needs to my partner.
16. ____ Men who touch other men make me uncomfortable.
17. ____ Finding time to relax is difficult for me.
18. ____ Doing well all the time is important to me.
19. ____ I have difficulty expressing my tender feelings.
20. ____ Hugging other men is difficult for me.
21. ____ I often feel that I need to be in charge of those around me.
22. ____ Telling others of my strong feelings is not part of my sexual behavior.
23. ____ Competing with others is the best way to succeed.
24. ____ Winning is a measure of my value and personal worth.
25. ____ I often have trouble finding words that describe how I am feeling.
26. ____ I am sometimes hesitant to show my affection to men because of how others might perceive me.
27. ____ My needs to work or study keep me from my family or leisure more than I would like.
28. ____ I strive to be more successful than others.
29. ____ I do not like to show my emotions to other people.
30. ____ Telling my partner my feelings about him/her during sex is difficult for me.
31. ____ My work or school often disrupts other parts of my life (home, family, health leisure).

32. ____ I am often concerned about how others evaluate my performance at work or school.

33. ____ Being very personal with other men makes me feel uncomfortable.

34. ____ Being smarter or physically stronger than other men is important to me.

35. ____ Men who are overly friendly to me make me wonder about their sexual preference (men or women).

36. ____ Overwork and stress caused by a need to achieve on the job or in school, affects/hurts my life.

37. ____ I like to feel superior to other people.
Appendix F

Recruitment Flier

Are you a gay man and 18 years or older? Want to help advance the study of gender roles and health, while also supporting The Trevor Project?

If you are a gay male over the age of 18, and you have access to the Internet I invite you to participate in a research study about the relationship between gender roles and health in gay men.

It will take approximately 15-min to complete and is entirely anonymous. Just log on to edu.surveygizmo.com/s3/1029617/Gender to complete the survey. For every completed survey, 1$ will be donated to the Trevor Project (www.trevorproject.org), a non-profit that’s mission is to prevent suicide in and empower LGBTQ youth. Your help is greatly appreciated, and please pass this on to any gay men over the age of 18 that you know.

(Scan QR code below to be linked directly to the study)

Please take a tab with you if you cannot scan the QR code
Appendix G

Information from The Trevor Project Organization

The Trevor Project is the leading national organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender and questioning youth.

Mission

The Trevor Project is determined to end suicide among LGBTQ youth by providing life-saving and life-affirming resources including our nationwide, 24/7 crisis intervention lifeline, digital community and advocacy/educational programs that create a safe, supportive and positive environment for everyone.

Vision

A future where the possibilities, opportunities and dreams are the same for all youth, regardless of sexual orientation or gender identity.

Acceptance

Inclusiveness is one of our mantras. We are rooted in the belief that everyone should be treated like a human being regardless of sexual orientation, gender identity or expression, race, ethnicity, religious practice, ability, or size. We as an organization will not turn away anyone asking for help. We will show compassion. And, in recruiting staff and volunteers we will reflect the diversity of our community.

Commitment

We promise to deliver the best crisis intervention and suicide prevention services for LGBTQ youth. We promise to create a safe space, online, in classrooms and on the phone for LGBTQ youth. We promise to deliver our message of suicide prevention in schools throughout the country. We promise to hire a highly qualified and professional staff. We promise to operate with the utmost integrity.

Innovation
We have been and will continue to be pioneers in reaching out to youth in crisis. We will be stewards in nonprofit fundraising. We will be innovative in our recruiting and retention of staff, volunteers, and board members.