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# Affectional Orientation, Sex Roles, and Reasons for Living.

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# Affectional Orientation, Sex Roles, and Reasons for Living

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ABSTRACT

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The purpose of this study was to research gender, affectional/sexual orientation, and sex roles to determine how people respond to the Expanded Reasons for Living Scale by Linehan, Goodstein, Nielsen, and Chiles (1983). This study used the Bem Sex Role Inventory, short form (Bem, 1981) to assess androgynous and nonandrogynous people.

Results from the statistical analysis revealed that bisexuals had the lowest reasons for living score followed by gay men/lesbians, and then heterosexuals on the Total RFL, as well as on the Responsibility to Family and Moral Objections subscales. On the Child-Related Concerns subscale heterosexuals had a higher RFL score than both homosexuals and bisexuals. The Fear of Social Disapproval subscale revealed that heterosexuals and homosexuals were significantly higher than bisexuals. Androgynous people had a higher RFL on the Moral Objections subscale than nonandrogynous people and Androgynous women scored higher than nonandrogynous women on the Survival and Coping Belief subscale.

# DEDICATION

This paper is dedicated to my parents, Raymond and Ruth Hamilton, as well as my two brothers, Jayrob and Jeremy. I thank my parents for teaching me that I can do anything I have the initiative to do in life. They have supported me throughout my education as well as in all facets of my life. Without the guidance and strength of my mother and father, I would not be where I am today in my life.

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# CHAPTER 1

# INTRODUCTION

## Suicide Statistics

Suicide is a very prevalent problem in American society. Approximately 32,000 people commit suicide each year in the United States. This number is not an account for the actual suicides that have been committed, as it is estimated that 4 out of 5 suicides are not recorded as suicide (Yufit, 1991). Suicide is the third leading cause of death among ages 15-34 (American Foundation for Suicide Prevention, 1996). For ages 15-19, it is the second leading cause (American Association of Suicidology, 1997). Since 1950 the suicide rates for ages 15-24 have tripled for men and almost doubled for women. The numbers of suicides within these age ranges continue to rise each year. In 1998, 4,235 suicides were reported for young adults ages 15-24. There is an average of 1 suicide every 17.2 minutes. By estimation, 5 million Americans have attempted suicide and there are 4.4 million survivors (family, friends, etc.) of those who have committed suicide. There are people who suicide in every geographic location, socioeconomic status, race, religion, affective orientation, and age group.

McIntosh (2000) suggested that there was a YPLL, or "Years per Life Lost Statistic" that would show how many years of life that would have remained for the individual who committed suicide, had he or she not committed suicide. From age 15-24 this YPLL was 198,289 years lost for the 4, 358 suicides that took place in 1996. For the ages 25-34 there were 208,066 years lost for the 5,861 suicides in 1996. This is an estimate of how many years were taken away from youth in the United States because of suicide. For the age range of 15-24 in 1996, there were 12 out of every 100,000 youth committing suicide that year, with a 5:1, male:female ratio.

## Homosexuality and Suicide

In ancient times, Hebrews thought of homosexuality as a sin for men and punishable by the death penalty; however, women who were homosexual were not assumed to be sinning (Erwin, 1994). This was because the law was not made to stop homosexuality from occurring but rather to discourage Jewish men from going to the Canaanite temples where they engaged in sexual acts with men who came to worship. By 1270, this had been included in the French legal codes and included both men and women. Homosexual acts were prohibited. Any person not adhering to that law was punished by death. These laws assumed that people chose to lead this lifestyle. Many religious organizations still believe affectional orientation is a choice. Suicide, for those who are gay, lesbian, and bisexual and belong to these religious organizations, may be an option that they choose rather than the "sin" of homosexuality.

In the nineteenth century a change was made from the homosexual lifestyle being a religious concern to being a medical and biological concern. There were then two theories of homosexuality. One theory stated that it was nonpathological and the other stated that it was a mental disorder. In the 1860s Karl Ulrichs, Havelock Ellis, Edward Carpenter, Edward Stevenson, and Magnus Hirschfield proposed that the theory stating that homosexuality was nonpathological, was correct. These men worked together to try to discontinue the law that prohibited homosexuality. Freud in the twentieth century suggested that homosexuality and bisexuality were neuroses. He saw suicide in homosexuals as a continuation of these neuroses.

By the 1930s it was well accepted that homosexuality was pathological. In the 1960s and 1970s this was changed in part because of the gay liberation movement. At that time the mental health field began to view homosexuality as nonpathological once again, and they began to challenge the church's beliefs about homosexuality. Mental health providers changed their

theories regarding why homosexuals/bisexuals commit suicide at a high rate. Instead of psychological distress and self-destructiveness, psychologists theorized that homosexuals and bisexuals had a high rate of suicide because of factors such as self-hatred, isolation, and society's intolerance. The APA (American Psychological Association), in 1975, stated that "homosexuality is neither a mental illness nor a personality trait that results in impairment of vocational capabilities, emotional adjustment, or judgment (Johnson, Brems, and Alford-Keating, 1997, p. 58)."

"Pervasive negative attitudes about homosexuality have continued in our society" (Johnson, Brems, & Alford-Keating, 1997, p. 58). However, homosexuals haven't been given protection under U.S. civil-rights legislation at this time (Agnew, Thompson, Smith, Gramzow, & Currey, 1993). This means that discrimination and negative treatment of people who belong to the GLBT (Gay, Lesbian, Bisexual, and Transgendered) community remains acceptable in America. Most Christian churches today believe that homosexuality/bisexuality is a sin; however, there are some churches that have changed with the field of science. Some churches that are allies for equal rights are the Catholic Theological Society of America, Christian Church (Disciples of Christ), Commission of Social Action Reform Judaism, Lutheran Church of America, National Counscil of Churches, National Federation of Priests' Council, Protestant Episcopal Church, Society of Friends (Quaker), Union of American Hebrew Congregations, Unitarian-Universalist Association, United Church of Christ, United Methodist Church, and United Presbyterian Church (Parents and Families of Lesbians and Gays, 2000).

## History of Sex Roles

The history of the definition of sex roles tends to parallel the history of suicide and affective orientation. Sex and gender during medieval times seemed to be about the relationships that men and women had with God and not each other (Connell, 1987). These relationships concerned moral relationships. When theologians and philosophers discussed sex, they stated what people should do but never theorized why people did what they did. A major time of change came during the French Revolution when people decided that God did not intend for men and women to conform to their gender. This was the beginning of early feminism and libertarianism when women fought for citizenship and their rights as equals of men. Religion remained closely associated with women's rights in America. By the 1920s women had fought for their right to education and to own property. Gender had been defined as how character was formed. Even though women had fought for equal rights, there were "men's jobs" and "women's jobs" and there were still conventional rules about women and how they should behave. Heterosexuality was taken for granted at that time.

Then scientists began to examine sex. Darwin suggested that there were evolutionary advantages to being able to reproduce. Sexology was founded by people who wondered what caused sexuality and gender. Different kinds of sexuality began to be studied including transvestism, homoeroticism, and others. Psychologists including Krafft-Ebing, Havelock Ellis, and Freud began to study sexuality. Freud began to study "the social contexts of emotional growth" (Connell, 1987, pp. 28) and not just focus on the person as a whole. He founded the concept of bisexuality and tried to theorize what "caused" homosexuality. Freud stated that homosexuality was pathological. Karl Ulrichs and Magnus Hirschfield contradicted Freud and

said that homosexuality was not pathological. Gender began to be questioned, as did what it meant to be male or female.

During the socialist movement in the first part of the twentieth century, women tried to break free of the work that they had been doing and get jobs other than "women's jobs". The women's efforts did not succeed at this time, but it did set the platform for later. Women questioning "men's work" in the 1920s caused people to ask what the difference between men and women were. In the 1930s, psychological tests were written that measured masculinity and femininity. Sex roles became a term in the 1940s and sex difference became somewhat less important in research. In the 1950s and 60s the female role was the role most written about, whereby women were supposed to be wives and mothers. Feminism and the gay liberation movement took place in the 1970s. Gender and how gender worked with social relationships became the focus during this time. Sex-role and sex-difference research increased at this time. It was then that Sandra Bem researched the new concept of androgyny. People began to realize that homosexuality and bisexuality existed more than they had thought. Women fought for jobs that they could do that were previously thought of as "men's jobs". This was the beginning of what we know as the feminist movement today.

## Affectional Orientation Theories

There are many biological theories concerning affectional orientations and have been many studies conducted regarding the differences in each affectional orientation's biological makeup. One study suggests that there is a lipid level difference (Snyder, Weinrich, & Pillard, 1994). Heterosexuals were found to have a significant ($p < 0.04$) difference in HDL levels, high density lipoproteins that are thought to reduce the risk of heart disease. Heterosexuals had higher

levels of HDL than did homosexuals or bisexuals; however, the homosexuals and bisexuals did not differ significantly from each other. The heterosexual group had higher levels of cholesterol than the homosexual group. High cholesterol levels can be found in people with artherosclerosis and heart disease. Cholesterol is also transformed into sex steroid hormones, testosterone, and adrenocortical hormones. The bisexual group scored in between both groups; however, was much closer to the homosexual group than the heterosexual group. There was almost a significance between bisexual and heterosexual, and was significance between homosexual and bisexual. Triglycerides, lipids that are used in storage of fatty acids and in fat metabolism, were also measured. In triglyceride levels, however, the bisexual group was closer to the heterosexual group, and the homosexual group had lower levels. The difference between the bisexual and homosexual group was significant; however, the homosexual and heterosexual groups were slightly away from significant ($0.05<p<0.06$).

Most biological theories of affectional orientation suggest that the brain is the reason for the different affectional orientations. The evolutionary sexology theory is that a person sees someone and he or she has what is called a lust response (Money, 1999). This response is what leads a person to other feelings such as love but does not have to be triggered by a person. The lust response can also be triggered by perceived images of a person or other representations of a person. The features of the body that one imagines or sees before the lust response occurs depends on the person's orientation. It is believed in this theory that from embryonic life onward the image that causes the lust response is programmed into the brain and is unchangeable throughout the life span.

The ethological theory suggests that the brain has certain "innate recognition and releasing mechanisms" that are coded into the brain at birth (Money, 1999, pp.222). Certain

stimuli cause this recognition and release during the person's life at certain stages of development. The brain in this theory is either male or female and is precoded to have the response of lust at certain stimuli. Each person has brain connections that go to the visual cortex and create a vision of what is called the sexual body morphology, the body of the person to whom one is attracted. For homosexuals the sexual body morphology would be same sex bodies. For heterosexuals the sexual body morphology would be opposite sex bodies. For bisexuals the sexual body morphology could be either male or female at a given time. The theory holds that the fetus female brain in heterosexual women is coded to release a lust response to the stimuli of a male. In a male heterosexual brain this coding is suppressed; however, it is not known what suppresses it. It is theorized that androgen may suppress this coding, which once suppressed in the male heterosexual brain is replaced with a coding for the lust response to occur from stimuli of a female. If this were not suppressed fully the male would be bisexual. If it does not at all occur the male would be homosexual. In female development, bisexuality would appear if the coding were partially suppressed as in a bisexual male. If it were fully suppressed as in a heterosexual male, then the female would be homosexual.

Many theories, such as the above examples exist regarding what "causes" homosexuality and bisexuality; however, few theories exist which suggest what "causes" heterosexuality. Most theories other than the few cited above are heterosexist, meaning that they assume that there is a "cause" for homosexuality, but underlying these theories, is the thought that heterosexuality is "normal" while homosexuality and bisexuality are "abnormal". Since the APA (American Psychological Association) has stated that homosexuality and bisexuality are no longer considered pathological, new theories are warranted for how sexual orientation is developed. It is probable that psychological, sociological, and biological factors are a part of a person's sexual

orientation. It is a mixture of psychological, sociological and biological factors, and dependent upon each different person to fully understand their sexual orientation.

## Identity Formation in Homosexuals

There are thought to be six stages in Gay/Lesbian Identity Formation (Kuehl & Bitter, 1999). The first stage is Identity Confusion, which occurs when there is personalization regarding homosexuality. In this stage a person begins to realize that his or her thoughts, feelings, or behaviors are possibly homosexual; however, they maintain a heterosexual image with the people around them. They may inhibit the feelings they have by denying them, becoming hypersexual (overly sexual towards the opposite sex), asexual (not caring about either sex), seek a "cure", or become an anti-gay crusader. They may deal with it with something called Personal Innocence, where they reject their homosexuality. Men generally keep emotional feelings out of sexual contacts and women keep relationships with women strictly nonsexual. They may become information seeking, trying to decide if they are homosexual.

The second stage is Identity Comparison which is when the person accepts that he or she might be homosexual. In this stage, homosexuals begin to examine the implications of being homosexual. They begin to have social alienation because they feel different from peers, family members, and society at large. They grieve the loss of the heterosexual life, which includes marriage, acceptance among society, etc. At this stage in life they may react positively to their homosexuality and to being different. They may devalue the importance of being a heterosexual. This works if the person is able to avoid negative confrontations with heterosexuals and can pretend to be heterosexual. They may accept the definition of homosexual as their own behavior but reject the fact that they are homosexual in order to feel less alienated from the important

heterosexuals in their life. This can work if they keep their sexuality separate from other aspects of their life. They may accept themselves and their behavior as a homosexual but still fear negative reactions from others so they keep their overt homosexual behavior inhibited. In this choice, homosexuality is devalued and heterosexuality is valued more positively.

The third stage is Identity Tolerance, which is when the person accepts his or her homosexuality and recognizes the sexual/social/emotional needs that come with being homosexual. There is more commitment to their homosexual identity in this stage. More time and energy are put into pursuing social, emotional, and sexual needs in their homosexual identity. They seek out other gay/lesbian people to provide a support system and have opportunities to meet partners. They have access to positive role models and can feel more at ease as a Lesbian or Gay man. Success in this stage depends on whether their contacts with others are perceived as positive or negative. If negative experiences occur the person may not continue; however, if positive experiences occur the person will explore their identity further.

The fourth stage is Identity Acceptance where the person accepts and has increased contact with other homosexuals. At this stage people have a positive feeling and identifications with other homosexuals. They may regard being homosexual as only partially legitimate which will make them self-disclose selectively to certain people but also distance themselves from heterosexuals and try to fit into society by not making waves. These individuals will then stop at this stage. Others may regard being homosexual as fully legitimate and find homophobic attitudes offensive. To deal with the anger created by an anti-homosexual society and continue self-acceptance, they will move to the next stage.

The fifth stage is Identity Pride where they become immersed in homosexual communities and have less to do with heterosexuals. In this stage they divide the world into

homosexuals and heterosexuals. Homophobic or homoprejudiced attitudes produce frustration and alienation, with which they confront others regarding these attitudes. They self-disclose to heterosexuals that are close to them. If the response to self-disclosure is negative this will confirm that there should be a division of homosexuals and heterosexuals and they will stop at this stage. If the responses are positive the person moves on to the next stage.

The sixth stage is Identity Synthesis, which occurs when they realize that, "the us and them", homosexuals and heterosexuals are no longer separated. In this last stage, homosexuals feel that heterosexuals can be supportive. They still have some anger but it is less intensive. Trust in heterosexuals that have positive feedback increases while people who are negative continue to be devalued. They no longer divide their world into heterosexuals and homosexuals. Their homosexual identity is now integrated with other aspects within themselves. These steps of identity for homosexuals are generally taking place within the young adult age ranges. Therefore, the stresses of their identity formation are added to all other stresses that heterosexual young adults have. Although bisexuals are not included in this identity formation, the writer will assume that it is somewhat like the identity formation of homosexuals, since there was no literature found regarding this.

## Sex Role Theories

Bem (1984) wrote an article discussing her theory of sex roles. She began by explaining what she calls sex typing, which is how children become masculine or feminine, through her Gender Schema Theory. This theory suggests that a child encodes certain information and then organizes this information, which Bem calls gender-schematic processing. The data depend on information within the culture of how men and women should act. Bem suggests that this is

learned through the child's environment. Through encoding and organizing the information, their gender schema (a "cognitive structure, a network of associations that organizes and guides an individual's perception" (pp.187) is formed. The child will use this gender schema to sort the information including people, behaviors, and other attributes in categories of either masculine or feminine depending on what they have learned from their environment. The children take this information and the gender schemas that they see and relate to what gender schemas they should have. In much of our society children learn that men are strong and women are weak. This is not overtly pointed out to children but they learn it by how the parents and society react to them. For example, parents suggest how strong their little boy is or how pretty the little girl is in the dress that she is wearing. Children learn that boys should be strong and girls should be pretty (not strong). Therefore, it is not the overt suggestion that men are strong and women are weak but the covert suggestions that this is how the world is to be that the children learn. The children learn what they are supposed to be and then evaluate themselves as to whether or not they are acting as the culture wants them to act. This can have a major impact on self-esteem, or lowering of self-esteem, should the child not act as society wants them to act. With this information people can be sex-typed and they will describe themselves as either masculine or feminine, or they can not be sex-typed and would describe themselves as having a combination of masculinity and femininity. This also depends on what the culture perceives to be the "norm". If the culture doesn't break people down into masculine and feminine then they would not learn this gender schema.

Bem used this Gender Schematic Theory to suggest that something called androgyny existed. Androgynous people "do not rely on gender as a cognitive organizing principle" (Bem, 1984, pp. 190). These people have both masculine and feminine traits. Bem suggested that

people who are androgynous are better adjusted mentally than people who are high in masculinity or femininity. Bem points out that some studies show that people who are higher in masculinity tend to be better adjusted but notes that this may not be substantial evidence of this fact. In the Bem Sex Role Inventory it is found that sex-typed individuals are highly gender schematic and that androgynous people and undifferentiated people (those with low scores on both masculine and feminine scales) were not as gender schematic.

## Suicide Theories

Many theories exist to attempt to explain why someone tries to commit suicide or has suicidal ideations. The Suicide Trajectory model, explained by Stillion, in 1994, is one of these theories. This theory encompasses four aspects of suicide including biological, psychological, cognitive, and environmental factors. It theorizes that each of these components has an amount of involvement in a suicide. The combined weight of all of these components together may lead to a point in a person's life that their coping skills collapse and, therefore, they feel that suicide is the solution to their problems. The biological component is made up of studies that suggest a genetic basis such as the lack of Serotonin in the brain, which is found in people who are suffering from depression. Psychological factors include feelings that people have about themselves such as feeling depressed, having a low self-esteem, feeling helpless or hopeless about the situations in their life, and not having developed good coping strategies and defense mechanisms that would allow them to deal with issues in their life in a positive way. The cognitive component is made up of what cognitive level people have at this point in their life, how they thinks about themselves and how they function in the world as a whole. It also consists of whether or not they are pessimistic about the world in general, whether they ignore the

positives in their life, and whether they label themselves negatively and then react to situations from that negative label. Environmental risks include anything in the person's environment such as negative family or friend experiences, loss, or negative life events. Once these components combine and are large enough to produce suicidal ideations, a person makes plans. At this stage a person has planned the suicide but hasn't acted on it and can be helped by crisis intervention such as questions making them think about alternatives to committing suicide. It is thought in this theory that triggering events and warning signs are often a part of the suicide attempt; however, they are not always evident to outsiders. The triggering event is also called the "last straw phenomena" (Stillion, 1994, pp. 191). This does not have to be a major event, but it takes place after suicidal ideation and all of the components are weighing heavily on the person. This event seems to the person to be the final event they can handle. Warning signs are generally seen after a triggering event occurs and can include "verbal threats of suicide, self-injurious behaviors, and closure behaviors such as unexpected calls or visits intended as a final goodbye" (pp.192). At this point the decision to commit suicide has generally already taken place, and the plan is complete.

The Escape theory is another theory of suicide where the person has expectations and standards of life called socially-prescribed perfectionism (Dean, Range, & Goggin, 1996). Socially-prescribed perfectionism includes the person thinking that someone in his or her life or society has unrealistic high goals for him and her and that the individual has to meet these goals (Dean & Range, 1996). A negative life event occurs when one does not reach these standards and the person internalizes these failures (have negative self attributions) (Dean, Range, & Goggin, 1996). The person blames himself or herself for not living up to the expectations he or she feels have been placed upon him or her, and the individual then has a high self-awareness, which

causes him or her to feel inadequate, guilty, incompetent, and/or unattractive. The individual has compared himself or herself with the high expectations. The person becomes anxious or depressed (negative affect). Then a shift is made to cognitive deconstruction where hopelessness is critical. This includes the person's only focusing on the present time, all goals become short-term, and the focus is on immediate movements and sensations. Inhibitions are lost and cognitive reasoning, such as reasons for living, are pushed away. At this point suicide is considered as a way out. An individual who has low expectations would not be suicidal, as would be the individual with high expectations because the person always meet his or her expectations (Dean & Range, 1999).

Another theory is proposed by Linehan called the social-behavioral theory (Linehan & Shearin, 1988). This theory suggests that suicide occurs because of several factors. One factor is due to stresses in the environment and within the person. Environmental stresses are divided into three categories including "a lack of social support, negative life events including personal loss, and social conflict" in their lives (Linehan & Shearin, 1988, p. 271). Stresses within the person can include factors such as the person's being ill, not feeling in control of their thoughts or behaviors, feeling negative emotions, and affective lability. Other factors regard ineffective problem solving skills, negative outcomes of events in ones life, and a low tolerance for stress. To be suicidal or have suicidal ideations one must have these factors. These factors stop most of the population from committing suicide because they have the needed problem solving skills and the high tolerance for stress. The third component involves the thought that suicide is the most effective solution to their problem. This theory suggests that suicide and suicidal ideation is a way of problem solving for the individual, and that people who have important reasons for living will be the least likely to commit suicide. This theory suggests that it is a combination of all of

the stresses in combination with what is going on within the person that concludes whether or not the person will believe that suicide is a solution to their problem. Linehan, Goodstein, Neilsen, and Chiles, in 1983, used the theory that people with high amounts of reasons for living would not want to commit suicide and invented the Reasons for Living Inventory, which is widely used today in suicide research. Instead of basing the inventory on why people commit suicide, they made it positive by asking why people would not commit suicide. This was the beginning of looking at suicide from the positive rather than the negative. They focused on "adaptive, life-maintaining characteristics" (pp. 276). The coping belief scale, a scale of the inventory, predicts suicide intent, and was found to be a stronger predictor to suicide intent than hopelessness (Linehan & Shearin, 1988).

## Empirical Studies

### Affectional Orientation and Reasons for Living

The only study found concerning Affectional Orientation and Reasons for Living was conducted by Hirsch and Ellis (1998). This study used 62 people including 38 from a university and 24 from the gay community. The study focused on homosexuals and heterosexuals. The volunteers were given the Reasons for Living Inventory. There were significant differences on 5 of the reasons for living subscales including Responsibility to Family, Child-Related Concerns, Fear of Social Disapproval, Moral Objections, and Responsibility to Friends. This study found a difference in the total RFL score as well. Overall, homosexuals including gay men and lesbian women, had significantly fewer reasons for living than did the heterosexuals in the study; however, there was not a difference as far as gender, male versus female, was concerned.

Affectional Orientation and Suicide

A comparison study between homosexuals/bisexual men and heterosexual men was conducted in 2000 (Cochran & Mays). This study used the NHANES-III, which was a survey given out to 40,000 people by the National Center for Health and Statistics of the Centers for Disease Control and Prevention. Only 31,000 people from this survey were assessed for suicidal behavior. Out of the 31,000 people assessed, only men were used in the study. These men were asked their sexual history. They asked the participants the number of sexual contacts that were in their past. There were three categories including no sexual partners, female partners only, and male partners. The first category had 187 participants (no sexual partners), the second was labeled behavioral heterosexuality and had 3208 participants, and the last labeled "behavioral homosexuality/bisexuality" consisted of 108 participants. Of the 108 people in the "behavioral homosexuality/bisexuality" group, 14 men had only had male partners and 94 men had both female and male partners. The survey participants were never asked if they considered themselves bisexual and homosexual as they were grouped together as one group. Four questions assessing suicide were asked. The first question asked of the participants was if they had thought about death for a period of 2 weeks or more at any time in their life. The second question ascertained whether there was a 2-week period or more in their life where they wanted to die. The third question asked if the person had ever had suicidal ideations. The fourth question asked if suicide was ever attempted. The study stated that they found that the participants "with differing sexual behavior histories" had a "lifetime prevalence of suicide symptoms and major affective disorders" (assessed by the Psychiatric Diagnostic Assessment) (pp. 574). This apparently meant the homosexual/bisexual group of men. The participants exhibiting any

suicide symptoms were as follows: the homosexual/bisexual group had 53.2%, female partners only had 33.2%, and no sexual intercourse had 28.1%.

Another study using heterosexual, gay, lesbian, bisexual, and not sure youth was conducted in 1999 (Garofalo, et al.). They had 3,365 youth participate from high schools in Massachusetts. Of those youth 129 gay, lesbian, bisexual, or not sure of their sexual orientation participants were used for the study. They were assessing suicide attempts that had occurred in the past year, sexual orientation, violence related behaviors (fights, not attending school because they felt unsafe, carrying weapons, injuries, and sexual contact against their will), drug use, and sexual behaviors. The mean age of the 3,365 participants was 16.1, with 49.6 % being female and 78.6% being Caucasian. Of these youth, 9.9% responded that they had attempted suicide at least once in the past year. Of the 129 GLBN (gay, lesbian, bisexual, or not sure) participants 17 said that they were either gay or lesbian, 67 said that they were bisexual, and 44 were not sure. The youth who identified as GLBN were 3.4 times more likely to have had a suicide attempt in the past 12 months than the heterosexuals. For men who identified as GLBN this increased to be 6.5 times more likely to have attempted suicide than the heterosexual men. Women who were GLBN were only 2.02 times more likely than the heterosexual women to attempt suicide within the last year.

Male-male twin pairs were researched in another study (Herrell et al., 1999). This study consisted of 103 pairs of twins. Each pair of twins had one twin who consistently had opposite-sex relationships and one twin who had had male sex partners after the age of 18. The subjects were all a part of the VET Registry and were born between 1939 and 1957 and served in the military between 1965 and 1975. They were given a questionnaire asking them if they had had sexual partners of the same gender as an adult. There were 4774 pairs of twins questioned for the

study. Approximately 2% of all of the twin pairs questioned had had same-sex sexual relations and were the participants used in this study. Comparing the twins who had had same-sex (SS) partners to the ones who had not had same-sex partners (NSS) the following was found: 17.5% more of the same-gendered partners had had a period where they thought about death, 16.5% more of the (SS) partners had had a period where they wanted to die, 35.1% more of the (SS) partners had reported suicidal ideation, and 11 more of the (SS) partners had attempted suicide than their twins who were heterosexual.

Homosexuality and Suicide

Hammelman (1993) used participants from a GLB support group in Des Moines, Iowa, and a GLB organization at Iowa State University for a study. The participants ages ranged from 15 to 32. The participants were predominantly Caucasian, were volunteers for the project, and filled out questionnaires that were devised by the author. These questions regarded the participants' sexual orientation, gender, age, ethnic background, whether they were alcohol or drug users, had been rejected by their family, and if they had ever been abused. They were then asked on a scale of 1 to 5, 1=was not the reason and 5=main reason, whether their sexual orientation was the cause of their suicidal ideations or attempts, alcohol or drug use, abuse, or rejection of their families. There were 20 (16 bisexual and 4 lesbian) women and 28 (2 bisexual and 26 gay) men in the study. Of all the respondents, 14 (7 male, 7 female) of them, equal to 29%, had attempted suicide. The age that they attempted suicide ranged from age 8 to age 28. Out of all of the participants 48% stated that they had considered suicide from the ages of 8 to 29. Of these 48%, 70% stated that their sexual orientation was a part of their consideration to commit suicide. On the other scales in the study, 45% of the participants had been abused and

62% of these participants stated that sexual orientation had been a factor in this. Thirty-five percent of the participants had used alcohol or drugs, and 59% of these participants answered that sexual orientation was a factor in this. In the family rejection question, 23% of the participants had been rejected and 70% of the rejections were suggested to have been because of their sexual orientation. All of these problems seemed to play a part in their suicidal ideations and acts. Of the participants who had been abused, 38% had attempted and 52% had considered suicide. For the youth who had alcohol and drug use, 41% had attempted and 59% had considered suicide. Of the youth who had been rejected by family members, 35% had attempted suicide and 55% had serious suicidal ideations.

Predictors for suicide among GLB youth have been assessed (Hershberger, Pilkington, & D'Augelli, 1997). The participants from this study were youth groups in lesbian/gay community centers. These groups came from 14 different large cities. In the study, 221 participants filled out the survey and 27 were excluded due to age, not including information, or questioning their sexual orientation. There were 142 men and 52 women included in the study. Most participants were Caucasian and the ages ranged from 15-21. This study assessed several variables including like of school, age, gender, ethnicity, place of residence, financial dependence and situation, suicidal attempts and ideations, sexual orientation, disclosure of sexual orientation, mental health problems, and victimization due to sexual orientation. They were also given the Rosenberg Self-Esteem Inventory and the Brief Symptom Inventory, an inventory that assesses psychiatric symptoms. This study found that of the 194 participants, 42% had attempted suicide at least once. They found that 43% of these attempts were made by women and 40% were made by men. Generally it was found that if they had made one attempt then other attempts were more common. The number of attempts made ranged from 1 to 15 in this study. When asked if they

had thought about suicide in the week prior to the questionnaire being filled out, 39% of the participants answered yes. A .005 significance level was used to ascertain what was significant for the participants who had attempted suicide compared to those that hadn't attempted suicide. Variables that were seen in attempters were that they became aware of their sexual/affective orientation at an earlier age than nonattempters, they had their first experience with a same-sex partner earlier, and they had more years of awareness of same-gender attraction. Attempters had more years between "coming out" to someone and then "coming out" to their parents. Attempters also had more partners of the same-sex than nonattempters. Attempters reported that they had a better relationship with their family and that their entire family including mother, father, and siblings knew of their sexual/affectional orientation. Attempters had told their friends that were not heterosexual and lost a larger number of friends due to their sexual/affective orientation than non-attempters. Attempters had more close friends who were gay and lesbian and were more "out" than the non-attempters. Non-attempters did not have as many verbal insults, property damage, physical assaults, sexual assaults, or being hurt by others as the attempters had. Non-attempters had higher self-esteem, less suicidal ideation, less alcohol abuse, more satisfaction with their sex lives, less problems in close relationships, and less feelings of depression than the attempters.

Gay men, lesbians, and bisexual youth ,with an average age of 18.5, were participants in a study (Proctor & Groze, 1994). There were 159 men and 62 women. The subjects were predominantly Caucasian. There were 52 lesbians, 139 gay men, and 30 bisexuals. The participants were found throughout community organizations for youth who are GLB in the United States and Canada. The AHQ (Adolescent Health Questionnaire) was used in the study which "measures adolescents' perceptions of their family, social environment, and self" (pp.

507). Of the participants, 40.3% had attempted suicide, 25.8% had seriously thought about it, and 33.9% had never thought about it or made an attempt to suicide. The participants who had attempted suicide scored the lowest on all three scales (family, social environment, and self). The family scale consists of questions about how good the participants family relationships are, how many times they have relocated, their medical history, and their suicide history. The social environment subscale deals with social groups such as church involvement, school performance, how they get along with peers, and questions such as "I think our country is falling apart" (pp.507-508). The self component of the questionnaire includes how they perceive themselves as far as level of self-esteem, feelings of depression, physical signs of depression, and other perceptions about themselves. Those who said that they had thought about suicide scored higher on the scales than did the attempters, and the youth who had never attempted scored the highest.

A study was conducted with gay and bisexual male participants (Rotheram-Borus, Hunter, & Rosario, 1994). Their participants were 131 men ages 14 to 19 at a nonresidential, community agency for lesbian and gay youth. This study consisted of a 10-minute interview that consisted of 13 questions regarding suicide. They were also given a scale consisting of 62 questions regarding stressful life events (The Adolescent Life Events scale). In this study participants were predominantly minorities including Hispanics and African-Americans. Of the 131 youth, 39% had attempted suicide and more than a half of those had attempted more than once. In addition to the participants who had attempted suicide, 33% reported serious ideations. When asked if they had thought about suicide in the last week, 57% stated that they had. Attempters were found to be 2.5 times more likely to have friends or family who had attempted suicide, to live somewhere other than their homes, and to have dropped out of school. There was a significantly lower number of gay-related stressors in nonattempters than in attempters. There

was no significant differences in age, ethnicity, grade level, grade point average, or highest grade that they wanted to complete.

Another study used only gay men as participants from gay and lesbian organizations and rap groups from a gay and lesbian community center (Schneider, Farberow, & Kruks, 1989). The participants ranged in age from 16 to 24. They had 108 participants between both groups. Each subject was given a questionnaire regarding suicidal thoughts and feelings, attempts, age of attempts, demographic questions, family and home background, sexual orientation, and what age they "came out". There were a significant number of gay men who reported no religious affiliation and were suicidal as opposed to the nonsuicidal men. This study found that the minorities were significantly more suicidal than the other participants but never stated what the minorities were or how many of the participants were minorities. There was also a significant difference in never having had a partner. More of the people who hadn't had a partner were suicidal than were the nonsuicidal participants without a partner. The only significance for family background that was found was that more of the suicidal participant's father had been an alcoholic than the nonsuicidal participant's fathers had been. The suicidal and nonsuicidal gay men had no significant differences in age, education, or employment. The study compared participants who were recently suicidal to the nonsuicidal group and found that the suicidal group felt that being rejected by social supports were more important than did the nonsuicidal group. They also found that the suicidal group had depended more on the social supports that had rejected them than the nonsuicidal groups. This study found that attempters were younger than the nonattempters when they were aware of their attraction for same-sex gender, labeled their feelings earlier, and were involved in a homosexual relationship earlier than nonattempters (these differences were significant).

Affectional Orientation, Sex Roles, and Coping Skills

A study conducted in 1994 concluded that male homosexuals and bisexuals rated more feminine than heterosexuals on the California Psychological Inventory Fy scale at a significant level, $p>0.0001$ (Snyder, Weinrich, & Pillard). This study included all male participants. Using the Bem Sex Role Inventory they found that homosexual and bisexual groups scored both less masculine and more feminine than the heterosexual groups used in the study. There was no difference between male homosexuals or male bisexuals on either of those scales. Only men were looked at in this study, however, and the men were not compared to heterosexual, homosexual, and bisexual women. The male homosexuals and heterosexuals in the study rated high on adjustment scales; however, bisexuals (over 40%) responded that they were not well adjusted. They responded that they had more depression than the other two groups. There was a significant difference between heterosexuals and homosexuals compared to bisexuals on scales such as ego strength, depression, and self-esteem. The bisexuals had lower self-esteem, lower ego strength, and more depression.

Androgyny and Adjustment

Street and Kromrey (1995) conducted a study using 329 undergraduate and graduate students at a university. Of these participants, 232 were women and 97 were men. Suicide was assessed by one question in a series of questions that were a part of a psychological test. This question assessed suicidal ideations and attempts. Ideations and attempts were also assessed by the Adult Suicidal Ideation Questionnaires. All participants were asked to fill out these items as well as the Bem Sex Role Inventory (BSRI). This study found that 15% of the participants

responded that they were at high risk (had ideations), and 4% of the participants had attempted suicide. The groups least at risk for suicide were androgynous men and women with masculine men being next and feminine women after that. The group most at risk was cross-sex types (feminine men and masculine women).

Flaherty and Dusek (1980) conducted a study using 357 introductory psychology students. Men made up 162 participants, while there were 195 female students. Each student was given the BSRI and a self-concept measure. The self-concept has four factors including adjustment, which measures whether you feel helpless or balanced in your environment, achievement/leadership, which measures people's perceptions of their leadership abilities, congeniality/sociability, which measures how much a person likes social contact, and masculinity/femininity, which measures sex roles. This study found that androgynous people scored significantly higher on all 4 subscales of the self-concept scale than the undifferentiated people. Undifferentiated and feminine groups scored lower on achievement/leadership than androgynous and masculine. Masculine and undifferentiated groups scored lower on congeniality/sociability than androgynous and feminine groups.

Another study was done in 1985 using 60 volunteers in an urban city. The volunteers ranged in age from 20-57 (Prager & Bailey). Each participant was asked to fill out the BSRI, the Inventory of Psychosocial Development, and the Washington University Sentence Completion Test. The Inventory of Psychosocial Development measures components of Erikson's stages on whether you have completed that stage or not. The Washington University Sentence Completion was designed to measure ego development. This study found that people who are androgynous have a higher level of psychological development, meaning that they are better psychologically adjusted. The androgynous participants in the study were found to be in the higher stages, using

Loevinger's hierarchical model of ego development. The androgynous people also had the highest score of pychosocial development. For ego development and psychosocial development, masculine subjects were higher than feminine but not as high as androgynous people.

Masculinity and Adjustment

Although Bem's theory suggested that better adjustment would be found in people who identified as androgynous, some studies show that masculinity seems to be the factor that is found in people with better adjustment. Jones, Chernovetz, and Hanson conducted a study in 1978, using 1,404 introductory psychology students as participants. Each subject took the Bem Sex Role Inventory (BSRI) and questionnaires that rated adjustment, neurosis, locus of control, introversion and extroversion, alcoholism, and self-esteem. They were also given a scale that determined learned helplessness. For this study they found that androgynous men were less adapted than masculine men. Feminine men were found to be less adaptive than androgynous men. Feminine men were also found to have lower self-esteem and more problems with alcohol than masculine and androgynous men. For women it was found that masculine women were more adjusted than androgynous and feminine women. It was found that feminine men, androgynous men, feminine women, and androgynous women would have preferred to be more masculine.

Lee and Scheurer (1983) conducted a study at Washington State University. This study used 236 introductory psychology students. All of the students were asked to fill out the BSRI as well as the Intellectual Achievement Responsibility Scale, which rates locus of control for positive and negative outcomes and the Self-Monitoring Scale, which measures social factors. They also filled out The Internal-External Locus of Control Scale which shows whether the

person thinks that the world is controlled internally or by external factors and the Expectations for Achievement and Affiliation which shows how they perceive their success with peers and academically. The study found that the most adaptive traits were rated higher in participants that identified themselves as masculine compared to the participants that identified themselves as androgynous or feminine.

### Sex Roles and Reasons for Living

Only one study was found which researched the BSRI and Reasons for Living (Ellis & Range, 1988). Participants included 100 undergraduate students (61 female, 39 male) at a university in the south. Their ages ranged from 17 to 44. Each participant was asked to fill out the BSRI and the Reasons for Living Inventory. In this study androgynous subjects scored significantly higher than nonandrogynous subjects on the Total RFL score. They were also significantly higher on the Survival and Coping Beliefs, Responsibility to Family, Child Concerns, and Moral Objections subscales. There was no difference found on two subscales: Fear of Social Disapproval and Fear of Suicide. Comparing feminine and masculine participants, it was found that the femininity score was significant for Responsibility to Family, Survival and Coping Beliefs, Moral Objections, and Child Concerns as well as for the Total RFL score. Therefore, this study suggests that androgynous and feminine participants are more likely to have reasons for not attempting suicide.

## Statement of the Problem

The purpose of this study was to research gender, affectional/sexual orientation, and sex roles to determine how each combination of types of people respond to the Reasons for Living

Scale. For the purpose of this study Male and Female is a category of gender and is dependent upon one's biological sex. Affectional/Sexual orientation, for this study, will encompass heterosexuals, homosexuals, and bisexuals. The label Affectional orientation will be used throughout the study. This allows the writer and readers to assume that the different orientations include not only sexual relationships with their partner, but also includes affection, love, and other attributes of the relationships as well. Heterosexuals are defined as men or women who prefer the opposite biological sex (male or female) when engaging in a romantic or sexual relationship. Homosexuals can be either lesbians (women) or gay male (men). A lesbian is defined as a female who prefers to engage in romantic or sexual relationships with women. A gay male prefers to engage in romantic or sexual relationships with men. Bisexuals are defined as women or men who do not have a preference in gender when engaging in a romantic or sexual relationship. They have relationships with either same sex partners or opposite sex partners. Sex roles include masculinity, femininity, androgyny, and undifferentiated. These different sex roles will be rated using the Bem Sex Role Inventory (BSRI) (Bem, 1974). People who identify as masculine have characteristics like the "typical male" and those who identify as feminine have characteristics like the "typical female" (Bem, 1984 pp. 189). People who identify as androgynous have "high levels of both masculine and feminine characteristics" (Downing, 1979, pp. 386). Those who identify as undifferentiated "represent individuals for whom the dimensions of masculinity and femininity are not highly salient" pp.386. One can be defined as sex-typed (men score high on the masculinity scale and low on the femininity and vice-versa for women) or cross-sex-typed (men score low on the masculinity scales and high on the femininity scales or vice-versa for women).

"Suicide is the leading cause of death among gay male, lesbian, bisexual, and transgendered youth" (Gibson, 2000, pp. 3-110). "Studies continue to show significantly higher rates of depression, substance abuse, and attempted suicide among lesbians and gay men than among heterosexuals in the United States" (Erwin, 1994, pp. 211). We have studies that show a percentage of the GLBT (gay, lesbian, bisexual, transgender) community and statistics for suicide, but those are only for the people that are "out" in our society. Many people aren't "out" and others deaths are not reported as suicide due to the shame associated with 1) committing suicide and 2) being homosexual or bisexual. Therefore, an accurate estimate of how many suicides are completed by people in the GLBT community is unknown. An accurate estimate of suicide overall is unknown.

According to McIntosh (2000) the following reasons were mentioned for youth ages 15-24 to commit suicide: interpersonal relations with peers, parents, or boyfriends/girlfriends, school, pressure to succeed, lack of effective methods for coping with stress, lack of experience with coping mechanisms, physical changes due to puberty, and feelings of loneliness and isolation. Young adults go through many changes during puberty and many stresses related to interpersonal relationships; however, for homosexual or bisexual youth, these stresses are multiplied. Gay/Lesbian/Bisexual young adults belong to two high-risk groups of suicide including youth and homosexuals/bisexuals (Gibson, 2000).

"Self-destructive behavior among many gays and lesbians in the United States is due to social isolation and the internalization of negative stereotypes (Erwin, 1994, pp. 211). There are many risk factors in gay/lesbian/bisexual youth suicide attempts, ideations, and suicides. Society is the greatest risk factor in homosexual/bisexual suicides (Gibson, 2000). A large amount of society has negative attitudes and often hostile responses toward homosexuals/bisexuals. There

is discrimination and oppression taking place daily in homosexuals/bisexuals' lives. "Homophobia, the irrational fear and hatred of homosexuals is the root of the problem" (pp.3-126)". Poor self-esteem is another reason for suicide in young adults who identify themselves as homosexual or bisexual. These young adults have sometimes been given the message that they are worthless and sick. They have low self-image which makes them lack self-confidence in coping with problems. Suicidal feelings are common if they come out and have negative responses at that time. Some youth attempt suicide when they try to "change" their orientation and recognize that they can't change. Family problems are more prevalent in homosexuals' families. They are subject to more verbal and physical abuse from their family members. Often the more open they are about their orientation the more abusive family members become. They may consider suicide because they feel that they have failed to meet their family's expectations. They don't feel loved by family but feel that they have disappointed them. Religion is another factor contributing to suicide among young adults who are homosexual/bisexual. It is considered a sin in many churches and is considered morally wrong or evil. This can become a serious internal conflict for youth who have strong backgrounds in religion. When they face the choice between public humiliation and/or personal shame versus taking their own life, they may choose to commit the second immoral act, taking their own life (Erwin, 1994). Social Isolation can be a major conflict for youth who are not involved in organizations with other young adults who are homosexual (Gibson, 2000). For many young adults there are no organizations and nobody to trust to tell them about their feelings regarding their affectional orientation. They have no one to turn to when they need to talk. All of these factors, as well as the factors that are common in youth, can play a part in young adults who are homosexual/bisexual and consider suicide. It is

shown in the empirical studies that homosexuals and bisexuals are far more at risk for suicide than heterosexuals.

Androgyny seems to be a factor in people who are least at risk for suicide. Bem suggested that androgynous people would be more adjusted psychologically than sex-typed individuals (people who are masculine or feminine). The empirical studies show that sometimes it has been found that Bem is correct and other studies have found that the people with more masculine traits are more adjusted. The studies do, however, show that when dealing with the question of suicide, it is the androgynous person that is more likely to not attempt suicide or have more reasons for living than the sex-typed individual. It has also been found that cross-sex-typed individuals (masculine women and feminine men) are sometimes a high risk for suicide. Again this is likely due to society's negative views toward these people.

There has not been a great amount of research conducted regarding affective orientation and reasons for living or affectional orientation and suicide. The studies that have been done do not include sex roles as a factor. This is an area that needs more research due to the high rates of suicide in the homosexual/bisexual community. If reasons for living in these populations can be found through research then suicide prevention might be possible. This research needs to encompass a comparison study of heterosexuals and other affective orientations in order to see how different the reasons for living are among the different populations and if sex roles are a factor in this.

These research projects and findings would be helpful to many different people and professions. Those most benefiting from these studies would be people working with crisis management and suicide prevention. This includes professionals such as counselors, psychologists, and social workers working in community health fields and private practices.

University faculty need to know suicide statistics and demographics from suicide studies in order to teach students suicide prevention and who is most at risk. Anyone who deals with youth in the community should be made aware of the demographics of suicide studies and how to assess suicide among the youth. They should also be taught certain stress factors which contribute to suicide attempts. Certain reasons for living should be ascertained in people who are at risk for suicide during assessments of them. The detrimental factor of suicide is death and every attempt should be made to avoid this.

The following hypothesis are made based on the literature review:

Hypothesis 1: Heterosexuals will have a higher total RFL than will homosexuals and bisexuals.

Hypothesis 2: Heterosexuals will have a higher RFL on the Responsibility to Family subscale than will homosexuals and bisexuals.

Hypothesis 3: Heterosexuals will have a higher RFL on the Child-Related Concerns subscale than will homosexuals and bisexuals.

Hypothesis 4: Heterosexuals will have a higher RFL on the Fear of Social Disapproval subscale than will homosexuals and bisexuals.

Hypothesis 5: Heterosexuals will have a higher RFL on the Moral Objections subscale than will homosexuals and bisexuals.

Hypothesis 6: Androgynous people will have a higher total RFL than will nonandrogynous people.

Hypothesis 7: Androgynous people will have a higher RFL on the Survival and Coping Beliefs subscale than will nonandrogynous people.

Hypothesis 8: Androgynous people will have a higher RFL on the Responsibility to Family subscale than will nonandrogynous people.

Hypothesis 9: Androgynous people will have a higher RFL on the Child Concerns subscale than will nonandrogynous people.

Hypothesis 10: Androgynous people will have a higher RFL on the Moral Objections subscale than will nonandrogynous people.

Hypothesis 11: Women will have a higher RFL on the Child Concerns subscale than men.

Hypothesis 12: Women will have a higher RFL on the Responsibility to Family subscale than will men.

Hypothesis 13: Women will have a higher RFL on the Survival and Coping Beliefs subscale than will men.

Hypothesis 14: Androgynous, heterosexual, women will have the highest Total RFL than will all others.

Hypothesis 15: Nonandrogynous, bisexual, men will have the lowest Total RFL than will all others.

Hypothesis 16: Androgynous women will score higher on the Total RFL than will nonandrogynous women.

Hypothesis 17: Androgynous women will score higher on the Survival and Coping Beliefs subscale than will nonandrogynous women.

Hypothesis 18: Androgynous women will score higher on Responsibility to Family subscale than will nonandrogynous women.

Hypothesis 19: Androgynous women will score higher on Child Concerns subscale than will nonandrogynous women.

Hypothesis 20: Heterosexual women will score higher on the Total RFL than will homosexual or bisexual women.

Hypothesis 21: Heterosexual men will score higher on the Total RFL than will homosexual or bisexual men.

Hypothesis 22: Heterosexual, Androgynous people will score higher on the Total RFL than will homosexual or bisexual androgynous people.

# CHAPTER 2

# METHODS

## Participants

There were 241 participants in this study. The participants volunteered to complete a packet of questions. The participants included many groups as well as other volunteers. The groups included undergraduate psychology students, graduate criminal justice students, and the chapter of Lambda at East Tennessee State University. Other groups included the PFLAG (Parents and Families of Lesbians and Gays) in Johnson City and Cookeville, Tennessee. A Gay, Lesbian, Bisexual student group and introductory classes in education at Auburn University participated in the study. Other groups came from Minneapolis, Minnesota, St. Louis, Missouri, Knoxville, Tennessee (including the Lambda chapter at University of Tennessee), Atlanta, Georgia, and Little Rock, Arkansas. There were various other unknown locations from which the questionnaires were sent anonymously. Heterosexual participants were from Sevierville, TN, Knoxville, TN, Johnson City, TN, and Auburn, AL. All other locations did not have heterosexual participants in this study. Almost all of the participants who identified themselves as Gay, Lesbian, and Bisexual were involved in a support group.

## Measures

This study included a cover sheet, a demographic sheet, the Expanded Reasons for Living Inventory, and the Bem Sex Role Inventory, short form. The cover page states "DO NOT PUT YOUR NAME ON ANY OF THESE PAGES and YOUR ANSWERS ARE COMPLETELY ANONYMOUS." The demographic sheet includes questions pertaining to sexual orientation,

age, gender, relationship status, employment status, race, religion, and if the participant has children (See Appendix A).

The Reasons for Living Inventory (RFL scale) was used to measure reasons for living. Linehan, Goodstein, Nielson, and Chiles derived this scale (1983) using Frankl's theory for reasons for living (Linehan et al., 1983). Frankl theorized about why Holocaust survivors did not commit suicide during the Holocaust despite the immensely painful conditions of that experience. This theory took into consideration survivors and their stories of why they did not commit suicide. It appeared that these people had some reason, whether it be that they did not believe in taking their own life, or they thought that the future had to be better, but something allowed them to find strength within themselves to go on. Therefore, the cognitive theory is that beliefs and what people expect in the future are found in people who are not suicidal whereas suicidal people do not have this. Based on Frankl's theory, Linehan, et. al proposed the Reasons for Living Inventory.

The Expanded Reasons for Living Inventory is a 72-item factor analytically derived measure. This inventory measures reasons for not committing suicide should someone consider suicide and beliefs and expectancies about not committing suicide. It has six distinct clusters in which questions about reasons for living are asked. The authors who devised the Reasons for Living Inventory reviewed people's reasons for living or not committing suicide. They researched whether or not people who were not suicidal and people who were suicidal would have certain differences in their belief systems, adaptive beliefs, and expectancies. The authors felt that people who were not suicidal would have these characteristics and those who were suicidal, would not. The six clusters in the Reason for Living Scale include Survival and Coping Beliefs, Responsibility to Family, Child Related Concerns, Fear of Suicide, Fear of Social

Disapproval, and Moral Objections. There was a seventh scale, Responsibility to Friends, that was omitted by Linehan after four factor analyses were done; however, it seems to tap into a separate factor that may be a reason for living, and, therefore, is kept in the Expanded Inventory. An example of Survival and Coping Beliefs would be "I believe I can find other solutions to my problems." (Linehan, et. al, 1983, p. 278). Responsibility to Family measures how much a person takes into consideration their family members when thinking about suicide. Child Related Concerns ask questions regarding how their children would feel if they committed suicide. Fear of Suicide can be taken literally as the fear of committing suicide. Fear of Social Disapproval measures the fear of what others would think about the person if they commit suicide. Moral Objections are how they feel morally about suicide and what happens if someone commits suicide.

The Survival and Coping subscale has 24 items and the Responsibility to Family subscale has 7 items. Child-related Concerns has 3 items and Fear of Suicide has 7 items. Fear of Social Disapproval has 3 items, and Moral Objections has 4 items. The participants respond to each item on the scale with a score ranging from (1) "not at all important" to (6) "extremely important" as a reason not to commit suicide. These numbers represent how important the item is for living if the person were to think about committing suicide. Scoring for each subscale is done by adding each item score for each subscale. The total RFL score is the total score for all subscales.

The first six subscales were reported to have a moderately high internal consistency from .72 to .89 when Linehan, et. al used a Cronback Alpha statistic in 1983. Osman, Jones, and Osman, in 1991, also found a high internal consistency based on the alpha coefficients and item-total correlations for the six subscales and the total inventory. For the total inventory the alpha

coefficient was .70 and for the six subscales the alpha coefficient ranged from .79 to .91. There was a range of .75 to .95 for the subscales for the test-retest reliability coefficient. Osman and others in 1999 found an alpha coefficient for the total inventory of .93. For the six subscales the alpha coefficient ranged from .77 to .95. Range and Knott in 1997 included the Reasons for Living Inventory in the three most recommended suicide assessment inventories (out of 20 inventories). They suggested that the positive way in which the statements were worded might have an effect (positively) on the people completing the inventory.

The Bem Sex Role Inventory, short form (Bem, 1981) was used to assess androgynous and nonandrogynous people. The short form has 30 items which is half of the items that were used on the original form. The 30 items on the short form correlate from .85-.94 with the scales that correspond to them on the original form. The 30 items are made up of 10 masculine adjectives, 10 feminine adjectives, and 10 neutral adjectives. The scale assesses masculinity, femininity, androgyny, and undifferentiated. For the purposes of this study, masculinity, femininity, and undifferentiated will be categorized as nonandrogynous. This scale is based on the theory that masculinity and femininity are not on a continuous bipolar continuum but rather they are separate scales (Bem, 1981). One can be high on both scales (androgynous) or low on both scales (undifferentiated). Each word is rated on a Likert scale ranging from 1 (never or almost never true) to 7 (almost or almost always true). Scoring is done by adding the masculine items and taking the mean of this score then doing the same with the feminine subscale. Items on the feminine subscale includes words such as “gentle”, “sympathetic”, and “affectionate”. Items on the masculine subscale includes words such as “assertive”, “willing to take a stand”, and “defends own beliefs”. These subscales are based on the traditional masculine and feminine attributes by cultural definitions. Bem found a coefficient alpha of .84 for women on the

feminine score and .87 for men in two different analyses. For women on the masculine scale the coefficient alpha was .84 in the first analyses and .86 for the second. For men on the masculine scale the coefficient alpha was .85 on both analyses. Test-retest reliability ranged from .76 to .91 on all of the subscales.

## Procedure

Each participant was given a packet consisting of the Demographic Sheet, the Reasons for Living Inventory, and the Bem Sex Role Inventory. The group was then told that the study regarded how people felt about important issues in life and asked to be as honest as possible when filling out the packet. They were told that their responses were confidential. The person administering the packet asked them not to discuss the survey or talk amongst themselves while they were answering the questions if they answered their packet in a group. They were then told that if they have questions they could ask the person administering the surveys. Once they completed the packet they would return it face down to the person who administered the surveys or mail it back if it had been mailed to them. The surveys were given to undergraduate classes as well as groups in the community (support groups for gays, lesbians, and bisexuals).

## Design

A 2 (male and female) X 2 (androgynous and nonandrogynous) X 3 (bisexual, homosexual, and heterosexual) between subjects ANOVA with unequal cell sizes was used for the data. Masculine, feminine, and undifferentiated people were grouped into a nonandrogynous category due to the small number of participants who volunteered for the study. It was run seven times across each dependent variable (the subtests and the total RFL). An alpha level of $p \leq .05$

was used to test for significance. There were 3 main effects (gender, sex role, and affective orientation). This provided four interaction effects for the study. A Tukey and Kramer was used for post-hoc testing following significant F-ratios, in order to examine the differences within means (Jaccard, Becker, & Wood, 1984). This post-hoc test was chosen because of unequal cell sizes.

# CHAPTER 3

# RESULTS

A 2 (male and female) X 2 (androgynous and nonandrogonous) X 3 (bisexual, homosexual, and heterosexual) design with unequal cell sizes was used to test for main effects and interaction effects for each of the hypotheses. Descriptive statistics were also run for each independent variable. Hypothesis one, which predicted that heterosexuals would have a higher total RFL than would homosexuals or bisexuals, was confirmed, $\underline{F}$ (2, 227) = 8.60, $\underline{p} < .0001$ (See Table 1). For total RFL mean scores by affectional orientation see Table 9. Homosexuals also had a significantly higher total RFL than bisexuals.

Hypothesis two, which stated that heterosexuals would have a higher RFL on the responsibility to Family subscale than homosexuals and bisexuals, was confirmed, $\underline{F}$ (2, 218) = 4.61, $\underline{p} < .05$ (See Table 2). See Table 9 for RFL mean scores by affectional orientation. Homosexuals also had a significantly higher score than bisexuals.

Hypothesis three, which predicted that heterosexuals would have a higher RFL on the Child-Related Concerns subscale than would homosexuals and bisexuals was confirmed, $\underline{F}$ (2, 218) = 10.74, $\underline{p} < .0001$ (See Table 3). See Table 9 for RFL mean scores by affectional orientation. The study found that 33% of bisexuals and 31% of heterosexuals had children, whereas only 15% of gay men and lesbians had children.

Hypothesis four, which stated that heterosexuals would have a higher RFL on the Fear of Social Disapproval subscale than would homosexuals and bisexuals was partially confirmed, $\underline{F}$ (2, 227) = 3.05, $\underline{p} < .05$ (See Table 4). See Table 9 for RFL mean scores by affectional

orientation. Heterosexuals and homosexuals were significantly higher on the subscale than bisexuals, but there was no significant difference between homosexuals and heterosexuals.

Hypothesis five, which predicted that heterosexuals would have a higher RFL on the Moral Objections subscale than homosexuals and bisexuals was confirmed, $F$ (2, 227) = 8.36, $p$ < .0001 (See Table 5). See Table 9 for RFL mean scores by affectional orientation. Homosexuals had a significantly higher RFL on the Moral Objections subscale than bisexuals.

Hypothesis six, which predicted that androgynous people would have a higher total RFL than nonandrogynous people, was not confirmed (See Table 1). See Table 10 for RFL mean scores by sex roles.

Hypothesis seven, which stated that androgynous people would have a higher RFL on the Survival and Coping Beliefs subscale than nonandrogynous people was not confirmed (See Table 6). See Table 10 for RFL mean scores by sex role.

Hypothesis eight, which stated that androgynous people would have a higher RFL on the Responsibility to Family subscale, was not confirmed (See Table 2). See Table 10 for RFL mean scores by sex role.

Hypothesis nine, which predicted that androgynous people would have a higher RFL on the Child Concerns subscale, was not confirmed (see Table 3). See Table 10 for RFL mean scores by sex role.

Hypothesis 10, which predicted that androgynous people would have a higher RFL on the Moral Objections subscale than nonandrogynous people, was confirmed, $F$ (1, 227) = 8.99, $p$ < .05 (See Table 5). See Table 10 for RFL mean scores by sex role.

Hypothesis 11, which stated that women would have a higher RFL on the Child Concerns subscale than men, was not confirmed (See Table 3). See Table 11 for RFL mean scores by gender.

Hypothesis 12, which predicted that women would have a higher RFL on the Responsibility to Family subscale than men, was not confirmed (See Table 2). See Table 11 for RFL mean scores by gender.

Hypothesis 13, which predicted that women would have a higher RFL on the Survival and Coping Beliefs subscale than men, was not confirmed (See Table 6). See Table 11 for mean scores by gender.

Hypothesis 14, which stated that androgynous heterosexual women would have the highest total RFL than all other groups, was not confirmed (See Table 1). See Table 9, 10, and 11 for RFL mean scores.

Hypothesis 15, which stated that nonandrogynous bisexual men would have the lowest total RFL than all the other groups, was not confirmed (See Table 1). See Table 9, 10, and 11 for RFL mean scores.

Hypothesis 16, which predicted that androgynous women would score higher on the total RFL than would nonandrogynous women, was not confirmed (See Table 1). See Table 10 and 11 for mean scores.

Hypothesis 17, which stated that androgynous women would score higher on the Survival and Coping Beliefs subscale than nonandrogynous women, was confirmed, $\underline{F}$ (1, 218) = 6.09, $\underline{p} < .05$ (See Table 6). The mean score for androgynous women was 4.91 with a standard deviation of .62. The mean score for nonandrogynous women was 4.49 with a standard deviation of .89.

Hypothesis 18, which predicted that androgynous women would score higher on the Responsibility to Family subscale than nonandrogynous women, was not confirmed (See Table 2). See Table 10 and 11 for mean scores.

Hypothesis 19, which stated that androgynous women would score higher on the Child Concerns subscale than nonandrogynous women, was not confirmed (See Table 3). See Table 10 and 11 for mean scores.

Hypothesis 20, which stated that heterosexual women would score higher on the total RFL than homosexual or bisexual women, was not confirmed (See Table 1). See Table 9 and 11 for mean scores.

Hypothesis 21, which predicted that heterosexual men would score higher than heterosexual women on the total RFL than homosexual or bisexual men, was not confirmed (See Table 1). See Table 9 and 11 for mean scores.

Hypothesis 22, which predicted that heterosexual, androgynous people would score higher on the total RFL than homosexual or bisexual androgynous people, was not confirmed (See Table 1). See Table 9 and 10 for mean scores.

TABLE 1

UNIVARIATE ANALYSIS OF VARIANCE FOR TOTAL RFL AS A FUNCTION OF GENDER, SEX ROLE, AND AFFECTIONAL ORIENTATION

| | SS | df | MS | F |
|---|---|---|---|---|
| GENDER (G) | 0.4 | 1 | 0.4 | 2.35 |
| SEX ROLE (SR) | 0.44 | 1 | 0.44 | 2.55 |
| AFFECTIONAL ORIENTATION (AF) | 2.94 | 2 | 1.47 | 8.6** |
| G X SR | 0.43 | 1 | 0.43 | 2.5 |
| G X AF | 0.34 | 2 | 0.17 | 0.99 |
| SR X AF | 0.39 | 2 | 0.2 | 1.14 |
| G X SR X AF | 0.65 | 2 | 0.33 | 1.91 |
| Error | 38.87 | 227 | 0.17 | |
| Total | 49.05 | 238 | 0.21 | |

**$p < .01$

TABLE 2

UNIVARIATE ANALYSIS OF VARIANCE FOR RESPONSIBILITY TO FAMILY AS A FUNCTION OF GENDER, SEX ROLE, AND AFFECTIONAL ORIENTATION

| | SS | df | MS | F |
|---|---|---|---|---|
| GENDER (G) | 0.15 | 1 | 0.15 | 0.15 |
| SEX ROLE (SR) | 3.43 | 1 | 3.43 | 3.31 |
| AFFECTIONAL ORIENTATION (AF) | 9.54 | 2 | 4.77 | 4.61* |
| G X SR | 0.07 | 1 | 0.07 | 0.07 |
| G X AF | 0.37 | 2 | 0.19 | 0.18 |
| SR X AF | 0.56 | 2 | 0.28 | 0.27 |
| G X SR X AF | 3.23 | 2 | 1.62 | 1.56 |
| Error | 225.8 | 218 | 1.04 | |
| Total | 263.42 | 229 | 1.15 | |

*$p < .05$

TABLE 3

UNIVARIATE ANALYSIS OF VARIANCE FOR CHILD RELATED CONCERNS AS A FUNCTION OF GENDER, SEX ROLE, AND AFFECTIONAL ORIENTATION

| | SS | df | MS | F |
|---|---|---|---|---|
| GENDER (G) | 5.5 | 1 | 5.5 | 2.57 |
| SEX ROLE (SR) | 1.74 | 1 | 1.74 | 0.81 |
| AFFECTIONAL ORIENTATION (AF) | 45.94 | 2 | 22.97 | 10.74** |
| G X SR | 0.57 | 1 | 0.57 | 0.27 |
| G X AF | 23.13 | 2 | 11.57 | 5.41* |
| SR X AF | 0.72 | 2 | 0.36 | 0.17 |
| G X SR X AF | 2.49 | 2 | 1.25 | 0.58 |
| Error | 466.38 | 218 | 2.14 | |
| Total | 562.71 | 229 | 2.46 | |

*p < .05
**p < .01

TABLE 4

UNIVARIATE ANALYSIS OF VARIANCE FOR FEAR OF SOCIAL DISAPPROVAL AS A FUNCTION OF GENDER, SEX ROLE, AND AFFECTIONAL ORIENTATION

| | SS | df | MS | F |
|---|---|---|---|---|
| GENDER (G) | 0.4 | 1 | 0.4 | 0.19 |
| SEX ROLE (SR) | 0.05 | 1 | 0.05 | 0.02 |
| AFFECTIONAL ORIENTATION (AF) | 12.72 | 2 | 6.36 | 3.05* |
| G X SR | 0.88 | 1 | 0.88 | 0.42 |
| G X AF | 0.77 | 2 | 0.38 | 0.18 |
| SR X AF | 4.54 | 2 | 2.27 | 1.09 |
| G X SR X AF | 3 | 2 | 1.5 | 0.72 |
| Error | 472.95 | 227 | 2.08 | |
| Total | 509.46 | 238 | 2.14 | |

*$p < .05$

TABLE 5

UNIVARIATE ANALYSIS OF VARIANCE FOR MORAL OBJECTIONS AS A FUNCTION OF GENDER, SEX ROLE, AND AFFECTIONAL ORIENTATION

| | SS | df | MS | F |
|---|---|---|---|---|
| GENDER (G) | 6.64 | 1 | 6.64 | 2.96 |
| SEX ROLE (SR) | 20.14 | 1 | 20.14 | 8.99* |
| AFFECTIONAL ORIENTATION (AF) | 37.44 | 2 | 18.72 | 8.36** |
| G X SR | 5.99 | 1 | 5.99 | 2.67 |
| G X AF | 3.92 | 2 | 1.96 | 0.87 |
| SR X AF | 8.36 | 2 | 4.18 | 1.87 |
| G X SR X AF | 5.01 | 2 | 2.51 | 1.12 |
| Error | 508.48 | 227 | 2.24 | |
| Total | 650.11 | 238 | 2.73 | |

*$p < .05$
**$p < .01$

TABLE 6

UNIVARIATE ANALYSIS OF VARIANCE FOR SURVIVAL AND COPING AS A FUNCTION OF GENDER, SEX ROLE, AND AFFECTIONAL ORIENTATION

| | SS | df | MS | F |
|---|---|---|---|---|
| GENDER (G) | 2.21 | 1 | 2.21 | 3.55 |
| SEX ROLE (SR) | 0.19 | 1 | 0.19 | 0.3 |
| AFFECTIONAL ORIENTATION (AF) | 11.62 | 2 | 5.81 | 9.34** |
| G X SR | 3.79 | 1 | 3.79 | 6.09* |
| G X AF | 3.18 | 2 | 1.59 | 2.55 |
| SR X AF | 2.76 | 2 | 1.38 | 2.22 |
| G X SR X AF | 4.56 | 2 | 2.27 | 3.65* |
| Error | 135.64 | 218 | 0.62 | |
| Total | 166.61 | 229 | 0.73 | |

*p < .05
**p < .01

TABLE 7

UNIVARIATE ANALYSIS OF VARIANCE FOR FEAR OF SUICIDE AS A FUNCTION OF GENDER, SEX ROLE, AND AFFECTIONAL ORIENTATION

| | SS | df | MS | F |
|---|---|---|---|---|
| GENDER (G) | 1.33 | 1 | 1.33 | 1.38 |
| SEX ROLE (SR) | 0.04 | 1 | 0.04 | 0.05 |
| AFFECTIONAL ORIENTATION (AF) | 9.48 | 2 | 4.74 | 4.89* |
| G X SR | 0.24 | 1 | 0.24 | 0.25 |
| G X AF | 2.38 | 2 | 1.19 | 1.23 |
| SR X AF | 3.04 | 2 | 1.52 | 1.6 |
| G X SR X AF | 2.67 | 2 | 1.34 | 1.38 |
| Error | 211.38 | 218 | 0.97 | |
| Total | 236.6 | 229 | 1.03 | |

*$p < .05$

TABLE 8

UNIVARIATE ANALYSIS OF VARIANCE FOR RESPONSIBILITY TO FRIENDS AS A FUNCTION OF GENDER, SEX ROLE, AND AFFECTIONAL ORIENTATION

| | SS | df | MS | F |
|---|---|---|---|---|
| GENDER (G) | 0.58 | 1 | 0.584 | 0.89 |
| SEX ROLE (SR) | 0.65 | 1 | 0.65 | 0.98 |
| AFFECTIONAL ORIENTATION (AF) | 3.48 | 2 | 1.74 | 2.64 |
| G X SR | 1.42 | 1 | 1.42 | 2.16 |
| G X AF | 1.71 | 2 | 0.85 | 1.3 |
| SR X AF | 2.9 | 2 | 1.45 | 2.21 |
| G X SR X AF | 1.39 | 2 | 0.7 | 1.06 |
| Error | 149.33 | 227 | 0.66 | |
| Total | 167.53 | 238 | 0.7 | |

TABLE 9

MEAN (SD) RESPONSE FOR TOTAL REASONS FOR LIVING BY AFFECTIONAL ORIENTATION

| | AFFECTIONAL ORIENTATION | | |
|---|---|---|---|
| | Bisexual N = 44 | Homosexual N = 68 | Heterosexual N = 129 |
| Survival and Coping | 4.11 (.97) | 4.39 (.84) | 4.85 (.70) ** |
| Responsibility to Family | 3.82 (1.24) | 4.23 (1.10) | 4.66 (.91) * |
| Child Related Concerns | 3.62 (1.76) | 3.42 (1.54) | 4.53 (1.36) ** |
| Fear of Suicide | 2.59 (.90) | 2.77 (1.12) | 2.35 (.98) * |
| Fear of Social Disapproval | 2.16 (1.22) | 3.00 (1.62) | 2.78 (1.43) * |
| Moral Objections | 2.08 (1.51) | 2.71 (1.35) | 3.80 (1.57) ** |
| Responsibility to Friends | 3.15 (.78) | 3.62 (.83) | 3.75 (,81) |
| Total RFL | 2.35 (.44) | 2.55 (.44) | 2.81 (.40) ** |

*p < .05
**p < .01

TABLE 10

MEAN (SD) RESPONSE FOR TOTAL REASONS FOR LIVING BY SEX ROLES

| | SEX ROLES | |
|---|---|---|
| | Androgynous N = 53 | Nonandrogynous N = 187 |
| Survival and Coping | 4.85 (.70) | 4.51 (.88) |
| Responsibility to Family | 4.68 (.86) | 4.30 (1.12) |
| Child Related Concerns | 4.37 (1.41) | 3.96 (1.60) |
| Fear of Suicide | 2.34 (1.04) | 2.56 (1.01) |
| Fear of Social Disapproval | 2.64 (1.50) | 2.75 (1.47) |
| Moral Objections | 3.67 (1.66) | 3.04 (1.63) |
| Responsibility to Friends | 3.80 (.84) | 3.56 (.83) |
| Total RFL | 2.80 (.37) | 2.61 (.47) |

*p < .05

TABLE 11

MEAN (SD) RESPONSE FOR TOTAL REASONS FOR LIVING BY GENDER

| GENDER | Female N = 151 | Male N = 90 |
|---|---|---|
| Survival and Coping | 4.56 (.85) | 4.62 (.84) |
| Responsibility to Family | 4.38 (1.13) | 4.40 (.99) |
| Child Related Concerns | 4.14 (1.53) | 3.93 (1.63) |
| Fear of Suicide | 2.60 (.98) | 2.36 (1.05) |
| Fear of Social Disapproval | 2.63 (1.38) | 2.89 (1.61) |
| Moral Objections | 3.09 (1.66) | 3.32 (1.63) |
| Responsibility to Friends | 3.56 (.82) | 3.68 (.86) |
| Total RFL | 2.64 (.47) | 2.67 (.44) |

# CHAPTER 4

# DISCUSSION

The purpose of this study was to research gender, affectional orientation, and sex roles to determine how each combination of types of people respond to the Reasons for Living Scale. Although there had been previous studies regarding gender and reasons for living, affectional orientation and reasons for living, and sex roles and reasons for living, there had not been a study that focused on the combination of these variables. The college population had been the most widely researched in these areas, and this study used a more broad population. Although there were no findings regarding gender, this study did confirm almost all the hypotheses regarding affectional orientation. It also confirmed one hypothesis regarding sex roles as well as one two-way interaction between sex role and gender.

The study showed that bisexuals had the lowest total RFL with homosexuals second and heterosexuals the highest, Hypothesis 1. This was found in the previous study regarding affectional orientation and reasons for living by Hirsch and Ellis (1998). The new finding shown by the current study regards bisexuals as they were not included in the study conducted by Hirsch and Ellis. Some factors that may cause bisexuals to have fewer reasons for living overall than homosexuals and heterosexuals are stressors in their lives. Both heterosexuals and homosexuals oftentimes have biases toward bisexuals. This does not allow the bisexuals to "fit into" either the heterosexual or homosexual world, thereby causing more stressors than homosexuals and heterosexuals. Homosexuals have stressors from heterosexuals but generally not from bisexuals. Some of the stressors that both bisexuals and homosexuals have are religious organizations feeling that they are sinning and family problems once they come out to family

members (Gibson, 2000). The dominant society does not accept bisexuality and homosexuality as a "normal" lifestyle and therefore, derogatory remarks and often hate crimes take place against people with alternative affectional orientations. All of this leads to low self-esteem and internalized homophobia in many who are bisexual and homosexual. Homosexuals and bisexuals constantly have to combat society's viewpoints in order to accept themselves for who they are. They are raised, generally, in a heterosexual family with heterosexist views, making it difficult to accept themselves. Bisexuals, especially if they choose to be polyamorous (have relationships with more than one person), also fight against societies views that one should partner with one person only. All of these stressors together would account for bisexuals and homosexuals having fewer reasons for living than heterosexuals.

Hypothesis 2 was confirmed and the study found that heterosexuals again were significantly higher than people whom identify themselves as lesbian, gay, and bisexuals on the Responsibility to Family subscale. This was also found in Hirsch and Ellis' study (1998). The current study also indicates that people who are lesbian and gay have significantly higher reasons for living than bisexuals. Again this can be because families do not accept their sons and daughters, brothers and sisters, or mothers and fathers as being lesbian, gay, or bisexual. In fact, oftentimes, the families "disown" or stop communicating with their children after they "come out". In other cases the person self-identifying as lesbian, gay, or bisexual do not tell their family members and put a distance between them so that they will not have to communicate their sexual orientation or explain their partners. Perhaps bisexuality is looked down upon more than homosexuality which would explain why bisexuals have fewer reasons to live than homosexuals. It may be hard for family members, disagreeing with a homosexual lifestyle, to understand why

the person identifying as bisexual would not just "choose" to have an opposite sex partner rather than going through the societal problems of a same-sex partner.

Hypothesis 3 was confirmed and the study showed that heterosexuals had significantly higher reasons for living than did lesbian, gay, and bisexual people on the Child-Related Concerns, which was also found in Hirsch and Ellis' study. There was no difference on this subscale between people who identified as lesbian, gay, and bisexual. Although some same-sex couples have children in America, most do not. Frequently when people who self identify as gay and lesbian have children it is from a previous heterosexual relationship. One conclusion of why this scale is different could be that the heterosexuals in the study have children more often than the gay, lesbian, and bisexual people. Although the study found that 33% of bisexuals and 31% of heterosexuals had children whereas only 15% of gay men and lesbians had children. Perhaps the participants that rated this as a low reason for living did not have custody of their children or their children were older. Another factor could be whether the children accept their parents' affectional orientation.

The Social Disapproval subscale did not confirm Hypothesis 4, which stated that heterosexuals would have a higher RFL than would homosexuals and bisexuals. Instead, this study found that lesbian, gay, and heterosexual people were significantly higher than bisexuals. This contrasted Hirsch and Ellis' study (1998). In society this would mean that bisexuals would not care what others think of them as much as would homosexuals and heterosexuals. However, because they seem to be lower on most other scales including the total RFL, this could be a defense mechanism in order to deal with the fact that they are not accepted by either homosexuals or heterosexuals, in most cases.

Hypothesis 5 confirmed Hirsch and Ellis' (1998) findings that heterosexuals had significantly higher reasons for living on the Moral Objections subscale than homosexuals and bisexuals. It also showed that gay and lesbian people were significantly higher than bisexuals. That homosexuals and bisexuals are significantly lower is justified by the fact that most religions find homosexuality and bisexuality to be a sin. As discussed previously, there have been some churches that have accepted homosexuality and bisexuality as a biological factor. These churches, although there are few, are welcoming to people who self-identify as gay, lesbian, and bisexual.

Hypothesis 6 stating that androgynous people would have more reasons for living than nonandrogynous people was not confirmed. Hypothesis 7, 8, and 9 were also not confirmed and stated that androgynous people would have more reasons for living on the Survival and Coping Beliefs subscale, the Responsibility to Family subscale, and the Child Concerns subscale, respectively, than nonandrogynous people. This study found only one main affect regarding androgynous and nonandrogynous people showing that on the moral objections subscale androgynous people were higher than nonandrogynous people, confirming hypothesis 10. Street and Kromrey (1995) found that nonandrogynous people were the most likely to have serious suicidal ideations, which would contrast most of these finding, if one assumed that people with serious suicidal ideations would have fewer reasons for living. These findings, other than the confirmation of hypothesis 10, also contrast Bem's theory (1984) in which she suggests that androgynous people will be more psychologically well-adjusted, again assuming that this means that they would have more reasons for living or better coping skills. It also contrasts a study by Ellis and Range (1988) in which they found all of the current study's hypothesis to be true. Perhaps the current study did not have enough participants to see an overall difference between

androgynous or nonandrogynous people in most of the subscales. Ellis and Range found that femininity had a large effect on the RFL scores, and this could have been cause for the hypothesis in the study not to be confirmed. This study did not look at femininity but grouped femininity with masculinity and undifferentiated people making a nonandrogynous group.

There was only one interaction effect hypothesis that included androgyny or nonandrogyny that was confirmed. This was hypothesis 17 which stated that androgynous women would score higher on the Survival and Coping Beliefs subscale than would nonandrogynous women. All other hypotheses including 14, 15, 16, 18, 19, and 22 were not confirmed.

There was also no main effect found regarding gender. Hypothesis 11, 12, and 13 which stated that women would have a higher RFL on the Child Concerns subscale, the Responsibility to Family subscale, and the Survival and Coping Beliefs subscale were, therefore, not confirmed. Ellis and Jones (1996) found that women scored higher on Responsibility to Family contrasting the current study's findings. Another contrast is that Hirsch and Ellis (1996) found that women scored higher than men on the Survival and Coping Beliefs subscale as well as the Child Related Concerns subscale. However, in the study done by Hirsch and Ellis (1998) concerning affectional orientation and reasons for living, no gender difference was found. There were no interaction effects and, therefore, any hypothesis including gender would not be confirmed. These include hypotheses 14, 15, 16, 17, 18, 19, 20, and 21.

The fact that there was only one main effect with sex roles and one interactions effect with sex roles and gender may be due to the population chosen in this study. Perhaps because the study focuses on bisexuals and homosexuals, as well as heterosexuals, sex role and gender are different than in many studies. Although the typical stereotype of gay men being feminine

and lesbians being masculine is not fact, there are some gay men, lesbians, and bisexuals, as well as heterosexuals who are going to be cross-sex-typed (meaning that some men will be feminine and some women will be masculine). In the dominant culture or society it is generally not acceptable to be a man with feminine characteristics and a woman with masculine characteristics; therefore, there would probably be a more distinct separation between sex roles and gender. Perhaps in this study, however, this is not the case. In fact, in order for equality to exist in America between men, women, and minorities, a distinct separation would not be possible. That there may not be a distinct separation between sex roles and gender may show that in this study at least the populations were equal. If in fact this could be the case in all three affectional orientations then society would be that much closer to equality. However, as seen by previous studies, this is not the case when the predominant culture of heterosexuals are the participants in the study, but only when we combine heterosexuals, homosexuals, and bisexuals. This study did not look at femininity and masculinity separately and, therefore, it is not known whether cross-sex-typed people were evident in this study.

## Limitations

This study has several limitations, as most research studies do. The first limitation is the number of participants in the study. To get a better view of what the populations, as a whole would be, this study would need far greater participants to participate, especially bisexuals as they were the lowest number of participants in the study. Another limitation to this study was that there was no account of social support in each of the participant's lifes. Except for whether they were in a relationship or not, no other questions were asked pertaining to what type of support they have in their lives such as friends, family, and other support. Some of these

supports would be negative and some positive in each participants life and it would help to know to what extent of support or nonsupport each participant received.

There are two other limitations involving the participants. First, the majority of the heterosexual participants came from undergraduate college classes, thereby not truly representing the population as a whole. The majority of the people in the study that self identified as gay, lesbian, and bisexual were participants in social groups supporting their affectional orientation. This also does not represent the population as a whole. In fact, it would be hard to represent gay, lesbian, and bisexual people as a whole, because they make up a hidden minority. Often people are not out to themselves, their family, or their friends and will not identify their sexual orientation. It is also hard to find people who identify as gay, lesbian, and bisexual without going to support groups and this makes it difficult to get a sample of the entire population. The people in support groups are also more likely to have better support than the people that aren't in a support group and do not have family or friends who support them. Another factor in this study is that many of the gay men, lesbians, and bisexuals were from locations that no heterosexual participants volunteered. One reason for the results might be that the location is different and, therefore, so is reasons for living among those populations.

## Future Research

The results of this study illustrates that further research regarding the topic is needed. It is apparent from these results that bisexuals are at the most risk for suicide without strong factors for therapists to use to get them to rethink the act. It is also apparent that both gay men and lesbians are at risk without strong reasons for living to help therapists when doing crisis intervention. Because of this, therapists need to keep in mind, when working with a person who

identifies themself as gay, lesbian, and bisexual to assess for suicide. Although they need to assess for heterosexuals, as well, it seems that gay, lesbian, and bisexuals are more at risk. This study showed that not only as past studies have shown, that teenagers are at risk, but that adults are at risk as well.

There are several factors that could have affected the outcome of the study. This study did not eliminate factors of suicide such as alcohol and drug problems. It is not known if the participants had tried to commit suicide or had suicide ideations before. It was not identified how much support that they have from families and friends or partners. This study did not have an ethnic difference among participants. This might have affected the results as well. For future research more participants should be used, with an equal amount of heterosexuals, homosexuals, and bisexuals. The sex roles were not broken down in this study. The only factors looked at were nonandrogynous and androgynous people. For future research, nonandrogynous people should be broken down into masculine, feminine, and undifferentiated to see if cross sex types play a role in reasons for living and other factors in this study. It was not asked in this study whether the participants had custody of their children, how often they saw their children, and how their children felt about their parents' affectional orientation. It should be asked how much they feel that their children rely on them. This may have something to do with whether they feel that their children are a good reason to stay alive. Social support among the participants should be identified such as the most important people in their lives and who they would go to talk to if they felt suicidal.

It is important to continue to research suicide and reasons for living among minority groups. Minority groups are at much more risk for suicide because of the stressors that are in their life due to the society that is ruled by the dominant culture. People who self identify as gay

men, lesbian, and bisexual constantly have to live in a heterosexist society where they are overlooked or worse discriminated against and degraded. It is important to focus on what type of interventions can be done if a gay man, lesbian, or bisexual is suicidal, as well as what can be done in order to stop suicidal ideation from occurring in the first place. This intervention needs to start at the beginning, not in adulthood. Counselors in schools need to be aware of different sexual orientations and accept the children for who they are. Teachers need to stop derogatory remarks toward people who are gay, lesbian, or bisexual. There need to be more role models for children to let them know that it is okay to by gay, lesbian, or bisexual. Society as a whole needs to be less heterosexist and more welcoming of diversity and change. Until these changes are made, research needs to continue that can help intervention strategies occur.

# REFERENCES


Agnew, C. R., Thompson, V. D., Smith, V. A., Gramzow, R. H., & Currey, D. P. (1993). Proximal and distal predictors of homophobia: Framing the multivariate roots of outgroup rejection. Journal of Applied Social Psychology, 23, 2013-2042.

American Association of Suicidology. (1997). U. S. A. suicide: 1997 official final data. [On-line]. Available: http://www.suicidology.org/suicide_statistics97.htm.

American Association of Suicidology. (1998). U. S. A. suicide: 1998 official final data. [On-line]. Available: http://www.suicidology.org/suicide_statistics98.htm.

American Foundation for Suicide Prevention (1996). Suicide facts. [On-line]. Available: http://www.afsp.org.

Bem, S. L. (1974). The measurement of psychological androgyny. Journal of Counsulting and Clinical Psychology, 42, 155-162.

Bem, S. L. (1981). Bem sex role inventory: Professional manual. Palo Alto, CA: Consulting Psychologists press.

Bem, S. L. (1984). Androgyny and gender schema theory: A conceptual and empirical integration. Nebraska Symposium On Motivation 179-226.

Cochran, S. D., & Mays, V. M. (2000). Lifetime prevalence of suicide symptoms and affective disorders among men reporting same-sex sexual partners: Results from NHANES III. American Journal of Public Health, 90, 573-578.

Connell, R. W. (1987). Historical roots of contemporary theory. In Gender and power (pp. 23-41). Cambridge, UK: Polity Press.

Dean, P. J., & Range, L. M. (1996). The escape theory of suicide and perfectionism in college students. Death Studies, 20, 415-424.

Dean, P. J., Range, L. M., & Goggin, W. C. (1996). The escape theory of sucide in college students: Testing a model that includes perfectionism. Suicide and Life-Threatening Behavior, 26, 181-186.

Dean, P. J., & Range, L. M. (1999). Testing the escape theory of suicide in an outpatient clinical population. Cognitive Therapy and Research, 23, 561-572.

Downing, N. E. (1979). Theoretical and operational conceptualizations of psychoological androgyny: Implications for measurement. Psychology of Women Quarterly, 3, 284-292.

Ellis, J. B., & Jones, L. N. (1996). Adaptive behavior in suicide ideators and non-ideators. Social Behavior and Personality, 24, 309-320.

Ellis, J. B., & Range, L. M. (1988). Femininity and reasons for living. Educational and Psychological Research, 8, 19-24.

Erwin, K. (1994). Interpreting the evidence: Competing paradigms and the emergence of lesbian and gay suicide as a "social fact". In L. A. DeSpelder & A. L. Strickland (Eds.), Readings in death and dying: The path ahead (pp. 211-220). Moutain View, CA: Mayfield.

Flaherty, J. F., & Dusek, J. B. (1980). An investigation of the relationship between psychological androgyny and components of self-concept. Journal of Personality and Social Psychology, 38, 984-992.

Garofalo, R., Wolf, R. C., Wissow, L. S., Woods, E. R., & Goodman, E. (1999). Sexual orientation and risk of suicide attempts among a representative sample of youth. Archives of Pediatric Adolescent Medicine, 153, 487-493.

Gibson, P. (2000, August). Gay male and lesbian youth suicide. Paper presented at A search for new understanding of lesbian, gay, bisexual and transgendered issues: A conference for mental health professionals, Johnson City, TN.

Hammelman, T. L. (1993). Gay and lesbian youth: Contributing factors to serious attempts or considerations of suicide. Journal of Gay & Lesbian Psychotherapy, 2, 77-89.

Herrell, R., Goldberg, J., True, W., Ramakrishnan, V., Lyons, M., Eisen, S., & Tsuang, M. T. (1999). Sexual orientation and suicidality: A co-twin control study in adult men. Archives of General Psychiatry, 56, 867-874.

Hershberger, S. L., Pilkington, N. W., & D'Augelli, A. R. (1997). Predictors of suicide attempts among gay, lesbian, and bisexual youth. Journal of Adolescent Research, 12, 477-497.

Hirsch, J. K., & Ellis, J. B. (1996). Differences in life stress and reasons for living among college suicide ideators and non-ideators. College Student Journal, ?, 377-386.

Hirsch, J. K., & Ellis, J. B. (1998). Reasons for living in homosexual and heterosexual young adults. Archives of Suicide Research, 4, 243-248.

Jaccard, J., Becker, M., & Wood, G. (1984). Pairwise multiple comparison procedures: A review. Psychological, 96, 589-596.

Johnson, M. E., Brems, C., & Alford-Keating, P. (1997). Personality correlates of homophobia. Journal of Homosexuality, 34, 57-69.

Jones, W. H., Chernovetz, M. E. O'C., & Hansson, R. O. (1978). The enigma of androgyny: Differential implications for males and females? Journal of Consulting and Clinical Psychology, 46, 298-313.

Kuehl, D., & Bitter, J. (1999, August). The case model of gay/lesbian identity formation. Paper presented at A search for new understanding of lesbian, gay, bisexual and transgendered issues: A conference for mental health professionals, Johnson City, TN.

Lee, A. G., & Scheurer, V. L. (1983). Psychological androgyny and aspects of self-image in women and men. Sex Roles, 9, 289-306.

Linehan, M. M., Goodstein, J. L., Nielson, S. L., & Chiles, J. A. (1983). Reasons for staying alive when you are thinking of killing yourself: The reasons for living inventory. Journal of Consulting and Clinical Psychology, 51, 276-286.

Linehan, M. M., & Shearin, E. N. (1988). Lethal stress: A social-behavioral model of suicidal behavior. In S. Risher & J. Reason (Eds.), Handbook of life stress, cognition & health (pp. 265-285). Britain, Anchor Brendon.

McIntosh, J. L. (2000). Epidemiology of adolescent suicide in the United States. In R. W. Maris, S. S. Canetto, J. L. McIntosh, & M. M. Silverman (Eds.), Review of suicidology, 2000 (pp.3-33). New York: Guilford Press.

Money, J. (1999). New phylism theory and the homosexualization of the visualization of lust. Medical Hypotheses, 53, 221-223.

Osman, A. Jones, K., & Osman, J. (1991). The reasons for living inventory: Psychometric properties. Psychological Reports, 69, 271-278.

Osman, A., Kopper, B. A., Linehan, M. M., Barrios, F. X., Gutierrez, P. M., & Bagge, C. L. (1999). Validation of the adult suicidal ideation questionnaire and the reasons for living inventory in an adult psychiatric inpatient sample. Psychological Assessment, 11, 115-123.

Parents and Families of Lesbians and Gays. (2000). Allies for equal rights. Handout presented at A Search for New Understanding of Lesbian, Gay, Bi, and Transgender Conference, Johnson City, TN.

Prager, K. J., & Bailey, J. M. (1985). Androgyny, ego development, and psychosocial crisis resolution. Sex Roles, 13, 525-536.

Proctor, C. D., & Groze, V. K. (1994). Risk factors for suicide among gay, lesbian, and bisexual youths. Social Work, 39, 504-513.

Range, L. M., & Knott, G. C. (1997). Twenty suicide assessment instruments, evaluation and recommendations. Death Studies, 21, 25-58.

Rotheram-Borus, M. J., Hunter, J., & Rosario, M. (1994). Suicidal behavior and gay-related stress among gay and bisexual male adolescents. Journal of Adolescent Research, 9, 498-508.

Schneider, S. G., Farberow, N. L., & Kruks, G. N. (1989). Suicidal behavior in adolescent and young adult gay men. Suicide and Life-Threatening Behavior, 19(4), 381-394.

Snyder, P. J., Weinrich, J. D., & Pillard, R. C. (1994). Personality and lipid level differences associated with homosexual and bisexual identity in men. Archives of Sexual Behavior, 23, 433-451.

Stillion, J. M. (1994). Premature exits: Understanding suicide. In L. A. DeSpelder & A. L. Strickland (Eds.), Readings in death and dying: The path ahead (pp.182-197). Moutain View, CA: Mayfield.

Street, S., & Kromrey, J. D. (1995). Gender roles and suicidal behavior. Journal of College Student Psychotherapy, 9, 41-56.

Yufit, R. I. (1991). American association of suicidology presidental address: Suicide assessments in the 1990's. Suicide and Life-Threatening Behavior, 21, 152-187.

# APPENDIX

## DEMOGRAPHIC QUESTIONNAIRE

PLEASE FILL IN THE BLANK OR CIRCLE THE CORRECT ANSWER(S). DO **NOT** PUT YOUR NAME ON THIS PAGE OR THE REMAINING PAGES.

1. What is your sexual orientation?
   1. Bisexual
   2. Lesbian/Gay
   3. Heterosexual

2. Age:____

3. Sex:
   1. Female
   2. Male
   3. Trangender

4. Relationship Status (Mark all that apply)
   1. Not in a relationship
   2. Dating
   3. Engaged
   4. Married/Partnered
   5. Separated
   6. Divorced
   7. Widowed

5. If you are currently in a relationship, how long have you been in the relationship?
   1. ___ Less than 6 months
   2. ___ Greater than 6 months, but less than a year
   3. ___ Longer than 1 year

6. Are you employed:
   1. Yes
   2. No

7. Race:
   1. African American
   2. Asian
   3. Caucasian
   4. Hispanic
   5. Other

8. Religion: 1. Catholic
   2. Jewish
   3. Protestant
   4. No Preference
   5. Other:_____

9. Do you have children? 1. Yes
   2. No

# VITA

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Fox, J. J., Gunter, P., Shores, P., & Hamilton, S. (2001). Multiple exemplar training in Encyclopedia for Psychoanalysis.

Fox, J. J., Hales, C., Blevins, L., Bralle, S., Carter, K., Hamilton, S., & Jones, V. (2000). 10 steps toward writing a successful behavior support plan. Presented at the 8th Annual NorthEast Special Education Conference, Knoxville, TN.

Fox, J. J., Hales, C., Blevins, L., Bralle, S., Carter, K., Hamilton, S., & Jones, V. (2000). 10 steps toward writing a successful behavior support plan. Presented at the Challenge of Change 2000 Joint Conference on Children and Youth with Disabilities from Birth to 21, Nashville, TN.

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