

IS GAY REALLY GAY?:
A HETEROSEXUAL/HOMOSEXUAL QUALITY OF LIFE COMPARISON

by

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ABSTRACT

This study examines differences in quality of life measures between heterosexual and homosexual respondents using General Social Survey data from 1996, 1998, 2000, and 2002. Analyses of quality of life are performed in an effort to compare the heterosexual and homosexual population of the United States. The three main areas which are explored in the analysis are physical health, general happiness, and life excitement. Few differences were found in subjective life satisfaction between heterosexuals and homosexuals; however, some control variables differed. Directions for future research regarding homosexuality and quality of life are discussed.

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CHAPTER ONE: INTRODUCTION

How do we measure well-being and happiness? Certainly, there are many variables that affect how a person feels about all of the aspects of their life; these feelings may change quite frequently due to small inconveniences or pleasures that occur during the course of an average day. However, the goal of subjective well-being research is to transcend daily occurrences, determine how people feel about their lives overall, and discover what qualities make their lives better or worse (Kahremanan, Diener and Schwarz 2000). Koenig, McCollough and Larson (2001:97), regarding well-being, state:

...it exists on a continuum, ranging from states of very low-well being (including severe depression and hopelessness) to those of very high well-being (genuine happiness) that are sustained over time. Rather than existing to avoid pain, humans strive to experience pleasure, joy, completeness, and meaning.

There are numerous variables that predict well-being or quality of life (QOL), many of which will be discussed later. There is a body of literature available regarding the broad topics of quality of life and homosexuality. The literature review focuses on the prevalent data regarding general, physical and mental quality of life research findings. This study will present and seeks to ascertain the differences between heterosexual and homosexual respondents on self-reported GSS variables. The goal is to tap the dimensions of subjective well-being using health, happiness, and life excitement indicators to ascertain potential differences. Finally, the question “Is gay really gay?”, posed in the title page, is a double entendre intended to highlight the word gay, which has seeped into our everyday lexicon to describe both happiness and homosexuality. The final result of this project leads to an understanding of the connection between sexual preference and general subjective life satisfaction.

CHAPTER TWO: LITERATURE REVIEW

The definition of sexual or gender orientation is confusing for both researchers and the general public (Hawkins and Stackhouse 1998). When discussing any aspect of gender and sexuality, it is important to assert that heterosexism is commonly practiced in the United States. Herek (1995:321) defines heterosexism as: “The ideological system that denies, denigrates, and stigmatizes any nonheterosexual form of behavior, identity, relationship, or community.”

Herek (1995:322) elaborates his definition of heterosexism by explaining:

Cultural heterosexism, like institutional racism and sexism, pervades societal customs and institutions. It operates through a dual process: homosexuality is usually rendered invisible and, when people who engage in homosexual behavior or who are identified as homosexual become visible, they are attacked by society.

Recent studies show that tolerance of homosexuality is rising (Herek 2000) (Altemeyer 2001). Herek (2000) states: “By the end of the millennium it appeared that sexual prejudice was dramatically diminishing.” While tolerance may be increasing, homosexuality is not generally accepted in our society today. “Negative attitudes toward homosexuals are prevalent in American and Canadian societies” (Herek and Grint 1993). These negative attitudes prevail despite the fact that the American Psychological Association eliminated homosexuality from its list of mental disorders in 1974 (Congor 1975:633):

The American Psychological Association supports that action taken on December 15, 1974, by the American Psychiatric Association, removing homosexuality from that Association's official list of mental disorders. The American Psychological Association therefore adopts the following resolution: Homosexuality, per se, implies no impairment in judgment, stability, reliability, or general social or vocational capabilities: Further, the American Psychological Association urges all mental health professionals to take the lead in removing all stigma of mental illness that has long been associated with homosexual orientations.

The statement made by the American Psychological Association is further validated by

Herek's (2000:149) assertion that: "...Most adults in the United States report that they never made a conscious choice about their sexual orientation and that they have always felt the same type of sexual attractions and desires." Additionally, he proposes that many homosexuals experience their sexuality as a deeply-rooted and unchangeable part of themselves (Herek 2000).

Regarding the prevalence of homosexuality, Herek (2000) discusses a 1992 survey which reported that nearly 8% of adults were currently experiencing homosexual attraction. The number of true homosexuals in our population may be higher than 8% because some respondents who did not feel comfortable identifying as homosexual may have hidden their true sexual identity (Herek 2000). Herek (2000:149) continues: "Thus, this figure – like other percentages derived from self-reports about homosexuality – most likely underestimates the actual prevalence of adult homosexual attraction."

The previous findings are contrasted by Smith (2003), who finds that only 1-2% of sexually active women and 2-3% of sexually active men are currently engaging in same-gender sex. Smith (2003:8) states: "Recent figures indicate that 3.4% of sexually active males have had a male sexual partner in the last 12 months, 4.1% during the last five years, and 4.9% since age 18." Additionally, the 2000 U.S. census finds the proportion of gay men in the population is approximately 2.5 percent, with the percentage of lesbians being 1.2 percent, which supports Smith's (2003) findings.

Herek (2000), regarding the prevalence of homosexuality in our society, relates stigma to the inability of individuals to openly identify as homosexual. "Despite this shift in attitudes, many gay men and lesbians – as well as heterosexual and bisexual people who are perceived to be homosexual – continue to be the targets of ostracism, discrimination, and even physical attack" (Herek 2000). This stigma, whether perceived or real, may be one of the causes of a

reduction in homosexual's quality of life.

Quality Of Life

The term "quality of life" is a catch-all term used to describe social indicators of subjective well-being and their effects on people's lives (Andrews 1976:4). It encompasses a number of specific concepts, including psychiatric symptoms, life satisfaction, morale and general happiness (George 1981). Most often, the concept of quality of life is measured subjectively by responses of participants in a study. As it is an indicator of people's subjective sense of well-being, it is often based on self-reports of happiness and life satisfaction (Schwarz and Strack 2000). Horowitz et al. (2001:205) emphasize:

The concept of QOL may be seen as including direct measures that ask respondents to rate the quality of some aspects of their life, such as job satisfaction, perceived health, or general life happiness, as well as a variety of lifestyle and health patterns (i.e. smoking, drinking and/or other drug behavior, physical activity, mental health, and health background.

Farquhar (1995:502) states: "Quality of life is of a central concern in evaluative research; improved quality of life is probably the most desirable outcome of all health care policies."

Farquhar (1995) points out that the term quality of life is a powerful phrase, one that has been assimilated into our everyday lexicon. It has been linked to various specialized areas such as sociology, medicine, nursing, economics, geography, social history, psychology, and philosophy (Farquhar 1995). The current lack of consensus regarding a firm definition is probably due to the multi-disciplinary usage of the term (Farquhar 1995).

General Well-Being

It has been surmised that homosexuals have a lower sense of general well-being due to their homosexual status (Horowitz et al. 2001). Homosexuals may have or perceive themselves to have a lack of social support from others, often times because they are still “in the closet,” and may feel unable to reveal or discuss their sexual orientation with others in or out of their sexual category (Vincke and Bolton 1994). This relates directly to the idea of personal control, which “refers to the individual’s belief that he or she can behave in ways that maximize good outcomes and/or minimize bad outcomes” (Peterson 2000:288). Additionally, Peterson (2000:289) states: “Individuals are greatly occupied with what they can and cannot control in their everyday lives; one can characterize this concern as a virtual obsession, matched only by the related pursuit of feeling good.” For homosexuals, it is possible that their quality of life is affected by the depression, physical illness, and poor achievement they believe they can’t alter or ameliorate due to their unequal place in society (Peterson 2000).

Mental Health

Anxiety, Mood and Depression

Gilman, Cochran, Mays, Hughes, Ostrow, and Kessler used National Comorbidity Survey data in order to assess the risk of psychiatric disorders among individuals reporting same-sex partners (Gilman et al. 2001). The respondents who had reported a total of 1 or more same-sex partners in the past 5 years had higher 12-month prevalence rates of anxiety, substance use, mood disorders, and suicidal thoughts than did respondents with opposite-sex partners (Gilman

et al. 2001). The results of the research project indicated that having same-sex sexual partners is associated with an elevated risk of general mental illness (Gilman et al. 2001).

Vincke and Bolton (1994) studied the relationship between low social support and low self-acceptance in gay men, with the main objective being to analyze how social rejection affects gay depression and self-acceptance. They found that: “depression following low social support because one is gay leads to low self-acceptance.... (1994:1058)” The despondent mood in some homosexuals may stem mainly from the lack of positive social support (Vincke and Bolton 1994). Otis and Skinner (1996) reinforce the importance of a social support system in order to help the individual.

Sprangers et al. (2000) designed a study to compare the quality of life across a wide range of chronic disease patients. Although the study did not identify homosexuality as a general risk factor for reduced quality of life, certain findings are applicable to the gay population (Sprangers et al. 2000). The study grouped alcohol abuse/dependence, anxiety disorders, and depression into the blanket category of psychiatric disorders. When specifically discussing psychiatric disorders, Sprangers et al. (2000:900) found that: “patients with depression reported consistently the poorest level of functioning.” The depression risk for homosexuals cannot be overstated; it is imperative to take into account how identifying as a homosexual can have multiple effects on mental health and general functioning.

Stress

Stress is another factor that may affect an individuals' quality of life, regardless of sexual orientation. However homosexuals may be affected by stress more often than heterosexuals, due

to our current heterosexist society (Meyer 1995). The concept of minority stress, which can be applied to homosexual populations, is based on the premise that gay people are subjected to chronic stress related to their stigmatization (Meyer 1995).

Ross (1990) found that stressful life events have a significant impact on mental health for both heterosexuals and homosexuals. Importantly, the highest correlations with psychological adjustment were obtained for HIV-related events (Ross 1990). Ross (1990:410) asserts: “This suggests that the impact of the HIV epidemic has psychological ramifications that extend far beyond the group of those infected.” Ross (1990) also postulates that a post-traumatic stress syndrome-like reaction to the HIV epidemic is occurring, with depression, anxiety, and insomnia the most prominent symptoms for even those not personally infected with HIV or AIDS.

HIV and its impact on mental health is amplified by Flowers, Duncan and Knussen (2003), who wished to understand the psychosocial costs and benefits associated with learning one’s HIV status. They found that the test could resolve anxiety and doubt for some men, but only when not knowing was perceived as less tolerable than a possible positive result (Flowers et al. 2003). The decision to test or not test for HIV was found to have three causal factors, including: reducing uncertainty, coping with an uncertain future, and living with uncertainty (Flowers et al. 2003). Flowers et al. (2003:179) state: “The decision to take an HIV test could be understood as a choice between living with uncertainty and the perceived impact of ascertaining HIV status.” Additionally, Flowers et al. postulate:

It appears that many gay men may well prefer to live with the possibility of HIV infection in the back of their minds, swept under the carpet, ‘in hiding’ or remaining ‘blissfully ignorant’ rather than addressing HIV and accessing available medical care and support. Ambiguity offers some hope as well as anxiety; after a positive diagnosis there is no turning back (2003:187).

The impact of HIV and AIDS on the homosexual population cannot be overstressed. It affects homosexuals, especially gay men, socially, physically, and psychologically (Flowers et al. 2003). Although HIV and AIDS are manifested in the physical body, the mental impact should not be downplayed. HIV and AIDS cause stigma in our society and have serious implications for the overall well-being of the homosexual population.

Physical Health

In addition to mental health, the physical health of gay men has been altered by the addition of HIV and AIDS in our society. An article by Cederfjall et al. (2001) discussed how a group of HIV positive patients perceived their health-related quality of life. Physical well-being can be compromised due to symptoms of the disease, such as loss of appetite, nausea, vomiting, exhaustion, night sweat, and weight loss (Cunningham et al. 1998). Cederfjall et al. (1998) also found that those infected with HIV had a weaker sense of cohesion and worse general health than HIV negative individuals. Finally, the impact of HIV and AIDS was summed up as more than just a physically-impacting disease: “Because HIV infected people must confront an array of psychological stressors as well as living with an incurable and contagious disease, this finding may not be so surprising” (Cederfjall et al. 1998).

In addition to an elevated level of HIV infection in the homosexual population, many homosexuals have to deal with the issue of “coming out” to their physician. As previously discussed, heterosexuality is the norm in our society. Physicians may assume that an individual is heterosexual, when in fact they are homosexual. The awkwardness of an incorrect assumption should be inherently apparent to all readers. Boehmer and Case (2004), while researching the

disclosure of sexual orientation among women with breast carcinoma, discovered that many health providers did not inquire as to the sexual orientation of the patient. They found that 72% of the participants did disclose their sexual orientation to their physicians, but there was a significant group that did not. It was the "...providers' lack of inquiry into sexual orientation that allowed the women to passively refuse disclosure of their sexual orientation" (Boehmer and Case 2004:1885). The three different reasons why the research subjects neglected to disclose their sexual orientation were listed as: fear of homophobia, being single, and that sexual orientation is private (Boehmer and Case 2004). Boehmer and Case (2004) recommend that providers should give non-threatening opportunities for the disclosure of sexual orientation to provide more complete care to homosexual patients.

Sobel (2004:55) outlines some of the increased general physical risks for homosexual patients:

Up to 50 percent of adult gay men are smokers, for example, compared with 28 percent of men in the general population. Lesbians indeed have a slightly increased risk of breast cancer compared with heterosexual women, possibly because many have not had children. They also undergo less frequent Pap smears despite needing them just as much as heterosexual patients.

These increased risks, as well as the assumption of sexual partners and risk factors, may be problematic for homosexuals when it comes to diagnosis and treatment (Sobel 2004).

Related Findings

A study by Horowitz et al. (2001) conducted bivariate analyses with regard to demographic, social background, lifestyle, health behaviors, health background, mental health variables, and quality of life between sexual orientation behavior groups, which they defined as

homosexual, bisexual, heterosexual, or no sex partners. The GSS data used from 1988, 1989, 1990, 1991, 1993, 1994 and 1996 contained responses from a total of 11,543 individuals.

“Within the literature, there is some question as to whether bisexual or homosexual persons practice more unhealthy lifestyles and experience a lower quality of life than heterosexual individuals” (Horowitz et al. 2001:205).

For the data set years used, the NORC surveys did not explicitly ask respondents to identify their sexual orientation (Horowitz et al. 2001). Individuals were asked to identify the sex of their sexual partners in two time periods: since age 18 and in the last 12 months (Horowitz et al. 2001). They utilized separate codings for each time period and analyzed each group separately. For each group, persons who indicated that all of their sex partners were of the same sex were classified as HOM, persons who indicated that all of their sex partners were of the opposite sex were classified as HET, persons who indicated that they had sex partners of both sexes were classified as BI, and persons who indicated that they had no sex partners during the time period specified were classified as NOSEX (Horowitz et al. 2001). Each respondent was given two independent classifications which may not be consistent (Horowitz et al. 2001). Because of the small number of persons classified as HOM or BI, gender distinctions could not be accounted for (Horowitz et al. 2001).

Although their study did not find that sexual orientation is either strongly or directly related to quality of life, lifestyle or health indicators, there were some background and demographic differences among the different sexual orientation groups (Horowitz et al. 2001). The HET and NOSEX groups were more likely to live in rural or suburban settings than the BI and HOM groups (Horowitz et al. 2001). The HET group was older than the BI group and was more religious than the HOM group (Horowitz et al. 2001). The BI and HOM groups were more

likely to socialize in a bar and watch television than the HET group. Additionally, the HOM tended to have more education than the BI or NOSEX groups (Horowitz et al. 2001). Only 6 variables of the 24 tested reached statistical significance, with none explaining more than 2% of the variance (Horowitz et al. 2001:215). Horowitz et al. (2001:216) assert: “Our analyses of data drawn from a series of national probability samples indicate that these behavioral categories have little direct association with a wide range of QOL, health, and lifestyle variables....”

They discussed the limitations of their study, cautioning the reader to recognize the limitations of the NORC self-report measure (Horowitz et al. 2001). Horowitz et al. (2001:216) maintain: “Finally, because our analyses focused on the behavioral dimension of sexual orientation, questions remain about the association between QOL, health, and lifestyle variables and other possible dimensions of sexual orientation.” Their article closes with considerations for future studies and the possible inclusion of other dimensions of sexual orientation deviating from the bifurcated heterosexual/homosexual categorization (Horowitz et al. 2001). This study used one-way analysis of variance with four categories of the independent variable and 28 dependent variables in a series of bivariate analyses. Many of the sample sizes within categories of the independent variable are remarkably low and are apparently the reason a multivariate analysis could not be preformed. The present study extends the Horowitz analysis by comparing two significant groups, heterosexuals and homosexuals, using ordinary least squares and logistic analysis on three significant dependent variables and incorporating several variables shown to affect quality of life in the literature for the general population.

Sandfort, de Graff, and Bijl (2003) also assessed differences in QOL between homosexual and heterosexual individuals and attempted to identify factors that accounted for the variations. QOL is affected by mental health and homosexual people are at a higher risk for

psychiatric disorders than heterosexuals (Cochran 2001). The data were taken from the Netherlands Mental Health Survey and Incidence Study (NEMESIS) (Sandfort et al. 2003). Differences in QOL as a function of sexual orientation were found in men, but not in women, as homosexual men scored significantly lower on five out of eight dimensions (Sandfort et al. 2003). Compared to heterosexuals, homosexual men reported their general and mental health as less positive, that emotional problems more often interfered with daily activities, and that they had less energy than heterosexuals (Sandfort et al. 2003). Differences in QOL between heterosexual and homosexual men seemed to be caused by lesser self-esteem and a lower sense of having control over the occurrences in one's life (Sandfort et al. 2003). These findings contrast those found by Horowitz, Weis and Laflin (2001), as discussed by Sandfort et al.:

...recently reported by Horowitz, Weis, and Laflin (2001), who concluded that, based on a study of 11,543 people, there was little evidence that the behavioral dimension of sexual orientation is either strongly or directly related to quality of life. This lack of agreement might be related to the fact that Horowitz et al. did not analyze their data separately for men and women. Our results indicate the importance of analyzing findings separately for men and women (2003:19).

Conclusion

As expressed, there are contrasting views regarding whether or not homosexuals have a lower quality of life than heterosexuals (Horowitz et al. 2001) (Sandfort et al. 2003). Restated, the purpose of this project is to explore the differences between heterosexual and homosexual responses to self-report quality of life questions on a personal interview survey of U.S. households (National Opinion Research Center 2004). The goal is to tap the dimensions of subjective well-being using health, happiness, and lifestyle indicators. Based upon the literature presented in this review, it is postulated that homosexuals and heterosexuals will have slight

differences on self-report questions in the GSS. This research project should shed light on some of the differences between homosexuals and heterosexuals, as well as spotlight some of the attributes that may serve to alienate those that do not fit into the heterosexual norm.

CHAPTER THREE: METHODOLOGY

The data for this analysis are provided by the General Social Survey (GSS). The analysis is conducted using data from years 1996, 1998, 2000 and 2002, to allow for appropriate multivariate analysis (Sherkat 1999). The GSS is a national personal interview survey that is currently conducted biannually by the National Opinion Research Center (NORC). The respondents for the survey are chosen using probability sampling. All interviewees are non-institutionalized English-speaking adults living in the United States. NORC representatives completed the interviews, which were administered after 3:00 pm, in the respondent's homes with a limit of one respondent per household. The length of each interview was approximately 90 minutes. The survey instrument was general in nature, and was used to obtain information regarding respondents attitudes, values, and beliefs concerning a large number of issues. All interviews were then coded and reported cumulatively in the GSS codebook. From the years 1996 – 2002, NORC representatives completed a total of 11,318 interviews (General Social Survey 2003).

This study is an attempt to ascertain the differences between heterosexual and homosexual respondents on self-report GSS variables which measure subjective quality of life. The goal is to tap the dimensions of subjective well-being using health, happiness, and life excitement indicators to ascertain potential differences.

Dependent Variables

The three dependent variables in this study are indicators of quality of life. The broad areas of quality of life studied here are physical health, general happiness, and life excitement.

The dependent variables are chosen for their relation to the three quality of life areas as well as their ability to act as indicators of subjective well-being.

The first dependent variable measures general health. The GSS asks: “Would you say your own health, in general, is excellent, good, fair, or poor?” The response choices are: Excellent (1), Good (2), Fair (3), Poor (4). To maintain continuity throughout the research project, a new variable is created. Excellent (1) is recoded to (4), Good (2) is recoded to (3), Fair (3) is recoded to (2), and Poor (4) is recoded to (1). Don’t know (8), No answer (9) and Not applicable (BK) are recoded as missing (SYSMIS).

The second dependent variable is a measure of subjective well-being. It is worded in the GSS as: “Taken all together, how would you say things are these days—would you say that you are very happy, pretty happy, or not too happy?” The response choices are: Very happy (1), Pretty happy (2), Not too happy (3). A dichotomous variable is created in an effort to analyze this dependent variable using logistic regression. The new variable has Very happy (1) and pretty happy (2) recoded to (1) and Not too happy (3) recoded to (0). Don’t know (8), No answer (9) and Not applicable (BK) are recoded as missing (SYSMIS).

The final dependent variable that serves as a general indicator of quality of life measures subjective life excitement. The GSS poses the question: “In general, do you find life exciting, pretty routine, or dull?” The answer choices are: Exciting (1), Routine (2), Dull (3). A dichotomous variable is created in an effort to analyze this dependent variable using logistic regression. The new variable has Exciting (1) recoded to (1) and Routine (2) and Dull (3) recoded to (0). Don’t know (8), No answer (9) and Not applicable (BK) are recoded as missing (SYSMIS).

Independent Variable

After considerable review of the available data, it is clear that the best way to analyze the data is to allow for two distinct categories of the independent variable: homosexual and heterosexual. For the purposes of analysis, this setup allows a functional comparison between the two groups while accounting for the same control variables. This permits six full models within the analysis as well as a direct comparison between the two groups.

As the General Social Survey does not overtly ask sexual orientation as part of its data set, alternate means of defining respondents are applied. The GSS asks two questions regarding the gender of respondent's sex partners for the years included in this sample. Although both variables are essentially the same question, they differ in that one (SEXSEX) asks the gender of sex partners for the past 12 months, and one (SEXSEX5) asks the gender of sex partners for the past 5 years. The variable which measures the gender of sexual partners within the past 5 years is chosen to divide individual responses into heterosexual or homosexual populations. It is chosen over the 12-month variable to be more inclusive of those who have had homosexual experiences as well as to increase the number of homosexuals in our sample. The question asks: "Have your sex partners in the last five years been..." There are six possible response choices: Exclusively male (1), Both male and female (2), Exclusively female (3), Don't know (8), No answer (9), Not applicable (BK). The answer choices Don't know (8), No answer (9) and Not applicable (BK) are recoded as missing (SYSMIS).

Within this analysis, any individual who responded that they had any experiences with someone of the same gender is considered homosexual, even those that reported having both male and female sex partners. The independent variable measuring sexual preference allows us

to divide our entire data set into two populations: heterosexual and homosexual. For the purposes of analysis, the independent variable has been recoded into a dummy variable titled (SEXSAME), with those identified as straight coded as (0) and those identified as gay coded as (1).

Preliminary analyses indicate that there are no between-group differences between gay men, bisexuals, and lesbians. Three one-way analyses of variances (ANOVAs) were run using the dependent variables measuring subjective health, happiness, and life excitement. These ANOVAs were analyzed with the variable measuring the sex of sexual partners within the past 5 years as the factor. None of the three dependent variables achieved statistical significance. Therefore, since the between-group difference is minimal, the combination of gay men, bisexuals, and lesbians for the formal analyses does not interfere with the final outcomes.

Control Variables

The goal of this study is to analyze three dependent variables that measure subjective well-being using health, happiness, and lifestyle indicators. The differences between heterosexual and homosexual responses on self-report GSS variables are examined. Control variables are included within the models in order to isolate the effects of the independent variable, sexual orientation, on the dependent variables, subjective well-being indicators. The control variables used in this analysis include age, gender, education, income, marital status, urban residence, southern residence, attendance at religious services and affiliation with either conservative Protestant or Catholic religion.

Age is expected to have some impact on an individuals' subjective well-being, as it has been observed that both life satisfaction and happiness may change with age (George 1981). Regarding the non-heterosexual population, it has been recorded that children and teens are exploring their sexuality and "coming out" at earlier ages than before (Wildman 2000). This openness has the potential to add to or detract from an individuals quality of life, depending on the level of acceptance they obtain from family and friends. The respondent's age is measured in actual years. No answer and Don't know (9) are recoded as missing (SYSMIS).

Gender is identified as a control variable due to its relation to overall quality of life. Additionally, Sandfort et al. (2003:20) state: "The absence of any difference in QL between homosexual and heterosexual women suggests that same-sex sexuality per se is not a decisive factor in determining QL." They conclude that the differences between homosexual males and females deserve future research (Sandfort et al. 2003). This variable is interviewer coded. A dummy variable is constructed such that Male is coded (0) and Female is coded (1).

Research has demonstrated that education is likely to be correlated with higher general well-being and quality of life (Argyle 2000). Respondents' educational level is measured using a 20 point scale as assigned by GSS. Answers are coded based on the number of years of actual formal schooling. No formal schooling is coded (0), completion of 1st grade is coded (1), completion of 2nd grade is coded (2), completion of 3rd grade is coded (3). This pattern continues through eight years of college (20). There is no response choice for more than eight years of college. Don't know (98) and No answer (99) are also listed as response choices. The choices Don't know (98) and No answer (99) are recoded as missing (SYSMIS).

Income is also a control variable since there is a correlation between higher income and higher quality of life (Argyle 2000). The GSS measures income using different scales which

vary depending on the year of the survey. Although the measurement options varied, the same question was posed: “In which of these groups did your total family income, from all sources, fall last year before taxes, that is?” For the 1996 GSS, income (INCOME91) was measured using a 21 point scale. Family incomes under \$1,000 are coded (01), family incomes between \$1,000 and \$2,999 are coded (02), family incomes between \$3,000 and \$3,999 are coded (03), family incomes between \$4,000 and \$4,999 are coded (04), family incomes between \$5,000 and \$5,999 are coded (05), family incomes between \$6,000 and \$6,999 are coded (06), family incomes between \$7,000 and \$7,999 are coded (07), family incomes between \$8,000 and \$9,999 are coded (08), family incomes between \$10,000 and \$12,499 are coded (09), family incomes between \$12,500 and \$14,999 are coded (10), family incomes between \$15,000 and \$17,499 are coded (11), family incomes between \$17,500 and \$19,999 are coded (12), family incomes between \$20,000 and \$22,499 are coded (13), family incomes between \$22,500 and \$24,999 are coded (14), family incomes between \$25,000 and \$29,999 are coded (15), family incomes between \$30,000 and \$34,999 are coded (16), family incomes between \$35,000 and \$39,999 are coded (17), family incomes between \$40,000 and \$49,999 are coded (18), family incomes between \$50,000 and \$59,999 are coded (19), family incomes between \$60,000 and \$74,999 are coded (20), family incomes of \$75,000 or over are coded (21). Refused is coded as (22), Don’t know is coded (98), No answer is coded (99), and Not applicable is coded (BK).

For the years 1998, 2000, and 2002, family income (INCOME98) was measured using another scale, which had 23 points. Family incomes under \$1,000 are coded (01), family incomes between \$1,000 and \$2,999 are coded (02), family incomes between \$3,000 and \$3,999 are coded (03), family incomes between \$4,000 and \$4,999 are coded (04), family incomes between \$5,000 and \$5,999 are coded (05), family incomes between \$6,000 and \$6,999 are

coded (06), family incomes between \$7,000 and \$7,999 are coded (07), family incomes between \$8,000 and \$9,999 are coded (08), family incomes between \$10,000 and \$12,499 are coded (09), family incomes between \$12,500 and \$14,999 are coded (10), family incomes between \$15,000 and \$17,499 are coded (11), family incomes between \$17,500 and \$19,999 are coded (12), family incomes between \$20,000 and \$22,499 are coded (13), family incomes between \$22,500 and \$24,999 are coded (14), family incomes between \$25,000 and \$29,999 are coded (15), family incomes between \$30,000 and \$34,999 are coded (16), family incomes between \$35,000 and \$39,999 are coded (17), family incomes between \$40,000 and \$49,999 are coded (18), family incomes between \$50,000 and \$59,999 are coded (19), family incomes between \$60,000 and \$74,999 are coded (20), family incomes between \$75,000 and \$89,999 are coded (21), family incomes of \$90,000 to \$109,999 are coded as (22), family incomes of \$110,000 or over are coded as (23). Refused is coded (24), Don't know is coded (98), No answer is coded (99), and Not applicable is coded (BK).

To account for the differences for the income scales, income answer choices are recoded to percentiles. The result is the high score for each scale is (100) and the low score is (0).

Marital status is also controlled for in this analysis. Evans and Kelley (2004) found that getting married elevates life satisfaction, even net of prior measured life satisfaction. This finding is important considering that same-sex marriages are not currently allowed in the United States. The GSS asks: "Are you currently married, widowed, divorced, separated, or have you never been married?" The response choices are married (1), widowed (2), divorced (3), separated (4), never married (5), and no answer (9). Married and widowed are coded into (1) and divorced, separated, and never married are coded into (0).

Another control variable contained within the analysis is region of country. As a control variable, region of the country is important as certain areas of the country, such as the South, are more likely to reject homosexuality (Seltzer 1992). Area of the country was not posed as a question but rather observed by the interviewer. The choices were as follows: New England (1), Middle Atlantic (2), East North Central (3), West North Central (4), South Atlantic (5), East South Central (6), West South Central (7), Mountain (8), and Pacific (9). For the purposes of this analysis, a dichotomous variable is created. Those respondents living in the South Atlantic (5), East South Central (6), and West South Central (7) are recoded as South (1) and all other responses are recoded as Non-south (0).

Living in an urban or rural area can affect subjective quality of life. According to Rodgers (1980:436): “Although the urbanization of the world’s population is a longstanding and almost universal phenomenon, there is considerable evidence that for most people large cities are relatively undesirable place to live.” City size was not posed as a question but instead observed by the interviewer. The choices were as follows: Central city of 12 largest Standard Metropolitan Statistical Areas (SMSAs) (1), Central City of remainder of the 100 largest SMSAs (2), Suburbs of 12 largest SMSAs (3), Suburbs of the remaining 100 largest SMSAs (4), Other urban (counties having towns of 10,000 or more), Other rural (counties having no towns of 10,000 or more) (6). To maintain continuity new variable is created. The response choice (6) is coded (1), (5) is coded (2), (4) is coded (3), (3) is coded (4), (2) is coded (5), (1) is coded (6).

Religion is related to quality of life in that: “results indicate that both devotional (private) and participatory (public) aspects of religiosity have relatively small but persistent positive relationships with life satisfaction (Ellison et al. 1989). The variable measures the frequency of the respondent’s church attendance. The question is worded within the GSS as: “How often do

you attend religious services?” The response choices are listed as Never (0), Less than once a year (1), About once or twice a year (2), Several times a year (3), About once a month (4), 2-3 times a month (5), Nearly every week (6), Every week (7), Several times a week (8), and Don’t know, No answer (9). The response choice, Don’t know (9), is recoded as missing (SYSMIS) so as to not interfere with the regression analysis.

Religious affiliation, as well as attendance, can affect quality of life (Ellison et al. 1989). The GSS poses the question: “What is your religious preference? Is it Protestant, Catholic, Jewish, some other religion, or no religion?” The responses are coded as Protestant (1), Catholic (2), Jewish (3), None (4), Other (5), Buddhism (6), Hinduism (7), Other Eastern (8), Moslem/Islam (9), Orthodox-Christian (10), Christian (11), Native American (12), Inter-Nondenominational (13), Don’t know (98) and No answer (99). The response choices Don’t know (98) and No answer (99) are recoded as missing (SYSMIS). This question is recoded into two dummy variables. The first dummy variable is intended to measure whether or not being conservative Protestant adds to or detracts from quality of life. Conservative protestant (1) is coded (1) and all other answer choices are coded (0). The second dummy variable is intended to measure whether or not being Catholic has an effect on quality of life. Catholic (2) is coded (1) and all other answer choices are coded (0).

Analytic Strategy

Multiple regression and logistic regression are employed to examine the effects of heterosexuality and homosexuality on the three dependent variables that tap subjective well-being. The analysis controls for age, gender, education, income, marital status, urban residence, southern residence, attendance at religious services and affiliation with either conservative Protestant or Catholic religion.

The final analysis produces a total of seven tables. Table 1 includes descriptive statistics, such as means and standard deviations of the dependent and control variables divided according to the independent variable. Table 2 contains a preliminary answer breakdown by gender and sexual preference. Table 3 contains a correlation matrix of the dependent and control variables divided according to the independent variable. Tables 4, 5, and 6 display the results of the analyses of the three dependent variables which measure subjective health, happiness and life excitement upon the independent variable, sexual preference. Table 7 exhibits the results of the analysis of the full model run with the independent variable, sexual preference, as well as a variable constructed to measure the impact of being a lesbian included within the regression.

CHAPTER FOUR: ANALYSIS AND RESULTS

The total number of respondents within this analysis is 8048, with 7681 being identified as heterosexual and 367 being identified as homosexual. For the homosexuals, 183 are women and 184 are men, as compared to 4097 women and 3584 men within the heterosexual population. The average respondents' age is 38.77 for homosexuals and 42.17 for heterosexuals and the average educational level is 13.82 for homosexuals and 13.53 for heterosexuals. Only about 31 percent of the homosexuals are married as compared to 58 percent of the heterosexual respondents.

The descriptive statistics are reported in Table 1. For those respondents who are identified within the analysis as homosexual, general happiness (.8829), general health (3.03) and general life excitement are fairly high (.5482). There are small differences as compared to the heterosexuals, who obtained scores of .8918 for general happiness, 3.05 for general health, and .4919 for general life excitement.

Six variables demonstrated statistical significance when measured using an independent samples t-test divided by the independent variable. Compared to heterosexuals, homosexuals are significantly younger, less likely to attend church, less likely to identify as a conservative Protestant, have lower incomes, are less likely to be married, and are more likely to live in an urban area.

Table 1 Descriptive Statistics for the Dependent, Independent, and Control Variables

Variables	Mean (Homosexual)	Standard Deviation (Homosexual)	Sample Size (Homosexual)	Mean (Heterosexual)	Standard Deviation (Heterosexual)	Sample Size (Heterosexual)	T Test
Health	3.03	.786	318	3.05	.833	6918	
Happiness	.8829	.32204	316	.8918	.31060	6722	
Excitement	.5482	.49894	197	.4919	.49999	4468	
Age	38.77	13.223	366	42.17	14.590	7666	**
Attendance	2.75	2.584	360	3.53	2.654	7544	**
Catholic	.2371	.42586	367	.2392	.42660	7681	
Protestant	.0954	.29412	367	.1403	.34737	7681	*
Education	13.82	2.726	367	13.53	2.743	7681	
Female	.4986	.50068	367	.5334	.49892	7681	
Income	52.6338	29.85591	367	58.8910	29.66506	7681	**
Marital	.3079	.46226	367	.5786	.49381	7680	**
South	.3106	.46338	367	.3479	.47633	7681	
Urban	3.4959	1.57832	367	3.0154	1.48632	7681	**

* = Significant at the .05 level

** = Significant at the .01 level

Before the three dependent variables were re-coded to allow for logistic regression as well as maintain continuity throughout the project, a simple crosstab was calculated. Table 2 presents a comparison between heterosexual men, heterosexual women, homosexual men and homosexual women. The table indicates the percentage of each group that answered “excellent” or “good” to the variable measuring subjective health, “very happy” to the variable measuring subjective happiness, and/or “exciting” to the variable measuring subjective life excitement. This table is intended to highlight the lack of differences between the populations as well as allow a simple comparison without sophisticated statistical analysis. As can be seen, initial differences in QOL between gender and sexual preference is minimal.

Table 2 Health, Happiness and Life Excitement by Homosexuals and Heterosexuals and Gender

	Homosexual Women	Homosexual Men	Heterosexual Women	Heterosexual Men
Health	82.3	82.1	81.2	80.9
Happiness	30.5	25.9	32.2	31.2
Life Excitement	51.6	57.7	45.9	52.8
Total Sample N=	183	184	4097	3584

Note: Cell entries are given as percentages

For the variable measuring subjective health, percentage listed is of those who answered “excellent” or “good” for the original variable.

For the variable measuring subjective happiness, percentage listed is of those who answered “very happy” for the original variable.

For the variable measuring subjective life excitement, percentage listed is of those who answered “exciting” for the original variable.

Table 3 presents a correlation matrix divided by the independent variable, sexual preference. 78 correlations are statistically significant at the .05 or .01 level. 22 of the significant correlations are for the homosexual respondents and 56 are for the heterosexual respondents. The dependent variables that have statistically significant correlations for both heterosexuals and homosexuals are health and happiness, life excitement and happiness, life excitement and health, health and education, happiness and income, health and income, and life excitement and education. Additionally, some control variables achieved statistical significance for both sample populations. Significant control variables include: education and income, age and income, age and marital status, income and marital status, education and marital status, income and southern residence, and marital status and church attendance.

Table 3 Correlation Matrix

	Happy	Health	Excite	Educ	Age	Income	Female	Marital	Urban	South	Attend	Protest	Catho
Happy		.198**	.182**	.110**	.027*	.190**	-.019	.159**	-.070**	.002	.065**	-.003	.007
Health	.270**		.222**	.192**	-.121**	.185**	.014	.016	.003	-.036**	.043**	-.021	.014
Excite	.207**	.251**		.217**	.008	.140**	-.069**	.048**	.015	-.028	.134**	-.011	-.003
Educ	-.004	.241**	.268**		-.034**	.334**	-.021	.038**	.098**	-.080**	.080**	-.097**	-.006
Age	.012	-.073	.085	.073		.125**	-.047**	.341**	-.070**	.027*	.138**	.031**	-.048**
Income	.146**	.172**	.077	.318**	.213**		-.085**	.371**	.006	-.039**	.094**	-.053**	.077**
Female	-.019	-.055	-.061	-.097	-.171**	-.064		.017	.014	.006	.114**	.007	-.005
Marital	.039	.039	-.010	-.120*	.170**	.306**	.031		-.161**	.025*	.228**	.049**	.007**
Urban	-.040	-.008	.063	.084	-.029	.041	-.065	-.101		-.066**	-.060**	-.078**	.064**
South	-.032	.020	-.032	-.077	-.013	-.135**	.072	.050	-.144**		.094**	.276**	-.163**
Attend	-.017	.080	.046	.079	.089	-.007	-.008	.136**	-.096**	.136**		.176**	.064**
Protest	-.012	-.038	-.049	-.094	.028	-.040	-.008	.045	-.055	.183**	.195**		-.227**
Catho	.067	-.018	-.068	-.007	-.030	.069	.021	.058	.056	-.111*	.062	-.181**	

Heterosexual

Homosexual

p < .05 = *

p < .01 = **

Two multiple regression analyses are examined, predicting the dependent variable measuring subjective health divided according to the independent variable, sexual preference (Table 4). The regressions controlled for age, attendance at religious services, affiliation with conservative Protestant or catholic religions, educational level, gender, income, martial status, southern residence and urban residence.

When the control variables are regressed on the dependent variable measuring subjective health, a significant regression equation is observed for the homosexual respondents. The results show that the model is significant, with $F = 3.156$, having a significance level of .001. The proportion of variance explained is .095, with a standard error of the estimate of .760. The constant is 2.349, which is the predicted response when all control variables are zero. The unstandardized regression coefficients predicted a frequency equal to $2.349 - .008 (\text{AGE}) + .022 (\text{ATTEND}) - .067 (\text{CATHO}) - .112 (\text{CONPROT}) + .059 (\text{EDUC}) - .087 (\text{FEMALE}) + .003 (\text{INC}) + .067 (\text{MARITAL1}) + .075 (\text{SOUTH}) - .010 (\text{URBAN})$. The control variables which obtained statistical significance are those indicating age, educational level and income.

When the control variables are regressed on the dependent variable measuring subjective health, a significant regression equation is observed for the heterosexual respondents. The model is significant, with $F = 54.568$, having a significance level of .000. The proportion of variance explained is .074, with a standard error of the estimate of .802. The constant is 2.584, which is the predicted response when all control variables are zero. The unstandardized regression coefficients predicted a frequency equal to $2.584 - .008 (\text{AGE}) + .012 (\text{ATTEND}) - .016 (\text{CATHO}) + .002 (\text{CONPROT}) + .040 (\text{EDUC}) + .035 (\text{FEMALE}) + .005 (\text{INC}) - .025 (\text{MARITAL1}) - .038 (\text{SOUTH}) - .012 (\text{URBAN})$. The control variables which obtained

statistical significance are those indicating age, attendance at religious services, educational level and income.

Table 4 Multiple Regression Results for the Dependent Variable Measuring Subjective Health

	Homosexual	Heterosexual
Age	-.008/-.138 (.003) *	-.008/-.138 (.001) **
Attendance	.022/.073 (.018)	.012/.039 (.004) **
Catholic	-.067/-.036 (.105)	-.016/-.008 (.024)
Protestant	-.112/-.042 (.155)	.002/.001 (.030)
Education	.059/.205 (.018) **	.040/.131 (.004) **
Female	-.087/-.055 (.088)	.035/.021 (.020)
Income	.003/.128 (.002) *	.005/.162 (.000) **
Marital	.067/.039 (.104)	-.025/-.015 (.023)
South	.075/.044 (.098)	-.038/-.022 (.021)
Urban	-.010/-.021 (.028)	-.012/-.022 (.007)
Constant	2.349 **	2.584 **
R ²	.095	.074
N	367	7681

Note: Cell entries are given as unstandardized regression coefficient/standardized (beta) coefficient with the standard error given in parentheses.

N = maximum number available for any one correlation coefficient.

p < .05 = *, p < .01 = **

Table 5 displays the logistic regression results for the dependent variable measuring subjective happiness divided according to the independent variable, sexual preference. Two logistic regressions are calculated. The regressions controlled for age, attendance at religious services, affiliation with conservative Protestant or Catholic religions, educational level, gender, income, marital status, southern residence and urban residence.

When the control variables are regressed on the dependent variable measuring subjective happiness, a regression equation is observed for the homosexual respondents. The results show that the model is not significant, as the chi-square = 9.624 with a significance level of .474. The constant is 2.669. The logit predicted a frequency equal to $2.669 - .006 (\text{AGE}) - .012 (\text{ATTEND}) + .421 (\text{CATHO}) - .003 (\text{CONPROT}) + .060 (\text{EDUC}) - .105 (\text{FEMALE}) + .018 (\text{INC}) - .200 (\text{MARITAL1}) - .042 (\text{SOUTH}) - .111 (\text{URBAN})$. As shown in Table 4, the effect of the control variables upon the dependent variables for homosexuals does not seem to impact one's general happiness.

When the control variables are regressed on the dependent variable measuring subjective happiness, a significant regression equation is observed for the heterosexual respondents. The model is significant, as the chi-square = 359.676 with a significance level of .000. The constant is .556. The logit predicted a frequency equal to $.556 - .008 (\text{AGE}) + .041 (\text{ATTEND}) - .036 (\text{CATHO}) - .074 (\text{CONPROT}) + .086 (\text{EDUC}) - .082 (\text{FEMALE}) + .014 (\text{INC}) + .745 (\text{MARITAL1}) + .018 (\text{SOUTH}) - .123 (\text{URBAN})$. As shown in Table 4, the effect of the control variables upon the dependent variables for heterosexuals does appear to influence one's general happiness.

Table 5 Logistic Regression Results for the Dependent Variable Measuring Subjective Happiness

	Homosexual	Heterosexual
Age	-.006/.994 (.014)	-.008/.992 (.003) **
Attendance	-.012/.988 (.072)	.041/1.042 (.017) *
Catholic	.421/1.523 (.485)	-.036/.965 (.101)
Protestant	-.003/.997 (.609)	-.074/.929 (.126)
Education	-.060/.942 (.073)	.086/1.090 (.016) **
Female	-.105/.900 (.371)	-.082/.921 (.084)
Income	.018/1.018 (.007) *	.014/1.014 (.002) **
Marital	-.200/.819 (.449)	.745/2.106 (.098) **
South	-.042/.959 (.390)	.018/1.018 (.090)
Urban	-.111/.895 (.114)	-.123/.884 (.026) **
Constant	2.669/14.430 (1.219) *	.556/1.743 (.265) *
Chi-square	9.624	359.676 **
N=	309	6581

Note: Cell entries are given as logistic regression coefficient/ odds ratio, with the standard error given in parentheses.

p < .05 = *, p < .01 = **

Table 6 displays the logistic regression results for the dependent variable measuring subjective life excitement divided according to the independent variable, sexual preference. Two logistic regressions are calculated. The regressions controlled for age, attendance at religious services, affiliation with conservative Protestant or Catholic religions, educational level, gender, income, marital status, southern residence and urban residence.

When the control variables are regressed on the dependent variable measuring subjective life excitement, a regression equation is observed for the homosexual respondents. The model is not significant, as the chi-square = 17.665 with a significance level of .061. The constant is -3.367. The logit predicted a frequency equal to $-3.367 + .014 (\text{AGE}) + .019 (\text{ATTEND}) - .360 (\text{CATHO}) - .285 (\text{CONPROT}) + .216 (\text{EDUC}) + .023 (\text{FEMALE}) - .005 (\text{INC}) + .286 (\text{MARITAL1}) - .197 (\text{SOUTH}) - .088 (\text{URBAN})$. As shown in Table 5, the effect of the control variables upon the dependent variables for homosexuals does not seem to impact one's general life excitement.

When the control variables are regressed on the dependent variable measuring subjective life excitement, a significant regression equation is observed for the heterosexual respondents. The model is significant, as the chi-square = 324.236 with a significance level of .000. The constant is -2.255. The logit predicted a frequency equal to $-2.255 - .003 (\text{AGE}) + .102 (\text{ATTEND}) - .109 (\text{CATHO}) - .059 (\text{CONPROT}) + .144 (\text{EDUC}) - .311 (\text{FEMALE}) + .004 (\text{INC}) - .001 (\text{MARITAL1}) - .129 (\text{SOUTH}) + .007 (\text{URBAN})$. As shown in Table 5, the effect of the control variables upon the dependent variables for homosexuals does seem to influence one's general life excitement.

Table 6 Logistic Regression Results for the Dependent Variable Measuring Subjective Life Excitement

	Homosexual	Heterosexual
Age	.014/1.014 (.012)	-.003/.997 (.002)
Attendance	.019/1.019 (.064)	.102/1.108 (.013) **
Catholic	-.360/.698 (.367)	-.109/.897 (.077)
Protestant	-.285/.752 (.526)	-.059/.942 (.098)
Education	.216/1.241 (.067) **	.144/1.155 (.013) **
Female	.023/1.023 (.314)	-.311/.732 (.064) **
Income	-.005/.995 (.006)	.004/1.004 (.001) **
Marital	.286/1.331 (.376)	-.001/.999 (.075)
South	-.197/.821 (.362)	-.129/.879 (.069)
Urban	.088/1.092 (.098)	.007/1.007 (.022)
Constant	-.3.367/.034 (1.099) **	-2.255/.105 (.208) **
Chi-square	17.665	324.236 **
N=	192	4390

Note: Cell entries are given as logistic regression coefficient/ odds ratio, with the standard error given in parentheses.

p < .05 = *, p < .01 = **

A final series of regressions are run in order to assess the impact of both sexual preference as well as gender within a full model. The dependent variables measuring subjective health, happiness, and life excitement are regressed using the entire valid sample as an independent variable. A new variable (GAYWOMEN) is created to account for the interaction effect of being both homosexual and female. Additionally, the variable measuring sexual preference is included in the regression equations. Thus, the final series of regressions brings us to the main question of the thesis, namely, whether being gay adds to or detracts from overall subjective quality of life. Although some control variables achieved significance within the regressions, neither sexual preference nor being both homosexual and female achieved statistical significance or affected the model.

When the control variables are regressed on the dependent variable measuring subjective health, a significant multiple regression equation is observed. The results concluded that the model is significant, with $F = 47.800$, having a significance level of $.000$. The R^2 is $.075$, with a standard error of the estimate of $.800$. The constant is 2.575 . The unstandardized regression coefficients predicted a frequency equal to $2.575 + .029$ (SEXSAME) - $.115$ (GAYWOMEN) - $.008$ (AGE) + $.013$ (ATTEND) - $.018$ (CATHO) - $.003$ (CONPROT) + $.041$ (EDUC) + $.034$ (FEMALE) + $.004$ (INC) - $.022$ (MARITAL1) - $.033$ (SOUTH) - $.012$ (URBAN). The significant control variables are those indicating age, attendance at religious services, educational level and income.

When the control variables are regressed on the dependent variable measuring subjective happiness, a significant regression equation is observed. The results concluded that the model is significant, as the chi-square = 360.939 with a significance level of $.000$. The constant is $.630$. The logit predicted a frequency equal to $.630 + .126$ (SEXSAME) + $.049$ (GAYWOMEN) - $.008$

(AGE) + .038 (ATTEND) -.017 (CATHO) - .068 (CONPROT) + .080 (EDUC) - .078 (FEMALE) + .014 (INC) + .712 (MARITAL1) + .012 (SOUTH) - .123 (URBAN). As shown in Table 6, the control variables which obtained statistical significance are those indicating age, attendance at religious services, educational level, income, marital status, and urban residence.

A significant regression equation is observed when the control variables are regressed on the dependent variable measuring subjective life excitement. The results concluded that the model is significant, as the chi-square = 337.756 with a significance level of .000. The constant is -2.289. The logit predicted a frequency equal to $-2.289 + .133 (\text{SEXSAME}) + .230 (\text{GAYWOMEN}) - .002 (\text{AGE}) + .099 (\text{ATTEND}) - .118 (\text{CATHO}) - .065 (\text{CONPROT}) + .146 (\text{EDUC}) - .311 (\text{FEMALE}) + .004 (\text{INC}) + .004 (\text{MARITAL1}) - .132 (\text{SOUTH}) + .011 (\text{URBAN})$. The control variables which obtained statistical significance are those indicating attendance at religious services, educational level, female gender and income.

Table 7 Regression Results for the Dependent Variables with Interaction Effect for Gender and Sexual Preference

Variables	Subjective Health (Health1)	Subjective Happiness (Happy1)	Subjective Life Excitement (Life1)
Sexsame	.029/.007 (.065)	.126/1.135 (.264)	.133/1.143 (.214)
Gaywomen	-.115/-.021 (.091)	.049/1.050 (.368)	.230/1.259 (.307)
Age	-.008/-.138 (.001) **	-.008/.992 (.003) **	-.002/.998 (.002)
Attendance	.013/.040 (.004) **	.038/1.039 (.016) *	.099/1.104 (.012) **
Catholic	-.018/-.009 (.023)	-.017/.983 (.098)	-.118/.889 (.075)
Protestant	-.003/-.001 (.030)	-.068/.934 (.123)	-.065/.937 .096
Education	.041/.134 (.004) **	.080/1.083 (.016) **	.146/1.157 (.013) **
Female	.034/.020 (.020)	-.078/.925 (.084)	-.311/.733 (.064) **
Income	.004/.161 (.000) **	.014/1.014 (.002) **	.004/1.004 (.001) **
Marital	-.022/-.013 (.023)	.712/2.038 (.096)	.004/1.004 (.073)
South	-.033/-.019 (.021)	.012/1.012 (.088) **	-.132/.877 (.068)
Urban	-.012/-.022 (.007)	-.123/.884 (.026) **	.011/1.011 (.021)
Constant	2.575 **	.630/1.879 (.258) *	-2.289/.101 (.204) **
R ²	.075 **		
	Chi-square	360.939 **	337.756 **
	N	6890	4582

Note: Cell entries for Multiple Regression are given as unstandardized regression coefficient/standardized (beta) coefficient with the standard error given in parentheses. Cell entries for Logistic Regression are given as logistic regression coefficient/ odds ratio, with the standard error given in parentheses.

p < .05 = *, p < .01 = **

CHAPTER FIVE: CONCLUSION

This study attempts to ascertain the differences between heterosexual and homosexual respondents on self-report GSS variables. The goal is to tap the dimensions of subjective well-being using health, happiness, and life excitement indicators to ascertain potential differences. Both logistic and multiple regression are used within the analysis.

The extant literature does not indicate a consensus as to whether or not homosexuals have lower quality of life. The results of this study indicate that, as a general assertion, there are few differences between heterosexuals and homosexuals with regard to subjective quality of life indicators. However, for both groups, there are several control variables that attained statistical significance and serve to predict a higher or lower general quality of life.

For the dependent variable measuring subjective health, regressions run for both heterosexual and homosexual respondents are statistically significant. For both populations, higher education and income are statistically correlated with having a higher level of subjective health, and age is statistically correlated with having a lower level of subjective health. Additionally, for the heterosexual population, attendance at religious services is statistically correlated with having a higher measure of self-reported subjective health.

Regarding the dependent variable measuring subjective happiness, the logistic regression analysis for homosexual respondents is not statistically significant, whereas the logistic regression run for the heterosexual respondents is statistically significant. The results show that a number of variables are important in predicting subjective happiness for heterosexuals but not for homosexuals. Within the model for heterosexuals, age, attendance at religious services, education, income, marital status, and urban residence are significant for their ability to predict

one's response. For the homosexual population, only the respondents' income is a statistically significant predictor of subjective happiness. However, when looking at age as a control variable for both homosexuals and heterosexuals, the logits are similar and the lack of significance for homosexuals is most likely an effect of small sample size.

For the dependent variable measuring subjective life excitement, the logistic regression analysis for homosexual respondents is not statistically significant, whereas the logistic regression run for the heterosexual respondents is statistically significant. A number of variables are important in predicting subjective life excitement for heterosexuals, but not for homosexuals. Within the model for heterosexuals, attendance at religious services, education, and income are significant for their capability to predict one's response. However, for the homosexual population, only the respondents' education is a statistically significant predictor of subjective life excitement.

Table 7 shows the regression results for all dependent variables regressed upon the entire sample. All models are statistically significant. Within these models both sexual preference and the effect of being a homosexual woman are controlled for. Neither is statistically significant for any of the dependent variables.

This finding is reinforced by the information contained in Table 1, which shows that when independent sample t-tests are performed with the dependent variable as the test variable and sexual preference as the grouping variable, none of the tests exhibit statistical significance. This is an indication that there is no significant difference between homosexual and heterosexual respondents.

Although there is no significant between-group difference for all dependent variables, there are some similarities, as indicated in Table 7. Attendance at religious services, education,

and income are positively correlated at a statistically significant level with a higher score on each of the three dependent variables. This shows that higher income and education as well as increased attendance at religious services transcends sexual preference and increases subjective quality of life for health, happiness, and life excitement for both heterosexuals and homosexuals.

As this project uses GSS data, the variables as well as the analysis and results that follow are limited by the data. First, the GSS does not explicitly ask the respondent about their sexual orientation. Therefore, some respondents who do not personally identify as homosexual yet have engaged in homosexual activity may be considered homosexual for the purposes of analysis. Another limitation of the data is the wording and answer choices for the variable measuring subjective happiness. The response choice for the original question regarding happiness consists of very happy, pretty happy and not too happy. Although the question is common in quality of life surveys, some advanced critics take offense to it and discount it as a serious question (Hamilton and Wright 1986). However, indicators of well-being and quality of life are subjective regardless of question and answer format. Their continued presence in survey research attests that the question format, although not perfect, is nonetheless functional.

This project seeks to extend the literature regarding subjective quality of life. As discussed earlier, there is no consensus as to whether sexual preference effects quality of life. Sandfort et. al. (2003) discussed the importance of analyzing data separately for men and women. This study did not analyze separately but did control for gender within all equations. The effect of identifying as both female and homosexual is controlled for in the final equation and did not achieve statistical significance. Although Horowitz et. al. (2001) failed to prove that sexual orientation is either strongly or directly related to quality of life indicators, they indicated that there are some background and demographic differences. This project has identified some

of those variables that serve to predict subjective quality of life for both homosexual and heterosexual individuals.

The findings reported within this research serve to contribute to the body of literature available regarding quality of life and sexual orientation. The findings may serve as a springboard to uncover those control variables which do affect subjective quality of life for homosexuals, as it is obvious that many of the variables which predict quality of life for heterosexuals do not have the same impact for homosexuals. The incorporation of additional control variables to understand their effects on quality of life for both populations is recommended. Additionally, further research should be completed regarding subjective quality of life, sexual orientation, and frequency of sexual intercourse to see if frequency of sexual activity predicts subjective quality of life.

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