DISSERTATION PROPOSAL

Sexual Compulsivity among Men who have sex with Men

Christian Grov

Department of Sociology
CUNY Graduate Center

Chair: Juan Battle
Committee Members: Jeffrey T. Parsons & Victoria Pitts

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ABSTRACT

How do social forces (norms, community attachment, anomie, homo-negativity, urbanization, class, race and ethnicity), socio-psychological factors (depression, anxiety, etc), sexual behavior, and substance use (drugs & alcohol) manifest in the lives of men who have sex with men (MSM) with symptoms of sexual compulsivity (SC)? Further, how do these factors differ between MSM with symptoms of SC and those without? SC is currently understood via medical and psychological models; meanwhile, little is known from a sociological standpoint.

Two existing datasets will be used to answer these questions. (1) Survey data of MSM from NYC and LA (n = 1851) will be quantitatively analyzed, comparing and contrasting MSM with symptoms of SC to those with less symptoms of SC. (2) Qualitative and quantitative data from a sample of MSM with symptoms of SC (n = 183) will be utilized. Structural Equation Modeling will be used to test and apply theories of social bonding and health behavior. Meanwhile content analysis and iterative process coding will be the basis for exploring qualitative discourses of resilience and the negative impact(s) of SC.

Data collection, entry and cleaning for all phases have been completed. Analysis and writing of results are expected to conclude by Fall 2006. Data management software and unpaid research interns are available in-kind via the Center for HIV Educational Studies and Training (CHEST). Funding for dissemination and professional development (i.e., conference travel) are being explored. Core conferences (ASA, ESS, APA & APHA) will cost approximately $3,500 to attend (including registration, membership, travel and accommodations).

BACKGROUND

Statement of the Problem

How do social forces (norms, community attachment, anomie, homo-negativity, urbanization, class, race and ethnicity), socio-psychological factors (depression, anxiety, etc), sexual behavior, and substance use (drugs & alcohol) manifest in the lives of sexually compulsive (SC) men who have sex with men (MSM)? Further, how do these factors differ between MSM with SC and those without?

Rationale

Sexual compulsivity (SC) has been discussed throughout many bodies of academia including psychological, medical, public health, and socio-behavioral literatures. From their standpoint, understanding SC is essential among MSM for many reasons, including the identified link between SC and risky sexual behavior (Benotsch, Kalichman & Kelly, 1999; Dodge et al., 2004; Kalichman, Greenberg & Abel, 1997; Kalichman et al., 1994; Kalichman & Rompa, 1995; 2001; Reece, Plate, & Daughtry, 2001). In essence, much of the current SC research among MSM is encapsulated around understanding risky sexual behavior as a public health phenomenon.

From a sociological standpoint, SC is not well understood. Medical sociologists have long argued many diseases/illnesses are socially constructed (Conrad, 1997). Furthermore, the uneven distribution of disease/illness is inherently linked to social structure including class, gender, and race & ethnicity (Conrad, 1997). This analysis will apply concepts of medical sociology and those of the sociology of human sexuality to understanding the creation, manifestation, and epidemiology of SC among MSM.

From a micro-sociological perspective, this analysis will contribute to an understanding of how MSM with symptoms of SC manage both identity and behavior (e.g., Goffman's

dramaturgy). From a macro-sociological perspective, this analysis explores the impact of social forces such as urbanization (i.e., moving to an urban epicenter) and technology (i.e., the Internet). Agents of socialization such as peer groups, community norms and attachment will also be explored as they impact SC. Socio-structural forces such as class, race and ethnicity will also be incorporated. In essence, questions central to the discipline of sociology are at the crux of this analysis.

Theoretical Framework

Sociology has documented the connection between social forces and human behavior (e.g., anomie & Durkheim's *Suicide*). Social forces have been discussed among many researchers and demonstrated themselves cardinal across a variety of academic disciplines (Battle, et al., 2000; Lemelle & Battle, 2004; Pitts, 2001; 2004). This analysis hypothesizes that factors such as norms in the gay community, attachment to the gay community, homonegativity[1], urbanization, race and ethnicity, class, and technology play a substantial role in the manifestation of SC among MSM. These social forces may also play mediating roles in socio-psychological well being (depression, anxiety, etc), sexual behavior, and substance use (drugs & alcohol).

One potential model that may explain these relationships is the Health Belief Model (Hochbaum, 1958; Kirscht, 1974; Rosenstock, 1960, 1974). The Health Belief Model (HBM) proposes behaviors are a product of both values and expectations. "Values" are operationalized as a desire to avoid illness (or get well), while "expectations" are the belief that a specific health action would prevent (or ameliorate) an illness. The HBM has been applied in many situations including explaining sexual behavior, such as the choice to use a condom (Laraque et al., 1997; Steers et al. 1996).

[1] The term "homonegativity" (Herek, 2000) is being used in place of homophobia (Weinberg, 1973) as negative attitudes and behaviors toward gay, lesbian, bisexual, and transgendered individuals are not essentially the result of a "phobia."

In attempting to assess the impact SC has on MSM, this analysis dually seeks to understand how MSM with symptoms of SC come to manage both their identity and behavior. Goffman's (1959) concepts of dramaturgy and impression management will serve as the theoretical foundation. Cooley's (1902) concept of the Looking Glass Self, whereby self identify is formed as a function of perceptions, will also be applied.

Literature Review

SC is characterized by sexual fantasies and behaviors that increase in frequency and intensity so as to interfere with personal, interpersonal, or vocational pursuits (Kafka, 1994, see Black, 1998 for a review of SC literature), resulting in: interpersonal conflict and distress; social and occupational problems resulting from lack of time to participate in non-sexual activities; psychological distress, especially regarding self-esteem; and financial problems resulting from the costs of pornography, paying for sex, and loss of income from avoiding work responsibilities (Muench & Parsons, 2004). Within academia, SC has also been called sexual addiction and compulsive sexual behavior (Black, 1998; Black, Kehrberg, Flumerfelt & Schlosser, 1997; Carnes, 1983; Coleman, 1992a, 1992b; Goodman 1993).

SC can be divided into paraphilic and non-paraphilic types (Kafka, 1994). Non-paraphilic SC represents exaggerated expressions of more socially acceptable behaviors including excessive use of pornography, searching for sex on the Internet and sex with multiple anonymous partners; (Coleman, Raymond & McBean, 2003) however, not hypersexuality, nymphomania, or Don Juanism (Barth & Kinder, 1987; Coleman, 1992a, 1992b; Gold & Heffner, 1998; Orford, 1978; Quadland, 1985). This analysis focuses exclusively on non-paraphilic SC, as treatment, policies, and interventions for paraphilic types would be significantly different. Further paraphilias are less associated with HIV infection or transmission risk among MSM.

SC has been likened to an addictive disorder, obsessive-compulsive disorder, and impulse control disorder (Gold & Heffner, 1998). Those investigating SC agree that non-paraphilic SC warrants classification as a mental health disorder (Black et al., 1998), but even among these researchers there is little consensus about its proper diagnostic classification (Coleman et al., 2001; 2003). The *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* is silent on diagnostic criteria of SC; however lists non-paraphilic forms of SC as a "sexual disorder not otherwise specified." Coupled with a lack of a clear definition for SC, there is little available large-scale research on the topic (Gold & Heffner, 1998). The prevalence of SC in the US is estimated from between 3% to 6% (Black, 1998; Coleman 1992a; Carnes, 1991), with significantly higher incidences among men (Dodge, Reece, Cole, & Sandfort, 2004; Gullette & Lloyns, 2005; Missildine, Feldstein, Punzalan, & Parsons, 2005).

A number of pioneering studies on the descriptive features of non-paraphilic SC have been conducted (i.e. Black et al., 1997; Carnes, 1991; Kafka, 1997; Kafka & Prentky, 1992; 1994; Kafka & Hennan, 1999; Raymond, Coleman & Miner, 2003; Coleman, Miner, Ohlerking & Raymond, 2001). However, these studies are limited in their ability to evaluate the classification of SC. First, these studies did not assess reliability nor rudimentary descriptive validity of a criteria set. Second, sample sizes were generally small and select. Specifically, participants were typically seeking treatment or identified themselves as sexually compulsive. These sample limitations make it difficult to determine whether the distress reported was a product of conflict between culturally defined sexual norms and individual behavior, or represented a clinically significant disorder. In addition, high comorbidity rates across prior studies, makes it unclear whether the participant's sexual problems were not simply manifestations of other underlying disorders.

The field of sociology is virtually silent on SC. Intensive literature reviews found only one instance where SC has been evaluated from a sociological standpoint. In their article, Levine and Troiden (1988) are highly critical of SC arguing "the diagnosis of sexual addiction or compulsion rests on culturally induced perceptions of what constitutes sexual impulse control" (p. 351) and that the diagnosis was "created" as a way of limiting individual freedom to experiment sexually (Gold & Heffner, 1998; Levine & Troiden, 1988). Levine and Troiden (1988) have offered keen insight both to how SC has been socially constructed, and to how these social definitions could potentially be used as a tool to constrict sexual freedom. In response, SC researchers and academics have recognized the dangers of defining "compulsive sexual behavior simply as behavior which does not fit normative standards," agreeing this interpretation of SC could be used as a tool to constrict sexual freedom (Coleman, 1992 p. 323). In essence, discourses of SC must differentiate themselves from *cultural* definitions of non-normative sexual behavior, and rather those align themselves with those at the crux of SC: behaviors or fantasies that may interfere with personal, interpersonal, or vocational pursuits

Medical sociologists have long argued all disease is socially constructed and, although disease itself may exist outside the realm of any social construction, it is *social* construction of disease that dictates how society and individuals come to both understand and *socially* treat disease (Conrad, 1997). Medical sociologists are additionally keen to the socio-historical and political contexts to which disease emerge. Whom the disease impacts plays a vital role in both contemporary and historical, treatment and discourses (or lack thereof). Although SC may have existed throughout history, it wasn't discussed among academics until the latter half of the last century. Discourses of SC emerged out of those surrounding the sexual liberation movement of the 1960s. Encapsulated in time, these discourses changed in the 1980's with the discovery of

HIV and AIDS. Socio-historical principles will be at the epicenter of understanding both how individuals view their own sexual behavior and how society perceives sexual behaviors/disorders.

Contribution to the Field

This analysis seeks to answer two questions: (1) How do social forces (norms, community attachment, anomie, homo-negativity, urbanization, class, race and ethnicity), socio-psychological factors (depression, anxiety, etc), sexual behavior, and substance use (drugs & alcohol) manifest in the lives of sexually compulsive (SC) men who have sex with men (MSM)? And (2) how do these factors differ between MSM with SC and those without? Current research on SC among MSM follows medical and psychological models and is based typically on small samples of MSM with SC currently seeking psychological/medical therapy/treatment. There is highly limited research of SC both within community-based samples of MSM and samples of MSM with SC who are not under medical/psychological treatment/therapy. Meanwhile a sociological perspective is completely absent. In an effort to fill these gaps, this analysis will utilize sociological theories and two existing datasets: (1) a community-based sample of MSM, and (2) a sample of MSM with symptoms of SC who were not currently under medical/psychological treatment/therapy.

METHODS

In an effort to adequately explore the research question(s), analysis will occur in three (3) phases and utilize two (2) existing datasets.

Phase I: Comparing and Contrasting MSM with symptoms of SC to MSM without

Much research on SC among MSM is typically from small samples of MSM who were currently in medical/psychological treatment/therapy. As a result, the epidemiology of SC as it

manifests in community-based samples is not well understood. Prior to an in-depth analysis of MSM *with* symptoms of SC, it is necessary to explore *how* MSM with symptoms of SC may differ from MSM without SC.

Participants and Procedures

A cross-sectional brief street-intercept survey method (Miller, Wilder, Stillman, & Becker, 1997) was used to administer the "Sex and Love Survey, Version 3.0" to 1,851 male participants at a series of gay, lesbian and bisexual (GLB) community events in New York City and Los Angeles in the fall of 2004. The brief intercept survey approach to collecting data has been used in previous studies, including those focused on GLB persons, and has been shown to provide data that is comparable to that obtained from other more methodologically rigorous approaches (Bimbi et al., in press; Grov, Bimbi, Nanin & Parsons, in press; Halkitis & Parsons, 2002; Koken, Parsons, Bimbi, & Severino, 2005; Missildine, Feldstein, Punzalan, & Parsons, 2005; Tider, Parsons, & Bimbi, 2005).

The response rate was high, with 87.0% of individuals consenting to complete a survey. As an incentive, those completing the 15-20 minute questionnaire were provided with a voucher for free admission to a movie. The survey instrument included items that assessed experience with a broad range of sexual behaviors, sexual compulsivity, history of sexually transmitted infections, substance use, physical health, and a series of scales related to psycho-social well-being. This study was conducted by the Center for HIV/AIDS Educational Studies and Training (CHEST) and approved by the Institutional Review Board of Hunter College of the City University of New York.

To protect their confidentiality, participants were given the survey on a clipboard so they could step away from others to complete the questionnaire. Participants were also requested not

to include any identifying information on the surveys. Upon completion, participants deposited their survey into a secure box at the event. Data were entered into an SPSS database and subsequently verified by project staff for accuracy.

Measures

Demographics. Among other variables, participants were asked to indicate their age, sexual identity, and race/ethnicity (by checking all that apply). Response categories to race/ethnicity included "African American," "Asian/Pacific Islander," "European/White," "Hispanic/Latino," and "Other (Specify)."

Sexual Compulsivity. SC was measured using Kalichman et al. (1994) ten-item Likert-type scale. This measure assesses the impact of sexual thoughts on daily functioning and the inability to control sexual thoughts and/or behaviors and scores can range between ten and forty. Kalichman discusses individuals "high" on SC, versus those not. For his measure, individuals scoring more than two standard deviations above the mean (a score above 24) are considered "high" on SC (Kalichman et al., 1994; Kalichman & Cain, 2004). This measure has been applied widely including HIV positive men and women (Benotsch, Kalichman, & Pinkerton, 2001; Kalichman & Rompa, 2001; Kalichman, Greenberg, & Abel, 1997), college students (Dodge, Reece, Cole Sandfort, 2004; Gullette & Loyns, 2005), gay, lesbian and bisexual individuals (Missildine, et al. 2005), and male sex workers (Parsons, Bimbi, & Halkitis, 2001).

Sexual Behavior. Participants, who were not in mutually monogamous relationships (n = 1,283), indicated their sexual behaviors for non-main partners of the same HIV serostatus and their sexual behavior with men of different or unknown serostatus. Participants further indicated if they were anal insertive and or anal receptive with these partners. This analysis is therefore able to assess serosorting (sex with similar HIV status partners) and positionality (anal

receptive/insertive) (Semple, Paterson & Grant, 2000; Simon et al., 1999; Van de Ven, et al., 2002), both of which are essential to grasp variant levels of sexual behavior.

Substance Use. Participants reported if they had ever used Crystal Methamphatamine, ketamine, GHB, cocaine, & MDMA/ecstasy, both in their lifetimes and in the three months prior to being surveyed. Responses were dichotomized as "yes" or "no."

Analytic Plan

Men reporting higher scores on Kalichman et al (1994) SC scale will be compared and contrasted to those with lower scores in an effort to understand both socio-demographic, socio-structural and behavioral differences between these two groups. Specifically factors such as HIV serostatus, age, race and ethnicity, class (i.e., income and education), substance use, depression, gay related stigma, temptation for unsafe sex, sexual behavior (safe and unsafe), etc. will be analyzed between these two groups in an effort to better understand the social epidemiology of SC among MSM. Essential questions include:

a. Does SC manifest in particular age groups?
b. Are there racial or ethnic differences in the prevalence of SC?
c. Are there class (i.e., income and education) differences in the prevalence of SC?
d. Are men with SC more or less likely to be HIV positive?
e. Are men with SC similar or dissimilar in their psychological and mental well being?
f. What kind(s) of comorbidity does substance use have in men with SC compared to those without?
g. How does sexual risk (and safety) vary between men with SC and those without?
h. Are men with SC more likely to be single?
i. Do they report more sexual partners?
j. Are there income disparities between men with SC and those without?
k. Are there differences in attachment to the gay community?
l. Have MSM with SC experienced different levels of homonegativity?

Understanding these basic differences between men with SC and those without in a community based sample of gay and bisexual men will contribute to literatures of sexual compulsivity, sexual minorities, and HIV prevention. Further, it will provide a global

understanding of sexual behavior and compulsivity from a community perspective, informing those seeking to provide services not only for those with SC but also gay and bisexual men in general.

Phase II: Quantitative Analysis of MSM with SC, Structural Equation Modeling (SEM)

Phases II and III will use the second dataset. Although there has been a growing body of research on SC, most sample sizes were small or came from populations currently seeking medical/psychological treatment/therapy. To address these sample limitations, Phase II will analyze the quantitative data and Phase III will analyze the qualitative data gathered from a sample (n = 183) of NYC-based MSM whom self-identified with symptoms of SC and were not currently under medical/psychological treatment/therapy. Social norms regarding sexual behavior are thought to be more liberal among MSM living in urban areas, than those for heterosexual populations. Thus, the sample offered an opportunity to reduce an important confound: that distress associated with sexual behavior was primarily related to socially-defined conflicts (such as norms against having multiple sex partners).

Participants and Procedures

Recruitment procedures were designed to identify a sample of MSM who were having trouble controlling their sexual behaviors. To avoid self-labeling, the recruitment materials read: "Is your sex life spinning out of control? Is sex interfering with your life? Are sexual thoughts getting in the way?" Recruitment included active techniques such as direct personal contact at venues where sex is known to occur among MSM, such as bathhouses and cruising locations. Further passive means, such as posting tear-off flyers in high-density spots where people search for sexual partners, also served as a recruitment technique. All participants were biologically male, at least eighteen years old, identified as gay or bisexual, scored one standard deviation

above the mean on the Kalichman Sexual Compulsivity Scale (KCSC; Kalichman 1994), had sex with at least two partners in the last ninety days, and evidenced geographical stability by not having changed addresses twice within the last six months. Participants were excluded if they were grossly cognitively impaired, were currently psychotic, and/or had been in more than two other research studies in the last two years.

In total, 364 persons were screened by telephone and 282 were eligible based on the phone interview. Of the 282 eligible, thirty-seven did not show for their interview, twenty-three were dismissed prior to completing the interview for inconsistent responses between the interview and the screening measure, and six reported being no longer interested. Of the 216 participants who completed the interview, thirty-three were dropped because they did not meet eligibility criteria once interviewed. The majority of these excluded men reported less than two sex partners in the last ninety days, or had inconsistent response patterns on self-report scales. The final sample was 183 men. Participants were provided a complete description of the study and written informed consent was obtained. Eligible persons were compensated $40 for participation, which included completing a one-time two to four hour assessment. The IRB of Hunter College of the City University of New York approved this project.

At no point were participants labeled or referred to as “sexually compulsive” by the research team, but rather asked what *they* preferred to call what they were experiencing. The research team then used that terminology while working with participants. As mentioned, none of the recruitment materials used the terms “compulsive” or “addiction.” Participants were a heterogeneous group of 183 gay or bisexual men ranging in age from 19-63 that *self identified* as having difficulty controlling their sexual behavior.

The sample consisted primarily of white men, though 41% were ethnic minorities. The sample was well educated, with 88.6% having completed at least some college. Approximately 58% were employed full or part-time. Most men were gay identified and 36.6% reported being in a current relationship. Nearly a quarter of the men were HIV positive and over three-quarters had experienced a sexually transmitted infection other than HIV in their lifetime.

Measures

All men completed a quantitative interview on the *Audio CASI system* (*ACASI*), using a computer and voice recordings so that the participant hears (through headphones) and sees (on the screen) each question and response list. Their response is then entered directly into the computer. *ACASI* has been found to be an effective interview method for people of diverse educational backgrounds, and eliminates the effects that reading ability have on internal validity (Gribble, Miller, Rogers, & Turner, 1999; Turner, Ku, Rogers, Lindberg, & Pleck, 1998). Studies have shown that *ACASI* increases the proportion of individuals admitting sexual behaviors and illicit drug use (Tourangeau & Smith, 1996; Turner, Ku, Rogers, Lindberg, & Pleck, 1998). One study found that intravenous drug users were more likely to report HIV sexual and injection risk behaviors, as well as more same-sex sexual activity, through an *ACASI* assessment, compared to a face-to-face interview (Des Jarlais et al., 1999). *ACASI* allows greater respondent privacy and removes barriers to honest responding, such as embarrassment, feedback from facial expressions of the interviewer, and other social influences (Gribble et al., 1999).

Members of the research team also gathered screening and interview data via paper and pencil, which were also entered into the *ACASI* database. Identifying information was kept separate from data and all computer files were password-protected, while paper files were stored in locked cabinets with access for research study staff only.

Participants answered a battery of questions including those on substance use, sexual behavior, homonegativity, gay community affiliation, depression, anxiety, norms for SC, etc.

Analytic Plan

In an effort to explore the multitude of factors having impact on the lives of MSM with symptoms of SC, univariate, bivariate, and multivariate analysis with structural equation modeling (SEM) will be used. Chiefly, this analysis will explore the interactive roles of social forces (norms, community attachment, anomie, homonegativity, urbanization, class, race & ethnicity), socio-psychological factors (depression, anxiety, etc), sexual behavior and substance use (drugs and alcohol) as they impact the lives of MSM with symptoms of SC. One theoretical framework to be adapted is the Health Belief Model (Hochbaum, 1958; Kirscht, 1974; Rosenstock, 1960, 1974).

Phase III: Qualitative Analysis of MSM with SC

The same 183 men from Phase II also completed a semi-structured interview that was recorded and transcribed. Interviewers received extensive didactic training on clinical interviewing, question intent, and supervision on coding, and participated in weekly interview meetings. An inter-rater reliability study established five ratings for 25 randomly selected interviews.

Measures

The interview included broad questions about how SC had impacted the respondent's lives, sexual behavior, relationships and psychological well-being. Additionally men were asked how they managed their SC, including treatment, management, and support.

Analytic Plan

Transcript data will be analyzed using Nud*ist qualitative data management software and using content analysis (Bernard, 2000) with an iterative process for coding, categories and concepts that emerge from text will first be identified, and these concepts will be linked into substantiate and formal theories. Content analysis of interview data has been used by numerous researchers in a variety of contexts (Ip & Chiu, 2002; Jirapaet, 2001; Mackey, 1990; Mazawi & Yogev, 1999; Quirouette & Pushkar, 1999). The basis of this analysis will be to explore discourses of both resilience and the negative impact(s) of SC. Further, the relationship between SC and social forces, socio-psychological factors, sexual behavior, and substance use will be assessed.

Quality Assurance:

Bourdieu (1990) argued sociologists must look within themselves to understand that process (methodology) and product (findings) are inseparable (i.e., reflexive sociology). Using these principles, I will continually acknowledge my goals as a gay man in conducting this analysis. Primarily, I wish to empower MSM and MSM with SC, while also contributing to the fields of sociology, psychology and public health. Quality assurance of this research will rely upon both sound methodology (such as theory driven research) and supervision/mentorship by the dissertation committee. Additional experts in SC and MSM will be consulted in addition to using previous research as benchmarks for comparison.

Logic Model of Current Study

Durkheim (1951) identified the power of social forces on human behavior, demonstrating that social facts (i.e., the rate of suicide) were a manifestation of social forces, such as the extent to which individuals are bonded to a society. Applying Durhkeim's concepts, this analysis will

explore *attachment* to the gay community and its role in SC (both as a predictor of SC and an outcome of SC). It will dually assess social support networks (i.e., social ties and social bonds). Further, adopting Durkheims concepts of the division of labor and organic solidarity (and alienation), this analysis will consider the impact of urbanization and technology on SC.

Cooley (1902), emphasized the impact of perceptions on both self-identity and behavior, demonstrating the power of society on the individual. Medical sociologists exploring the social construction of disease have long emphasized the importance of understanding both how society treats disease and how individuals come to view themselves as having "disease." Applying Cooley's concepts of the looking glass self, while incorporating medical sociologists' concepts of the social construction of disease, this analysis will consider how individuals with SC come to self identify and how perceptions of others influence this self-identity

Goffman (1963) emphasized both how individuals act out roles in society, and how individuals manage stigma(s) that were created by society and placed on individuals. Applying Goffman, this analysis will explore the "stigma" of SC and how men may manage this stigma (i.e., front stage and back stage behavior, keeping face). It will also explore how other "stigmas" (i.e., being a sexual minority, person of color) may interact with that of being SC.

Finally, this analysis will adopt the Health Belief Model (Hochbaum, 1958; Kirscht, 1974; Rosenstock, 1960, 1974), in exploring how social forces, socio-psychological factors, sexual behavior, and substance use, manifest in the lives of MSM with SC (see Appendix A: Figures 1, 2).

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APPENDICIES

APPENDIX A: FIGURES

Figure 1. Theoretical Framework

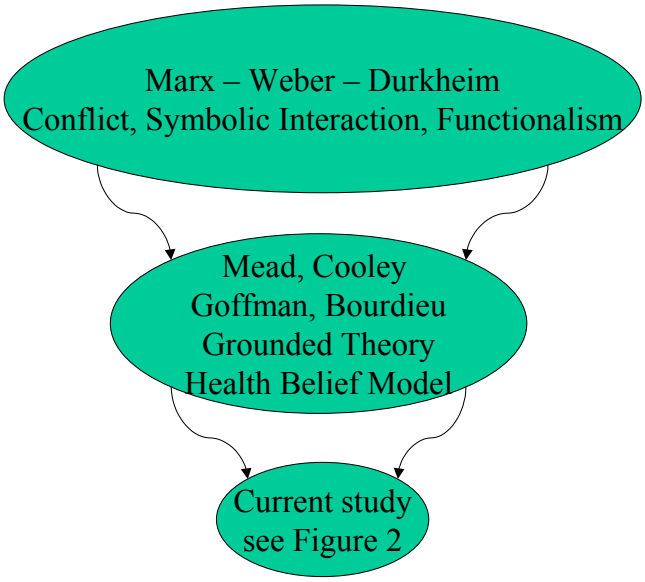
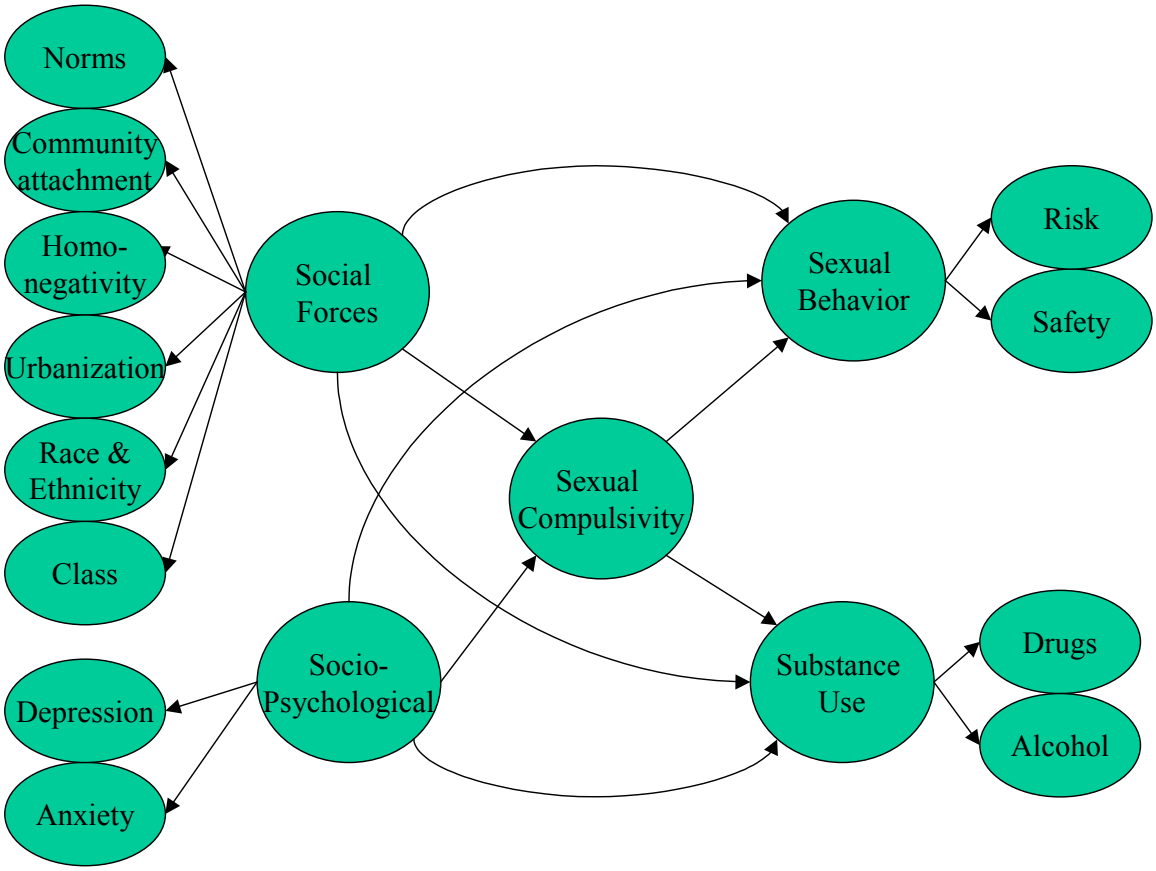


Figure 2. Logic Model of Current Study



APPENDIX B: CHAPTER OUTLINE

Chapter 1: Background and Introduction

This chapter will briefly cover the socio-political history of sexual compulsivity (roughly 1950s-Present). It will briefly analyze how our understanding of SC has changed with particular emphasis into how SC has come to be understood among MSM. Special emphasis will be allocated to the emergence of the HIV/AIDS epidemic of the 1980's and to new technologies such as the Internet in how SC has come to be understood among MSM. This chapter will additionally incorporate sociological standpoints (including medical sociology), sociological theory, and health behavior theories

Chapter 2: Research Methods

This chapter will briefly cover the research methods of previous SC researchers, highlighting both strengths and weaknesses. It will next address the research methods of this study (Phases I, II, and III).

Chapter 3: Results

Because several phases have been incorporated into this analysis, the results section has been divided into respective phases.

Chapter 3a: The Sex and Love Study. Phase I of the analysis compares and contrasts men low on SC to men high on SC using data gathered at large scale GLB events from the Sex and Love Study. This will be a quantitative comparison

Chapter 3b: Project SPIN Quantitative. Phase II of this analysis utilizes the quantitative data of 183 men with symptoms of SC from Project SPIN. This analysis will incorporate Structural Equation Modeling.

Chapter 3c: Project SPIN Qualitative. Phase III of this analysis utilizes the qualitative data of 183 men from project SPIN. This portion of the results section will be subdivided into sections based on data themes having emerged (i.e., "The impact of SC," "SC and sexual behavior," "SC in the new Millennia: Urbanization and technology"). In addition to discussing themes having emerged from the data, the concepts of dramaturgy and stigma (Goffman) and the looking glass self (Cooley) will be qualitatively assessed as they may or may not appear within the data.

Chapter 4: Discussion

This chapter will briefly revisit the results of chapter 3. It will further offer interpretation of findings in addition to synthesizing the findings from all the parts of Chapter 3. It will revisit the different perspectives of SC including the medical sociological standpoint. Finally, it will revisit sociological standpoints of Durkheim, Cooley and Goffman as applied in this analysis.

Chapter 5: Future Directions

This chapter will visit current directions in SC research and offer additional directions based both on where current research is lacking and from the findings of this study. It will also offer new directions in conceptualizing and treating SC (from a sociological standpoint). Finally, it will offer an anecdotal evaluation of incorporating interdisciplinary perspectives in research (i.e., sociology, social-psychology, public health).

APPENDIX C: TIMELINE

This dissertation utilizes data from two completed studies. Data collection, entry and cleaning for all phases have already been completed. Conducting analysis and writing results are projected to be the most time intensive portions of seeing this dissertation to fruition. Pending committee approval of this proposal by the close of the Fall 2005 term, this project is expected to finish by the close of the Fall 2006 term. See the Gant chart/timeline on the next two pages.

TIMIELINE PART 1 of 2

Christian Grov, Progress Toward PhD Timeline 1/1/2006

	2005				2006							
	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Topic Agreement with Battle	■											
Proposal Draft 1 to Battle		■										
Edits to Proposal Draft 1		■										
Finalized Selection of Dissertation Committee		■										
Proposal Draft 2 to Full Committee (Battle, Parsons, Pitts)		■	■									
Face to face meeting with entire committee			■									
Edits to Proposal Draft 2			■									
Final Proposal to Full Committee			■									
Final Edits to Proposal, Prep for FMC			■									
IRB Approval			■									
Submit to FMC				■								
Review by FMC					■	■						
Writing Intro/Background						■						
Submit Intro/Background for Comments						■						
Edit/Finalize Intro/Background							■					
Writing Methods							■					
Submit Methods for Comments							■					
Edit/Finalize Methods								■				
Data Analysis					■	■	■	■	■	■	■	■
Writing Results								■	■			
Submit Results for Comments									■			
Edit/Finalize Results									■	■		
Writing Conclusion / Discussion / Future Directions										■	■	
Submit Conclusion for Comments											■	
Edit/Finalize Conclusion											■	
Finalize Full Dissertation												■
Full Dissertation Review by Committee												
Edits to Final Dissertation (prepare for Defense)												
Defend Dissertation												
Finalize Defended Dissertation												
Deposit Dissertation												
NRSA Grant Application Prep	■	■	■	■								
Funding from NRSA (if funded)									■	■	■	■
Practice/Deliver Job Talk												■
Teaching (Adjunct at John Jay)	■	■	■	■		■	■	■	■			■
Working at CHEST	■	■	■	■	■	■	■	■	■	■	■	■
Apply for Post Docs												
Apply for Jobs (Starting 10/2006)												
Interviewing (Jobs/Post Doc)												
Start Job / Post Doc (9/2007)												
Writing for Publication	■	■	■	■	■	■	■	■	■	■	■	■

TIMELINE PART 2 of 2

Christian Grov, Progress Toward PhD Timeline 1/1/2006

					2007								
	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept
Topic Agreement with Battle													
Proposal Draft 1 to Battle													
Edits to Proposal Draft 1													
Finalized Selection of Dissertation Committee													
Proposal Draft 2 to Full Committee (Battle, Parsons, Pitts)													
Face to face meeting with entire committee													
Edits to Proposal Draft 2													
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Final Edits to Proposal, Prep for FMC													
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Review by FMC													
Writing Intro/Background													
Submit Intro/Background for Comments													
Edit/Finalize Intro/Background													
Writing Methods													
Submit Methods for Comments													
Edit/Finalize Methods													
Data Analysis													
Writing Results													
Submit Results for Comments													
Edit/Finalize Results													
Writing Conclusion / Discussion / Future Directions													
Submit Conclusion for Comments													
Edit/Finalize Conclusion													
Finalize Full Dissertation													
Full Dissertation Review by Committee													
Edits to Final Dissertation (prepare for Defense)													
Defend Dissertation													
Finalize Defended Dissertation													
Deposit Dissertation													
NRSA Grant Application Prep													
Funding from NRSA (if funded)													
Practice/Deliver Job Talk													
Teaching (Adjunct at John Jay)													
Working at CHEST													
Apply for Post Docs													
Apply for Jobs (Starting 10/2006)													
Interviewing (Jobs/Post Doc)													
Start Job / Post Doc (9/2007)													
Writing for Publication													

APPENDIX D: BUDGET

The data for all phases have already been collected, entered into data management software (SPSS, Nud*ist), and cleaned, hence research expenses associated with project administration have already been expended. Foreseeable expenses include office supplies and some human labor involved with coding qualitative data. Fortunately, via the Center for HIV Educational Studies and Training, the researcher has ample access to a pool of undergraduate interns whom can be trained on Nud*ist coding.

Other research expenses for professional development and research dissemination (i.e., conference travel) can exceed thousands of dollars. Core conferences such as the American Sociological Association (ASA), Eastern Sociological Society (ESS), American Public Health Association (APHA) and the American Psychological Association (APA) are estimated to cost about $3,500 for membership, registration, accommodations and travel. Alternate sources of funding via the Department of Sociology, the Center for Lesbian and Gay Studies (CLAGS), the Society for the Scientific Study of Sexuality (SSSS), the Doctoral Students Counsel of the Graduate Center, the Graduate Research Grants Program at CUNY, etc. are being pursued.

Additionally, I have applied for the Ruth L. Kirschstein National Research Service Award, for a twelve month training fellowship awarded by the NIH. If approved, funding will begin in May 2006.

APPENDIX E: IRB HUMAN SUBJECTS

The data for all phases have been gathered via Hunter College's Center for HIV Educational Studies and Training (CHEST) and approved by the IRB of Hunter College of the City University of New York. As my appointment is at the Graduate Center (GC), I have applied for expedited review and been approved via the GC's IRB for the secondary analysis of data.

All participants were over the age of 18 and personally identifiable information is not available.