The Impact of Homophobia, Poverty, and Racism on the Mental Health of Gay and Bisexual Latino Men: Findings From 3 US Cities

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A B S T R A C T

Objectives. This study assessed the relation between experiences of social discrimination (homophobia, racism, and financial hardship) and symptoms of psychologic distress (anxiety, depression, and suicidal ideation) among self-identified gay and bisexual Latino men in the United States.

Methods. Data were collected from a probability sample of 912 men (self-identified as both Latino and non-heterosexual) recruited from the venues and public social spaces identified as both Latino and gay in the cities of Miami, Los Angeles, and New York.

Results. The study showed high prevalence rates of psychologic symptoms of distress in the population of gay Latino men during the 6 months before the interview, including suicidal ideation (17% prevalence), anxiety (44%), and depressed mood (80%). In both univariate and multivariate analyses, experiences of social discrimination were strong predictors of psychologic symptoms.

Conclusions. The mental health difficulties experienced by many gay and bisexual Latino men in the United States are directly related to a social context of oppression that leads to social alienation, low self-esteem, and symptoms of psychologic distress. (*Am J Public Health.* 2001;91:927–932)

As overlapping members of sexual minority and ethnic minority groups in the United States, gay and bisexual Latino men have been affected by at least 3 socially oppressive forces—homophobia, poverty, and racial discrimination—that have prevented their full and fair participation in family life and the gay community and have limited their educational and professional opportunities. Their highly stigmatized social situation would predict a wide range of health-related problems,[1,2] but little is known about the physical or mental health of gay and bisexual Latino men in the United States. Given that this group shows some of the highest rates of HIV seroprevalence, seroconversion, and sexual risk behavior in the nation, the few empiric studies that exist have been conducted in the context of HIV prevention research.[3–5]

Most of the available data in other important areas of health, such as history of childhood sexual abuse or substance use, have been examined and reported only as predictors of sexual risk behavior. The present study addressed this gap by examining the prevalence and social predictors of mental health outcomes, such as symptoms of anxiety, depression, and suicidal ideation, in a venue-based probability sample of gay and bisexual Latino men.

The relation between factors of social inequality and disease has been mostly inferred from differences in health outcomes *between* groups that are differentially disadvantaged, discriminated against, and oppressed (e.g., observed health disparities between African American, Latino, and White populations in the United States). Rarely have studies measured and examined specific factors of discrimination as they affect the health, behavior, and risk of individuals *within* the most affected groups.

In this article, we present an analysis of individual differences in experiences of social discrimination in terms of their prediction of mental health outcomes within a sample of gay and bisexual Latino men. We hypothesized that increased experiences of social discrimination based on sexual orientation and race, and experiences of financial hardship owing to poverty status, would predict symptoms of psychologic distress both directly and indirectly through a sense of social alienation and low self-esteem. In addition, we examine the role of reported sources of resiliency and strength—such as family acceptance, supportive social networks, and participation in social activism—in moderating the impact of social discrimination on mental health.

Methods

Sampling, Recruitment, and Interviewing Procedures

Between October 1998 and March 1999, as part of a multisite study of self-identified gay and bisexual Latino men in the United States, a probability sample of 912 men was drawn from men entering social venues (bars, clubs, and weeknight events primarily attended by Latinos and gay men) in the cities of New York (n=309), Miami (n=302), and Los Angeles (n=301). Briefly, the sampling procedures can be described in terms of the following steps.

First, we conducted a mini-ethnography in each city to determine the universe of social

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spaces defined as both Latino and gay, and we mapped weekly hours of operation for each venue. Estimates were made of overall crowd sizes at peak times, and information was gathered on the level of acculturation of patrons and on predominant age groups.

Second, for New York City and Miami, we stationed a person ("counter") at each venue and instructed this individual to count the number of people who entered during each 15-minute interval. In as many cases as possible, counters would show incoming patrons a list of our universe of venues in the given city and ask whether this instance represented their first visit of the current week to one of these venues. At different times during the night, counters also estimated the number of people present in the venue (the "house count"). On the basis of this information, we divided the time of operation of each venue into meaningful 4- to 5-hour segments that we labeled "bar sampling units."

Third, we derived a measure of size for each bar sampling unit by multiplying the number of attendees by a ratio of those reporting that this instance represented their first visit of the current week and dividing by the total number of people interviewed (i.e., the number of people who were briefly asked about their first time at the venues that week). The measure of "size" was thus our estimate of the number of first-time attendees for that week during the given period of venue operation.

(For Los Angeles, we counted only a subset of the bar sampling units, but we conducted the house count in all instances. We then used the data from New York and Miami in conjunction with the Los Angeles house count information to produce estimates of the number of first-time attendees during each bar sampling unit. These estimates represented our measure of size. Note that the estimates were sufficiently accurate for the purpose of sampling because we used the same measure of size that formed the probability of selection in determining the final weight of each bar sampling unit.)

Fourth, within each city, we ordered all of the bar sampling units in such a way as to cluster them by age and acculturation and to distinguish between weekends and weekdays. This ensured that the resulting sample would be balanced by age, acculturation, and days of the week. A sample of bar sampling units was drawn from each city.

Fifth, we selected a target number of interviews for each bar sampling unit. We tried to apportion the approximately 300 interviews per city uniformly across all bar sampling units. Exceptions were very small units and very large "disco nights." We then developed a sampling rate, which was the estimated number of attendees divided by our targets. Note that although we used estimates to determine the probability of selecting the bar sampling unit and the individuals within the unit, the actual number of individuals later recruited in each venue depended on the number of eligible people who actually entered the bar during the recruitment period (recruitment occurred several weeks after the counting sessions).

Sixth, we conducted a publicity campaign to advertise the study and, above all, to communicate and explain the random selection procedure, which was somewhat foreign to men who typically see advertisements asking volunteers to participate in different studies. The catch phrase "If selected, will you say yes?" proved extremely useful in explaining the nature of random selection. Posters and palm cards, in both English and Spanish, were distributed and placed widely in all of the targeted venues. To avoid the bias of recruiting frequent bar patrons, we conducted all of the recruitment and screening for the study within the period of 1 week in each city. We screened men according to 4 inclusion criteria: Latino ethnicity, city resident, male nonheterosexual, and first visit of the week.

Finally, each interview was assigned a weight equal to the probability of the selected bar sampling unit multiplied by the sampling rate of the unit. Because we knew the age and acculturation of those completing the interview, we explored the possibility of a noninterview adjustment. However, we found that there was not enough difference between those completing and not completing the interview to justify such an adjustment.

Using the procedures just described, we were able to approach a total of 5097 men in the 3 cities, among whom 3086 (61%) agreed to be screened at the venue at the time of recruitment. Of those we screened at the venues, 1546 (50%) met qualifying criteria for inclusion in the study. Of those who qualified, 1324 (86%) provided contact information. Appointments for individual interviews were made either at the time of recruitment or through the contact information. Interviews were conducted individually, face to face, in different accessible locations (typically, interviewing rooms of marketing research companies) in the 3 different cities. The interview process ended when we reached (actually, slightly exceeded) our sample size goal. The final sample included 912 respondents (309 in New York, 302 in Miami, and 301 in Los Angeles).

Measures

The quantitative survey was preceded by a qualitative study (conducted between November 1996 and March 1997) in which we interviewed approximately 300 gay and bisexual Latino men, in the context of 26 focus groups, in the 3 cities. The transcribed focus group discussions were used to create items for the quantitative survey; the goal was for survey items to reflect as closely as possible the lived subjective experiences of men who experience multiple sources of discrimination and struggle with safer sex practices. During 1997 and 1998, 18 months were devoted to an analysis of the qualitative data and the construction and pilot testing of the questionnaire to ensure its sensitivity, appropriateness, and psychometric quality. The final survey instrument contained several scales (described subsequently) used to measure the relevant study constructs.

Symptoms of psychologic distress. This variable was assessed through a 5-item measure; items were rated on a 4-point Likert scale ranging from *never* (0) to *many times* (3). Scale items measured symptoms of anxiety, depression, and suicidality during the previous 6 months (e.g., "In the last 6 months, how often have you felt sad or depressed?" "In the last 6 months, how often have you thought of taking your own life?"). A reliability analysis showed that the scale had strong internal consistency (Cronbach α=0.75). Higher scores indicated more psychologic distress.

Experiences of homophobia, racism, and poverty. Eleven items measured respondents' experiences of homophobia both as children and as adults (e.g., "As you were growing up, how often did you feel that your homosexuality hurt and embarrassed your family?" "As an adult, how often have you had to pretend that you are straight to be accepted?"); 4 of these items focused on experiences of verbal harassment and physical assaults in relation to both perceived sexual orientation and gender nonconformity (e.g., "As you were growing up, how often were you hit or beaten up for being homosexual or effeminate?"). Ten items measured respondents' experiences of racism as children and as adults (e.g., "How often have you been turned down for a job because of your race or ethnicity?" "In sexual relationships, how often do you find that men pay more attention to your race or ethnicity than to who you are as a person?").

Finally, 3 items measured recent experiences of poverty or financial hardship (e.g., "In the last 12 months, how often did you run out of money for your basic necessities?" "In the last 12 months, how often have you had to borrow money from a friend or a relative to get by financially?"). Ratings for all of the items on the 3 scales were made on the same 4-point *never* to *many times* scale. The scales showed high levels of internal consistency: homophobia, α=0.75; racism, α=0.82; and poverty, α=0.71.

Social isolation and low self-esteem. The self-esteem scale (α=0.77) contained 8 items that assessed the respondent's satisfaction with

his life and personality, perceived levels of self-care and self-respect, and a general sense of self-determination and purpose in life (e.g., "Do you like most aspects of your personality?" "Do you feel you have a sense of direction and purpose in your life?"). Items were rated on a 4-point Likert scale ranging from *definitely yes* (0) to *definitely no* (3); higher scores reflected higher levels of low self-esteem.

The social isolation scale (α=0.78) contained 7 items (e.g., "How often do you feel you lack companionship?" "How often do you feel there is no one you can turn to?"). Ratings for 4 of the items were made on the 4-point *never* to *many times* scale, and ratings for the other 3 items were made on the 4-point *definitely yes* to *definitely no* scale. Higher scores reflected more social isolation.

Resiliency. The resiliency scale was based not only on the transcripts of focus groups but also on conversations we had with community leaders and service providers about the factors they view as sources of strength in the community that can be protective against health risks such as substance abuse and HIV. These factors can be divided into 5 domains: extent to which family and peers are aware of the respondent's sexual orientation (e.g., "Have you told your mother or female guardian that you're homosexual/bisexual?"), family acceptance (e.g., "Is there at least someone in your immediate family that you can talk openly with about your homosexuality/bisexuality?"), life satisfaction (e.g., "Are you satisfied with your sex life?"), community involvement with referent social group (e.g., "Are you involved with Latino gay organizations?"), and presence of a gay role model while growing up (e.g., "Growing up, were there older gay friends or relatives whom you looked up to or who served as role models for you?"). The scale (α=0.71) contained 14 items, and ratings were made on the 4-point *definitely no* to *definitely yes* scale. Higher scores indicated greater resiliency.

Data Analysis

To account for the complex nature of the sampling plan, which involved stratification by city, clustering by venue, and sampling weights, we used the Stata *svy* routines in conducting the data analysis.[6] These routines provide analogues of standard statistical procedures that adjust for complex survey structures. For example, linearization methods are used to compute standard errors of prevalence estimates, and the Rao and Scott second-order χ^2 correction (which produces an F statistic) is also used.[7] All multivariate analyses controlled for the effects of 3 variables: age, acculturation, and city.

Results

Demographic Profile of the Population

Analyses of the weighted data yielded the following demographic profile for the population of men studied. Within the population of nonheterosexual men who attended Latino gay venues in Miami, New York, and Los Angeles, 54% (95% confidence interval [CI]=50.9%, 56.5%) self-identified as gay, 30% (95% CI=27.5%, 32.1%) self-identified as homosexual, 15% (95% CI=13.8%, 16.8%) self-identified as bisexual, and 1% (95% CI=0%, 1.3%) self-identified as "other" (e.g., "queer," "pansexual," or "joto," a Mexican equivalent of the word *faggot*). The overwhelming majority (72.2%; 95% CI=67.3%, 77.1%) were immigrants, and about half of all immigrants (52.6%; 95% CI=46.7%, 58.5%) had been in the United States for 10 years or less. More than a third used exclusively or primarily the Spanish language in interacting with friends.

As expected from a population of bar patrons, the respondents were relatively young as a group; the estimated mean age was 31.2 years (95% CI=30.0, 32.4), and 86.8% (95% CI=83.1%, 90.5%) of the respondents were between the ages of 20 and 40 years. The population had a high level of education, with 64.2% (95% CI=58.8%, 69.5%) having some college education or more. However, for a highly educated group, the rate of unemployment was surprisingly high (27.3%; 95% CI=21.0%, 33.6%). According to self-report, a conservative measure of HIV status, 21.8% (95% CI=13.8%, 29.8%) of the respondents were HIV positive, 67.3% (95% CI=60.3%, 74.3%) were HIV negative, and 10.9% (95% CI=7.9%, 13.9%) did not know their HIV serostatus.

Prevalence of Psychologic Symptoms

Table 1 presents prevalence estimates for the 5 symptoms of psychologic distress measured. The most frequently reported symptoms were depressed mood and sleep difficulties. An estimated 80% of the men had experienced feelings of sadness and depression at least once or twice during the past 6 months, with 22% experiencing depressed mood at a relatively high ("many times") frequency. Sixty-one percent had experienced sleep problems at least once or twice during the past 6 months, and 20% had experienced sleep problems many times.

About half of the men had experienced feelings of anxiety (i.e., experiences of fear or panic, or both, for no apparent reason) and a general feeling of being sick or not well at least once or twice during the past 6-month period. The most serious symptom of psychological distress measured—thoughts of taking one's life—was experienced by 17% of the men at least once or twice in the past 6 months, and 6% reported having suicidal ideation "a few times" or more.

Experiences of Homophobia, Poverty, and Racism

Table 2 presents estimated prevalence rates for different experiences of social discrimination due to sexual orientation (i.e., experiences of homophobia) and race/ethnicity (i.e., experiences of racism) during childhood and adulthood, as well as experiences of financial distress (i.e., experiences of poverty) during the past 12 months. The 3 most common experiences of homophobia during childhood were hearing that gays are not normal people (91%), hearing that gay people grow up to be alone (71%), and a deep feeling that the respondent's homosexuality hurt and embarrassed his family (70%). The majority of men (64%) reported having to pretend to be straight at some point in their adult lives, 29% reported that they had to move away from family or friends to live their homosexual lives, and 20% reported some form of police harassment in relation to their being gay.

Experiences of racism were reported less frequently than those of homophobia, and,

TABLE 1—Prevalence of Psychologic Distress in Past 6 Months: Gay and Bisexual Latino Men in 3 US Cities, 1998–1999

	At Least Once, % (95% Confidence Interval)	Once or Twice, %	A Few Times, %	Many Times, %
Feeling sick, not well	54 (49, 59)	34	14	5
Sleep problems	61 (56, 66)	16	25	20
Anxiety (fear or panic for no apparent reason)	44 (39, 49)	17	19	7
Sad or depressed mood	80 (76, 84)	24	34	22
Suicidal ideation	17 (15, 20)	11	4	2

TABLE 2—Experiences of Homophobia, Racism, and Poverty and Their Relation to Suicidal Ideation: Gay and Bisexual Latino Men in 3 US Cities, 1998–1999

Social Discrimination	Ever Experienced, % (95% Confidence Interval)	Suicidal Ideation in Past 6 Months, % Yes	Suicidal Ideation in Past 6 Months, % No	*P*
Homophobia				
Made fun of as a child	64 (60, 68)	81	61	.0013
Violence as a child	18 (15, 21)	37	14	.0000
Made fun of as an adult	50 (45, 54)	68	46	.0003
Violence as an adult	10 (7, 12)	18	8	.0000
As a child heard gays grow old alone	71 (67, 75)	77	69	NS
As a child heard gays are not normal	91 (89, 94)	94	90	NS
As a child felt gayness hurt family	70 (66, 75)	87	67	.0004
Has had to pretend to be straight	64 (59, 69)	78	61	.0019
Job discrimination	15 (12, 18)	28	12	.0003
Had to move away from family	29 (25, 33)	43	26	.0019
Police harassment	20 (17, 24)	32	18	.0018
Racism				
Made fun of as a child	31 (26, 37)	45	29	.0005
Violence as a child	9 (6, 12)	21	6	.0000
Made fun of as an adult	5 (3, 7)	11	4	.0145
Treated rudely or unfairly	35 (30, 41)	44	34	.0976
Police harassment	22 (17, 27)	36	19	.0049
Job discrimination	15 (11, 19)	26	13	.0186
Uncomfortable in white gay spaces	26 (22, 31)	34	25	.0591
Difficulty finding lovers	17 (13, 21)	16	23	NS
Objectified sexually	62 (56, 67)	73	59	.0176
Rejected for sex	20 (14, 26)	34	17	.0031
Financial hardship				
Ran out of money	61 (55, 67)	75	58	.0092
Had to borrow money	54 (49, 60)	75	50	.0000
Had to look for work	45 (41, 49)	56	43	.0644

when reported, they tended to occur more frequently in adulthood. This finding might be explained by the fact that most of the men (72%) were immigrants, and many did not grow up as a member of a racial minority in the United States. Nonetheless, about one third of the men (31%) reported racially motivated verbal harassment as children, and more than one third (35%) reported being treated rudely as adults as a result of their race/ethnicity. Many men reported experiences of racism in the context of gay community and sexual activity, and 26% reported discomfort in spaces primarily attended by White gays. A majority of the respondents (62%) reported having been sexually objectified owing to their race or ethnicity.

Many of the men reported experiences of poverty or financial hardship in the past 12 months, with the majority indicating that they had run out of money for basic necessities (61%) and had been forced to borrow money to get by (54%) at least once or twice in the past year. Also, close to half of the sample (45%) had been forced to look for work at least once or twice during the past year. These high levels of financial hardship are surprising considering the high level of education of the sample, but also somewhat expected as a result of the high level of unemployment reported (27%).

Relationship Between Social Discrimination and Suicidal Ideation

Table 2 also shows univariate relations between experiences of social discrimination and the single most severe symptom of psychologic distress measured: suicidal ideation in the past 6 months. In this analysis, both experiences of social discrimination and suicidal ideation were dichotomized as occurring at least once vs never; χ^2 analyses were used in testing the univariate associations between the 2 types of variables.

As can be seen in Table 2, there were very strong relationships between experiences of social discrimination, in both childhood and adulthood, and suicidal ideation within the past 6 months. Of the 24 χ^2 analyses conducted, 18 (75%) were statistically significant; of the remaining 6 tests, 3 had *P* values between .06 and .10.

Predicting Psychologic Symptoms From Experiences of Social Discrimination

According to our theoretic model, social discrimination (operationalized as experiences of homophobia, poverty, and racism) influences mental health (operationalized as symptoms of psychologic distress) through its effects on 2 crucial psychosocial factors: social isolation and low self-esteem. We further hypothesized that the impact of social discrimination would be counteracted by the independent effects of resiliency factors that diminish social isolation and increase self-esteem.

Given that all of the constructs in the model (predictors as well as outcome variable) were measured as continuous variables with reliable scales, we used multiple linear regression techniques to test our multivariate model. We first tested the predictive strength of the full model in a hierarchical regression. Psychosocial variables were entered in the first step, social discrimination variables were entered in the second step, and the resiliency variable was entered in the third step. In addition, we tested the mediation model using procedures suggested by Baron and Kenny.[8]

Table 3 shows the results of the hierarchical linear regression analysis. Social isolation and low self-esteem predicted 26% of the variance in psychologic symptoms, with experiences of social discrimination predicting an additional 11% of the variance and low resiliency an additional 1%. All of the model variables other than racism and resiliency were statistically significant. The full model was statistically significant ($F_{6,77}$= 88.27, P<.001), predicting a substantive 38% of the variance in symptoms of psychologic distress.

Finally, to test the mediation model of psychologic symptoms, in which social isolation and low self-esteem were hypothesized to mediate the effects of social discrimination and low resiliency, we followed the approach suggested by Baron and Kenny.[8(p1177)] We performed multiple regressions examining whether (1) social discrimination and low resiliency predicted loneliness and low self-esteem, (2) social discrimination and resiliency predicted psychologic symptoms, and (3) loneliness and low self-esteem predicted psychologic symptoms after social discrimination and low resiliency.

The multiple linear regression analysis (Figure 1) showed that experiences of homophobia, racism, financial hardship, and low resiliency were strong predictors of social isolation (R^2=0.27, $F_{4,79}$=40.57, P<.001) and low self-esteem (R^2=0.17, $F_{4,79}$=33.34, P<.001), with all 4 predictors contributing independently. As expected, resiliency was negatively associated with the outcome variable in the 2 different equations. Also, experiences of homophobia, racism, financial stress, and low resiliency significantly predicted symptoms of psychologic distress (R^2=0.27, $F_{4,79}$=38.29, P<.001). Finally, after social discrimination and resiliency had been controlled, loneliness and low self-esteem remained strong and significant predictors of psychologic symptoms. These analyses confirmed the hypothesized mediational model.

TABLE 3—Stepwise Linear Regression Predicting Psychologic Symptoms: Gay and Bisexual Latino Men in 3 US Cities, 1998–1999

Step	Predictor Variable	b	SE	*t*	*P*	ΔR^2	R^2
1	Social isolation	0.27	0.05	5.43	<.0001	. . .	. . .
	Low self-esteem	0.21	0.07	3.17	<.01	0.26	0.26
2	Homophobia	0.09	0.04	2.50	<.05	. . .	. . .
	Racism	0.04	0.03	1.05	<.30	. . .	. . .
	Poverty	0.33	0.07	4.85	<.0001	0.11	0.37
3	Resiliency	0.03	0.02	1.60	<.11	0.01	0.38

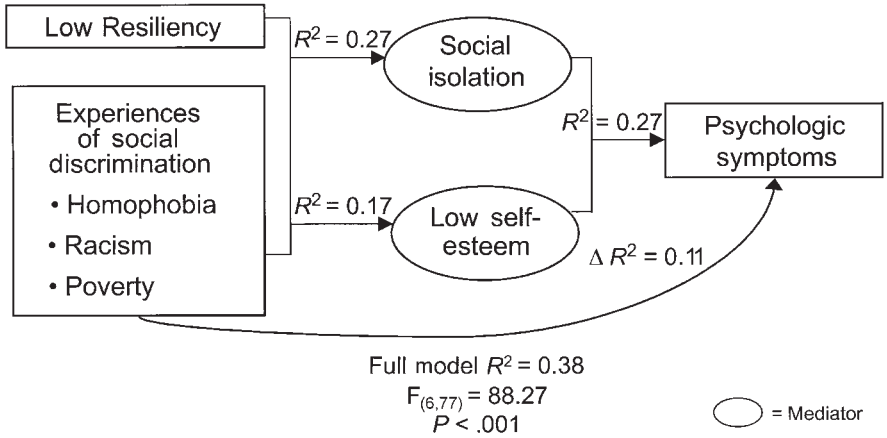

FIGURE 1—Sociocultural model of mental health in gay and bisexual Latino men.

Discussion

A major strength of the present study is that survey items were based on extensive formative work, and thus our measures of social discrimination reflected actual homophobia, racism, and poverty as subjectively experienced by members of the population. For example, our measures of homophobia included items on deeply felt shame in response to family attitudes toward homosexuality, as well as experiences of police harassment and sexual exile. These particular experiences of homophobia are consistent with Latino family values, immigration patterns, and negative encounters with the judicial system reported elsewhere in the literature on Latino populations.

We analyzed the data for the entire sample for the specific purpose of this article, but this does not mean that we consider gay and bisexual Latino men to be a homogeneous group. In fact, the target population varied in terms of important dimensions such as age, level of acculturation, socioeconomic status, nationality, and HIV serostatus, among others. All of these characteristics were potentially relevant to the outcome variable of this study, and most were measured in our survey. Our multivariate analyses did control for 3 important sources of variation: age, level of acculturation, and city. However, an analysis of the impact of nationality and HIV serostatus on mental health was beyond the scope of the present study. Not surprisingly, the HIV-positive men in our sample reported a higher level of psychologic symptoms. A report that focuses on the impact of serostatus differences and takes into account relevant variables related to treatment and health care use is forthcoming.

Finally, the results of the present study should be considered in the context of 3 important limitations. First, participants were sampled from patrons of Latino gay venues, and thus the findings may not apply to men who do not attend gay venues or to men who, for reasons of class and acculturation, may prefer to attend mainstream (mostly White and middle-class) gay venues. Second, because the men in this population were mostly immigrants, the findings may not apply to the experience of many US-born Latinos, particularly those who do not attend Latino gay venues. Third, the survey data were based solely on self-reports, and thus the findings are vulnerable to the biases inherent in all self-report measures, including the tendency to underreport stigmatized behavior and a lack of objective criteria to assess the external validity of the constructs measured.

Conclusions

The data from the present study suggest that a large proportion of gay and bisexual Latino men who reside in US urban centers exhibit a relatively high frequency of symptoms of psychologic distress that compromise their mental health and well-being. Their psychologic symptoms, however, cannot be merely understood as a product of individual pathology. The negative mental health outcomes observed in this study are deeply connected to a lifelong history and current experiences of social discrimination owing to sexual orientation and racial/ethnic diversity, as well as to high levels of financial hardship due to severe unemployment and poverty.

As predicted, social discrimination has a negative impact on levels of social support and self-esteem, and, not surprisingly, psychologic symptoms of distress are more prevalent among those who both are socially isolated and have a low sense of self-worth. These findings have important implications for mental health and prevention programs that target the population of gay and bisexual Latino men in the United States, particularly immigrants. For example, programs must address social isolation and low self-esteem as emerging from experiences of social discrimination. Also, programs should build on the reported factors of high resiliency, from family acceptance to community involvement and social activism, that significantly alleviate the negative consequences of social discrimination on mental health. □

Contributors

R. M. Díaz designed and obtained funding for the study and wrote most of the manuscript. G. Ayala collaborated in the theoretical conceptualization of the study, directed the implementation of the study, and helped design the survey instrument. E. Bein assisted in the

data analysis and conducted all of the statistical analyses. J. Henne supervised all of the data collection activities and had major input in the conceptualization and implementation of the sampling design. B. V. Marin helped design the study and the survey instrument.

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