Avoidance Coping and HIV Risk Behavior among Gay Men

James I. Martin, Jo G. Pryce, and James D. Leeper

This study describes how coping strategies are related to unprotected anal intercourse (UAI) among gay men, and provides support for a new theoretical underpinning for HIV prevention practice and research with this population. A sample of 470 gay and bisexual men completed a self-administered questionnaire that included a measure of coping strategies used in relation to a recent problem. More participants who reported recent UAI endorsed avoidance strategies than did those who did not report UAI. There was a positive relationship between avoidance coping scores and odds for reported UAI. Among the study’s implications was the importance of the larger context in which prevention efforts with this population occur, one that is marked by stigmatization, discrimination, loneliness, and other stresses. In addition, prevention practice and research must attend to the meaning and purpose of sex in gay men’s lives.

KEY WORDS: avoidance; coping; gay men; HIV prevention

During the 20-plus years since the HIV epidemic began in the United States, numerous researchers have attempted to uncover the determinants of sexual risk taking among gay men that might suggest effective prevention strategies. Much of the early research was based on theoretical models that assumed risky sexual behavior, like other health-related behaviors, could be changed through a rational decision-making process (for example, Becker, 1974; Fishbein & Middlestadt, 1989). For many years prevention efforts in the United States, which were based on the same assumption, had as their goal strict adherence to safer sex practices (Rofes, 1998). Although gay men initially made dramatic changes in their sexual behavior by adopting these practices (Becker & Joseph, 1988), many did not maintain them, and successive generations of gay men have not adopted them as consistently (Stall, Hays, Waldo, Ekstrand, & McFarland, 2000). More recently practitioners have developed prevention strategies based on negotiated safety, in which seronegative primary partners agree to engage in unprotected sex with each other and to use condoms if they engage in extra-relational sex. Although these strategies assumed a sexuality that is under rational control, as much as earlier ones did, they reduced the unreasonable expectation that gay men must engage in only protected sex for the rest of their lives. Recent evidence suggests that the effectiveness of even these strategies may be limited over time (Van de Ven, Rawstorne, Crawford, & Kippax, 2002).

The prevalence of HIV infection among men who have sex with men (MSM) in the United States remains quite high (Catania et al., 2001; Koblin et al., 2000). At least one recent study reported an increase in the incidence of infection in this population (Coates et al., 2000), and this study and others reported increases in rates of risky behaviors (Fox et al., 2001; Wolitski, Valdiserri, Denning, & Levine, 2001). Although the self-report category “MSM” obscures evidence for men who identify themselves as gay, there is little reason to believe that the trends are any less disturbing among them.

These trends suggest that the theoretical models underpinning HIV prevention practice among gay men may be considerably flawed, with research in this area having significant limitations. Some authors claim that American HIV prevention research has tended to be overly reductionist, focusing too much on static individual factors stripped of their interpersonal, interactive, and cultural context (Díaz,
1999; Henriksson, 1995; Wright, 1998). Such reductionism may be particularly problematic with respect to stigmatized minority populations such as gay men. In addition, this research has insufficiently examined the extent to which sexual behavior might not be subject to rational decision-making processes (Martin & Knox, 1997b; Wright). According to Coates and colleagues (2000), sexual behaviors “are basic, often urgent, and engaged in without complex cognitive analysis. A brochure can be informative on Tuesday morning; in a moment of intense passion on Friday night, a different analysis occurs….for some individuals chronic loneliness, isolation, and alienation lead to remedies, which may include high-risk behavior” (p. 4).

In light of these trends, acquiring a better understanding of the determinants of risky sexual behaviors among gay men is increasingly important. Toward this end, Martin and Knox (1995, 1997b) proposed adapting the diathesis-stress model (Oquendo & Mann, 2001), which theorizes that problematic behaviors occur among individuals with specific vulnerability factors when they encounter sufficient environmental stress. In their adaptation of the model, Martin and Knox (1995, 1997b) suggested that risky sexual behavior may be activated episodically when individuals with particular vulnerabilities (for example, unstable self-esteem, loneliness, and reliance on avoidance coping) encounter sufficient environmental stress (for example, lack of support and intimacy, antigay discrimination, and threats of or actual violence). Using qualitative methodology, Diaz (1999) found considerable evidence for similar ideas in a sample of 30 gay men. Findings of positive associations between self-esteem instability and unprotected anal intercourse (UAI) (Martin & Knox, 1997b), and between loneliness and UAI (Martin & Knox, 1997a), provide additional support for the model.

Reliance on avoidance coping to manage stress is a key vulnerability factor in this model. In other words, risky sexual behavior is more likely to occur among people who rely on avoidance to cope with stress than among those who use more active coping strategies. Several studies have found an association between avoidance coping strategies and risky sexual behavior in samples of gay men (Barrett et al., 1995; Folkman, Chesney, Pollack, & Phillips, 1992; Robins et al., 1994; Semple, Patterson, & Grant, 2000; Williams, Elwood, & Bowen, 2000). However, the use of different measures and conceptualizations of avoidance coping and dissimilar samples limit the comparability of these results. For example, Semple and colleagues used the Ways of Coping Questionnaire (WCQ) Revised (Folkman & Lazarus, 1988) with a sample of HIV seropositive gay men. Folkman and colleagues (1992) used a shortened version of the WCQ with a sample of nonmonogamous gay and bisexual men regardless of their serostatus. Williams and colleagues (2000) focused on cognitive escape in their qualitative study of gay and bisexual men.

Robins and colleagues (1994) used a modified version of the Billings and Moos (1984) coping inventory with a sample of HIV seropositive gay men who were instructed to endorse responses in relation to their coping with HIV/AIDS. Those who reported risky sexual behavior were more likely to endorse using drugs to reduce tension, one of the avoidance coping items. This finding is consistent with others associating drug use with risky sex in a variety of samples of gay and bisexual men (for example, Dolezal, Carballo-Diéguez, Nieves-Rosa, & Díaz, 2000; Stueve, O’Donnell, Duran, San Doval, & Geier, 2002). However, these studies did not conceptualize drug use as a coping response.

The possibility that sex might be used by some gay men for avoidance coping has received little research attention. Barrett and colleagues (1995) proposed that “HIV sexual risks may be part of the stress relief process” (p. 1068) and called for further research into this possibility. Using qualitative methodology, Williams and colleagues (2000) found that sex facilitated gay and bisexual men’s cognitive escape from stress associated with HIV risk and the constraints of safer sex standards, as hypothesized by McKirnan and colleagues (1996). More broadly, Martin and Knox (1997a, 1997b) proposed that sex might be used by some gay men to cope with loneliness, low self-esteem states, and other negative affects not necessarily associated with HIV.

The purpose of the present study was to examine in greater depth the relationship between coping strategies and UAI in a general sample of gay
men, with particular focus on avoidance coping. The study had two main hypotheses: (1) UAI would be more strongly associated with avoidance coping than with active behavioral or active cognitive coping strategies; and (2) the odds of reporting UAI would increase with higher scores on avoidance coping.

METHOD

Participants

We used a combination of purposive and convenience strategies to obtain a sample of 470 gay and bisexual men in a large city in the southwestern United States. In collaboration with an agency that provided HIV and counseling services for members of the local lesbian and gay community, the researchers developed a list of more than 15 social, political, athletic, and religious groups from which they recruited volunteer participants. They also recruited at lesbian and gay public events, local bathhouses, and from the participating agency itself. Fifteen hundred individuals were given copies of the study questionnaire in person, of which 475 were returned using a preprinted postage-paid envelope. Thus, the return rate was 31.7 percent. Five questionnaires were rejected from the study because of missing pages or failure either to complete the survey or to meet the study’s selection criterion of male gender, leaving a total of 470 participants for the current analysis.

Participants ranged in age from 17 to 69, with a mean of 37.3 years (SD = 9.8) and a median of 35 years. Demographic characteristics include collapsed categories for ethnic heritage and relationship status (Table 1). Participants were given the opportunity to endorse multiple sources of ethnic heritage, and many of them did so. For the purpose of this analysis, 13 categories of ethnic heritage were collapsed into three. Participants were classified as having “European ethnic heritage” if they endorsed Jewish heritage or heritage from any of the nations of Europe, but not from elsewhere. Those who endorsed only African, Arabic, Asian, Mexican, Native American, or Pacific Island heritage were classified as having “Non-European ethnic heritage.” Participants who endorsed both European and non-European heritage were classified as having “mixed ethnic heritage.” For relationship status, the categories of “committed open relationship,” “dating one person with sexual involvement,” “dating one person, no sexual involvement,” “dating and sexually active with more than one partner,” and “dating more than one person, no sexual involvement” were collapsed into the single category of “other.”

MEASURES

In addition to answering a series of demographic questions, participants indicated whether they engaged in UAI at least once during the preceding six months with a primary and/or nonprimary partner. An adapted version of a coping inventory developed by Holahan and Moos (1987) measured...
participants’ coping strategies. This inventory was a later version of the measure adapted for use by Robins and colleagues (1994). Participants were instructed to reflect on the ways in which they responded to a recent problem, and to endorse items consonant with their response according to a four-point scale ranging from 0 = no use at all to 3 = used most often. The original inventory consisted of 32 items corresponding to a variety of possible coping responses. The adapted version contained two additional items. “Tried to reduce tension by taking more tranquilizing drugs” was included in an earlier version of this inventory (Billings & Moos, 1981), and it was used in at least one previous study (Knox, 1990). “Tried to reduce tension by having more sex” was added for the present study. In addition, the wording of one item was changed slightly to improve its sensitivity to a gay male population.

The coping inventory measures three methods of coping: active behavioral, active cognitive, and avoidance (Billings & Moos, 1981; Holahan & Moos, 1987). Active behavioral and active cognitive coping methods involve problem-solving and emotional distress-regulating responses. Avoidance coping involves escaping, avoiding, or denying distress, without any attempt to resolve the problem associated with it. In the present study, 13 items measured active behavioral coping, 12 measured active cognitive coping, and nine measured avoidance coping. A higher score indicated greater use of a coping strategy. The lowest possible score was zero. The highest possible scores were 39 for active behavioral coping, 36 for active cognitive coping, and 27 for avoidance coping. Estimates of internal consistency were .71, .64, and .65 respectively, similar to those reported for the original inventory (Holahan & Moos). According to Billings and Moos (1981), an upper limit on the internal consistency of the inventory might occur because the items are not entirely independent. In other words, when one or more coping responses are effective in solving a problem or reducing distress, the need for additional coping responses for that particular situation is reduced.

Procedure

The study reported in this article was part of a larger survey of psychosocial factors in HIV risk behavior among gay men that was conducted between July 1994 and August 1995. Survey packets included a cover sheet, a self-administered questionnaire, and a self-addressed and postage-paid envelope. Each potential participant was handed a packet in person and instructed to complete the questionnaire on his own and return it by mail in the attached envelope. The cover letter explained the study’s purpose, gave a rationale for participating, and ensured participants of their anonymity and voluntary status. To ensure anonymity a signed consent form was not included. As the cover letter stated, participants who returned a completed questionnaire were assumed to have given consent.

Statistical Analysis

Frequencies and percentages, means, and standard deviations were used to describe the sample’s demographics, and chi-square and t tests were used to examine the demographics in relation to UAI. Chi square, with the correction for continuity, was also used to examine the relationship between UAI and participants’ coping strategies. For this first level analysis, all non-zero (1–3) coping scores were collapsed into a single “yes” category and scores of zero were labeled “no,” resulting in a 2 x 2 cross tabulation. Next, logistic regression was used to model the relationship between avoidance coping and UAI. For this second-level analysis the non-dichotomized raw scores of the coping inventory were used. A criterion of .01 (two-tailed) was used for determining statistical significance in all analyses.

RESULTS

Two hundred and two (43 percent) participants reported engaging in UAI at least once during the preceding six months, with 268 (57 percent) reporting no UAI during the same time period (Table 2). There were no differences on any of the demographics according to UAI except for age. Those who reported UAI were slightly younger than those not reporting UAI, t(468) = 2.71, p < .01. Also, there were no differences on active behavioral and active cognitive coping total scores between participants who reported engaging in UAI during the previous six months and those who did not. However, the difference between the two groups on avoidance coping was significant, t(457) = −3.95, p < .01, with those who reported UAI scoring higher than those who did not report UAI. Among those who reported engaging in UAI, 113 (56 percent) did so with a primary partner, 63 (31 percent) with a nonprimary partner, and 26 (13 percent)
with both primary and nonprimary partners. One-way analysis of variance, with post-hoc comparisons using the Bonferroni method, indicated that participants reporting UAI with a nonprimary partner scored significantly higher on avoidance coping ($M = 6.73, SD = 4.28$) than those who did not report UAI ($M = 4.62, SD = 3.89$), $F(3, 455) = 6.081, p < .001$. None of the other pairwise comparisons were significant.

An analysis of responses to each item on the coping instrument was used to determine differences on use of specific coping responses between those who reported UAI and those who did not. There was no association between UAI and any of the active cognitive coping responses. There were associations between UAI and three active behavioral coping responses, with participants reporting UAI endorsing “talked with a significant other about the problem” ($\chi^2 = 6.80, p < .01$) more frequently, and “talked with a friend about the problem” ($\chi^2 = 9.66, p < .01$) and “bargained or compromised to get something positive from the situation” ($\chi^2 = 8.13, p < .01$) less frequently than those reporting no UAI.

UAI was associated with several avoidance coping items. Participants who reported UAI endorsed “tried to reduce tension by having more sex” ($\chi^2 = 21.65, p < .01$), “refused to believe it happened” ($\chi^2 = 9.13, p < .01$), and “kept my feelings to myself” ($\chi^2 = 6.76, p < .01$) more frequently than those who did not report UAI. In addition, participants reporting UAI endorsed “tried to reduce tension by drinking alcohol more” ($\chi^2 = 4.49, p = .034$) and “avoided being with people in general” more frequently ($\chi^2 = 4.33, p = .037$) than those who did not report UAI. These last two differences approached significance.

All participants endorsed active behavioral and active cognitive coping strategies. However, 10 percent of participants did not endorse avoidance coping strategies. Participants who endorsed avoidance coping strategies were significantly more likely to report UAI than those who did not endorse them (Table 3). According to logistic regression analysis, the odds of reporting UAI were between two and three times greater for those endorsing avoidance coping strategies than for those who did not (odds ratio = 2.68, 95 percent confidence interval 1.33–5.42).

Using logistic regression and the scale’s raw scores, the coefficient for avoidance coping was .094. This coefficient was used to calculate the probabilities of reporting UAI and odds ratios across the range of avoidance coping scores (Table 4). The distribution ranged from 46 participants scoring zero to one participant scoring 25. As avoidance scores increased, so did the likelihood of reporting UAI. Forty-nine percent of the sample had avoidance coping scores between zero and four, with probabilities for reporting UAI of .40 or less and odds ratios increasing to 2.30. For scores higher than nine, the odds ratios increased more rapidly to a maximum of 10.38.

### Table 2: Differences on Coping Total Scores and Age, by Reported UAI

<table>
<thead>
<tr>
<th>Variable</th>
<th>Reported UAI ($n = 202$)</th>
<th>Reported No UAI ($n = 268$)</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Avoidance coping</td>
<td>6.1</td>
<td>4.6</td>
<td>4.0</td>
</tr>
<tr>
<td>Active behavioral coping</td>
<td>21.3</td>
<td>21.3</td>
<td>6.4</td>
</tr>
<tr>
<td>Active cognitive coping</td>
<td>20.3</td>
<td>20.6</td>
<td>5.9</td>
</tr>
<tr>
<td>Age</td>
<td>35.9</td>
<td>38.3</td>
<td>9.1</td>
</tr>
</tbody>
</table>

Note: UAI = unprotected anal intercourse. NS = not significant. *p < .01.

### Table 3: Association of Avoidance Coping with Reported UAI

<table>
<thead>
<tr>
<th>Avoidance Coping</th>
<th>UAI</th>
<th>No UAI</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endorsed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>189</td>
<td>224</td>
<td>413</td>
</tr>
<tr>
<td>Percent</td>
<td>45.8</td>
<td>54.2</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>200</td>
<td>259</td>
<td>459</td>
</tr>
</tbody>
</table>

Notes: $\chi^2 = 7.173, p < .01$. Odds ratio 2.68, 95% CI (1.33–5.42). UAI = unprotected anal intercourse.
The study’s findings strongly supported its two hypotheses. Total scores on avoidance coping were significantly higher among participants who reported engaging in UAI during the preceding six months, but there were no differences on either active cognitive or active behavioral coping total scores. In addition, incremental increases on avoidance coping predicted increased probabilities and odds of reporting UAI. In other words, it is not just the endorsement of avoidance coping strategies in general predicted UAI. The greater the number of avoidance coping responses that participants endorsed, or the more strongly they endorsed them, the greater the odds of reporting UAI. Those who scored a nine on avoidance coping, a very modest score, had odds of reporting UAI that approached two and a half times those of participants who did not endorse such coping strategies. These findings add to others associating avoidance coping with risky sexual behavior among gay men.

There were interesting differences on reported UAI according to several coping responses. Three of the nine avoidance coping responses were endorsed more often among those who reported UAI, and differences on two others approached significance. The most striking difference was on “tried to reduce tension by having more sex,” with a chi-square statistic more than twice that of any other item. Although Folkman and colleagues (1992) reported similar results among nonmonogamous gay men, the current results cut across relationship categories. The results on this coping response also went beyond those reported by Williams and colleagues (2000) in that they showed the use of sex as a coping response not necessarily related to the stress of maintaining safer sex habits. As had been theorized by Martin and Knox (1997a, 1997b), many gay men in this sample used sex to cope with a variety of problems.

The two other avoidance coping responses on which significant differences were found, “refused to believe that it happened” and “kept my feelings to myself,” represent the type of avoidance that Compas and colleagues (2001) labeled “disengagement,” as does “avoided being with people in general,” on which differences approached significance. Differences on “tried to reduce tension by drinking alcohol more,” a coping response that Williams and colleagues (2000) considered another form of disengagement, also approached significance. These findings may indicate the importance to HIV prevention of gay men engaging with others in emotionally significant ways during periods of stress. Results on one of the active behavioral coping responses, “talked with a friend about the problem,” appear to reinforce this idea given that participants who endorsed this response were less likely to report UAI. “Bargained or compromised to get something positive from the situation” may not necessarily represent engagement with other people, but engagement with the problem. Thus promoting active engagement with one’s problems and with other people to cope with stress may be an important strategy for HIV prevention programs.

Findings on “talked with a significant other about the problem” may appear to contradict the idea that engagement with others is beneficial, because those who endorsed this response were more likely to report UAI. However, the higher report of UAI between participants and their primary partners, compared with nonprimary partners, explains these
findings. Participants who reported UAI with a primary partner were more likely to endorse this item than those reporting UAI with a nonprimary partner or no UAI \( \chi^2(3) = 27.77, p < .001 \) (Bonferroni method). These findings are consistent with others associating risky sexual behavior with emotional intimacy among gay men (for example, Appleby, Miller, & Rothspan, 1999), and they suggest a major problem with HIV prevention strategies among gay couples. That is, adhering to safer sex habits interferes with love, intimacy, and desire (Dowsett, Davis, & Connell, 1992; Henriksson, 1995).

The present study’s findings indicate another possible reason why HIV prevention strategies are not more successful in helping gay men maintain safer sex habits. They tend to be conceptually related to active cognitive and active behavioral coping, as exemplified by the responses “tried to step back from the situation and be objective,” “went over the situation in my mind trying to understand,” “tried to find out more about the situation,” and “made a plan of action and followed it.” Such responses reflect a rational problem-solving approach to problems in life. Thus, prevention strategies that fail to account for nonrational, nonproblem-solving approaches to life’s problems, such as avoidance forms of coping, might not address the obstacles that some gay men face in attempting to maintain safer sex habits. That is, although such men may be able to initiate safer sex habits, they might not be able to maintain them during periods of high stress.

According to Miller and Kaiser (2001), people are likely to use disengagement coping when they believe they have no control over stressful situations. For example, members of stigmatized populations might use disengagement when they cannot find alternatives to prejudice-tainted situations. This theory seems highly applicable to the lives of gay men today. AIDS is an omnipresent threat over which many gay men believe they have little control (Schönnesson & Ross, 2001). However, there are many other sources of stress in the lives of gay men that might also lend themselves to avoidance coping. For example, gay men continue to be stigmatized in U.S. society, and stigma is a powerful source of stress (Miller & Kaiser). Many gay men live with the daily threat of physical violence (Cahill, 2000; Russell, Franz, & Driscoll, 2001), and discrimination and prejudice remain common threats in their lives (Meyer, 2001). In addition, political, economic, and social obstacles to building and maintaining positive relationships with each other might contribute to chronic loneliness or difficulties with maintaining self-esteem (Martin & Knox, 1997a, 1997b).

The present study’s findings contribute to a more complex conceptualization of risky sexual behavior among gay men. Sex between men may serve many purposes, including affiliation, affection, love, and spirituality (Turner, 1997). And as the current findings indicate, it may help men to cope with a variety of problems. It may be easy to forget that safer sex is not normal, though it is certainly a rational response to a deadly epidemic. Unfortunately, sex and passion are inherently nonrational (McKinnan et al., 1996). HIV prevention strategies that assume otherwise cannot help being seriously flawed.

This study had several important limitations based on its methodology. We examined the association between coping strategies and reported UAI, not actual transmission of HIV. Participants’ HIV serostatus was unknown, and those who reported UAI were not describing potential HIV transmission if both they and their partner were HIV seronegative. In addition, the study did not examine precipitants of UAI, and as a cross-sectional study it could not establish cause and effect relationships between variables. The coping instrument used was a retrospective measure of responses to a specific problem that participants identified. As such, responses might not reflect the ways in which participants coped with other types of problems. Because the measure was retrospective, responses might also contain biases based on selective recall or other distortions of memory. In addition, the study did not account for the possibility of a social desirability response bias among participants. Thus, it is possible that some participants who engaged in UAI might not have reported it because of concerns about social disapproval. The study used a nonprobability sample, and participants were not likely to be representative of the larger population of gay men in the United States or elsewhere. Consequently, generalizations about its findings could not be made. Comparisons between these results and those of other studies are difficult because of the use of different measures of avoidance coping and different samples of gay men. However, findings of an association between avoidance coping and risky sexual behavior cutting across measures...
and samples would seem to strengthen the theory relating these two variables, allowing for an elaboration of theory and a series of recommendations as described below.

HIV prevention strategies with gay men must be based on a conceptualization of risky sexual behavior that acknowledges the normality and multifaceted importance of sex, and they should provide opportunities for gay men to talk honestly about the role of sex in their lives. They should widen their focus to include gay men’s life problems in general, including victimization, discrimination, and prejudice. HIV prevention materials should state clearly that maintaining safer sex habits over time could be stressful. The role of coping strategies should be integrated into prevention efforts, with a focus on the ways in which reliance on avoidance coping could contribute to episodic risky behavior. Interventions should be delivered in a group format whenever possible to maximize the opportunities for engagement, and they should include information about avoidance coping. Interventions should include examples of avoidance coping responses, taking care not to pathologize them, and they should help participants examine the extent to which they rely on such responses to cope with stress. More elaborated interventions can help gay men recognize the situations that elicit avoidance coping responses and develop alternative strategies for managing such situations. However, people’s coping strategies develop over time, and the effectiveness of short-term coping skills training in changing such strategies has not been established.

As indicated earlier, HIV prevention with gay men must be conceptualized in the larger context of being a stigmatized minority group. For many gay men attempting to cope on a daily basis with threats to their self-esteem, discrimination, loneliness, prejudice, and acts or threats of violence, attention to the stress associated only with HIV will be entirely inadequate. Although it is important to deliver interventions designed to help gay men cope with the stress they experience, these interventions will not change the conditions that cause the stress. In U.S. society adults are expected to carry responsibility for their individual behavior. But in the absence of significant efforts to change the external conditions contributing to risky sex, expectations of lifelong changes to gay men’s sexual habits will continue to be unrealistic.

REFERENCES


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