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The association between minority stress and oppression in the lives of men who have sex with men in Cape Town, South Africa

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ABSTRACT

The association between minority stress and oppression in the lives of men who have sex with men in Cape Town, South Africa

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2005

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An abstract of
A thesis submitted to the faculty of the
Rollins School of Public Health of Emory University
In partial fulfillment of the requirements for the degree of
Master of Public Health
In the Department of Behavioral Sciences and Health Education
May 2011

ABSTRACT

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By Ayesha McAdams-Mahmoud

Objectives: The objectives of this study were to determine the extent to which a sample of men who have sex with men (MSM) in Cape Town, South Africa have experienced factors related to minority stress and explore how those experiences were associated with their identity formations, relationships and coping strategies.

Methods: Twenty-two MSM ages 18 to 55 who lived or worked in Cape Town participated in semi-structured in-depth interviews and completed questionnaires about their experiences with prejudicial events, internalized homophobia, perceived discrimination, and coping strategies. Descriptive statistics and phenomenological thematic analysis were used to summarize findings.

Findings: MSM in Cape Town are affected by societal oppression, which has external and internal manifestations resulting in minority stress. Survey results revealed that internalized homophobia, violence and trauma levels were low while concealment behaviors and perceived stigma and discrimination levels were high among study participants. Interview results demonstrated that race, culture, religion, economic status, and environmental setting may determine the degree to which minority stress is experienced. Participants with low socioeconomic status, black Xhosas, white Afrikaners, and coloured Muslims reported having more experiences with incidents of direct prejudicial events and hiding their sexual preference in public settings when compared to other participants. Minority stress impacts aspects of respondents' sexual relationships, identity formations, coping strategies, mental wellness, and overall comfort in navigating the city. Coping strategies for managing these stressful experiences were diverse. The work of existent and emerging MSM support networks is promising, but is insufficient for meeting the mental health needs of these growing, diverse communities.

Conclusions: This study suggests that inclusive policy changes, like gay marriage rights, have had limited impact on discriminatory attitudes and behaviors toward sexual minorities at institutional and individual levels in Cape Town. The lack of research on this topic and the diversity within South African MSM communities demand further exploration of these experiences to develop tailored, successful, and comprehensive mental health promotion, stigma reduction, risk prevention, and sexual minority support interventions.

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ACKNOWLEDGEMENTS

I must begin by acknowledging the 22 brave and honest participants in Cape Town, South Africa, who shared their time, opinions and deeply personal experiences with me. This work is in honor of them and the many young men and women who have lost their lives to narrow-minded bullies and oppressive societies.

I would like to thank Dr. Rob Stephenson for trusting me with incredible research opportunities, and for always being an enthusiastic reader, listener and mentor. I would also like to thank my committee chair, Dr. Kimberly Jacob Arriola, for being an advocate for academic rigor and the concerns of students. To my final committee member, Dr. Hannah Cooper: Thank you for your kindness, constructive criticism and for always highlighting the importance of qualitative data to the field. I would also like to thank Dr. Tanisha Grimes and each member of the thesis workgroup for reading drafts of my work and providing helpful feedback. I owe special thanks to my mother, Vanessa McAdams-Mahmoud, for introducing me to Frantz Fanon and the concept of residual effects of oppression – I am honored to contribute to your scholarship.

I acknowledge Glenn de Swardt, Geoff Jobson, Renaldo Adams, George Armani Xhola, Helen Struthers, James McIntyre and the rest of the forward-thinking Health4Men/ANOVA Health Institute team. Your generosity won't soon be forgotten, and your vision for a more accepting South Africa will be rewarded. I also acknowledge the work of the Ivan Toms Health Centre for Men, the Triangle Project, the Inner Circle, the Treatment Action Campaign, the Desmond Tutu Foundation, SWEAT and the other HIV prevention agencies in the Cape Town area.

I owe hearty thanks to Trish and Ben Struthers, who housed, nursed, fed and nurtured us for the duration of our research stay in Cape Town. Special thanks to my Cape Town family: Alex de Voux and the Salo clan, Lauren Dollar, Brittanie Richardson, Brittany Stephenson, Andile Mabheka and Tobela Pemba. I thank my sisters, brothers, nieces, nephew, father, and friends for the countless ways they supported this research and this young researcher. Finally, I owe special thanks to my research colleague, Christopher Rentsch, with whom I learned to be fearless.

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GLOSSARY OF TERMS & ACRONYMS

Sources: African Studies Center at Michigan State University, 2010; Meyer, 2003

Afrikaner: Dutch term meaning "native of Africa"; refers to white South Africans who speak Afrikaans as their first language

AIDS: Acquired Immune Deficiency Syndrome

Apartheid: Afrikaans term meaning "apartness"; a social and political policy of racial segregation and discrimination enforced by white minority governments in South Africa from 1948 to 1994

Black: An apartheid-era term of racial classification referring to South Africans who speak as a first language one of the 10 Bantu languages including isiZulu and isiXhosa; still in use

Coloured: An apartheid-era term of racial classification referring to mixed-race South Africans of Bantu, Khoisan and European descent; still in use

Heteronormativity: A term referring to a set of lifestyle norms, which state that there are two distinct genders (male, female) and heterosexuality is the normal sexual orientation

HIV: Human Immunodeficiency Virus (the virus that causes AIDS)

Homophobia: Prejudice, fear or dislike of homosexual people or homosexuality

MSM: Men who have sex with men

Shebeen: A township bar, often operating without a liquor license, where black and coloured South Africans gather to drink and socialize

Stigma: Social stigma is severe social disapproval of personal characteristics or beliefs that are perceived to be against cultural norms

Township: The often underdeveloped, urban living areas on outskirts of major cities that were reserved for blacks, coloureds and working-class Indians from the 19th century until the end of apartheid

White: A term that refers to people from South Africa who are of Afrikaner, British or other continental European descent

NOTE: In this paper, I use the term ***MSM***. "Men who have sex with men" and "MSM" are terms used by epidemiologists and researchers to distinguish a group by virtue of their sexual behavior instead of their sexual identity. Men who have sex with men may self-identify as gay, bisexual, transgender, heterosexual or straight, if they choose to self-identify at all. It is important to recognize that this term describes behavior alone and that the behavior may not be exclusive. MSM may have sexual relationships with women and may only engage in sex with men in specific contexts (UNAIDS, 2010).

CHAPTER ONE: INTRODUCTION

I. Background

The mental health outcomes of men who have sex with men (MSM) are understudied in resource-poor settings. African MSM are members of those understudied populations, as their lived experiences and psychiatric outcomes are rarely explored in scientific literature. The lack of research persists despite growing networks of same-sex activity throughout the continent and high estimates of disease burden caused by psychiatric disorders worldwide (WHO Atlas, 2005; Cloete et al., 2008). This research study aimed to address that gap by exploring varied experiences with minority stress and discrimination in a sample of MSM in Cape Town, South Africa, where the paucity of targeted research interventions on the population is especially pronounced and the population's mental health outcomes are unexplored. Since little research exists on the mental health of South African MSM, this introduction will address the global context in which this knowledge gap exists. I will show that African MSM are members of a sexual minority at greater risk for adverse mental health outcomes than the general population due to external cultural and sociopolitical forces and uncoordinated mental health care. For this reason, they are in need of targeted research interventions addressing their unique issues.

It is well established that MSM are at a greater risk for mental health problems when compared to the general population (CDC, 2010). Since 1974, when the American Psychiatric Association de-pathologized homosexuality as a mental illness, several U.S. studies have shown homosexual persons at substantially higher mental and sexual health

risks than the general public (Rosser et al., 2008; Meyer, 2003; Preston et al., 2004). MSM are more likely to meet criteria for mood, anxiety, panic and substance abuse disorders, and are more likely to have attempted suicide in their lifetimes when compared to their counterparts who solely engage in male-female sex acts (Cochran, Sullivan, Mays, 2003). Young MSM have a greater propensity towards depressive symptoms, less utilization of mental health services and higher rates of substance use than their older counterparts (Salomon, et al., 2009). Depressive symptoms, in particular, may impact self-esteem, self-assertion and self-protective behaviors and may contribute to greater rates of substance use and other risk-taking behaviors (Salomon, et al., 2009). There are many reasons why people develop mental disorders, including genetic predisposition, significant life events, lifestyle, and diets (CDC, 2010). But in the case of MSM, researchers have highlighted their hostile sociopolitical environments as primary drivers of adverse mental issues (CDC, 2010).

Men who have sex with men face environmental factors that heighten their risk for adverse mental health outcomes everywhere in the world. The World Health Organization states that mental disorders are inextricably linked to human rights issues that result in stigma, discrimination and human rights violations (WHO, 2010). In Africa, there is an overarching "culture of denial", and same-sex behavior is deemed "un-African" and a "Euro-American perversion" (Reddy & Sandfort, 2008). Between 85-99% of African respondents to an international opinion poll said they found MSM behavior unacceptable (Desmond Tutu Foundation, 2009). Additionally, vulnerability to HIV infection is increased where sex between men is criminalized, as men are either excluded from, or exclude themselves from, sexual health and welfare agencies out of fear; and

MSM behavior is illegal in most African nations, with four countries imposing the death penalty for same-sex "transgressions" (UNAIDS, 2010; Reddy & Sandfort, 2008; Desmond Tutu HIV Foundation, 2009). Many African countries, including the South African government, which progressively deemed discrimination against same-sex couples unconstitutional, have ignored homosexuals in HIV treatment and prevention programs (South African Department of Health, 2007; Reddy & Sandfort, 2008). MSM have only recently begun to be widely recognized in sub-Saharan African research and in HIV prevention campaigns (South African Department of Health, 2007). These realities justify a study on the residual effects of stigma-related social stress, trauma and discrimination, all demonstrated to be psychologically damaging (Szymanski & Gupta, 2009; Kelley & Robertson, 2008; Meyer, 1995).

Researchers argue that markers of poorer mental and sexual health in homosexual persons are the effects of internalized homo-negativity and cultural victimization, which is a direct result of the aforementioned social, cultural and political forces (Rosser, Bocktin, Ross, Miner, Coleman, 2008). When an individual is a member of a stigmatizing and discriminating society, the conflict between him or her and the dominant culture can be onerous and the resultant minority stress can lead to internalized negative self-regard and adverse mental health outcomes (Meyer, 1995). Stigma has also been shown to negatively impact coping strategies for MSM often leading to methods of avoidance and cognitive escape (Alvy et al., 2010; Bauermeister et al., 2009; Courtenay-Quirk et al., 2006). These avoidance coping strategies have been shown to mediate the link between depression and risk behaviors (Alvy et al., 2010).

Many countries lack the mental health infrastructure and pool of culturally competent healthcare workers equipped to respond to the unique mental health needs of MSM (Desmond Tutu HIV Foundation, 2009). Mental health resources worldwide are lacking (WHO, 2010), with countries averaging less than 1% of their total health budget spending on mental health expenditures. This is in stark contrast to the World Health Organization's estimate that 13% of all disease burden is caused by a range of neuro-psychiatric disorders (WHO Atlas, 2005). In most countries in the African, Eastern Mediterranean, Southeast Asian, and Western Pacific regions the presence of a child psychiatrist is in the range of 1 to 4 per million. On the African continent, only Algeria, South Africa and Tunisia have more than 1 psychiatrist per 100,000 people, though they are often only accessible by the wealthy (WHO Atlas, 2001). For these reasons, many African countries lack the capacity to prevent and treat adverse mental health conditions in vulnerable populations. Currently, there are limited counselor or health provider training manuals, which address MSM specific health needs (Desmond Tutu HIV Foundation, 2009). In South Africa's most recent National Strategic Plan, the government acknowledged that stigma, discrimination and prejudice interfere with HIV prevention efforts, yet the country does not have campaigns targeting the mental wellness of sexual minorities who may experience these prejudices frequently (South African Department of Health, 2007).

Most literature to date has focused on the mental health of MSM in the context of HIV and AIDS incidence. While it is true that MSM bear a disproportionate burden of HIV infection worldwide – representing 53% of all new HIV cases in the U.S. alone – this is not the only context in which mental disorders occur and there is little

understanding about the psychosocial and contextual determinants of high-risk HIV behaviors (CDC, 2010; McIntyre & Dladla, 2008). Mental health problems can occur as risk factors for HIV, coincidentally with HIV or as a result of HIV infection and its complications. Additionally, widespread homophobia is providing an ideal climate for the spread of HIV by driving MSM away from the information, services and security they need to protect themselves and others against HIV (Cournos, McKinnon, Wainberg, 2005). Much of the research that does focus on the mental wellness of MSM has not been conducted in Africa, as multiple searches of Medline, PsycInfo and PubMed interchangeably using the terms "MSM", "Africa", "mental health", "depression" and "psychology" found.

The goal of this study is entrenched in the aforementioned context. South African MSM are an understudied population in HIV/AIDS epidemiological and social science research (Reddy & Sandfort, 2008). Their mental health outcomes are nonexistent in research literature, and the intersection of MSM populations, mental health and HIV prevention is not well explored. Additionally, there are no mixed methods studies that focus on multiple mental health outcomes like trauma, internalized heterosexism or perceived discrimination and stigma in African MSM. Mixed methods research draws on the strengths and minimizes the weaknesses of quantitative and qualitative methods, thus legitimizing the approach of using multiple approaches to answering unexplored research questions (Johnson & Onwuegbuzie, 2004). It is particularly well suited for exploratory research because it is inclusive, inductive, deductive, and uncovers the best set of explanations for understanding one's results (Johnson & Onwuegbuzie, 2004). Understanding the psychosocial conditions of South African MSM and the impact those

conditions have on their coping strategies, constructions of identity and relationships may give local organizations information needed to provide valuable, culturally competent, targeted services for this population. For that reason, this study aims to contribute to the limited existing evidence base in this area and provide policy and program recommendations.

II. Objectives

The objectives of this study were to determine the degree to which a sample of MSM in Cape Town, South Africa have experienced factors related to minority stress – internalized oppression, physical violence, internalized heterosexism, perceived discrimination and stigma, and Post Traumatic Stress Disorder symptoms – and explore how those experiences are associated with events in their daily lives, identity constructions, relationships and coping strategies.

III. Research Questions

1. What types of experiences related to minority stress – trauma, stigma-related physical violence, and perceived stigmatized and discriminatory treatment – are faced by MSM who live in Cape Town?
2. In what ways are those stressful experiences associated with the ways MSM construct their personal identities, interact with their communities and engage in interpersonal relationships?
3. What coping strategies do MSM utilize to manage those stressful experiences?

IV. Study Setting

This research was based in Cape Town, the capital of the Western Cape province in South Africa (See Figure 1). South Africa is located on the southern tip of the African

continent, just south of Namibia, Zimbabwe and Botswana. The country spans 1.2 million square miles and is nearly twice the size of Texas. It has nine provinces and its capital, Pretoria, is located in the Gauteng province in the northeastern part of the country. South Africa has the most advanced economy in Africa, with a Gross Domestic Product ranked 26th in the world and $505.3 billion in assets reported in 2009 (CIA, 2010; Republic of South Africa, 2009). It is a middle-income, emerging market with an abundant supply of natural resources. It relies heavily on its mining industry, and is the world's number one supplier of chromium, gold and platinum. It has a population of approximately 49 million with a median age of 24 years (CIA, 2010). The population life expectancy is about 49 years old. Most South Africans live in urban sectors (61%) and are highly literate (86.4%). South Africa has 11 official languages including isiZulu, isiXhosa, Afrikaans, Sepedi, and English. Its population is composed of four major sub-populations described in the 2001 census in the following ways: Black African (79%), White (9.6%), Coloured (8.9%), and Indian/Asian (2.5%) (CIA, 2010).

Figure 1: Map of South Africa. Source: World Atlas.

South Africa and HIV/AIDS

South Africa is one of the countries hardest hit by the AIDS epidemic, with the largest number of HIV infections in the world (Republic of South Africa, 2010). It is home to 5.7 million people living with HIV or AIDS. Its HIV/AIDS

prevalence rate is among the highest in the world, at 18.1%, although prevalence rates have begun to stabilize (Kaiser Family Foundation, 2008). Contrastingly, the prevalence rate in sub-Saharan Africa is 5% and 0.8% globally (Kaiser Family Foundation, 2008). Due to few studies on the population, or perhaps multiple simultaneous epidemics, current HIV prevalence estimates amongst MSM in South Africa range from 12% to 47% (Shisana et al., 2009). Heterosexual sex is recognized as the predominant mode of HIV transmission in the country followed by mother-to-child transmission, and drivers of the epidemic include migration, low perceptions of risk, and multiple concurrent sexual partnerships (Republic of South Africa, 2010). On December 1 2009, President Zuma made important policy announcements regarding expanding access to antiretroviral treatment to specific groups of patients, namely pregnant women, people with dual HIV and TB infection, and those with CD4 counts of 350 or less. In addition, all HIV-infected infants will be started on treatment, irrespective of CD4 count. The number of persons receiving treatment at public health facilities reached approximately one million in 2009 (Republic of South Africa, 2010).

V. Study Significance

This exploratory study offers preliminary evidence about the mental health needs of MSM, a highly discriminated and stigmatized sexual minority group in Africa, and in Cape Town. African MSM are understudied in many respects: They are not targeted by national HIV prevention campaigns; their mental health outcomes are understudied and underserved; and the intersection of homophobic living environments, adverse mental health outcomes and resource-poor settings has not been addressed. By illustrating important knowledge gaps in health outcomes for a sample of MSM, in South African mental health care services, and

targeted interventions for this population, this study provides the preliminary data needed to create and implement research studies and community-based programs designed to reduce adverse mental health outcomes amongst MSM in South Africa. Study results also may have implications for the ways communities approach mental health in HIV prevention campaigns.

VI. Theoretical Framework

The theoretical framework guiding the development of this study is the Minority Stress Theory. Ilan Meyer describes minority stress as "psychosocial stress derived from minority status" (Meyer, 1995). His theory is based on the premise that gay people, like members of other minority groups, are subjected to chronic stress related to their stigmatization, which leads to adverse mental health outcomes especially when they live in discriminating societies. Meyer suggests that minority stress operates through three processes, which I have measured directly in the survey scales and in-depth interview questions: internalized homophobia (including concealment of one's sexual behavior), perceived stigma (expectations of rejection and discrimination), and actual prejudice events (Meyer, 1995).

Additionally, I referenced Gordon Allport's Scale of Prejudice and Discrimination, which was created to be a measure of the manifestation of prejudice in a given society. It partially informed Meyer's theory (Allport, 1954; Meyer, 1995). The scale is divided into five distinct contributors: Antilocution (hate speech), avoidance, discrimination, physical attack (violence), and extermination. In addition to the overlapping constructs present in the Minority Stress Theory, I incorporated scales and questions on physical attack and coping habits into the survey and the in-depth interview question guide.

Data collection instruments were created with a phenomenological lens, which focuses on understanding people's everyday experiences of reality, in great detail, in order to gain an understanding of the phenomenon in question (McLeod, 2001). In this case, the phenomenon was living life in public in a discriminating society as an MSM, and the various health issues associated with that experience.

VII. Summary

In summary, this study is important for expanding the limited research that exists on African MSM whose lives are often seen solely through the lens of HIV, if they are seen at all. The next chapter will illustrate the environment South African MSM occupy, the forces shaping their mental health outcomes, the institutions they have for support, and the gaps in care needed to meet their unique needs. In this way, the overview of existing literature will justify the need for the current study.

CHAPTER TWO: LITERATURE REVIEW

> ***"...the institutionalization of oppression in daily living also entails an internalization of the oppressor's values, norms, and prohibitions. Internalized oppression is most resistant to change, since this would require a battle on two fronts: the oppressor within and the oppressor without."***
>
> - Frantz Fanon and the Psychology of Oppression, p. 123

I. Introduction

This study follows in the traditions of Ilan H. Meyer, Gordon Allport, and Frantz Fanon, who examined the pathways by which external forces that oppress minority populations can shape and impact the behavior of those populations. This literature review features articles about oppression manifesting as minority stress. Meyer created the Minority Stress Theory, which posits that gay people, like members of other minority groups, are subjected to chronic stress related to their stigmatization, which can lead to adverse mental health outcomes especially when they live in discriminating societies (Meyer, 1995). Meyer suggests that minority stress operates through three processes: internalized homophobia, perceived stigma and actual prejudice events, which include violence and hate speech (Meyer, 1995). Allport's Scale of Prejudice and Discrimination and Fanon's work on the psychological effects of oppression support Meyer's theory – that discriminating societies have created many of the psychological problems faced by oppressed minority communities (Allport, 1979; Bulhan, 1985).

Few studies have investigated the impact of oppressive, discriminating societies on the behavior or mental health outcomes of MSM living in Africa. A 2007 U.S. qualitative study found that perceptions of social oppression – homophobia, racism and poverty – were predictive of negative coming-out events and risky sexual situations among a sample of 92 African-American and Latino MSM (Greene, 2007). Since intolerance to gay people is more

than three times higher in South Africa than it is in the U.S., a study on the impact of oppression on this population is warranted (Roberts & Reddy, 2008).

Scientific literature on South African MSM is emerging slowly and mostly focuses on their sexual behaviors within the context of history, anthropology, apartheid, blood donation, and the epidemiology of the HIV epidemic (Lane, 2010). Though a recent study explored the impact of homophobia on the health-seeking behaviors of South African MSM, very few studies have considered adverse mental health outcomes of South African MSM who have experienced oppression or internalized homophobia (Lane et al., 2008). To better understand the current knowledge-base about this topic and the lived experiences of South African MSM within and outside the aforementioned contexts, the following review will disentangle understandings of gay spaces and sociopolitical experiences of MSM in South Africa, examine the stigmatizing experiences and mental health outcomes amongst MSM, and discuss common coping strategies, as has been reported in recent scientific literature. The review will include some research conducted on MSM communities in the U.S. and elsewhere in Africa, since research focusing on the mental health and sexual behaviors of MSM in South Africa is scant (Cloete et al., 2008). In the end, I will address gaps in knowledge about the mental health outcomes and targeted services for South African MSM before introducing the methodology of my research.

II. The socio-political realities for MSM in South Africa

In Sub-Saharan Africa, there is an overarching "culture of denial" toward same-sex behavior, which is deemed largely as "un-African" and a "Euro-American perversion" (Reddy & Sandfort, 2008). For instance, between 85-99% of African

respondents to an international opinion poll said they found MSM behavior unacceptable, opinions shared by South Africans in a 2008 study (Desmond Tutu Foundation, 2009; Roberts & Reddy, 2008). Many of these sentiments are supported by legal policies and HIV prevention campaigns. Same-sex behavior is illegal in most African nations, with four countries imposing the death penalty for same-sex "transgressions" (Reddy & Sandfort, 2008; Desmond Tutu HIV Foundation, 2009). MSM have only recently begun to be widely recognized in sub-Saharan African research and in HIV prevention campaigns, despite the fact that many HIV epidemics began in MSM sexual networks (South African Department of Health, 2007). South African MSM may enjoy unique legal protections, but they are not immune to discriminating environments. The historical, legal and spatial realities of South African sexual subcultures justify a study on the residual effects of stigma-related social stress, trauma and discrimination, all demonstrated to be psychologically damaging (Szymanski & Gupta, 2009; Kelley & Robertson, 2008; Meyer, 1995).

To understand modern experiences of South African MSM, one must first understand the country's political history, which is fraught with racial discrimination and political oppression. In 1948, after decades of racist propaganda centered on Afrikaner nationalism, the Afrikaner Nationalist Party was elected into power (African Studies Center, 2010). The Nationalist Party campaigned on and enforced apartheid, a system based on earlier segregation laws, which more aggressively institutionalized racial segregation in public spaces. In 1950, through the Population Registration Act, the government established four classes of racial stratification: white, coloured, black, and Asian/Indian, classifying terms that are still used as identifiers by residents and census

designers today, and which will be used throughout this report for consistency. The government went on to pass legislation that would restrict blacks, coloureds and Indians from attending white universities, outlawed education for blacks that wasn't Bantu Education (inferior education, designed to produce manual laborers), and enforced residential segregation by forcibly relocating millions of black and coloured residents to townships and homelands that were overcrowded, resource-poor, and isolated. These relocations irreparably damaged families, communities, vibrant businesses, and essentially stripped blacks of their rights to South African citizenship. The white minority controlled 80% of the land and enjoyed the highest standard of living in cities like Cape Town, Durban and Johannesburg, while other racial groups remained disadvantaged in terms of income, education, housing, and life expectancy (African Studies Center, 2010). In 1990, after years of internal protests, activism and insurgency by black South Africans and their allies, the Nationalist Party released Nelson Mandela from prison and lifted the ban on the African National Congress and other political organizations. The country held its first democratic elections in 1994, which saw Mandela and the African National Congress come to power (Thompson, 2001).

As the fight for South African civil rights reached its peak, so did activism within gay and lesbian communities, which helped create an unprecedented turn-around in the legislative landscape for same-sex attracted individuals. These activists spoke out against laws that kept sodomy illegal from the 19th century until 2002. Under apartheid, homosexuality was a crime that was punishable by up to seven years in prison, and in the 1960s, Parliament enacted a variety of laws intended to suppress "homosexual" behaviors, including the Prohibition of Disguises Act of 1969 that criminalized males

dressing in feminine clothing (Newstrom, 2007; Cameron, 1994). But after apartheid ended, the National Coalition for Gay and Lesbian Equality was formed to lobby for constitutional rights for gays and lesbians (Visser, 2003). South Africa's 1996 constitution became the first in the world to outlaw discrimination based on sexual orientation, and after a coalition of 74 gay, lesbian and bisexual organizations united, Supreme Court decisions later gave homosexuals equal rights to adopt children and serve in the military (Newstrom, 2007). In 2006, South Africa became the fifth country in the world to grant same-sex couples the right to marry (Tucker, 2009).

Recently, researchers have begun to document the colorful apartheid-era history of South Africa's lesbian, gay, bisexual, drag, and transgender communities. During World War II, gay subcultures that catered mostly to white middle-class men flourished in port cities like Durban and Cape Town (Visser, 2003). At the same time, coloured same-sex individuals created some of the richest gay subcultures in Cape Town and mocked gender and sexual conventions during annual heterosexual festivals like the Coon Carnival, but they remained segregated in traditional coloured communities like Athlone, Woodstock, Salt River and District Six (Visser, 2003). In South Africa's diamond and gold mines, black men would engage in same-sex relationships known as "mine marriages," with more feminine male partners acting as sources of sex, companionship and domestic service (Swarr, 2004). Feminine male mine partners were tolerated by apartheid officials because it kept black men from demanding higher wages to fund visits from their wives (Swarr, 2004). Drag performances were commonplace in black mining culture, elite white clubs, military units like the South African Defense

Force, gay township shebeens, and as part of mainstream community celebrations (Swarr, 2004).

Since apartheid ended, South African gay and lesbian communities have grown and become more visible in the major city centers of Cape Town, Durban, Johannesburg and Pretoria, which each boast a range of gay and lesbian facilities and services (Visser, 2003). These were and remain the same city centers that had substantial white populations and thriving tourism industries during apartheid (Visser, 2003). Lesbian and gay communities existed before apartheid – although less visibly – and after it ended, the residual effects of the system continued to shape these sub-populations (Swarr, 2004). In turn, present-day MSM communities are growing within spatial realities that have been complicated by this racial history (Swarr, 2004). For example, in the 1980s, white gay men had the economic and social capital to enjoy gay leisure spaces like clubs and bars, while the movement of black and coloured gay men was restricted by apartheid laws. In Cape Town, the gay village in De Waterkant is located 6.2 miles away from Langa, the nearest black township, and Athlone, the nearest coloured area. The majority of Cape Town's black and coloured residents live in Khayelitsha and Mitchell's Plain, 18.6 miles away from the gay city center, and most do not have the means to travel to these areas at night (Visser, 2003). For a visual representation of these distances, see Figure 2 below. The yellow star is in De Waterkant, the red circle is in Mitchell's Plain, and the blue square is in Khayelitsha. Some researchers argue that Cape Town's gay village welcomes the wealthy, empowered white gay community and marginalizes the already disempowered populations of different racial backgrounds and income brackets (Visser, 2003).

Figure 2. Map of Cape Town – Distance to Khayelitsha and Mitchell's Plain, Source: keystonesymposia.org

Though Cape Town is an international gay tourist destination with progressive constitutional guarantees of non-discrimination against lesbian, gay, bisexual and transgender South Africans, researchers say the struggle to establish equality for these individuals is not over (Nel, Rich, Joubert, 2007). In 2008, a study on the intensity of sexual prejudice in South Africa found that negative attitudes towards lesbians and gay men are widespread with more than 80% of the population aged 16 years and above expressing the view that sex between two men or two women could be considered 'always wrong' (Roberts & Reddy, 2008). Prejudiced views on same-sex relations appear closely related to education, race and environment with more highly educated, wealthy, white, urban residents being more tolerant (Roberts & Reddy, 2008). The legal rights attained do not necessarily equate to daily improvements in the lives of MSM and

are considered marginal by the vast majority of queer individuals in the country (Tucker, 2009). Many laws still have to be reformed, while to date only a small minority of progressive employers has eradicated practices discriminating on the grounds of sexual orientation (Nel, Rich, Joubert, 2007). For instance, the South African Police Service does not keep statistics on homophobic crimes, which increases the invisibility of crimes against gay men and lesbian women (Polders, Nel, Kruger, Wells, 2008). A South African study found that current policies and programs are unresponsive to the needs of MSM and that epidemiologic information is lacking, in spite of mention of MSM in the country's HIV/AIDS National Strategic Plan for (Rispel & Metcalf, 2009).

As shown above, researchers have begun to investigate the impact of discriminating societies on gay spaces and community-level interactions with the legal system. Positive strides have been made; even South Africa's most recent National Strategic Plan mentioned MSM for the first time with a goal to "Ensure a supportive legal environment for the provision of HIV and AIDS services to marginalized groups" (Department of Health, 2007). But the picture on paper is much different than the close-up view on the ground. The next section will show what associations researchers have found between oppressive societies and modern experiences amongst MSM with discrimination, stigma and mental illness.

III. MSM, stigma and mental health outcomes

> ***"If LGB people are indeed at risk for excess mental distress and disorders due to social stress, it is important to understand this risk, as well as factors that ameliorate stress and contribute to mental health. Only with such understanding can psychologists, public health professionals, and public policymakers work toward designing effective prevention and intervention programs."*** - Meyer, 2003

Given the sociopolitical and cultural histories and realities of South African MSM communities, internalized oppression is a salient topic of study. The last section showed how South African MSM communities have experienced apartheid-era racial oppression, which is manifested spatially and economically. It also showed that legal gains have not swayed cultural beliefs about same-sex attraction. This section will expand on the latter point by examining what anthropological, psychological and sociological research has told us about the associations between components of minority stress, mental illness and MSM-behavior in multiple sectors, notably healthcare.

According to the Minority Stress Theory, experiences with discrimination and social stigma related to one's sexual orientation can lead to multiple behaviors in MSM including increased sexual risk and guarded interactions with healthcare institutions (Meyer, 2003). The cultural and sociopolitical sentiment that same-sex attraction is un-African has influenced MSM behavior in healthcare sectors especially in the context of HIV prevention. In many parts of the world, HIV surveillance, prevention, and treatment are impeded by the social stigma and secrecy that surround same-sex behavior (Cournos, McKinnon, Wainberg, 2005). South African MSM have reported that their options for non-stigmatizing sexual healthcare services were limited by homophobic verbal harassment by healthcare workers (Lane et al., 2008). Gay-identified men seek out clinics with reputations for employing healthcare workers who respect their privacy and their sexuality, and challenged those who mistreated them (Lane et al., 2008). This type of widespread homophobia is providing an ideal climate for the spread of HIV by driving MSM away from the information, services, and security they need to protect themselves and others against HIV (Cournos, McKinnon, Wainberg, 2005). A 2007 South African

study of 18 young gay and lesbian participants found that institutionalized homophobic sentiment was widespread and often led to statements of denigration that impacted people's willingness to seek psychological services (Butler, 2007). Further, a 2002 U.S. study found that when internalized homophobia is present, it is likely to hamper the utilization of HIV prevention services because men are less likely to feel similar to other members of intervention groups so they score poorly on post-intervention perceptions of change in condom use self-efficacy (Huebner et al., 2002). Many studies have found links between discriminating environments and risky sexual behavior in MSM including a 2008 South African study in township communities near Johannesburg (Lane et al., 2008).

HIV stigma dominates the type of stigma studied amongst MSM internationally (Williamson, 2000). A 2008 South African study on stigma and discrimination among 92 HIV-positive MSM and 330 men who have sex with women living in Cape Town found that more than half experienced stigma related to their HIV status (Cloete et al., 2008). There is some overlap with experiences of HIV-stigma and heterosexist stigma. A U.S. study of 40 young HIV-positive African American MSM found that 90% of those surveyed experienced sexual minority stigma, 88% experienced HIV stigma, and 78% experienced dual stigma. Heterosexist stigma was characterized by experiences of social avoidance, HIV stigma, and shame, which impacted the likelihood for engaging in risky sexual behaviors (Radcliffe et al., 2010).

Research on experiences with social stigma and homophobia among African MSM are limited outside the context of HIV. The World Federation for Mental Health has an Africa Initiative that has funding to examine mental health needs *only* as they

relate to persons living with HIV and AIDS (WFMH, 2010). Additionally, a search of the PubMed, PsycInfo and Medline search engines with the terms "stigma", "MSM", and "homophobia" found just 21 articles on the topic. After pairing the terms "homophobia" and "Africa" in the Medline search engine, eight studies emerged, seven of which were focused on homophobia in the context of HIV. One recent study, however, focused on homonegativity among a sample of MSM in Uganda (Ross, M.W., et al., 2010). The study legitimized the cross-cultural use of Ross & Rosser's Internalized Homonegativity scale and found that men who experienced violence or abuse for being gay had significantly higher scores on the personal discomfort with being gay subscale (Ross et al., 2010). While it is important that African MSM be included in HIV prevention research, researchers must also recognize that stigma and homophobia have their own serious and adverse health outcomes in this population, which are only compounded by the presence of HIV. A South African study recently found that HIV policies and programs focus on heterosexual transmission and mother-to-child transmission to the detriment of MSM residents (Rispel & Metcalf, 2009).

Mental Health Outcomes

The aforementioned experiences of discrimination and stigma are not only related to sexual and health-seeking behaviors, but they are also directly related to adverse mental health outcomes amongst MSM. Like everyone else, the majority of MSM are highly resilient and able to cope successfully with many negative life stressors, but they are at increased risk of mental disorders due to the negative effects of social marginalization (CDC, 2010). According to Ilan H. Meyer's Minority Stress Theory, gay people, like other minority groups, are subjected to chronic stress related to their

stigmatization (Meyer, 1995). In consequence, they can develop adaptive and maladaptive responses that may include mental health symptoms. Meyer wrote that negative regard from others leads to negative self-regard and adverse mental health outcomes (Meyer, 1995). Scientific research has supported Meyer's theory by providing evidence that MSM are a vulnerable, minority population with high rates of adverse mental health outcomes (Meyer, 2003).

The following psychological conditions are not certainties, but they are more likely to occur within MSM populations especially if they live in highly stigmatizing environments. The most frequently reported outcomes include suicidal ideation, substance abuse, depression, anxiety, risky sexual behavior, and internalized heteronormativity (also known as internalized homophobia) (Desmond Tutu HIV Foundation, 2009). Anxiety, depression and substance abuse are the most common mental disorders affecting South African MSM (Desmond Tutu HIV Foundation, 2009). Additionally, it has been shown in multiple studies that internalized homophobia is associated with greater relationship problems both generally and among coupled participants independent of outness and community connectedness (Frost & Meyer, 2009).

Stigma resulting from being a sexual minority is directly tied to feelings of internalized homophobia. Meyer defines internalized homophobia as a proximal process related to concealment, which involves the internalization of the stigma associated with homosexuality (Meyer, 2003). There has been much academic debate about the accuracy of this term because of its focus on the fear aspect of prejudice and because it contextualizes fear within the individual instead of society (Wiliiamson, 2000). Many

researchers prefer the terms *homonegativism* (referring to the beliefs and value systems of prejudiced individuals) or *heterosexism* (referring to an underlying belief that heterosexuality is the natural, normal, acceptable or superior form of sexuality) (Williamson, 2000). For the purposes of this paper, these three terms will be used as they have been in the literature and interchangeably to refer to general prejudice and disapproval for same-sex behavior.

Stigma can also result in internalized heterosexism, as a 2007 South African study found (Nel, Rich, Joubert, 2007). The study confirmed earlier findings that indicated that due to marginalization and the threat of discrimination, many gay individuals are prone to experiencing perceived rejection by society, self-devaluation, identity confusion, hiddenness and isolation, excessive self-reliance, lack of trust, control issues and difficulties in familial interactions (Nel, Rich, Joubert, 2007). The same study confirmed that internalized homophobia has also been found to be prevalent in South African lesbian, gay, bisexual and transgender persons (Nel, Rich, Joubert, 2007). There is evidence that researchers in other African countries are studying internalized homophobia amongst MSM, as a recent study with 216 gay and bisexual men in Uganda validated the cross-cultural use of Ross & Rosser's Internalized Homonegativity scale (Ross et al., 2010).

HIV stigma has been found to be associated with increased levels of anxiety, loneliness, depressive symptoms, engaging in avoidant coping strategies, and a history of suicidal ideation. HIV/AIDS stigma exists within the gay community and has a negative effect on the mental health of people living with HIV (Courtenay-Quirk et al., 2006). Stigma has been found to contribute to elevated rates of alcohol abuse and depression,

further fueling the HIV epidemic and creating additional barriers to care (Cournos, McKinnon, Wainberg, 2005).

Men who have sex with men are also prone to depression and anxiety largely due to the fact that many people see sex between men as unacceptable; many African countries still regard MSM behavior as a criminal act; MSM grow up believing that their attraction to men is wrong or sinful; and they often feel stigmatized and excluded from mainstream society (Desmond Tutu HIV Foundation, 2009). Depression and anxiety in MSM can lead to concealment of their sexual orientation and a desire to lead double lives, which cements their status as members of a stigmatized social minority and leads to increased stress (Desmond Tutu HIV Foundation, 2009). Depression can manifest in low mood, poor self-concept, and suicidal ideation, which is higher amongst MSM who are just coming out than among those who have accepted their sexual identity (CDC, 2010; Desmond Tutu HIV Foundation, 2009). Though South African research on the etiology of depression among gay men and lesbians isn't rich, international research suggests that they are populations at increased risk of depression. Self-esteem has been found to mediate the impact of physical victimization on psychological distress (Polders et al., 2008). In 2008, South African researchers developed and validated a model, which indicates that increased self-esteem can decrease vulnerability to depression among gay men and lesbian women in South Africa (Polders et al., 2008). Experiences of MSM with anxiety are less well understood than those with depression, but many social scientists think its causes relate to the social stigma surrounding homosexuality, the hidden ways that MSM live their lives compared to heterosexuals, substance abuse issues, and poor

self-concept. Anxiety can manifest in panic disorder, generalized anxiety disorder, phobias and post-traumatic stress disorder (Desmond Tutu HIV Foundation, 2009).

Some studies show that the prevalence of drug use is higher amongst MSM than among heterosexuals (CDC, 2010). The main reasons why MSM abuse drugs include discrimination they face for being members of a minority group in society and wanting to feel a sense of social acceptance and community (CDC, 2010; Desmond Tutu HIV Foundation, 2010). Commonly abused substances amongst South African MSM include alcohol, marijuana, methamphetamines, and crack cocaine (Desmond Tutu HIV Foundation, 2010). A 2008 South African study on sexual risk behaviors amongst MSM found that 59% of the 147 MSM participants were engaging in unprotected anal intercourse, which was associated with regular drinking and intoxication (Lane, Shade, McIntyre, Morin, 2008). Another 2008 study was a qualitative rapid assessment of MSM substance using behaviors in three South African cities – Cape Town, Durban and Pretoria (Parry et al., 2008). Researchers found that one-third of respondents willing to be tested were HIV-positive and were using drugs like crack cocaine, cannabis, and methamphetamines. This drug use led to inconsistent condom use, shared needles and other high-risk sexual activities, even when HIV risk knowledge was high. Most importantly, MSM reported that homosexual stigmatization at health facilities was a major barrier for asking for help for their substance using problems (Parry et al., 2008).

Intimate partner violence (IPV) amongst MSM is an emerging area of inquiry, which is associated with institutionalized homophobia, sexual risk taking and substance use. Though little research on this topic has been published in reference to African populations, authors of a 2010 article on the topic argued that U.S. victims of same-sex

IPV may be hesitant to seek help due to internalized or institutionalized homophobia, the nature of the abuse itself, or a perceived lack of useful resources resulting in underreporting of abuse (Stephenson, Khosropour, Sullivan, 2010). Their evidence suggested that IPV affects 25% to 50% of all same-sex relationships. The internet-based study found that 11.8% of MSM participants reported physical violence from a male partner, while around 4% reported experiencing coerced sex. Men who reported recent unprotected anal sex were more likely to also report experiencing physical IPV (Stephenson, Khosropour, Sullivan, 2010). Other researchers suggest that social marginalization and homophobia often foster the production of syndemics and health disparities among MSM populations. One study found a large percentage of participants in a community-based organization reported being forced by partners to have sex (41%) and feeling unsafe to ask their abusive partners to use protection (28%) (Heintz & Melendez, 2006).

Less work has been conducted on MSM and experiences with trauma or post-traumatic stress disorder (PTSD), although a U.S. cross-sectional survey with 189 MSM found that 60% of participants screened positive for having PTSD symptoms (Reisner, Mimiaga, Safren, Mayer, 2009). Screening positively for PTSD symptoms was significantly associated with having engaged in unprotected anal sex in the past 12 months and for concurrent depressive symptoms, over and above any effects of whether a traumatic/stressful event occurred during the year (Reisner, Mimiaga, Safren, Mayer, 2009).

In closing, more research is needed on the associations between African MSM who live in discriminating societies and mental health outcomes like IPV, PTSD, and

internalized homophobia, which are under-researched in those settings. However, if researchers begin to unearth these issues, supportive mental health institutions must be in place to offer care.

Mental Health Infrastructure

The mental health needs of MSM communities in South Africa are unique and multidimensional, so they require a mental health infrastructure that is responsive to them. Unfortunately, the current South African mental health infrastructure isn't well suited for MSM patients or general members of the population. Many of the mental health services in the country are organized at the provincial level (WHO, 2005). There are no national budget allocations for mental health and details about expenditures on mental health are not available. There is no mental health reporting system in the country and no prevalence estimates of mental disorders included in national indicators. Additionally, the existing mental health legislation – the Mental Health Act – hasn't been updated since it was passed by Parliament in 2002 (WHO, 2005). Only 10.8% of South African psychiatrists are able to communicate fluently in one or more African languages due to the low amount of black doctors being trained as psychiatrists. Most people who are able to access mental health services have high socioeconomic status. Due to these issues, non-governmental organizations often offer assistance in advocacy, life skills courses, promotion, prevention, treatment and rehabilitation for MSM mental health needs (WHO, 2005).

Several professional societies exist to promote mental wellness in the country including the South African Depression and Anxiety Group, the Psychological Society of South Africa (PsySSA) and the South African Society of Psychiatry (SASOP). The South

African Depression and Anxiety Group is the most well-known and community-entrenched mental health organization in the nation. It refers callers to and operates 180 support groups country-wide (even in rural areas), operates a national call center open seven days a week, a national suicide crisis line, and a website that receives 600,000 hits per month (South African Depression and Anxiety Group, 2010).

There is encouraging work being conducted to grow the mental health infrastructure in the country. The South African Human Sciences Research Council is engaged in a five-year research project funded by the United Kingdom's Department for International Development to develop and evaluate mental health policy in five African countries (Bhana, Deshanle, Chakauya, 2010). Authors hope the project will provide new knowledge regarding comprehensive multi-sectoral approaches to breaking the negative cycle of poverty and mental illness. There are also two other studies currently examining the mental health effects of poverty, HIV and AIDS among children and in primary healthcare environments (Petersen & Bhana, 2010; Roundtable Discussion Study, 2010).

IV. MSM and Coping Strategies

In the majority of the aforementioned studies on MSM behavior and mental health outcomes in response to experiences with discriminating societies, coping strategies have been highlighted as important tools for buffering against mental illness and for the success of future STI and HIV prevention interventions. This section will focus on what researchers have found about the risk and protective factors associated with coping habits of MSM in the context of substance abuse, bare-backing, discrimination, and other areas of study.

Sexual minority identity is linked to a variety of positive coping strategies and

stress processes. For example, some people may be vigilant in interactions with others due to expectations of rejection while others hide their identity for fear of harm (Meyer, 2003). Allport suggested that minority members respond to prejudice with coping and resilience (Allport, 1954). Minority status is associated not only with stress but with important resources such as group solidarity and cohesiveness that protect minority members from the adverse mental health effects of minority stress (Meyer, 2003). Meyer wrote that through coming out, lesbian, gay and bisexual people learn to cope with and overcome the adverse effects of minority stress, which means stress and resilience interact in predicting mental disorder. Other researchers found that same-sex attracted individuals counteract minority stress by establishing alternative structures and values that enhance their group, practicing self-acceptance, and talking to family members and supportive peers (Meyer, 2003). These results were confirmed by a 2008 South African study, which found that self-esteem mediates the impact of victimization on psychological distress, decreasing vulnerability to depression among gay men and lesbian women in South Africa (Polders, Nel, Kruger, Wells, 2008). Most recently, a U.S. study found that seeing a health care provider regularly was associated with MSM who had more social support and those who identified as gay or bisexual as opposed to heterosexual (Merighi, Chassler, Lundgren, Inniss, 2010).

Some MSM cope with social stigma and minority stress with unhealthy strategies including avoidance, risky sex, and substance use. Men who have sex with men may avoid using condoms in order to cope with psychosocial vulnerabilities and create intimacy with other MSM (Bauermeister, Carballo-Dieguez, Ventuneac, Dolezal, 2009). In a recent U.S. study, MSM who identified as barebackers – those who enjoy having sex

without condoms – tended to report greater stigma, gay-related stress, self-blame-related coping, and substance abuse coping (Kelly, Bimbi, Izienicki, Parsons, 2009). Social stigma has also been shown to negatively impact coping strategies for MSM often leading to methods of avoidance and cognitive escape (Alvy et al., 2010; Bauermeister et al., 2009; Courtenay-Quirk, C. et al, 2006). A "cognitive escape" perspective maintains that feeling overwhelmed by rigorous sexual norms may lead one to cognitively disengage from these demands as a coping strategy (McKiman, Houston, Tolou-Shams, 2007). These avoidance coping strategies have been shown to mediate the link between depression and risk behaviors (Alvy et al., 2010). A U.S.-based qualitative study with 21 straight-identified MSM found they coped with social stigma by avoiding intimacy, by depersonalizing male sexual partners, limiting affectionate gestures in public, and by distancing themselves from gay-identified venues (Reback & Larkins, 2008). Internalized homophobia has a small impact on coping, but it has been demonstrated to have a strong relationship with psychological distress over time in HIV-positive gay men (Wagner, Brondolo, Rabkin, 1996).

Negative coping strategies may impact health promotion in MSM. A 2008 South African study found that non-gay identified MSM in Johannesburg presented masculine, heterosexual identities and avoided discussing their sexuality when visiting healthcare workers (Lane et al., 2008). Authors suggested that the strategies MSM employ to confront or avoid homophobia from healthcare workers may not be conducive to sexual health promotion in this population (Lane et al., 2008). Some researchers have suggested alternatives to condoms such as pre- and post- exposure prophylaxis and rectal microbicides for this population since condom usage appears to be affected by

psychosocial vulnerabilities (Bauermeister, Carballo-Dieguez, Ventuneac, Dolezal, 2009). Self-efficacy for sexual safety and cognitive escape mediated the link between depression and risk behavior, suggesting that psychosocial vulnerability plays an important role in the association of depression with sexual risk (Alvy et al., 2010).

V. Conclusion

This chapter situated the current study in the context of research on South Africa's history of general oppression toward its citizens, including MSM communities, and their subsequent experiences with sociopolitical forces, discriminating environments, mental illness, mental health institutions, and coping behaviors. There is currently a gap in the scientific research for qualitative data addressing Cape Town MSM experiences with discrimination and their mental health outcomes. The current study aimed to address that gap, and the next chapter will provide an overview of this study's methodology and analysis.

CHAPTER THREE: METHODS

I. Introduction

This study employed a mixed-methods exploratory research methodology with a sample of MSM in Cape Town, South Africa. Twenty-two MSM participated in qualitative, semi-structured in-depth interviews and short quantitative surveys, which assessed their mental wellness, relationship status, ideas about identity, experiences with discrimination, and coping strategies. Since little is known about the mental health outcomes of MSM in Cape Town, this methodology was appropriate.

Qualitative in-depth interviews have been used for similar reasons in recent exploratory studies targeting MSM in settings where they are understudied. In South Africa, one study has used in-depth interviews to understand MSM's interactions with healthcare workers in Johannesburg (Lane et al., 2008). Similarly, in the Republic of Georgia, researchers used focus group discussions and in-depth interviews to better understand how MSM have been impacted by tremendous political upheaval and contributed to the HIV epidemic since the fall of the Soviet Union (Costenbader et al., 2009). Study topics range from understanding the determinants of drug using behavior (Myers, T. et al, 2004), determining factors related to the initiation of a same-sex relationship in China (Wong, W.C., 2007), assessing the process of disclosure (Padilla et al., 2008; Ko et al., 2007; Gorbach et al., 2000) and exploring the experiences with stigma and discrimination in India (Chakrapai et al., 2007). Most researchers who used qualitative data to explore MSM experiences have recommended targeted programs and services for the communities, mostly centered on raising awareness and preventing stigma and HIV infection.

Qualitative interviews allowed the researcher to ask open-ended, probing questions with respect to the reflexive research process. Though mixed-methods studies amongst MSM are not commonly published, quantitative data collection methods on their own would not have been appropriate considering that too little is known about the mental health of African MSM.

Study Setting: Cape Town

This study took place in Cape Town, which is situated in the heart of the Western Cape on the western coast of the country. The gay village in Cape Town is in De Waterkant, a safe space for gay men since the early 1990s (Visser, G., 2003). Of the 4.5 million people who live in the Western Cape, Cape Town – unofficially known as the gay capital of Africa – is home to 201,171 people (Statistics South Africa, 2005). There is a large gay tourism market that attracts international visitors (Visser, G., 2003). Fifty-nine percent of the population is between the ages of 15 and 49 years old (Statistics South Africa, 2005). It is demographically divergent from national and even provincial statistics. In the Western Cape, coloured residents comprise the majority of citizens, but in Cape Town, coloured residents represent 30.6% while whites comprise 51%. Black residents comprise 16.3% of Cape Town proper, though they are the second most populous group in the Western Cape (see Graph 1). Indians and Asians comprise 2% of the city. The Western Cape province has the lowest HIV prevalence in the country and oddly enough, the lowest reported condom use in the country. There are multiple community-based organizations serving the interests of MSM including Health4Men, the Triangle Project, the Desmond Tutu HIV Foundation, and the Inner Circle. The mental health infrastructure for MSM is modest comprising private clinicians and non-profit agencies. Most MSM in Cape Town rely on psychological services from the Inner Circle, the Ivan Toms Health Centre for Men, or the Triangle Project.

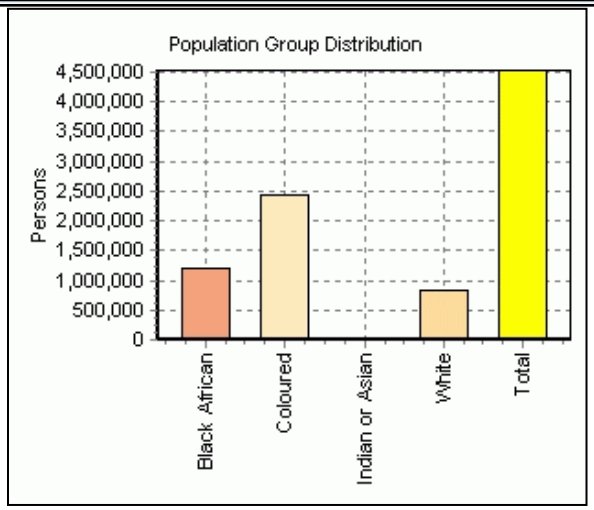

Chart 1 (Above): Population Group Distribution of Western Cape. Source: Statistics South Africa, 2010.

II. Recruitment and Data Collection

A combination of convenience, quota and snowball sampling techniques were employed to recruit. Twenty-two MSM were recruited between May and August 2010 in Cape Town to participate in a qualitative, exploratory study on their mental health outcomes, daily experiences and attitudes toward HIV testing and counseling. Results of the research on HIV testing and counseling is presented elsewhere. Men could volunteer to participate in focus groups and/or in-depth interviews, dependent on preference and availability. Approximately half of the in-depth interview sample (54.5%, n=12) was recruited after participating in focus group discussions regarding HIV testing and counseling services. The remaining participants were referred by friends or by local health organizations. All research activity was conducted in partnership with a local community-based organization, Health4Men, which assisted in the recruitment of MSM and provided space to hold the screening and data collection activities. All respondents met the inclusion criteria of being men who lived or worked in Cape Town, were 18 or older, and reported having had sexual relationships with at least one man in the past 3 months. Since a racially heterogeneous sample was desired, recruitment was based on quota sampling.

To recruit, we utilized resources from our host agency, Health4Men, and met with leaders from other well-known local health organizations to request their assistance in referring to the study men who met the inclusion criteria. All responding organizations catered to the health needs of HIV-positive individuals and/or MSM including the Ivan Toms Health Centre for Men, the Treatment Action Campaign, the Inner Circle, the Triangle Project, and the Sex Worker Education and Advocacy Taskforce (SWEAT).

Health4Men, a subsidiary of the Anova Health Institute, had working relationships with each of these organizations. It is located in the heart of Cape Town's gay village, in between two gay bars and restaurants and is the first MSM-focused state health center in the country. It offers HIV support groups, educational workshops, an annual male nude photo auction to advocate safe sex, psychosocial counseling, and operates the Ivan Toms Health Centre for Men (Health4Men, 2010).

Interested men called or e-mailed researchers and volunteered to participate in a focus group and/or an in-depth interview. In addition to active recruitment, at the conclusion of ongoing focus groups and interviews, participants were given "Refer a Friend" cards, which featured contact information for the researchers so that others who were interested could be screened for and enrolled in the study. In-depth interviews were conducted at the offices of nonprofit organizations that were considered safe spaces for MSM, namely Health4Men and the Inner Circle. Some interviews were also held in quiet diners that the participants chose for reasons related to access and confidentiality concerns. Interviews continued until recruitment efforts reached saturation.

Ethics and Consent

All participants gave written informed consent to be interviewed and audio-digitally recorded. Participants were invited to sign their first and/or last name on informed consent forms and travel incentive log sheets. Signed consent forms, incentive logs and completed questionnaires were kept in a locked cabinet in a locked room to which study researchers had sole access. Notes and digital audio files of interviews were saved on a password-protected computer, which belongs to the researcher. All names and other identifiers were deleted from verbatim interview transcripts so that study

participants could not be traced. All verbatim transcripts were saved to a password-protected computer, which belongs to this researcher.

Upon arrival to the agreed-upon private meet space with the researcher, each participant was briefed on the informed consent process, assigned a study identification number, given a three-page survey and underwent an interview, which explored the themes raised in the survey. The interview process was limited to one hour, though three participants chose to exceed this timeframe. Interviews were conducted in English, and survey questions and answer options were read aloud to control for error. At the conclusion of each interview, men received an envelope with a hand-written "Thank You" card, their travel compensation in cash (ZAR80, USD$10), and a mental health resource guide. The guide was created in partnership with Health4Men to ensure cultural appropriateness and to address the needs of men who may have experienced psychological distress after participating in the interview. It listed contact details for local, easily accessible, affordable mental health services targeted toward MSM.

The study received approval from the Anova Health Institute, the University of Witswatersrand Ethics Committee, and the Emory University Institutional Review Board.

A. In-Depth Interviews

The in-depth interview (IDI) component was designed to fit a standardized open-ended format. An IDI is an open-ended, discovery-oriented method that is well suited for describing process and outcomes from the perspective of the target audience (Braun, V. & Clarke, V., 2006). Qualitative IDIs are used to deeply explore participants' perspectives and feelings. When semi-structured, as these were, they can yield rich information. The interview question guide was created with a phenomenological lens,

which focuses on understanding people's everyday experiences of reality, in great detail, in order to gain an understanding of the phenomenon in question (McLeod, 2001). In this case, the phenomenon was living life in public in a stigmatizing society as a MSM, and the various health issues associated with the experience.

Questions for this study's interviews were theoretically based and created using the study's overall research questions. In-depth interview questions focused on participants' comfort with their sexuality, comfort and levels of trust in their most recent relationships, experiences telling others about their sexual practices, experiences with discrimination, their coping strategies, and their opinions on HIV testing. The interview also featured a sexual networking exercise, which delved into substance use.

There was an ongoing reflexive approach to IDI data collection, which enhanced the descriptive validity of the data. The researcher wrote detailed field notes immediately following the completion of each interview. The notes comprised important issues related to the interview itself, including assumptions made on the part of the researcher, appearance of participants, and events that may have disrupted or enhanced the interview process. Interview inconsistencies were also captured in this manner. This interview guide was created with support from thesis committee members and members of the Health4Men research team to ensure cultural competence and scientific relevance. See Appendix B for the IDI question guide.

B. Survey Instrument: Measures

Like the IDI instrument, survey development for the study began in December 2009 in Atlanta, Ga. Intensive training and consultation on survey development, recruitment strategies, and applied fieldwork experience continued with the assistance of

thesis committee members and MSM researchers in Cape Town. The instrument was pilot tested and revised three times with members of MSM communities in Atlanta and Cape Town before it was implemented with consented participants. See Appendix A for the survey instrument.

The survey assessed participants' demographic information with basic questions on age, race/ethnic background, relationship status and method of recruitment. The survey also comprised five scales that considered the components of the Minority Stress Theory – including internalized homophobia, actual prejudice events like violence and trauma, and perceived stigma – and assessed their relationship dynamic, experiences, attitudes and beliefs regarding life as MSM in Cape Town.

Internalized Heterosexism

Level of internalized heterosexism was assessed using Wagner's Internalized Homophobia Scale (IHS). The IHS is a 20-item Likert scale derived from the Nungesser Homosexual Attitudes Inventory (Nungesser, 1983). Wagner defined internalized homophobia as negative attitudes and beliefs about one's own sexuality. Item responses were on a 5-point scale ranging from "Strongly Agree" to "Strongly Disagree." Item scores were summed to yield a total score. Sample statements included "*Male homosexuality is a natural expression of sexuality in human males*" and "*I wish I were heterosexual*". The original scale's alpha was .92 (Wagner et al., 1994). In this study, the Chronbach's Alpha was .86. Lower scores on this instrument represented lower levels of internalized homophobia, and have been associated with earlier landmarks in gay sexual identity development (such as coming out to a friend, or starting to have positive feelings about being gay), more liberal religious and political ideation, and greater integration into

the gay community (Wagner et al., 1994). To date the IHS has only been used for studies on gay men. It is important to note that the men in this study were not asked how they self-identified in terms of their sexual orientation. They were only asked if they were men who had sex with men. For this reason, this is one of the first studies to use the IHS scale on a non-gay identified population.

Abuse History

Abuse history was assessed using four questions on the perpetration and experience of intimate partner violence following standards set by Dr. Rob Stephenson, who conducts research on the etiology and pathways to intimate partner violence amongst MSM (Stephenson, Khosropour, Sullivan, 2010). As done in a recent study on IPV amongst MSM, participants in this study were asked to answer "Yes" or "No" if they had ever been physically hurt by their current male partner (Stephenson, Khosropour, Sullivan, 2010). A sample question includes, "*In the last 12 months has any partner been physically violent to you? This includes pushing, holding you down, hitting you with his fist, kicking, attempting to strangle, attacking with a knife, gun or other weapon?*"

They were also asked if a recent male partner had ever used physical force to force them to have sex when they did not want to. In the same manner, men were also asked if they had perpetrated either physical or sexual violence against any male partner. Men were also asked one additional question about lifetime incidence of being physically attacked for their sexual orientation by a non-partner.

Trauma History

History of trauma was assessed using Bresleau's 7-item screening scale for DSM-IV post-traumatic stress disorder (PTSD). On this PTSD screening scale, a score of 4 or

greater defined positive cases of PTSD with a sensitivity of 80%, specificity of 97%, positive predictive value of 71%, and negative predictive value of 98% (Bresleau et al., 1999). The short screening scale is an efficient method to screen for PTSD in epidemiologic and clinical studies, given limitations on resources and burden on respondents (Bresleau et al., 1999). Bresleau identified a score of 4 on the 7-symptom screening scale as the optimal cutoff point for separating subjects with and without PTSD. This cutoff point minimized the probability of missing true cases of PTSD at the expense of somewhat raising the probability of classifying subjects without the disorder as having it (Bresleau et al., 1999). In the current study, the Chronbach's Alpha for the Bresleau scale was .87 and 6 participants exceeded the cutpoint for PTSD.

Questions were read aloud following this prompt: "*Many people have experienced different kinds of events and situations in their lives. In your life, have you ever had any experience that was so frightening, horrible or upsetting that in the past 12 months…*" The first of six questions following that prompt was, "*Did you avoid being reminded of this experience by staying away from certain places, people or activities?*"

Perceived Stigma

Experiences with stigma were assessed using Meyer's 6-item stigma scale. This was a scale that assessed expectations of rejection and discrimination based on one's homosexuality. It was modified by Martin and Dean (1987) and further tailored for this study.

The scale has good psychometric properties in lesbian, gay and bisexual people (Martin & Dean, 1987). Before proceeding with the questions, the researcher read the following prompt: "*These statements refer to a person like you; by this I mean persons*

who have the same gender and sexual orientation as you. In answering, I would like you to respond on the basis of how you feel people in general regard you in terms of such groups. Please respond by saying how much you agree with the statements." A sample statement is "*Most employers will not hire a person like you*". Participants responded to 6 items like the above statement utilizing a 4-point scale ranging from 1 ("agree strongly") to 4 ("disagree strongly"). In Martin and Dean's study, the measure was internally consistent with an alpha of .88. In this study, the Chronbach's Alpha was .77. Responses were coded so that higher scores reflected more perceived social stigma. The researcher summed scores across the scale to obtain mean total scores for the group.

Interpersonal Relationship Quality

Interpersonal relationship quality was assessed using subscales from Garthoeffner's modified Interpersonal Relationship Quality scale (Garthoeffner, Henry, Robinson, 1993). The modified version contained 49 of the original 52 items. Responses were made on a 5-point Likert scale, ranging from "Strongly Agree" to "Strongly Disagree". The modified scale has a reliability of .93. Internal consistency was .95 in the Gerthoeffner et al. study. There were six subscales in Garthoeffner's original scale: Trust, Self-disclosure, Genuineness, Empathy, Comfort, and Communication (Garthoeffner, Henry, Robinson, 1993). For the purposes of this study, only the Trust, Comfort and Communication subscales were included and measured, resulting in 26 line items for participants to complete. Reliabilities for the subscales were: .91 for trust, .72 for comfort, and .71 for communication (Garthoeffner, Henry, Robinson, 1993). In the current study, reliability for the combined subscales was .81.

II. Analysis

The researcher utilized SPSS 18.0 to analyze results from the three-page survey. The quantitative survey instrument was analyzed using descriptive statistics, for instance, the average score for participants on scales measuring internalized heterosexism, trauma, and perceived stigma. Due to the limited sample size ($n<30$), no parametric statistical analysis, such as ANOVA, could be performed. Data were classified as missing if participants answered with "Don't Know" or "Refuse to Answer." The researcher did not exclude all of the responses from participants who submitted missing responses. Only the items that were missing data for a specific question were excluded.

The qualitative in-depth interviews were analyzed using thematic analysis. Thematic analysis is considered a foundational method for qualitative data analysis (Braun, 2006). Again, phenomenology is about understanding people's everyday experience of reality, in great detail, in order to gain an understanding of the phenomenon in question (McLeod, 2001). Inductive methodology requires themes that are strongly linked to the data themselves (Patton, 1990). The themes are not driven by the researcher's theoretical interest in the area or topic, and involve the process of coding the data without trying to fit it into a preexisting coding frame (Patton, 1990). Latent thematic analysis was employed, meaning the researcher organized themes based on the implied concept as stated by the participants. The researcher determined importance of themes based on the importance participants placed on them at the time of the interview and also the number of participants that mentioned similar themes. In other words, the researcher looked for prevalent patterns across the data set and within each data item. Additionally, the researcher noted themes that captured unique responses to the research

question posed, even if they were not prevalent. The validity of all results was examined by comparing them to similar studies published on the mental health of MSM, domestic and abroad. To avoid simply categorizing the study results, each theme was explored to infer meaning within the prevalence of themes.

CHAPTER FOUR: RESULTS

Introduction

This chapter presents an overview of the qualitative and quantitative findings from this study. Findings are presented according to their relevance to each of the study's three research questions, which centered on the types of minority stress experienced by Cape Town MSM, the association those stressors have with men's daily activities and psychological well-being, and the coping strategies MSM employ to manage those stressors.

Findings are organized using thematic domains, which represent the general topic areas that comprise all of the raw data addressing the phenomenon of interest. The constructs of the Minority Stress Theory contributed three primary, inductive domains that housed related subcategories: *Actual prejudice events*, *internalized homophobia*, and *expectations of stigma*. Additionally, three other domains emerged inductively from the data bringing the total number of themes to six. The additional domains include *constructions of identity*, *coping strategies*, and *relationship functioning*. See Table 1 for coding criteria of each domain. The researcher identified several subcategories that further explain the domains such as specific types of discrimination and stigma expectations by cross-referencing the research questions, interview question guide, and core ideas in participants' responses.

Table 1. *Coding criteria for inductive and deductive domains*

Domain	Coding Criteria
Actual Prejudice Events	Verbal and physical attacks made because of a person's sexual orientation
Internalized Homophobia	Indications that MSM have adopted the antigay sentiments of heterosexist society

Expectations of Stigma	Experiences that produce anticipation for discriminatory actions based on sexuality
Constructions of Identity	Indicates how MSM see themselves in the context of their sexuality
Coping Strategies	Methods participants use to manage experiences with antigay sentiment
Relationship Functioning	Descriptions of participants' most recent sexual partners, habits and encounters

Participants

The study sample included 22 ethnically heterogeneous MSM who lived in Cape Town and were involved in sexual relationships with men in the three months prior to the interviews. Due to recruitment strategies, all respondents were affiliated with MSM support or HIV prevention programs in the city. The average age of the sample was 32 (range: 18-55, SD=11.81), and there was a somewhat even racial distribution. See Table 2 for more details. Neither HIV status nor employment status were measured in the study, but two respondents voluntarily disclosed they were HIV-positive and most black respondents self-reported being unemployed.

Table 2: *Sample Characteristics of MSM Participants* (n=22)		
Variable	Participants	
Racial, Ethnic, Religious Background	**(n)**	**%**
Black	8	36.4
*(*Xhosa)*	*(*7)*	*(*87.5)*
White	6	27.3
*(*Afrikaner)*	*(*3)*	*(*50.0)*
Coloured	8	36.4
*(*Muslim)*	*(*3)*	*(*37.5)*
Relationship Status (past 3 months)	**(n)**	**%**
Single	7	31.8
Casual	2	9.1
Main Partner	7	31.8
Multiple Partners	6	27.3
(Note: *Values & percentages for these respondents are within racial groupings listed directly above)		

Findings by Research Question

1. Experiences related to oppression and minority stress

Quantitative and qualitative results show that most respondents had experienced direct or indirect stress and oppression related to their status as sexual minorities. In interviews, men said they understood Cape Town to be one of the most gay-friendly cities in the country and on the continent, but most of the sample could easily describe episodes in Cape Town wherein they or their peers were discriminated against based on their status as MSM.

In interviews, prejudice events were described as either enacted by people close to the participant like friends, family, or peers, or enacted by institutions and authority figures like public clinics, employers, teachers and police. The researcher grouped

prejudicial events into two distinct subcategories, “close discrimination” (prejudice at the hands of friends, family or peers) or “institutional discrimination” (prejudice at the hands of institutions or authority figures). In this study, prejudice events took the form of antilocution or hate speech, violence, expulsion from homes and communities, and corrective therapy.

Prejudice events were said to occur in specific places including shebeens (see Glossary for definition) in black townships (Khayelitsha, Langa, Philippe and Gugulethu), the northern suburbs, Afrikaner-dominated venues like rugby games, government or public clinics, around family, and at tourist attractions in the central business district such as the V&A Waterfront and Long Street. Respondents said prejudice events were also likely to occur in business settings during the day.

Participants also described places where prejudice events were unlikely to occur including venues located in Green Point (also known as the gay village), at gay shebeens in black townships, at the tourist-friendly restaurant, Mzoli’s in Gugulethu, or on gay beaches. As one respondent noted, “people come here [Green Point] and they like themselves; they feel free.”

***Close Discrimination*: Prejudice at the hands of friends, family, peers, or neighbors**

Most respondents shared experiences of discriminatory acts perpetrated by family, peers and community members, and threats of violence in multiple sectors. These experiences varied according to race, culture, religion and geographical location. In general, Afrikaner white men, black men who identified as Xhosa, and coloured men who identified as Muslim tended to report being called derogatory names by peers,

experienced rejection from family members and to cite isolation from their communities more than other respondents.

Most participants' reported experiences with prejudice events took the form of hate speech and discriminatory treatment. Participants were particularly bothered when homophobic slurs like "moffie" (a common South African slang term for gay men) and "fairy" were used to describe them or their gay peers, or if family members told them they should "go get a wife". A 55-year-old white man experienced indirect verbal discrimination from colleagues at his job:

> "I'm in a work environment. Other people in the office will actually talk about other fairy working there or the moffie working there or be rude about it. So you know exactly how the other people in the office feel about it. So what are they saying about you behind your back?"

Respondents who reported severe rejection from their families and who were kicked out of their homes for being MSM said that culture, religious values and politically conservative perspectives held by their families were to blame. Men described the offending parties as Christians, Muslims, and Afrikaners.

Few men reported direct physical assaults at the hands of homophobic members of the community, though in interviews, nearly all respondents voiced serious worry about the fact that anti-gay violence occurred in specific places. Results from the quantitative survey showed that 13.6% (n=3) of study participants had been physically attacked due to their sexual orientation in their lifetimes. Intimate partner violence emerged as a slightly more prominent health issue with 22.7% (n=5) reporting that in the past year, a partner physically tried to hurt them by hitting, punching, kicking, attempting

to strangle or using a weapon against them, or used physical force to tried to force them to have sex when they did not want to.

Though 5 men disclosed on their questionnaires that they had experienced physical violence in their interpersonal relationships in the past 12 months, those occurrences were not discussed in the in-depth interviews as being related to their sexual orientation. In fact, just one participant described a physical assault as a result of discrimination from his peers. Others described threats of violence made by family members and peers due to their sexual orientation.

A 26-year-old coloured respondent described one particularly damaging episode:

> "The last time I was physically assaulted, there was a group of guys who were following myself and my friend home and they were throwing us with all sorts of things like bricks and Coke cans. And it wasn't the physical assault that got to me so much. It was the humiliation because our neighbors and all – they were all outside just watching. They could see this and they did nothing."

Many men described close prejudice events as being associated with stories of coming out, discussions about race, culture and religion, and interactions with heterosexual peers and friends. Men from all three racial groups described the coming out experience as scary, and several had been kicked out of their homes. Many of these events were borne from ignorance, as one 18-year-old black participant described in this story about telling his mother he is gay:

> "And she said to me 'How? I do not understand because that only happens in prison where there's no woman. Men have sex with other men because they just want to come and all that because there's no woman...' I said to her, 'Even in real life, it does happen in this society.

> I'm one of those people.' And she said to me, 'I don't think I can live with you. I think you must go and live with your father somewhere.'"

Institutional Discrimination: Prejudice at the hands of institutions and authority figures

Institutional discrimination, including that from authority figures and perceived institutionalized discriminatory practices, were rare occurrences among this sample of MSM. Unique cases of institutional discrimination included incidents involving employers, therapists, teachers, and health practitioners.

Most respondents were wary about revealing their sexual orientations in work settings out of fear of employer discrimination. Just a few men were able to recount episodes of direct discrimination from intolerant employers. A 43-year-old Muslim coloured man was fired from a Cape Town madrasa after he said he was gay and offered support to other closeted Muslims in local newspapers:

> "…I was pulled into the [school] office and then I was asked, 'Why didn't you tell us you were gay?' And I was like, 'Nobody told me that you were straight, so why did I have to tell you I was gay?' [Laughs]. And then they just immediately said this is going to be a problem, and they were worried about children being pulled out of school so, 'You're going to have to leave…' I was rated as one of the best Arabic teachers that they'd had at that school. And I was like, 'Now for the past two years that I've taught here, I was gay. Now that I've just announced it, suddenly I'm not worth nothing?' It made me feel terribly angry."

Similarly, a 20-year-old black respondent from Khayelitsha described a discriminatory experience while on a job interview:

> "[The interviewer] said to me, 'May I ask you something? How do you represent yourself?'…And I said, 'I represent myself as a man.' And she

> said to me, 'How do you think your customers will react when they see your name … and they see… you're having your hairstyle and you have on make-up?' So, she was asking me in a polite way, but it was very critical… And I said, '… I do not feel comfortable with you asking me those type of questions.'"

Several respondents from all three racial groups reported being forced to undergo "corrective therapy" wherein members of their families hired therapists to teach them how to be heterosexual. Though families were complicit in this process, corrective therapy is being classified as institutional discrimination. During their therapy sessions, men were given literature on "aversion therapy" while others were coached on the Christian way to eradicate homosexual thoughts and tendencies. Other respondents described incidents when their schoolteachers did not defend them when other students cursed and called them homophobic slurs. They viewed their teachers' actions as discriminatory.

Nurses and public healthcare institutions were sources respondents indicated as infamous for their discriminatory treatment of sexual minorities. Many respondents had experienced incidents when nurses gossiped about them and asked about their girlfriends, implying that their sexual orientation was "unnatural" and inappropriate. A 39-year-old coloured respondent described the incident that convinced him to steer clear of public clinics:

> "When I first discovered that I was HIV-positive… I went to a government health institution where I was interviewed by a social worker... And she was supposed to brief me on taking ARVs and all that, but she wasn't really interested in that. All she was interested in was one thing… the dynamics of my relationship. She… asked me, 'Who's the

> man and who's the woman in your relationship?' … It was almost as if she had never come across homosexuals in her life… She should, being a social worker that deals with people, she should be more informed. She should know about homosexuality."

There were a few participants who said they had never experienced discrimination of any form due to their sexual orientation. Respondents who never experienced prejudice events described themselves as "sheltered", "privileged", "closeted", and used phrases like, "I look straight" or "I never tell anyone" so they weren't affected. A 37-year-old white professor had this to say about social oppression and his lack of experience with prejudice events:

> "You know, racism is still rife. Homophobia is still rife even though it doesn't really affect me because I'm well educated and I don't move in circles that aren't empowered. And I am empowered because of the system that was in place. I had the opportunities. So I have had it very, very good."

Some participants said only certain types of men face homophobic discrimination like those who dressed like women or who are flamboyant. Others said those who are open about their status, yet respect people's boundaries, don't get discriminated against. A 40-year-old black respondent described how being "carefully" open about one's sexual orientation can be a protective trait:

> "Despite those things, it's not hard…. If you tell people what kind of person you are right from the start then you don't have any difficulties. But if you hide from different things and you act in a different way from them, then they start calling you, like, funny names."

2. The impact of minority stress-related experiences on the daily lives of MSM

The experiences with prejudice events described in the prior section impact MSM in various ways including shaping their expectations of stigma, their constructions of sexual identity, their comfort in certain places in the city, how they meet their partners, relationship functioning, and how they negotiate their daily activities and interactions.

Perceived Stigma and Discrimination

The oppressive sociopolitical climate contributed to an increase in perceived discrimination among respondents, according to quantitative data. The mean score on the six-item Perceived Discrimination and Stigma Scale indicates that most respondents perceived slightly elevated levels against MSM in the Cape Town area. Responses were coded so that higher scores reflected more perceived social stigma. With a range of 6 to 24, the average score for this sample was above average at 12.68 with a standard deviation of 4.39.

Qualitative interviews supported these data. In interviews, all men, no matter their race, reported that they perceived black South Africans to be least accepting of MSM behavior while white and non-Muslim coloured South Africans were perceived to be most accepting. White respondents also noted that Afrikaners were "still very narrow-minded" in regards to sexual minorities. These perceptions of racialized homophobic stigma shape the way respondents moved within the city, with MSM reporting avoiding public clinics and shebeens in black areas, and Afrikaner venues they deemed unfriendly to gays. These perceptions also informed men's interactions with neighboring communities. Black MSM respondents were especially frustrated with their community's "stubborn" intolerance. An 18-year-old black man said:

> "We are much more violent and discriminative than [white people]. When they do their things, nobody takes note… But… If you do something wrong, then there's people watching you who will say, 'No he did this and this and this.' But if you're white, you don't even take note of that. A white man might kiss another white man and we would laugh and say, 'Oh, it's fine.' But if a black man kisses another black man, it's an issue."

Another 18-year-old black MSM respondent agreed, adding that the black community often associates the concept of "gay identity" with being less of a man:

> "Some people say it's a disgrace 'cause usually… black men must, like, be strong, protect the house and stuff here in South Africa… A black guy being gay and hanging around with girls and in clubs and stuff… people would look at us in a strange way… and say that we are not man enough and stuff, even though we have went to the bush and gotten initiated."

Another widely held perception among the study sample was that residential environments figured more directly into perceptions of stigma than did race, culture or religion. In general, black and coloured men who lived in the city center described fewer incidents with discrimination than did their counterparts who lived in townships or suburbs. A 37-year-old coloured man said "uptown to countryside to city boy is a big difference" noting that experiences with and responses to stigma are different depending on where one lives. As a 50-year-old white participant noted:

> "I mean you often hear of young men who come to Cape Town because they've been thrown out because their family has found out they're gay. It's because they come from a small town or whatever. Whether they're black, Afrikaans or whatever."

Trauma and Internalized Homophobia

Despite high levels of perceived stigma, results from the survey demonstrated that MSM in this study had relatively low levels of trauma and internalized homophobia. The mean score for the 22 respondents on the Short Form Post Traumatic Stress Disorder Scale was 2.18 (SD=2.28), well below the 4-point cutoff that indicates signs of PTSD. Six men (27%) showed symptoms indicating signs of PTSD.

Results from the Internalized Homophobia Scale results were similar. On a scale ranging from 20 to 100, the sample's mean score was 35.45 (SD=10.29), demonstrating low levels of internalized homophobia. Again, 6 respondents scored 40 or above, indicating somewhat elevated feelings of internalized homophobia (the degree to which a gay man internalizes the antigay sentiments from larger heterosexual society).

Similarly, in interviews, descriptions of traumatic events or feelings of hatred for one's sexual orientation were rare. The vast majority of study participants self-identified as gay and reported comfort with their sexuality, but the extent to which they allowed their sexual preference to be visible to others varied according to factors that mediate discriminatory experiences including level of perceived stigma, race, religion, environmental setting, relationship functioning, and economic privilege. In qualitative interviews, trauma and internalized homophobia were discussed with nuance, and were found to be related to participants' comfort with their sexual orientation in public, the level of mental stress they experienced in relation to their sexual orientation, their coming out process, and whether they chose to live a double life.

Mental Stress

Younger respondents were more apt to report intense dismay with their sexual orientation, as opposed to participants aged 30 and older. Before asking me if there was a pill that could change his sexuality, an 18-year-old black participant shared this story about the mental stress caused by his experiences with the intolerance of others:

> "In this stage I think I'll grow up, and realize, ok, I have to have a family and a wife and all of that... That's what I think, you know, so I don't know if it's going to last or what. It kind of, like, makes me distant from my feelings. I feel like I'm running away from what I feel 'cause, yeah, I'm hiding it."

The negative sentiments of others caused two respondents great mental stress, which led them to self-harm and engage in risky behavior. One 26-year-old coloured respondent described the fallout from his experience with "corrective therapy," which led to him to attempt suicide:

> "When his sort of therapy failed, I convinced myself that I must have been a mistake because I'm not normal… And I'd also gotten thrown out of my home because of my stepfather… So all of this coupled with this confusion that I was now dealing with – I decided that I was going to undo this error. So I said goodbye to my grandmother. I got to school… and I swallowed 20 painkillers."

Concealment

Most men said they prefer to conceal their sexual preference and "act straight," in settings they perceived to be unfriendly or high-risk, though many expressed frustration with this process. Several men said phrases similar to this one from a 24-year-old white

respondent: “if [straight people] can live their lives without fear, why can’t I?” A 50-year-old white man originally from Zimbabwe discussed this topic:

> “I think any person that’s sort of grown up gay has that sort of meter that – they can actually tell or gauge the level of danger or insecurity. I think that we’ve been sort of so used to prejudice and the threat of violence or ridicule – that you sort of sort out where you can get away with some things and where you can’t. You shouldn’t have to. It shouldn’t be that way, but that’s the way it is. Even in a place like Cape Town.”

Hiding one’s sexual preference often manifests as living a double life, as many respondents from all racial backgrounds admitted to doing before they learned healthy coping strategies, and continue to do in spaces they deem unfriendly to same-sex attracted individuals. For the purposes of this study, living a double life refers to incidents when an MSM pretends to be heterosexual or dates women to maintain public appearances of heteronormativity, while also maintaining sexual relationships with men in private. A 27-year-old coloured Muslim participant said that he abused drugs and lived a double life for years while he struggled to resolve his sexual feelings for men.

> “I just made a decision that the only thing that’s keeping me back from leading a clean and sober life is me being in the closet. Because every time I use a drug it’s because I want to cover up something and it’s mostly because I want to cover up the whole gay part of it all.”

Sexual Relationships

Other participants expressed frustration with the impact of stigma on their sexual relationships. Participants said they are limited in their public displays of affection, subjects of conversation, and places where they spend time with their partners due to pervasive societal stigma. This was most noteworthy amongst white Afrikaner and black

Xhosa participants, who reported being sexually involved with men who were closeted and/or who had sex with women, far more than any other group segments in this study. Black men referred to these sexual partners as "after-9s" – similar to what Americans call men on the "down-low," also known as those who don't publicly acknowledge their private sexual encounters with men. Respondents said their after-9 partners were extremely concerned about stigma, which had severe ramifications for their relationships. When speaking about one of his casual partners who he labeled as an after-9, a 20-year-old black participant said, "He said he might kill himself if people know [that he and I are together sexually.]" Another respondent said of his partner, "He said someday, he really wishes he could be gay like me, because I am out, but because of his family and all of that he cannot be gay." These relationships caused respondents severe mental stress with one man noting "it's like you're not good enough." In white men, these relationships had a significant duration, with the longest lasting for 20 years.

Economic Status

Financial independence and economic privilege were highly related with how comfortable men felt telling others about their own sexuality. The more financially independent men reported themselves to be – business owners, independent contractors, and homeowners – the less impact societal stigma had on their personal lives. Financial independence gave those participants a sense of personal and sexual empowerment. This point can be seen when comparing the cases of an 18-year-old black Xhosa respondent from Khayelitsha and a 55-year-old Afrikaans respondent originally from Pretoria. The 18-year-old shared the following about his economic dependence:

> "Well, the thing is that I'm still dependent on my parents so it's a little bit hard for me to tell them that I'm gay… When I'm finished my studies and

> then when I'm independent and then that's when I'll actually tell them… 'Now, I'm independent and I'd like to thank you for this and that. And I'm gay.' … if I tell them now anything can happen. They might push me away while I still need education to have a future."

The 55-year-old Afrikaans participant shared this about the impact becoming his own boss had on his identity and the incidences of prejudice he faces:

> "Um, I'm self-assured now. I don't have a boss to answer to or anybody that I have to impress. Now I can open my mouth and say, 'Now wait, you can't talk about people like that.'"

Some men were so severely impacted by the expectation of further prejudice events, they self-isolated and completely disassociated from all communities. A 20-year-old black participant shared a story about how he felt after being bullied relentlessly by peers in his secondary school:

> "…I got tired. I didn't go to school for about two weeks, and you know it started frightening me. And I was so scared of what everybody thought about me, that they hated me… I just couldn't bear the thought. So I quit school last year."

Some men reported that they aren't impacted at all, and are instead protected from potentially stressful experiences by their geographical location, privileged financial status, sense of self-worth, and race. A 27-year-old white, Afrikaner hair stylist shared this about the impact of prejudice on his identity and daily life:

> "I don't think it matters…. Um, I'm very stable with my business, friends, clients – they're all very much aware of who I am and what I get up to… I think it helps me more than anything being who I am when it comes to clients, straight friends, whatever. I don't think it's ever really affected me."

Another respondent said that it was his perspective on the world that enabled him to avoid internalizing the stress caused by homophobic individuals and heterosexist institutions in society.

> "But it all depends on the individual for me. I really don't think it's a general, group thing. If you as a gay man are confident in who you are, you don't have to be subject to that. But people who are sort of sheltered and don't have a strong opinion about themselves or their beliefs are going to be trampled on, unfortunately."

It is important to note that many of the feelings and behaviors described as products of social stigma and discrimination – including high-risk activities, avoiding heterosexist spaces, and seeking financial independence – can also be considered coping strategies, which will be discussed further in the next section.

3. Coping strategies employed by MSM to manage oppression and minority stress

In this study, respondents reported utilizing myriad coping strategies to manage the experience of being members of a sexual minority in Cape Town. Most men practiced more than one coping strategy in their daily lives. Quantitative data were not available for this research question, but qualitative data revealed most men coped by attaching themselves to a group of MSM peers, becoming advocates for the MSM community, hiding their sexual identity and relationships, abusing substances, engaging in high-risk sexual behaviors, participating in counseling, or doing activities that brought them comfort. Others avoided heterosexist environments, relied on themselves, or directly confronted malicious instigators. Participants' constructions of identity often comprised the value they placed on their community relationships and the value they placed on feeling confident with their sexual orientation.

Support Resources: Peers

All respondents agreed that the most prominent and successful coping strategy was seeking counsel, friendship and resources from other MSM peers. After coming out or just prior to doing so, most respondents reported moving closer to the city center (for university or job opportunities) and interacting with open-minded people from different backgrounds, which enabled them to feel less stressed about revealing their sexual orientation to others. Respondents placed a considerable amount of value on the role their same-sex communities have in their lives. They said those communities made them feel safe and protected. In some cases, they said that having a supportive group of friends even prevented verbal discrimination from taking place. For one coloured participant, his safe haven existed in one friend who he confided in daily, while a black participant had a large group of associates with whom he danced, laughed and commiserated weekly:

> "…So I've got a lot of gay friends and lesbian friends. So like, we have like our own special group, and we like chilling and like talking and sharing our experiences. And then like people in our community like know us, so they don't swear at us like they used to because we are now like a collective of gay guys and a few lesbian girls."

Support Resources: Advocacy and Community Support

An extension of the same-sex community coping strategy exists for MSM who choose to become advocates and seek resources within the gay community. As mentioned earlier, all respondents were affiliated with an MSM support/advocacy or HIV prevention organization of some type. Participants reported high levels of community value associated with these groups. They said having a community of supporters helped them manage the daily pressures associated with being sexual minorities. Others, like this 50-

year-old white respondent, said that acting as advocates is a tribute to their friends who died of AIDS and others who struggled for gay rights for decades:

> "What's happened here is because a lot of people think that, 'Oh well, we have certain guarantees in the constitution. We don't have to be active or vigilant or whatever.' [That] is an attitude that I get very angry about because I know from personal experience that constitutions can be changed and democracy demands vigilance and people cannot be complacent."

There were a handful of specific community resources that men reported turning to for support. Many black men mentioned a weekly group in a local township sponsored by the Desmond Tutu Foundation where they meet to talk about their lives and daily experiences. Other respondents were affiliated with Health4Men, Triangle Project and Gay Pride annual festivities. Three coloured participants were dedicated to creating and expanding resources for same-sex attracted individuals living in coloured-majority areas like Manenberg and Mowbray. Muslim respondents used resources provided by Mowbray-based The Inner Circle, which caters to the unique needs of Muslim gays and lesbians. A black respondent spoke about his participation in the Desmond Tutu support group:

> "You can call them when you have problems. You can go there for more information to, like, gain more information about who you are. It's also very supportive because you might have problems that you can't face. But if you go there, they can sort of like give you that prior knowledge that you didn't have."

A substantial minority of respondents said they recently sought psychological counseling or support group services to manage issues related to their status as sexual

minorities. Others said they wish they had more counseling options in the form of support groups, one-on-one counseling sessions and resources to reference in times of need. The majority of respondents said they didn't feel like they needed any psychological support because they were comfortable with their sexuality and their positions in the community.

Support Resources: Sexual Partners

Many respondents who coped with social stigma through community support outlets also found comfort in support from their sexual partners. Having partner support – when partners attend to one another if others are cruel toward them or if one is feeling sad or lonely – was as an important deductive coping strategy for respondents. Though nearly all respondents were uncomfortable asking their partners for monetary support, most of them who were in relationships with self-identified gay men found tremendous value in the emotional support their partners could provide. This type of support was valuable to respondents because it made them feel self-confident, listened to, comfortable, protected, respected, and loved unconditionally especially at times when they faced trouble. Having their partners' support also allowed respondents to feel empowered to face personal challenges with confidence. In general, respondents who were in casual sexual relationships or had partners who were after-9s said they could not rely on their partners for emotional support.

Self-Reliance & Confrontation

Still, many respondents said self-reliance was a fail-proof coping strategy. They turned to humor and sarcasm, or activities like reading, studying, music, dancing, and writing. These private activities catered to respondents' desire to avoid judgment and seek solace in quiet space. Financial independence proved to be a key component of self-

reliance for many participants, which enabled them to feel confident enough to confront others who were discriminating against them and to be "out" about their sexual orientation in public spheres. Participants described episodes of direct confrontation with those who were discriminating against them or partners who discouraged them from expressing affection in public spheres. These men were also likely to report being comfortable with others knowing their sexual orientation no matter where they were.

Avoidance

Avoidance of heterosexist environments, hiding one's relationships, and pretending to be straight were all major themes when men were describing coping strategies for managing minority stress. The reasons men gave for employing these strategies were mostly environmental and circumstantial. For men who had received verbal threats from homophobic peers or family members, they reported that staying away from their residential neighborhoods was the only way they could feel safe. Most white men reported being comfortable with non-family members knowing their sexual orientations, one white participant said he felt safer living his life as a straight man. A black man who reported being comfortable in most places "as I am," also boasted that he "looked straight" and if he were in a straight-oriented bar he would advise his gay friends to "have your beer, and go quickly." A 31-year-old coloured respondent said that coping strategies are often reactionary. "Different situations require different actions," he said. "Sometimes it's not about me. Sometimes it's better to assess first and see what's at stake."

Substance Use

Many men reported turning to alcohol and weed to “relieve the pressure” and cope with social stigma associated with their sexual orientation. Just a few reported abusing prescription medications or illicit drugs, but these men also reported concurrent mental health diagnoses. A small number of men said they engaged in high-risk sexual encounters when they felt particularly depressed, but the depression they described was general in nature and not directly tied to their status as sexual minorities.

Conclusion

In summary, study results demonstrate that among a sample of Cape Town MSM, minority stress symptoms were rife, a fact which respondents explained as being highly associated with oppressive and discriminatory environmental, geographical, cultural and racial factors. The implications of these findings will be discussed in the next chapter.

CHAPTER FIVE: DISCUSSION

Introduction

The purpose of this study was to explore the lives of Cape Town MSM and their experiences with sources of minority stress and general oppression in order to better understand how those experiences affected their mental wellness, and to learn what coping strategies they use to manage those experiences. Twenty-two MSM who live or work in Cape Town completed semi-structured in-depth interviews and questionnaires.

Findings from this study reveal that MSM in Cape Town are severely affected by societal oppression, which has external and internal manifestations resulting in minority stress – internalized homophobia, perceived stigma, and actual prejudice events. Survey results revealed that internalized homophobia, violence and trauma levels were low, while reports of concealment of sexual identity and perceived stigma and discrimination levels were high. In interviews, the study sample reported that race, culture, religion, economic status, and environmental setting are important factors that may determine the degree to which minority stress is experienced. Participants who self-reported being financially dependent on others, black Xhosas, white Afrikaners, and coloured Muslims reported having more experiences with incidents of direct prejudicial events and concealing their sexual preference in public settings. These were also the groups who participants perceived to be least tolerant to homosexuals. In general, participants reported that minority stress impacts aspects of their sexual relationships, identity formation, coping strategies, mental wellness, and overall comfort in navigating the city. Coping strategies for managing these stressful experiences were diverse, and the work of existent and emerging MSM support networks appears to be promising.

Establishing Findings in Context of Theory and Literature

Findings from the study support certain aspects of Meyer's Minority Stress Theory, and refute others. Overall, this study demonstrates that participants living and working in Cape Town, a city with a history of discriminatory and stigmatizing policies, experienced stress and negative life events because of their minority status. Additionally, these negative life events were compounded when study participants were living at an economic disadvantage or were members of historically disadvantaged racial groups, specifically low-income black and coloured respondents.

Meyer's theory posits three key constructs affect a gay person's psychological adjustment throughout his life: internalized homophobia, perceived rejection and discrimination, and actual prejudice events. However, this study found that internalized homophobia was not a lasting factor throughout the lives of MSM. Instead, participants reported that any internal feelings they may have had related to societal anti-homosexual attitudes peaked when they were younger, coming out and becoming comfortable with their sexual orientation, but became essentially non-factors as respondents grew older. To be fair, there may have been unconscious aspects of internalized homophobia in the study sample that this study could not measure, as concealment, a related proximal process, was reported to be prevalent. Internalized homophobia did appear to have major impacts on the study participants' sexual partners who are heterosexual-identified and encouraged their partners to hide their relationships.

The study supports the idea that the remaining two Minority Stress theoretical processes continue to be issues for men throughout their lives. In this study, perceived stigma resulted in experiences of "fear and mistrust in interactions with the dominant culture", as Meyer predicted – a process that Gordon Allport called chronic "vigilance," an especially stressful trait that targets of prejudice might develop in coping with their minority status (Meyer, 1995). Actual prejudice events including the threat of violence and the use of hate speech (terms like "moffie" and "fairy") directed at MSM, evoked feelings of deep rejection and fears of violence in the study sample, as the theory predicts.

Meyer found, and this study supports, that coping strategies and social supports were variables that alter the strength of the association between stress and distress. Men who reported practicing coping strategies that involved their same-sex attracted peers, sexual partners, local support organizations, mental health practitioners, and activism said they felt safe, self-confident, and comfortable in multiple settings. However, coping strategies and social support resources were most beneficial when the participants were in gay-friendly spaces, as opposed to townships, Afrikaner-dominated areas, religious venues, and suburbs where they reported feeling less secure, unsafe and frustrated by social stigma. Some respondents said their peers helped them affirm and validate their values when spending time in their neighborhoods, but others said they had to remain on guard in their neighborhoods because of the predominant social stigma. This suggests that there is an uneven rate of success for social support agencies and individuals equipping MSM with coping strategies that are transferrable to multiple locations. Additionally, this study supports previous research that has found homosexuality to be

viewed as "un-African" and public clinics to be highly discriminatory (Reddy & Sandfort, 2008; Desmond Tutu HIV Foundation, 2009).

Concealment and avoidant coping strategies have been shown to be psychological risk factors for adverse responses to stressful life events (Holahan & Moos, 1987). Respondents who reported utilizing avoidant coping strategies like substance abuse and high-risk sexual activities had experienced severe social stigma in their lifetimes. In recent studies, stigma has been shown to negatively impact coping strategies for MSM often leading to methods of avoidance and cognitive escape (Alvy et al., 2010; Bauermeister et al., 2009; Courtenay-Quirk et al., 2006). These avoidance coping strategies have been shown to mediate the link between depression and risk behaviors (Alvy et al., 2010). Most respondents in this study engaged in multiple coping strategies, including both active and avoidance types. Active coping strategies include behavioral or psychological responses designed to change the nature of the stressor itself or how one thinks about it (i.e., seeking psychological support), whereas avoidant coping strategies lead people into activities or mental states that keep them from directly addressing stressful events (i.e., substance abuse) (Holahan & Moos, 1987).

In making recommendations for future researchers, Meyer wrote, "To understand causal relations, research also needs to explain the mechanisms through which stressors related to prejudice and discrimination affect mental health" (Meyer, 2003). This study identified key mechanisms through which prejudice and discrimination impact mental health including environmental setting, socioeconomic status, and norms dictated by culture, race and religion. These findings support the work of social science researchers Gustav Visser and Andrew Tucker who write about the complexity of "gay visibilities"

and the exclusiveness of South African "gay leisure space" as important factors in gay identity formation (Visser, 2003; Tucker, 2009). Visser noted that gay leisure spaces in Cape Town are not inclusive to non-white sexual minorities of low socioeconomic status (Visser, 2003). In Tucker's cross-community study, he found that one's identity changes according to one's race and position in urban spaces (Tucker, 2009). He argued that the legal rights that South Africa granted to sexual minorities in recent years don't translate to the daily lives of these people due to the "diversity of queer experiences" across urban spaces in Cape Town, which are complicated by the oppressive ways the apartheid government separated racial and economic populations (Tucker, 2009). This study revealed similar experiences, in that all respondents spoke about spaces where they felt safe and unsafe in the context of Cape Town's image as a gay-friendly city.

Finally, Minority Stress Theory disputes the idea that minority status does not have deleterious effects among people with high socioeconomic statuses. But in this study, high socioeconomic status *did* act as a buffer for MSM who experienced direct or indirect prejudicial events or perceived stigma. To be clear, perceptions of discrimination and rejection were detected among respondents who self-reported living and working in areas with high socioeconomic status. However, participants who could afford to live in the city center and access resources in the city center reported fewer prejudicial incidents, few to no feelings of internalized homophobia, and perceived lower levels of discrimination than their counterparts who lived in poorer parts of town. This finding challenges Meyer's idea that one's status as a sexual minority will always trump one's socioeconomic status.

To ensure that the study had high interpretive validity and that interpretation of the data was not based on the Minority Stress Theory alone, the researcher reported findings in the language of the people studied as often as possible. In this way, respondents contributed directly to the theoretical validity of the study by voicing the connections and meanings they made regarding various experiences. In general, respondents acknowledged that Cape Town was a city with freedoms and resources that are unparalleled in South Africa and throughout the continent. However, every participant – no matter his race, culture, religious affiliation or socioeconomic status – said that the perceptions others had about their status as sexual minorities impacted their daily lives.

Limitations

Bearing the above key findings in mind, this study had some significant limitations. The Minority Stress Theory has its own limitations that may have shaped the scope of the study. The theory was designed with white gay men in mind, not ethnically heterogeneous men who fall into gray areas along the sexual orientation spectrum like bisexual, transgender, and straight-identified MSM (Meyer, 2003). Meanwhile, the gray areas appeared to be where many black and coloured respondents focused their responses because their partners were overwhelmingly straight-identified MSM contending with cultural and religious values that multiplied the impact of minority stress. Additionally, there was a participant in this study who self-identified as a gay man, but who also experimented with gendered projections of body concepts by surgically enhancing his breasts and testicles. He said his struggle for self-acceptance was unique when considered

in the context of the general MSM population. Finally, the theory has been criticized for viewing sexual minorities as victims of systems instead of resilient actors (Meyer, 2003). These theoretical limitations narrowed the scope of the study to focus on gay-identified MSM, but the researcher made attempts to recruit an ethnically heterogeneous sample and prompt discussions about systemic problems as well as coping strategies so that participants could be seen as active, not solely as acted upon.

Though qualitative data aren't meant to be generalizable, it is important to remember that this study's participants weren't representative of average Cape Town MSM. They were each affiliated with MSM support groups or HIV prevention organizations, which could mean they were more comfortable speaking about issues related to their sexual orientation than others would have been. As Meyer wrote, "self-acceptance is related to better psychological adjustment and less distress" so estimates of residual effects from minority stress among these participants could be underestimated (Meyer, 1995). Respondents were also highly educated about support services available throughout the community, which may have had an impact on the variety and types of coping strategies on which they relied and discussed. For Muslim participants specifically, they were chosen from a support group that caters to the needs of people who had a difficult transition coming out, which may have skewed the data on the types of discrimination faced by this segment of the population. Men who saw themselves as activists may have also based their responses on issues related to social desirability bias, given their positions as spokespersons for their communities.

Additionally, interviews were conducted by a foreign, heterosexual identified woman in English, a second language for most participants in the study. In preliminary

recruitment meetings, a few members of local HIV prevention and men's health organizations said they doubted that local MSM would be willing to disclose sensitive information to a straight and foreign woman. While no respondents cited gender, nationality, or language as a barrier, results may have been different in unknown ways had interviews been conducted by a gay South African man in English, Afrikaans and Xhosa.

Lastly, the age of the participants was not distributed evenly in this sample, which may have had a significant impact on the types of experiences captured by the researcher. Black and coloured respondents were much younger, on average, than white respondents, which may figure into the fact that younger black and coloured participants were more likely to report feelings of discomfort with their sexuality. This may also relate to the fact that the age that participants came out was not even. Additionally, in this sample, younger and older MSM reported being at different life stages and levels of sexual risk and self-acceptance, with translated to more mental stress and risk-taking coping strategies for younger MSM. Older men tended to be less risky sexually and cite surviving the 1980s AIDS epidemic as the reason why. In sum, the uneven age distribution may have had an unintended generational effect.

Implications

Findings from the current study suggest several implications for public health practice.

First, public health practitioners hoping to impact the behaviors of sexual minorities in Cape Town must consider the perceived differences in minority stress according to age, race, culture, religion and economic status. Study participants agreed

that specific populations living in certain sectors in low-resource conditions were at a disadvantage in terms of exercising their rights to lives without discrimination. Interventions targeting sexual minorities must consider the generational, racial, cultural and religious factors that contribute to risky coping behaviors. Tailoring interventions to specific segments of the MSM population is critical to impacting behavior. It is also important to note that any efforts that target sexual minorities should be extended to lesbians. Though their experiences were outside the scope of this study, their battles with discrimination, corrective rapes and violence in South Africa deserve concentrated attention by the public and mental health sector.

Respondents recommended that more be done in Cape Town to educate healthcare practitioners and link resource-poor populations with MSM-support resources. Public educational and healthcare policy in the Western Cape should be transformed to promote self-confidence in young MSM by including gay-affirmative programs as options in school curricula and promote tolerance among healthcare workers by disseminating the instructional handbooks created by the Desmond Tutu Foundation and Health4Men about working with MSM in healthcare settings. Same-sex attracted individuals should have access to support groups in their neighborhoods, not just in the city center. Elements of social media can also be utilized to educate members of the general public about the need for tolerance in all sectors of care and service. Interactive education, respondents said, may be key to fighting stigma on a societal level.

Finally, psychosocial vulnerability, such as that created by elements of minority stress, has been demonstrated to play an important role in the association of depression with sexual risk (Alvy. et al, 2010). Members of this study sample admitted that their

mental stress was so great, they turned to high-risk sexual behaviors as avoidant coping strategies, which put them at risk of contracting or passing along sexually transmitted infections. Many of those same participants admitted to living a double life or dating others who do so which increases the possibility for risk-related infections to be spread to both MSM and women. If the mental health needs of MSM aren't attended to when they are young and engaging in risky behaviors, multiple communities both within and outside MSM social and sexual networks could suffer health-wise.

Recommendations for future Research

Based on the findings and limitations of the current study, additional research is needed to further explore this topic. Recognizing the need for more qualitative research on the topic area, this study should be replicated with a different population of South African MSM, particularly focusing on young men in resource-poor areas of the country. Furthermore, adding more psychological measures and scales to the quantitative questionnaire, namely depression and anxiety scales, can also expand this study in important ways. Depression and anxiety are among the most commonly diagnosed mental health issues in MSM, yet they were not measured in this study. A longitudinal study design might also enhance the research community's understanding of how psychological vulnerability and coping strategies change over time, which would improve the impact of behavioral interventions. A psychological service mapping project using geographic information systems would be helpful to understanding where mental health care for sexual minorities exists, who is accessing it and at what price. Also, more efforts must be made to recruit straight-identified MSM into future studies on this topic. Finally, additional research is needed to better understand the types of coping strategies used to

manage different levels of stigma and violence experienced, and their relationship to risk taking behaviors.

In addition to research recommendations, several programs could be beneficial to South African MSM populations. Peer support groups that focus on empowering men and improving self-esteem must be created in areas that are easily accessed by men from all age, racial and socioeconomic backgrounds. Before programs can be accepted by the general public or funded by local or international agencies, South Africans would benefit from a long-term multimedia stigma reduction media campaign. Practitioners should take advantage of the increasing popularity of mobile phones and radio to create and circulate these awareness and stigma reduction messaging campaigns. These initiatives should be created with a community-based participatory approach by integrating the insights and opinions of MSM from diverse backgrounds. Finally, mental health program infrastructure nationwide could be expanded substantially, specifically to focus on preventing feelings of low self worth among minority youths.

Conclusion

The findings from this study illustrate the importance of examining the lived experiences of MSM in South Africa as they relate to societal oppression and minority stress. This study also suggests that inclusive policy changes, like gay marriage rights, have limited impact on discriminatory attitudes and behaviors toward sexual minorities at institutional and individual levels. Though South African MSM have lived with certain legal protections for years, oppression and minority stress still pose a threat to their mental and emotional wellness, and contribute to the uptake of undesired avoidant coping strategies. These findings have the potential to shape myriad public health issues

including HIV prevention strategies, mental health infrastructure, and attitudes toward disempowered minorities. The lack of research on this topic and the diversity within South African MSM communities demand further exploration of these experiences to develop tailored, successful, and comprehensive mental health promotion, stigma reduction, risk prevention, and sexual minority support interventions.

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Appendix A: Survey Instrument

Date of Interview: _____ **Participant ID**: _____

Location: _____ **Length of Interview**: _____

Instructions: This is a brief questionnaire about your experiences, attitudes and beliefs regarding life as a gay or bisexual man living in South Africa. Please remember your answers are strictly confidential and your honesty is greatly appreciated.

How old are you? _____

What is your ethnicity? White/European ❑ Black ❑ Coloured ❑ Indian/Asian ❑ Other: _____

Are you in a relationship? Yes ❑ No ❑

If YES, what type of relationship are you in? Casual ❑ Main Partner ❑ Multiple Partners ❑

Have you ever been physically attacked because of the fact that you're gay or bisexual? Yes ❑ No ❑

Thinking about recent relationships, in the last 12 months, has a partner ever tried to hurt you? This includes pushing, holding you down, hitting you with his fist, kicking, attempting to strangle, attacking with a knife, gun or other weapon? Yes ❑ No ❑

Have you ever tried to hurt a partner by pushing, holding down, hitting, kicking, attempting to strangle, attacking with a knife or gun or other weapon? Yes ❑ No ❑

Thinking about your recent relationships, in the last 12 months, has your partner ever used physical force or verbal threats to force you to have sex when you did not want to? Yes ❑ No ❑

Have you ever used physical force or verbal threats to force a partner to have sex when he did not want to? Yes ❑ No ❑

Below are some statements individuals can make about being gay and bisexual. Please read them carefully and check the one box indicating the extent to which you agree or disagree with each statement.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know
Male homosexuality is a natural expression of sexuality in human males.						
I wish I were heterosexual.						
When I am sexually attracted to another gay man, I do not mind if someone else knows how I feel.						
Most problems that homosexuals have come from their status in society as an oppressed minority not from their sexual behavior.						
Life as a homosexual is not as fulfilling as life as a heterosexual.						
I am glad to be gay/bisexual.						
Whenever I think a lot about being gay/bisexual, I have negative thoughts about myself.						
I am confident that my homo-/bisexuality does not make me inferior.						
Whenever I think a lot about being gay or bisexual, I feel depressed.						
If it were possible, I would accept the opportunity to be completely heterosexual.						

	Strongly	Agree	Neutral	Disagree	Strongly	Don't

	Agree				Disagree	Know
I wish I could become more sexually attracted to women.						
If there were a pill that could change my sexual orientation, I would take it.						
I would not give up being gay or bisexual even if I could.						
Homosexuality is deviant.						
It would not bother me if I had children who were gay.						
Being gay is a satisfactory and acceptable way of life for me.						
If I were heterosexual, I would probably be happier.						
Most gay people end up lonely and isolated.						
For the most part, I do not care who knows I am gay.						
I have no regrets about being gay.						

Many people have experienced different kinds of events and situations in their lives. In your life, have you ever had any experience that was so frightening, horrible or upsetting that in the past 12 months…

	YES	NO
Did you avoid being reminded of this experience by staying away from certain places, people or activities?		
Did you lose interest in activities that were once important or enjoyable?		
Did you begin to feel more isolated or distant from other people?		
Did you find it hard to have love or affection for other people?		
Did you begin to feel that there was no point in planning for the future?		
Did you become jumpy or get easily startled by ordinary noises or movements?		
After this experience were you having more trouble than usual falling asleep or staying asleep?		

These statements refer to a person like you; by this I mean persons who have the same gender and sexual orientation as you. In answering, I would like you to respond on the basis of how you feel people in general regard you in terms of such groups. Please respond by saying how much you agree with the statements.

	Agree Strongly	Agree Somewhat	Disagree Somewhat	Disagree Strongly	Don't Know	Refuse to Answer
Most employers will not hire a person like you.						
Most people believe that a person like you cannot be trusted.						
Most people think that a person like you is dangerous and unpredictable.						
Most people think less of a person like you.						
Most people look down on people like you.						
Most people think you are not as intelligent as the average person.						

As you respond to the following statements, think about the most recent sexual relationship you have had with a man. Please answer with your feelings as they are or were, not as you hoped they could have been.

	Agree Strongly	Agree Somewhat	Undecided	Disagree Somewhat	Disagree Strongly	Refuse to Answer
There are times when my partner cannot be trusted						
My partner would tell a lie if he could gain by it						
In our relationship, I have to be alert or my partner is likely to take advantage of me						
My partner is honest mainly because of a fear of being caught						
I'm better off if I don't trust my partner too much						
Even though my partner tells me many stories, it's hard to get an objective account of things						
There is no simple way to decide if my partner is telling the truth						
In our relationship, I am occasionally distrustful and expect to be exploited						
My partner can be counted on to do what he says he will do						
I do not believe my partner would cheat on me even if he could get away with it						
My partner can be relied on to keep his promises						
My partner treats me fairly and justly.						
The advice my partner gives cannot be regarded as being trustworthy						
I am afraid my partner will hurt my feelings						
My partner pretends to care about me more than he really does						
My partner is willing to say what he believes rather than what I want to hear						
I wonder how much my partner really cares about me						
I believe most things my partner says						
I seek my partner's attention when I'm facing troubles						
I would like my partner to be with me when I'm lonely						
I feel comfortable when I'm alone with my partner						
I would like my partner to be with me when I receive bad news						
I feel relaxed when we are together						
I face life with my partner with confidence						
I listen carefully to my partner and help him solve problems						
I understand my partner and sympathize with his feelings						

Appendix B: In-Depth Interview Question Guide

1. I want to start by discussing your current romantic and sexual relationships. In order to do that, I need to draw a picture. That's the best way for me to understand. So I'm going to start off with a little square, and that's going to represent you.
    a. How many partners do you currently have?
    b. Are they men or women? (Men represented by triangles/Women represented by circles)
    c. Did any outside influence like alcohol, drugs or environment play a role in your most recent sexual relationships with men?

2. If you think about your current male partner: What is the most important thing that this partner does for you/with you?
    a. Does this partner support you if other people verbally abuse you, or discriminate against you in any other way?
    b. Would you ask this partner for help if you needed money?
    c. Can you talk to this partner if you are feeling sad, depressed, or lonely?

3. As you know, some men are more comfortable with and open about their sexual relationships with men than are others. Can you tell me how you feel about being in a sexual relationship with a male?
    a. Are you comfortable being seen with your male partner in public? Are there specific places that you are more or less comfortable being seen together?
    b. Does your partner encourage or discourage you from telling people about your relationship, or showing him affection in public?

4. Please tell me how long you have known you were sexually attracted to other men by sharing a story about "coming out" or the moment you knew you had feelings for men?

5. Does the fact that you have sex with men impact on your willingness to be screened for HIV and other sexually transmitted infections? How often are you screened now, and where do you go?

6. Let's consider your race, religion, culture and personal values. As a man who has sex with men, how does your race impact the way you live your life in public here in Cape Town?
    a. How do you think your experiences as a [race] man who has sex with men are different from the experiences of other men who have sex with men from different racial backgrounds?

7. Please tell me a story about one personal experience you've had with discrimination from any local institutions or authority figures like health practitioners, nurses, doctors, family, educators, police officers or government due to your sexual orientation.
    a. How did those experiences make you feel?

8. How did you/do you usually cope when things like that happen?
    a. Did you rely on support from others or rely on yourself?
    b. Did you turn to an activity or habit like alcohol, drugs, music, more sex, partying, exercise or sports? Talk a little about that.

   c. Did you utilize any supportive services available for men who have sex with men?

9. Do you consider yourself a member of a local group or community of men who have sex with men? What is your involvement and how important is it to you?

10. Earlier, we talked a little about your comfort being screened and counseled for HIV. What do you think of your options for testing resources? Are you comfortable going to those spaces?
    a. Have you ever tested with a partner in those spaces?

11. If you think about the relationship that you are in now: Has this partner ever suggested that you get tested for HIV?
    a. Did you then go and get tested? If yes, did your partner go with you?
    b. Have you ever suggested to this partner that he get tested for HIV? If yes, what was his reaction?
    c. Would you want to go for HIV testing with this partner? Why/why not?
    d. What is the main thing that would encourage/discourage you from going to get tested with this partner?

12. You may have attended a focus group about couples voluntary testing and counseling services, which are offered elsewhere throughout the continent for straight couples to test together. The proposed process involves two male sexual partners attending a pre-test counseling session together, then being tested together, and receiving their results and post-test counseling together.
    a. If this service was available for two men in a relationship in Cape Town, do you think people would use it?
    b. What would need to be different? What types of couples do you think would use this service?
    c. Who wouldn't want to? Why not?
    d. How secure would one need to feel in his relationship to undergo testing together?
    e. What would be the implications for the sexual relationship if both partners hear each other's results?