**AN EXPLORATION OF MIDDLE-AGED AND OLDER GAY MEN'S HEALTH
AND ILLNESS PRACTICES**

by

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Abstract

Background: Despite a wealth of knowledge that demonstrates middle-aged and older gay men experience substantial health inequities when compared to heterosexual men, little information is available pertaining to the health and illness practices of gay men.

Methods: This dissertation includes three qualitative manuscripts with the overarching aim of exploring middle-aged and older gay men's health and illness practices. Data were collected via conversational interviews with 25 men who self-identified as gay. The first qualitative descriptive manuscript examined how middle-aged and older gay men developed resilience over time to promote health and wellness. Next, a grounded theory was conducted to describe the processes by which middle-aged and older gay men managed their health. The third manuscript involved a qualitative description of how men experienced their mental health and the strategies they used to mitigate the deleterious effects of mental health challenges.

Results: The findings from the first manuscript demonstrated that resilience was developed over time by: (1) building and sustaining networks, (2) addressing mental health, and (3) advocating for self. The grounded theory indicated that the core process of health management is overcoming adversity, which is achieved by three overarching and interrelated processes: (1) advocating for health needs, (2) knowing about health issues and treatments, and 3) engaging in health promoting practices. The third manuscript findings yielded three categories as to how mental health was experienced, and how the deleterious effects of mental health challenges were mitigated: (1) gaining new perspectives of mental health over time, (2) reaching out to formal health services for support with mental health challenges, and (3) engaging in practices to maintain and improve psychological well-being.

Conclusion: These findings highlight the influence of age and experience, historical and ongoing discrimination, as well as capacity, to middle-aged and older gay men's health and illness practices. Consequently, meaningful and effective health services must be developed with recognition of men's strengths and capacities amidst discrimination. Potential approaches to health service development and delivery to improve health outcomes include equity-oriented primary health care, trauma-informed care, social public health approaches and peer-based services and resources.

Lay Summary

The overarching purpose of this study was to explore middle-aged and older gay men's health and illness practices in the context of homophobia and heteronormativity. The three specific research objectives addressed were:

1. To describe how middle-aged and older gay men developed resilience over time to promote health and wellness

2. To provide an account of how middle-aged and older gay men manage their health in the context of homophobia and heteronormativity

3. To describe how middle-aged and older gay men experience their mental health and the strategies they use to limit the deleterious effects of the mental health challenges they might experience.

The information from this research will inform recommendations for service and resource development to better promote and protect the health of middle-aged and older gay men.

Preface

This doctoral dissertation is the original work of the author, Ingrid E. Handlovsky. All the research activities for this doctoral dissertation were approved by the University of British Columbia Behavioural Research Ethics Board (BREB) under the project title "Exploring the process of health management amongst gay men: A grounded theory study" (Certificate H14-01112). The co-authors of the manuscripts included in this dissertation were supervisory committee members: Dr. V. Bungay, Dr. J. Oliffe, and Dr. J. L. Johnson. Chapter 3 has been submitted for publication in a peer-reviewed journal with the following authors, in order: Ingrid Handlovsky, Vicky Bungay, John Oliffe, and Joy Johnson. Chapters 4 and 5 will be further developed for publication in peer-reviewed journals with the following authors, in order: (Chapter 4): Ingrid Handlovsky, Vicky Bungay, Joy Johnson, and John Oliffe. (Chapter 5): Ingrid Handlovsky, Vicky Bungay, John Oliffe and Joy Johnson. I, Ingrid Handlovsky, was responsible for the data analysis and initial drafts of each chapter. The members of the supervisory committee provided guidance with the development of the project, including the purpose and research objectives, data analysis and final write-up of the dissertation.

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Acknowledgements

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the guidance you provided to ensure the logic lined up and that the components of this dissertation flowed.

I wish to extend my gratitude to my family and friends who provided ongoing emotional support and encouragement throughout this journey. To Marc, who has been my biggest cheerleader and picked me up and dusted me off numerous times, I couldn't have kept going without your encouragement. To my parents who instilled a curiosity and love for knowledge acquisition from a young age, and who cared for our infant son so I could return to my studies, I could not have done this without you.

For my Dad, Peter Handlovsky. If it were not for your contributions: unwavering support, unbridled encouragement and stubborn will (which I clearly inherited) this accomplishment would not have been possible

CHAPTER 1: INTRODUCTION

There is increasing evidence that gay men experience substantial health inequities when compared to men who identify as heterosexual (Eaton, Kalichman, & Cherry, 2010; Garofalo, Herrick, Mustanski, & Donenberg, 2007; Gastaldo, Holmes, Lombardo, & O'Byrne, 2009: Sandfort, de Graaf, Bijl, & Schnabel, 2001; Stall et al., 2001; Wang, Hausermann, Ajdacic-Gross, Aggleton, & Weiss, 2007). Situating gender within power and inequity, these health inequities are recognized as the consequence of discrimination; specifically, homophobia and heteronormativity as discriminative processes that collectively contribute to poor health outcomes among gay men (Aguinaldo, 2008; Brennan, Ross, Dobinson, Veldhuizen & Steele, 2010; Rosenberger, Reece, Novak, & Mayer, 2011).

Homophobia represents discrimination at the individual or interpersonal level and is often described as constituting a range of negative attitudes and feelings towards individuals who are not heterosexual (Kitzinger, 2001). Homophobia is observable in hostile behaviour such as acts of physical violence and derogatory name calling and as such situates discrimination firmly within the psychology of specific individuals: the manifestation of harbored fear and/or hatred towards those who are not heterosexual (Aguinaldo, 2008; Kitzinger, 2001).

Heteronormativity, however, represents discrimination at the macro or structural level via oppressive practices and attitudes directed toward those who do not identify as heterosexual (Aguinaldo, 2008). Heteronormativity represents an ideological system that denies, derogates, or penalizes any non-heterosexual form of behaviour, identity, relationship, or community (Kitzinger, 2001). As an ideological process, heteronormatively is understood as operating insidiously at the subconscious level to influence thoughts and behaviours which can

contribute to inadvertent harm. Heteronormativity contributes to harm explicitly by effectively excluding individuals who do not ascribe to the heterosexual "norm" by exclusion from basic civil liberties in laws and policies and implicitly by percolating the realm of interpersonal interactions as an ideological process infiltrating the consciousness and behaviours of individuals. For example, as heteronormativity is rooted in the belief that all human existence is inherently heterosexual (Yep, 2002), and thus interacting with others who are not in fact heterosexual under this assumption can introduce inadvertent harms.

Gay men experience an overrepresentation of HIV and other sexually transmitted infections (STIs) (Eaton et al., 2010; Garofalo et al., 2007; Gastaldo et al., 2009; Klein, 2012; Mustanski, Lyons, & Garcia, 2011) in addition to mental illnesses that include depression, anxiety, and suicidality and substance overuse (including alcohol) (Gilman, Cochran, Mays, & Hughes, 2001; Meyer, 1995; Sandfort et al., 2001; Stall et al., 2001; Wang et al., 2007) when compared to other groups of men; namely, heterosexual men. In Canada, gay men are three times more likely to have a mood/anxiety disorder, four times more likely to have a history of lifetime suicidality and six times more likely to experience STIs (Brennan et al., 2010).

The literature pertaining to the state of gay men's health is extensive. While there remains an emphasis on documenting rates of HIV and STIs, the focus has shifted in recent years from documenting incidence rates to gaining deeper understandings as to why increased susceptibility to HIV and STIs continues to be an issue for many gay men (Carballo-Dieguez, 2001; Gastaldo et al., 2009; Wolitski & Fenton, 2011). It is most frequently within this body of literature that the additional health concerns of mental illness and substance use are presented as predictors believed to contribute to HIV and STI susceptibility (Klitzman,

Greenberg, Pollack, & Dolezal, 2002; Parsons, Grov, & Golub, 2012; Stall et al., 2003). Less is understood about how these pressing health issues impact health outcomes for gay men removed from the context of HIV and STIs. In addition, despite the expansive literature on the health inequities experienced by gay men, even less is known about gay men's health and illness practices: specifically, how they perceive health issues and what sources they seek out and engage with for support, guidance or treatment with health issues. The information available is most often in the context of HIV pertaining to engagement and experiences with health services (including help-seeking[1]) (Bernstein et al., 2008; Eliason & Schope, 2001; Meyer & Northridge, 2007; Yun Gao & Wang, 2007) and resilience, which outlines the protective processes gay men engage in amid adversity to promote their health (Buttram, 2015; Herrick et al., 2012; Herrick et al., 2014; Quinn et al., 2015).

Recognition of the impact social positioning has on men's health warrants consideration of how self-identification as a gay man—and consequent discrimination—potentially influences perceptions of health and the sources sought for support with health issues. It is known that gay men experience marked health inequities directly associated with homophobia and heteronormativity as discriminative processes (Aguinaldo, 2008; Brennan et al., 2010; Rosenberger et al., 2011), but how being gay potentially influences perceptions of health and health and illness practices is poorly understood. What is available is limited to gay men's experiences with health services and health providers, mainly in the context of HIV and STI testing and/or care. This information is of importance given that, in general, interactions with care providers influence people's health outcomes and behaviours, including access to

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[1] Seeking assistance and guidance from health professionals and services for health issues (Galdas, Cheater & Marshall, 2005; Husaini et al., 1994).

specialist services and adherence to treatment (Hightow-Weidman, Smith, Valera, Matthews, & Lyons, 2011; Neighbors & Howard, 1987; Worthington & Myers, 2002). Although this literature provides some important insights about help-seeking and care experiences within these contexts, there is limited empirical inquiry that permits the transferability of these findings to the context of other health issues. Furthermore, what we know is focused on younger gay men and, while not discounting this important information, there is a gap in knowledge specific to middle-aged and older gay men.

Few investigations have considered gay men's health and illness practices to capture the numerous resources drawn on for health promotion, guidance and support. Health and illness practices, in this dissertation, are conceptualized as the variety of social practices geared towards promoting health in addition to addressing and navigating illness. Social practices are skillful procedures, methods or techniques performed by individuals situated within social contexts that give rise to constraining and enabling circumstances (Giddens, 1984). As such, health and illness practices are directed to promoting health according to social and financial conditions, as well as navigating the psychosocial complications associated with illness (DiClemente, Salazar, & Crosby, 2007). In this way, social contexts are recognized as constraining and enabling of personal agency which is the capacity of an actor to act in a given context (Sewell, 1992). Actors are recognized as members of society who all have some knowledge of the rules of social life and control over some measure of resources (Sewell, 1992). Presently, I was unable to find literature pertaining to health and illness practices within this perspective in the context of discrimination (homophobia and heteronormativity) that considers the collective influence of these discriminative processes on gay men's health.

Study Purpose and Research Objectives

Situated in Victoria, Canada, the overarching purpose of this study was to explore middle-aged and older gay men's (40 years and older) health and illness practices in the context of homophobia and heteronormativity. I sought to understand how years of living in a heteronormative environment influenced how men thought about health and the practices they engaged in to promote health, as well as to acknowledge and navigate illness(es). From this overarching research purpose, I developed three specific research objectives that are addressed in three correspondingmanuscripts comprising the findings of this dissertation. Essentially, the gaps in the extant literature available on middle-aged and older gay men's health and illness practices are tackled in these three articles. The first article provided the contexts of middle-aged and older gay men's lives by considering how men developed resilience over the course of their lives amid unique social, historical and political circumstances. In the second article, I conducted a grounded theory study to chronicle the processes by which middle-aged and older gay men managed their health. Health management in this context was defined as the specific processes by which middle-aged and older gay men employ health and illness practices to promote their health and address and navigate illness. In the third article, I considered how gay men experienced their mental health and the strategies they used to mitigate the deleterious effects of mental health challenges. The specific objectives, which correspond with each manuscript, were:

- To describe how middle-aged and older gay men developed resilience over time to promote health and wellness

- To provide an account of how middle-aged and older gay men manage their health in the context of homophobia and heteronormativity

- To describe how middle-aged and older gay men experience their mental health and the strategies they use to limit the deleterious effects of mental health challenges.

The information from these manuscripts informed the overarching goal of developing recommendations to better promote and protect the health of middle-aged and older gay men in which are detailed in Chapter Six. The health inequities currently experienced by gay men are understood to be rooted in discrimination and thus gaining insight into gay men's health and illness practices amid homophobia and heteronormativity is fundamental to improving health outcomes.

Review of the Literature

To determine the current state of knowledge pertaining to the health issues affecting middle-aged and older gay men along with their health and illness practices, I conducted a review of relevant literature. In recognition of the tremendous depth and breadth of available information, I focused on literature for the period 1995–2017 with an emphasis on the Canadian context, but I included American and European sources if they were deemed relevant. I also included two studies prior to 1995 that provided a historical foundation for the development and current landscape of gay men's health resources. This literature was specific to the emergence of the AIDS virus and the subsequent development of community-based resources to support gay men at the time and how this shaped future health service development. I accessed information from a variety of databases including CINAHL, PsycINFO, Web of Science and PubMed in addition to grey literature sources, principally from health organizations such as the BC Centre for Disease Control (BCCDC), the Centers for Disease Control (CDC), The British Columbia Centre for Excellence in HIV/AIDs (BCCFE) and The Department of Health.

It was immediately evident that a considerable amount of information exists pertaining to health issues experienced by gay men, but very little was available regarding gay men's health and illness practices. As such, I accessed literature that documented various social practices geared towards promoting health and addressing and navigating illness. I began by examining literature pertaining to the resources that men engage with for support and guidance with health issues, which was entirely specific to health services. The other body of knowledge that documented social practices, albeit specific to promoting health, was the resilience research that outlined the protective processes (comprised of various social practices) that gay men engage in amid adversity to promote their health. Consequently, to best present the information retained from this review, I organized the chapter in the following manner: (a) epidemiology of health issues affecting gay men, (b) gay men's engagement and experiences with health services (including help-seeking), and (c) resilience and gay men.

Prior to embarking on a discussion of the literature, I first offer clarity regarding the age range in the literature search, terminology used and a brief history of HIV/AIDS. First, due the dearth of literature that examines age as it relates to health and illness practices, the literature search was inclusive of gay men in general, but I noted when age was taken into consideration. Second, in reviewing the literature, the term most frequently used in research concerning gay men is 'men that have sex with men' (MSM). Presently, use of the term MSM has received considerable criticism, and debates concerning the utility of the term are ongoing (Young & Meyer, 2005). Historically, the term was a socially constructed behavioural category devised and employed by epidemiologists for the study of disease risk, as opposed to an identity-based category such as gay, bisexual or straight (Young & Meyer, 2005). Consequently, the term has been scrutinized for contributing to a process of erasure by virtue

of disregarding sexual identity (Young & Meyer, 2005). Rarely is the term defined in the literature, and many men in the community whose opinions I elicited stated that a lack of consensus on its meaning remains, and therefore preference for the use of gay as opposed to MSM was emphasized. As a central responsibility in conducting research, I selected language appropriate and representative of the participant population. To ensure the work I conducted reflects the needs and concerns of the community for which it is meant to benefit, I specified the population of interest specifically to be men that self-identify as gay. Some of the literature I discuss did use the terminology of gay, but the majority used MSM. Regardless, I speak to this literature as referring to gay men.

Due to the fact this investigation was specific to middle-aged and older gay men (i.e. men 40 years of age and older) a brief overview of the historical significance of the emergence of HIV/AIDS is necessary. The havoc, fear and trauma the infection brought to communities of gay men during the 1980's and into the 1990's cannot be understated. As Forstein (2013) writes, in the late 1970's gay men were mobilizing efforts pushing for civil rights and subsequently flocked to urban centres where they could live and love as they chose. However, the joy of this movement was short-lived. A disease began to spread that exclusively affected gay men, and at first made no sense, seemed to have no clear cause and no immediate or direct treatment. As gay men began to die of opportunistic infections, namely pneumocystis carinii and Kaposi's sarcoma, panic, fear and dread became rampant in gay communities (Forstein, 2013).

With growing recognition that this deadly new infection appeared to target gay men, derogatory labels followed such as the "gay plague" and "gay cancer" (Altman et al., 2012; Forstein, 2013; Patton, 1988). Gay men found themselves increasingly despised and rejected

and held responsible for the emergence and spread of this deadly new infection (Adam, 2005). For those that acquired the infection, many were let go from their places of employment, others were shunned from their families while some faced homelessness due to unemployment, rising medical costs and eviction (Forstein, 2013). Ultimately, as the disease progressed, gay men began to die in mass numbers amidst the absence of any public health movement to address the crisis (Adam, 2005). As such, gay men banded together in what can only be described as one of the most formidable displays of compassion and community in the form of grassroots movements to support one another amidst the horrors of the infection. Community-based organizations and AIDS service organizations (ASOs) sprung up to lobby governments and provide support for gay men affected by the illness. Essentially, volunteers and activities within the gay community helped establish the first networks of AIDS care and support by advocating for a public response to the crisis (Forstein, 2013).

In 1995 there was a sense of great hope with the development of a treatment for the infection after the lukewarm effectiveness and high cost of the drug zidovudine (AZT) in the mid 1980's. The new drug was called saquanavir and was in the category of treatment termed highly active anti-retro viral therapy (HAART) which suppressed replication of the virus (Forstein, 2013). This development had a huge impact on gay communities, as it meant men with HIV/AIDS could restore and improve their immune function. From this point on the trajectory of the illness changed and the death rates brought upon by HIV/AIDS in gay communities was markedly diminished. However, the lasting impact of loss and the guilt that accompanies survivorship cannot be understated. Gay men who lived through this era lost entire circles of peers and are forever impacted by the trauma of loss, fear, grief and confounded discrimination.

Epidemiology of health issues affecting gay men

Gay men are disproportionately affected by a number of health issues when compared to other heterosexual men. In particular, there is an overrepresentation of HIV and sexually transmitted infections (STIs) among gay men (British Columbia Centres for Disease Control, 2014a, 2014b; Public Health Agency of Canada [PHAC], 2014). Estimates from 2014 indicate that gay men represent 2.4% of the Canadian population (aged 15 and older) yet they also comprise 57% of new HIV infections (PHAC, 2014). Gay men are 131 times more likely to acquire HIV when compared to heterosexual men (PHAC, 2014). Furthermore, the incidence[2] rates of STIs such as syphilis, gonorrhea, chlamydia, genital herpes, hepatitis A virus (HAV), and hepatitis B virus (HBV) have been steadily rising among gay men since the mid-1990s (PHAC, 2014). In addition to HIV and STIs, the prevalence of mental health concerns and substance use are well documented; gay men experience poorer mental health and higher rates of anxiety, depression, suicidality and self-harm when compared to heterosexual men (Cochran & Mays, 2000; Brennan et al., 2010; Sandfort et al., 2001).

In Canada, gay men are three times more likely to have a mood/anxiety disorder and four times more likely to have a history of lifetime suicidality when compared to heterosexual men (Brennan et al., 2010). Use of illicit substances, most specifically what are described as club drugs (specifically, ketamine, MDMA-methylenedioxymethamphetamine, GHB-gamma hydroxybutyrate, cocaine and methamphetamine), is prominent among gay men (Grov, Ventuneac, Rendina, Jimenez, & Parsons, 2013). Alcohol overuse is also concerning, with gay

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[2] Incidence is the term used to describe the number of new infections within a one-year time period (Public Health Agency of Canada, 2011).

men more likely to drink heavily (Drabble, Midanik, & Trocki, 2005) and report more alcohol-related social consequences when compared to heterosexual men[3] (Midanik, Drabble, Trocki, & Sell, 2007). Furthermore, age has been considered in the growing body of literature that finds middle-aged and older gay men (40 years of age and older) experience higher rates of mental health challenges (including anxiety, depression, suicidality and grief) when compared to other men and the general population (Conron, Mimiaga, & Landers, 2010; Wright, LeBlanc, de Vries, & Detels, 2012).

The literature related to documenting health issues among gay men has limitations. For example, the prevalence of mental health issues cited in the Brennan et al. (2010) article must be viewed with caution as the study relied on self-report measures and no clear indication was provided as to what constituted suicidality, anxiety disorder and mood disorder. The measure used for suicidality in this article was whether the participant had ever "seriously considered suicide" (p. 257) in their lifetime. What constitutes serious consideration is not clear, and furthermore, the study refers to anxiety and mood disorders, but is not explicit as to which disorders in particular. There are many anxiety and mood disorders that may affect individuals, differentiated by strict diagnostic criteria laid out in the American Psychiatric Association Diagnostic and Statistical Manual V (DSM-V) (DSM-V, 2013). In this article it was unclear what particular disorders the participants in this study were affected by (Brennan et al., 2010).

Within this broader literature it is also clear that mental health concerns and substance use are rarely discussed as stand-alone issues, but rather in relation to HIV and STIs. This represents a shift in HIV and STI research in gay men's health. Initially, in the 1990s, the

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[3] What was explicitly meant by alcohol related social consequences was not made clear

literature was primarily concerned with documenting rates of HIV and STIs, whereas the emphasis steadily gravitated to investigating predictors and/or risk factors that contribute to acquisition of HIV and STI via regression and other statistical modelling (Klitzman et al., 2002; Parsons et al., 2012; Stall et al., 2003). It is within these models that mental health and substance overuse are frequently discussed as predictors or risk factors contributing to susceptibility (Klitzman et al., 2002; Parsons et al., 2012; Stall et al., 2003). Given that mental health issues and substance overuse have the potential to bring about numerous health disparities it is troubling that little research has been dedicated to these concerns in isolation from HIV and STIs. Of crucial importance is recognition that gay men do experience numerous specific health disparities in addition to HIV and STI when compared to other subpopulations of men such as heterosexual men. Recognition of the numerous health issues affecting gay men substantiates investigation into how gay men subsequently address, grapple with, and ultimately manage health and health issues. Gaining a greater understanding of the processes employed by gay men to manage their health will enable recommendations for service approaches to protect and enhance the health of gay men.

Gay Men's Engagement and Experiences with Health Services

In this study, I was principally interested in exploring middle-aged and older gay men's health and illness practices in the context of homophobia and heteronormativity. Because there is a dearth of information pertaining to gay men's health and illness practices as encompassing the variety of social practices directed towards promoting health, in addition to addressing and navigating illness, I sought out literature pertaining to social practices inherent to health and illness practices. Men's engagement with health services was captured by the help-seeking literature, which focused mainly on the contextual factors that influence proclivity to seek help.

The area with the most documented information was gay men's experiences with health services. I searched for studies that included potential resources sought out for support and guidance with health issues that extended beyond health services, such as family, friends and peers. However, the literature was limited to investigations specific to health services. For organizational purposes I identified two main categories: formal and informal. Formal health services were those that involved engaging with health professionals, either face-to-face or remotely (as is the case with telephone health hotlines, for example). Informal health services were those that did not involve health professionals; for example, due to the prevalence of the internet in daily life I was attuned to online resources. In addition, the historical contributions of community-based organizations providing health services for gay men since the emergence of HIV in the 1980s (Forstein, 2013) motivated my search for community-based and/or peer-based services.

In surveying this information, the majority of the health service literature remains situated within HIV- and STI-specific services. Such services included HIV care clinics, internet-based sexual health sites, sexual health clinics and peer-support groups for persons living with HIV. Some studies were situated within primary care health services; however, the impetus of these investigations was most frequently to explore STI and HIV testing experiences, or HIV care experiences (Guy et al., 2010; Maulsby et al., 2014; Tong, Lane, McCleskey, Montenegro, & Mansalis, 2013; Wall, Khosropour, & Sullivan, 2010). A few explorations considered health issues more broadly, but this was rarely the case (Bernstein et al., 2008; Eliason & Schope, 2001). Additionally, the only literature available regarding men's experiences with their mental health and strategies to mitigate the deleterious effects of mental health challenges pertained to engagement with formal health services. Thus, I organized the

engagement and experiences with health services literature as follows: (1) gay men's engagement with health services: help-seeking; (2) gay men's experiences with health services: informal health services; (3) gay men's experiences with health services: discrimination and/or stigma within formal health services; (4) gay men's experiences with health services: mental health; and (5) gay men's experiences with health services: service and provider attributes for a positive health service experience.

Help-seeking

Help-seeking is recognized as a social practice geared toward health promotion and addressing and navigating health issues and essentially reflects engagement with health services. The information contained within these studies speaks mainly to the contextual factors that influence gay men's willingness to seek guidance and support from health services; thus, I situated help-seeking as a component of the larger theme of gay men's engagement and experiences with health services. Help-seeking among gay men, however, refers to social practices mainly geared towards addressing and navigating illnesses due to the large representation of HIV and STI service literature; in particular, numerous studies investigated men's help-seeking with regards to HIV- and STI-specific health services (Hays, Catania, McKusick, & Coates, 1990; Peterson et al., 1995). To begin, one study dating back to 1990 specifically investigated the help-seeking behaviours of four groups of gay men divided into four distinct groupings: AIDS-diagnosed, HIV-seropositive, HIV-seronegative and unknown infection status (Hays et al., 1990). The measure of help-seeking behaviour used was self-report of worries specific to AIDS within the past year. Multivariate analysis of covariance demonstrated that significantly greater percentages of AIDS-diagnosed and HIV-seropositive men sought help for AIDS concerns during the past year as compared to HIV-seronegative

men and men with unknown infection status. The absence of a valid and reliable scale to measure help-seeking, however, raised questions about the results.

Particular contexts have also been the focus of investigations, such as the work of McClennan, Summers and Vaughn (2002) and Merrill and Wolfe (2000) that considered help-seeking with regards to intimate partner violence. Both studies indicated that gay men exhibited a propensity to seek help when experiencing violence in an intimate relationship. Gay men were also found to seek help more readily when compared to heterosexual men in a study that examined help-seeking for psychological distress (Sanchez, Blocklandt, & Vilain, 2013). The study compared help-seeking behaviours among monozygotic male twins in which twins self-identified with differing sexual orientations; that is, one twin self-identified as gay, and the other as heterosexual (Sanchez et al., 2013). The findings indicated that the heterosexual twins were less open to the idea of seeking professional psychological help when compared to their gay co-twins (Sanchez et al., 2013). Help-seeking was measured via a shortened version of the Attitudes Toward Seeking Psychological Help (ASPH) scale originally developed by Fischer and Farina (1995) and the scores of each pair were compared using the Wilcoxon signed-rank test. The authors provided no indication, however, as to the validity and reliability of this modified scale, which raises questions about their results.

Another study with gay men considered the relationship between several health behaviours (smoking, drug use, alcohol use, lifetime HIV testing, depression and social isolation) sexual risk behaviours (low efficacy for sexual safety, consistent drug use with sex, HIV transmission risk) and health care access (McKirnan, du Bois, Alvy, & Jones, 2012). Health care access was operationalized in terms of three indicators: perceived barriers, insurance status, and recent medical visit. Participants were coded as having 0 to 3 health care

access indicators: any primary care medical visit in the past 2 years (57% of participants), current health insurance (50%), and no perceived health care barriers (35%). Each of the behavioural health indicators, with the exception of alcohol use, was strongly associated with health care access, which the authors argued demonstrated the importance of health care access to general behavioural health among gay men (McKirnan et al., 2012).

Additional research included a report that discussed the health of lesbian, gay, bisexual, and transgender (LGBT) individuals (Dean et al., 2000). The authors discussed the implications of discrimination, articulated as homophobia and heterosexism, on the health and well-being of gay men and asserted that perceived stigma within the health care system could contribute to reluctance among gay men to seek out health services (Dean et al., 2000). The same concern was raised in a paper by Harrison (1996) that considered the primary care needs of gay and lesbian patients. In addition, social stigmatization was stated to lead to outcomes such as depression, substance use, and a sense of powerlessness that could limit help-seeking behaviours (Meyer & Northridge, 2007).

The information covered here is of paramount importance to an investigation of gay men's health and illness practices; however, it is limited predominantly to help-seeking in the context of HIV and STIs. To broaden understandings of health and illness practices with gay men, this study will be situated within a broader health and health issues context to ensure the focus is not limited exclusively to HIV and STIs. Furthermore, to move beyond help-seeking to capture the variety of social practices geared towards promoting health and navigating illness, it will be crucial to consider sources for health guidance and support beyond health services. In the next section I document what evidence was available regarding the sources sought out by gay men for health guidance and support.

Informal health services

Few studies examined pertained to the use of informal health services and were mostly situated within the context of HIV and/or STIs. Of the internet studies, only one actually investigated gay men's use of the internet for health and health-related resources (Mustanski, Lyons, & Garcia, 2011); several provided reviews of the literature, advocating for the utility of the internet as a valuable sexual health resource for gay men (Mustanski, Lyons, & Garcia, 2011; Rosenberger, Reece, Novak, & Mayer, 2011). These arguments reflect the internet having become the focus of a number of HIV and STI studies; namely, to investigate whether meeting sexual partners online is linked to increased HIV and/or STI susceptibility (Benotsch, Kalichman, & Cage, 2001; Garofalo et al., 2007; Mustanski, Lyons, & Garcia, 2011). The results of these studies remain limited and without consensus (Rosenberger et al., 2011) and, due to the prevalence of the internet and other social media in day-to-day life, several authors have drawn attention to the potential benefits of the internet for promoting gay men's sexual health. For example, a 2009 survey specific to gay men and internet use demonstrated that most participants (86%) accessed online sexual health content, which prompted the authors to indicate that additional research is necessary to inform the development of online sexual education targeted to gay men (Jones & Fox, 2009). Another review of internet use by gay men drew attention to the valuable web-based health supports for HIV-positive men—such as www.thebody.com and www.poz.com—which provide men with a wealth of knowledge that can be conveniently accessed (Rosenberger et al., 2011).

The one study that investigated internet use by gay men used qualitative interviews with 16 young ethnically diverse gay men (Mustanski, Lyons, & Garcia, 2011). All participants had used the internet to find health information specific to HIV and/or STIs, such as general

facts about symptoms, transmission, prevention, or information about testing sites. In addition, all participants stated that the internet facilitated sexual identity development by providing a connection to the gay community (online and/or in person), finding information about coming out, or viewing gay pornography to validate their sexual attractions (Mustanski, Lyons, & Garcia, 2011). The internet was described as a medium to facilitate feelings of belonging, which the authors argued has positive mental health benefits. Despite the positive feedback regarding the internet for health purposes, the findings are limited to a small sample within one location in the United States and, although ethnically diverse, there was no information on socioeconomic status. In fact, none of the studies reviewed noted that the internet was a resource available only to those within a particular social location (that is, having access to a computer, being literate, etc.) and therefore a proportion of men are inevitably excluded from the potential health-promoting benefits of this medium.

The other informal resource featured in the literature was that of peer- and/or community-based resources to promote the health of gay men. A peer-based service is one that, as articulated by Dennis (2003), provides assistance and encouragement by an individual considered equal to the recipient; in the case of gay men this would include services that are run and delivered to gay men in the community by gay men in the community. Similarly, community-based services refer to those whereby the community informs the shape, direction and implementation of services to community members (Yun Gao & Wang, 2007). While none of the studies reviewed examined gay men's use of peer- and/or community-based services, they provide useful finds related to the effectiveness of these services. This is pertinent information as gay men are clearly utilizing these services, even if there is no current information available pertaining to frequency of uptake.

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All peer- and community-based studies highlighted the utility of these services for the promotion and maintenance of gay men's health. Yun Gao and Wang (2007) described a community-based education strategy aimed at HIV prevention in China. The initiative employed gay men ("peers") in the community to develop and run several "edutainment" (p. 802) activities: social activities designed to promote discussions about safe sexual practices and promote socialization among gay men in the community. Results indicated that at the end of the intervention there was a significant increase in uptake of condom use during anal sex with casual partners as well as regular partners (Yun Gao & Wang, 2007). The authors advocated for the necessity of peer-based education regarding HIV prevention in China as transmission rates continue to grow despite government-led top-down education delivery methods.

Similarly, a community-based peer-led intervention for gay men in Glasgow, Scotland evaluated the efficacy of the initiative in reducing sexual risk behaviours for HIV transmission and increasing uptake of sexual health services: specifically, HIV testing and hepatitis B vaccination (Williamson, Hart, Flowers, Frankis, & Der, 2001). The project (titled the Gay Male Task Force, GMTF) involved the use of 42 peer educators in gay bars within the city centre. Results indicated that men who visited the bars frequently were significantly more likely to report contact with the peer educators and among the subgroup of men who reported speaking to a peer educator, 49% reported having thought about their sexual behaviour and 26% reported having changed their sexual behaviour. These results, however, are vague as neither sexual behaviour nor change in sexual behaviour were clearly defined. To the authors' surprise, contact with peer educators did not significantly impact propensity of HIV testing or hepatitis B vaccination. The results of this study are also limited to a sample of predominantly

middle-class, University-educated White men who accessed gay bars (Williamson et al., 2001).

In a study by Veinot (2010), the utility of peer-support groups for persons with HIV was assessed. Although not exclusive to gay men, the study was a qualitative investigation in which interviews were conducted with 34 rural-dwelling individuals living with HIV in three rural Canadian settings. Echoing the positive results from the studies outlined above, the results overwhelmingly spoke to the value of peer-based exchange for health and resource information, as well as emotional support. Participants endorsed the value of health information, especially within a rural community. This was, however, a small study in a particular geographic location, which necessitates additional research pertaining to the potential health benefits rendered from peer-support-based services.

Discrimination and/or stigma within formal health services

Discrimination and/or stigma was a recurrent motif in the literature pertaining to formal health services (that is, those services in which health care professionals were involved in care and/or information provision). In a study conducted by Eliason and Schope (2001) the authors investigated disclosure of sexual identity to primary health providers among participants that self-identified as gay, lesbian or bisexual. Many participants espoused that they had experienced unpleasant encounters with health providers, or had been subject to heterosexist[4] assumptions; however, what was explicitly meant by the statement heterosexist assumption was not made clear in the study (Eliason & Schope, 2001). Similarly, Knight, Shoveller, Oliffe,

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[4] Heterosexism refers to macro-level oppressive practices and attitudes directed toward those who do not identify as heterosexual; that is, it is a phenomenon incorporated within the fabric of society (Aguinaldo, 2008). This differs from homophobia, which is a term frequently used in health research to describe heterosexuals who harbour fears, hatred and anger toward those who are not heterosexual, reflecting an individually enacted phenomenon (Kitzinger, 2001).

Gilbert and Goldenberg (2012) highlighted how heternormative assumptions can negatively influence the experience of STI and HIV testing for gay men; namely, by constructing gay men as the "risky other, in opposition to heterosexual men as the (hetero)normal" (p. 1). Shoveller et al. (2009) echoed like findings in a study that considered youth perceptions of STI testing in the province of British Columbia. Results demonstrated that environments perceived to be homophobic were a marked barrier to testing for youth who did not identify as heterosexual (Shoveller, Knight, Johnson, Oliffe, & Goldenberg, 2010).

A study conducted by Alvy, McKirnan, Du Bois, Jones, Ritchie and Fingerhut (2011) found that gay men were less likely to report a recent medical visit when compared to heterosexual men after controlling for race/ethnicity, age, education, income and geographic region. The two samples, however, differed markedly in size. The heterosexual sample of n = 7,783 vs. the sample of gay men at n = 871. Furthermore, the heterosexual sample was obtained through the National Health Interview Survey (NHIS) whereas the sample of gay men was obtained through recruiting participants at gay venues (gay bars, organizations, street fairs, Pride events) in one American city. Sample bias was evident in that only those men who were actively involved in specific aspects of select gay communities, attending gay venues and events were recruited, as opposed to the national survey sample with a randomized recruitment process that captured a more representative sample. There was no qualitative component to this study, which led the authors to speculate about the results, drawing on previous research to conclude that discrimination due to "sexual minority status" (p. 517) was responsible for discouraging gay men's access and use of medical resources.

Additional studies spoke to stigma and discrimination specifically within STI testing settings (Feldman, Hile, & Weinberg, 2011; Mimiaga, Goldhammer, Belanoff, Tetu, & Mayer,

2007; Taegtmeyer et al., 2013). In a Kenyan-based qualitative study, the authors attributed the demonstrated stigma in part to cultural perspectives on STIs and HIV. This conclusion was made in light of care provider perspectives about homosexuality (13 counsellors and three physicians were interviewed) namely; the prevailing perspective of homosexuality as a psychological problem. In particular, within Kenyan culture the term "incongruent" (p. 5) was used to describe homosexuality, referring to someone who has "not dealt with their issues" (p.5). How a stigmatized testing environment presents a marked barrier for gay men to receive essential services was emphasized (Taegtmeyer et al., 2013).

The work of Mimiaga et al. (2007) spoke to the importance of eliminating stigma in a study that collected perspectives on the ideal STI testing. The results endorsed the need for a community-based, friendly, culturally competent, gay positive environment that normalized sexuality along with STI and HIV testing (Mimiaga et al., 2007). A study by Feldman et al. (2011), based out of an AIDS service organization (ASO), described a community needs assessment conducted for HIV prevention specifically for young, gay Black and Latino men residing in New York City. The authors indicated that homophobia and stigma toward individuals with HIV can be particularly strong within non-White communities, stressing the importance of provider support in cultivating a non-judgemental and relaxed approach to education, testing and counselling (Feldman et al., 2011).

Another study by Worthington and Myers (2003) reported that gay participants felt the effects of social stigma when undergoing HIV testing. Participants were recruited from ASOs in three Canadian cities and the test settings included family physician clinics, sexual health clinics, hospitals and jails. Men expressed having felt that they were deserving of their situation in addition to shame for, as one participant articulated, "spreading the plague" (p. 646). The

experienced stigma was indicated as a marked barrier to engagement with additional health services, which the authors indicated had great ramifications for negative health outcomes (Worthington & Myers, 2003). The results, however, spoke to the experiences of a relatively small group of respondents limited to three specific geographic locations in Canada and the gay participants were very few in number.

Mental health

The third theme in the literature specific to men's experiences with health services related to access and utilization of formal health services, which in fact constitutes the only available literature on men's experiences with mental health (Blackwell, 2015; Coleman, Bauer, Aykroyd, Powell, & Newman, 2017; Grella, Greenwell, Mays, & Cochran, 2009; Tate & Ross, 2003). In particular, this literature documents men's experiences with seeking support for mental health challenges (Blackwell, 2015; Coleman et al., 2017; Grella et al., 2009; Tate & Ross, 2003). Mental health challenge is a term inclusive of diagnosed mental illness as well as emotional distress, which refers to feelings of anxiousness and/or sadness and/or suicidality in the absence of a formal diagnosis of mental illness (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009). In step with the theme of discrimination evident in this literature review, these studies emphasized the contributions of homophobia and heteronormativity on poor mental health outcomes, in addition to poor health service experiences (Aggarwal & Gerrets, 2014; Conron et al., 2010; Ferlatte, Dulai, Salway Hottes, Trussler, & Marchand, 2015).

A number of studies, for example, documented support services within primary care in addition to specialized mental health resources and described help-seeking (connecting with formal health services) as a key means to preventing and treating mental health challenges (Blackwell, 2015; Coleman et al., 2017; Grella et al., 2009; Tate & Ross, 2003). An

overarching finding within these investigations is the recognition of discrimination as wielding tremendous influence on accessing, and the need for, supportive services for mental health challenges. Once again, discrimination (described as homophobia and heteronormativity) within health care encounters was cited as a major barrier to seeking support from formal mental health services (Coleman et al., 2017; Grella et al., 2009: Tate & Ross, 2003.) For example, Tate and Ross (2003) developed a community model that identified and addressed the concerns of lesbian, gay, bisexual, transgender and queer (LGBRQ) university students in accessing formal supports. The investigation was informed by recognition of discrimination as a key influence and researchers worked collaboratively with LGBTQ students to produce knowledge with the goal of informing effective mental health services and resources (Tate & Ross, 2003). Other authors examined the efficacy of primary and acute care settings in supporting gay men's mental health (Blackwell, 2015; Grella et al., 2009). Additional training for health professionals working with gay men was advocated as necessary to adequately support the mental health of gay men. Across the studies, the conundrum of discrimination was articulated as contributing to the need for health support services for mental illness, but also as a barrier to seeking support via formal health services for mental health challenges.

Service and provider attributes for a positive health service experience

The fourth theme observed in the literature pertaining to gay men's experiences with health services was that of characteristics of health settings and attributes of providers deemed necessary for a positive health service experience. Although I seek to look beyond health services to include any potential sources men engage with to facilitate their health, the information pertaining to health services and the attributes of the people working within these services is relevant to a review on gay men's health and illness practices. These characteristics

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and attributes were elicited from gay men, service providers, or in some cases both. In terms of health setting characteristics, Worthington and Myers (2002) conducted a study regarding client perspectives of elements deemed desirable in HIV testing services. Recruitment occurred via ASOs in three Canadian cities, and included HIV-positive and negative participants. The findings spoke to several components of the testing experience, including characteristics of the venue, the test itself, and the health provider conducting the test (Worthington & Myers, 2002). Participants articulated the need for venues close to their place of residence, flexible hours, and brief wait-times along with comfortable, soothing, and private waiting areas (Worthington & Myers, 2002).

A study conducted by Hightow-Weidman et al. (2011) examined the impact of a program in HIV care designed exclusively for gay African-American and Hispanic youth. The program combined a community-informed social marketing campaign, community outreach, and tailored HIV support services (namely regular contact with a board-certified, infectious diseases physician) were found to provide timely and efficient engagement in care, while improving overall retention (Hightow-Weidman et al., 2011). A systematic review of HIV testing among gay men, including testing preferences, cited several of the studies mentioned and echoed many of the concepts brought forth regarding services; in particular, accessible venues with limited wait-times and flexible hours (Lorenc et al., 2011).

There were several studies that elicited gay men's preferences regarding essential provider attributes. In the Worthington and Myers (2002) investigation of desirable HIV testing services, gay men stressed that providers be kind, compassionate, respectful, and judicious with regards to "questions asked about risk behaviours" (p. 541). In the Lorenc et al. (2011) review participants stressed a non-judgemental approach to be of fundamental

importance to a positive experience. Similar results were echoed in a study conducted by Mimiaga et al. (2007) where the authors stressed that providers must be compassionate, respectful, and nonjudgmental when engaging with clients.

Several studies cited judgmental health providers as a major barrier to accessing testing and additional health services. For example, in a study by Hult, Maurer, and Moskowitz, (2009), a participant disclosed that a particular health provider conveyed the positive HIV test result by stating "well, this shouldn't come as a surprise, we discussed your high risk behaviours" (p. 6). The exchange left the client feeling invalidated, disrespected, and reticent to connect with necessary health service follow-up. This study also determined, via brief demographic survey, that clients were tested in one of four settings: hospital, sexual health clinic, private physician and research study. Given the concern expressed by the authors regarding the rushed nature of providers in conveying a positive test result, it would have been valuable to investigate if the time constraints are possibly linked to the testing setting.

Resilience and Gay Men

The concept of resilience is defined as a process of adaptation to significant adversity (Fergus & Zimmerman, 2005) and has attracted increased attention in the gay men's health literature (Herrick et al., 2012; Herrick et al. 2014). Resilience is increasingly accepted as the development of internal and external protective processes to tackle adversity: internal processes refer to innate traits such as optimism and self-efficacy, while more attention is being paid to external processes that draw on social ecology to appreciate the influence of the external social environment on grappling with risk; for example, the presence of social support networks (Fergus & Zimmerman, 2005; Luthar, Sawyer, & Brown, 2006; Masten, 2004; Masten, 2007). Protective external processes consist of various social practices integral to

health and illness practices and sought out literature pertaining to gay men's resilience in a variety of contexts that include mental illness, HIV and discrimination.

The majority of studies into resilience with gay men have been quantitative designs employed to measure resilience in the face of risk situated as discrimination most often defined as internalized homophobia (IHP)[5] (Herrick et al., 2012; Herrick et al. 2014; Quinn et al., 2015). These studies have produced a wealth of knowledge and the foundation for future research. For example, Herrick et al (2012) defined resilience as movement towards greater health among gay and bisexual men via resolution of high levels of IHP over time. The findings indicated that men who resolved their feelings of IHP had significantly higher odds of not being distressed, having no or low stress, not experiencing interpersonal violence and having no or low sexual compulsivity compared to those who were unable to resolve their IHP. Although the findings alluded to the role of protective processes in contributing to resolving IHP, the study did not identify what these processes were nor was age considered in this investigation. Quinn et al. (2015) looked at IHP among gay and bisexual Black men, and identified resilience as a psychosocial factor (measured via a 5-point Likert scale) that can diminish feelings of IHP.

Numerous studies in resilience with gay men have also focused on the HIV context, considering resilience measures as somewhat predictive of HIV susceptibility (Buttram, 2015; Kurtz, Buttram, Surratt, & Stall, 2012; White Hughto et al., 2016). For example, findings from a study by Kurtz et al. (2012) state that men with higher measures of resilience were more

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[5] Internalized homophobia is stated as the experience of negative feelings toward oneself as result of internalizing negative messages pertaining to homosexuality that are pervasive in mainstream society and was measured via an IHP scale consisting of nine questions (Herrick et al., 2012).

likely to take part in serosorting[6] as a practice to reduce the likelihood of HIV transmission. White Hughto et al. (2016) considered HIV susceptibility in online settings. The researchers conducted a study in which they operationalized indicators of HIV-risk resilience[7] in the profiles of 933 gay men accessing a sexual networking website and found that HIV-risk resilience was common among the participants (White Hughto et al., 2016).

Fewer research efforts, however, have employed qualitative methods to provide more nuanced understandings about how men develop resilience amid adversity. The information available documents the protective processes associated with resilience most often in the context of mental illness, reinforcing the importance of such processes for gay men's health. For example, Kushner, Neville and Adams (2013) demonstrated that building a strong social support network—comprising a partner, friends and/or family—was foundational to facilitating the aging process of older gay men amid homophobia and heteronormativity. Family and peer support were also found to contribute to decreased psychological distress associated with gay identity and victimization among gay youth in a study by Mustanski et al. (2011). Another investigation reported that the risk of depression was mitigated among gay men who belonged to a gay community and had strong social ties as compared to those who did not (McLaren, Jude, & McLachlan, 2008). Toro-Alfonso, Varas Diaz, Andujar-Bello and Nieves-Rosa (2006) showcased the role of building strong ties within a social support network in mitigating levels of depression with a sample of gay Puerto Rican youth. Dickinson and Adams (2014) identified additional protective processes to social connections including

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[6] Serosorting refers to a practice engaged in by some MSM to reduce HIV risk in which unprotected anal intercourse is limited to partners with the same HIV status.

[7] Indicators included a number of practices; for example, endorsing foreplay only (non-penetrative sex) or a versatile sexual position; being "out" (e.g. disclosed sexual orientation), seeking friendship, serosorting and not endorsing drug and/or alcohol use.

engaging in personal reflection, having interests and hobbies, and seeking professional support such as counselling were foundational to mental well-being among gay participants. Furthermore, personal reflection, having hobbies, and seeking professional support such as counselling were other protective processes central to the development of resilience in the context of mental health promotion (Dickinson & Adams, 2014). What is unclear from this literature is how gay men have developed these protective processes, what reinforces these processes, what creates barriers and what this may look like for middle-aged and older gay men.

The fundamental aim of the current study was to explore middle-aged and older gay men's health and illness practices in the context of homophobia and heteronormativity. The literature pertaining to health and illness practices among gay men is largely situated in engagement with health services and is extensive and varied: the studies available considered health services with an emphasis on provider dynamics. The resilience literature is likewise varied and has focused on quantitative and a growing body of knowledge that has identified key protective processes integral to resilience that gay men employ to thrive amid adversity. To assess health and illness practices in a way that encompasses the variety of social practices geared towards promoting health and navigating illness this project will appreciate social practices inclusive of resources outside of health services that gay men potentially seek out and engage with for guidance and support with health and health issues.

Furthermore, this investigation is specific to middle-aged and older gay men who, despite ample evidence of a disproportionate burden of illness, have been largely overlooked. This burden of illness is demonstrated by a growing body of literature which highlights chronic health issues beyond HIV and STIs experienced by middle-aged and older gay men. For

example, the ratio of hypertension, diabetes, psychological distress symptoms, physical disability and fair/poor health status was reported to be higher for middle-aged and older gay men when compared to heterosexual men of the same age group with similar demographics (Wallace, Cochran, Durzao & Ford, 2011). The authors also assert that fair or poor self-assessed health status is a widely used measure of overall health problems and the rate of fair or poor health among middle-aged to older gay men was noted as 1.5 times higher when compared to heterosexual men of the same age group with similar demographics. Additionally, middle-aged and older gay men experience overrepresentation of mental health challenges including anxiety, depression and suicidality (Conron et al., 2010; Fredriksen-Goldsen et al., 2013). In one report, less than one-quarter of middle-aged and older gay men reported psychological distress symptoms, but that rate is 1.45 times the rate of heterosexual men of the same age and similar demographics (Wallace, Cochran, Durazo & Ford, 2011). Further, preliminary research has argued that middle-aged and older gay men face unique obstacles to health and wellness in the form of years of discrimination confounded by the presence of numerous chronic health issues and the subsequent psychosocial adjustment and support required to navigate these challenges (Fenkl, 2012). By focusing on health and illness practices, the opportunity to gain a more comprehensive understanding of the dynamic processes employed by gay men to promote health, as well as navigate and grapple with health and health issues, is made possible.

Organization of the Dissertation

This paper-based dissertation is drawn from an overarching research focus on middle-aged and older gay men's health and illness practices that gave rise to three specific objectives. As such, the dissertation is comprised of six chapters. The first chapter is an introduction to

provide context for the investigation: the overall purpose and objectives are stated (and later addressed in three corresponding findings chapters) followed by a review of the extant literature to provide rationale for the investigation. The second chapter outlines the research approach: how I went about answering the three questions rooted in the overarching aim, the constructs that make up the theoretical framework for the investigation, a brief overview of data collection and analysis, followed by details regarding negotiating entry, scientific quality, usefulness of the research, and ethical considerations. The findings section is comprised of the three manuscripts that correspond with the specific research objectives rooted in the overall research aim: these manuscripts effectively constitute Chapters 3, 4 and 5. It is within these chapters that the specific details pertaining to data collection and analysis are outlined, as the approaches differed somewhat for each manuscript based on the research objectives and therefore could not be addressed in an overarching fashion in Chapter 2.

In Chapter 3, I examine the concept of resilience and chronicle how middle-aged and older gay men develop resilience over the course of their lives to promote health and wellness. This was an essential component of the overall investigation of health and illness practices to provide the necessary context of men's historical and ongoing experiences of homophobia and heteronormativity. In this chapter, I outline the protective processes men developed and employed to promote and protect their health amid historical and ongoing discrimination. In Chapter 4, I present a grounded theory study in which I chronicle the processes by which middle-aged and older gay men managed their health. Chapter 5 describes how middle-aged and older gay men experience mental health; specifically, how they define mental health, the mental health challenges they experience, and how they address these challenges to mitigate their deleterious effects. Each of these findings chapters consists of an introduction, literature

review, methods section and findings, their implications for research and practice, and limitations. Chapter 6 is the conclusion for this dissertation and outlines the key findings and their implications for future research and practice.

Summary

I began this chapter by identifying the current overrepresentation of health issues among gay men, rooted in inequity. I followed with recognizing the dearth of information pertaining to gay men's health and illness practices, advocating for recognition of health practices as encompassing what men do to promote their health and navigate illness. I then provided a summary of the existing literature. I began with an epidemiologic review of the health issues presently faced by gay men, followed by the extensive literature pertaining to engagement and experiences with health services and closed with an overview of the work in resilience with gay men. The health inequities gay men experience aside from HIV and STIs is well documented, but what exists pertaining to health and illness practices remains limited. As per the more encompassing understanding of health and illness practices employed in this project—as the variety of social practices geared towards promoting health and navigating illness—the literature that is available speaks to particular social practices; namely, engagement and experiences with health services (including help-seeking) and resilience. Not to discount this valuable information, but given the documented incidence of mental health and substance use issues, it is concerning that little information is available regarding gay men's health and illness practices more comprehensively. There were also a few qualitative studies that employed interviews to elicit men's approaches to promoting their health day-to-day and the practices employed (aside from engaging with health services) to navigate illness. This dissertation addresses a gap in the literature and builds on what is presently known by

offering understandings of middle-aged and older gay men's health and illness practices. Ultimately, the information obtained informs recommendations to better support and promote the health of middle-aged and older gay men.

CHAPTER 2: RESEARCH DESIGN AND METHODS

The overarching purpose of this study was to explore middle-aged and older gay men's health and illness practices in the context of homophobia and heteronormativity. I specifically sought to understand how living in a heteronormative society influenced men's health and illness practices. The research objectives addressed in three separate manuscripts were:

1. To describe how middle-aged and older gay men developed resilience over time to promote health and wellness

2. To provide an account of how middle-aged and older gay men manage their health in the context of homophobia and heteronormativity

3. To describe how middle-aged and older gay men experience mental health and the strategies they use to mitigate the deleterious effects of mental health challenges they might experience

I conducted a qualitative exploration of middle-aged and older gay men's health and illness practices in the context of homophobia and heteronormativity. In this chapter, I provide a brief overview of the research design, setting, participants, data collection and analyses to abridge additional details provided in the three separate manuscripts presented in chapters 3, 4 and 5. I begin this chapter with an overview of qualitative description as the research design and explicate how this research design in combination with grounded theory methods for data collection and analysis guided the development of the three manuscripts that correspond with the research objectives. I follow this with an overview of the constructs of gender and sexual identity situated within power and inequity and recognized as key social processes that influence how men think about health and their health and illness practices. I then describe

negotiating entry into the field, ensuring scientific quality, and all manner of details pertaining to ethical considerations. The chapter concludes with a brief summary.

Qualitative Description

As articulated by Sandelowski (2000) qualitative description enables researchers to strive for the goal of producing a comprehensive summary of events in the everyday terms of those events. Given the limited information available on the health and illness practices of middle-aged and older gay men, this research approach was well-suited as it is frequently the method of choice when a comprehensive, nuanced description of phenomena is the desired outcome (Sandelowski, 2000). Researchers engaging in qualitative descriptive work stay close to the data and the surface words of the events, but this should not be interpreted as superficial as it is no easy task to obtain the facts and the meanings participants ascribe to those facts and proceed to convey them in a "coherent and useful manner" (Sandelowski, 2000 p. 336).

However, as I had three specific research objectives to ensure a comprehensive understanding of middle-aged and older gay men's health and illness practices in the context of homophobia and heteronormativity, the focus of these research objectives influenced the approach for data collection and particularly, analysis within each manuscript. The research design of qualitative description, however, informed the overall sampling approach (purposive and snowball) common to many qualitative designs (Patton, 1990) which is elaborated upon later in this chapter. Because each research objective had a focus on process; for example, to describe how men develop resilience over time, to provide an account of how men manage their health, and to describe how men experience mental health and navigate the deleterious effects of mental health challenges, grounded theory methods were drawn upon for data collection (Charmaz, 2006). Specifically, data collection and analysis were concurrent as per

grounded theory methods although this approach is recognized as common across qualitative

designs (Sandelowski, 2000).

It is, however, with regards to analysis that grounded theory methods were greatly

drawn upon with each of the manuscripts to facilitate appreciation of process and the influence

of time. As such, analysis proceeded in the case of all three manuscripts with a broad read of

the transcripts, to establish a level of familiarity with the data as a whole, a technique frequently

used in a variety of qualitative traditions (Thorne, 2008). Next came a process of reading and

re-reading transcripts at the open coding level, capturing larger sections of data in more

succinct, active statements as directed by grounded theory (Charmaz, 2006). I then progressed

to focused coding, which entailed comparing earlier codes to newer ones with a focus on

identifying similarities and differences a process termed constant comparison (Charmaz,

2006). At this time memo writing was crucial to keep an analytical log of potential connections

between codes (Charmaz, 2006). For objectives #1 and #3 which were primarily vested in

describing a process and not developing a theory per se, analysis culminated at the axial level

with the identification of overarching categories. For objective #2, for which I sought to

develop an account of how men managed their health in the context of homophobia and

heteronormativity, taking the analysis up another level to theoretical coding was necessary as

the intent was to generate a theory. Therefore, in the case of objective #2, theoretical coding

entailed identification of the core process or core category, that which accounts for the

variability in the data (Charmaz, 2006).

Gender and Sexual Identity

In conducting this qualitative exploration of middle-aged and older gay men's health

and illness practices in the context of homophobia and heteronormativity, I drew on grounded

theory methods for data collection and analysis as described by Charmaz (2006). These methods necessitate researchers go beyond the surface in seeking meaning in the data, searching for and questioning tacit meanings about values, beliefs, and ideologies, a process that is essential to appreciating how contextual circumstances potentially influence health and illness practices (Mills, Bonner, & Francis, 2006). Consequently, I was able to consider the influence of the theoretical constructs of gender and sexual identity as social processes that potentially impacted men's health and illness practices. I achieved this by developing probes that subtly addressed the influence of gender and sexual identity during the interview process and by actively reflecting on, and querying the role and impact of these processes on the data during the analysis phase, which I elaborate on in each of the three manuscripts.

Gender refers to the responsibilities, roles, and experiences attributed to individuals most often by virtue of biological sex (Johnson & Repta, 2012). As such, it can be conceptualized as a powerful dynamic, social process, "a set of socially constructed relationships which are produced and reproduced through people's actions'' (Gerson & Preiss, 1985, p. 327). In this way gender is understood to intersect with culture, social class, and history, actively constructed and produced (Connell & Messerschmidt, 2005; Gerson & Preiss, 1985). It is a concept of fundamental importance to a study concerned with gay men's health and illness practices: as an essential social determinant of health, gender impacts health decision-making by intersecting with other determinants within broader social contexts of power and privilege to affect control, access and opportunity (Bird & Rieker, 2008; Mikkonen & Raphael, 2010).

Sexual identity is also understood as a process that is informed by dynamic social and historical forces and tied closely to gender due to societal expectations regarding sexual

attraction and desire (Irvine, 2003). Sexual identity is subject to immense scrutiny and discrimination outside assumed heterosexual norms (Yep, 2002). Heteronormativity, or the presumption that all human experience is unquestionably and automatically heterosexual, is described as a form of discrimination "embedded in our individual and group psyches, social relations, identities, social institutions, and cultural landscape" (Yep, 2002 p. 168). Consequently, sexual identity and gender, as distinct social processes, are embedded within power relations that contribute to interpersonal discrimination towards gay men (homophobia) and more subtle forms of heteronormativity. Thus, they are processes of key relevance to a study concerning gay men's health and illness practices as they collectively influence health and illness behaviours: how gay men think about their health, the practices they employ to maintain health and navigate illness and interactions with the health care system.

Ultimately, I sought to gain an understanding of middle-aged and older gay men's health and illness practices. Situating gender and sexual identity within power relations allowed for scaffolding of the probes developed for the interview guide. It was integral to craft probes with a sensitivity to the presence and influence of discrimination on men's perceptions of health and health and illness practices. Awareness of how power relations perpetuate dominant cultural stereotypes (and consequent discriminative processes) pertaining to gender and sexual identity was essential in speaking with gay men about the interconnections between their health and illness practices. Attention to gender and sexual identity was possible by applying questions informed by Charmaz's (2006) grounded theory approach; that is, I assessed, in particular, how discrimination manifested in the data and over time influenced men's perspectives and actions. In a study principally concerned with developing an understanding of middle-aged and older gay men's health and illness practices in the context

of homophobia and heteronormativity, it was necessary to frame the study with an appreciation of how discrimination (understood as gender and sexual identity situated within power relations) influences men's health and illness practices.

Research Approach

In conducting a qualitative exploration of middle-aged and older gay men's health and illness practices in the context of homophobia and heteronormativity, over an eight-month period I engaged in individual conversational interviews with 25 men who self-identified as gay, were middle-aged and older (defined in this dissertation as aged 40 and over), resided in the Victoria area and were able to converse in English. Conversational interviews were employed specifically due to their more flexible structure when compared to semi-structured interviews (Mischler, 1991). This flexibility enabled explicit opportunities for participants to tell their stories without interruption (Mischler, 1991). The conversational interview reflects the recognition that discovery arises from the interactive process of researcher and participants (Charmaz, 2006) by conceptualizing the interview as a type of discourse, a speech event (Mischler, 1991). Interviews lasted approximately 45–60 minutes in duration and were transcribed by an experienced transcriptionist. Participants were recruited via a snowball sample: a recruitment flyer was disseminated by men known to the author and who expressed interest in the project and were connected to other circles of gay men. The flyer was subsequently distributed at social and educational events. Data collection and analysis were concurrent, and analysis was informed by qualitative approaches (Thorne, 2008) and grounded theory approaches as per Charmaz (2006). For example, I first engaged in a broad read of each transcript to establish familiarity with the data (Thorne, 2008). Furthermore, I initially coded sections of data with an active phrase to capture the energy of what the participants were doing,

and engaged in constant comparison to guide the development of subsequent codes. The full details of data collection and analysis are outlined in each individual findings chapter.

Negotiating Entry

Negotiating entry into where participants can be found living out their day-to day lives is an essential component of inquiry that requires an ethical and respectful approach (Madison, 2005). This investigation sought to produce knowledge to better understand middle-aged and older gay men's health and illness practices in the context of homophobia and heteronormativity. In the spring of 2013, while attending conferences and other educational forums designed to promote and protect the health of men of varying gender and sexual identities, I made the acquaintance of several gay men residing in the Victoria area who expressed support for this project and offered to facilitate recruitment. Shortly thereafter I was asked to join a newly formed gay men's health initiative in Victoria as a nurse representative. The health initiative is a collective consisting of gay men involved in community organizations, researchers, or who reside in the Victoria area and are committed to promoting health and wellness for gay men. The main aim of the initiative is to provide a forum for gay men, researchers and health professionals to discuss health issues and strategize approaches to enhancing gay men's health in Victoria. Involvement in the initiative allowed me to further cultivate relationships with gay men in the area, many of whom are involved with local organizations or are actively involved in networks of gay men. My research interests were again well-received by initiative members who further offered to assist with recruitment.

Additionally, I was involved with the local organization AIDS Vancouver Island (AVI) as a volunteer. Although AVI is a not-for-profit organization that exercises the imperative of improving the lives of people living with HIV or AIDS and contributing to prevention efforts,

its services are not exclusive to individuals with HIV or AIDS (AVI, 2013). In particular, the Men's Wellness Program (MWP) offers a space for gay, bisexual, trans, two-spirit, queer and other men who have sex with men to talk about health issues and sexuality, including the consequent impact on sexual, physical, emotional, psychological and spiritual health and well-being (AVI, 2013). Although the MWP is open to a diverse group of men, the majority are men that self-identify as gay. The Men's Wellness Program coordinator, executive director and communications coordinator all expressed support for this project.

Ensuring Scientific Quality

This study sought to produce an account of middle-aged and older gay men's health and illness practices. The phenomenon of interest is thus one of human experience, which does not render itself to objective measures (Streubert Speziale & Carpenter, 2007). Qualitative research seeks to develop an understanding and provide meaningful accounts of the complex perspectives and realities studied, in contrast to a finite, objective conclusion as in quantitative inquiry (Cohen & Crabtree, 2008). Thus, qualitative research requires alternative, however equally stringent, adherence to protocols to ensure the results obtained are in the practice of "good science". Sandelowski (1986) draws on Guba and Lincoln who identify credibility as the criterion against which the value of a qualitative study be evaluated. This approach asserts that a qualitative study is credible when it depicts such an accurate description or interpretation of a human experience that people who have had the experience would recognize it from the descriptions as their own. Consequently, it is the prerogative of qualitative researchers to apply strategies to establish such a level of credibility within their work (Guba & Lincoln, 1981). Therefore, I applied several methods to ensure the experiences described in the findings of this study were a genuine depiction of the experiences of the participants.

A key strategy to ensure scientific quality in this project was adherence to reflexive practice. Reflexivity is the researcher's acknowledgement that the knowledge produced is inevitably constrained by his/her own history and institutional structures within which he/she works (Simon & Dippo, 1986). Of key importance to this study, given the position that truth and knowledge are co-constructed via participants and the researcher (Charmaz, 2006), was vigilant insight into my own perspectives, biases and reactions that are greatly shaped by my social positioning. While academic and personal integrity are of utmost importance to qualitative research (Knafl, 1994) there is a specific intellectual integrity of situating oneself within a particular research project, which behoves the researcher to critically reflect on the influence of his/her social position on the research process (Simon & Dippo, 1986; Thorne, 2008). Researchers are often powerfully influenced by certain ideas, theories, or inquiry approaches prior to, or during, the process of conducting the study (Thorne, 2008). Recognition of the researcher's own implications in the research process is essential and made possible via reflecting on practices, as well as social and historical biases during project development, data collection and analyses (Simon & Dippo, 1986).

My engagement in reflexive practice began at the onset of embarking upon this dissertation. I maintained reservations about how my social positioning as a female heterosexual health professional would create barriers first and foremost to eliciting participation in a project focused on middle-aged and older gay men. I deliberated with other researchers who engage in work with groups who are situated in social locations which differ from their own to obtain some guidance. I was encouraged to be transparent and honest about my research prerogatives and further seek guidance from advisors; i.e. in the case of this dissertation, middle-aged and older gay men who could provide direction as to how to best

proceed with the project. I spent some time reflecting on my vision for the project along with assumptions and biases that I maintained as a heterosexual, female health provider; namely, misconceptions pertaining to my naïve belief that currently health provider and service approaches are inherently progressive and nurses do not contribute to discriminatory approaches in care delivery. I then met with several middle-aged and older gay men who expressed support for this project to obtain some direction as to the language to use for the project, how to best communicate the goals of the research and ideas for recruitment.

The advisors I spoke with were instrumental in guiding my use of language in this dissertation, specifically the use of "self-identify as gay" as meaningful and appropriate for the age group of interest for the study. The advisors also offered support with recruitment, and offered suggestions for interviewing participants; namely, to be honest about what I sought to obtain from this research and explicate how my experiences as a nurse and, namely, the anecdotal conversations in my personal life with gay men that led to my interest in pursuing this topic. Initally I was operating under the bias that health services and providers (particularly nurses) were inherently progressive and contributing to redressing discrimination by providing informed, supportive and appropriate care for gay men. I was met with multiple personal accounts that contradicted my beliefs which led to my interest to investigate men's health and illness practices in the context of homophobia and heteronormativity. I opened up each interview by disclosing this information, and I truly sought to develop rapport and a level of comfort with participants by telling them a little bit about me and my motivation to do this work.

After each interview, I engaged in reflection via journaling to capture my feelings and reactions to the interview as a whole, which also served as a means to take note of my own

ideas, reactions, and thoughts with regards to particular situations and concepts. This process of keeping an analytical log of my perceptions, reactions and biases continued throughout data analysis. I documented my perceptions and reactions which facilitated further investigation into identified themes and concepts by actively writing down ideas, returning to them, and re-evaluating the concepts in an attempt to strip away any biases I may have applied (Hall & Callery, 2001; Polit & Beck, 2008). Maintaining the reflexivity log allowed for an account of all issues I wished to further explore, ideas I struggled with, nuances I sought to flush out, and additional questions to pose to participants (Polit & Beck, 2008). Central to the reflexive process during analysis was the taking back of the analysis, at two points of writing during each manuscript, to participants to ensure that I was on the right track, and had not misinterpreted or misrepresented what participants shared. Asking for clarification from participant was fundamental for me to progress in the research as I recognized the depth, breadth and intensity of information that participants shared with me and I needed to ensure the information was handled and represented respectfully, appropriately and meaningfully.

Relationality is another concept I applied to strengthen the scientific quality of the study. Hall and Callery (2001) explain the importance of power relationships in qualitative research, in particular, the moral obligation of the researcher to emphasize equity in the power relationships with participants. As a result, relationality in qualitative research must embrace commitments to community along with new and emergent relationships between inquirer and respondent, with trust and respect at the core (Hall & Callery, 2001). The first step to establish rapport with participants (in particular, gay men who may have experienced discrimination) was by providing information regarding my research background, nursing involvement, and dedication to improving health outcomes and health care experiences of gay men. I openly

communicated that it was my goal to work collaboratively with participants to gain understandings of gay men's health perspective and experiences, in addition to identifying meaningful and effective health provider engagement with gay men to improve health outcomes. I encouraged participants to ask questions and often lengthy discussions about my interest in this research topic unfolded, contributing to reflexive practice. Being transparent and genuine about my research prerogatives promoted participant involvement, as participants disclosed feeling comfortable speaking with me and this facilitated recruitment. Involvement with the gay men's health initiative also helped to establish my reputation as an ally. I also ensured a safe environment for the interviews by first inquiring with the individual if there was a preferred location, and if not, I provided several suggestions from which the participant could choose. In doing so I ensured individuals felt an adequate level of choice, central to comfort and ease with the setting for the interview.

Usefulness of the Research

In accordance with the social justice mandate of nursing, the goal of nursing research is ultimately to produce knowledge that can be put towards efforts to reduce health disparities and/or improve health outcomes (Reimer Kirkham & Anderson, 2002; Thorne, 2008). The fact that gay men remain underrepresented in the men's health literature, aside from issues pertaining to HIV and other STIs, is indicative of inequity. The findings from this dissertation will be put towards development of meaningful and appropriate resources and health services for gay men. This dissertation puts forth recommendations for research, policy, education, and practice that are necessary to bring about change to enhance gay men's health. Dissemination of findings entailed, and will continue to entail, involvement from the gay men's health initiative and input from participants, which verified that the knowledge produced was deemed

representative of men's perspectives. Documents containing key findings and recommendations have been produced for presentation at the gay men's health initiative and the feedback obtained will facilitate further service and resource development for men's health, including guidance and support for health providers. In this way I seek to improve health outcomes by contributing to meaningful and appropriate health services for gay men. I am also in the process of publishing the findings within peer-reviewed journals and conference presentations as a means to share with academic audiences.

Ethical Considerations

A number of ethical considerations were addressed in the design and implementation of this research study including: informed consent, confidentiality, data storage, financial honorariums, and the maintenance of respectful relationships. First, I have employed the guidelines and protocols for behavioural research ethics outlined by the University of British Columbia, and completed the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans Research Course (TCPS, 2014). Prior to the initiation of any research activities, approval from the University of British Columbia (UBC) Behavioural Research Ethics Board (BREB) was obtained.

Informed consent

For the study I used a verbal approach to informed consent because gay men may have experienced discrimination. The rationale for verbal consent is gleaned from researchers (Bungay, 2008; Spittal et al., 2002) working with populations that have been exposed to marked social stigma for a variety of reason, such as illicit substance use and engagement in sex work, and are thus frequently reticent towards activities requiring a written signature (Bungay, 2008). Thus, verbal consent is a more appropriate and respectful alternative (Bungay,

2008). Again drawing on the work of Bungay (2008), who engaged in research with populations that experience discrimination, I developed a brief one-page summary that identified the purpose of the study, proposed research activities, rights of participants, approximate time requirements, and honorarium details. Each participant received a hard copy (or email attachment, if preferred) of this document for their personal records. The summary document was reviewed verbally with each participant and they were encouraged to voice any questions or concerns. Verbal consent was obtained from each participant prior to the initiation of any data collection.

Confidentiality

Confidentiality was ensured by enacting several measures. Prior to engaging in one-on-one interviews, I emphasized that the session was completely confidential and encouraged participants to raise any questions or concerns regarding confidentiality at that time. I also informed participants that if they wished to share something of a deeply personal or sensitive nature that they did not wish to be captured on the audio-recording, to simply indicate so, and I would pause the recording. I also employed a number of strategies to ensure the highest level of confidentiality was maintained with regards to the data, including assigning a numerical identification number to each participant, and removal of all information pertinent to identities from any recorded data, computer files, or written documents. For the process of transcription, the data were stored on an encrypted flash drive for which only the transcriptionist and I had knowledge of the password. In accordance with UBC ethics protocols, all data files and documentation will be destroyed after a 5-year period.

Respectful research relationships

As emphasized previously, developing rapport and trust with research participants is crucial to conducting any study (Hall & Callery, 2001). Tending to reflexivity throughout the research process, including engagement with participants, enabled me to stay true to gaining knowledge of gay men's health and illness practices. Moreover, constant reflexive practice was essential given that I maintained a focus on how the processes of sexual identity and gender potentially influenced gay men's health and illness practices. Ongoing engagement with the community was maintained throughout the research process from inception of the project, to verification of findings from the analysis, to how the findings should be disseminated.

In addition, self-identifying myself as a novice researcher, and thus cultivating my own strategies for developing respectful relationships with my participants, was paramount to this study. As outlined by Bungay (2008), recognition of my own strengths and limitations within the research relationship was vital, and the application of the "researcher as learner" approach was fundamental to developing rapport with participants. My approach has been and remains transparent, genuine, and open with participants regarding my concerns pertaining to health inequities as the impetus for engaging in the research I conduct. This has been especially important as a straight woman in developing preliminary relationships with community agencies and researchers involved in gay men's health pursuits. As a nurse who adheres to the professional mandate of social justice, I am deeply dedicated to promoting the health and well-being of gay men.

Financial incentives

Debates pertaining to remuneration for participation in research are ongoing. The Tri Council Policy Statement (2014) regarding ethical conduct for research involving humans defines incentives as "anything offered to participants, monetary or otherwise, for participation in research" (p. 29). The TCPS (2014) does not recommend or discourage the use of incentives, but rather indicates that it is the responsibility of the researcher to justify to the Research Ethics Board (REB) the "level of incentive" (p. 29). Having assessed a wide depth and breadth of literature pertaining to gay men and health research, it was my observation that remuneration for the time and effort participants provided was necessary. The literature I surveyed most frequently offered between $20 and $30 for participation (Carballo-Dieguez, 2001; Garofalo et al., 2007; Knight et al., 2012). After deliberation with my academic supervisor the amount of $25 was decided upon as appropriate for participant's time and contribution. I also provided the alternative of a gift card of equal value to offer a choice. Participants were provided with remuneration for contribution to the research project at the end of each interview. Because incentives encourage participation, the influence on voluntariness is of great importance: to ensure voluntariness, participants were free to withdraw their consent to participate in the research at any time, and need not offer any reason for doing so (TCPS, 2014).

Summary

The overarching study aim was to explore middle-aged and older gay men's health and illness practices in the context of homophobia and heteronormativity. I situated gender and sexual identity within power and inequity as a study framework to enable examination of how homophobia and heteronormativity influenced middle-aged and older gay men's health and illness practices. In doing so, I was afforded the opportunity to produce a nuanced

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interpretation of gay men's health and illness practices in the context of homophobia and heteronormativity. As I drew on Charmaz's (2006) approach to grounded theory in this qualitative exploration, which recognizes that the co-construction of truth occurs through the interaction of participants and researcher, vigilance with regards to reflexivity was of paramount importance. I recognized that my own social positioning had the potential to greatly influence how the data were interpreted, and thus ongoing reflection on my own thoughts and biases was crucial throughout the investigation. By carrying out this project I gathered knowledge to fill a notable research gap and provide meaningful recommendations to support and protect the health of gay men.

CHAPTER 3: DEVELOPING RESILIENCE: GAY MEN'S RESPONSE TO SYSTEMIC DISCRIMINATION

Gay men experience marked health disparities when compared to heterosexual men (Brennan et al., 2010; Eaton et al., 2010). To date, gay men's health research has emphasized illness with a focus on risk factors that include the deleterious effects of discrimination across the lifespan (Aguinaldo, 2008; Brennan et al., 2010). In particular, homophobia[8] and heteronormativity[9] have been identified as discriminative processes that collectively contribute to poor health outcomes among gay men (Aguinaldo, 2008; Brennan et al., 2010; Rosenberger et al., 2011). There is a growing body of literature, however, that highlights factors associated with fostering health and well-being and shows how gay men are actively involved in an array of health and illness practices to promote and protect their health and navigate illness. Resilience has been central to investigations of men's active engagement in health promotion and is regularly positioned by scholars as an effective means to appreciate how gay men promote their health and wellness in the face of adversity (Herrick et al., 2012; Herrick et al., 2014). Definitions of resilience vary, but there is wide recognition that it entails a process of individual adaptation within the context of significant adversity to overcome the negative effects of risk exposure (Harper, Bruce, Hosek, Fernandez, & Rood, 2014). Integral to resilience is the presence of both risk(s) in the individual's environment, as well as internal and external protective processes[10] (Fergus & Zimmerman, 2005; Luthar et al., 2006; Masten,

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[8] Homophobia comprises discrimination enacted at the interpersonal level by individuals who harbor fear and/or hatred towards those who are not heterosexual (Kitzinger, 2001).

[9] Heteronormativity represents macro-level discrimination via oppressive practices and attitudes directed toward those who do not identify as heterosexual (Aguinaldo, 2008).

[10] Protective processes are defined as strategies that are key to the development of resilience and which encompass social/relational dynamics such as family/peer support, mentors and community-based organizations (Luthar et al., 2006; Masten, 2007; Masten, 2004; Smith & MacKenzie, 2006).

2007; Zimmerman, 2013). Internal processes refer to personal processes or perspectives such as optimism; external processes, however, draw on tenets of social ecology and refer to processes situated within social environments such as social support networks (Fergus & Zimmerman, 2005). Due to the recognition of resilience as a developing process, research efforts have focused on external protective processes.

Most research into resilience with gay men has drawn on quantitative designs, yielding a wealth of knowledge and the foundation for current work (Lyons, Hosking, & Rozbroj, 2014; McLaren et al., 2008; Ngamake, Walch, & Raveepatarakul, 2014). Few studies, however, have employed qualitative methods to provide nuanced understandings about the unique stressors and life circumstances gay men experience and the protective processes integral to cultivating positive health outcomes over their lifespan. In particular, how middle-aged and older gay men develop resilience to promote health and wellness is poorly understood. Information pertaining to resilience in this demographic group is needed given the propensity of chronic illness (Conron et al., 2010; Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013). The investigation reported here was part of a larger study on health and illness practices of gay men. Permeating the men's experiences were multiple forms of discrimination which shaped their state of well-being. Consequently, discrimination emerged as a risk, and the focus was on identifying protective processes integral to the development of resilience in middle-aged and older gay men. The specific research question was:

How have middle-aged and older gay men developed resilience over time to promote health and wellness?

Background

Resilience and gay men's health

Recently, there has been an increasing interest in the concept of resilience and how it can facilitate understandings of gay men's capacities for health and illness across their lifespans (Herrick et al., 2014; Lyons, 2015) with a particular emphasis on HIV, other sexually transmitted infections (STIs), and mental illness (Dickinson & Adams, 2014; King & Richardson, 2016; Mustanski, Newcomb, & Garofalo, 2011). Within these studies, resilience is often examined in relation to the protective processes or factors that can foster positive health outcomes (e.g., family/peer support, mentors and community-based organizations). Mustanski, Newcomb & Garofalo (2011), for example, found support from family and peers (described as potential resilience processes) contributed to decreased psychological distress associated with sexual orientation-related victimization among gay youth. Another investigation reported that the risk of depression was mitigated among gay men who belonged to a gay community and had strong social ties when compared to those who did not (McLaren et al., 2008). Dickinson and Adams (2014) demonstrated that resilience processes (described as having social connections, engaging in personal reflection, having interests and hobbies, and seeking professional support such as counselling) were key factors contributing to mental well-being among gay participants. Similarly, Toro-Alfonso et al. (2006) showcased the facilitative role of building strong ties within a social support network in mitigating levels of depression within a sample of gay Puerto Rican youth.

The few qualitative investigations of resilience and gay men have also emphasized protective processes associated with resilience reinforcing the importance of such processes for gay men's health. Harper and colleagues (2014) studied young gay and bisexual men living

with HIV and identified resilience processes such as seeking support and providing support to others as integral to developing resilience. Kushner et al. (2013) demonstrated that building a strong social support network—comprising a partner, friends and/or family—was foundational to facilitating the aging process of older gay men amid homophobia and heteronormativity. What is less clear in the literature is a nuanced understanding of how gay men have developed these protective processes, what reinforces these processes, and what creates barriers. Additionally, only one published study was found (Kushner et al., 2013) that has addressed resilience in the context of the passage of time. Yet, men over 40 experience a marked burden of illness (Conron et al., 2010; Fredriksen-Goldsen et al., 2013). They have also historically experienced pervasive discrimination by virtue of sexual identity, and the generation specific risk or adversity in the form of the pre-treatment HIV era (additional discrimination via association of HIV with being gay, suffering, grief and trauma (Adam, 2005; Forstein, 2013). Ultimately, information about how gay men develop resilience and engage in processes to promote and protect their health is needed to inform service development and health provider strategies toward effectually supporting the health of gay men.

Methods

Research design

A qualitative descriptive design drawing on grounded theory methods (Charmaz, 2000) was used. The intention was not to develop a theory of resilience per se, but rather to describe how men, over time, developed resilience in the face of discrimination and how this process may have shifted over time. Grounded theory methods were employed to examine these problem-solving practices and process (Charmaz, 2006), central to the development of resilience. Charmaz (2006) asserts that discovered reality arises from the interactive processes

and its temporal and structural contexts. By applying grounded theory methods in this way, it was possible to examine the impact of contextual, historical and socio-structural elements on men's experiences of discrimination and the development of resilience.

Setting and recruitment

Ethics approval for this study was granted by the University of British Columbia Behavioural Research Ethics Board. The study setting was the city of Victoria, British Columbia, the provincial capital situated on Vancouver Island with a population of approximately 85,000 (BC Statistics, 2015). A total of 25 participants were purposefully sampled based on specific inclusion criteria to enhance understandings of the phenomenon of interest (Polit & Beck, 2008). The sampling process was aided by several men, connected to networks of other gay men, and who were known to the first author and expressed interest in the project. These men distributed the recruitment flyer at social, educational, and community-based events. At the outset of the project, men were required to self-identify as gay, be currently residing in Victoria and over the age of 18.

Data collection

Data were collected over an eight-month period via conversational, one-on-one interviews held in public spaces, including cafes, in the city of Victoria. Each interview was conducted by the lead author (IH), and verbal consent was obtained from each participant prior to initiating the interview. A verbal approach to informed consent was used with the understanding that gay men may have been subject to discrimination and stigma associated with pathologizing being gay and inaccurate conflation of gay identity and HIV risk (Adams, McCreanor, & Braun, 2013; Aguinaldo, 2008; Bungay, 2008; Flicker et al., 2015). Each participant was offered the choice of $25 cash, or a gift card for Starbucks's coffee of equal

value. To ensure voluntary consent, participants were informed that they may withdraw from the study at any time and need not offer any reason for doing so (TCPS, 2014).

A total of 25 men between the ages of 40 to 76 years, with a mean age of 54, took part in the study. Of the 25 men, 23 identified as White, 12 self-disclosed their positive HIV status and 22 had a primary care provider (defined as a family physician or nurse practitioner). Participants maintained a variety of occupations including architecture, teaching, various roles in local government and non-profit organizations, finance and accounting. The majority of men had relocated to Victoria from other parts of Canada, which many men described as a process to escape discrimination in smaller communities. Stories of being bullied or simply being regarded as "different" were pervasive when they discussed their childhoods.

To gain an understanding of how gay men developed resilience over time to promote health and wellness the questions focused on the men's everyday life experiences. As the interviews progressed, questions focused on health issues over time; for example, how issues were experienced and navigated and how sexual identity potentially impacted these experiences. To adequately capture resilience, questions were of a temporal nature addressing experiences at different time points over their life (e.g., youth, 20s, 30s, present day). By gathering information that spanned many years, the practice of resilience was made visible. Interviews were loosely structured by a topic guide comprising several questions and probes. Conversations, however, frequently expanded beyond the specifics of health and illness into a variety of personal experiences and stories that shed light on the processes that contributed to the development of resilience. Reflexive practice was employed by journaling thoughts, impressions and potential biases after each interview. The interviews were approximately 60 minutes in duration, and all were audio-recorded and transcribed verbatim.

Data Analysis

Data were collected and analyzed simultaneously, reflecting the iterative nature of grounded theory approaches (Charmaz, 2006). Beginning with several broad reads, the focus shifted to identifying recurrent similarities and differences followed by open coding, which assigned a short name or phrase to summarize sections of data (Charmaz, 2006). The preliminary open codes drew attention to recurrent concepts requiring additional exploration: namely, the prominence of men's reactions to discrimination. Constant comparison fuelled recognition of discrimination as embedded in men's resilience and, more importantly, that much of what men were doing to foster health and wellness was in reaction to discrimination.

As more data were collected, focused coding—which entailed comparing newer codes to earlier ones—commenced and memos were kept to chronicle possible connections between codes and what participants were experiencing and/or expressing through the codes (Charmaz, 2006). Memos provided an analytical account of forms of discrimination, what men did and how this impacted their approaches to health and wellness (Charmaz, 2006). Feedback was then elicited from participants to ensure effective and accurate representation (Sandelowski, 1986). Analysis culminated in axial coding, which entailed identification of the relationship between categories and subcategories. It was at this time that three main categories that illustrate the interrelated processes of developing resilience were identified (Charmaz, 2006).

Findings

Most participants described their health in positive terms, using descriptors such as "strong", "healthy" and "fit"; however, many suffered acute and chronic illness issues throughout their lives. Men also spoke about their health in the context of having experienced the onset of HIV in North America during young adulthood. During this time, care was

palliative to minimize pain and discomfort and many men experienced substantial loss of friends. It was also a period of intense discrimination for gay men. HIV was perceived in society and health care as being a "gay disease" (Altman et al., 2012; Forstein, 2013; Patton, 1988) exacerbating the ongoing pathologizing of gay men. The historical and ongoing discrimination associated with homophobia was fundamental to men's development of resilience by creating conditions in which gay men actively resisted systemic, institutional and interpersonal discrimination. In doing so participants actively engaged in resisting the discrimination they faced. Ultimately, the product of ongoing resistance was resilience via the development and implementation of protective processes over time. Three categories of protective processes were identified to illustrate the interrelation of these processes in developing resilience: (1) building and sustaining networks, (2) addressing mental health, and (3) advocating for self. Described below is how men employed these protective processes over time.

Building and sustaining networks

Most men talked about their early life experiences and provided candid accounts of pondering their sexuality and the consequent discrimination faced when living an openly gay life.[11] For many participants, one of the first strategies employed to combat adversity and buffer the harmful effects of discrimination was building supportive networks, most often with other gay men. Building these networks frequently involved leaving their home communities, particularly for those who experienced extensive bullying in their hometowns. Men described

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[11] Being openly gay was defined as voluntary disclosure of sexual identity, such that being gay was made known to the myriad individuals, groups and communities in a person's life including family members, friends, peers and employers.

moving to larger centres as enabling connection to a supportive community, an essential aspect of "coming out".

> P1: In High School we never talked about it (sexual identity) much you know, especially I grew up in Northern Ontario you never talked about it…I was conditioned, and grew up with the same notions that (gay people) 'those people are disgusting, those people do horrible things'…when I first came out in university, I went from having zero gay friends, not knowing a single gay person, to suddenly having 200 friends. Like that…that's like a real fundamental shift, to suddenly have people. (50 years old)

The emotional benefit derived from building friendships with other gay men and the level of comfort and safety bestowed by involvement in an established gay community was described as emancipatory. Nevertheless, participants spoke of the overarching socio-structural inequities that remained an ever-present obstacle. This was especially the case for participants who were young men during the 1970s and 1980s, an aggressively discriminative time period for gay men (Forstein, 2013; Lyons, 2015). During these decades, men faced significant discrimination by virtue of sexual identity in every facet of life: from the threat of eviction from housing, to fear of losing employment, to denial of visitation rights in hospital settings. To resist this discrimination, participants described facing and fighting adversity by building networks to advocate for their rights, despite the aforementioned risks that included to their personal safety.

> P1: We were marching for equal rights and public accommodation, hospital visitation I think, and employment non-discrimination because back then I still could've been fired from my job for being gay, kicked out of my apartment for being gay. This was the early 80s so like it was really complicated. You needed to be really cautious back then, with the apartment, being kicked out, or being fired. I wanted to be a school teacher and knew there was no way. (50 years old)

When discussing their teenage and early adult years specifically, the men frequently addressed living through the pre-treatment HIV era. The powerful impact of HIV on the lives

of participants was clearly evident by the prevalence of this topic in conversations, despite any

questioning on the matter. Men experienced confounded discrimination: discrimination for

being gay aggravated by the arrival of HIV. The sense of foreboding was overwhelming due

to the uncertainty about the disease and the lack of treatment options. The persistent loss and

grief culminated in a belief that death was certain for many.

> P12: I mean for me, coming out in the 80s when, that decade was, it had a lot of
> unfortunate circumstances with HIV and AIDS and all that…going into the 90s as a
> 20-year-old it's very much in your mind and it is something you never forget. We talk
> about this actually quite regularly, [name] and I, with other friends, and say oh,
> 'remember in the 80s, or remember in the early 90s?' It was like, 'oh God, you were
> going to die'…so it took a long time to pass. (42 years old)

The fear, suffering and grief dealt with on a daily basis were wrapped in the realization

that little support was available; for example, support in the form of medical treatment,

information or grief counselling. Gay men not only fought discrimination in the form of

homophobic discourses and heteronormative assumptions amid devastating loss and suffering,

they remained perseverant in their action for care, services and resources. Several participants

described their involvement in HIV/AIDS grassroots initiatives as an attempt to alleviate the

sense of helplessness that permeated that time period. Some participants described how, in

moving to action, men effectively contributed to a healing process.

> P3: When really the deep rationality of it was how community came together in the
> face of any crisis, but certainly the AIDS crisis, and we made it up. In doing so, we
> had meaning, purpose and belonging. Which induced health, which induced a sense
> of mobilization. (48 years old)

Many participants acknowledged that working through the effects of the pre-treatment

HIV era was an ongoing process. Due to the lack of resources to address this specific need,

gay men had again come together to develop supportive networks to work through the guilt

and sorrow that for many accompanied survivorship. One participant shared a community-led event that was developed to provide men the opportunity to share their experiences and emotionally support one another in various dimensions, including addressing the grief and loss incurred from HIV/AIDS. The visible, lasting impact of that loss was evident to men in a very literal way.

> P1: So [name] and [name] and like 34 gay men who went to Salt Spring Island for the weekend. You're immersed…a wonderful experience…I remember us all standing around in a circle in order of age. We kind of started with the youngest one, and that gap that existed because of AIDS. There was that actual gap in ages, whereas like these are the people we lost. People should be in this age range right here. That's who we lost. (50 years old)

The building of supportive networks developed by men served to further spur advocacy efforts and is recognized as a powerful protective process in shaping resilience. In connecting with one another, gay men derived a sense of community, emotional support and well-being that facilitated their efforts to resist and transcend discrimination. Over time, many men became more actively involved in communities, and their efforts for supporting one another grew. The passing of time served to fortify networks and facilitate advocacy as men derived strength and support from one another, fuelling their confidence as individuals and their collective efforts in fighting for equity.

Addressing mental health

Despite participants describing their health optimistically, a multitude of health issues were disclosed and included mental illnesses spanning anxiety, depression, bipolar disorder, posttraumatic stress disorder (PTSD), and suicidality. These mental health challenges were directly connected to discrimination and how it is interpersonally, institutionally and structurally enacted in the day-to-day life of gay men (Ferlatte et al., 2015; Mustanski,

Andrews, Herrick, Stall, & Schnarrs, 2013). Substance use, also directly related to discrimination (Aggarwal & Gerrets, 2014; Mustanski et al., 2013), was another persistent challenge and most often included alcohol, marijuana and "party drugs" (e.g., methamphetamine, cocaine and ecstasy). Most participants shared that mental health challenges and substance overuse eventually necessitated the involvement of health services. Initiating contact for health services, however, was described as extremely exigent because many men had faced multiple discriminations within health settings. Consequently, the potential for discrimination was a major obstacle to seeking help, but one that participants surmounted due to recognition of their need for support.

Men often talked about mental illness throughout their lives as occurring amid emotionally challenging situations, such as acknowledgement of sexual identity and living through the pre-treatment era of HIV. Anxiety was commonly discussed in the context of the coming-out experience and was often debilitating and all-consuming; for some, it was incited by recognition of sexual identity and identified as the greatest health challenge faced.

> P12: I felt sick and insecure, and I felt so scared, terribly scared. And the insecurity is just, it's beyond description, it's just this vacant, void feeling in the pit of your stomach that is just so hollow…it is exhausting…it wears you down. It kills your spirit. It forced me to go [to see a psychologist]…It was helpful to admit that I was gay and I had never admitted it aloud up until that point…it took like five sessions to say it. Once it was said there was a portion of weight that was lifted off my shoulders, and yet the journey continues but that was the first step. (42 years old)

For this participant, garnering the support of a health professional was incumbent to fostering health. Through the process of regularly meeting with a trained therapist, he was able to address, and to some degree alleviate, the crippling anxiety that was taking a marked toll on his well-being.

Depression was stated as a significant concern, perhaps even the most prominent and debilitating health issue currently affecting gay men.

> P2: It's micro-crises. We're seeing it in depression. Not that I, I don't identify as being depressed but because so many people around me, certainly so many gay men in the context of our conversation here, it's like, that is a cultural miasmic state. (48 years old)

Homophobia and heteronormativity are recognized as discriminative processes that contribute to depression (Choi, Paul, Ayala, Boylan, & Gregorich, 2012; Lyons, 2015). For many participants, depression was perceived as stemming from deeper sources, an issue rooted in unaddressed emotional conflict and trauma. For example, the disruption of family relationships after disclosing sexual identity was a major source of sadness for a number of participants. In some cases, men had not spoken to family members for years because of the conflict that emerged on the premise of sexual identity.

> P8: Yeah, because even when I went back home my Dad, I haven't seen my parents for 18 years, so, and I just talked to my mother through the phone. And my Dad basically disowned me, so, because I was gay and he just couldn't accept it. (49 years old)

For many, seeking the support of others was greatly facilitative to addressing and working through depression. In creating dialogues about depression within social networks, men described how the prevalence of depression became evident and they no longer felt alone in their struggles. Having established relationships within which men felt cared for and safe enabled conversations about depression and further set the stage for potentially asking for professional help and connecting with health services. Of key importance was men's acceptance of depression and no longer viewing the need to ask for help as weakness. For these men, their networks served to provide support that was two-fold: emotional support that was

beneficial for addressing depressive symptoms, and relationships that created a space for conversations about getting connected to health supports, as articulated by this participant.

> P21: Ask for help. Have an advocate. Peer navigation. People taking care of people. It's a gift. My need for help doesn't mean there is anything wrong with me. It actually means we're in a help and healing process together. (48 years old)

This participant delineated how, in asking for help, he actually served to further strengthen his support network. In asking for help he contributed to a greater supportive process that illuminated the fact that many others had, or were currently experiencing, similar challenges. The strength derived from support networks fostered many men's ability to voice their health issues and seek help because they felt cared for, highlighting the mutual help obtained from supportive communities: the affirmation of struggles as real and common coupled with the sharing of strategies for identifying cause(s) and addressing depressive symptoms.

Many participants identified that they and other gay men continued to suffer from depression because of a dearth of appropriate resources. This was especially evident in the case of depression stemming from living through the pre-treatment HIV era. Some thirty years later, the lasting effects of the pre-treatment era were evident in the men's narratives. Loss became a fixture of daily life that persisted for many years and was only truly understood by those who lived during this time period. The need for a space to express the feelings rooted in the trauma experienced during pre-treatment HIV was identified as a crucial need.

> P2: There's also this culturally induced shame of long-term survivorship which is such a blanket statement that hasn't necessarily been mapped out…that's where there's a lot of depression out there. We're still carrying the burden. A lot of conversations and experiences people haven't talked about. There's no space to talk about it. (48 years old)

Several men spoke to the value of individual and/or group counselling, but it often took years to connect with such a resource. In almost all cases, men instigated connecting to a service because the sorrow had become overwhelming, and even the support of friends, peers, and partners was insufficient in alleviating the grief. Supportive networks, however, played a critical role in the development of resilience by facilitating community acknowledgement that depression exists widely, and by facilitating men's propensity to reach out for help.

Mental illness was often intertwined with substance use as participants sought to obtain what they described as obtaining "relief" from debilitating anxiety, fear and depression. Alcohol was the most commonly cited substance used in this context. For some men it allowed for a level of functioning and normalcy by blunting depressive symptoms. Alcohol consumption as a relief strategy usually continued until it was no longer effective, or a health crisis situation arose.

> P6: I wasn't asking for help, I was in active addiction. I tried to take my own life on several occasions. Damn near did it right the last time… if you can't ask your doctor for help, ask a friend, ask somebody you know because they might know something…don't be afraid to ask for help, because you'll get it. There's lots of it out there if you're willing to seek it out. (56 years old)

How participants conceptualized "addiction" was a major barrier to seeking help due to disclosure of frequent media portrayal of individuals with substance use problems as street-involved and impoverished, which was not the case for most participants. Even after reaching out for help some men struggled with their perceptions of addiction and stereotypes about individuals who use substances.

> P6: Even walking in the door at the addictions outpatient treatment centre on [street], I didn't think I belonged there. I had until recently been employed, I'm a professional, in my own mind I didn't think I was an addict. I don't know how I couldn't recognize that, but to me those were the people you find living under a bridge or on the street,

but I guess I was a functional addict, until I wasn't. With the PTSD, the drugs lower your PTSD symptoms until you stop using and your PTSD symptoms take off again so it's a vicious cycle. (56 years old)

For many men, an individual or a supportive network was crucial to cultivating self-acceptance with regards to viewing substance use issues. For some, it helped coming to terms with recognizing that use can affect anyone, regardless of social positioning, and thereby prompt getting the necessary support(s). Substance use, however was entrenched as a means of reprieve: substances diminished some of the feelings associated with acts of discrimination during youth and proceeded to address the symptoms of depression later on. Substance use was, however, a double-edged sword in the development of resilience. There was temporary relief of mental health symptoms, but this was coupled with the risk of exacerbating those same illnesses. Furthermore, "recreational" substance use was frequently regarded as the norm in many social circles/supportive communities; therefore, ceasing use could run the risk of a degree of separation from those supportive networks. Substance use is entrenched as a means of reprieve. Men experienced relief from discrimination during their youth and currently from the debilitating symptoms of depression (rooted in discrimination) when using substances. Substances ultimately continue to provide temporary relief but posed the danger of exacerbating mental illness and potentially disrupting resilience.

Advocating for self

Developing the strength to stand up and advocate for oneself was a process that developed over time and was largely influenced by experiences within health settings. In particular, advocating for the self was strongly developed in relation to discrimination within the health system and, more importantly, how gay men resisted discrimination. Ultimately, these incidents were foundational to the development of resilience. As stated earlier, in many

cases despite men connecting to health services by their own volition, discrimination in these settings enacted by health professionals was a persistent issue. Many men resisted this discrimination by confidently advocating for their health needs. According to participants the discrimination within health settings drew on stereotypes wherein health care professionals pathologized HIV risk as entwined with sexual identity, as outlined by this participant who reflected on an interaction with a physician.

> P5: So if I keep hearing things about venereal diseases, and I've told you already I'm not promiscuous, I have a partner. That should be the end of it. If I was a straight woman, would you be having this same conversation? So I question that when it happens, and it has happened in the past. (56 years old)

To combat these assumptions men would, as this participant did, question the conduct of health professionals. Such assertiveness necessitated a level of confidence to address the health professional's approach and inappropriate and harmful judgment. This self-advocacy was the product of confidence and proficiency that had developed over time. Men recognized that if they wanted their needs met, they would have to make it happen.

Some discrimination was more blatant wherein some participants explained in the interview that they exited health interactions due to mistreatment. Ultimately, men wished to have their health issues dealt with and did so by accessing a different health provider. A number of these situations involved HIV being broached in a flippant, insensitive manner, without any consideration as to how referencing this chronic illness might affect the individual in question.

> P14: It became really chronic tonsillitis and by that time I had informed my family doctor of that, of my sexuality…and he goes, well, either you have tonsillitis or you have AIDS…I never questioned him on his statement to me…so I went in after my checkup and pulled out my file and flipped it open. I am at the receptionist desk and

I flip it open…and on one page unto itself is the word HOMOSEXUAL in big letters…I didn't confront him, I just moved on … (51 years old)

For participants living with HIV, many described obstacles when dealing with health professionals. The most prominent issue was the shaming of gay men who disclosed HIV infection and which remains an ongoing issue for many. In particular, recurrent among participants who had HIV were accounts of providers insinuating their recklessness and lack of responsibility in contracting the virus. Initially, these incidents left men feeling shamed and embarrassed. Over time, however, men reflected and recognized these episodes for what they were: exemplars of glaring discrimination.

P7: I didn't get tested until 1995 and I came down with shingles and thrush at the same time and shingles was on my face. So I went to the hospital, so this is homophobia, I went to the hospital. Lying on the gurney and waiting for the doctor, waiting, waiting, waiting and finally the doctor shows up…I say, I'm a gay man…it's 1995 it's most likely HIV. And he just looked at me and all he said was 'well, you know as a gay man you should be using condoms when you're having sex'. (53 years old)

The incident had occurred over 20 years ago, but at the time he did not view the interaction as discriminatory; rather, his reaction was embarrassment and shame over his HIV status. Over time, however, he was able to critically reflect on this interaction as a flagrant example of discrimination. Many men described their engagement with supportive communities, advocacy, and connection to meaningful health resources as facilitative to confidence building, which in turn helped enable recognition of discrimination. In this way, several protective processes were recognized as fortifying men's confidence and ability to self-advocate. In addition, the passing of time was crucial: over the years, men built and engaged with supportive networks and received effective support with health issues. This served to

build and fortify their confidence as individuals, which then permeated all facets of life, including health service settings.

Confidence and proficiency was demonstrated not only by the ability to advocate for their health needs, but by actively gaining knowledge of various health issues to enable informed conversations with health providers. This proficiency with health services and health knowledge was a particularly marked shift for older men who had grown up in the 1960s, 1970s and even 1980s—a time when health provider approaches (namely physicians) were seldom questioned (Goodyear-Smith & Beutow, 2001; Parsons, 1951). Due to the confounding effects of discrimination and a strained health system (that frequently translated into shorter windows of time with primary care providers) participants stressed the importance of being informed and organized in order to have their health concern(s) adequately addressed.

> P11: I have, and both doctors that I went to, my old GP and the new one, they laugh because I always have a list…you certainly get the sense of how much time they're going to have or how chatty they are and you prioritize the list…some of the stuff, if it's really important then I bring it up, or at least say I want to talk to you next time, or I need to make another appointment…so you learn to prioritize, re-evaluate, or evaluate or whatever. (60 years old)

The participant outlined being organized and informed as essential to having his health needs met. Here he took the initiative to gather information and maintained awareness of time constraints on the part of the provider, a factor that he recognizes directly affects his care. By being informed and engaged he maximized the health visit and ensures his concerns are addressed, in turn fostering his health and well-being.

Though remarkable proficiency was demonstrated in health service settings, the lasting impact of adversity was evident in the importance placed on the need for safety. Countless years of discrimination necessitate a safe place for care delivery. This is also evidenced by the

many participants who continued to see primary care providers in Vancouver due to established rapport and acceptance. When asked to describe a safe place, simply an indication that the health service was open and accepting of individuals who identify as gay would suffice, as articulated by this participant, involved with a local AIDS Service Organization (ASO).

> P4: People I think are afraid to come out, like in the health care system, like the doctors, you don't see anything that advertises diversity welcome in the community. So people are kind of scared to approach…I think a lot of people are being missed in the gay community because of that factor. Sure, if we've lived here for years we know where all the places are, but someone new coming in doesn't know that. (46 years old)

Preference of a gay health provider was indicated by some; however, most men stated that providers must simply be open-minded and express genuine concern for the health needs of the consumer. Being prompted by discrimination to speak up, resilience was bolstered by the ability to not only advocate for health needs but to also insist on a respectful provider. By refusing to engage in a negative and potentially harmful environment, men set a precedent for their health that ensured meaningful and effective health delivery in the form of a respectful provider. In doing so, participants greatly contributed to the cultivation of their own wellness.

Discussion

The purpose of this investigation was to explore how middle-aged and older gay men developed resilience over time; specifically, identifying the external protective processes that comprise resilience to promote health. The extensive discrimination experienced by gay men solely by virtue of their sexual identity is recognized as a structural risk factor that played out over the course of life. Ultimately, resistance to discrimination in the form of the three interrelated protective processes prompted developing resilience. In the following section four key insights are discussed: the contributions of this study to the gay men's resilience literature,

discrimination as a determinant of health, the utility of equity-oriented primary health care (PHC) for health service delivery, and the integration of safety into an equity-oriented PHC design.

This is potentially the first qualitative investigation into resilience development among middle-aged and older gay men. The sample, however, was predominantly comprised of White educated men, representing a particular social location that bears influence on the development of resilience. Currently, gay men's resilience research has focused on young men, emphasizing the extensive adversity faced during adolescence (Herrick et al., 2014; Herrick et al., 2011). However, the findings highlight that discrimination continues to be a current fixture in gay men's lives, necessitating the ongoing development and implementation of protective processes. In particular, building and sustaining networks was found to be a central protective process to resilience, as stated in the literature (Herrick et al., 2012; Herrick et al., 2014).

The findings indicated involvement in formal networks (e.g. HIV grassroots initiatives) in early adulthood was integral to health promoting by laying the foundation for continued engagement with networks of gay men throughout life. The protective process of addressing mental health offers preliminary insight into how gay men promote their mental health, and signals the importance men placed on mental health. This is a key finding given the dearth of information on gay men's mental health promotion, despite extensive documentation of mental illness and emotional distress among gay men (Conron et al., 2010; Wright et al., 2012). Furthermore, the integral role of time to resilience development was also identified: time contributed to the development of illness via discrimination, but also to experience and confidence through years of learning how to respond and ultimately thrive. Advocating for respectful care encounters speaks to ongoing discrimination in health settings and recognizes

gay men to be informed, responsible health care consumers, in opposition to the discourses that position gay men as irresponsible (Adam, 2005; Forstein, 2013). Attention is paid to the shift in confidence that accumulated over time, especially for older men who had grown up in the 1960s, 1970s and even 1980s—a time when health provider approaches (namely, physicians) were seldom questioned (Goodyear-Smith & Beutow, 2001; Parsons, 1951).

Despite recent societal strides toward equity for individuals of diverse sexual orientations and genders (Berg, Ross, Weatherburn, & Schmidt, 2012) being greatly driven by individuals from within these specific communities, discrimination remains a pervasive obstacle to health. The historical and ongoing experiences of discrimination directly contribute to health inequities for gay men (Ferlatte et al., 2015; Mustanski et al., 2013). To fully support the health of gay men, discrimination must be situated as a determinant of health (Krieger, 2014). Several major pathways have been theorized that link discrimination and health inequities, including: economic and social deprivation, social trauma, health-harming responses to discrimination, and inadequate medical care. These insights have been drawn from ecosocial theory to demonstrate specifically how exposures (e.g. discrimination) from our societal contexts are biologically embodied, creating the potential for health issues (Krieger, 2014). Fundamental to this framework is recognition of the individual's power and ability to act in response to risk exposure to enable understanding how health inequities are monitored, analyzed, and addressed. Active resistance of discrimination was a key finding in this study: gay men are not passive victims of discrimination, but rather they actively resisted historical and ongoing systemic discrimination to develop resilience over the course of their lives. Essentially, gay men responded to discrimination with tremendous strength and tenacity to overcome the adversity present in their everyday lives.

The pervasiveness of discrimination behooves socio-structural-level change to ensure people of various sexual and gender identities enjoy the same civil liberties as everyone in society. Dismantling the structures that perpetuate discrimination is a huge undertaking that will require more time; therefore, practical strategies to support individual efforts are needed in the interim (Browne et al., 2016). One such approach gaining momentum is equity-oriented primary health care (PHC) (Browne et al., 2016), which has been demonstrated as an effective means to support the health of individuals within groups that have been subject to systemic disadvantage (Starfield, 2006; WHO, 2008). For gay men, an equity-oriented PHC approach would necessitate recognition of historical and ongoing discrimination as the fundamental systemic contributor to the health inequities many gay men face.

An equity-oriented PHC framework would take knowledge of systemically induced inequities among gay men and integrate this information into practical strategies via four general approaches: partnerships with gay men, action at all levels (patient–provider, organizations, systems), attention to local and global histories, and attention to unintended and potentially harmful impacts of each strategy (Browne et al., 2016). To begin, allied health professionals must advocate for the development of needed policies and processes within their organizations to support the development and implementation of equity-oriented PHC services. Findings from this study showcase that health providers are in need of guidance to meaningfully support the health of gay men. Discrimination toward gay men by health providers was prominent in this study and although possibly unintentional, was nonetheless harmful, a finding well-substantiated in the literature (Alvy et al., 2011; Knight et al., 2012). Furthermore, the need for support guidance for providers regarding HIV treatments and health needs of individuals with HIV is indicated. The findings showcased men with HIV face unique

challenges in the health setting; namely, perseveration by health providers on HIV status. Many concerns were overlooked or ignored because of the emphasis on HIV, a finding which is supported in the literature (Robinson, Petty, Patton, & Kang, 2008). The need for updated knowledge for providers regarding HIV treatments and training to address health issues for individuals who are HIV positive is indicated to ensure health issues and concerns are not overshadowed by HIV.

Equity-oriented PHC would also support the resilience demonstrated by gay men: despite the numerous challenges and unfavourable health care experiences the participants shared, the overwhelming majority of men displayed an unwavering dedication to maintaining and bettering health. In accordance with the resilience literature specific to sexual and gender identity diverse populations, men's development of supportive social networks is integral to cultivating wellness and optimism (Harper et al., 2014; Kushner et al., 2013). Appreciating the value of supportive networks as fuelling resilience via complex interactions at the personal and interpersonal level necessitates additional research to inform the development of meaningful support services for gay men. The findings from this study indicate that men in Victoria would benefit from established, community-based peer networks to be able to connect and engage with other gay men. Such community-based services would also prove beneficial in addressing health issues, most notably, those that were prevalent in this investigation: anxiety, depression and substance use. Of specific note is the need for such a service to support men experiencing depression rooted in HIV pre-treatment trauma and men who lived the experience are in the best position to determine what will be most effective in terms of service design and delivery (Bates & Berg, 2014; Im & Rosenberg, 2016; Thupayagale-Tshweneagae & Mokomane, 2014). The literature is rife with support for the effectiveness of such services for gay men,

principally with regards to HIV and STI prevention (Harris & Alderson, 2007; Veinot, 2010; Yun Gao & Wang, 2007).

The development of primary care services inclusive and sensitive to men of varying sexual and gender identities is indicated and would benefit from an equity-oriented PHC design. Drawing attention to the impact of systemic discrimination is fundamental; for example, the importance of establishing the health setting as a safe place was a finding of key importance to middle-aged and older gay men. Mostly, this translated into something as simple as a rainbow flag placed conspicuously to indicate an acceptance of diversity. Other men stated that a listing to identify gay-friendly health services would greatly improve men's access, especially when considering newcomers to the city. Considering that access to health has been identified as a key determinant of health (WHO, 2013) this finding is integral to the health and well-being of gay men. In particular, it has been reported that older gay men are five times less likely to seek health care and social services out of fear of discrimination (Sharma, 2006). If men do not feel safe then they will not access services, as described at length in the gay men's health service literature (Alvy et al., 2011; Quinn et al., 2015). Unfortunately, the generalized dearth of primary care options in Victoria currently (specifically, family physicians) confounds this issue. Many participants expressed their discontent with walk-in clinics, primarily due to the inconsistency with regards to health providers: in essence, you rarely see the same provider twice, creating difficulty in developing rapport and communicating health issues of a more sensitive nature (e.g., sexual health issues). Consequently, several participants maintain a family physician in their former place of residence (namely, Vancouver), which incurs travel costs and is impractical. The need for appropriate, meaningful primary care services for gay

men equipped with respectful, open-minded health professionals is greatly indicated to provide support and guidance to gay men.

This study has a number of limitations. First, the snowball sample entails potential exclusion of men who are not necessarily connected to other gay men, or who are not openly gay. Data were not collected pertaining to relationship status, socioeconomic status or age of "coming out", all of which could influence the development of resilience. Also, the sample predominantly consisted of White, well-educated men, which necessitates further investigation of ethnicity, education and socioeconomic status on the development of resilience. The study was also limited to gay men, meaning that investigations into other sexual identities such as bisexual, are needed. Lastly, all the men in this sample were facing health issues warranting further investigation into how absence of health issues potentially differs with regards to resilience development.

Conclusion

The findings from this investigation highlight the profound discrimination faced by middle-aged and older men and the remarkable resilience participants cultivated through actively resisting discrimination. Discrimination continues to be a tremendous stumbling block to health. Dismantling structural discrimination is a priority, but a massive undertaking. In the meantime, equity-oriented PHC is a possible approach to providing practical strategies to support men's resilience while addressing the overarching structural discrimination that warrants investigation. The need for health services provided by health professionals aware of the health issues that affect some groups of gay men, coupled with open-mindedness and respect in care delivery, are significant. This sample of men demonstrated, despite various health complications and challenges, a tenacious commitment to maintaining and improving

health and well-being. Health support services for gay men must be developed upon a foundation that recognizes systemic discrimination while supporting men's resilience.

CHAPTER 4: OVERCOMING ADVERSITY: A GROUNDED THEORY OF HEALTH MANAGEMENT AMONG MIDDLE-AGED AND OLDER GAY MEN

Introduction

There is substantial evidence that gay men are overrepresented in many health issues compared to heterosexual men (Brennan et al. 2010; Eaton et al., 2010; Ferlatte et al., 2015). The emphasis in the gay men's health literature has been on HIV and other STIs (Eaton et al., 2010; Gastaldo et al., 2009; Klein, 2012), but more recently, mental illness including depression, anxiety, suicidality and substance use have drawn attention (Aggarwal & Gerrets, 2014; Ferlatte et al., 2015; Wang et al., 2007). In particular, middle-aged and older gay men (40 years and older) are at risk for not only HIV but also mental illnesses such as PTSD, depression and suicidality and substance use (Conron et al., 2010; Wright et al., 2012). This body of work emphasizes the deep connections between physical and mental health; however, the two have been historically disaggregated in research pertaining to gay men.

A growing body of knowledge positions gay men's health problems as the consequence of social inequity and unjust oppression and discrimination (Aggarwal & Gerrets, 2014; Ferlatte et al., 2015; Mustanski et al., 2013), thereby shifting the language of health disparities to health inequities and showcasing the social processes (namely, multiple forms of discrimination) that contribute to illness among gay men (Aggarwal & Gerrets, 2014; Ferlatte et al.; Mustanski et al., 2013). There is also preliminary evidence illustrating that gay men are active in managing their health although much of this work has focused on gay men's engagement with the health care system in the context of HIV and other STI treatment and prevention (e.g., Blackwell, 2015; Coleman et al., 2017; Grella et al., 2009).

Health management is a broad concept that encompasses the variety of health and illness practices employed by individuals to promote health and address and navigate illness (Bourbeau & van der Palen, 2009). The term is frequently used in the chronic health literature to describe the practices employed by individuals to address illness and improve health outcomes but is often limited to help-seeking (Grady & Gough, 2014). However, because management as a concept infers a methodical approach to identifying approaches and courses of action (Bourbeau & van der Palen, 2009) health management in the context of this dissertation was extended in specificity beyond the identification of practices to further consider process; particularly, the specific processes by which middle-aged and older gay men employ health and illness practices to promote their health and address and navigate illness. Currently, there is a dearth of knowledge pertaining to how middle-aged and older gay men manage their health outside of engagement with the health system pertaining to HIV and STI prevention and treatment. Without this information, current public health and primary care programs may have limited effectiveness in improving health outcomes. Therefore, the purpose of this study was to describe the processes by which middle-aged and older gay men manage their health.

Background

Discrimination, gender and health outcomes

The interpersonal discrimination towards gay men (homophobia) and overarching heteronormativity are influenced by gender as a social process embedded within power relations. Gender as a multidimensional construct used to understand health and illness (Johnson & Repta, 2012) is often closely linked to sexual identity due to societal and self-expectations regarding sexual attraction and desire (Deutsch, 2007; Numer & Gahagan, 2009).

Sexual identity is subject to immense scrutiny, especially when it resides outside heterosexual practices (Yep, 2002). The discrimination gay men face has been directly linked to poorer health outcomes that include HIV risk and psychosocial issues (Ferlatte et al., 2015). A Dutch study echoed these findings, showing that despite the Netherlands' progressive gay rights movement and social policies, heteronormative values prevailed in schools (Aggarwal & Gerrets, 2014). Consequently, acceptable male behaviours were constructed within a heteronormative masculinities framework, internalized by young gay men and strongly associated with increasing rates of mental health issues (Aggarwal & Gerrets, 2014). This growing body of literature demonstrates that discrimination is harmful to the health of gay men by contributing to HIV susceptibility and suicidality, and further supports Krieger's (2014) assertion that despite ample evidence showing that discrimination is harmful to health it often remains unacknowledged as a determinant of health.

Gay Men's Health Management

Despite evidence that gay men experience significant health concerns there remains limited knowledge of the processes that gay men use to manage their health. This oversight is particularly important for middle-aged and older gay men, who have been notably absent in gay men's health literature despite nascent evidence indicating a disproportionate burden of illness among this subgroup (Conron et al., 2010; Fredriksen-Goldsen et al., 2013). Health management refers to individuals' processes and practices to promote and protect their health over time, including establishing and maintaining health and navigating illness (Cameron & Leventhal, 2003). Ecosocial frameworks highlight the complexity of health management processes wherein individual practices are embedded within larger social systems, accentuating the interactive characteristics of individuals and environments that underlie

health outcomes (Sallis & Owen, 2015). Consequently, the practices incumbent to health management are directed to promoting health according to social and financial conditions, as well as navigating the psychosocial complications associated with illness (DiClemente et al., 2007).

While the importance of health management has been illustrated in diverse contexts including diabetes (Bodenheimer, Lorig, Holman, & Grumbach, 2002) and arthritis (Holman & Lorig, 2004), there is a veritable dearth of information in the context of gay men's health outside the realm of the acquisition and transmission of STIs and HIV. Ultimately, research efforts have primarily been quantitative and emphasized men's sexual practices as influential for STIs and HIV susceptibility (e.g., Dickinson & Adams, 2014; King & Richardson, 2016; Mustanksi, Newcomb, et al., 2011). A key component of these studies has been consideration of if and how discrimination influences sexual practices and consequently, HIV and STI susceptibility. Many of these studies have considered specific ethnic groups (e.g., African-American, Latino) that are overrepresented in HIV and STIs in the United States (Goldhammer & Mayer, 2011; Rhodes et al., 2015) or within counties where same-sex relations remain criminalized (Wirtz et al., 2014). Findings from these investigations have indicated that discrimination, defined as stigma or internalized homophobia, was correlated with increased number of sexual partners, substance use and unprotected anal intercourse (UAI).

The few studies that have considered men's health management inclusive of, but not limited to, sexual health practices focused on engagement with social supports as important health management processes (Harper et al., 2014). In one study of older (defined as 65 years and older) gay men, their experiences of interpersonal discrimination (homophobia) were reported as negatively influencing health and could be mitigated by the development of strong

supportive networks—consisting of partner(s), friends and/or family (Kushner et al., 2013). Furthermore, Mustanski et al. (2011) found support from family and peers contributed to decreased psychological distress associated with sexual orientation-related victimization among gay youth. Dickinson and Adams (2014) also demonstrated that having social connections—along with engaging in personal reflection, having interests and hobbies, and seeking professional support such as counselling—were key contributors to mental well-being among gay participants.

Other researchers have focused on engagement with health services as a health management strategy, again primarily in the context of STIs and HIV. Studies were specifically concerned with sexual help-seeking[12] and gay men's experiences with HIV and STI health services (Guy et al., 2010; Maulsby et al., 2014; Tong et al., 2013; Wall et al., 2010). Discrimination was reported as a significant issue for engagement with, and receipt of, effective health services. Men felt uncomfortable accessing services due to being gay, and expressed a discomfort in disclosing sexual identity in clinical encounters (Guy et al., 2010; Maulsby et al., 2014; Tong et al., 2013; Wall et al., 2010). One study cited heteronormativity as a major concern and reported gay men were constructed by health care providers as the "risky other, in opposition to heterosexual men as the (hetero)normal" (Knight et al., 2012, p. 1).

Discrimination has also been cited as an impediment to health service engagement for health issues beyond STIs and HIV (Dean et al., 2000; Meyer & Northridge, 2007; Quinn et al., 2015). Studies indicate health providers' generalized overemphasis on HIV and other STIs

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[12] Help-seeking is described as men's willingness to seek help from health services for a variety of health problems (Johnson et al., 2012; Smith et al., 2007).

perpetuated by discourses that position gay men as hypersexual and/or deviant and conflate gay men with illness (Adam, 2005; Adam et al., 2014; Race, 2010), which resulted in decreased access to health services such as primary care. Other studies noted that gay men were less likely to report a recent medical visit when compared to heterosexual men (Alvy et al., 2011) and were reticent to disclose their sexual identity to providers, which contributes to oversights in care (Quinn et al., 2012).

Ultimately, there is growing interest in understanding how gay men manage their health, inclusive of prevention, promotion and managing illness, with a broader perspective of health that appreciates the interconnectedness of physical and mental health. Currently, the research in gay men's health management has been somewhat limited to the realm of STI and HIV infection susceptibility. This study provides timely and important exploration of the health management practices of middle-aged and older gay men. Consequently, the research question was:

What are the processes by which middle-aged and older gay men manage their health?

Methods

Research design

This study employed a grounded theory design as it is particularly well-suited to an examination of the processes underpinning the management of health and illness (Charmaz, 2006). In particular, Charmaz's (2000) approach to grounded theory was employed as it allowed for appreciation of contextual circumstances and processes; namely, gender and sexual identity. Charmaz's (2006) approach to grounded theory ensured that men's experiences would be examined as situated within power and inequity, with specific attention paid to discrimination at the interpersonal and socio-structural levels during analysis. By

integrating gender and sexual identity embedded in inequity and power, a rich nuanced understanding of gay men's health management was possible.

Setting and Recruitment

Following university ethics approval the data were collected in Victoria, British Columbia, the provincial capital with a population of 85,000 (BC Statistics, 2015). Inclusion criteria were as follows: men who self-identified as gay, age 40 and over (middle-aged and older), English-speaking and residing in the Victoria area. The sampling process was aided by several men who were connected to networks of other gay men, and who were known to the author and expressed support for the project. A recruitment flyer was developed and distributed by these individuals at community-based, social and educational events. In doing so, a snowball sample evolved whereby participants furthered recruitment efforts by passing along the recruitment flyer to prospective individuals within their social, educational and community circles.

Data Collection

Data were collected over an eight-month period via conversational, one-on-one interviews held in public spaces such as cafes in the city of Victoria. The individual interviews were used to encourage story-telling with depth and breadth without interruption (Mischler, 1991). The use of conversational interviews facilitated the opportunity for participants to give accounts of their experiences in their own everyday language in a sequence unhampered by rigid questioning (Brown, 1995). Verbal consent was obtained prior to each interview conducted by the first author (IH). Each participant was offered the choice of $25 in cash, or a gift card for Starbucks's coffee of equal value to acknowledge their contribution to the study. To ensure voluntary consent, participants were informed that they could withdraw from the

study at any time without needing to offer any reason for doing so (TCPS, 2014). In total, 25 men ranging in age from 40 to 76 years (mean of 54 years), took part in the study. Twenty-three self-identified as White and most had completed some post-secondary education. The participants had a variety of occupations spanning architecture, teaching, various roles in local government and non-profit organizations, finance and accounting.

Conversations were organized around a topic guide comprising several questions and probes to build rapport that were informed by the literature on health management and the experience of the research team. As the interviews progressed with each participant, questions focused on health issues throughout the participants' lives and how they engaged with these health issues. This approach supported recognition of potential changes in practices over time; for example, how issues were experienced and navigated during the teen years and early 20s vs. present day, and how sexual identity and gender politics and practices potentially impacted these experiences. Conversations followed the lead of participants, beyond the specifics of health experiences to health management and life experiences more generally, most often drawing attention to the ubiquity of discrimination in men's lives. The interviews lasted approximately 60 minutes, were audio recorded and transcribed verbatim by an experienced transcriptionist.

Data Analysis

As per the iterative nature of grounded theory approaches, data were collected and analyzed simultaneously (Bryant & Charmaz, 2007). The first step was a broad read of each interview transcript to establish familiarity with the text and an opportunity to reflect on the information as a whole (Charmaz, 2006). Next, open coding commenced wherein large portions of data were summarized by assigning a short phrase. The inductive process of

constant comparison was then used to establish patterns (Charmaz, 2006). For example, open codes included "going to the YMCA 3x/week to boost energy levels", "telling the physician about concerns regarding side effects of the medication" and "being bullied in high school". Analyzing the data in this way facilitated identification of processes by coding participant histories. Next was focus coding, which drew further attention to recurrent concepts in the data such as discrimination in multiple contexts that necessitated further exploration and guided subsequent interviews. The impact of gender and sexual identity on perceptions and health management decision-making was assessed at this time; in particular, how men dealt with numerous issues and experiences associated with gay identity such as discrimination, health issues, problematic engagement with health services and of HIV. Memo-writing by the researcher was integral and included questions and/or thoughts about how the codes were related and what participants were experiencing (Charmaz, 2006). For example, "staying away from sugar, exercising, all of the healthy living talk, this is all part of a larger overarching process". Memos also integrated sexual identity and gender by questioning and reflecting on how men managed their health amid the numerous issues and experiences rooted in gay identity; for example "the physician is ignoring the health inquiry, keeps looping back to HIV = huge barrier for the participant, has to keep asserting what he needs" and "contextual pieces of discrimination, being treated badly by health professionals and HIV are all a part of this knowledge-as-responsibility focus, how is this best articulated?"

Selective coding began as data saturated on key processes. At this time, the codes were examined for processes and actions to yield three thematic processes. Theoretical coding then commenced, and category linkages were tested to further refine the theory and identify the central or core process that account for the variation in the data. To ensure accuracy, feedback

and guidance were elicited from participants to clarify data interpretation (Charmaz, 2006; Sandelowski, 1986). Feedback was obtained by providing participants with a short summary document that outlined preliminary themes via email[13], twice during the analyses.

Findings

The men who took part in this study faced an array of acute and chronic health issues. Twelve participants, for example, were living with HIV, five had rheumatoid or osteoarthritis and 16 reported struggling with varying degrees of anxiety, depression, suicidality and/or substance overuse. Men recognized the complexity of their health and were invested in living a long and healthy life. Health was described specifically as a process of living a life full of possibility, a situation influenced by their experiences during the 1980s and 1990s where they witnessed substantial suffering and death of peers and community members associated with HIV and AIDS. The men discussed life as being fragile and how their experiences with the loss of friends, family and partners fuelled their perception of health as the means to not only survive, but to also have the opportunity to enjoy, engage and live life to the fullest:

> P2: So it's not just the opposition of health and illness, but health equals what's possible. What I can do now with the privilege of energy, vitality, interest, passions, ability. So yeah, it's the ability to have a vision of what's possible is not just the product of health, but the role health plays, it's what health does: it allows. (48 years old)

Participants were involved in varied activities to help them achieve their wish to live a long and healthy life. These activities were developed over the course of their 40-plus years and reflected a series of processes shaped by the need to manage the everyday complexities

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[13] At the outset of each interview participants were asked their willingness and permission to be contacted via email to provide feedback during analysis.

associated with being a gay man in a predominantly heteronormative society. Men grappled with historical and ongoing discrimination and its effects on their health and health care. Consequently, their stories reflected that overcoming adversity was the central process by which they strove to achieve a healthy life, the details of which are discussed below, first presenting overcoming adversity as the nascent theory of managing health and then the interrelated processes involved with how overcoming adversity was enacted in managing their health.

Overcoming adversity

Of fundamental importance to how middle-aged and older gay man manage their health is appreciation of the years lived in an overwhelmingly heteronormative society. It is well known that gay men have historically faced tremendous interpersonal and structural discrimination that precipitated numerous issues and experiences proven to be major obstacles to well-being—this continues today. Consequently, health management necessitated grappling with these interconnected issues and experiences and the harmful, lasting effects thereof. As Krieger (2014) notes, discrimination contributed to harm in a myriad of ways by means of psychosocial stress and the biological consequences of exposure to toxic stress throughout their lives: examples in this study included men being bullied, denied residency in certain buildings, job opportunities and partner visitation in health care settings (Handlovsky, Bungay, Oliffe, & Johnson, in review).

This, in turn, contributed to the development of numerous health inequities disclosed by participants; namely, HIV, and mental health issues that included anxiety, depression and suicidality as well as substance overuse (Ferlatte et al., 2014; Ferlatte et al., 2015; Mustanski et al., 2013). Discrimination further percolated into the health services context where

participants reported mistreatment by health professionals, including assumptions that gay men are hypersexual, and/or deviant and therefore at risk for HIV and STIs. Many participants expressed that health professionals had a focus on HIV, which also distracted from having unrelated health issues addressed. Amid these challenges, men's accounts of loss and suffering during the arrival of HIV in the mid-1980s aggravated pre-existing discrimination. The interconnected and evolving nature of these issues and experiences—historical and ongoing discrimination, multiple acute and chronic health issues, problematic engagement with the health care system and living through pre-treatment HIV—was recognized as marked adversity in the lives of middle-aged and older gay men:

> P17: I remember being depressed at times in my teenage years and not really knowing why…and once I figured out what was going on at age 26 and realized oh, duh, you're gay, life has been a lot better. But yeah, there have been health challenges. And there have been social challenges…I've had to fight for my rights and sometimes my life… at the very least I hope that when queer youth are growing up and becoming adults, that they're not going to have the same obstacles in front of them when it comes to dealing with social issues, with health issues as people who are now in their 40s or 60s had to put up with, or people before them. (65 years old)

Ultimately, adversity created multiple barriers to health and wellness for the men in this study; health management therefore necessitated overcoming adversity, which they did by developing and implementing a series of practices represented analytically within three overarching categories that reflect the processes inherent to managing health: (1) *advocating for health need,* (2) *knowing about health issues and treatments,* and (3) *engaging in health promoting practices.* Employing these processes provided men with the means to overcome adversity, as evidenced by the overwhelmingly enthusiastic stance men communicated about the state of their well-being. Hence, overcoming adversity was recognized as the core process to how middle-aged and older gay men go about managing their health.

The interconnected and multidirectional nature of the thematic processes that illustrate this advocating for health needs is presented first. Much of overcoming adversity was anchored in advocating for health needs, which thereby influenced the development and implementation of the other two processes. Ultimately, men's practices are understood as a circuitous overarching process with overcoming adversity as the core process to what men did to manage their health, as illustrated in the following diagram.

Figure 1. Overcoming adversity.
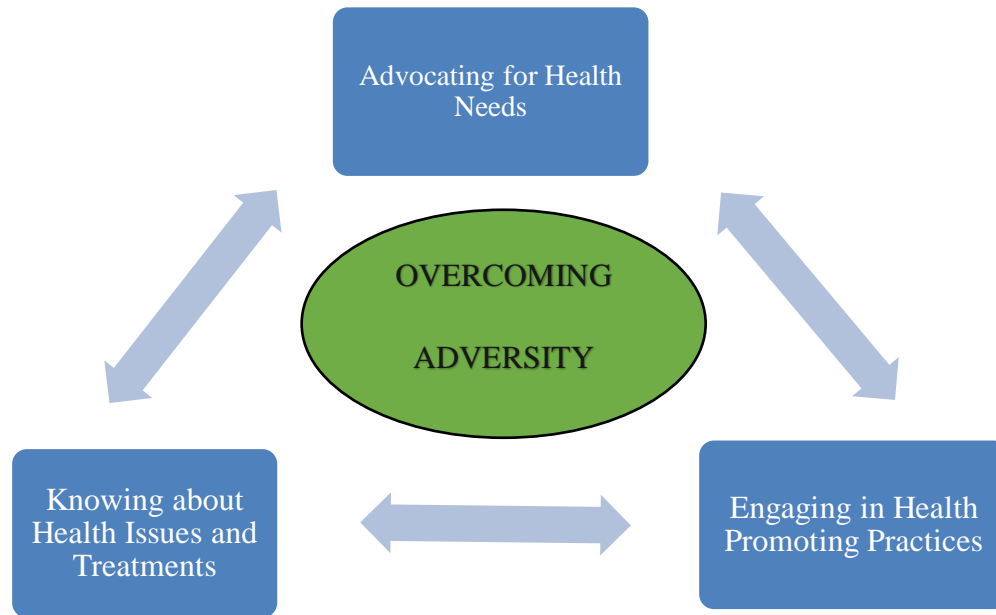
Advocating for Health Needs

The complexity of men's acute and chronic health issues over the course of many decades necessitated their regular engagement with health services, namely, a health provider.[14] Experiences of discrimination and pathologization due to sexual identity were frequent in health settings, however, and these incidents were confounded by the traditional patient–provider hierarchies. Men recounted feeling "uncomfortable, dirty, or simply wrong" in their sexual identity within health care settings. Additionally, numerous harmful assumptions were made by health providers that contributed to marked oversights in care; for example, participants indicated that providers often assumed gay men to be promiscuous, reckless, and taking part in "risky" sexual behaviour and/or substance overuse. Conversations were therefore frequently redirected by the provider to the topic of HIV and other STIs, despite the visit being prompted by an unrelated issue.

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[14] Most often a primary health provider; namely, a family physician or nurse practitioner.

In fact, the most profound insight gained from descriptions of health encounters was the recurrence of how men were pathologized in the clinical encounters by clinicians' conflating gay identity with HIV and/or STIs and how profoundly this influenced men's perceptions of themselves and spurred concerns about disclosing gay identity to health providers:

> P12: I had severe anxiety going to him (GP) at first just because I was guarded and I didn't want him to get to know me too well or whatever, and find out that I'm gay and then he'll send me for an HIV test or something like that. So there were those issues…I just didn't want that stigma being attached. (42 years old)

The discriminatory incidents within health settings draw attention to the adversity gay men faced to manage their health: essential health services were and remain potential sites of harm. Somewhat paradoxically, however, discriminatory incidents in health settings also inspired action.

When asked what was believed to prompt the development of capacity to advocate for oneself within health care environments, gay identity was cited as a major contributor. By deviating from some masculine norms, gay men were situated in a particular social location and subject to discrimination that necessitated the development of tools and strategies to survive an inherently heteronormative society. Participants talked about developing confidence over time to simply deflect negative comments about sexual identity and focus on the health issue at hand. Men remained focused on the health issue and tuned out comments or intrusive/inappropriate questioning pertaining to sexual identity. By being marginalized, strength was cultivated, a belief in oneself that aided the ability to speak up and contest their subordination:

> P25: I think being gay helped. You're kind of self-identified as different in any event, and so, you see things a bit differently and you have to be a bit stronger to survive. (70 years old)

In a display of strength, prompted by discrimination, over time men developed the ability to advocate for their health needs, which was greatly fostered by being actively involved in health

matters. Active involvement required knowledge about various health issues and treatments and obtaining this knowledge required being informed about health issues: developing understandings of diagnostics and various treatment options. Furthermore, active involvement in health was reflected by engagement in health promoting practices. By gathering knowledge about health issues and treatments and engaging in "healthy" practices, men situated themselves as informed health care consumers, which fuelled confidence to advocate for their needs. By being positioned as responsible and informed, men maintained a level of confidence in deliberating with health professionals and were able to speak up and question approaches to care. At times, however, advocating for oneself could lead to tensions with health professionals and contribute to an additional obstacle in care provision:

> P18: A lot of these pamphlets and information I was getting from the clinic, the infectious disease clinic, I was reading that these things (low red blood cell count) could be going on. So I tried to get an emergency meeting with my specialist to discuss these sorts of things, but he doesn't discuss, he just gets a little bit upset. 'Don't you think I'm looking after you? You can leave if you want you know. You can go somewhere else.' He sort of plays his game. (71 years old)

Contesting discrimination throughout life was also integral to building confidence. For many, having lived through the pre-treatment HIV era was a tremendous influence on the development of capacity as men rallied together and supported one another. There were many incidents of concerns being pushed aside and/or overlooked. These incidences over time led gay men to realize that they, in fact, were best positioned to advocate for what they needed. During the period when no HIV treatment was available, for example, accessing vital information about transmission was often obscured from public knowledge due to association with unacceptable, deviant sexual practices:

P1: One of the places you could get some information was from pornographic magazines. I remember getting a pornographic magazine and it had 'here are the top 10 things to avoid so that we don't get HIV' and at least four of them were blacked out by the censor when they came across the border. So you're telling me that you can't tell me what I need to avoid because you're too squeamish about anal intercourse? Really? You're going to hide vital information about how to save my life all because we can't talk about it? Wow. (48 years old)

Despite reticence to connect with family physicians and/or nurse practitioners, however, support and guidance was often sought from integrative health services (most notably acupuncture, naturopathy, chiropractic, massage therapy). Participants would engage with these supportive services because they were recommended by trusted family members and/or friends:

P15: The Chinese acupuncturist, again, talking to dear friends about some of the things that they tried, and they suggested this Chinese medicine person and that was pretty interesting. I just finished a couple months ago, sessions with a psychotherapist who went into a deeper-seeded, introspective, how some experiences with my ex may have, understanding how I may have ended up in that situation…and that was from a friend…so word of mouth to be honest. So that comes from a place of being comfortable sharing with people, so having great friends. (52 years old)

Due to the extensive discrimination experienced within health settings, referral to an integrative service via trusted individuals increased the likelihood of safety; that is, an environment where men would not be subject to discrimination by virtue of their gay identity. For gay men, adversity hindered access such that the potential for discrimination required assessment prior to accessing the service. This scenario is counter-intuitive: the potential for harm within a setting designed to enhance health. In this way, the participant's willingness to access integrative resources can be viewed as a protest to traditional health services that were steeped in discriminatory actions. Contesting discrimination as gay men over the span of several decades cultivated assertiveness. By being situated differently in day-to-day life, a certain level of proficiency was developed to address and deal with adversity.

The capacity to advocate for health needs within health services was a practice foundational to health management and was paradoxically fuelled by the very discrimination gay men experienced in health settings. The presence of multiple health issues necessitated ongoing support from health services and thus served as a consistent contributor to cultivating skills such as deliberating with health providers and pushing for necessary tests/services/resources. Advocacy was intertwined with knowledge acquisition and engaging in health promoting practices that fostered confidence, as men possessed the necessary information and assertiveness to call into question the service delivery of a course of action on a given health issue.

Knowing about health issues and treatments

The men in this study worked hard to establish their reputation as responsible, informed citizens who were deeply invested in their health and well-being. They achieved this by vigilantly collecting information relevant to health and illness, and this also facilitated understandings and subsequent management of various illnesses that enhanced communication with health professionals. Participants were well informed about health promoting practices and demonstrated proficiency in assessing health information in the face of a health issue. The information sought spanned a broad range of topics (from medications to exercise) and sources (the Internet, friends, and health professionals). This process is understood, in part, as resisting discourses that positioned gay men as irresponsible within social and health contexts to the point of being blamed for the spread of HIV, unlike dominant heterosexist discourses that norm hypersexuality among non-gay men as "masculine" (Adam, 2005; Adam et al., 2014; Lupton, 1995). Many sources of information were accessed, with men gauging their situation and matching resources appropriately. The Internet was a prominent resource, although many men voiced the need for caution:

P3: What I find with the Internet is you have to be careful because it doesn't mean what is there is true. So that part for me is, I go to the Internet, and I'm so-so with the Internet. I'll take it with a grain of salt that that's what they're saying. (54 years old)

Family and friends were a key source of information, particularly because trusted individuals ensured safety and thereby eliminated the potential for discrimination in a health setting. Due to extensive negative experiences with health professionals, speaking with family or friends to gather health information was a common practice. Many of these sources were, in fact, health professionals, or individuals working within health care environments/additional settings whereby information pertaining to health and illness(es) were readily acquired and proved invaluable:

P6: The other resource I use quite a bit is my sister, she's a nurse…So she's a great source, I'll call her and ask "what do you know about x y and z?" and if she doesn't know she has ideas about other sources. So she's been a really big support for me. (56 years old)

Eliciting information from family and friends enabled empowerment: the men became more informed about their bodies, illness processes and health-promotion strategies that further facilitated future conversations with health providers. Maintaining an arsenal of knowledge was an essential strategy for the participants to engage with health providers and refute perceptions of gay men as unaware, irresponsible and/or reckless with their health.

The commitment to knowing about health and illness was evident across participants and included the specific context of gay men with a diagnosis of HIV. These men endured confounded discrimination layered atop the daily challenge of living with a chronic illness. To avoid stigmatization and demonstrate their proficiency as responsible, informed health care consumers, participants with HIV not only dealt with the physical and emotional challenges inherent to a chronic illness, but maintained a central position in their HIV care. This position required access

to, and comprehension of, various test results. For example, several participants stated that they had copies of their bloodwork sent to them for assessment prior to meeting with their specialist. By doing so, they could take an active role in their health management by reviewing the information and preparing questions prior to the appointment. Participants emphasized that involvement to this degree was a process, and some expressed disappointment in those who did not take an active role:

> P25: A couple of our members at [association] right now are so lackadaisical about seeing physicians. They don't know what their blood test results are before they go in…I have copies mailed to me so I can be prepared. I have questions, 'what's the relationship of these two tests?' Because you learn I mean it's not going to be 20 minutes of discussion and there's everything you have to know. It's very slow going. It's the same with nutritional supplements you know, or diet, learning to have a better diet. It's very slow. It doesn't happen overnight. You have to work at it. Take that attitude. (70 years old)

Showing up to the appointment with previous knowledge of test results and health information demonstrates the reputation of an informed individual committed to health matters. The level of dedication to this end was evident in the comprehension of immune function, the meaning of cell counts in relation to health and illness, and how the virus and medications influence these markers. The information was complex and required additional learning and effort.

Being informed was also key to improving health. For example, keeping abreast of HIV treatments enabled querying alternative medications and was perceived as necessary, given the historical complacency regarding the lack of public health support for gay men in the pre-treatment HIV era.[15] Gay men carried the legacy of neglect that occurred during the HIV/AIDS crisis (Adam, 2005; Forstein, 2013) and this was managed in a positive way—by questioning treatment

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[15] Refers to the1980s and 1990s during which time care for HIV/AIDS was palliative to minimize pain and discomfort and many men experienced substantial loss of friends. It was also a period of intense discrimination for gay men.

approaches. The only way to ensure survival is making it happen yourself, just as gay men did in the pre-treatment HIV era. Challenging a specialist, however, was particularly arduous for participants given discrimination due to their gay identity and aggravated by discourses of irresponsibility. Despite these challenges, participants regularly questioned medication side effects. In one case, a participant disclosed recognizing a side-effect that if not addressed immediately could have had grave ramifications. In this instance, he was well informed about the various side effects of his current HIV medication and was concerned about the impact on the integrity of his bones:

> P6: When I had the last rib fracture, this was like the third in a row and the fifth in my life…so I thought this needs looking at, you don't just bump into something and fracture your rib…so I went in to him (HIV specialist) and he didn't even know if I'd qualify for a bone-density test, and I knew I would because I used to book them (laughs)…so I said it's fine you can go ahead and order it…and I really didn't expect to come back with a diagnosis of osteoporosis, maybe osteopenia but it came back as (osteoporosis) moderate risk. (56 years old)

Regardless of their health status, the men in this study emphasized the importance of being knowledgeable about the state of their bodies, which included proficiency in several domains including physiology (body and disease processes, as well as subsequent treatments) and health service options. Being knowledgeable about health services provided options and often included, as noted previously, integrative options. For example, this participant who recognized anxiety to be a growing issue for him wished to seek out a non-pharmaceutical option to provide support:

> P19: So I did a lot of research into it (acupuncture). For me now, if I don't go and get acupuncture every week, my stress levels, the anxiety levels go off the charts. So for me, I need my acupuncture…maybe it's not for everyone; for me it is…I didn't want Western medicine, here's the pill, here's the drugs, la la la. (54 years old)

For these men, it was not simply about managing an illness: being informed refuted discriminative stereotypes about gay men and facilitated dialogue with health professionals about

health issues and treatment options. Ultimately, knowing about health issues and treatments was an effective strategy to overcoming adversity.

Engaging in Health Promoting Practices

In addition to knowing about health issues and treatments, participants described engaging in a variety of health promoting practices—for instance, eating well and getting exercise. Moreover, the men, were motivated by the desire for wellness. Men's dedication to health management practices, however, was also motivated by discriminative discourses regarding gay men as reckless and disengaged with health matters and the significant losses they experienced as gay men living during the pre-treatment HIV era.[16] The collective influence of motivation, discrimination and living through HIV was evident in the dedication to healthy living as a means to wellness:

> P25: I've got to at least make the first move towards better lifestyle or living, you know, feeling better. So I've been in control of my health right from the get-go. (62 years old)

Using the language of being "in control" emphasized the gravity of taking the lead in optimizing well-being. Being in control reflected a commitment to being responsible, a belief that the work of health was a personal responsibility to leverage a connected healthy mind and body. The goal of health enabled a life rich with possibility and therefore men dedicated tremendous effort and attention to health promoting practices.

At the crux of many conversations was an emphasis on dietary choices and exercise. For the men in this study, a "healthy diet" meant limiting processed foods, refined sugars, alcohol and red meat while increasing vegetable, fruit and water intake. Exercise referred to a continuum of

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[16] The pre-treatment HIV era (essentially the 1980s with the emergence of the virus, into the 1990s) marked a time where there was no available treatment, care was essentially supportive/palliative (to minimize pain and discomfort) and HIV was associated with being gay.

activities on a near-daily basis ranging from high impact (e.g., running, swimming) to less intense

(e.g., walking the dog, gardening). Evident in these conversations was the adherence to discipline

and the vigilant weighing of pros and cons. In adhering to discipline, discourses of recklessness

and hedonism among populations of gay men—most often in reference to substance overuse and

risky sexual practices (Adam, 2005; Forstein, 2013)—were resisted, while building the reputation

of a good health citizen:

> P12: Good eating. What I'm putting into my body. Lots of fruits, lots of vegetables, enjoying that food. Being physical; you know, going to yoga, you know, going three times a week. Disciplining myself. Trying to sit up straight at my desk. Shoulders back. Just trying to, on a day-to-day level, just watching what's going on. When it comes to alcohol intake or drug intake you know, providing a balance that's not going to be life changing or detrimental down the road. (42 years old)

The goal was to live in good health, this was situated as one's own personal responsibility

necessitating control and restriction. Despite the wealth of research that illustrates a focus on diet

and exercise by gay men (in particular, younger gay men) for the purposes of obtaining a specific

physique (Brennan et al., 2010; Brennan, Craig, & Thompson, 2012;), participants identified diet

and exercise as integral to overall wellness. Adopting healthier dietary choices and engaging in

exercise enhanced feelings of wellness, providing men with the motivation to adhere to these

practices:

> P10: I swam my way out of that loss (abrupt breakup) in an unheated pool in the winter in Berkeley, California. It's kind of like our winter temperatures here. And I knew exercise is a good thing, and I have no hand–eye coordination, so I've never been a team athlete but I did have speed and anybody can run. So I started running. It doesn't matter if you run fast or slow. You just do it. The same way anyone can bicycle. So I exercise because I think it's good for my physical health and my emotional health. (68 years old)

Engaging in health promoting practices facilitated participants in coping with the numerous

health issues they faced. For example, the link between diet and health was frequently emphasized

by participants who were HIV positive. For one HIV-positive participant and his partner, making dietary changes was viewed as a means to promote health and required a complete shift in perspective and attitude:

> P25: So, I said, 'well, we're going to have to change our lifestyle, but that's probably a good thing'. He (partner) gave up smoking, drinking, we gave up coffee. We started cooking Indian vegetarian food for months on end. It was a real change, you have to change your attitude. (70 years old)

This participant acknowledged that implementing changes would foster wellness, regardless of the presence of HIV. The desire to obtain health behooved personal responsibility for health promotion and protection by undergoing several major dietary changes and ceasing of cigarette smoking. These changes were likely not easy to implement and required tenacity and dedication.

Mental health was recognized as a crucial component of well-being, of particular relevance to the wellness of gay men, as the literature demonstrates the deleterious effects of discrimination on mental wellness (Ferlatte et al., 2014; Ferlatte et al., 2015; Mustanski et al., 2013). In particular, the chronicity of mental health issues for middle-aged and older gay men is tremendous. Struggles frequently began in childhood spurred by a heteronormative society: disapproval of family members, bullying, name-calling, and physical violence often described as "gay bashing" all further aggravated by the grief, suffering and loss incurred during pre-treatment HIV:

> P1: I've got to maybe walk by this corner where I was gay bashed. What if I see those assholes who were assholes to me in high school or grade school? You know…and we both didn't know what it would be like to move away from a gay community to somewhere that had zero gay community…and then it's like you're losing 12 friends in a year (during pre-treatment HIV). Wow, it's no wonder we're so friggin' traumatized. To be fighting your own war with the rest, it seemed at the time, that the rest of the world didn't give a shit about it (HIV). Let them die (gay men), who cares, they're killing each other off. You know. It was pretty horrific. (50 years old)

However, conversations about mental health—a topic wrought with stigma—were broached without reticence and the importance of seeking counsel and support was emphasized. Furthermore, the development of varied and unique strategies to promote mental health was essential to health management. Exercise as a health promoting practice—encompassing physical and mental wellness—was found to be of utmost importance to emotional well-being. Participants described the effect of elevated mood and generalized sense of wellness that came with taking part in exercise. This positive impact on mood was the biggest motivator as articulated by this participant:

> P14: I'd go (to the YMCA) and sometimes I wouldn't exercise, but after a while it became such a habit that if I didn't go I started feeling not the greatest. So as time has gone on, exercise has been a good stress reliever for me…I do feel that it lends to my sense of overall mental health as well as physical health. (51 years old)

Music was also described as a powerful means to support emotional wellness. As a conduit for emotional release, often coupled with movement, music was the means to express joy but also allowed for expression of grief or sorrow depending on the need:

> P7: I really like music, so if there, singers have, like yesterday was, whose birthday was it yesterday? Diana Ross…I'm bopping around my apartment singing Diana Ross at the top of my lungs, and that is really good for me. Like, I find just that singing and being into the music and listening to the music and moving to it that really helps me, too…and I know for example there are a few pieces that just make me like weep uncontrollably, so if I know I want a good cry I can go to this song or that song and I'll just wail and it's good because it releases it as opposed to me just holding it in. (53 years old)

This participant outlined strategies for wellness not typically associated with male practices, such as dancing and weeping. This quote illustrated that participants, by virtue of non-adherence to dominant masculine norms, drew upon their own unique strategies as a means to promoting their health. Engaging in health promoting practices was demonstrated as foundational

to overcoming adversity; namely, coping with physical and mental health issues rooted in discrimination:

> P13: I used to be an over a pack a day smoker up until I turned 40. It's been almost 10 years ago that I've quit smoking. When I quit smoking, I really changed, I started exercising, that's what helped me through. Talk about addiction. (I smoked) to deal with all the stress, anxiety, all the garbage (in my life), I think. But I thought I have to make something good out of this, so I decided to take care of myself and quit smoking…it slowly got better (the feelings of stress and unhappiness), I started going to the gym every day and stuff. I felt so much better (51 years old).

Ascribing to healthy living not only helped men feel better on a daily basis, it provided the means to alleviate some of the symptoms of multiple mental health issues that many participants grappled with. Diligent engagement in health promoting activities not only contributed to the construction of gay men as actively engaged and invested in their health matters, but served as a powerful tool to bolster the physical and mental health and wellness of gay men.

Discussion

It is well established that middle-aged and older gay men experience marked health inequities that are influenced by systemic discrimination perpetuated through social processes embedded in homophobia and heteronormativity (Aggarwal & Gerrets, 2014; Ferlatte et al., 2014; Mustanski et al., 2013). How gay men grapple with illness in the context of systemic discrimination, however, is less well known, particularly concerning how they make decisions about and engage in practices to manage their health. Without an adequate understanding of how middle-aged and older gay men manage health and illness in the context of discrimination associated with gender and sexual identity, the health care system and clinicians are limited in their effectiveness to build upon men's capacities to promote and protect their own health. Moreover, without adequate theory about health management, researchers are limited in their capacity to

adequately measure this concept or to design and test the effectiveness of interventions aimed at supporting gay men's health management.

This study examined the processes by which middle-aged and older gay men manage their health. It was inspired by gay men's health research that emphasizes the influence of inequity and power relations in health and illness experiences, particularly in how discrimination, gender and sexual identity play out to influence men's health management strategies (Aggarwal & Gerrets, 2014; Meyer, Schwartz, & Frost, 2008). The findings generated a nascent theory that illustrates how the adversity men faced over their 40-plus years due to systemic discrimination against gay men necessitated a process of overcoming adversity as central to how men manage their health and illness. Theorizing about gay men's health management as a process of overcoming adversity through the interconnected processes of knowing about health issues and treatments, advocating for health needs, and engaging in health promoting practices can be used to design and test innovative health service reforms to support the health of gay men. As a collective of issues and experiences rooted in discrimination, adversity further substantiates recognition of discrimination as a determinant of health.

The most profound insight gained from this study was recognition of a theoretical position—overcoming adversity—that showcased adversity as a fundamental challenge to the health of middle-aged and older gay men. This finding is supported by the substantial body of knowledge that recognizes discrimination as a major impediment to health and contributes to the extant literature that emphasizes, in particular, the influence of structural-level discrimination (Krieger, 2014). Currently, there are no theories of gay men's health management, particularly within the context of illness and discrimination. What is known pertains to the various strategies, namely protective processes, that men engage in to promote and protect their health as a response

to the myriad forms of discrimination that make up adversity (Dickinson & Adams, 2014; Kushner et al., 2013; Mustanski, Newcomb, et al., 2011). However, much of this information is in reference to sexual practices in relation to HIV and STI susceptibility (Dickinson & Adams, 2014; King & Richardson, 2016; Mustanski, Newcomb, et al., 2011).

This study employed the broader concept of health management to capture the strategies men employ to promote health and navigate illness on a daily basis that is inclusive of, but extends beyond, sexual practices and HIV susceptibility. Overcoming adversity as the core process to health management also demonstrated the temporal, personal and structural influences on men's health management practices. Time played a foundational role to how men managed their health: via historical circumstances that greatly influenced perceptions and actions, through the accumulation of experiences that further influenced perceptions and practices, and by the comfort and confidence that come with living many years of life. Furthermore, overcoming adversity as the core process offers guidance to health services and health service delivery that prioritizes patient-centred and non-discriminatory approaches. Doing so would support men's proficiency in engaging in health promoting practices and knowing about health issues and treatments because providers could focus conversations on what men are doing and what is working to promote health. Patient-centred and non-discriminative approaches would further diminish the time and intention participants directed to advocating for health needs as health providers recognize gay men's historic and ongoing experiences of discrimination and consequent health needs.

The men in this study demonstrated tremendous strength and capacity to move beyond coping with adversity to overcoming it via the tenacious commitment to developing and implementing facilitative strategies. The men were actively involved in health and health matters and this active involvement was essential to overcoming adversity. For example, our findings

highlight that men's ability to advocate for their needs within health settings was foundational to how they manage their health, and was reflected in the gay men's resilience work (Herrick et al., 2012; Lyons et al., 2014; McLaren et al., 2008). This advocacy was cultivated by knowledge acquisition regarding health matters (e.g. biological processes, various illnesses, their etiology and modes of transmission, treatment approaches) and engagement in health promoting practices (e.g. exercising regularly and eating nutritious foods). Health provider recognition of men's knowledge base and engagement in health promoting practices could shift health approaches to collaboration and informed discussion about how to best facilitate individual efforts and support a patient-centred approach.

In essence, men's ability to advocate resisted traditional perspectives of risk argued in the more critically positioned literature as a means to blame or hold individuals responsible for illness, or to distract from the real source of poor health, and to express outrage at behaviour deemed unacceptable (Petersen & Lupton, 1996; Lupton, 1995). For gay men specifically, uncritical perspectives of risk positioned gay men of all ages in a particular way; that is, as irresponsible and lacking knowledge with regards to health matters (Adam, 2005 Forstein, 2013). These simplistic and harmful risk discourses are evident in the health services domain via the assumptions around gay identity espoused by health providers that the men disclosed. Adopting a strengths-based approach in this investigation enabled identification of the health promoting processes men employ despite tremendous disadvantage. By being informed and engaging in healthy living practices, men resisted these tropes and constructed themselves as informed, engaged health care consumers who were fully aware of a multitude of risks to health and well-being. This cultivated a level of confidence to deliberate with health providers and advocate for health needs. As such, they not only resisted uncritical risk discourses but promoted their health and well-being. Identifying the

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processes by which individuals confront and grapple with health challenges provides key insights for how to most effectively support and treat health problems (Tedeschi & Kilmer, 2005).

Recognition of overcoming adversity as central to how gay men manage their health is essential to developing effective health supports for men in this age group. The theory of health management developed in this investigation—that of overcoming adversity—and the processes inherent to the theory illustrate the need for health services to be supportive and to foster men's capacities for health management in a non-discriminative and patient-centred way. The findings from this investigation highlight key processes that can be incorporated into health care services and service delivery to reduce the discrimination middle-aged and older gay men experience and thereby foster their health management strategies.

The overarching active nature of men's involvement in matters of health and illness, for example, necessitates that men's efforts are supported and cultivated in a supportive, respectful manner that appreciates the marked obstacles to health and well-being men have, and continue to face. A growing body of literature demonstrates a developing trend in that people, in general, are taking a more active role in health care matters (Epstein & Street, 2011; Fiscella & Epstein, 2008; Street & Haidet, 2011). This literature showcases that supporting individuals to be actively involved in their own care contributes to more meaningful care experiences, and consequently improved health outcomes (Epstein & Street, 2011; Fiscella & Epstein, 2008; Street & Haidet, 2011). With active involvement in health experiences, researchers argue people are situated in the context of their own social circumstances, "listened to, informed, respected, and involved in their care—and their wishes are honored (but not mindlessly enacted) during their health care journey" (Epstein & Street, 2011 p. 100). By establishing an active role in health decision-making and care trajectories, individuals tend to derive a greater sense of autonomy leading to motivation and

optimism regarding the scenario in question (Epstein & Street, 2011; Saba, Wong, & Schillinger, 2006), but it is incumbent upon health providers to support and facilitate individual efforts with a respectful and open approach.

There are several recent developments in approaches to care delivery that prioritize engagement with individuals in a non-discriminatory, patient-centred manner. Based on the findings that showcased overcoming adversity as the core process to health management for middle-aged and older gay men, one example is equity-oriented primary health care (PHC). This approach to care emphasizes attention to core elements of care delivery by behooving recognition of contextual circumstances that contribute to disadvantage for groups of people (Browne et al., 2012; Starfield, 2006; WHO, 2008). In the case of middle-aged and older gay men, an equity-oriented PHC approach would ensure that men's trauma is recognized and incorporated into the care approach to ensure men are not re-traumatized within the clinical encounter (Browne et al., 2012). This approach is built upon recognition of the unique contexts of people's lives (Browne et al., 2012): for middle-aged and older gay men, providers would maintain a level of comprehension as to the adversity men face in their daily lives and focus on conversations about how to further support men's health promoting efforts. Providers would maintain a transparent, non-judgemental approach to interacting with men to foster rapport and further bolster meaningful deliberation about health promotion, treatment options, diagnostics and so forth. Ultimately, care would be delivered with a sensitivity to the historical and ongoing discrimination that plays a central role in men's health management, while simultaneously supporting men's health promoting efforts.

Sex-positive informed health programs are another example of an approach to care that would support the health management efforts of middle-aged and older gay men. A sex-positive approach recognizes the pleasurable, rewarding and non-procreative aspects of sex, the

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tremendous cultural diversity in sexual practices, and acknowledges substantial variation in personal meanings and preferences (Popovic, 2006). Consequently, a sex-positive approach embraces a wide range of sexual expression that considers sexual identities, orientations and practices, gender presentation, accessible health care and education, and multiple important dimensions of human diversity (Williams, Prior, & Wegner, 2013). A sex-positive approach within health care delivery would facilitate non-discriminative health encounters with middle-aged and older gay men via open communication; specifically, health providers would open the dialogue with questions about the social context of men's lives, such as work and life as a starting point to health conversations. Furthermore, open communication would allow for health providers to speak to the historic and ongoing discrimination in gay men's lives by inquiring about men's experiences and the potential impact on health and health management. Non-discriminative health encounters would foster encouragement and cultivation of men's demonstrated strengths and capacities in managing their health. For example, in the absence of discrimination by virtue of sexual identity or conflation with HIV and STIs, men's efforts could focus on health issues and treatments rather than pushing for appropriate care. As such, the process of men's knowing about health issues and treatments would be enhanced in a meaningful and effective way; for example, men would be in a position to deliberate with staff regarding their concerns and needs in a safe environment, as opposed to having to focus their energy on redirecting the conversation from HIV and STIs or risky sexual behaviours to the health issue at hand.

The processes identified in this theory of middle-aged and older gay men's health management warrant further investigation. Advocating for health needs, and knowing about health issues and treatments and engaging in health promoting activities were central processes to how men overcame adversity, and ultimately managed their health. Additional inquiry into these

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particular processes and how they play out in middle-aged and older gay men's health management is necessary to build on this nascent theory. Additional information is needed specific to the characteristics of health services that gay men would find useful and meaningful. More research is needed pertaining to men's health management as a broader concept that is inclusive of, but not limited to, help-seeking and context-specific practices (e.g. sexual practices) and the contextual factors that influence these processes for gay men, including what works for gay men and what constitutes therapeutic alliances.

This study has several limitations. The purposive sample was largely drawn from convenience, with men recruiting additional participants from within their own social circles. Consequently, many of the men who took part in the study were well connected to communities of gay men and therefore the sample does not necessarily speak to the health experiences and assumptions of other gay men living in Victoria. Data were not collected pertaining to relationship status, socioeconomic status or age of "coming out", all of which could influence health management and arguments for health inequities. Additionally, the sample predominantly consisted of White, well-educated, middle-class men, which necessitates further investigation of social location on health management. Lastly, all the men in this sample were facing health issues, thereby warranting further investigation into how absence of health issues potentially differs with regards to health management. Moreover, the study was limited to men who were English speaking and who had lived in Victoria for at least a year.

Conclusion

The findings from this study of middle-aged and older gay men's health management emphasize the influence of inequity and power relations in health and illness experiences, particularly in how discrimination, gender and sexual identity play out to influence men's health

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management strategies. Specifically, the core process by which middle-aged and older gay men manage their health was recognized as overcoming adversity. In effect, the processes inherent to gay men's health management—advocating for health needs, knowing about health issues and treatments and engaging in health promoting practices—collectively and interrelatedly enabled men to surmount historic and ongoing discrimination in their day-to-day lives. Recognition of men's active involvement in matters of health and illness, and the subsequent resistance and overcoming adversity necessitates that health services support men's capacities and strengths. Non-discriminative approaches sensitive to the traumas middle-aged and older gay men have and continue to face are essential to promoting the health of gay men in this specific age group.

CHAPTER 5: MIDDLE-AGED AND OLDER GAY MEN'S EXPERIENCES WITH MENTAL HEALTH

Introduction

Gay men, particularly middle-aged and older (40 years of age and older) experience higher rates of mental health challenges when compared to other men and the general population (Conron et al., 2010; Wright et al., 2012). Mental health challenges refer to those negative experiences that deleteriously affect men's psychological well-being, inclusive of mental illness, and emotional distress that includes feelings of anxiousness and/or sadness and/or suicidality in the absence of a formal diagnosis of mental illness (Almeida et al., 2009). Anxiety, depression, suicidality, isolation, and grief are among an array of mental health challenges that significantly compromise gay men's mental health (Almeida et al., 2009; Brennan et al., 2010; King et al., 2008; Klein, 2012). In Canada, gay men are three times more likely to have a diagnosis of depression and/or anxiety and four times more likely to have a history of lifetime suicidality when compared to heterosexual men (Brennan et al., 2010). There is growing evidence that gay men's overrepresentation of mental health challenges is the result of significant social inequities perpetuated through societal, institutional and interpersonal forms of discrimination (Aggarwal & Gerrets, 2014; Ferlatte et al., 2015; Mustanski et al., 2013). Findings from a growing number of investigations argue that chronic exposure to structural and interpersonal discrimination becomes embodied and subsequently manifested as mental health challenges (Aggarwal & Gerrets, 2014; Hatzenbuehler, Nolen-Hoeksema, & Erickson, 2008).

There is also preliminary evidence illustrating that gay men engage in an array of health and illness practices to promote health and navigate illness, although what is known is primarily

in the realm of HIV, other STIs and men's engagement with the health care system (e.g., Blackwell, 2015; Coleman et al, 2017; Grella et al., 2009; Tate & Ross, 2003). Given the enormity of the burden of mental health challenges among gay men, very little is known about how gay men experience their mental health and the strategies and practices they use to mitigate the deleterious effects of mental health challenges they might experience. There is an urgent need to increase understanding of how men experience mental health and the processes undertaken to address mental health challenges that inform the development of health programming able to promote and protect the mental health of gay men. The purpose of this study was to explore how gay men experience their mental health and the strategies they use to mitigate the deleterious effects of mental health challenges they experience.

Background

As noted above, mental health among gay men is an increasing public health concern. Researchers and advocates for gay men's health have indicated an urgent need for effective programming to promote and protect the mental health of gay men (Logie & Lys, 2015; Safren, Blashill, & O'Cleirigh, 2011). It is well substantiated that health programming initiatives are increasingly effective when they build upon individuals' existing efforts and capacities (Holman & Lorig, 2004; Golden & Earp, 2012). Without this information, tailored programs will be less effective in improving health outcomes (Bates & Berg, 2014; Im & Rosenberg, 2016). There is little information pertaining to how gay men experience their mental health and the strategies and practices they use to mitigate the deleterious effects of mental health challenges. For the purposes of this investigation, I adhered to the World Health Organization (WHO) definition of mental health that refers to a spectrum inclusive of numerous experiences including psychological well-

being—that encompasses enjoyment, recognition of one's ability and potential, the opportunity to build and engage in relationships, and the capacity to address and manage everyday challenges— as well emotional distress, and mental illness (WHO, 2016). This definition draws attention to the fact that emotional distress and mental illness are the two core areas that negatively affect men's mental health (Almeida et al., 2009; Brennan et al., 2010; King et al., 2008; Klein, 2012). Furthermore, this conceptualization enables an understanding that an individual may be experiencing emotional distress and/or mental illness but identify as mentally healthy.

The literature pertaining to the overrepresentation of mental health challenges among gay men has situated these issues within frameworks that emphasize the contributions of interpersonal (often termed homophobia) and socio-structural (often termed heteronormativity) dynamics on poor mental health outcomes (Aggarwal & Gerrets, 2014; Conron et al., 2010; Ferlatte et al., 2015). For example, a Canadian investigation illustrated that ongoing exposure to interpersonal and structural discrimination contributed to negative and distressing thoughts pertaining to one's sexual identity (described as internalized homophobia) and increased serum levels of the stress hormone cortisol, both of which are associated with depression, anxiety and suicidal ideation (Benibgui, 2010).

In terms of the strategies and practices gay men use to mitigate the deleterious effects of mental health challenges, what is available has tended to focus on access and utilization of formal health services (Blackwell, 2015; Coleman et al., 2017; Grella et al., 2009; Tate & Ross, 2003). This body of literature included a range of studies of support services from primary care to specialized mental health resources and recognized help-seeking (connecting with formal health services) as a key means to preventing and treating emotional distress and mental illness (Blackwell, 2015; Coleman et al., 2017; Grella et al., 2009; Tate & Ross, 2003). An overarching

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finding within these investigations is the recognition of discrimination as wielding tremendous influence on accessing, and the need for, supportive services for mental health challenges.

Discrimination (described as homophobia and heteronormativity) perpetrated by health professionals in particular, is recognized as a major barrier to seeking formal health services (Coleman et al., 2017; Grella et al., 2009: Tate & Ross, 2003.) For example, Tate and Ross (2003) used discrimination as a study framework[17] to develop a community model that identified and addressed the concerns of lesbian, gay, bisexual, transgender and queer (LGBTQ) university students in accessing formal supports. As such, the researchers worked collaboratively with LGBTQ students to produce knowledge with the goal of informing effective services and resources (Tate & Ross, 2003). Other authors considered gay men's engagement with primary and acute care settings for mental health support and espoused the need for specialized training for health professionals working with gay men as a key strategy for mental health promotion (Blackwell, 2015; Grella et al., 2009). Overall, discrimination is recognized as contributing greatly to the need for health support services for mental illness; however, it remained a marked obstacle in the health services setting.

One qualitative investigation that focused on mental health promotion, but considered practices beyond engagement with health services, provided a description of factors conducive to gay men's psychological well-being (Wagner et al, 2013). The authors identified effective coping with internal and external sexual stigma foundational to psychological well-being that was inclusive of numerous strategies and practices including: cultivating self-esteem via channelling

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[17] The study framework recognized ongoing discrimination to be a major impediment for lesbian, gay, bisexual, transgender and queer (LGBTQ) university students to seek formal mental health service supports (Tate & Ross, 2003).

energy into work and/or academic performance, engaging with spirituality and/or religion and disclosing sexual identity to family and friends (Wagner et al., 2013).

There remains, however, a dearth of knowledge that identifies how middle-aged and older gay men experience their mental health and the strategies and practices they use to limit the deleterious effects of the mental health challenges they might experience. Not only is this age group recognized as susceptible to mental health challenges (Conron et al., 2010; Wright et al., 2012) but men in this age group have also experienced pervasive discrimination by virtue of sexual identity over the course of their lives, including the generation-specific adversity of living through the pre-treatment HIV era (additional discrimination via association of HIV with being gay, suffering, grief and trauma), processes known to contribute to poorer mental health outcomes (Aggarwal & Gerrets, 2014; Ferlatte et al., 2015; Wright et al., 2012). This investigation focused specifically on how middle-aged and older gay men experience their mental health and the strategies and practices they use to limit the deleterious effects of the mental health challenges they might experience. This is essential knowledge to inform meaningful service development to promote the mental health of gay men. The research question was:

> How do middle-aged and older gay men experience their mental health, and what
> strategies do they use to mitigate the deleterious effects of mental health challenges?

Methods

This investigation employed a qualitative descriptive design, an approach that is often used to provide a comprehensive summary of events experienced by individuals and/or groups in everyday terms (Sandelowski, 2000). Ethics approval for this study was granted by the University of British Columbia Behavioural Research Ethics Board. The study setting was the city of Victoria,

British Columbia, the provincial capital situated on Vancouver Island with a population of approximately 85,000 (BC Statistics, 2015). A total of 25 participants were purposefully sampled by selection based on specific inclusion criteria to enhance understandings of the phenomenon of interest and specific age group; that is, middle-aged and older gay men (Polit & Beck, 2008). At the outset of the project, men were required to self-identify as gay, currently reside in Victoria and be over the age of 40. The snowball sampling process was aided by several men connected to networks of other gay men, and who were known to the first author and expressed interest in the project. These men distributed the recruitment flyer at social, educational, and community-based events and interested individuals contacted the first author to determine eligibility.

Data Collection

Data were collected over an eight-month period via conversational, one-on-one interviews held in cafes in the city of Victoria. Each interview was conducted by the lead author (IH), and verbal consent was obtained from participants prior to initiating the interview. Each participant was offered the choice of $25 cash, or a gift card for Starbucks's coffee of equal value. Participants were informed that they could withdraw from the study at any time and need not offer any reason for doing so.

To gain an understanding of how gay men experienced mental health, questions initially focused on men's everyday life experiences and progressed to health perceptions and experiences; for example, participants were asked to outline a health issue and how it was dealt with. Questioning then progressed to inquiring about how men went about mitigating the deleterious effects of mental health challenges they experienced. Questions targeted practices during different points over the course of life (e.g., youth, twenties, thirties, present day) to capture how experiencing mental health and the strategies and practices to mitigate the deleterious effects of

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those challenges may have evolved and shifted over time. Interviews were loosely structured by a topic guide comprised of several questions and probes. Conversations, however, frequently expanded beyond the specifics of health and illness into a variety of personal experiences and stories that shed light on the importance of historical and social context on how mental health was experienced. Reflexive practice was employed by the first author (IH) via journaling thoughts, impressions and potential biases after each interview. The interviews were approximately 60 minutes in duration, and were audio recorded and transcribed verbatim by an experienced transcriptionist.

Data Analysis

Methods drawn from a grounded theory approach were used to analyze the data. Specifically, Charmaz's (2006) approach to analysis was employed to appreciate how men's historical and ongoing social contextual circumstances potentially influenced how men experienced mental health and the strategies and practices used to mitigate the deleterious effects of mental health challenges. Charmaz (2006) asserts that discovered reality arises from the interactive processes and their temporal and structural contexts. By applying a grounded theory approach in this way it was possible to examine the impact of the historical and ongoing social contexts of men's everyday lives on how mental health was experienced at various stages of data analysis. This was achieved by reflecting and querying, for example, the influence of circumstances such as gay identity and associated discrimination, living through HIV, and the societal stigma attached to mental illness.

Data collection and analysis were concurrent. Analysis began with several reads of each transcript to establish an overall feel of the information before proceeding to open coding, which entailed assigning a concise phrase to summarize portions of data (Charmaz, 2006). Integral to

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open coding was using active phrases, termed gerunds, to capture the energy of what participants were experiencing and/or perceiving (Charmaz, 2006). The preliminary open codes drew attention to recurrent concepts; namely, men's conceptualization of mental health and practices employed to bolster psychological well-being. Examples included "perceiving health inclusive of mental, physical and spiritual wellness" and "valuing mental wellness". As more data were collected, focused coding and involved constant comparison of newer codes to earlier ones and memo writing, which chronicled possible connections between codes and what participants were experiencing and/or expressing through the codes (Charmaz, 2006). Memos provided an analytical account of men's approaches to engaging with emotional distress and/or mental illness that were influenced by the social conditions within which men lived and continue to live (Strauss & Corbin, 1994). Examples of memos at this stage included: "exercising, taking medication…it's all part of a bigger process". Feedback on the developing categories was then elicited from participants to ensure accurate representation (Sandelowski, 1986). Analysis culminated in selective coding, which yielded three interrelated overarching categories that illustrated how mental health concerns were experienced throughout the course of men's lives, the factors that influenced these concerns, and their strategies and practices in addressing these concerns to mitigate their deleterious effects as they strove to live a life full of potential.

Findings

The age range of participants included in the study was 40 to 76 years, with a mean age of 54. Of the 25 men, 23 identified as White, and 22 had a primary care provider (defined as a family physician or nurse practitioner). Participants had diverse occupations ranging from teaching to various positions in local government and non-profit work and most of the men had completed some form of post-secondary education. All the men reported experiencing marked challenges to

their mental health over the course of their lives, ranging from emotional distress to mental illnesses including anxiety, depression, PTSD and suicidality. Additionally, many men were living with an array of physical health complications such as diabetes, heart disease and osteoarthritis. Although men were not asked specifically about HIV, 12 men did report a positive HIV status.

Although men acknowledged these diverse health issues, current states of health were talked about optimistically, in that men described themselves as "healthy". Overall, men expressed a desire and commitment to live life to the fullest, a situation they equated with "being healthy".

In what follows I present three overarching and interrelated categories: gaining new perspectives of mental health over time, reaching out to formal health services for support with mental health challenges, and engaging in practices to maintain and improve psychological well-being. These categories demonstrate that how men experienced their mental health was situated in the larger arena of stigma and discrimination by virtue of gay identity that was endured over the course of their lives. This was in addition to their personal experiences of identifying that their mental health mattered to their overall well-being, and learning over time how to work within formal health service and engage with additional supports and services to mitigate the deleterious effects of mental health challenges.

Gaining new perspectives of mental health over time

Of crucial importance to understanding how gay men experience mental health is recognition of the integral role of time; namely, how the influence of history, in the form of accruing myriad experiences over the years, inspired a shift from prioritizing physical health to focusing on mental health and consequently, addressing mental health challenges. For most men, minimal attention was paid to mental health until recently, which they defined as within the last

five years. The process of accruing experiences contributed to evolving perceptions about life, priorities, and ultimately, health. With the passage of time, the desire to live a healthy life became a key priority; however, most men found themselves to be in what they described as poor health. With reflection, conversing with peers, friends, health providers, and learning more about health through accessing information recommended by these resources, mental health was now understood as crucial to attaining the life they desired.

During the interviews men were asked to share their perspectives on the meaning of health in their own words. The participant's conceptualizations positioned health as a multidimensional concept: the overarching product of physical, mental, and for some, spiritual health. In describing health this way, men emphasized mental health as a crucial component to overall well-being with balance regarded with great importance in that physical and mental health were afforded equal importance:

> P9: Your mood is inseparable from your health. If you're feeling really crummy, if you feel emotionally bad, you start to feel physically bad. If your physical health is poor, your emotional state will be poor, too. They're very connected. (65 years old)

Such a perspective represented a fundamental shift for many of the men who, for most much of their lives, had thought about health as physical health, and therefore focused their attention solely on grappling with physical health problems and maintaining physical wellness. Numerous experiences rooted in the historical and ongoing social contexts of men's everyday lives were identified as key contributors to this perspective; for example, the historical emphasis on physical health was informed, in part, by numerous illnesses over the years (namely HIV) that demanded attention. In the case of HIV, for example, men learned about the virus, how it affected the body, and then proceeded to seek out and engage in numerous practices believed to bolster the

immune system. This was especially the case during the pre-treatment HIV period[18] when there were no treatment options and the goal was to remain alive. As such, tremendous energy and intention were directed towards tracking the impact of the illness on the physical body; namely, monitoring cell counts and viral load and taking whatever measures possible to improve physical wellness, as described in detail in Chapter 4 of this dissertation.

For others, emphasizing physical health was greatly due to processes of socialization regarding health and wellness. For many of the men, mental health was simply not discussed with family or friends, particularly when difficult situations arose, whether that be experiencing anxiety or perpetual grief: health as a concept was solely located within the realm of the physical body:

> P3: It's got a lot to do with my upbringing… we didn't talk about feelings (laughs)…don't rock the boat. (47 years old)

Understanding health as limited to the realm of the physical, combined with the stigma associated with mental illness, was understood to contribute to the emotional restraint and stoicism described by numerous participants. Normalizing feeling anxious and/or sad was a recurrent topic: experiencing emotional distress for years led to being accustomed to these feelings and downplaying their impact on daily life. Within these conversations men often recounted self-pressure to shake off their emotions, which led to internalizing the emotional distress: "tell myself, get over it. It's not a big deal" (47 years old).

The emotional impact of living through pre-treatment HIV was another contextual circumstance identified as a key contributor to shifting perspectives on health. The hardships men

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[18] The pre-treatment HIV era (essentially the 1980s with the emergence of the virus, into the 1990s) marked a time where there was no available treatment, care was essentially supportive/palliative (to minimize pain and discomfort) and HIV was associated with being gay.

experienced were perceived as major threats to psychological well-being. For some men, the experience was so traumatic that it was understood over the years to be embodied and eventually manifested as mental illness such PTSD and/or major depression. For others, the guilt surrounding survivorship greatly contributed to ongoing mental health challenges. Men's experiences varied, but ultimately having witnessed death and suffering on such a grand scale it had a major impact on the participants' mental health:

> P7: Mental health is huge. I mean physical health is one thing but it's the mental health piece…I was around in the 80s and saw tons of guys dying; the community was devastated. So I learned through all that stuff. It's like, no, mental health is a really important aspect, because I think of mental health and physical health tying in together. So if your mental health is off, your physical health is going to be off, too and I've seen that with people and I've seen it with me. I'm more likely to get sick if I'm feeling depressed or anxious or whatever is going on. (53 years old)

For some participants, encountering debilitating mental illness was the driving force to recognizing the crucial role of mental health to overall health. The men that had faced arduous mental illness paid particular attention to their state of mental health. For these participants mental illness was often recognized as the product of intensive discriminative experiences; most often, violent homophobic acts that were endured. One participant disclosed a long history of struggling with PTSD and depression, a situation that culminated in a suicide attempt. Due to the gravity of this experience, he began to pay attention to the state of his mental health:

> P6: Physical, mental and spiritual health go hand-in-hand and people tend to ignore one over the other sometimes…I didn't see the connection before because I didn't really understand it. I think once you've had mental health issues you begin to understand more about if, if you have mental health issues and receive help for them, you see it, the whole physical, spiritual, it all comes together, right...For me, I pay more attention to it [mental health], I wouldn't say it supersedes [physical and spiritual health], but I do pay it more mind…based on what I've been through. (56 years old)

Ultimately, men faced many experiences that were major obstacles to psychological well-being: concealing negative emotions, living through HIV, experiencing discrimination by virtue of gay identity, and/or managing HIV. Consequently, many men experienced emotional distress or mental illness that remained relatively unaddressed for years. Only once men began to develop changing perspectives on health that appreciated the importance of mental health to overall health did acknowledging and consequently grappling with emotional distress and/or mental illness become a priority. This meant committing time and intention to strategies and practices geared towards addressing with these challenges in addition to improving psychological well-being.

Reaching out to formal health services for support with mental health challenges

Once men had acknowledged mental health challenges, there were two main approaches by which they went about mitigating deleterious effects: reaching out to formal health services for support with mental illness and emotional distress, and engaging in practices to maintain and improve psychological well-being. These approaches were frequently combined and there was diversity in how men reached out and in the practices they employed. The intricate combinations of these approaches are described in detail below.

In this investigation, formal health services involved face-to-face engagement with a health professional; for example, family physicians, counsellors, psychologists and psychiatrists. For most participants, reaching out to formal health services had occurred recently. Just as the process of developing new perspectives on health is understood as greatly influenced by numerous experiences rooted in contextual circumstances, so too was when and how men sought support from formal health services for mental health challenges. Firstly, reluctance to connect with formal health services was rooted in discriminative experiences in health care settings solely by virtue of

sexual identity. Men shared that health providers tended to conflate gay identity and HIV and other

STIs and thus conversations tended to loop back to sexual practices, despite the fact that the current

health concerns were completely unrelated to sexual health. Some of the men who had HIV

disclosed feeling dirty and shameful when engaging with health providers, as if contracting the

illness was the product of their own negligence:

> P18: And then he incorrectly assumed that I had been taking my HIV medications for a
> very long time but I quickly told him I had only been diagnosed in the last 3 years
> …Oddly, I felt sleazy and dirty like it was my fault I was HIV positive. (71 years old)

Experiences based in living as gay men in a heteronormative world were also recognized

as impeding participants' willingness to reach out to formal health services. Discrimination

associated with sexual identity was further aggravated amid the pre-treatment HIV period, which

brought about the labelling of HIV/AIDS as the "gay disease" (Forstein, 2013). These overlapping

influences were understood as contributing greatly to reluctance to seek support from formal health

services and sadly, in some cases, this resulted in connecting to supports due to a crisis situation:

most often, attempting suicide:

> P6: I didn't tell anyone what was going on with me for a long time until it reached crisis
> situation. I could have averted that (suicide attempt) if I'd been a little more self-caring
> or not afraid to ask someone for help 'what do I do this is what's going on with me?' I
> think because you grow up identifying as gay or bi or whatever you're sort of, you play
> your cards, or I did, play my cards very close to my chest…maybe it's different for
> younger people today because the stigma is less intense, people are more open about
> that kind of thing. The biggest thing is getting over myself…I'm sure that's it for other
> people too…you know, don't be afraid to ask for help, because you'll get it. (56 years
> old)

In these cases, participants often struggled with concurrent mental illness, or extreme

emotional distress and substance use issues, of which they were not always fully aware until the

situation became dire. Many men spoke to the immense value of supportive services and how

being diagnosed with a mental illness was foundational to initiating the path to cultivating wellness. The words of this participant drive home the point that reaching out for help is essential to promoting mental health:

> P21: So, rule number one, ask for help. Admit to needing help…Help! I ought to be able to go to a health care provider and say 'this is a cry for help'. (46 years old)

Confounding the discrimination rooted in gay identity and exacerbating the reluctance to seek formal health services was the generalized stigma attached to mental health challenges. For example, some men expressed reservations about disclosing their experiences for fear of being labelled "crazy" and the fears of what would happen next:

> P6: If I told someone I was hearing voices they'd like lock me up, that's it, white jacket and the whole nine yards. I didn't know depression could get that bad…so it got pretty bad before I told somebody. (56 years old)

After years of coping with mental illness in isolation, these men shared the belief that support could have alleviated much of their suffering, and encouraged others who may be experiencing mental health challenges to reach out for help:

> P14: Well, I have always been anxious my entire life, but getting to that point of trying to address it through mental health providers, medication, etcetera, was a huge step for me because there is so much stigma attached to it. But I want to live healthfully. I want to live less anxiously. So I look for those things that will help me. (51 years old)

As conversations progressed, there was a palpable tension evident between men's autonomy and the weakness associated with needing outside help. However, eventually reaching out to formal health services for support was greatly influenced by the extended length of time that men endured mental health challenges. Many men described fatigue: stating that the burden to mental health incited by mental health challenges eventually became too overwhelming, and this prompted recognition that outside support was needed:

P3: I ignored it (depression) for a long time…but it kept snowballing and snowballing. I just couldn't deal with it anymore and I was exhausted. It's fairy new and recent, that I'm actually doing something about it. I talked to my doctor. I'm accessing a counsellor there as well. (47 years old).

In addition to being overwhelmed by relentless mental health challenges for years and recognizing the need for outside help, many men articulated a strong position of personal responsibility for health, which also contributed to reaching out to formal health services. Personal responsibility for health was often described in relation to autonomy and being able to grapple with health challenges in the absence of outside support(s); however, the influence of time was again evident in that this perspective changed over the years. That is, as men gained experiences throughout life and faced numerous health issues that, over time, became chronic in nature, perspectives on responsibility shifted. They recognised that seeking support from formal health services did not represent failure, but rather, at times, reaching out for help in fact *demonstrated* responsibility:

P12: It's (responsibility for health) about what I'm putting in my body…being active…watching what's going on…but it's also about knowing when I need to visit the doctor…when I have a concern, when I need help…we (family physician and I) manage my anxiety with medication so I know when I need to see him. (46 yrs old)

As such, personal responsibility was acknowledged, in part, as contributing to reaching out to formal health services. In almost all cases relating to formal health services, men engaged with these services by their own accord. In most scenarios, getting connected to formal health services was made possible by disclosing mental health challenges to a family physician. This was a crucial move as speaking with a family physician resulted in either a trial of medication(s), and/or referral on to an appropriate resource such as a counselling service, a psychologist or psychiatrist. This process required a trusting relationship with the family physician, one that enabled sharing of

mental health concerns, a big stumbling block for many participants who had experienced discrimination during clinical encounters with health providers.

Once men were connected with formal health services, experiences of mental health challenges were alleviated in a variety for ways. For example, diagnosis of a mental illness was often addressed with medications, counselling services or both. Furthermore, sessions of cognitive–behavioural therapy (CBT) or individual and/or group counselling services were supports frequently offered to participants. These support services cultivated men's autonomy as they provided a skill set to diminish the all-consuming emotions. For example, CBT was often used in cases of anxiety and provided a practical guide to break down seemingly overwhelming stressors into smaller, more manageable pieces. Counselling provided support in a similar manner, offering guidance and strategies and practices for men to tackle the distressing emotions. In doing so, men developed a level of proficiency and confidence in their ability to address and manage the feelings that were disruptive to their health and wellness:

> P19: It's about having adequate support but it's also about confidence. If you don't have that confidence you're not going to be able to help yourself…to be able to do too much that's good for you. (62 years old)

Ultimately, by connecting with formal health services men were offered guidance and support to address and work through mental health challenges. This support and guidance was identified as foundational to mental health promotion by contributing to the development of proficiency and confidence to recognize and manage one's own unique challenges and stressors.

Engaging in practices to maintain and improve psychological well-being

Engagement in practices to maintain and improve psychological well-being was also foundational to addressing mental health challenges. Important for men across a range of mental

health experiences, there was tremendous diversity in the practices that men employed and that were guided by individual preference. For men with a mental illness diagnosis, medications were often prescribed but were rarely the sole approach treatment approach. Participants did not view medication as sufficient to fully alleviate the feelings of sadness and/or anxiety that were disrupting their day-to-day activities; therefore, antidepressant and/or anti-anxiety medications were used in combination with a variety of additional practices including talk therapy (e.g., seeing a therapist/attending group therapy), engaging in exercise, sharing emotional hardships with family/friends/peers, and for some, using substances. For example, medications were frequently combined with exercise such as running or yoga. Men often referred to the documented benefits of exercise in contributing to positive emotional experiences and relaxation, and this effect was viewed as synergic with medications:

> P12: The yoga was beneficial for many reasons: physically, emotionally, mentally. It contributed to good health. It came along at the right time. That's balanced with trazadone [antidepressant medication]. My partner before [name] was on trazodone…my doctor is very anti-pill, anti-prescription, anti-anything, but he said trazodone has been around since the 50s and it's very safe…so the yoga was part of it, the journey, yoga has been part of the journey. (46 years old)

By engaging in exercise, some men experienced elevated mood and enhanced relaxation, which facilitated enjoyment, engagement in relationships and the ability to deal with everyday stressors and was thus complementary to the use of medication. Even when taking medications diligently, participants talked about the utility of exercise to provide that added lift, especially on days with additional challenges, such as work or relationship struggles. For some men, exercise almost always facilitated relaxation, which was particularly valued for those who were dealing with anxiety or feelings of anxiousness:

P10: After a while [exercise] became such a habit that if I didn't go I started feeling not the greatest. So as time has gone on, exercise has been a good stress reliever for me. And it's a necessity. (54 years old)

Substance use (specifically alcohol and/or marijuana) for the management of mental health challenges was shared by several participants with anxiety and/or depression. Despite recognition that alcohol and marijuana are generally contraindicated for use with anti-anxiety and antidepressant medications, these men did not perceive use as problematic. Rather, use was tied up in social connectedness, which was viewed as an essential component to promoting mental health. For many of the men, anxiety and/or depression negatively impacted their personal relationships; namely, the negative emotional experiences would result in retreating from social engagements, or internalizing feelings and ceasing to share struggles with partners, friends or family. For some, using substances in what was described as a 'recreational manner' (essentially, 2–3 times per week) encouraged social engagement and was facilitative to enjoyment and therefore psychological well-being:

P12: And it's not like it's every night [substance use]. It's like when I'm, like on a Saturday night we'll go to friends and we'll have a BBQ and we'll have a little, you know, a little toke [of marijuana] or a little hoot [of marijuana] here and there and it's, like, yeah. And then we'll have wine. For me it's…it's like marijuana is like woven within the fabric of my community and socially it's very entwined in my peers. (40 years old)

Seeking support from integrative resources[19] was also common, especially in the case of men diagnosed with anxiety, or who were experiencing recurrent panic attacks or bouts of anxiety. Accessing these resources was described by some as easier than accessing formal health services because the possibility of discrimination was lessened. These resources were suggested to

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[19] For the purpose of this investigation, formal health supports that do not require a physician referral and can therefore be selected and accessed by the individual; for example, acupuncture, naturopathy, massage therapy, chiropractic therapy.

participants by close friends or family, which ensured safety and therefore the setting would be accepting of diverse sexual and gender identities. Massage therapy and acupuncture were identified as especially effective for anxiety due to their ability to promote sustained relaxation wherein experiences of panic and/or anxiety were alleviated for hours beyond the therapeutic session and which promoted well-being. For others, more novel therapies were tried and tested, all which were geared toward strengthening men's proficiency and ability to tackle negative emotions stemming from challenging experiences:

> P15: I came out quite late in life, processing that, processing being HIV-positive, processing a tumultuous relationship…I went to a retreat and met a Buddhist master who was amazing. I also saw a Chinese acupuncturist who tried the method of tapping, which I found intriguing, like just talking as we are now, but getting to a place of vulnerability and then reprogramming your brain, the technique called tapping, to reprogram your brain to deal with it [trauma]. (51 years old)

Some form of exercise combined with various integrative resources was also a common approach. Acupuncture, in particular, was used in combination with various forms of exercise for its proficiency to promote relaxation and contribute to a generalized sense of well-being:

> P23: With the acupuncture, it keeps [the stress] under control. More relaxed. More able to deal with people. Do I sleep more? No. But that's okay…it'll come eventually. Also, the other reason that sport, physical activity is really good for me, because physically I'm tired, so I'll rest more…it does quiet the mind in the sense that when I run, I don't think of anything else. When I play volleyball, I don't think of anything else. So for that moment, it's just what the activity is all about. (54 years old)

Another key strategy that was highly valued and used in combination with others to maintain and improve psychological well-being was having someone with whom to share emotional hardships, whether that be a close friend, family member, group of peers, or a formal counsellor/group counselling service. Recognition of the importance of expressing feelings and sharing emotions was regarded as essential to shedding negative emotions and, in turn, cultivating

a state of psychological well-being. Gaining a level of comfort with expressing emotional struggles and/or hardships with others was often described as a practice engaged in more recently, as many participants disclosed this was not a readily used strategy in their younger years. The current comfort with expressing emotion is understood as another example of the process of grappling with tensions between stoicism/emotional restraint and expressing emotions. Many participants described sharing emotional struggles to be an effective practice to promote mental health because it provided an outlet, a means to expel the negative emotion; consequently, it was often a strategy used in combination with other practices that discharged harmful, negative emotions such as engaging in art, writing, and musical endeavours:

> P7: I think that's the other thing that's been really important for me is talking to people about what's going on for me…and I didn't always do that…a lot of times I would just bottle it up. I wouldn't tell people [about feelings]. I burnt out from one job and it was, I mean, I think I'd been feeling the stress for quite a while but I wasn't talking about it…then one morning I was driving to work and I said 'I'm burnt' and burst into tears…like everything just came out all at once so I think I've learned since then to pace myself better, to talk to people about what's going on for me, to write, in doing the blog writing it's all sort of form a personal perspective…it's not clinical. (53 years old)

Participants demonstrated tremendous proficiency in developing collaborative systems of strategies to promote their mental health using various combinations of formal health services, integrative therapies and self-directed strategies. Several participants, however, emphasized the need for supportive mental health services specific to middle-aged and older gay men due to the unique experience and needs of this age group:

> P21: That's where there's a lot of depression…a lot of conversations and experiences people haven't talked about. There's no space to talk about it. If you ask what is health, health is sitting together, or creating processes where people can actually, like older folks do. They sit down and talk about their aches and pains. We need to talk about our soul's aches and pains as much as our somatic ones. (46 years old)

Some participants spoke about various peer-based support services that had operated at one time or another, but now ceased to exist. Some of these supports were offered through larger resource centres but tended to be temporary in nature. Men talked about the relatively small, defined gay community in Victoria as contributing to the difficulty in establishing and maintaining peer-based mental health supportive services, or any supportive health service specific to gay men. Having the opportunity to connect with others who have gone through similar experiences and challenges in a safe and supportive environment was viewed as greatly beneficial. Despite the efforts demonstrated by men to address mental health challenges, the value and importance of the support of others was alluded to frequently in conversation, despite the difficulty in organizing and maintaining such opportunities.

Discussion

The overrepresentation of mental health challenges among middle-aged and older gay men is a growing public health concern. The epidemiological documentation of a wide range of mental health challenges including depression, suicidality, isolation, anxiety, and grief overwhelmingly demonstrates that these mental health challenges continue to compromise the mental health of gay men (Almeida et al., 2009; Brennan et al., 2010; King et al., 2008, Klein, 2012). Despite recognition of the extent of mental health challenges among gay men in this age group, little is known about men's experiences of mental health and the strategies and practices undertaken to mitigate the harmful effects of mental health challenges. This is essential knowledge to inform the development of health programming to promote and protect the mental health of gay men, as it is well substantiated that targeted programming is most effective when informed and built upon the efforts and capacities of individuals (Holman & Lorig, 2004; Golden & Earp, 2012).

This investigation explored how middle-aged and older gay men experienced their mental health, and the strategies and practices they used to mitigate the deleterious effects of the mental health challenges they experienced with a focus on the influence of contextual circumstances (namely discrimination) on these processes. Participants described an array of mental health challenges they faced over the course of their lives including anxiety, depression, suicidality, and grief which are substantiated by the literature specific to this topic (Almeida et al., 2009; Brennan et al., 2010; King et al., 2008, Klein, 2012). The mental health challenges participants faced contributed to tremendous suffering throughout their lives and were confounded by the historical and ongoing social contexts of their lives; specifically, discrimination by virtue of gay identity, the difficulties associated with living through HIV, and the societal stigma attached to mental illness.

The most striking finding from this investigation was the extent to which middle-aged and older gay men experienced, and continue to experience, extensive suffering. The mental health challenges endured for years must be understood in the context of homophobia, heteronormativity, circumstances of living through HIV and the societal stigma surrounding mental illness. These circumstances at times aggravated or contributed to the development of mental health challenges (in the case of homophobia, heteronormativity, circumstances of living through HIV), or created obstacles to employing strategies and practices to mitigate the deleterious effects of mental health challenges (e.g., discrimination as an impediment to accessing formal health service supports, the societal stigma surrounding mental illness). This finding is in accordance with the extant literature specific to the challenges faced by aging gay men that draws attention to historical and systemic discrimination as a major impediment to receiving adequate support for a range of health complications, including long-standing HIV (Halkitis, 2010) and mental health challenges (D'Augelli, Grossman, Hershberger, & O'Connell, 2001; David & Knight, 2008).

Genke (2004), for example, outlined several contextual issues that contributed to the struggles that aging gay men experience with regards to their health: the impact of HIV/AIDS, invisibility, marginalization, ageism within gay communities and heteronormativity. The author contended that these issues, whether individually or in combination, contributed to the marked barriers within the health care system based on the cultural imperialism of a heteronormative society. Cultural imperialism produces reticence when accessing health services and the potential of reawakening fears of discrimination experienced earlier in life (Genke, 2004). Similarly, an investigation by Clover (2006) highlighted assumed heterosexuality as the primary barrier to older gay men's seeking support from health services, often resulting in the decision to forego health service support altogether.

Another key finding was that men came to recognize the extent of their suffering over time as they aged, which was partly due to gaining new perspectives on mental health; namely, perceiving mental health as integral to overall health. The literature that exists regarding how individuals come to recognize mental health challenges, and the factors that influence recognition (Ciarrochi, Wilson, Deane, & Rickwood, 2004; Crisp & Rickwood, 2006; Wilson & Deane, 2001) has predominantly considered youth populations, but offers some valuable insights. A key finding is that mental health literacy played a huge role in recognizing mental health challenges and consequently seeking support (Ciarrochi et al., 2004; Wilson & Deane, 2001). In essence, young people were found to be most likely to recognize they had a mental health challenge if they had knowledge about mental health challenges and the emotional competence to identify and describe their emotions (Crisp & Rickwood, 2006). In these studies, recognition was a crucial step to seeking help from health services for mental health challenges. There remains, however, little information on this topic with regards to adult populations, including middle-aged and older gay

men. In this investigation, age and experience were found to wield tremendous influence on men's recognition of mental health challenges and their subsequent actions to seek help with these issues.

Given that middle-aged and older gay men continue to maintain considerable suffering due to mental health challenges, and they have, over the passage of time, come to acknowledge the detriment this poses to their well-being, this signals the need for specialized mental health services. An important caveat, however, is that these services must be designed and implemented with sensitivity to the barrier discrimination has posed for middle-aged and older gay men's access and utilization of formal health services. One approach to ensure appropriate and meaningful services would be to incorporate peer-based approaches. Individuals who lived through particular experiences are in the best position to inform services designed to address and navigate the negative emotional experiences associated with anxiety, depression and grief via group engagement and support such as a peer-based design (Bates & Berg, 2014; Im & Rosenberg, 2016; Thupayagale-Tshweneagae & Mokomane, 2014). The efficacy of peer-designed and implemented health resources has been well established in the gay men's health literature, but has been largely situated in HIV and other STI education, prevention and treatment (Harris & Alderson, 2007; Veinot, 2010; Yun Gao & Wang, 2007). Furthermore, employing an overarching social public health approach for the development of specialized mental health services may be of added benefit to further integrate and build social relationships and communities in pursuit of the change that is critical to improving health outcomes; for example, government support via resources provided to community organizations and groups for mental health services 'by the community for the community' (Siconolfi, Halkitis, & Moeller, 2015, p. 566). Such an approach would be informed by the strengths of middle-aged and older gay men and grow and evolve as per the identified needs of the men (Siconolfi et al., 2015).

Middle-aged and older gay men's strategies and practices to minimize some of the deleterious effects of mental health challenges is valuable information to inform health services and health service approaches. In particular, because primary care was a frequent first point of contact for men seeking support with mental health challenges, health providers in primary care are in need of guidance, education and training as to how to best support middle-aged and older gay men with mental health challenges. The literature indicates that primary care providers, in general, are ill-equipped to adequately support individuals seeking support with mental health challenges (Care Quality Commission, 2013; Maust, Oslin, & Marcus, 2013).

In primary care settings, mental health remains relegated to physical health, confounded by lack of a clear understanding of what mental health constitutes (Greenberg et al., 2014; Olfson, 2016). The fact that men take it upon themselves to seek support from health providers in mitigating the deleterious effects of mental health challenges demonstrates remarkable capacity. Participants overcame their reservations rooted in the stigma of mental illness, or worry about discrimination based on gay identity, ultimately to get the help they needed because of the priority placed on mental health. Therefore, it is crucial that reaching out for help be met in primary care with equal regard for the importance of mental health; that is, an informed and supportive approach of the health provider.

Despite increased federal funding for mental illness surveillance and the existence of several public health campaigns and initiatives designed to raise awareness of mental illness and combat stigma such as Changing Lives, Changing Directions: A Mental Health Strategy for Canada and The Anti-Stigma Campaign (Mental Health Commission of Canada, 2012) and the "No health without mental health" mandate (Public Health Agency of Ontario, 2014), there remains little evidence as to whether these initiatives are improving mental health outcomes. In

particular, the question of how health providers are receiving education and guidance as to how to better support individuals with mental health challenges, or the extent to which this is even happening remain unclear.

To support middle-aged and older gay men's efforts to mitigate the deleterious effects of mental health challenges, health programming could derive guidance from mental health initiatives proven to be successful in meeting their proposed goals elsewhere. For example, the Rural Mental Health Project in Ireland (Barry, 2003) drew on a community model to strengthen community capacity through partnerships for mental health promotion. Membership of the project planning group was drawn from a wide range of community members who were engaged through a process of participation to effect community change through implementing a range of local initiatives (Barry, 2003). Mass media interventions, particularly if they are supported by local community action, can have a significant impact on increasing understanding, reducing stigma and increasing knowledge, as well as having a positive impact on mental health literacy (Jane-Llopis, Barry, Hosman, & Patel, 2005). Examples of media campaigns that achieved these goals include the Norwegian Mental Health Campaign launched in 1995 (Søgaard & Fønnebø, 1995) and the United Kingdom's *You In Mind* television series (Barker et al., 1993). The Youth Life Enrichment Program in the Philippines is a school-based initiative demonstrated to improve self-awareness, positive relationships with others, leadership skills and effective communication—as well as fostering positive attitudes towards mental health and people suffering from mental health challenges (de Jesus, 2003). Although the programs and initiatives were diverse with regards to groups targeted and approaches taken, central concepts included education and information on mental health and illness, strategies to build supportive networks and personal skills (namely

communication and the ability to identify and describe various emotional states), and redressing the stigma attached to mental health challenges.

The findings from this study warrant further investigation into middle-aged and older gay men's experiences with their mental health, and how they go about mitigating the deleterious effects of the health challenges they experience. Men's continued suffering necessitates attention be paid to the mental health challenges faced and how men's efforts are being supported to improve their mental health and well-being. Very little is known about middle-aged and older gay men's experiences with mental health. To our knowledge, this is one of the few qualitative investigations to address mental health experiences and gain an understanding of men's strategies to address and manage mental health challenges. More information on men's strategies is necessary to inform meaningful health support services.

This study has several limitations. The purposive snowball sample was drawn mostly from convenience, with men recruiting additional participants from their own social circles. As such, many participants were well connected to groups of gay men and therefore the sample does not necessarily speak to the experiences of men not connected to other gay men, or men who are not openly gay. Furthermore, the study was limited to men who were English speaking and situated within a particular social location—educated, middle-class—which has great bearing on the opportunity these men had to engage with a variety of strategies and practices to better their mental health. More qualitative research is needed pertaining to how not just middle-aged and older gay men, but gay men of all age groups experience and engage with mental health challenges and what they do to maintain and improve psychological wellness. Furthermore, research into the mental health experiences of gay men must be situated within frameworks that appreciate individual

practices embedded within complex social environments that wield great influence on individual practices with an emphasis on structural-level factors; namely, discrimination.

Conclusion

The findings from this investigation support the literature that documents extensive mental health challenges—including anxiety, depression, suicidality and grief—have been, and continue to pose, a marked threat to the mental health of middle-aged and older gay men. The influence of age and experience were recognized as foundational to men's recognition of their suffering and struggles with mental health challenges, which prompted a shift to appreciate mental health as an essential component to overall health. The approaches men employed to minimize the deleterious effects of mental health challenges were found to be situated within the historical and ongoing social contextual circumstances of their lives; namely, discrimination rooted in gay identity (including interactions with the health system) and the stigma surrounding mental illness. Understanding men's strategies to address and attend to mental health challenges is necessary to inform health service supports; most notably, primary care. The current challenge, however, is that several mental health initiatives and campaigns are in existence in Canada, but their efficacy in reducing the stigma attached to mental health and encouraging individuals to seek help remains to be determined. Training and support for primary health providers in strengthening middle-aged to older gay men's efforts in addressing mental health challenges is necessary but must be guided by evidence, with international campaigns and efforts able to provide some preliminary guidance.

CHAPTER 6: CONCLUSION

This chapter begins with a brief summary of the key findings of the dissertation. Next, I describe the unique contributions made to the literature on middle-aged and older gay men's health and illness practices, followed by recommendations for research and practice. I outline suggestions for future research and strategies to dismantle systemic discrimination and improve health services for middle-aged and older gay men. Lastly, I describe knowledge translation approaches to signal how the information from this dissertation will be used beyond scholarly publications to influence policy and practice. The chapter closes with study limitations and a conclusion.

Summary of Findings

The overarching aim of this dissertation was to explore middle-aged and older gay men's health and illness practices in the context of homophobia and heteronormativity. I sought to understand how years of living in a heteronormative environment influenced gay men's health and illness practices and experiences. From the overarching aim, three research objectives were addressed in three separate manuscripts (chapters 3, 4 and 5 respectively). There is a growing body of knowledge that gay men engage in an array of health and illness practices to promote health and navigate illness (Blackwell, 2015; Coleman et al., 2017; Grella et al., 2009; Tate & Ross, 2003); however, this literature is largely centred on engagement with health services, which represents but one component of health and illness practices. Detailed information about middle-aged and older gay men's health and illness practices is fundamental for generating evidence-informed recommendations to improve Canadian public and primary health programs. This investigation offers insights into middle-aged and older gay men's health and illness practices to ultimately inform and improve the effectiveness of health services, programs and resources for gay men.

Essentially, the three research objectives contributed to comprehensive, nuanced understandings about middle-aged and older gay men's health and illness practices in the context of homophobia and heteronormativity. The first objective, describing how men developed resilience over time to promote health and wellness, provided essential information about the unique social contextual circumstances of participant's lives. This information pertaining to social context drew attention to the fact that these men had lived through, in their words and those of the literature, an aggressively discriminative period (Adam, 2005; Forstein, 2013). This discrimination included prohibition of living with the same same-sex partner, an inability to visit a partner in hospital because of negating that a same sex partner was family and the inability to pursue career options such as teaching. Further, how men discussed the emergence of HIV/AIDS and the subsequent crisis brought about by the disease provided valuable insights to understanding how men developed resilience over time. This accounting for how and why resilience developed was necessary to adequately address the second research objective: to provide an account of how men manage their health in the context of homophobia and heteronormativity.

The strength and capacity derived via developing resilience were recognized as essential for men to manage their health in the context of homophobia and heteronormativity. Ultimately, adversity was recognized as ever-present in the day-to-day lives of participants. Adversity was conceptualized as the intersections of historical and ongoing discrimination, acute and chronic health issues, problematic engagement with health services and living through HIV. For men to manage their health, this adversity had to be addressed, faced and ultimately, overcome. The strength and capacity derived from the development of resilience greatly facilitated the ability to overcome this adversity, which was identified as the core process to health management.

In exploring the development of resilience and how men managed their health, it became very clear that mental health is foundational to the health and illness practices of middle-aged and older gay men. Addressing mental health was identified as one of the protective process that comprises resilience, as many men faced a multitude of mental health challenges throughout their life. In managing their health, men identified strategies that were geared towards targeting mental health symptoms such as grief, sadness and anxiousness and were instrumental to their ability to overcome adversity. The focus on how men experience mental health and the strategies they use to mitigate the deleterious effects of mental health challenges drew attention to men's changing perspectives of and consequent prioritization of mental health in their daily lives. In the section that follows I provide a brief summary of each of the three manuscripts.

In Chapter 3, the first of the three manuscripts addressing the three research objectives, I examined how middle-aged and older gay men developed resilience over the course of their lives to promote and protect their health. The focus was on the protective processes that gay men drew on to promote their health in the face of historical and ongoing interpersonal and structural discrimination. Three interrelated protective processes developed in and across men's lives were used to promote and protect their health and the health of their communities, namely: (1) building and sustaining networks, (2) addressing mental health, and (3) advocating for self. Ultimately, resilience was developed by the men's persistent, active resistance to the discrimination they faced in day-to-day life—the tenacity, dedication and capacity they demonstrated to promote and protect their health.

Chapter 4 showcased the grounded theory investigation exploring how middle-aged and older gay men managed their health. Health management was deliberately addressed to examine the specific processes by which middle-aged and older gay men employ health and illness practices

to promote their health and address and navigate illness. Men were committed and actively engaged in a variety of health and illness practices greatly influenced by experiences of living through the emergence of HIV where substantial suffering and the deaths of friends, loved ones and community members were witnessed. The core process for health management, overcoming adversity, comprised numerous challenges rooted in discrimination experienced over the course of their lives. This included historical and ongoing discrimination, acute and chronic health issues, problematic engagement with the health system, and living through the emergence of HIV. To effectively manage their health, the men had to overcome this adversity, which they did by developing and employing a series of practices represented by three interconnected thematic processes: (1) advocating for health needs, (2) knowing about health issues and treatments, and (3) engaging in health promoting practices.

Finally, in Chapter 5 I examined how middle-aged and older gay men experienced their mental health and the strategies they used to limit the deleterious effects of mental health challenges. I drew on the WHO definition of mental health (WHO, 2017) that recognizes mental health as a spectrum of possible experiences ranging from psychological well-being to emotional distress and mental illness. This conceptualization moved away from minimizing mental health as simply the absence of illness, which allowed for a more comprehensive understanding of men's perceptions and experiences with mental health challenges and the strategies used to mitigate the deleterious effects of these challenges. Mental health was revered by the participants as invaluable to overall health, a perspective often adopted after years of prioritizing physical health. Drawing on grounded theory methods, three overarching and interrelated categories were identified that demonstrated how men engaged with mental health promotion strategies to mitigate the deleterious effects of mental health challenges. These strategies included: (1) gaining new perspectives of

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mental health over time, (2) reaching out to formal health services for support with mental health challenges, and (3) engaging in practices to cultivate psychological well-being. The men were found to be committed and actively engaged in developing and implementing these processes to better their mental health.

Unique Contributions

The findings from this dissertation collectively make several unique contributions to a growing body of literature about middle-aged and older gay men's health and illness practices. Although these contributions have been described in detail in each of the findings chapters situated within this manuscript-based dissertation, here the four collective contributions are revisited: theory development, the persistence of discrimination, the utility of a strength-based approach, and recognizing gay men's prioritization and active involvement in mental health matters.

The qualitative design of this dissertation enabled a nuanced, comprehensive understanding of the complexity of contextual circumstances that wield tremendous influence on the health and illness practices of middle-aged and older gay men. The findings also demonstrated that these contextual circumstances are rooted in historical and ongoing discrimination, and the extent of disadvantage this particular group of gay men experienced, and continue to experience, at the hands of heteronormativity and homophobia. Discrimination contributes to poor health outcomes in myriad ways. Years of living in an unjust society has had direct (homophobia) and indirect (heteronormativity) consequences for health and wellness that ranged from withstanding acts of violence (Adam, 2005; Yep, 2002), to exclusion from basic civil liberties (Adam, 2005; Forstein, 2013), to the development of various illnesses including HIV, anxiety, depression and

posttraumatic stress disorder (PTSD) (Conron et al., 2010; Eaton et al., 2010; Ferlatte et al., 2015; Wang et al., 2007).

The first unique contribution of this dissertation is theory development (Chapter 4). Theory development is essential in health research to enable a systematic way of understanding events, behaviours and/or situations (Wacker, 1998) and to guide effective health service development and delivery (Neuhauser & Kreps, 2014). Presently, there is some information in the literature concerning men's health and illness practices that details how middle-aged and older gay men manage their health (Dickinson & Adams, 2014; Harper et al., 2014; Kushner et al., 2013), but this nascent health management theory of overcoming adversity offers understandings of the specifics of *how* men go about these processes and *why*. This theory is possibly the first of its kind for gay men in this age group that can be built, tested and expanded upon. This theory is unique in its consideration of age and temporality as features of health and illness practices and offers conceivable opportunities to examine how these practices develop over time. Additionally, by situating these practices in the larger conceptualization of adversity over time, this theory adds to the growing body of evidence highlighting the need for research aimed at improving the health of gay men to also consider health and health behaviours in the context of historical and ongoing discrimination (Aggarwal & Gerrets, 2014; Ferlatte et al., 2014; Ferlatte et al., 2015; Mustanski et al., 2013). Ultimately, the theory represents a strength-based approach to middle-aged and older gay men's health and illness practices to inspire and motivate other gay men and inform health care providers as well as health services.

This nascent theory of middle-aged and older gay men's health management also can serve as a basis for action within health service development and health delivery. For example, the identified theoretical processes highlight specific practices to support and build upon, and a

potential approach to employ would be the development, application, and trialling of an equity-oriented primary health care (PHC) design for health service and delivery. Specifically, an equity-oriented PHC design would foster men's health practices via a supportive environment established largely by health professional approaches that encourage men's advocating for health needs. Supporting men's advocating for their health needs (and thereby their perspectives and positions pertaining to their health needs) sets the stage for meaningful, informed dialogue about men's knowledge of health and health issues and engagement in health promoting practices. Moreover, given the evidence presented in this dissertation, and elsewhere, that gay men are actively engaged in an array of health and illness practices to manage their health (Blackwell, 2015; Coleman et al., 2017; Grella et al., 2009; Tate & Ross, 2003), this theory provides targeted direction for programming that builds on men's effective capacities to manage their health by identifying the practices and strategies men used to promote their health and navigate illness. Men's knowledge about their health and their capacity to build on effective community support networks have much to offer the revision of health services that are client-centred. Recognition is made to the fact that the men in this study occupied a particular social location in that they shared similar characteristics pertaining to financial stability and educational preparation. It is necessary to consider the potential influence of the benefits associated with this social location with regards to the strength, capacity and tenacity associated with men's health and illness practices.

Second, the work of this dissertation demonstrated that discrimination—at the interpersonal (homophobia) and structural (heteronormativity) levels—*continues* to be a major impediment to the health of middle-aged and older gay men. This is not a new finding as a wealth of literature exists that speaks to the oppression and discrimination existing in heteronormative societies (Aggarwal & Gerrets, 2014; Aguinaldo, 2008; Hatzenbuehler, Keyes, & Hasin, 2009;

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Hatzenbuehler, Phelan, & Link, 2013). Every participant in this investigation shared experiences of being treated differently/poorly by virtue of sexual identity and was currently facing or had faced acute and/or chronic health issues for which powerful examples were provided in the interviews. This study's findings further emphasized the contributions of both forms of discrimination to health inequities; in particular, the influence of heteronormativity within health services, spurring interpersonal discrimination within health encounters. The nefarious effects of discrimination on health outcomes are well documented in the gay men's health literature (Aguinaldo, 2008; Aggarwal & Gerrets, 2014; Ferlatte et al., 2015; Wang et al., 2007) along with the refrain that "gay oppression is killing us" (Banks, 2001, p. 13). Our findings showcased that heteronormative relations of power continue to be reproduced in the micro-relations of interpersonal interactions, thereby highlighting the urgent need for further strategies to reshape both ideologies and interpersonal clinical encounters. These findings serve as a reminder of the disparities between what people say and do.

The health of the men in this investigation was negatively affected by stereotypical assumptions pertaining to gay men and hypersexuality. Despite so-called policy and societal progress, the harmful effects are long-lasting and the social inclusion policies have not translated to the level of the clinical encounter (Aggarwal & Gerrets, 2014; Berg et al., 2012). Health authorities throughout British Columbia all have an anti-discriminatory policy, or mission statement, that declares a commitment to equity and health promotion. For example, the local health authority in Victoria, the Vancouver Island Health Authority (VIHA), has a respectful workplace policy that outlines the dedication to upholding equity via non-discrimination and anti-discriminatory harassment position statements (Vancouver Island Health Authority, 2013). This raises the issue of how do these anti-discrimination policies and/or mission statements truly get

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taken up and applied in practice? Currently, health services and supports for gay men are argued to focus solely on interpersonal discrimination by assisting men's adaptation to an oppressive society, thereby accommodating oppression (Aguinaldo, 2008; Ferlatte et al., 2015; Hatzenbuehler, Keyes & Hasin, 2009; Wang et al., 2007).

One approach to redressing structural discrimination, with a focus on improving clinical encounters, is what is described as a social public health approach. Such an approach considers the interrelationships between individual, social, and structural aspects relevant to health (Kippax, 2012; Kippax & Stephenson, 2012; Siconolfi et al., 2015). Additional approaches include equity-oriented PHC and trauma-informed care, all of which are described in detail in the recommendations for practice section. All these care approaches require the mobilized efforts of health professionals to advocate for equity and lobby local and provincial health authorities to support these efforts. Advocacy and action on the part of health professionals, researchers and members of society is needed to shift structural-level discrimination.

Third, this investigation explored the health and illness practices of middle-aged and older gay men from a strength-based position, focusing on men's capacity and ability to maintain their health and navigate health issues. These men were not passive victims of historical and ongoing discrimination. By contrast, as outlined in Chapter 3, men's active resistance to discrimination enabled the development of resilience over the course of their lives. A strength-based approach can make valuable contributions to improving health outcomes by shedding light on protective processes that individuals employ to overcome adversity that facilitates development of health services and health provider approaches to support extant efforts and ultimately, improve health outcomes; in short, building and supporting what works for individuals (Lyons, 2015). In addition, acquiring information as to how individuals confront and grapple with health challenges provides

key insights to effectively supporting and treating health problems (Tedeschi & Kilmer, 2005). The men's ability to advocate for their needs within health settings was a key finding that indicated that advocating for health needs is an essential health practice middle-aged and older gay men maintained in their health management, which is congruent with the growing research in the area of gay men's resilience (Herrick et al., 2012; Lyons et al., 2014; McLaren et al., 2008). Advocating for self in health encounters has been noted in other contexts, such as chronic illness, to be essential for health management (Fenkl, 2012; Lipton, 2005). For these gay men, having extensive knowledge about their health concerns (e.g., biological processes, various illnesses, their etiology and modes of transmission, treatment approaches) enabled them to engage in informed discussions with health providers. By being informed and engaging in healthy living practices, men constructed themselves as informed, engaged health care consumers, which cultivated a level of confidence to deliberate with health providers and advocate for health needs. This finding contrasts dominant discourses that have positioned gay men as irresponsible with regards to health matters (Adam, 2005; Forstein, 2013) and that are pervasive within the health services domain via the espoused assumptions of health providers around gay identity that the men disclosed.

The participants in this study were driven by the desire to live a healthy life. Unlike literature that documents masculine norms around stoicism and reluctance to seek help with health matters (Galdas, Cheater, & Marshall, 2005), these men identified a sense of personal responsibility for health that included engaging with health care providers. The crucial role of primary care in gay men's health management is well documented (Hightow-Weidman et al., 2011; Quinn et al., 2015; Mimiaga et al., 2007) and accentuates the importance of the relationship with primary health providers; most specifically, family physicians and/or nurse practitioners. For participants, a trusting respectful relationship with a family physician meant willingness to address

health concerns in general, but particularly those of a more sensitive nature such as sexual or mental health issues. Men were willing to seek out a trusting relationship with a primary health provider as they recognized the importance of this relationship to health management, and consequently, overall health. These findings echo the importance of trust for positive and effective health care encounters and offer areas of further inquiry into what constitutes a trusting relationship for men and their care provider.

Fourth, recognition that mental health is indeed prioritized by gay men is a key finding. When men spoke of health and illness practices, their perspective on health was such that physical and mental health were essential, equivocal and deeply connected. Despite extensive documentation of mental health challenges among gay men (Conron et al., 2010; Wright et al., 2012), and growing evidence that gay men are actively involved in health matters (Blackwell, 2015; Coleman et al, 2017; Grella et al., 2009; Tate & Ross, 2003), this is one of few qualitative explorations into how men think about their mental health, and the strategies used to mitigate the deleterious effects of mental health challenges. As with physical health, men were actively involved in addressing mental health challenges and prioritized maintaining and improving psychological well-being. The perspective that physical and mental health are inseparable and equal contributors to overall health inspired men to pay attention to their mental health with the same degree of vigilance and commitment as they had for years with physical health. Just as with physical health matters, men perceived health services, namely family physicians, as essential to promoting their mental health.

Despite the historical and ongoing stigmatization of mental illness, confounded by the discrimination associated with gay identity, men in this study actively sought support from their family physicians by disclosing mental illness and/or emotional distress. Doing so required rapport

to ensure adequate, appropriate support. Despite men's efforts the separation of mental and physical health was experienced in primary care, with physical and mental health addressed and treated as distinct entities. This created tensions and difficulty for the men who perceive their health to be the equal contributions of their physical and mental states. The lack of formal health service support that conceptualizes and approaches health as a collective of physical and mental components was a barrier to mental health promotion and necessitated that men conjured their own strategies to promote mental health. Although this once again demonstrated the strength and capacity of men as deeply committed and engaged in their health matters, the dearth of such support services represented a great barrier to mental health promotion.

Recommendations for Research and Practice

While specific recommendations were detailed within the discussion of each findings chapter, the collective work of this dissertation informs recommendations for health research and practice. Specifically, the findings from this dissertation represent a preliminary body of work on the health and illness practices of middle-aged and older gay men with the impetus to improve health outcomes by adjusting existing health services and developing new, effective services, while guiding health professionals to deliver effective and appropriate care. In particular, the findings suggest specific frameworks such as equity-informed PHC and trauma-informed care may be used to develop meaningful health services and changes to nursing and medical school educational curriculums. Furthermore, ongoing professional development opportunities for nurses and physicians could support health professionals in engaging meaningfully and appropriately with middle-aged and older gay men.

Recommendations for research

The current study findings offer insights into gay men's health and illness practices that encompass a variety of social practices gay men engage in to maintain their health and navigate illness. A key point is the recognition of health as encompassing physical and mental health. The gay men's health literature has tended to focus on HIV and STIs, with growing attention paid to mental illness and emotional distress; however, these issues are most often disaggregated and treated as separate concepts and experiences. There is growing recognition of physical and mental health as deeply connected and equal contributors to overall health (Dunn, Handley, & Shelton, 2007; Fagerlind, Ring, Brulde, Feltelius, & Kettis-Linblad, 2010). The findings from this dissertation that demonstrated gay men aligned with this perspective indicate that further research into gay men's health and illness practices would benefit from using frameworks that position health as the overarching product of mental and physical health. In doing so, the findings derived would speak to this comprehensive conceptualization of health that is growing in popularity (Dunn, Handley, & Shelton, 2007; Fagerlind et al., 2010) and was clearly supported by the men who took part in this project. Moreover, intervention research that investigates the efficacy of health service approaches adopting the conceptualization of health as a collective of physical and mental components is needed. Such interventions could be simple in design, for example, exploring the impact of non-judgmental approaches to care with the goal of improving patient trust and satisfaction. The intervention could involve providers beginning each health encounter by inquiring about how the individual perceives their health at the present moment, similar to the questioning used in the interviews in this dissertation followed by formal evaluation. This could allow for elaboration on all aspects of wellness deemed meaningful to the individual and with formal evaluation to indicate effectiveness, provide a valuable starting point.

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Further qualitative investigation into middle-aged and older gay men's perspectives pertaining to meaningful and effective health services and health service provision is indicated and would be a valuable follow-up investigation to this dissertation. In particular, including the perspectives and identified needs of health providers as to how to best provide support to adequately and meaningfully provide care for middle-aged and older gay men is indicated. Comparing and contrasting men's perspectives and needs to those of health providers could generate valuable insights as to how to most effectively align middle-aged and older gay men's needs with health service provider approaches to ensure respectful and effective interactions and ultimately, care provision.

This study also illustrates the need for research that explores the diversity of gay men's experiences of discrimination and its impacts on health and illness practices across geographical contexts. Evidenced by the extent of discrimination men disclosed experiencing when living in smaller communities in this dissertation (which often prompted relocation to larger centres), further exploration is indicated into how residing within a smaller community may influence health and illness practices for middle-aged to older gay men. This would build on the extant research into the health needs of gay men in rural contexts (Imrie, Hoddinott, Fuller, Oliver, & Newell, 2013; Preston, D'Augelli, Kassab, & Starks, 2007). Additionally, research that takes into consideration a lifespan approach for gay men's health is urgently needed. Longitudinal research to examine how health and illness practices may shift and evolve across the lifespan are necessary. Exploration into the persistence of homophobic and heteronormative policies within schools is indicated. As illustrated in this dissertation, years of life brought about experience and perspective that served to inform and shift men's health perceptions and consequently, health and illness practices.

There is also an important need to expand research beyond the epidemiology of mental illness and emotional distress, particularly among middle-aged and older gay men. This dissertation provides one of the first qualitative explorations of how Canadian-based middle-aged and older gay men experience their mental health and the strategies they use to mitigate the deleterious effects of mental health challenges. Gay men disclosed their experiences with mental health challenges despite the stigma attached to these issues; this further validates the value placed on mental health as an essential component of health. Thus, additional qualitative research into men's perceptions of mental health, experiences with mental health, and recommendations for support services is needed to build on the findings in this dissertation. Given this age group of men not only faced myriad forms of discrimination over many years, the trauma of living through HIV and witnessing tremendous death and suffering has great ramifications for mental health and necessitates investigation of how the mental health of gay men can best be supported and promoted by services and health providers. Investigations that focus on gay men's experiences across the lifespan are needed to appreciate and gauge change across time and generation.

Given the findings in this dissertation indicated that structural discrimination persists and is reproduced within interpersonal interactions, exploration into the ways that heteronormativity is produced and reproduced would facilitate ongoing education for health professionals, particularly by drawing attention to heteronormative ideology and how it permeates health encounters. Because ideological processes are understood to be entrenched in contemporary society to the extent that their presence and consequent impact is challenging to recognize (Heywood, 1992), explorations of the multitude of subtle and obvious ways heteronormativity occurs and remains unchallenged are necessary. For example, analysis of video and print media (that is, media and discourse analyses) to examine the various ways by which heteronormativity is manifested in institutional

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and everyday discourses to exclude gay men could be used to guide the curriculums of health disciplines. Such an analysis could also inform ongoing professional development and teaching for health professionals, as well as to guide health service development including formal evaluation of such efforts. As Aguinaldo (2008) asserts, doing so positions discrimination at the structural level, as opposed to focusing on homophobia, by supporting men to live in an unjust society.

Lastly, given that the participants in this study occupied a similar social location, in that they shared similar characteristics with regards to their financial stability and educational preparation further investigation into the potential influence of social location on men's health and illness practices is warranted. Specifically, consideration of the potential influence of privilege in terms of socio-economic standing and education is warranted. A follow-up study with a larger sample size along with diversity of social location would facilitate understandings of how social location plays out in middle-aged and older gay men's health and illness practices.

Recommendations for practice

The findings from this dissertation indicate that middle-aged and older gay men continue to experience discrimination within health settings, and this discrimination represents an impediment to their health and illness practices and subsequently, overall health. Although discrimination in health settings was recognized as, at times, facilitative to confidence building and advocating for health needs, gay men have suffered tremendously by the harmful and ill-informed assumptions they faced within these settings. The dearth of meaningful and effective health programming for gay men is also representative of discrimination as it represents inequity via the unavailability of needed health services to promote health and well-being. To address the

issue of ongoing discrimination, I align with Aguinaldo's (2008) assertion that current health promotion efforts for gay men must focus outward to enact change within the broader social world (e.g., targeting structural discrimination) and simultaneously address how heteronormativity is reproduced at the interpersonal level in health settings.

Situating discrimination at the broader societal level and reproduced at the interpersonal level effectively dictates the type of health promotion programming possible by drawing attention not only to individual experiences (interpersonal level discrimination) and the consequent practices put in place to combat this discrimination, but also the contextual circumstances that strongly influence these experiences (Aguinaldo, 2008). As such, practice recommendations focus on addressing structural discrimination with existing health services, (for example, rainbow stickers to advertise welcoming of diversity, health professionals informed as to the health challenges faced by gay men). Recommendations also emphasize the development and design of new services (pushing for equity-oriented PHC, trauma-informed care, and participatory models), and within delivery via interactions with health professionals (support and guidance for health professionals via educational and professional development training opportunities). The need for incorporation of the health challenges and needs of middle-aged and older gay men in medical and nursing school curriculums is also warranted. Approaching both forms of discrimination simultaneously is necessary to abolish harmful discriminative stereotypes perpetuated by heteronormative ideology that manifests within health service environments, including the dearth of health services altogether.

Another viable strategy to combat structural discrimination while preventing interpersonal discrimination in health settings is adopting an equity-oriented PHC design (Browne et al., 2016; Starfield, 2006; WHO, 2008). Equity-oriented PHC would behoove recognition of the

disadvantage gay men face due to structural discrimination while calling for this very discrimination to be redressed; for example, tenets of this design include partnerships with gay men, action at all levels (patient–provider, organizations, systems), attention to local and global histories, and attention to unintended and potentially harmful impacts of each strategy (Browne et al., 2016). Due to extensive discrimination they experienced, the establishment of a safe space was also a fundamental concern of the men who took part in this investigation, and could be achieved using an equity-oriented PHC approach (Browne et al., 2016). The assurance of safety must be clearly advertised for men to access the service, achievable by the simple addition of a rainbow sticker or a slogan to emphasize inclusion of diversity. Safety within the space is of equal importance and well documented in the literature (Feldman et al., 2011; Mimiaga et al., 2007; Quinn et al., 2015; Taegtmeyer et al., 2013). Other strategies to support safety in the space include placement of service policies about equity and action on the walls of waiting areas as a way to redress discrimination, and ensuring that staff are respectful, welcoming and informed about inequities perpetuated via structural discrimination.

A key component to equity-oriented PHC that holds great relevance for middle-aged and older gay men is trauma-informed care, which recognizes that most people affected by systemic inequities have experienced varying forms of discrimination, with traumatic impact (Browne et al., 2016). For older gay men, awareness of the trauma and grief associated with HIV would greatly facilitate discussions about mental health. Due to the openness with which men discussed mental health issues, and the emphasis on the need to ask for help, it is likely that a meaningful dialogue with providers can be established if broached appropriately. Additionally, trauma-informed care would facilitate awareness and understanding of the interconnections of discrimination and mental health issues to encourage discussions about substance overuse, which some participants in this

investigation disclosed, and which the literature identifies to be a pressing issue with some groups of gay men (Aggarwal & Gerrets, 2014; Ferlatte et al., 2015; Wang et al., 2007).

Drawing on an equity-oriented PHC and/or trauma-informed approach would necessitate health providers working with middle-aged and older gay be knowledgeable about the extensive discrimination faced by middle-aged and older gay men, and how this discrimination creates numerous obstacles to health. To do so, health discipline curriculums (primarily in medicine as family physicians were the most frequent contact for health provision) must firstly recognize and appreciate the varied ways by which discrimination contributes to poor health outcomes. The push for this curriculum shift would be facilitated by recognition of discrimination as a social determinant of health, as advocated by extensive work in social epidemiology (Krieger, 2014). Furthermore, health discipline curriculums require guidance for health professionals to effectively meet the needs of gay men, an issue raised in the literature (Blackwell, 2015; Gee, 2006; Rutherford et al., 2012; Substance Abuse and Mental Health Services Administration [SAMHSA], 2012). Ongoing professional education and training opportunities are also indicated for health providers (Blackwell, 2015; Gay and Lesbian Medical Association, 2006; Rutherford et al., 2012). In particular, additional and ongoing training and education for health providers regarding HIV is indicated, based on the findings from this investigation; in particular, current treatment approaches to facilitate addressing concurrent health issues. Our findings demonstrated a dearth of understanding as to transmission and current treatment approaches, in addition to a general perseveration on HIV, when the visit was prompted by an unrelated issue. These oversights on the part of the health provider disrupted rapport and effectively dissuaded men from further engagement with the service, thereby creating another barrier to health and wellness.

The theory developed in this dissertation indicates the potential utility of a participatory, or user-centred design for program development and evaluation of health services (Neuhauser & Kreps, 2014). A participatory design in this case would involve middle-aged and older gay men in the development, assessment and evaluation of new health services. The input of middle-aged and older gay men would guide health service development, including supporting health professionals in their conduct with gay men as well as evaluation of overall service procedures (Neuhauser & Kreps, 2014). This approach tightly links development and evaluation so there is constant feedback about problems, solutions and needed revisions (Neuhauser & Kreps, 2014).

The need for specific health services for gay men; in particular, services informed by a conceptualization of health as the collective of mental and physical components, was evident in this investigation. Among middle-aged and older gay men, the accumulation of issues and experiences rooted in discrimination including the trauma of living through HIV, has proven a heavy burden on the health and wellness of gay men in this age group. One such approach to developing such support services with the aim of targeting structural discrimination is a social public health approach. This integrates and builds on social relationships and communities in pursuit of the change that is critical to promoting health outcomes; for example, government support via resources provided to community organizations and groups for mental health promotion 'by the community for the community' (Siconolfi et al., 2015, p. 566). Social public health is rooted in the sharing of strengths and capacity that can engender social change, while supporting individual-level health promoting strategies and is harmonious with the concept of peer-based resources. Resources and programs specific to mental health promotion are needed for men in this age group and must be informed by the men themselves to determine what will be most

effective in terms of service design and delivery (Bates & Berg, 2014; Im & Rosenberg, 2016; Thupayagale-Tshweneagae & Mokomane, 2014).

The efficacy of peer-designed and implemented health resources has been well established in the gay men's health literature, but has been largely situated in HIV and other STI education, prevention and treatment (Harris & Alderson, 2007; Veinot, 2010; Yun Gao & Wang, 2007). Participants identified the need for specific resources for gay men aged 40 and above; in particular, resources that would enable conversation and healing with respect to multiple traumas experienced over the course of many years that also include myriad forms of discrimination and living through the pre-treatment HIV era. Individuals who lived through these experiences are in the best position to inform services designed to address and navigate the negative emotional experiences associated with diagnosed anxiety, depression, as well as emotional distress via group engagement and support (Bates & Berg, 2014; Im & Rosenberg, 2016; Thupayagale-Tshweneagae & Mokomane, 2014).

Knowledge Translation

Knowledge translation (KT) is an essential component of health research and delineates specifically how the information gleaned from inquiry will be put towards improving health outcomes (Harrison, Legare, Graham, & Fervers, 2010). The Canadian Institutes for Health Research (CIHR) identifies KT as a dynamic and iterative process that includes the synthesis, dissemination, exchange and ethically sound application of knowledge to improve the health of Canadians via more effective health services and strengthening of the overall health care system (CIHR, 2016). Specifically, Harrison et al. (2010) specify that the KT process takes place within a complex system of interactions between researchers and a variety of key knowledge users, which

may vary in intensity and level of engagement depending on the nature of the findings and needs of the particular knowledge user. Therefore, the findings from this dissertation will be shared with several key knowledge users, including community members (that is, middle-aged and older gay men), health providers, health authority and provincial ministry representatives, as well as medical and nursing curriculum development organizations.

First, beyond the dissemination of the findings in academic forums such as scholarly journals and conferences, the key insights from this investigation will be shared with members of the community in settings such as the Community Based Research Centre (CBRC). To develop services and incorporate approaches to service delivery congruent with the findings from this dissertation—such as equity-oriented primary health care, trauma-informed care and participatory action models—necessitates lobbying the VIHA. In addition, meeting with and giving presentations to health professionals within nursing and medicine is required to encourage advocacy for, and prioritize development of, the needed policies and processes within their organizations to support services such as equity-informed PHC and trauma-informed care. Furthermore, lobbying at the level of the British Columbia Ministry of Health and sharing the key contributions with representatives of the Provincial Government is the first step towards policy change. Additionally, connecting with organizations that influence curriculum development within medicine, such as the Association of Faculties of Medicine in Canada and the Canadian Association of Schools of Nursing, is needed to facilitate education of health professionals. To incorporate the key findings from this dissertation into medical and nursing school curriculums, starting at the level of the associations, could incite dialogue with individual schools and faculties throughout the country to initiate conversations about how to incorporate the key findings pertaining to heteronormativity and the need for specialized approaches to care into the medical

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and nursing school curriculums. The use of media and social media platforms also provides an opportunity to share key findings and inspire dialogue amongst nursing and medical students, faculty, and individuals involved in the organizations that influence curriculum development.

Limitations

This dissertation has several limitations. Firstly, the purposive sample was drawn largely from convenience, as men recruited subsequent participants from within their own social circles. As such, most men who took part in the investigation were well connected to communities of gay men and therefore the sample does not necessarily speak to the health experiences and health and illness practices of other gay men living in Victoria. For example, men who are not necessarily connected to other gay men, or openly gay. Another limitation is recognized in recruiting men who self-identified as gay. Self-identification with a particular sexual identity does not guarantee the individual openly identifies with family, friends, employees and so forth. The literature indicates experiences of men who self-identify as gay, but are not necessarily openly gay, face unique challenges such as psychological distress (Legate, Ryan, & Weinstein, 2012; Quinn & Chaudoir, 2009). This investigation was also limited to men who were English speaking. The cross-sectional design of this investigation and specific location are additional limitations inherent to the study design and sample.

Conclusion

The findings of this dissertation detail the health and illness practices of middle-aged and older gay men in the context of homophobia and heteronormativity. They also illustrate the tremendous resilience demonstrated by gay men in resisting historical and ongoing discrimination to promote and protect their health, as well as the value and importance placed on mental health

as an integral, albeit historically relegated aspect of overall health. The findings underscore the need to redress structural discrimination while supporting the array of health and illness practices men engage in to promote their health and navigate illness to ultimately improve health outcomes. The need for health service design and delivery to be steeped in recognition of the historical and ongoing influence of discrimination on middle-aged and older gay men's health was made clear. The strengths and capacities demonstrated by the health and illness practices men employed to promote their health and navigate illness can be used to inform meaningful health service delivery to support gay men's health. There is also a continued need to better understand how gay men in this age group experience mental health and the strategies used to mitigate the deleterious effects of mental health challenges. These are necessary steps to ultimately improving the health outcomes of middle-aged and older gay men.

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Appendix A: Consent form

The University of British Columbia
School of Nursing Vancouver Campus
T201-2211 Wesbrook Mall
Vancouver, BC V6T 2B5
Phone: 604-822-7417
Fax: 604-822-766
www.nursing.ubc.ca

Project Title: Exploring the Process of Health Management amongst Gay Men: A Grounded Theory Study

Dear Study Participant,

Ingrid Handlovsky, as part of the requirement for completion of the degree of doctor of philosophy (PhD) in nursing is conducting a study with Drs. Victoria Bungay, Joy Johnson and John Oliffe to better understand how gay men go about health management (that is, maintaining health in addition to navigating health issues). Our aim is to better grasp the resources gay men seek out for guidance and support with regards to health and health issues. We hope that by conducting this study we can inform new and pre-existing health resources in the Victoria area to meaningfully support and protect the health of gay men.

The study will involve individual interviews with gay men and resource people who were identified by participants as having been affiliated with a resource that was sought out for health guidance and support. Each interview will last for approximately one hour. The interview will be guided by Ingrid Handlovsky. Each interview will be audio-recorded and transcribed. All names of people and places will be removed from the recordings during transcription. You will be asked some questions regarding the work that you do and how you came to be involved in this work. You will receive the option of twenty-five dollars or a gift card of equivalent value for your participation.

Your responses in the interview are confidential and no identifying information will be recorded. Participant names and other identifying information including place of employment will be kept strictly confidential. Participants will be assigned unique numerical codes and no identifying qualifiers will be associated with any participant. The results of this study will be communicated in a written thesis, written papers and possibly oral presentations with all personal and employment identifiers removed. No health care clinics, resource centre, or individuals' personal identifiers associated with these services will be reported in communicating the results. Data about providing services to gay men will be aggregated in the analysis to ensure that no place or person is identifiable in communicating the results. Individual information collected during the interview will not be shared with your employer. Participation will in no way affect employment.

You have the right to decline to participate in the study or may withdraw at any stage without consequence. If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Research Participant Complaint Line in the UBC Office of Research Ethics at 604-822-8598 or if long distance email *RSIL@ors.ubc.ca* or call toll free 1-877-822-8598.

Thank you for your assistance. Please keep this information in case you have questions in the future and wish to contact me, Ingrid Handlovsky, or Dr. Vicky Bungay.
Ingrid Handlovsky

Appendix B: Recruitment flyer

The University of British Columbia
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T201-2211 Wesbrook Mall
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Gay Men's Health Maintenance and Navigation of Health Issues

Are you a man who self-identifies as gay, and are 40 years or older?

Do you currently live in Victoria?

Participation in this study is open to men who identify as gay, currently live in Victoria and are over the age of 18; however, for this phase of interviews we are specifically seeking men who are 40 years of age or older.

The purpose of this study is to understand how gay men maintain their health and go about navigating health issues, with a focus on the resources sought out for health guidance and support. We hope to share what we learn with existing health resources as well as to inform resource development to better promote and protect the health of gay men.

This study is being conducted by the school of nursing at the University of British Columbia (UBC).

Please contact Ingrid Handlovsky, or Dr. Vicky Bungay for more information.

Appendix C: Interview Guide

Exploring the Process of Health Management Amongst Gay Men: A Grounded Theory Study

Thank you for agreeing to be interviewed for this project. As you know, we are conducting a study to learn more about the process by which gay men manage their health and the various factors that influence this process. We would like to hear what you have to say about your own health experiences and concerns, what kinds of resources you have sought assistance from and why, and what resources have been helpful and/or unhelpful and why.

Probes:
- To get us started, I would like you to share a little bit about yourself
  - What you do for a living? What do you enjoy doing in your spare time?

- How might you describe your health?
  - What comes to mind when you think about your health?
  - IF health issues/concerns come up:
    - How did you first come to recognize this health concern?
    - What do you do to address this health concern?
    - What sort of things have influenced how you go about dealing with this health issue?
  - IF participant does not identify any health problems/describes self as "healthy"
    - How do you stay so healthy?
    - What kinds of things do you do to stay healthy?
    - What has influenced how you go about staying healthy?

- Can you walk me through one of your first experiences with a health issue-tell me a little bit about what that experience was like for you
  - What did you first think about? How did you know that there was an issue?
  - Can you tell me how you went about dealing with the health issue-how did you learn to do that?
  - Was there someone or something you turned to for support?
  - Is that how you would usually deal with something like that?
  - How did you come to approach dealing with the issue that way?

- Is this how you would deal with a health issue now?

- What do you think others can learn from your experiences?

- Do you have any questions for me?