CHAPTER 8

Mental Health and Sexual Health

Abstract In this chapter, the reciprocal relationship between mental health and sexual health is outlined. Social stigma and its impact for identity processes are considered. Following a discussion of key empirical research into mental and sexual health among gay men, a model for predicting health outcomes and preventing poor mental and sexual health in this population is described. This chapter explores the epidemiological, psychological and socio-structural factors that can impinge on health outcomes in gay men.

Keywords Mental health · HIV · Sexual health · Psychological trauma

Gay men face significant inequalities in relation to mental health and sexual health, both of which are broad and multifarious categories. In some cases, poor mental health is the antecedent to poor sexual health as it can predispose the individual to engage in sexual risk behaviour. In others, poor sexual health, such as infection with human immunodeficiency virus (HIV), can cause or exacerbate mental health issues, such as depression. Moreover, every health condition—be it physical or mental—has a psychosocial dimension. The condition is given a label. It will evoke particular social representation. It will be experienced differently by different people. Social representations and identity concerns play a fundamental role in how health and illness are construed and experienced.

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The Role of Social Stigma

Poor mental health, poor sexual health and homosexuality are stigmatised in society. Social stigma on the basis of sexual orientation, which, as indicated in Chapter 2, constitutes a fundamental, immutable aspect of the individual's identity, can take its toll on gay men's psychological wellbeing. It may lead some gay men to conceal or deny their sexual orientation, to feign heterosexuality on false pretences, and to avoid seeking social support with sexual identity issues.

Yet, sexuality is not the only source of social stigma for gay men. Since the first clinical observations of acquired immune deficiency syndrome (AIDS) in 1981 and the subsequent observation that gay men were disproportionately affected by HIV (the virus that causes AIDS), the stigma of this 'gay disease' has bedevilled the gay community, often reinforcing the stigma of homosexuality itself. HIV carries stigma due partly to its public association with taboo issues, such as sexual promiscuity, sex work and drug use, and the beliefs that HIV is synonymous with AIDS and invariably life-limiting.

In attempting to explain public disengagement from HIV, Joffe (2007) has argued that human beings tend to 'other' adversity, disease and markers of stigma from the self and ingroup and, conversely, to associate them with outgroups. The perception of HIV has been no different. Given the stigma of the condition, many gay men prefer not to test for HIV, perceive themselves to be at low risk of infection, and disengage from HIV care when diagnosed. Many understandably fear the reactions of significant others, sexual partners and healthcare professionals if they disclose their HIV status and, thus, fail to do so. Poor mental health may be a precursor to HIV infection, often paving the way for engagement in behaviours that can increase the risk of infection. On the other hand, the stigma of HIV itself can adversely impact mental health among those exposed to both the virus and the associated stigma.

The social stigma appended to poor mental health such as depression, suicidal ideation and self-harm, and the taboo of discussing it may lead some individuals to conceal symptoms, to delay seeking treatment, and to adhere poorly to treatment. In communities with a collectivist cultural orientation, social stigma can also extend to the patient's family, which in turn could affect employment, marriage prospects and, more generally, the family's standing in the community (see Chapter 6). Although social networks can be protective, primarily by providing the

individual with a source of social support, they may sometimes constitute an obstacle to positive coping. Some people do not recognise the severity of poor mental health, believe that sufferers should 'pull themselves together', or pejoratively label poor mental health as 'madness' (Robinson, Turk, Jilka, & Cella, 2019). Thus, social networks might not provide the desired social support, but may inadvertently stigmatise the individual experiencing poor mental health. Devoid of social support, the individual may resort to maladaptive strategies for coping with mental health problems, e.g. self-medication, use of substances to cope, disengagement from mental health services.

In Chapter 3, identity process theory was described. The theory provides a useful heuristic framework for understanding the inter-relations between stigma, identity and wellbeing. The central premise of the theory is that individuals attempt to construct identity in ways that provide satisfactory levels of the identity principles and that, when the identity principles are curtailed, identity is threatened. This volume is replete with examples of identity threat among gay men. The case studies in Chapter 1 are especially illustrative of the multiple psychosocial stressors that can result in threatened identity.

Yet, the social stigma associated with poor mental health, poor sexual health and HIV infection—all of which are more prevalent in gay men than in the general population—merit special attention. The imposition of undesirable change as a result of coming out as gay, or being diagnosed with HIV could challenge continuity, self-esteem and self-efficacy. Unresolved, chronic threats to identity (like the chronic illness of HIV) can undermine psychological wellbeing and potentially lead to mental health issues, such as depression, anxiety and suicidal ideation (Breakwell, 1986).

In addition to the potential adverse impact of identity threat for mental health, some of the strategies intended to alleviate threat may lead to poor mental health outcomes. Intrapsychic strategies that enable the individual to deflect, rather than confront, the threat have limited effectiveness. Denial enables the individual to ignore the threat, but the threat continues to exist and may in fact be aggravated by inaction. Isolation can exacerbate depression as it precludes group support for the threatened individual—a strategy, which, conversely, is associated with better psychological wellbeing outcomes. Furthermore, some strategies themselves can become pathological in nature—transient depersonalisation is a temporary state of psychological detachment from the self,

which can buffer the negative effects of identity threat in the short term, but chronic depersonalisation may be indicative of psychosis. It is therefore essential that gay men facing psychological adversity be guided towards adaptive and productive coping strategies (Jaspal, 2018a).

Mental Health

The World Health Organization (2001, p. 1) defines mental health as 'a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community'. This definition acknowledges the individual's inevitable exposure to events and situations which can cause psychological stress and captures the importance of both self-efficacy and community belonging in mental health. Mental health conditions are multifarious and can include psychological distress, anxiety, depression, suicidality (suicidal ideation, attempted suicide and actual suicide), self-harm and others. There is evidence that gay men experience poorer mental health outcomes than the general population and that there is a higher prevalence of these specific depressive psychopathological conditions in gay men than in the general population (Sandfort et al., 2006).

Psychosocial Stressors

The Minority Stress Model (Meyer, 1995) postulates that prejudice, expectations of rejection and discrimination, concealment of sexual identity and internalised homophobia predict poor mental health outcomes. On the basis of this model and the research that underpins it, the risk factors for poor mental health can be divided into two broad categories:

- Situational stressors (e.g. homophobia, racism, rejection from significant others, victimisation, lack of social support, decreased access to services).
- Psychological self-schemata (e.g. low self-esteem, decreased 'outness', internalised homophobia).

These situational stressors and negative psychological schemata are inter-related—it is easy to see, for instance, how chronic exposure to homophobia may lead the individual to internalise that homophobia

and, conversely, how low self-esteem may encourage the individual to accept uncritically victimisation from others (see Jaspal, Lopes, Jamal, Paccoud, & Sekhon, 2017). Collectively, these situational stressors and psychological self-schemata may increase the risk of poor mental health.

Gay men may experience heterosexism, internalised homophobia and a lack of social support. In response, they may engage in maladaptive behaviours, such as substance misuse and chemsex (McCall, Adams, Mason, & Willis, 2015). The prevalence of situational stressors appear to be high in gay men. In their survey of 8382 Canadian gay men, Ferlatte, Dulai, Hottes, Trussler, and Marchard (2015) found that 47% had experienced harassment, 16% workplace discrimination and 13% physical violence due to their sexual orientation. Gay men are especially vulnerable to both situational stressors (e.g. homophobia, discrimination, rejection from significant others) and negative psychological self-schemata (e.g. internalised homophobia), which may predispose them to psychopathology (Jaspal, Lopes, & Rehman, 2019).

Poor mental health appears to be prevalent in gay men. In a survey of 6861 gay men in the UK (Guasp, 2013), it was found that 13% of those surveyed were experiencing symptoms of either anxiety or depression. Seven percent of gay men had self-harmed in the last year, and 21% of those aged between 16 and 19 had done so. The survey also revealed that over a quarter of respondents reported suicidal ideation, and that 3% of respondents had actually attempted suicide in the last year. Suicidality was particularly prevalent in younger gay men, with 10% of those aged between 16 and 19 having attempted suicide.

The Gay Men's Health Survey also revealed that half of the gay men surveyed had, at some point, felt that their life was not worth living, indicating low levels of self-esteem. Furthermore, in their study of 7872 Canadian gay men, Salway et al. (2018) found that 19% of respondents had reported suicidal ideation or a suicide attempt in the previous 12 months, of whom 42% had sought no professional support for their mental health problem. Older age, access to larger social support networks and outness about one's sexual identity were associated with engagement with mental health care, suggesting that those most vulnerable to suicidality (e.g. younger men, those devoid of social support and those living in secrecy) are less likely to seek the support they need.

There is much empirical support for the hypothesis that the high prevalence of situational stressors and negative psychological schemata in gay men is associated with poor mental health outcomes in this

population. In their study of 304 gay men, Hart et al. (2019) found that childhood bullying due to gender nonconformity was associated with adult loneliness, depression and anxiety, highlighting the significance of childhood adversity in the onset of poor mental health in adulthood. In their survey of 1423 gay and bisexual men, Sattler and Christiansen (2017) found a higher prevalence of mental health problems in those who had experienced high levels of victimisation and those who expected to be rejected by others.

In addition to first-hand experience of discrimination, the *expectation* of discrimination is associated with poor mental health—Hatzenbuehler, Nolen-Hoeksema and Erickson (2008) found that those gay men who perceived the world a dangerous place for gay people were more likely to report depressive symptoms than those who did not hold this perception. Social representations in one's context will, in part, determine one's expectations regarding rejection. As a potential strategy for coping with anticipated stigma and rejection on the basis of their sexual identity, some gay men conceal their gay identity and feign heterosexuality. Although this may provide temporary respite from discrimination, it is a maladaptive coping strategy in that sexual identity concealment can be psychologically exhausting, carries the risk of involuntary exposure, and is generally associated with psychological distress (Cohen, Blasey, Taylor, Weiss, & Newman, 2016).

In addition to outgroup discrimination on the basis of sexual orientation, gay men also face *intragroup* discrimination, that is, from other gay men, due to stigmatised characteristics, such as high body mass and HIV status. Survey data from 796 Australian gay men (Marmara, Hosking, & Lyons, 2018) revealed that body image disturbance was associated with several mental health outcomes, including satisfaction with life, self-esteem, positive wellbeing and psychological distress. In that study, being in a relationship did not moderate the relationship between body image disturbance and mental health outcomes, suggesting that perceived rejection from the gay community, rather than perceived difficulty in finding a partner, may underpin poor mental health outcomes.

In a study of 206 HIV-positive gay men, it was found that perceived HIV stigma from other gay men was associated with anxiety, loneliness, depressive symptoms, suicidal ideation and engagement in avoidant coping behaviours (Courtenay-Quirk et al., 2006). Thus, rejection from the gay community (on the basis of body image or HIV status, for instance) may result in isolation, which in turn is associated with depression.

Socio-demographic Factors

There is evidence that socio-economic factors also influence mental health outcomes. Gay men from higher socio-economic backgrounds experience quicker reductions in enacted stigma on the basis of their sexuality (Pachankis, Sullivan, Feinstein, & Newcomb, 2018) and they are less likely to report depressive psychopathology than gay men from lower socio-economic backgrounds (Jaspal, Lopes & Rehman, 2019). Furthermore, in a survey of 5977 gay and bisexual men, Hickson, Melendez-Torres, Reid, and Weatherburn (2017) reported that 21.3% prevalence of depression and 17.1% prevalence of anxiety and that those of lower income and lower education were more likely to experience these poor mental health outcomes. In a separate study (Gamarel et al., 2012), discrimination on the basis of low socio-economic status was predictive of depressive and anxious symptoms in gay men.

As indicated in Chapter 6, there are specific psychosocial challenges associated with being both gay and of ethnic or religious minority background. The mental health consequences can be considerable, most likely due to the pronounced situational stressors and negative psychological self-schemata experienced by members of this population. Several studies indicate that those who identify as both sexual and ethnic minorities are at heightened risk of depression and suicide. For instance, Meyer, Dietrich, and Schwartz (2008) found elevated rates of suicidality in Black and Latino gay men compared to White gay men. Researchers predict that suicide risk among Black and Latino gay men is more strongly related to major stressful events associated with coming out, such as assault, abuse and homelessness, than to mental disorders per se (Haas et al., 2011).

As indicated in Chapter 6, it has been found that British South Asian gay men (a significant ethnic minority group in the UK) face homophobia from both their ethnic ingroup *and* the general population. These early situational stressors include perceived or actual rejection from significant others, such as parents, siblings and friends, victimisation and discrimination (Jaspal & Cinnirella, 2010). Furthermore, British South Asian gay men face multiple social stressors associated with racism, religious prejudice and homophobia (Chapter 6). Perceived exclusion from multiple social groups can lead to feelings of marginalisation, leaving individuals with decreased self-esteem, internalised homophobia, and few sources of social support.

In their survey study of an ethnically diverse sample of 289 gay, lesbian and bisexual individuals, Jaspal, Lopes and Rehman (2019) found that ethnicity was associated with depressive psychopathology and that this relationship was mediated by situational stressors (i.e. rejection, discrimination, victimisation), psychological self-schemata (i.e. outness, internalised homophobia) and coping variables (i.e. drug use, help-seeking). In short, they found that those individuals who reported higher exposure to situational stressors, a negative psychological self-schema (i.e. internalised homophobia) and maladaptive coping (i.e. drug use) were more likely to manifest psychological distress, depression and suicidality. These data suggest that situational stressors and resultant negative psychological self-schemata predispose gay men (and indeed other sexual minorities) to depressive psychopathology. A significant sequela of poor mental health among gay men is poor sexual health.

Sexual Health and HIV

Gay men experience poorer sexual health outcomes than the general population, especially in relation to HIV infection. Many of the underlying factors are social and psychological, given that effective prevention methods now exist. In this section, the epidemiological aspects of sexual health and HIV and the psychological aspects of testing, treatment, risk and prevention are outlined.

Sexual Health and HIV Epidemiology

Although gay men are estimated to represent just 2% of the London population, an epidemiological report by Public Health England (2015) showed that gay men constituted 28% of the diagnoses with sexually transmitted infections (STIs) recorded in the city in 2014. This demonstrates the disproportionately high incidence of STIs among gay men. The incidence of syphilis and gonorrhoea—two treatable bacterial infections—is especially high, with 90% of all syphilis cases and 69% of gonorrhoea cases being reported among gay men. There was a 14% increase in syphilis diagnoses between 2015 and 2016, and 23% of cases of chlamydia (another treatable bacterial infection) were among gay men (Public Health England, 2017). The high incidence of STIs can be attributed, in part, to the higher number of sexual partners reported by gay men, the increasing practice of condomless sex in this group, the

growing prevalence of chemsex, and low levels of sexual health awareness among gay men (Jaspal, 2018a).

The most significant sexual health condition that disproportionately affects gay men is HIV. Since the first clinical observations of AIDS in 1981, 78 million people have been infected with HIV and 35 million have died of AIDS (UNAIDS, 2017). There is no known vaccine or cure for HIV/AIDS. However, the illness is now treatable with ART, which can inhibit disease progression by interfering with the ability of HIV to replicate. Therefore, in countries in which ART is widely available, like the UK, HIV is now considered to be a life-altering, rather than life-limiting, chronic condition.

HIV prevalence in the UK is approximately 0.18% of the population aged between 15 and 59. According to a recent HIV epidemiology report (Public Health England, 2015), some 103,700 people are currently living with the chronic condition in the UK. However, approximately 45,000 gay men were living with HIV in 2014, and in London it is estimated that 1 in 11 gay men is HIV-positive. In 2014, there were 5850 new diagnosed cases of (sexually transmitted) HIV, of which 57% were among gay men.

Black, Asian and Minority Ethnic (BAME) gay men constitute the group at highest risk of HIV and other STIs. Soni et al. (2008) conducted a case note review of 203 BAME gay men attending a London GUM clinic and found that BAME gay men were more likely to report unprotected anal sex with casual male partners in the last 3 months, indicating higher risk of HIV acquisition in this population. BAME gay men are more likely to report high-risk sexual behaviour than other gay men, and there are higher rates of bacterial STIs in Black African and Black Caribbean gay men than in other gay men.

In a study of HIV risk, it was found that BAME gay men were more likely to have a history of substance abuse and less likely than other gay men to have heard of biomedical HIV prevention approaches, such as post-exposure prophylaxis (PEP) and pre-exposure prophylaxis (PrEP) (Millett et al., 2012). Furthermore, the same study reported that BAME gay men were 3 times more likely than other gay men to test positive for HIV and 6 times more likely to have undiagnosed HIV.

Testing and Treatment

HIV can be treated effectively if diagnosed early. Moreover, there is evidence that a virally suppressed patient (under effective ART) will not

transmit HIV to their sexual partners. It is therefore vital that gay men test for HIV on a regular basis, that is, at least once per year. Although national campaigns for HIV testing in the UK, such as the 'It Starts With Me' campaign and National HIV Testing Week, have certainly increased rates of testing in gay men, many are testing infrequently or not at all. It was estimated that in 2015 13% of people living with HIV in the UK were unaware of their infection.

In a qualitative study of testing preferences among gay men in London and the English Midlands, Jaspal (2018b) identified a series of barriers to testing in genito-urinary medicine (GUM) clinics, the most important of which was perceived social stigma from healthcare professionals. Moreover, some gay men felt uneasy about testing for HIV in community settings due to fears of being involuntarily 'outed' as gay. Although some expressed a preference for HIV self-testing at home, several doubted the accuracy of the test and feared a reactive test result in the absence of any professional support. Studies of this kind can enable policy-makers to increase access to testing by obviating the barriers to HIV testing.

Given the significant increases in rates of HIV testing among gay men, those infected are being diagnosed and linked into HIV care soon after infection, with good individual and public health outcomes. The INSIGHT START Study Group (2015) has clearly demonstrated the physical health benefits of early initiation of ART regardless of the individual's CD4 count or viral load. In view of this evidence, the British HIV Association (BHIVA, 2012) recommends initiation of ART regardless of the patient's CD4 cell count.

However, not everyone initiates ART immediately after diagnosis. In his interview study of 15 gay men living with HIV, Jaspal (2018a) identified several social psychological barriers to adherence to ART. Participants reported difficulties in managing lifestyle change necessitated by life-long adherence to ART. They reported exposure to social stigma and poor mental health, which, in some cases, had preceded their HIV infection and, in others, resulted from it. This could lead some individuals to question the merits of initiating and adhering to ART. In order to cope with social stigma and poor mental health, participants reported engaging in maladaptive behaviours, such as substance misuse and chemsex, which could interfere with ART adherence. Sin and DiMatteo (2014) found that HIV patients were 83% more likely to adhere to HIV care if they received an intervention for psychological distress or depression.

ART adherence appears to be especially problematic in BAME gay men who are living with HIV. In a study of uptake of, and retention in, HIV care among gay men by ethnic group, the United Kingdom Collaborative HIV Cohort Study Group (2012) found that BAME gay men were more likely than White gay men to be lost to follow-up after HIV diagnosis (3.4% vs 2.2%, respectively), and that gay men of other/mixed ethnicity were most likely to be permanently lost to follow-up. BAME gay men were 18% less likely to initiate ART than White gay men with a similar CD4 cell count. BAME gay men may also be deterred from seeking sexual health care due to cultural norms that stigmatise sex, concerns about being asked about one's immigration status, insufficient knowledge of how to navigate the health system, and language difficulties (Jaspal & Williamson, 2017). In short, the social psychological factors underlying decision-making about health and wellbeing are multifarious.

Risk and Prevention

Since the end of 2016 there have been significant decreases in HIV incidence in the UK (Brown et al., 2017), which can actually be attributed to two additional factors, namely treatment as prevention (TasP) and PrEP.

TasP has been effective in reducing the risk of onward HIV transmission, because successful ART reduces the individual's viral load to 'undetectable' levels, which in turn reduces infectiousness. Evidence from the PARTNERS Study (Rodger et al., 2016) suggests that the risk of onward HIV transmission—with or without a condom—is effectively zero, provided that the individual has been virally suppressed for at least 6 months, is adhering to their medication, and does not have other STIs.

Despite the scientific evidence of 'U=U' (or 'undetectable=untransmittable'), this social representation is not consensually shared by everyone in the gay community—many remain fearful of having sexual relations with a person living with HIV (Wilkinson et al., 2018). Furthermore, it has been found that even HIV-positive gay men themselves may doubt the veracity of U=U, leading to trepidation about having sex with an HIV-negative person (Bourne, Dodds, Keogh, & Weatherburn, 2016). It is not possible to exploit the full potential of TasP unless social representations are consistent with the science.

PrEP is a bio-medical HIV prevention option for individuals at high risk of HIV exposure. Clinical trials in a number of countries and distinct population groups converge in evidencing the high effectiveness of PrEP as a means of preventing HIV infection (Anderson et al., 2012). A mathematical modelling study of the effect of PrEP on HIV incidence among gay men in the UK suggested that rolling out PrEP to just 25% of high-activity gay men could greatly reduce HIV incidence in this population (Punyacharoensin et al., 2016). Indeed, the positive impact of PrEP uptake among men on HIV prevention has been increasingly observed in HIV epidemiological data.

In the UK and in other Western countries, PrEP has caused controversy, particularly in relation to its funding (see Jaspal & Nerlich, 2017). Critics argue that the National Health Service (NHS) should not fund an expensive biomedical approach to preventing HIV given that condoms are also very effective—not only against HIV but also other STIs. This controversy surrounding PrEP has been fueled partly by the press—Jaspal and Nerlich (2017) describe the 'risk representation' in the British press which constructed PrEP as a medical, social and psychological setback for gay men at risk of HIV infection, and argue that this representation encouraged the perception of PrEP as risky and led to uncertainty and fear in relation to it. In the absence of full provision of PrEP on the NHS, some gay men obtain generic versions of the drug online given that generic PrEP is considerably cheaper than Truvada.

Yet, not all of those gay men who could benefit from PrEP wish to use it. In several studies of PrEP (Jaspal & Daramilas, 2016; Williamson, Papaloukas, Jaspal, & Lond, 2018), it has been found that stigma in relation to both HIV and PrEP, assumptions about the 'prototypical' PrEP user, and the anticipated impact of PrEP on future condom use discourage gay men from initiating PrEP. Following their survey of 191 HIV-negative gay men, Jaspal, Lopes, Bayley, and Papaloukas (2019) concluded that adequate HIV knowledge, accurate HIV risk appraisal and regular testing might increase PrEP acceptability in gay men at risk of infection.

How Are Mental Health and Sexual Health Related?

In this chapter, it has been demonstrated that there is a close relationship between mental health and sexual health outcomes. Much of the available evidence suggests that poor mental health increases the risk of HIV

acquisition through engagement in sexual risk behaviours, such as condomless sex, sex with multiple partners and substance abuse (Hughes, Bassi, Gilbody, Bland, & Martin, 2016). Some of these behaviours may in fact constitute maladaptive strategies for buffering threats to identity associated with earlier traumatic life events (Jaspal, Lopes, Jamal, Paccoud, & Sekhon, 2017).

On the other hand, the experience of living with HIV can increase one's risk of developing a mental health disorder. Since the advent of ART, mental health problems constitute the most common comorbidity in HIV patients (Adams, Zacharia, Masters, Coffey, & Catalan, 2016). Mental health problems in HIV patients can be attributed inter alia to psychological maladjustment to HIV diagnosis, the physical ailments that can accompany HIV infection, the side effects of ART and experiences of stigma and trauma. Predictors of depressive psychopathology—a prevalent mental health problem in HIV patients—include unemployment, negative life events, poor social support, childhood trauma, HIV-related physical symptoms, a low CD4 count and impaired function (Krumme et al., 2015).

Enacted, anticipated and internalised HIV stigma can all increase depression, anxiety, and feelings of hopelessness, and adversely impact self-esteem. Stigma can jeopardise all of the identity principles and make it difficult to assimilate and accommodate HIV in identity, which is a key step to self-acceptance, HIV status disclosure, and the derivation of social support (Daramilas & Jaspal, 2016).

Given the threatening nature of stigma and its origins in interpersonal behaviour, the strategies frequently used to avoid stigma are deflective intrapsychic strategies and those interpersonal strategies that facilitate isolation or concealment of one's HIV status. The threat and the coping strategies employed may exacerbate mental health problems. HIV stigma is also negatively associated with ART adherence, and this relationship is likely to be mediated by the mental health problems associated with stigma, reduced self-efficacy and fears of involuntary disclosure of one's HIV status (Sweeney & Venables, 2016).

Predicting Poor Mental and Sexual Health Outcomes

Throughout this volume, various situational stressors, negative psychological self-schemata and their potential impact for mental health have been described. Effective coping is key to both psychological and

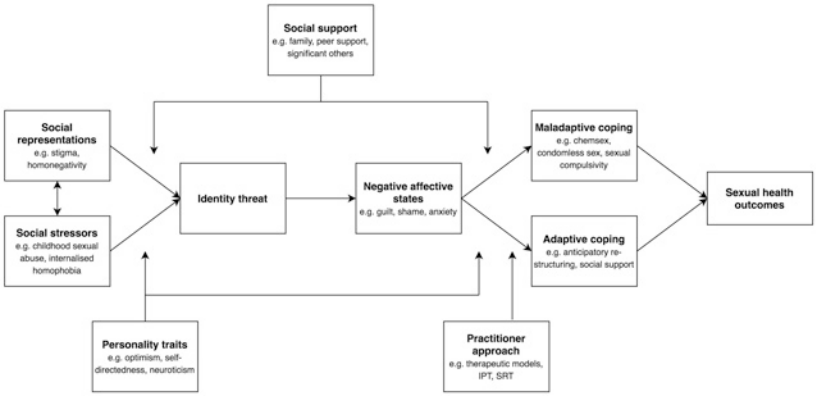

Fig. 8.1 A framework for understanding self-identity, wellbeing and sexual health among gay men (from Jaspal, 2018a)

physical wellbeing. Jaspal (2018a) has proposed a multi-level model that can enable practitioners to predict, and to intervene in order to mitigate, poor sexual health outcomes in gay men (see Fig. 8.1).

All human beings experience what can be loosely described as 'adverse events'. These are essentially social representations, events and situations which can cause psychological stress. As highlighted in this volume, gay men are, to varying extents, exposed to negative social representations of their sexual identity as a result of their socialisation in heteronormative contexts, on the one hand, and due to exposure to overt homophobia, on the other hand. Some may come to internalise the homophobia that they encounter, leading to internalised stigma. In addition to these negative social representations of their identity, there is a higher prevalence of particular situational stressors among gay men, such as childhood sexual abuse and HIV stigma.

Both these negative social representations and the situational stressors have the potential to undermine the principles of self-esteem, continuity, self-efficacy and so on, leading to identity threat. Yet, not everyone exposed to negative social representations or situational stressors will necessarily experience identity threat. The relationship between the adverse event and identity threat is likely to be mediated by personality traits, on the one hand, and by the availability of social support, on the other.

If the adverse event does threaten identity, the individual will experience a negative affective state, such as guilt, shame or anxiety. Negative affect is likely to be accentuated if the adverse event challenges more than one principle of identity. Negative affect amounts to poor mental health—in its most chronic and severe form, it can cause depressive psychopathology. An HIV diagnosis (one sexual health condition) can pose 'hyper-threats' to identity because it simultaneously undermines various, if not all of, the identity principles which habitually guide identity processes (Jaspal, 2018a).

Coping with Threats

As a model of identity threat and coping, identity process theory predicts that the threatened individual reacts to the threat by deploying coping strategies. The ways of coping can also be meaningfully categorised into adaptive and maladaptive strategies. Examples of adaptive coping include anticipatory restructuring, reconceptualisation and the derivation of social support. Examples of maladaptive coping include denial, engagement in chemsex and sexual compulsivity. At least three variables will determine the choice of coping strategy: personality, the availability of social support and the practitioner.

First, personality traits will predispose an individual to cope in particular ways. For instance, the individual who values conservation may be less inclined to elect a coping strategy such as anticipatory restructuring due to their desire to maintain a sense of continuity between past, present and future. They do not wish to entertain the idea of change because they strive to hold onto the past.

Second, the availability of social support is a significant determinant of coping strategy. Put simply, only those who actually possess a social support network can make use of it. The socially supported individual is more likely to engage in effective strategies, such as self-disclosure and to make use of the support offered by others than the individual who lacks a social support network. For instance, in a study of 371 highly sexually active gay men (Salfas, Rendina, & Parsons, 2018), it was found that involvement in the gay community was significantly associated with better mental health outcomes and that gay community involvement also buffered the adverse impact of internalised homophobia on mental health outcomes.

Third, practitioners working with gay men at risk of poor sexual health outcomes have the potential to channel their clients and patients towards effective coping strategies. Tenets of social psychological theory, such as social representations theory and identity process theory, can enable the practitioner to gauge their patients' awareness, understanding and potential behaviour in any given context. This can also allow the practitioner to predict patterns of behaviour in their patients, allowing them to intervene to mitigate negative patterns of coping.

Overview

In this chapter, it has been highlighted that gay men are at higher risk of poor mental health (such as depressive psychopathology) and sexual health outcomes (most notably, HIV infection), and that there is a close reciprocal relationship between both components of health. The social stigma appended to homosexuality, poor mental health and HIV can indirectly undermine both mental and sexual health outcomes in gay men. Some gay men may refrain from disclosing health problems and to seeking social or professional support, leading to an over-reliance on intrapsychic and often maladaptive coping strategies.

The model presented in this chapter illustrates the potential pathways through which social stressors can threaten identity processes, induce negative affect and, thus, challenge mental health, and lead to either adaptive or maladaptive strategies for coping. Crucially, there appears to be significant social and psychological antecedents to, and consequences of, poor mental and sexual health. Acknowledgement of relevant social psychological factors can enable practitioners and policy-makers to predict, and intervene to mitigate, risk of poor mental and sexual health among gay men.

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