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ORIGINAL PAPER

Garnering an In-depth Understanding of Men Who Have Sex with Men in Chennai, India: A Qualitative Analysis of Sexual Minority Status and Psychological Distress

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Abstract Men who have sex with men (MSM) in India are a hidden and largely understudied population, and have an HIV prevalence 17 times higher than that of the general Indian population. Experiences of social marginalization and negative psychosocial conditions occur concurrent to HIV risk among Indian MSM. To better understand the contextual variables driving HIV risk and inform intervention development, five focus groups ($n = 46$) and nine key informant interviews were conducted with 55 MSM in Chennai in 2010. NVivo software was used to code the transcripts, and data were analyzed using qualitative descriptive analysis methodology. Participants described sources of psychological distress and low self-worth related to gender non-conformity and sexual minority status. These included stigma from society, pressure to marry, lack of familial acceptance, childhood sexual abuse, and the imperative to keep sexual minority status a secret. Participants' personal evaluations revealed that self-acceptance may be an important resilience factor that can shield these psychosocial and HIV risk factors. In promoting health-seeking behavioral changes for Indian MSM at an individual level, our findings point to the potential strength of strategies that focus on self-acceptance of one's sexual minority identity to foster better psychosocial and overall health.

Keywords HIV · Men who have sex with men · Gay men · Bisexual men · Sexual orientation · Stigma

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Introduction

With nearly 412,000 men who have sex with men (MSM), India is a country with one of the largest number of sexual minority men in the world (National AIDS Control Organization of India, 2013a). Sexual behavior in India may vary without regard to sexual identity or dominant orientation (Closson et al., 2014; Dey et al., 2011). Indian MSM have developed a distinct lexicon through which they refer to themselves and other male sexual partners, including terms such as *kothi* (receptive and effeminate partner), *panthi* (insertive and masculine partner), and *double decker* (both insertive and receptive partner) (Aggarwal, Sharma, & Chhabra, 2000; Asthana & Oostvogels, 2001; Boyce, 2007; Chakrapani et al., 2002). Importantly, these labels do not always predict sexual behavior. Some MSM define same-sex behavior as *masti*, or "fun" and may reject being categorized as MSM (Kumta et al., 2010). Regardless of how men label their actions, MSM in India are at high risk for HIV.

While there is a declining trend in the number of new HIV infections among MSM from 2007 to 2011 (National AIDS Control Organization, 2013b), surveillance data show that this population continues to be disproportionately affected by HIV. The HIV prevalence for MSM nationally is currently 4.4 % (range 14.9–0.36), which is 14.8 times higher than that of the general population (National AIDS Control Organization, 2013b). The HIV prevalence for MSM in the southern state of Tamil Nadu is higher than the national average. A 2010 study of 721 sexual minority men across the state detected an HIV prevalence of 9 % (Solomon et al., 2010).

Among MSM in India, recent literature points to the existence of psychosocial health outcomes associated with unprotected anal sex (Logie, Newman, Chakrapani, & Shunmugam, 2012; Mimiaga et al., 2013; Safren et al., 2009). However, HIV prevention interventions among MSM in India have not yet addressed psychosocial factors that occur within the context of HIV risk (Thomas et al., 2011). The majority of prevention programs do not go beyond condom distribution and HIV education. Many MSM in Chennai, India, feel that they have reached saturation and fatigue in terms of these methods and messages (Thomas et al., 2012). The present study therefore sought to elucidate the social and personal factors that shape the psychological and behavioral profile of MSM in Chennai, the capital city of Tamil Nadu State in southern India. Based on our findings, we present a conceptual model (Fig. 1) which depicts how these psychosocial issues converge and may influence HIV acquisition risk among MSM in Chennai. The model also considers self-acceptance of sexual minority identity as a tool to promote wellbeing and self-care for MSM in India through encouraging positive definitions of self and improving mental health.

Method

Participants and Procedure

In 2010, 55 MSM in Chennai, India, were interviewed in five focus groups ($n = 46$) and nine individual interviews with key informants. These data were collected as part of a multi-phase study to develop and implement an HIV prevention intervention that addressed the psychosocial outcomes occurring within the context of sexual risk among MSM in Chennai. The protocol was approved by the Indian National Institute for Research in Tuberculosis (NIRT) Ethics Committee and the Fenway Health Institutional Review Board.

The key informants were members of the MSM community in Chennai with experience in health promotion or social advocacy for MSM. All focus group participants were over the age of 18 and reported sexual behavior with another man in the last 6 months. Between nine and ten men participated in each focus group. Because homogeneity is considered essential for group interactions (Morgan & Krueger, 1993), four of the five focus groups were restricted to kothis and double-deckers. From previous experience working with this population, we knew that kothis and double-deckers were generally comfortable interacting together. The two panthi-identified focus group participants were accompanied by their long-time kothi partners. Staff ensured that all other attendants were comfortable before the start of the group interview.

Both focus group participants and key informants were recruited by peer outreach workers from Sahodaran, an Indian MSM non-governmental organization. Recruitment continued until interview responses reached redundancy (Miles & Huberman, 1994). Study procedures were conducted in Tamil and took place in a private research office of NIRT in Chennai. All participants completed written informed consent before data collection commenced. They received reimbursement for travel expenses (approximately $2.20 USD) and a meal voucher.

Measures

A brief interviewer-administered demographic questionnaire was given to all participants. Key informant interviews and focus groups were digitally recorded, transcribed in Tamil, and then translated into English by NIRT staff. The key informant interviews were approximately 60 min long and were conducted by doctoral and masters-level interviewers from the NIRT. Focus group discussions took approximately 80 min to complete. To enhance comfort and encourage participants to share freely, focus groups were co-facilitated by a doctoral-level behavioral scientist (BT) with expertise in qualitative interviewing and focus group facilitation, and a member of the MSM community from Sahodaran. Interviewers and facilitators were trained by study investigators, and the quality of the data was monitored locally by the Indian PI (BT).

The focus groups and key informant interviews were semi-structured and guided by pre-specified open-ended questions. Response clarification was directed through the use of probes. Questions were tailored to the individual or group dynamic per the natural flow of conversation (Lindlof & Taylor, 2002; Morgan & Krueger, 1993). The content of the guides was informed by formative qualitative research conducted by the investigators. Prior to utilization for this study, the key informant interview and focus group discussion guides were pilot tested among staff from Sahodaran who identified as MSM.

The key informant interviews addressed three broad domains: (1) influences on sexual risk taking (e.g., "Who or what influences sexual behaviors of MSM?"); (2) issues relevant to sexual risk taking among MSM in Chennai (e.g., "What are the main problems of kothis, panthis, and double deckers (respectively) in Chennai?"); (3) perception of effectiveness of existing HIV

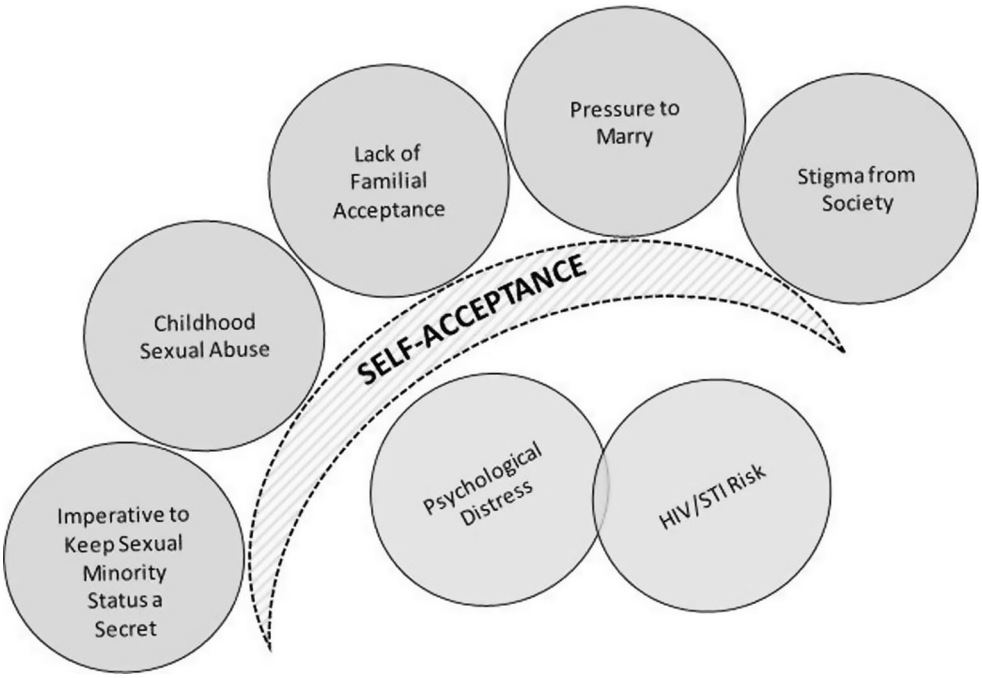

Fig. 1 Conceptual model depicting the social factors and distressed experiences that converge to potentiate negative individual outcomes and the potential role of self-acceptance as a protective influence for MSM in Chennai

prevention interventions (e.g., "Tell me about any current or prior HIV prevention programs you are aware of in Chennai."). The one-on-one interview format was particularly appropriate for the key informants because it is a methodology that allows for in-depth responses from individuals with extensive knowledge on a specific topic or population.

The focus group guide included questions on (1) issues relevant to sexual risk taking among MSM in Chennai (e.g., "How does the type of MSM one is (panthi, kothi, double decker) influence what risks you may take, if at all?"); (2) perceptions of effectiveness of existing HIV prevention interventions (e.g., "What are the least helpful aspects of HIV prevention programs for MSM in Chennai?"). The guide also included a free-listing brain storm section when participants were asked to list and briefly describe the main problems faced by MSM in Chennai. Unlike the key informants, the MSM who participated in the focus groups were not involved in sexual minority health advocacy and may have been less familiar with the interview topics. A group format was chosen to enhance the accessibility of the interview questions. Participants were encouraged to ask questions, exchange anecdotes, and comment on each other's experiences or points of view. Social interactions between attendants seemed to spark discussions that allowed them to clarify and explore their ideas using their own vocabulary (Krueger, 1988).

In addition to the key informant interviews and focus groups, four community advisory board (CAB) meetings were conducted with leaders and advocates from the community who were familiar with the MSM population in Chennai. CAB member input informed the development of the interview and focus group guides. CAB feedback was also elicited on the interpretation of the findings during the data analysis phase.

Data Analysis

Data were analyzed using qualitative descriptive analysis methodology (Sandelowski, 2000). Initial themes related to the central research questions were based on the qualitative interview guides. These concepts were used to construct categories and to develop a code book comprised a label, a definition, and an illustrative quote from the data (Silverman, 2010). Transcripts were reviewed for errors and categorically organized by a single coder and facilitated by NVivo qualitative analysis software (version 8). For the purposes of establishing reliability, several coding stability assessments were conducted to ensure that the coder was consistently re-coding the same data in the same way over a period of time (Weber, 1990). Regular discussions between the coder and study investigators allowed for further revision of the coding schema based on the interconnections between emergent themes in the data. Investigators then reviewed coded transcripts and agreed on the categorical organization of the data and final overarching themes.

Results

Descriptive Characteristics

Forty-six participants and nine key informants were included in the study and represented a wide range of demographic

characteristics (Table 1). Participants' mean age was 27 ($SD = 6.9$) years. The majority (65 %) identified as kothi (receptive or effeminate partner), 9 % as panthi (insertive or masculine partner), 22 % double decker (both insertive and receptive partner), and 4 % did not disclose their sexual minority status. Ninety-three percent of participants were employed or enrolled in school full-time.

Qualitative interviews revealed social and individual-level sources of stress and negative life experiences for MSM in Chennai. The results of these qualitative data are presented in terms of the following themes: (1) stigma from society; (2) lack of familial acceptance; (3) pressure to marry; (4) childhood sexual abuse (CSA); (5) imperative to keep sexual minority status a secret; (6) psychological distress; and (7) self-acceptance as a protective factor that shields MSM from these types of psychosocial/contextual issues. Table 2 presents example quotations representing individual themes.

Table 1 Sociodemographic characteristics of study participants ($N = 55$)

Mean age (SD)	27 (6.9)	
	n	%
Gender		
Male	55	100
Sexual orientation identity		
Kothis	36	65
Panthis	5	9
Double-decker	12	22
Did not disclose	2	4
Education		
Partial completion of secondary school or less	13	24
Secondary school	26	47
Baccalaureate degree	13	24
Post-graduate degree	3	6
Marital status		
Unmarried	50	91
Legally married	5	9
Unemployment	4	7
Type of industry/occupation		
Non-profit sector	22	40
Administrative or clerical position	20	36
Technical trade	5	9
Transactional sex	2	4
Full-time student	2	4
Living arrangements		
Parents and siblings	44	80
Nuclear family	5	9
Alone	3	5
Friends	2	4
Same-sex partner	1	2

Stigma from Society

All participants said that they had experienced stigma from members of their community and society more generally. Participants overwhelmingly agreed that same-sex sexual behavior was highly stigmatized by society. They reported experiences of harassment and discrimination from strangers, co-workers, peers, and teachers. Many said that they felt socially rejected because same-sex sexual behavior was not considered socially acceptable. Due in large part to the more visible indications of gender non-conformity, feminine-appearing kothis were said to have greater difficulty with social assimilation compared to panthis or double-deckers.

Lack of Familial Acceptance

In addition to feeling stigmatized by society, the majority of participants said that their parents, siblings, and relatives also struggled to accept their sexual minority status. At best, most participants said that their same-sex sexual behavior was ignored by their families; at worst, participants described openly hostile relationships or abuse.

Pressure to Marry

The expectation that men and women will marry and procreate is a central and defining social norm in Indian culture (Asthana & Oostvogels, 2001). Many men felt an unyielding sense of pressure from family members to fulfill these gender and sexuality roles. According to some participants, parents were afraid of "spoiling" the family name and voiced concern about the potential hostility of their community if their sons did not marry. One participant reported that his unwillingness to marry was viewed by his family as a violation of the "natural order." Another worried that his sister might also be stigmatized if people found out that she had a brother who was not married.

Childhood Sexual Abuse

Nearly one quarter of participants said that they had experienced unwanted sexual contact as children or adolescents. Participants cited the particular vulnerability of kothis to CSA. Perpetrators were adult male teachers, peers, coaches, employers, neighbors, uncles, and cousins. A number of participants viewed these early non-consensual sexual encounters as precipitating their current involvement in same-sex behavior. Two men said that sexual interactions with an adult male at a young age had caused them to be "addicted" to sex with men. While not all of these experiences of CSA were described as negative, some participants said that

Table 2 Illustrative quotations

	Sexual ID	Age
Stigma from society		
I had a bad experience when I was traveling in a train, I accidentally touched a man and he started verbally abusing me in such filthy language and he immediately washed his hand with water as I had brushed against him. This hurt me a lot and I cried wondering why we had to live like this. We are like untouchable people, no one is thinking that we are also humans.—*FG2.1*	K	23
The way they (society) refer to MSM is very raw- like 'they changed as women then what the hell happening?' The stigma is more for MSM than the other men.—*FG5.4*	DD	31
I would say panthis have no problems as we look like men. Maybe…the kothis have problems, as they are so visible.—*KI5*	P	27
Lack of familial acceptance		
How do you expect society to accept us when those who were close to me treated me differently when they came to know my identity?—*FG1.3*	K	21
When we inform our family [of our MSM status], they shout at us. They say that other boys are not getting into problems. The style of walking, talking, and the way you dress make it very obvious, so change yourself—then there will be no problems.—*FG2.3*	K	30
My family knows [that I have sex with men], but I haven't told them. They never talk to me about it. They have not discussed the issue of my sexuality. He was ashamed to tell our relatives about me. The prestige of the family is affected because of me.—*FG1.7*	K	26
Pressure to marry		
I'm not married. I decided to not go get married: my sister has not accepted me. She has chosen a girl for me to marry.—*FG1.8*	DD	25
I have no parents, so my brother said that he was scared that I am changing and all my friends are effeminate like me and he tried to hint at marriage. One day he called all my close relatives, and made me sit with them and said he wanted me to get married and I told them that I am not interested in getting married, and if they force me to get married, I will leave the house. But I told my brother that I will do all the work like cooking and cleaning the house, so that the feminine side in me is satisfied but if he forces me to get married, I will have to leave. Till today neighbors ask my brother why he has not got me married. But he has not spoken about it.—*FG1.4*	K	22
I am panthi, I know a kothi very well from childhood. Earlier we were just friends and my family knows her very well but after some time we fell in love and started living together and I have a happy life. My family knows her only as friend, they don't know about our relationship. Most parents still want their sons to get married to a woman and have children and lead a happy life. This we can't change. It is natural in all human beings. No one will accept any relationship like this.—*FG2.2*	P	23
Childhood sexual abuse		
One kothi who studied with me had a brother who caught him in the sex act with a boy. Later on, the brother forced the kothi to have sex with him. He threatened the kothi, saying that he will tell [their] parents if he doesn't have sex with him.—*FG1.5*	K	27
Kothis start sexual experiences from the age of 12 because of their friends and neighbors. A kothi seems to be recognized as "different" from a small age. I still remember a man coming and touching me all over against my will when I was 9 years old.—*KI1*	K	31
I was abused sexually when I was very young on different occasions by different men and boys. At first I used to be scared but now I have become addicted to sex, I feel bad and ashamed. I blame it on all those who sexually abused me. I feel angry that I am so sexual now. I cannot seem to help it.—*FG3.5*	DD	24
When I was 16 years old I was working in Chennai and I went on a tour with some relatives. I shared a room with a male relative who initiated me into homosexual sex and I was very aroused and had sex with him. He was a panthi and I continued to see him when he was alone since his wife had gone to her mother's house for her delivery.—*FG5.1*	K	30
When I was in VIII standard [grade], my swimming coach made a pass at me, I felt very uncomfortable and he used to harass me a lot, tried to touch me and kept calling me home and tried to get close to me, I avoided him as I felt uncomfortable. I told my friends about it.—*FG4.7*	K	22
In school we were also sexually harassed by the rowdies in that area. Seniors would take us to the terrace or outside and sexually harass us just because of our effeminate ways, and they would force us to have sex even if we didn't want to. I had to drop out as I could not bare it. I couldn't tell this at home also.—*FG1.5*	K	27

Table 2 continued

	Sexual ID	Age
Imperative to keep sexual minority status a secret		
I have a lot of love for my family, so I am not thinking of my own happiness, I am thinking of their happiness. So at home I am what they want me to be. Only when I am outside, I wear a sari and do what I want to do. …but at home my family allows me to do all domestic chores, whatever females do.—*FG1.5*	K	27
No Freedom. I cannot live as an MSM. I cannot dress up like an MSM. I have made a circle around me and live within it. I feel I am caged. MSM are more pressurized to get married in order to hide their sexuality.—*KI1*	K	31
We have our own code language. We talk to them and by the way they talk, we can find out if they want sex by indirect things they say.—*KI4*	DD	44
Psychological distress and HIV/STI risk		
A panthi once pretended to love a kothi but married the kothi's sister. The kothi attempted suicide. Love and failure seem to be a part of us.—*FG3.4*	K	20
MSM lead a double life where their sexual orientation remains a secret for a very long time, and this causes a terrible stress. I have never told anyone that I am a MSM. Even my closest friends do not know, and I don't intend telling anyone. I am really scared that someone may come to know about me.—*KI8*	P	25
The whole spectrum of MSM sexual behavior is outside of what is considered normal and legitimate. So I think that's the problem. Everybody who doesn't fit the bill is not normal. You tend to do it in covered ways, and that has real psychological implications.—*KI3*	DD	28
Because of all the stigma and discrimination, kothis begin to dislike themselves, have low self-esteem. I feel scared [about] the way I walk, the way I face my family, and so I have a lot of problems. My mental burden is so high. I ask, "For whom should I live? Why should I use condoms?" I don't mind having sex with anyone. My low esteem makes me vulnerable to HIV.—*KI2*	K	42
When [MSM] are expelled from their house, they have nobody to care for them, and they feel badly about themselves. Their attitude is "So what if I get infected with HIV?" And hence they practice unsafe sex.—KI7	DD	34
Self-acceptance as a protective factor		
I don't have a problem, I give them money every month and they have not questioned me about my sexual orientation. They know that I cross dress and that I carry a sari in my bag, but it's not an issue in my house as I contribute to the family income.—*FG5.1*	K	30
I told [my family] that that I can't change myself for their sake. Now they have accepted. We have to stand up for our beliefs. We should not change our sexual identity out of fear of being abused by the family.—*FG4.6*	K	21
I have told my family about our relationship and my family knows him [partner].I told them because I cannot change and it's natural for me to be like this. I have taken him to my house and introduced him as my partner and they have accepted it now. At first they refused, but now they don't say anything about us living together. When we both go out, we usually walk together. We are—*FG2.4*	K	20
There are sensitization programs for the police. I have spoken in one of these programs. I told them about my personal life. Now the police are becoming more accepting. The main idea behind these programs is for them to accept us. We keep reminding them that we could be one of their family members like their brother. —*KI2*	K	42
Identifying as MSM, it is not somehow legitimate and loses credibility in the eyes of people. This has an impact on the lives of MSM as they find it difficult to accept their identity and hence also to some extent in their own eyes. They therefore land up doing whatever or whenever there is a sexual activity—it has to be like stealthy, like under cover I mean just that… So I think that brings with it guilt… I mean this something I think MSMs anywhere are facing, the problem that their sexual behavior is not legitimate and then there is the associated thing of problem of the fear of being found out.—*KI3*	DD	28
I therefore feel a prevention program should increase self-esteem. This would influence an MSM's health-seeking behavior and MSM would claim rights as an individual. I feel that only then can an HIV prevention intervention be successful. They would want to abstain from alcohol, look after their STIs, take their medicine they need, protect themselves from HIV.—*KI6*	K	25

Table 2 should be positioned closely to the "Results" section

KI key informant, *FG* focus group discussant; Sexual identity: *K* Kothi, *P* Panthi, *DD* Double-decker

they felt ashamed and emphasized their discomfort with these situations. Several said that were abused by teachers and older students at school. A few said that they dropped out of school because they were no longer able to take the abuse.

Imperative to Keep Sexual Minority Status a Secret

Participants described behaviors they perceived as being in conflict with Indian definitions of masculinity, such as

wearing saris, taking dance lessons, lack of facial hair, or enjoying house chores. Nearly three-fourths of participants mentioned the need for some degree of secrecy around same-sex sexual attraction and behavior and the need to shift behavior in different contexts to avoid being identified as MSM. Men said that they were compelled to keep their MSM behaviors secret for a number of reasons, including the potential negative effect on their families, embarrassment in front of friends, fear of violence, and risk of blackmail.

Participants described strategies to avoid being identified as MSM, including walking or dressing in what would be perceived as an overtly masculine way and growing a beard. Given the perceived need for secrecy, participants said that MSM in Chennai used code words related and secret signals to communicate with each other about sex. For instance, participants said that condoms were referred to as *caklaṭ* (chocolate), anal sex *as ganz,* and sex work as *danda*.

Psychological Distress

Many participants said that MSM experienced psychological distress as a consequence of stigma from society, lack of familial acceptance, and sexual minority status concealment. Specifically, they used words such as "psychological implications," "high mental health burden," "terrible stress," "scared," and "anxious" when discussing the effects of these negative life events. Some men explained that engagement in sexual risk behaviors (e.g., multiple casual partners and unprotected sex) was related to feelings of low self-worth and mental stress that resulted from adverse experiences related to being MSM.

Self-Acceptance as a Protective Factor

MSM identified certain factors that helped them to avoid stressful experiences or limited the impact of negative life events on their wellbeing. A few participants reported tolerance from family members with regard to their sexual minority status. Specifically, participants said that their mothers were accepting of their sexual minority status. Others said that their families were tolerant because they were reliant on them for financial support or to help with household responsibilities. When describing how they attempted to garner acceptance from family members, several MSM said that they had to assert their self-identity and self-advocate for themselves. Participants also underscored the role of self-acceptance in the promotion of health-seeking behaviors such as abstaining from alcohol and engaging in health care services. Participants highlighted examples of positive societal attitudes toward MSM. For example, one participant perceived that the lower class communities in Chennai were generally more accepting of MSM compared to members of the upper or middle class. While many described situations where police in Chennai targeted MSM, a double-decker participant spoke about the positive effects of a recently initiated sensitization program for police officers.

Discussion

The present study examined the way that men experience sexual minority status in an attempt to gain insight into the HIV risk environment for MSM in Chennai, India. We were able to assemble a conceptual model (Fig. 1) based on our findings. The circles along the arc represent the themes that adversely affect the psychosocial and risk profile of MSM in Chennai. *Stigma from Society*, *Lack of Familial Acceptance,* and *Pressure to Marry* are the broadest layers of influence, while *Childhood Sexual Abuse* and *Imperative to Keep Sexual Minority Status a Secret* are distressed experiences that are responsive to these wider social factors. The shield shape depicts *Self-Acceptance* as a potentially valuable tool to protect MSM from *Psychological Distress* related to these personal and social factors. Self-identity assertion was an important theme in narratives about families "accepting" men's sexual minority status. Reflections by some of the participants suggest that positive definitions of self may be a precursor to personal advocacy. Although it is not directly articulated by our findings, improving notions of self-worth and addressing psychological distress could in turn support reductions in *HIV/STI Risk*. A number of participants emphasized the importance of self-acceptance in supporting health-seeking behavior, such as engagement in health care and reductions in sexual risk and substance use. These findings are in line with research that underscores self-acceptance as a broad-spectrum approach for mental health promotion (Mann, Hosman, Schaalma, & de Vries, 2004).

Gender non-conformity and sexual minority status were common threads in discussions about sources of stress and negative life events experienced by participants. This is consistent with theoretical constructs that seek to explain mechanisms driving health disparities of sexual minorities (Meyer, 2003; Stall, Friedman, & Catania, 2007). MSM experienced societal and familial rejection which was often framed in terms of feeling an unyielding pressure to fulfill social expectations of masculinity such as fatherhood and marriage. Social expectations determine the acceptability of particular modes of self-expression and ways of acting and interacting in social settings (Williams, Wyatt, Resell, Peterson, & Asuan-O'Brien, 2000). As Asthana and Oostvogels (2001) assert the Indian concept of masculinity allows for a range of sexual behaviors, but minority sexual identities are highly stigmatized. Research shows that social stigma increases the susceptibility of a variety of negative outcomes including family rejection and harassment by peers (Berlan, Corliss, Field, Goodman, & Austin, 2010; Bontempo & D'Augelli,

2002; D'Augelli, Grossman, & Starks, 2006; Stall et al., 2007). Such experiences can have both immediate and long-term psychosocial health effects that are associated with sexual risk-taking behavior, including traumatic stress and substance use (Beyrer et al., 2010; Herek, 2007; Parker, Shivananda, & Aggleton, 1998).

In addition, we found that men in this sample described frequent experiences with CSA. Kothis were said to experience more physical and sexual abuse than other boys. This may be explained by their feminine behavior and appearance, as visible presentations of gender non-conformity are thought to increase vulnerability of abuse in sexual minority children in the U.S. (D'Augelli et al., 2006; Roberts, Rosario, Corliss, Koenen, & Austin, 2012). While participants did not specifically discuss the mental health consequences of CSA, several participants described these experiences as unsettling and uncomfortable. There is evidence to indicate a predictive relationship between CSA and a variety of negative emotional, cognitive, and interpersonal outcomes later in life, including sexual risk taking (Gore-Felton et al., 2006; Mimiaga et al., 2009; Paul, Catania, Pollack, & Stall, 2001; Welles et al., 2009).

Participants used code words and signals to communicate with men about sex, avoided public displays of attraction to men and often change their appearance to limit visible indications of gender non-conformity. Concealment of sexual minority status is a coping strategy aimed at avoiding the negative consequences of social stigma (Chakrapani, Newman, Shunmugam, McLuckie, & Melwin, 2007; D'Augelli, Pilkington, & Hershberger, 2002; Herek & Capitanio, 1996; Khan, Bondyopadhyay, & Mulji, 2005). Data from the U.S. show that efforts to conceal male–male sexual behavior are linked to adverse mental health outcomes such as depression and negative self-image (D'Augelli et al., 2002; Herek & Capitanio, 1996), both of which are associated with risky sexual behavior.

Psychological distress and low self-worth were largely attributed to negative life experiences linked to gender non-conformity, including stigma by society, lack of familial acceptance, and the imperative to hide same-sex behavior or limit visible indications of sexual minority status. Logie et al. (2012) have documented a similar relationship between gender non-conformity and depression for MSM in Chennai. These adverse mental health outcomes also aligned with quantitative data from other work with Indian MSM. Among a sample of 150 MSM in Mumbai, 45 % screened positive for suicidal ideation, 29 % for symptoms of major depression, and 24 % for anxiety (Mimiaga et al., 2013). These and other manifestations of psychological distress are strongly associated with increased sexual risk taking among MSM in India (Thomas et al., 2011). These data also emphasize a connection between sexual risk behaviors and mental stress/low self-worth. This is consistent with U.S. studies among MSM, which imply a correlation between HIV risk and negative evaluations of self where sexual behavior reflects efforts to be accepted by others or to gain attention (Reston, 1991; Rolf & Johnson, 1993; Somali et al., 2001). Moreover, existing research on Indian MSM substantiates self-acceptance as a moderator of psychological distress (Sivasubramanian et al., 2011).

Our findings should be interpreted in light of limitations inherent to the study. Some potentially sensitive or stigmatizing questions were included in the interview, and it is possible that participants were not entirely truthful about their own experiences. Due to the explanatory aims of the study, the sample was small and recruited through only one community site (Sahodaran). Participants may represent a group that is different from MSM who are not exposed to health prevention messaging. Given the heterogeneity of Indian MSM, the extent to which the conceptual model applies to other sexual minority men in India is not clear. As we further develop the construct of self-acceptance, expanding on these factors will be critical.

Despite these limitations, our study presents an opportunity to gain a deeper understanding of the context in which HIV risk may occur for Indian MSM. Our findings have implications for the development of future interventions that may buffer MSM from some of the negative life events linked with sexual minority status. Such programs may benefit from emphasizing the role of personal environments that increase self-acceptance. Skills that build competencies, emphasize self-determination, and enhance optimism for the future may increase self-acceptance (Catalano, Berglund, Ryan, Lonczak, & Hawkins, 2002). Promoting safer ways to meet and forge supportive relationships with other MSM could foster broader social support networks and enhance community engagement (Meyer, 2003; Spencer & Patrick, 2009). A group-based program may give men the opportunity to identify and share their own accomplishments while also building connections and strengthening the capacity of the collective community. The positive social relationships and enhanced self-acceptance resulting from this support may be protective against the adverse mental health outcomes that are known to potentiate risky sexual behavior and HIV infection. Content for such a program should also explore specific strategies for coping with psychosocial stressors and how to problem solve and manage sexual triggers (mood, substance use, etc.) related to these stressors. The current public health paradigm tends to emphasize shortfalls in knowledge or behavioral skills among MSM (Herrick et al., 2011; Safren, Reisner, Herrick, Mimiaga, & Stall, 2010). Existing models of HIV risk can be strengthened by focusing on and integrating protective factors such as self-acceptance (Herrick et al., 2011; Herrick, Stall, Goldhammer, Egan, & Mayer, 2014; Safren et al., 2010). Further research is needed to identify other resilience factors and protective resources available to sexual minority men in India. The proposed model, with self-acceptance as a shield for the negative effects of social, familial, and contextual stress, also highlights

the need for larger societal interventions to decrease stigma against sexual minority individuals in India. The current political climate in India is such that deeper community-level interventions are going to require intensive and multisectoral changes. This past year (December 2013), for example, the Supreme Court in India upheld Indian Penal Code Section 377, making same-sex behavior illegal and punishable by law. Accordingly, family interventions, community-level interventions, or other structural interventions currently face substantial barriers, and intervening at the individual level is therefore not only timely but urgently needed.

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