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Identity, Culture & Wellbeing among MSM: A Model for Enhancing Clinical Practice

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What is ‘identity’?

The individual’s psychological image of himself
Informed by the external social world
Consists of multiple elements

What is ‘culture’?

An interaction process with two main component processes: the creation of shared activities (cultural practices) and the creation of shared meaning (cultural interpretation) (Greenfield, 1997)

A relatively organised system of shared meanings (Smith & Bond, 1998)
What is ‘wellbeing’?

Psychological equilibrium between the challenges one faces and the resources for coping (Dodge et al., 2012)

The absence of resources undermines wellbeing
Case Study 1: Ahmed

- Ahmed, a 25 yo HIV- British Pakistani Muslim gay man
- Lives in a close-knit community in North of England
- Exposed to homonegativity across life course
- Experiences guilt, shame and anxiety vis-à-vis sexual orientation
- Perceptions of identity inauthenticity in relation to religion
- Disengaged from the gay scene due to perceived racism
- Using gay social networking applications and gay saunas
- Increase in sexual risk-taking – at risk of HIV
Case Study 2: Juan

- Juan, a 33 yo gay man living with HIV
- Faced significant childhood adversity – sexual abuse
- Socialised within a deeply religious family
- Diagnosed with HIV in Spain but experienced adjustment difficulties
- Starts ART but has a bad experience
- Faces rejection from sexual partners
- Himself stigmatises others living with HIV
- Experiences stigma, loneliness and depression
- Disengages from HIV care
- Seeks intimacy on the ‘chemsex’ scene
Identity Process Theory*

• Model of identity construction, threat and coping

• The identity processes
  – assimilation-accommodation and evaluation

• The identity principles
  – Self-esteem
  – Self-efficacy
  – Continuity
  – Distinctiveness
  – Belonging
  – Coherence

Coping with threat

• If salient principles are jeopardised, **identity is threatened**

• We attempt to cope

• Intrapsychic
  – e.g. denial, re-conceptualisation, anticipatory re-structuring

• Interpersonal
  – e.g. self-isolation, passing, self-disclosure

• Intergroup
  – e.g. group departure, deriving social support
Threats to identity

• Childhood sexual abuse
  – 4x greater prevalence in MSM than heterosexual men (Friedman et al., 2011)
  – One study, MSM with CSA more likely to be HIV+ (Lloyd & Operario, 2012)
  – Morbidity and mortality in adulthood (Brown et al., 2009)
  – Increased HIV risk (Boroughs et al., 2015)
  – Increased risk of disengagement from care (Meade et al., 2009)

• Homophobia across the life course
  – Minority stress (Jaspal & Dhairyawan, 2018)
  – High prevalence of anxiety and depression (Walsk et al., 2016)
  – Difficulties in relationship formation (Jaspal, 2017)
  – ‘Passing’ & authenticity (Johnson, 2015)
Threats to identity

- **Internalised homophobia**
  - Poor self-esteem & negative emotions (Pucket et al., 2016)
  - Escapism behaviours
  - Self-distancing from LGBT information networks (Jaspal, 2018)

- **HIV stigma** (Earnshaw & Chaudoir, 2009)
  - Poor self-esteem & negative emotions
  - Self-disclosure & social support
  - Internalisation of stigma
  - Disengagement from care
  - Decreased testing behaviours
Sexual abuse and HIV-risk behaviour among black and minority ethnic men who have sex with men in the UK

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Spotlight on CSA (2)

Figure 1. Pathway analysis with sexual abuse and frequency of homophobia, racism and drug use impacting sexual risk. *p < .05; **p < .005.
Possible coping behaviours

• Sexual compulsivity
  – Higher prevalence among MSM than heterosexual men
  – Higher prevalence in HIV+ MSM than HIV- MSM (Coleman et al., 2010)
  – Emotion dysregulation & internalised homophobia are predictors (Pachankis et al., 2015)

• Chemsex
  – 21.8% prevalence of chemsex in last 3 months (Sewell et al., 2017)
  – Associated with diagnosed depression/anxiety – escapism (Bourne et al., 2015)
  – Associated with a myriad of other risk behaviours (Lee et al., 2015)
KEY AREAS FOR CLINICAL PRACTICE
Knowledge of HIV

Awareness-raising campaigns are particularly needed in some communities*

- A two-way ANOVA indicated a significant main effect of ethnicity ($F(2, 498)=11.61, p<0.001$) on level of HIV knowledge but not education ($p=.09$). There was no significant interaction effect between level of education and the ethnicity of the individual, on level of HIV knowledge, ($p>0.05$).

- Across all 3 education levels, South Asians ($M=3.18$, $SD=1.9$) possessed less HIV knowledge than Black ($M=4.47$, $SD=2.25$) and Latin respondents ($M=4.89$, $SD=2.06$).

Threatened identity & risk-taking*

• Racism and self-esteem
  – As an Asian on a White gay scene, I did face quite a bit of rejection from White guys, sometimes blatant racism. You know, the whole ‘you’re a Muslim, so you must support terrorism’. It makes you feel pretty down about your culture... It made me feel a bit vulnerable and I didn’t really have confidence with anything (MSM, 19)

• Anti-gay prejudice and self-esteem
  – My priority was more like having sex without being found out and I didn’t think, I didn’t care about condoms. I was more focusing on ‘this is against my religion. My parents will kill me’ Each time I thought I just felt like a really bad person (MSM, 28)

• Internalised homophobia & coherence
  – As a Muslim, I’m basically there thinking to myself “am I an abomination?” I was basically just struggling with who I was. I was bullied about it but I tried to hide it. You reach a point where you are so mixed up that you don’t respect yourself any more. I just didn’t respect myself enough to look after myself and look where it got me (MSM, 30)

Communicating HIV prevention*

- Polarised reporting of PrEP in the print media**
- ‘Wonder drug’ vs ‘party drug’
- Interviews with gay and bisexual men in Leicester & London*
- Poor knowledge
- Social stigma around ‘risk’
- Stigmatisation of other users


Understanding identity change*

- Diagnosis entails the **assimilation** and **accommodation** of a **new identity element**, namely being HIV-positive.

- When I heard the news, I just froze basically and it was like the nurse was talking about someone else. I was just thinking ‘it can’t be me. How could it be?’.. I avoided any appointments and just didn’t want to hear the letters “H-I-V” (MSM, 25)

- It took a lot of alcohol, a lot of drugs and a lot of ups and downs to get to that point in my life where I can say I’m positive and it’s who I am now (MSM, 28)

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Understanding identity change*

- Diagnosis entails the **assimilation** and **accommodation** of a **new identity element**, namely being HIV-positive

- Since my diagnosis, I’ve started up a group and I’m quite active on Twitter and I feel that I’m making a difference, and I feel like I’m contributing something back, turning my life around, you know (MSM, 31)

- He told me and I just started reading. I started like finding out about what it’s like and that and then it wasn’t a massive shock when the clinic told me (MSM, 23)

Identity change & proactive behaviour change

• Channelling patients towards proactive coping strategies

• The idea of going to the doctor and actually admitting it to him and then to me that I’ve got HIV was a nightmare. That’s what I needed the support with, accepting it as the new me (27)

• I started and managed to forget about it for a while and then started [ART] and each time I took that pill it hit me and I felt awful. Like a bad person (MSM, 30)

• Now I’m an advocate for this and I tell new people that it’ll be fine, that they’re going to live and I feel like it’s good to help others. It helps me too (MSM, 35)

• I don’t know where I’d be without their support and just telling me ‘it’ll be OK’ (MSM, 21)

A Model for Clinical Practice

Social support
- e.g. family, peer support, significant others

Social representations
- e.g. stigma, homonegativity

Social stressors
- e.g. childhood sexual abuse, internalised homophobia

Identity threat

Negative affective states
- e.g. guilt, shame, anxiety

Maladaptive coping
- e.g. chemsex, condomless sex, sexual compulsivity

Sexual health outcomes

Adaptive coping
- e.g. anticipatory re-structuring, social support

Personality traits
- e.g. optimism, self-directedness, neuroticism

Practitioner approach
- e.g. therapeutic models, IPT, SRT

Figure 5: A framework for understanding self-identity, wellbeing and sexual health among MSM
Recommendations

• Challenging inaccurate representations of HIV and prevention
• Identifying potential risk factors for adversity & risk-taking
• Awareness of the complexity of the patient’s identity
• Understanding potential threats posed by our solutions
• Understanding & predicting coping responses in patients
• Challenging maladaptive strategies & making available proactive strategies