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HIV/AIDS: Friend or Foe?

Searching for meaning in the face of HIV/AIDS among men who have sex with men (MSM) in Cape Town, South Africa.

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Dedication

This thesis is dedicated to the one person who has journeyed alongside me, through the darkness and the light. Who has given me unconditional love. Who has seen me for who I am.

Abstract

This research paper set out to discover whether a Christian Spiritual perspective (within a framework of a theology of affirmation and a psychological strengths perspective of fortigenesis) on basic threatening existential issues, such as HIV/AIDS Stigma, Homophobia, etc. can help MSM to reformulate the quest for meaning and be integrated in a holistic approach to spiritual healing in order to overcome the schism in HIV/AIDS: Friend or Foe?

Setting the stage for exploring the world's worst global challenge within the health sector, and how it relates to the South African context for MSM. The research uncovered that MSM face the greatest challenge and burden of HIV/AIDS in many countries, however little research has focused on MSM and HIV/AIDS in South Africa. Literature links this to the fact that throughout Africa, the predominant view of same sex relationships as being un-African, sinful and an abomination.

Pointing out that for MSM, the development of God-images usually occurs during the process of growth and maturation as an individual, where a multitude of experiences are based primarily through the filter of belonging to a minority, which are seen predominantly from society as being sinful. The possible multitude of traumatic and often fearful life experiences, including the potentially highly stressful and difficult process of informing their parents and families of their sexuality, may influence their emotional experience and ultimately their God-image. The God-image of parental love, acceptance and caring may be impacted on by fear of rejection and the lack of acceptance. The development of ambivalence may strongly impact on MSM God-images, resulting in conflicted experiences and understanding of God, where the God-image could become distant and judgmental (Hoffman, 2009:15-18).

Something that is exacerbated by the stance of some belief systems promote the concept of "love the sinner, hate the sin", which only results in MSM being ignored or having their partners/relationships rejected, thus isolating them within their own faith community. This impacts their spiritual/religious development and their participation in a non-affirming faith community can result in levels of increased internalized homonegativity (this is defined as negative attitudes to one's own homosexuality), causing poorer psychological health and lower self-regard.

The dignity, identity and meaning of MSM are further impacted on by their minority existence within the context of South Africa, which places various traumatic stresses on MSM. These traumatic stresses are amplified by the constant negotiation of fear regarding the contracting of HIV/AIDS or even being diagnosed with the life threatening disease.

Despite all these external and the resultant internal stressors, Graham and Kiguwa (2005) found that religion and spirituality is important to MSM-youth as it provides possible supportive structures and environments. Many of the MSM-youth believe in the Bible or ancestors (or even both), yet have chosen to adapt their beliefs by taking what was important for them from the Bible and ancestral belief systems. This they have done as the traditional view of religion and the Bible held by most people, where the scriptures are taken literally, is that homosexuality is a sin (Graham and Kiguwa, 2005:7-8).

Within this research, the interviewees experienced all this; however the results also showed that all the participants found some beneficial aspects out of contracting HIV/AIDS, with various levels of meanings relating to a sense of growth for each interviewee, while 4 out of 5 indicated that spirituality played an important role in assisting them in improving their lives. It aided in helping them to develop a sense of connection to themselves and others, something that many felt was missing within their lives. They felt that if it hadn't been for HIV, they would not have increased their levels of spirituality. This is an important empirical finding with respect to the research question and hypothesis, which hypothesized that HIV/AIDS promoted changes within MSM that results in spiritual growth and the development of internal strengths that allow them to transcend above the stressor of HIV/AIDS.

The idea that MSM experience spirituality as something helpful and essential, makes it important to note that comments in the empirical research indicated that they tended to believe that if a Higher Power is involved, that it is unconditionally loving, kind and friendly. This is an important description of a God image within Christian Spirituality, a possible God-image of a Partner for Life or Friend. Thus, for Christian Spirituality to play a role within the healing of MSM and to better enhance spirituality and lay a better spiritual foundation, and develop better internal strengths and existential states, it thus becomes important to explore how Christian Spirituality will be able to address these needs of MSM, within a theological framework of affirmation.

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Chapter 1: Background of Research Topic and Field

"Once you choose hope, anything is possible."

Christopher Reeve

1.1. Introduction

When HIV/AIDS began its meteoric rise to one of the world's worst global challenges in the health sector, it was originally identified among the community of men who have sex with men (MSM) in the USA in the early 1980s.

The term MSM refers to men who identify themselves as "gay", "bisexual", as well as those that identify themselves as "straight," many of whom do this in order to hide their same-sex behaviours from their family, friends and female partners (Lane et al, 2009:430).

Today literature shows that MSM still face the greatest challenge and burden of HIV/AIDS in many countries, and are often an important target group for HIV/AIDS projects and campaigns, yet in the Joint United Nations Programme on HIV/AIDS (UNAIDS) report it has been highlighted that globally there is a failure to understand and respond to the health needs of MSM (UNAIDS, 2009:2). Is the same true for the spiritual needs for MSM? When turning to review the situation in sub-Saharan Africa, where the HIV/AIDS epidemics have been found to have the most destructive effects, MSM are often overlooked (Smith et al, 2009:416).

In the past, many of the leaders in sub-Saharan African countries refused to acknowledge the link between HIV and AIDS. These are the very countries which have been hardest hit by the HIV/AIDS epidemic on the African continent (Garrett, 2005:51). South Africa was one of these countries, where the government's approach to the HIV epidemic in the past has been highly controversial and politicized (Rohleder, 2007:403). Research carried out by Lane, McIntyre and Morin (2006:1) found that among the South African MSM community, who practice high-risk sexual behaviour, with the black African MSM being the most vulnerable group to HIV infection. However the HIV prevalence and incidence among MSM in South Africa still remains unknown (Cloete et al, 2008:1105). This lack of information about MSM and HIV/AIDS is disconcerting, considering that the countries in Sub-Saharan Africa, including South Africa, have the highest prevalence of HIV (Baral et al, 2009:1).

Some relate the lack of research into MSM and HIV/AIDS to the fact that the predominant view in Africa is that same sex activity is un-African or an abomination or sin that needs to be eradicated. Even in South Africa, despite the protection within the constitution to protect sexual rights, many MSM experience a variety of homophobic experiences. These experiences are often either singular traumatic events, or continuous daily traumatic events[1] that are precipitated from living within a heterosexist society. These traumatic events have a major impact on the overall state of being and quality of life.

Another traumatic event that impacts on a person's state of being and quality of life is being diagnosed with a life threatening disease, such as HIV. In this case it is the interplay between being MSM, past traumas and the additional trauma of being HIV-positive and the resultant meaning that is made thereof that becomes important. This would aid the development of intervention programmes.

To research this, it is important to further develop an understanding of the prevalence and incidence, so that we are better able to structure these intervention programmes. These programmes are better able to inform people that since the introduction of highly active antiretroviral therapy (HAART), those infected with HIV do not necessarily face death any more, but will have the challenge of dealing with a chronic disease (Kraaij et al, 2008:395).

Along with dealing with HIV as a chronic disease, other diverse problems may begin to enter their lives, due to the unpredictable progression of HIV, the stigma and other social factors (Ueno and Adams, 2001:303-304). These other problems, combined with the life-threatening illness of HIV, can impact on a person's sense of identity and their taken for granted concepts around the temporal framing of their lives. That is why understanding of peoples' exposure and response to HIV is important, as many experience changes or transformations in their values, spirituality and life priorities (Ezzy, 2000:605-616, Lutz et al, 2011: 399-407).

[1] Judith Herman (1992a) in order to define trauma, states that traumatic events, 1) through overwhelming force, render victims helpless; (2) involve perceived threats to life or bodily integrity, or even possible close personal encounters with violence and death; (3) interferes with a person's sense of control, connection and meaning; (4) expose a person to be confronted with the extremities of helplessness and terror; and (5) result in the evoking responses of catastrophe.

Spirituality is usually concerned with the individual's quest to understand and find meaning, purpose and value to life (Ridge et al, 2008:414). Dalmida (2006:187) states that spirituality also encompasses the domain of inner/soul growth and the individual's connection to a higher power or transcendent practices/beliefs. He goes on to report that many people with HIV/AIDS express that spirituality is an important element in their wellbeing. Heerman, Wiggins and Rutter (2007:711), as well as Ironson et al (2002:34-35) explain this by the awareness that spirituality and religion are important dimensions of being human. It even aids in identity development, making it an important element in mental health. Studies into HIV/AIDS and mental health show that HIV affects meaning-making, coping and overall feelings of wellness (Tuck et al, 2001:777-778).

The search for meaning and meaning-making is a human response to life's challenges, of which HIV/AIDS is, a part. It is a cognitive reaction in the process of developing strength in the face of these challenges, and assists in the development of mental health as a part of fortigenesis[2] (Strümpfer, 2006:13).

Fortology, a study of psychological wellbeing (of which fortigenesis is included), and thus how to expand human capacities and improve psychological wellbeing, focuses on developing strength (it is a strengths perspective) and courage, through specific components of human wellness in response to life challenges (Louw, 2008), of which HIV/AIDS is one of these major challenges facing MSM, making it a considerable reality to be considered within the lived experience of MSM. The term fortology and a strengths perspective are equivalent to the existential concept of "the courage to be" as well as the theological concept of parrhesia.

Within affirmation theology, fortigenesis is directed more towards the direction of existential and ontological categories, rather than the emotional, cognitive and behavioural attitudes as expressed in psychology. It is also linked to an ontic state of being, which means that a person's very being quality is affirmed by eschatology.

This new state of being in Christ means that a person is strengthened to live life with courage and through hope, by the charisma (fruit) of the Spirit. Thus spiritual fortigenesis and

[2] latin fortis= strong + greek genesis, from gen= to be produced

fortology relates to the spiritual strength and courage that is derived from a person's new being in Christ.

Pastoral care is directed towards the exploration of a person's state of being, as related to their quest for meaning. Pastoral anthropology is interested in improving life through faith and spiritual issues (Louw, 1998:126).

Thus by researching the meaning MSM have developed in the face of HIV/AIDS, pastoral care will be better able to determine a person's state of being, as expressed by the meaning Of HIV/AIDS that they have developed. By isolating the meanings made by MSM, we are better able to assist in the development of improved qualities of being functions within MSM who face HIV/AIDS.

In the case of MSM communities, the interplay between being MSM, possible exposure to past traumas and then the additional possible trauma of being HIV-positive should be recognized and considered in addition to all the other problems to aid the development of intervention programmes with a focus on spirituality.

1.2. Problem Statement

Whether a Christian Spiritual perspective on basic threatening existential issues, such as HIV/AIDS Stigma, Homophobia, etc. can help MSM to reformulate the quest for meaning and be integrated in a holistic approach to spiritual healing in order to overcome the schism in HIV/AIDS: Friend or Foe?

In order to understand the problem within the problem proposed in the statement above, it becomes necessary to engage with the following questions:

1. In the case of the human quest for meaning, what is unique to this question within the realm of MSM?

   Within the human quest for meaning, the unique question within the realm of MSM is that religion has always had a powerful influence on a variety of spheres within the human context, especially on a variety of aspects of the private life spheres of individuals,

one of the most important being sexuality. With religion/spirituality and its variety of doctrines informing society's social norms with respect to what is considered acceptable and unacceptable sexual intimacy. The understanding of the broader context of faith within the lives of MSM has therefore been one of predominant silence and a resultant scarcity of information. This has resulted in little being known about how MSM conceptualise or frame religion/spirituality within their lives (Halkitis et al, 2009:251).

Schwartzberg (1993: 488) stated within his research into MSM and the question of the meaning within the face of HIV/AIDS, that MSM place a fundamental importance on creating meaning in order to cope with dealing with HIV/AIDS, with many gaining some special benefit from HIV-positive. He went on to explain that ascribing meaning to illness as a basic human undertaking, and the ascribed meaning being powerfully influenced by cultural and personal factors, in the case of MSM are often unique.

2. What are the characteristics of MSM with regards to the meaning question?

Schwartzberg (1993:486-489) identified four overall frameworks for ascribing meaning when researching HIV-positive MSM. These are: high meaning, defensive meaning, shattering meaning and irrelevant meaning. These four categories he expressed could be beneficial in assisting the understanding of the style and success of an individual to negotiate creating meaning within the face of a crisis, such as HIV/AIDS.

3. How is this question related to the existential context of MSM and what are the unique spiritual needs of MSM?

When looking at the existential context of MSM, it is important to take note of the outcomes of social ridicule that is directed at them. Some of the possible outcomes are pervasive feelings of shame, unworthiness, self-debasement, intense need to atone (Carbone, 2008: 305), self-revulsion and hostility (Ross et al, 2008:548). With the use of religion/spirituality to legitimize this social ridicule, marginalization and stigmatization of MSM throughout history, making same sex intimacy sinful, it becomes important to realize that this group of people still persist with their faith and harness these beliefs to negotiate challenges such as HIV/AIDS. This highlights the fact that MSM, as a marginalized people, are able to break through society's barriers in order to achieve transcendent relationships with other people and with God (Halkitis et al, 2009:261).

4. In order to establish a holistic approach to the spiritual healing of MSM, what is meant by healing and becoming whole in the case of MSM?

   In the case of healing and becoming whole within MSM, the establishment of a holistic approach to spiritual healing needs to be cognizant of the interplay between theology and psychology and the strengths perspective. Widespread scientific literature and historical accounts of gay culture indicate the evidence for strength and resilience within MSM. By moving towards interventions that do not focus on the deficits of MSM, but rather on their strengths in order to address the deficits (Herrick et al, 2011:3), we are better able to design pastoral care interventions for MSM.

5. How is the human quest for meaning experienced, viewed and formulated by HIV-positive MSM?

   Within South Africa, statistics show that there are approximately 5.5 million people living with HIV/AIDS in the general population. However the risk of acquiring HIV among MSM is far higher. It is because of this disproportionate impact on MSM that it becomes necessary to focus research into this community (Rispel and Metcalf, 2009:133-134). The challenges faced by MSM in the face of HIV needs to be understood.

As well as the research questions as proposed by Schwartzberg (1993:483):

6. "What are the strategies HIV-positive gay men have developed to maintain or reconstitute the belief in a meaningful world?
7. How has AIDS affected beliefs about such issues as fate, religion, death, the meaning or purpose of life, and the degree to which people control their own destiny?"

These questions assist in guiding the research in order to come to some conclusions with respect to the proposed problem statement.

In attempting to understand these questions, the research that has been done in this field, shows that people with HIV/AIDS often approach the existential issues that arise by a re-

examination of their spirituality and religiousness. This makes spirituality and religion an important resource to tap into, to assist in coping with the illness and its impact on their lives, even among MSM who experience judgment, discrimination and exclusion from society in general and especially among religious institutions (Pargament et al, 2004:1204).

1.3. Hypothesis

By using spiritual and religious resources, people with HIV/AIDS should develop a new way of making meaning of events and how they react to them. They should be able to make a transition from the view of a God/Higher Power that is judgmental to that of a loving God/Higher Power; one that is possibly a friend or partner for life, an important positive impact on coping with living HIV/AIDS (Koss-Chiono, 2006:15-1).

For MSM, the development of God-images usually occurs during the process of growth and maturation as an individual, where a multitude of experiences are based primarily through the filter of belonging to a minority, which are seen predominantly from society as being sinful. The possible multitude of traumatic and often fearful life experiences, including the potentially highly stressful and difficult process of informing their parents and families of their sexuality, may influence their emotional experience and ultimately their God-image. The God-image of parental love, acceptance and caring may be impacted on by fear of rejection and the lack of acceptance. The development of ambivalence may strongly impact on MSM God-images, resulting in conflicted experiences and understanding of God, where the God-image could become distant and judgmental (Hoffman, 2009:15-18).

1.4. Objective of Research

By doing explorative research I would like to expand on the understanding of how HIV-positive MSM in Cape Town, South Africa develop meaning in their lives. In understanding the meaning achieved and how it was achieved, and the role that spirituality/religion played, so that better approaches to the care of MSM who live with HIV/AIDS can be developed.

This exploration will be guided by the questions proposed in the research question to allow for improved pastoral care and counselling therapy to be developed for MSM living with HIV/AIDS, due to the new understanding of the meaning that MSM make of HIV/AIDS.

1.5. The Interplay between Psychology and Theology within the Field of MSM

This research endeavor within the field of Practical Theology, particularly Pastoral Care, takes into account the interplay between psychology and theology, with respect to the development of strength and courage to be MSM in the face of HIV/AIDS. In order for it to do this, it becomes important to understand the frameworks it is embedded in and the methodology used to carry out this research, especially with regards to the empirical research that took place within this research, and the procedure taken to do this research.

A multitude of studies have explored the interaction between religion/spirituality, existential meaning, physical health and mental health (Rempel, 2005:1), however very few have explored it within the realm of MSM and HIV/AIDS, making it an important field for theological and psychological research.

Meaning making and its importance to the state of an individual being, is an important field in both psychology and theology. That is why when exploring the meaning that HIV positive MSM in Cape Town have developed from their sero-status, it becomes important to explore the interplay between theology and psychology, and what each has to offer.

1.6. Theological Framework, Methodology and Procedure

In order to negotiate the specific theological approach taken in this thesis in working with MSM, it becomes important to understand its theological context of practical theology and pastoral care. By understanding this theological context, a better understanding can be developed as to the necessity of exploring the interplay between theology and psychology within this field of research.

1.6.1. What is Practical Theology?

Essentially, Practical theology is an interdisciplinary activity that is in dialogue with others, most importantly the social sciences. This is because it works in the public domain, at the meeting point of faith and action, belief and culture, and various different professional

decisions. Thus it is argued to be the heart of genuine theological activity, for it is that form of theology that is exposed to the entirety of the human experience (Ballard, 1995:115).

Louw (2008) expands upon this by commenting that Practical theology refines theological interpretations through reflecting on the empirical dimension of human responses, whilst studying human behaviour. Through doing this, it is able to more clearly define the focus of care and counselling practices within pastoral hermeneutics. It thus confirms the validity and appropriateness of the scientific method of theory-praxis-theory (circular and spiral). This ensures that Practical theology remains in essence theology, removing it from being considered sociology or psychology: it is the only theology that "reflects on and deals with the praxis of God as related to the praxis of faith within a vivid social, cultural and contextual encounter between God and human beings" (Louw, 2008:17)

The founding father of Practical theology is Friederich Schleiermacher, who saw it is as being "the theory of practice," and was concerned with methodology and how it relates to the churches activities (Gřab, 2005:181). Yet now, as Louw (1998:91) expresses, Practical theology has moved beyond prescribing technical regulations as they relate to ecclesiastical practice, and rather focuses on designing praxis theories and strategies to inform necessary actions for social and personal transformation, "this shift is away from saying (word) in the direction of doing (action)" (Louw, 1998:91).

Ballard (1995:114-115) sums up Practical Theology as:

1. "A practical disciple [where] attention [is] paid to the relation between theory and practice
2. A recognizable field of study – [which] finds its coherence in its concern for the life and practice of the community of Christian Faith in all its kaleidoscope"
3. A critical, reflective discipline – [that is] part of that theological critique that is constantly addressing questions of truth and meaning as well as those of appropriateness and validity, challenging the Church to become what it is called to be and to live realistically and creatively in the actual world"

Louw (1998:87) builds on this by reflecting upon Heitink's work when he states that "Practical theology is about a mediating event: how God's actions are mediated through human service... [which] reveals an anthropological shift in reformed theology. God Himself is no longer the subject of investigation in a practical theology: the focus is on the human experience of God, the Christian faith. Heitink thus describes practical theology as a communicative and action oriented science. This approach implies that practical theology is empirical theology which mediates the Christian faith in the praxis of modern society" (Louw, 1998:87).

This also highlights how Practical theology is needed to explore how the symbolic strength of Christianity can be harnessed by the church and pastoral care, for making sense of life and to develop successful coping within the complexities of life today (Grab, 2005:196).

We can thus conclude from reflecting on these understandings of what Practical theology is, that the task of Practical theology is hermeneutical, where hermeneutics refers to principles and the science of interpretation. "This process involves the interpretation of the meaning of the interaction between God and humanity, the edification of the church and becoming engaged in praxis through communities of faith in order to transform the world or to impart meaning in life" (Louw, 1998:97).

"Ontology within Practical Theology… [is] taken to mean a hermeneutical endeavour that tries to link God to human life in order to deal with the spiritual dimensions of significance and the ultimate meaning of life" (Louw, 2008:18). This is important as the research topic is trying to engage in ascertaining the meaning that MSM have developed in the face of HIV/AIDS, so as to provide a better understanding and framework of the approaching MSM through Pastoral Care. Thus allowing MSM, through pastoral therapy to approach the schism of HIV/AIDS: Friend or Foe?

1.6.2. Pastoral Care within Practical Theology

The term 'pastoral' is not a biblical term, but stems from an ancient tradition. In the Greek world, 'soul care' was concerned with the development of those ideological elements and ideas which could influence people's attitudes and enable them to deal with life more effectively. Within the Christian tradition, the term 'pastoral care' has gained acceptance. The

influence of the Enlightenment can be discerned in those approaches which viewed pastoral care as the development of virtue and the promotion of human autonomy. Under the influence of psychology, 'soul care' is often understood as the transformation of human beings through psychoanalysis or other psychotherapeutic techniques in order to encourage self-realisation. Frankl (1967) concludes that the existential act and reality of humanity is to elevate one's spirituality above one's psychological condition. "Most would agree with the notion that pastoral care concerns the total human being within a specific relationship: a faith relationship with God. It also concerns the relationships between fellow beings, who are created in the image of God" (Louw, 1998:20-22).

Pastoral care thus emerges from a theological stance touching on spirituality and faith, where it is not primarily about techniques, methods or skills, but rather about the mediation of God's faithfulness, love and Grace (Louw, 1998). It is often viewed as a theological science that conveys the meaning of humanity within the Christian faith perspective that is primarily guided by the "eschatological perspective (the fulfilled promises of God in terms of salvation/new creation, which implies the tension of a vital hope: the already and the not yet of our new being in Christ). The eschatological stance in a theology of pastoral care inevitably addresses the problem of meaning (significance and purposefulness) and spirituality (an awareness of the presence of God within crucial life issues – to live *coram Deo*)" (Louw, 1998b:235).

The eschatological stance is thus able to indicate the quality and condition of the human existence of actual being in Christ. Not only does it describe the end of time, but is able to reveal the essence of humanity's new being in Christ. Using the cross and the resurrection, eschatology is able to define the stance of pastoral care, thus connecting pastoral care to hope (Louw, 1998).

> "Eschatology, as a basic principle for a design for pastoral care, links together two concepts: death and life, fear and hope. Eschatology deals with the following dynamics:
>
> 1. The component of death and dying. In the expiatory death of Christ: "We were therefore buried with him through baptism into death" (Rm 6:4)

2. The component of resurrection and life. “We have been resurrected from death with Christ” (Eph 2:6) so that “we too may live a new life” (Rm 6:4). Redemption brings life, and this life is qualified by the victory of the resurrection. “And if Christ has not been raised, your faith is futile” (1 Cor 15:17). The ‘but’ of 1 Corinthians 15:20 directs pastoral care towards faith care. “But Christ has indeed been raised from the dead.” Christ’s resurrection gives meaning to life. A life that is founded on resurrection hope will provide a continual process of faith development and growth. The hope of the resurrection destines the Christian’s life for victory and imparts a future dimension to faith. Without this future dimension, pastoral ministry loses much of its therapeutic dimension: hope based on fulfilled promises of God.” (Louw, 1998: 59)

In expanding further, the eschatological perspective within pastoral care has the following implications, as:

- It is able to provide a horizon of meaning. Eschatology addresses humanity’s fundamental need for restoration, peace, integration and conciliation through its referral to the fulfillment of God’s promises with respect to salvation
- It is able to provide evidence of God’s faithfulness to the believer, who is offered a guarantee of God’s presence during all circumstances of life. This creates a measure of stability and security that is essential for any healing to occur.
- It established a normative framework: that a meaningful life needs norms by which to live.
- It is able to impart uniqueness to the identity of the pastoral act, as the pastoral caregiver acts within the faith dimension (Louw, 1998).

It is the role of pastoral care to sustain the sick and healthy, in order to assist them and prepare them for diverse experiences, including the most common issues relating to illness: the inability to cope; and anxiety with respect to suffering and death.

This implies that pastoral care has a special role within preparation and prevention care to life, where the emphasis is placed on the “creative powers in life and faith; and not on pathology” (Louw, 2008: 10).

It is this that allows for pastoral care to transcend psychology. It is not trapped in pathologising as psychology is, as this inhibits pastoral care (Louw, 2008; Friedman 1985). Pastoral care becomes about:

- "'Somebody' to be with
- Empowerment
- Recognition
- Comfort, consolation and compassion" (Louw, 2008:14).

In the exploration of meaning and transcendence of the psychological self-actualisation, Frankl (1969:38) states that: "Self-actualisation [refers to the fulfillment of the available possibilities or potentialities] is not man's ultimate destination. It is not even his primary intention. Self-actualisation, if made an end in itself, contradicts the self-transcendent quality of human existence. Like happiness, self-actualisation is an effect, the effect of meaning fulfillment. Only to the extent to which man fulfills a meaning out there in the world, does he fulfill himself. If he sets out to actualize himself rather than fulfill a meaning, self-actualisation immediately loses its justification…[in other words] Excessive concern with self-actualisation may be traced to a frustration of the will to meaning…[this means that man] is intent upon self-actualisation only if he has missed his mission." If humanity focuses on achieving pleasures as a direct intention, he will always miss his existential aim. In other words humanity needs to move beyond thinking and believing to an existential state of being (Frankl, 1967).

"Pastoral care enables an experience of the transcendent reality of God" (Bruinsma-de Beer, 2006:172), making the caring for life and the soul one and the same. This is because "Soul care does not make distinctions between dimensions of persons" (Tisdale, Doehring and Lorraine-Poirier, 2003:52). This ensures that Pastoral care uses "sophisticated approaches and models of care based upon the interconnectedness of issues across dimensions of being" (Tisdale, Doehring and Lorraine-Poirier, 2003:52).

The approach in this thesis is that proposed by Louw (2008:11) which states that

> "*Cura Vitae* is about a theology of life and the healing of life from the viewpoint of Christian spirituality. It is about how new life in the risen Christ and the indwelling presence of the Spirit can contribute to the empowerment of human beings. It is about hope, care and the endeavour to give meaning to life within the reality of suffering, our human vulnerability, and the ever present predicament of trauma, illness and sickness. This approach is an attempt to shift the paradigmatic thinking within care giving from a focus on "knowing and doing" to rather "being" functions."

Louw (2008) expands upon this by highlighting that from a Christian spiritual perspective; 'To be' implies that there is a growth process of anticipation and transformation that occurs away from the ethics of performance and achievement to that of the sacrificial ethics of unconditional love.

This he claims, also implies that there is a shift to ego transcendence (the transcendent self), away from the ego obsession (the depleted self). The framework of this paradigmatic shift lies within the eschatological thinking: where there is a move from cause and effect to that of the networking of pastoral hermeneutics. In explanation, it is then about the linking of "fundamental existential issues (anxiety, guilt, despair, helplessness, anger) to appropriate God-images and the human quest for meaning. It essentially deals with questions about attitude (ensoulment) and the quest for meaning" (Louw, 2008:12).

Thus, pastoral care is about the caring for the soul and caring for human life, where the concept of soul relates to the qualitative stance in life. "Therefore we say: one does not have a soul but one is soul in every fibre of one's being human" (Louw, 2008:83).

The understanding makes it imperative that the humanity of MSM be recognized and cared for to improve their quality of life through pastoral care, which strives to care for the soul of the human being, thus implying the care for all arenas of MSM experience.

Pastoral care can be described as encounter with the Gospel that occurs within the all embracing love of God, where the Gospel is humanity's spirituality and existential needs, as well as about faith and life. Thus any pastoral action without an encounter is not pastoral care. All events between human beings and God require an encounter. Pastoral care requires

the entry into a relationship with others in order to demonstrate and interpret God's care to all dimensions of human existence. Pastoral care therefore becomes a concrete demonstration of God's presence within an encounter. With his presence, the encounter brings true healing through the peace of salvation; fellowship with God and harmony with all of creation (Louw, 1998).

> "The theological design of pastoral care [indicates that] the reciprocal covenantal relationship between God and humankind becomes truth through the incarnation of Christ which reveals the history of salvation. …The God-human relationship is concretized within a covenantal encounter and can be expanded for pastoral theology [in the following way]. During the pastoral encounter, and as a result of it, the covenantal God-human encounter obtains the character of sensitive closeness (intimacy) and comfort. Pastoral care, and therefore pastoral counselling as well, should express God's covenantal closeness and togetherness. It should convey the partnership between God and Humanity" (Louw, 1998:68)

Thus the pastoral encounter is a human expression of God's love, which can be viewed as intrinsically 'sacramental.' The covenantal encounter between God and humanity is portrayed through the pastoral care act becoming a metaphor. This implies that a covenantal dialogue occurs when pastoral care is exercised. The Spirit thus establishes a covenantal encounter between humans and God, and demonstrates this relationship though human actions and words (Louw, 1998).

Pastoral care can be understood through Louw's (1998:70) explanation:

> "Pastoral care is the embodiment of an encounter with the Gospel…The encounter is thus the medium through which this theological learning process becomes a human experience….To summarise, 'encounter' means: the communication process that takes place between God and humanity within a real situation where they discover meaning through faith and are guided by Scriptures….The pastoral encounter remains thenomous; it is 'created' by God in his mercy. Yet it is always humane and contextual; the Spirit

> empowers a person – the 'living human document' and endows the believer with spirituality (an awareness of the presence of God in life issues)."

1.6.3. MSM from the Perspective of Affirmation Theology: The Quest for Identity

This thesis relies on affirmation theology as the primary theology paradigm that frames the pastoral care approach, making it important to understand the theological principles of affirmation.

Affirmation theology is a psycho-pastoral model which recognises the "interplay between pastoral anthropology and a psychological understanding of maturity" (Louw, 2008:58). This theological understanding of Christian spirituality, impacts upon the pastoral caregiving healing process, through its emphasis on the eschatological perspective. This perspective imparts a new understanding on human identity and the significance of human being functions (Louw, 2008).

This new understanding of the human identity is constituted through the ontology of salvation (the new creation and corporate reality of humanities new being in Christ and the transformed status as God's children), which is a consequence of the enfleshment of God and the embodied presence of God through Christ within a human body which results in the state of a new cosmic recreation. Incorporating the holy event of the inhabitation, which is: "the indwelling presence of God through the Pneuma (Spirit) in our human bodies (spiritual corporeality)" (Louw, 2008:28).

In explanation, this means that,

> "a theology of affirmation …seeks to deal with ontological issues that affects the status and identity of human beings…Within a Christian spiritual approach to life events, a theology of affirmation describes the status of our being human in terms of eschatology…Eschatology is understood as an ontological category that defines our being human in terms of the events of the cross and the resurrection. Eschatology is about the essence of things and their implications for the end of things and the qualification of time and

> history…Affirmation theology describes signification and ascribes human dignity and subject particularity. It emanates from the ontological "Yes" in Christ to our being human (as demonstrated through Baptism and celebrated in the Eucharist) and is demonstrated in new patterns of pneumatic living) pneumatology and inhabitational theology)." (Louw, 2008:30).

Affirmation theology is then understood to address soul care of human beings, through understanding the lived experiences and its impact on people, always emphasizing the eschatological recreation of a human beings natural state as a pure, innocent and loved being in the eyes of God; a result of God's action through the crucifixion and resurrection, an important stance when addressing MSM and their lived experience, especially in the face of HIV/AIDS.

Conclusion

The theological framework used within this thesis is that Practical theology is an interdisciplinary activity that is in dialogue with other disciplines, most importantly those within the social science. Within this thesis, the social science discipline that is proposed is psychology, as this allows theology, as exposed through practical theology, to the entirety of the human experience.

It is through the empirical responses of humans that practical theology is able to refine theological interpretations, allowing for improvement in defining the pastoral act and counselling practices within pastoral hermeneutics.

It is within pastoral care that the focus is able to maintain the mediation of God's faithfulness, love and grace. This faithfulness in this thesis is proposed to be best approached through affirmation theology. This is a psycho-pastoral model which recognizes the interplay that exists between pastoral anthropology and psychology. The perspective taken being that of eschatology which creates a new understanding of the human identity and the significance of human being functions. The new being functions are defined by being new creations in Christ and having a transformed status as God's children through the crucifixion, resurrection and inhabitation.

1.7. Psychological Framework

In understanding the Pastoral Approach to the development of meaning by MSM in the face of HIV/AIDS it is necessary to explore the psychological meaning-making process. In this research, it is proposed that this can best be done through understanding the psychological paradigm of Fortigenesis (as a variant of positive psychology) which allows for the development of resilience in the person being assisted. This resilience is achieved through coping mechanisms that use spirituality and religion as resources to strengthen identity and overall wellbeing.

In psychology, the focus has predominantly been on determining what is wrong psychologically with a person and their behaviour or personality. This meant psychopathologising people, a bias that has dominated the field of psychology for many decades. It was because of this that many researchers and psychologists felt that mental health needed to be re-defined positively, rather than focusing on mental health as the absence of any mental illness (Strümpfer, 2006:11-12). It was believed that preventing mental illness was far more desirable and effective than curative therapy (Crous, 2007). So was Positive Psychology born.

Seligman and Csikszentmihalyi (cited in Crous, 2007) defined positive psychology as a catalyst of changing the focus of psychology from attempting to repair, to building positive qualities. Paying attention to the positive subjective experience (positive emotions), positive individual traits (positive character) and positive institutions.

Out of this concept of positive psychology, grew the beginnings of 'Salutogenesis'. Strümpfer (1995:81) states that Aaron Antonovsky developed the concept of salutogenesis, which is derived from Latin, meaning salus (= health) and Greek, genesis (= origins). It focused more on an "appreciative set of assumptions and attributions about health, motivation, capacities, potential, and social functioning" (Strümpfer, 2006:13) and the origins of health (Strümpfer, 2007).

Later arguments then proposed that the concept of salutogenesis should rather be broadened to 'Fortigenesis', which deals more with the origins of psychological strength (Strümpfer, 2007). These strengths are displayed on the endpoints too, "for instance in developmental transitions, marriage, parenthood, and work" (Strümpfer, 2007).

Strümpfer (1995) comments that fortigenesis, which is derived from Latin, fortis (= strong), is a more descriptive paradigm than salutogenesis, from which is has grown out of. He expands on the term by highlighting that the English words, "fortify (= to impart physical strength, vigour or endurance, or to strengthen mentally or morally), fort (= a fortified place), and fortitude (= strength and courage in adversity or pain), all have the same root". By introducing this construct, Strümpfer (1995:81-86) did not attempt to deny that it is necessary to search for the origins of health; it is just that in the process of determining health one can't help but acknowledge the correlation to the origins of strength that is needed at the end-points of human functioning. He thus believed that the term fortigenesis was more encompassing and holistic than salutogenesis.

He comments on the applicability of this concept with respect to South Africa and globally:

> "One only has to be vaguely sensitive to the conditions of life for the vast majority of South Africans (and increasingly for many formerly privileged ones too) -- not to mention people in numerous other parts of the world -- to realize that fortitude is what it most frequently takes to carry on with such a life. To deal with bleak and dismal phenomena, one needs a philosophy of life -- and a psychology -- concerned with strengths and their origins. An understanding of why and how some people find the strength to withstand and overcome pressures toward increasing entropy, whereas others do not, is also likely to lead to ways of increasing the numbers of those who do" (Strümpfer, 1995).

1.7.1. Fortigenic Strengths

Strümpfer (cited in Nel, 2007) identified several constructs that describe psychological strengths that are put into play as a result of a person's appraisal[3] of inordinate demands[4] that they face in life:

- *Sense of coherence* (as described in salutogenesis previously)
- *Locus of control* is the ability to adapt to inordinate demands that appear to be outside an individual's control

[3] Appraisal is the internal assessment and judgement process of inordinate demands

[4] Inordinate demands are negative to positive events that result in change.

- *Self-efficacy* is that belief that an individual holds in their capacity/ability to achieve their desired outcomes by taking effective action
- *Subjective wellbeing* the focus of attaining happiness (psychological, emotional, physical and spiritual)
- *Meaning making* is the process in which meaning is derived out of inordinate demands, incorporating the following dimensions: *Assumptive world, Will to meaning, Rumination and cognitive processing; Positive illusions, Personal ideology, religion and spirituality; and End of the quest* (Strümpfer, 2006:19-24).

Out of these constructs, this research primarily focuses on meaning-making within fortigenesis and its relationship to the existential state of being within MSM, making it imperative to expand further on this construct.

1.7.2. Meaning-making in the Human Quest for Meaning

Meaning-making is the active process that re-evaluates experiences, as part of the fortigenic response of people to challenges. It is a cognitive reaction that is dominated by the search for meaning and existential significance (Strümpfer, 2006:19-24).

Strümpfer (2006:19-23) refers to five areas that are inter-related and when looked at collectively describe meaning-making within mans' quest for meaning:

- *Assumptive World* can be understood as the basic schemas[5] people hold about themselves, others and the world. The SOC is what is proposed as aiding in maintaining these schemas, through the meaningfulness component of SOC which results in the person demonstrating spirit and a questing for understanding.
- *Will to Meaning* as derived by Frankl's explanations in his works, where this concept is seen as the primary motivational force. It is the need for humankind to strive towards finding overarching meaning and purpose to life.
- *Rumination and Cognitive Processing* is the mental processing that occurs, through which challenges are pondered upon and contemplated. This is done to try to make sense of the challenge, and serves to create meaning through interpreting the

[5] Schemas are defined as the "Mental frameworks centering around a specific theme that helps us to organise social information" (Baron and Byrne, 2003, pp. 80)

experience. The new information that is gained about oneself and the world through this process is then assimilated into the person's assumptive world.

- *Positive Illusions* are self-serving biases that involved the meaning-making process. They are employed to distort perceptions of threatening challenges, so as to reduce any possible negative impact on beliefs or views about the world and the self.
- *Personal Ideology*[6], *Religion*[7] *and Spirituality*[8] are overlapping concepts of belief systems that vary in each individual with respect to their contribution to sense-making.

The development of meaning is part of the innate tendencies towards strength and the development of flourishing/thriving. If flourishing is to be achieved, it becomes important to understand what meanings are developed by people in the appraisal process of inordinate demands. By doing this the promotion of flourishing within others can be developed by assisting them in developing a different perspective of the inordinate demand.

Conclusion

Out of this analysis of paradigmatic and construct change, comes the awareness of how psychology has largely been the domain of determining what is 'wrong' with an individual. It has been focused on psychopathology and curative therapy. It is because of this bias of psychopathologising individuals that a new paradigm: positive psychology developed. It was believed that it is better to prevent mental illness than treat it. Building upon this approach, further constructs developed: salutogenesis and fortigenesis.

These constructs explored the concept of wellbeing of an individual, looking at their attributes and internal strengths to meet and overcome inordinate demands to reach a state of flourishing. In order to understand these strengths, constructs were developed to understand how in the face of an inordinate demand, individuals appraised the objective situation through

[6]Personal ideology is defined as the system of belief with respect to judging good/evil states of human existence and behaviour (Strumpfer, 2006:22)

[7] Religion is defined as the organized institution of religious beliefs and practices (Strumpfer, 2006:22)

[8] Spirituality can be defined as the search for the ultimate or within the understanding of Frankl (1959/1967/1969) who proposes a noetic dimension, which is the search for the human spirit and the quest for meaning

their own subjective experiences in order to determine how they incorporated their internal coping mechanisms in order to resile. Thus moving them along the continua of illness/wellbeing and flourishing/thriving.

In order to be resilient, and move positively along the continuum to flourishing and well-being, the various fortigenic strengths are need to be developed through the activation of the innate resilience of the individual, which is achieved through positively appraising inordinate demands and overcoming them. In so doing, an individual is able to develop new strengths and confidence in their own abilities, while developing new found growth and personal development.

By approaching the research through the understanding of fortigenesis and peoples resilience, and the development of well-being, it is proposed that a better understanding of the meaning obtained by MSM in South Africa in the face of HIV/AIDS can be beneficial. This would allow for the opportunity to develop better health prevention and treatment programmes and strategies.

This approach to research through the positivistic psychological paradigm of fortology allows Pastoral Care to enter the domain. From a theological perspective the strength perspective and fortology correlate to the concept of the courage to be as proposed by existential theology (Louw, 2008).

1.8. Methodology and Procedure

The methodology involved in this research involved the following:

- **Hermeneutical Approach**

  This approach is concerned with the lived experiences and life worlds of human beings. It explores and illuminates details and events of the lived experiences, that may be taken for granted, to be able to develop meaning and understanding. Therefore it is about interpretation of the lived human experience, to create an understanding of meaning (Laverty, 2003:6-11). This makes it a vital approach in this research as Practical Theology is about interpreting people's behavior and faith, through reflection on the empirical dimensions of being human, taking into account the praxis of God and his relatedness to the lived human experience (Louw, 2008: 17).

- **Literature Review**

  A review of literature is necessary and vitally important, as it allows for a correct understanding of the topic of MSM, HIV/AIDS and Spiritual Wholeness; as well as what research has already been done, how the research into the topic has previously been done and the issues that have been discovered.

- **Interdisciplinary Approach**

  Louw (2008:16) indicates that the task of theology is to ensure that humans are assisted to keep going and instilling a level of hope that nurtures meaning and significance in life. And it is pastoral care that is the medium of doing this, making it necessary for pastoral theology to always interact with other disciplines to ensure a fuller understanding of the lived experience of human beings through an inductive approach, with an emphasis on human needs (Louw, 1998:27). Pastoral care needs to be placed within an interdisciplinary approach (Louw, 2008:20), making it necessary when doing research within Pastoral care, to take an interdisciplinary approach. Within this research the disciplines of psychology and theology will be explored as they relate to the topic, as these will allow for a greater understanding of the lived human experience and how God relates to it.

  An interdisciplinary approach allows for new solutions to new problems. It pushes the researcher intellectually (allowing for broadened mindsets and promoting lateral thinking); enables the researcher to do things they normally couldn't do on their own, using skills, strengths and tools from other discipline perspectives; while broadening the researcher's literature base that may give rise to new and fresh insights (Conole et al, 2010:7).

- **Empirical Research**

  The empirical approach was decided upon to elucidate and try to understand how HIV positive MSM in Cape Town understand the world around them and their perception of God, by focusing on their life worlds and experiences. The methodologies selected allow for a qualitative understanding of the subjective understanding of MSM and the meaning they develop of being HIV-positive. This is because it allows for a clearer focus on the thoughts and beliefs brought forward by the interviewee. This is important when it comes to Practical Theology, which explores the lived experience of human beings and their encounter with God within these experiences.

Thus, in order to explore the human life world, perceptions of God, and the experiences of MSM within Cape Town, and how God relates to these, it is necessary to empirically explore this using participatory observation[9], before any hermeneutical interpretations can be made so as to develop an understanding with pastoral theology. The empirical research will entail interviewing a minimum of 5 MSM from the City of Cape Town's CARE Programme for people living with HIV/AIDS (see appendix 1). These interviews will be carried out in a semi-structured format, based on Schwartzberg (1993) research into MSM and the meaning they developed of being HIV-positive. The methodological approach to the empirical research is to be Interpretative Analysis Phenomenology (see appendix 2, 3 and 4), which is an ideal methodology that allows for an understanding of the person's life world and their subjective experiences of life and the meanings they develop of them (Kvale, 1996:38; Willig, 2001:50-53). This approach allows for an overlap with theology, where the lived experience (phenomenon) can be empirically determined (ie. The question of "What is going on?" can be described [Osmer, 2008:99]), and then interpreted (ie. The question of "Why it is going on?" can be interpreted [Osmer, 2008:99]). This links the empirical research approach to the topic to the hermeneutical approach of the research topic. Where the empirical findings of the meanings across all the MSM of being HIV-positive (see Appendix 4) will then be interpreted as to how God relates to these experiences, and the implications it has to the approach to theory formation within the topic.

Thus the empirical human experience of MSM in the face of HIV/AIDS is then able to aid Practical Theology to improve upon theological interpretations. In other words we are better able to approach an understanding of the concept proposed by Louw (2008:17), that the "praxis of God as related to the praxis of faith within a vivid social, cultural and contextual encounter between God and human beings" as it relates to the meaning MSM develop in the face of HIV/AIDS within South Africa, and the role that Christian Spirituality plays; and how this can improve upon Pastoral Care and Counselling practice in South Africa.

[9] Participatory Observation is defined as the process that enables researches to be able to learn about the people being studied in their natural setting through the use of observation and participation (Kawulich, 2005)

1.9. Ethical Clearance

The University of Stellenbosch has granted Ethical clearance in order to carry out this research as per appendix 4.

1.10. The Procedure of Exploration

Firstly (in **Chapter Two**), the specific focus is on the hermeneutical dimension of exploring trauma and the phenomenon of MSM within the context of South Africa, and especially Cape Town. Through understanding the history and context of MSM, and the multitude of trauma's and stressors of being MSM within a heterosexist society a better understanding can be gained as to this communities heightened vulnerability to HIV/AIDS. It explores the predicament and how MSM experience themselves. This creates a foundation for further exploration into the interplay between HIV/AIDS and MSM.

Chapter three explores the often traumatic interplay between HIV/AIDS and MSM and is explored by looking at the situation of HIV/AIDS within South Africa and its approach to dealing with the epidemic. The situation of MSM and South Africa's response (societal and governmental) to HIV/AIDS and non-conforming sexuality, gives a clearer indication as to the complex situation that MSM find themselves in, especially when negotiating their identity and existence, in the face of HIV/AIDS.

Chapter Four focuses on MSM and the existential pathology within the crisis of identity formation and search for dignity. This is achieved through exploring identity formation through the interplay between sexual identity, religious/spiritual identity and the impact that HIV/AIDS has on identity formation and existential state of being. This allows for the exploration of why any approach needs to reframe their anthropological presuppositions and how it is affecting theory formation in pastoral theology.

Ultimately **Chapter Five** focuses on MSM and the human quest for meaning within the parameters of spirituality and religion. It explores the conceptual understanding of religion and spirituality and the interplay between: spirituality/religion and wholeness; health and healing; HIV/AIDS and MSM; and the phenomenon of prejudice. This exploration allows for the further understanding of the empirical research findings within the context of this interplay.

Chapter 2: MSM - The South African Scenario

"One would have hoped that the rights of LGBTI are accepted and one need only celebrate that right, rather than still fight for it. However, it seems there are still people who do not acknowledge some rights embedded in the constitution, and that we definitely still have a lot of work to do in this regard."
UCT Vice-chancellor Max Price

South Africa has always experienced same-sex relationships among its original inhabitants. However, it is important to note that these same-sex relationships did not always indicate homosexuality. They included relationships as seen in the gendered "marriages" among black men on the diamond and gold mines (Swarr, 2004:78), as well as the intricate relationships among men within the prison systems (Gear, 2005:199). These self-same relationships were even promoted by the Apartheid State in as it served its interests of maintaining the image of black people as immoral and degenerate. This aided the Apartheid states interests in being able to maintain the supremacy of the white, heterosexual family standards that ensured growth in the white population. This was done in order to attempt to counter the growth in the black population. The state enacted various laws to suppress "homosexual" behaviours (Swarr, 2004:79) to try to promote heterosexual sex and reproduction.

In contrast to this, the post-apartheid South Africa became preoccupied with eradicating discrimination in all spheres (Hames, 2007:53), resulting in South African MSM being the first in the world to be constitutionally protected, based on their sexual orientation, as stipulated in Section 9 of the Bill of Rights (The Constitution of the Republic of South Africa, 1996). Despite this constitutional right, discrimination still occurs. MSM continue to live in a society that is fraught with contradictions: socially, economically and even politically (Swarr, 2004: 74). One of these contradictions is that despite the increasing international acceptance of homosexuality (Oswin, 2007:95) and the explicit constitutional protection from discrimination, MSM are still stigmatised in South Africa (Lane et al, 2008:430). This continued stigmatisation is highlighted by the fact that although sexual orientation is constitutionally protected, it did not automatically translate to equality and substantive access to the standard privileges that are offered to full citizens. These have only

been granted through "protracted legal litigation, class action, and activism" (Hames, 2007:54; Cock, 2003:38).

South Africa is often perceived as the most gay-friendly democratic state on the African continent, which is in conflict with the image that media depict of a South African society which is still essentially conservative and homo-prejudiced (Hames, 2007:55; Cock, 2003:38). This is highlighted in research done among students attending a Cape Town university, where MSM find it easier to be accepted if they "act straight" and try to "pass as heterosexual or straight," something that can only be considered to be nothing more than a survival strategy (Hames, 2007:70).

The reason for this starkly different attitude between the laws and society's standing is due to South Africa's colonial history and Apartheid era, where legally-sanctioned discrimination against same-sex practices occurred. South Africa held laws against MSM that were harsher than many of its neighbours. These laws had been in existence since the colonization of the country (Christiansen, 2000). The result of this is that many MSM experience trauma's throughout their lives that impact upon them.

2.1.Trauma of Growing up MSM in SA

Today, more and more of society's MSM-youth, as a collective extension of the Lesbian, Gay, Bisexual, Transgendered, Intersexed and Questioning (LGBTIQ) community, are becoming aware of their own gender and sexual identities, and their place in society as MSM. In their early youth they start to develop their self-concept, which is the unique set of traits, values, perceptions and characteristics that identify an individual, by the person themselves. They also start to develop self-esteem[10], which is the internal, personal feelings of worth, to the extent to which one senses one's attributes and actions are good, desired, and valued. However these are impacted on by society's values, beliefs and perception of gender roles and identity. This also then affects the MSM-youths physical, social, emotional, and cognitive development (Bukatko & Daehler, 1995).

[10] Self-esteem is the level to which a person values themselves, where a high self-esteem indicates a positive self-view and a low self-esteem indicates a negative self-view (Polders, 2006:20)

The MSM-youth not only experiences the angst of growing up into an adult, but faces the challenge of acceptance of their own sexuality. In addition to this they face the daunting prospect of "coming out"[11] (or possible fear of being found out) to friends and family, due to the inherent fears of rejection and stigmatisation, and even possible abuse (Griffith and Hebl, 2002:1191). This is because most MSM grow up in heterosexual families, thus making "coming out" a necessity. Yet "coming out", is both an act of acceptance of self and then a searching for acceptance of others. This process is a way of integrating the youth's sexual orientation into a complete sense of being an individual. This is a serious time in the youth's development, as society's discrimination of MSM is still blatantly apparent. This questioning of their role as they grow up creates the feelings of isolation, and differentness from their peers, resulting in "gay-related stress" (Close & Rigamonti, 2008). Those MSM who do not come out about their sexual practices are found to experience lower levels of psychological well-being, as well as a lower sense of life satisfaction (Griffith and Hebl, 1999:191).

This feeling of separation and lack of identification with their peers is entrenched during early childhood development, where child play has a major role in gender development. This is because the adoption of behaviours typical to a specific sex is enforced by the peer group, and non-conformity results in punishment, in the form of taunts, name calling and social isolation during play (Bukatko, & Daehler, 1995). This isolation is an act of heterosexism[12] on the part of the heterosexual youth. Sandfort (2007:181) found that gender non-conforming male's experienced higher levels of mental distress than their gender conforming counterparts.

It has been found that some MSM-youth in the face of this heterosexism, turn to high risk behaviours in order to try and cope with their confusion over their sexual identity, and to escape from daily abuses and the constant necessity of hiding their sexual identity (Graham & Kiguwa, 2005:16). These behaviours can include use of abusive substances and taking part in risky sexual behaviours. These high risk behaviours may result in higher incidences of

[11] Coming out is a process whereby a person comes to terms with their same-sex behaviours and identity (Samelius and Wagberg, 2005:38)

[12] Heterosexism is the assumption and attitude that all people are and should be heterosexual (Reddy, Sandfort and Rispel, 2009:40).

suicide, HIV transmission (with all its implied stigma and health implications), sexually transmitted diseases, unwanted pregnancies and possible abuse due to hate crimes. Yet most of these youths just want to talk, to discuss their feelings within a safe environment, with a person whom they trust. However, this can result in a daunting challenge, as acknowledgement of their sexual orientation can possibly place them in harms reach (NCTSN, 2006:2). Graham and Kiguwa (2005:15-18) found that violence due to a youth's sexual identity was one of the most frequently faced issues. They found that most of the youth they interviewed had experienced some form of violence due to their sexual orientation. Often this violence had been carried out by people known to them, with the implication that they had deserved the abuse.

Despite all these external and resultant internal stressors, Graham and Kiguwa (2005) found that religion and spirituality is important to MSM-youth as it provides possible supportive structures and environments. Many of the MSM-youth believe in the Bible or ancestors (or even both), yet have chosen to adapt their beliefs by taking what was important for them from the Bible and ancestral belief systems. This they have done as the traditional view of religion and the Bible held by most people, where the scriptures are taken literally, is that homosexuality is a sin (Graham and Kiguwa, 2005:7-8).

2.2.Trauma of Being MSM in a Heterosexist Society

"Heterosexism and homophobia are often key drivers
of many negative things in society."
Dr. Aaron Motsoaledi

In general, most heterosexual men and women are never forced to question their sexual attraction to, or love for, members of the opposite gender. This is because they assume that their feelings and emotions are just a "natural" or "normal" part of being a man or woman. For many MSM, on the other hand, their feelings of sexual desire and love for a person are often questioned on a daily basis. This is due to the fact that they are constantly bombarded with messages regarding the deviance of their feelings and emotions for members of the same sex, that to them are "natural" and "normal" (Polders, 2006:4-10; Nel and Judge, 2008:19; Arndt and de Bruin, 2006:16-18) .

Theunick, Hook and Franchi (2002:130) found that when developing a gay identity within a heterosexist society, the gay identifying MSM person may go through various experiences ranging from: "subtle and overt forms of rejection, discrimination, threat or assault" (Theunick, Hook and Franchi, 2002:130). However they found that gay-related stress continues even after the MSM person's identity had been formed. This is because they are continuously dealing with marginalisation, victimisation and various other fears about living as a member of a minority group within a dominant heterosexist society. This is compounded by feelings of needing to mask their sexuality, dealing with their own sexuality with its resulting disappointments to self and family, especially when the MSM person is living in an isolated environment (Theunick, Hook & Franchi, 2002).

In masking their sexual orientation, MSM start to lead a "double life," where they only talk about MSM-related experiences with those friends, family, and co-workers who are aware of their MSM identity. MSM who are only "out" to close personal friends or family become adept at "pronoun switching" when talking about same-gender dating partners or love interests. This is the use of opposite gender pronouns around those who are not aware of their orientation and same-gender pronouns around those who are aware, when referring to their partners. Some members of this group adopt a specific set of behaviours and language that they use around those to whom they are not "out" in order to retain their perceived heterosexual identity. This continuous masking of identity brings: prolonged stress and anxiety of possible exposure, as well as an elevated risk of physical illness (Cole, Kemeny, Taylor & Vischer, 1996:243).

While other compounding factors of prolonged exposure to stressors, is the "gay-minority" stressor of being subjected to the feeling of belonging to a minority group. This type of stress is long-term, encompassing the entire life-time of the MSM individual. These stressors are amplified by the heterosexist environment that may subject the individual to specific events of rejection, abuse and violence. Ultimately, this results in a negative impact on the individuals cognitive functioning and affect (Theunick, Hook & Franchi, 2002).

Then there is the continuous exposure to oppressive actions that may lead to a state of internalized oppression. This is a broad term that has been used to describe the experience of a person within a minority group accepting the negative societal views of the majority. Consiorek (1993) stated that MSM express this internalized oppression in overt and covert

ways. The overt expressions are seen in the form of self-deprecating comments and not taking advantage of social supports due to ideas of low self-worth, while covert expressions are more difficult to detect, as the person may present with healthy levels of self-acceptance, yet always places themselves in situations that lead to stressful circumstances. Theunick, Hook and Franchi (2002) also stated that homosexual people, especially MSM, are more likely to manifest psychopathologies, due to these various environmental stressors and trauma due to their sexual orientation.

This was also confirmed by Meyer (1995:51-52) who pointed out that the chronic negative stressors and oppression experienced by MSM, as a stigmatized minority, result in symptoms of "minority stress". When looking at a sample of MSM, he demonstrated that the minority stressors of "internalised homophobia[13]", stigma, and homophobic violence and discrimination are each independently related to psychological distress. Diaz et al (2001:93) highlighted this issue in their study on MSM and bisexual latino-men in the United States. They found that individual psychological symptoms could not be attributed to individual pathology, but rather to a "deeply connected to a lifelong history and current experiences of social discrimination owing to sexual orientation and racial/ethnic diversity, as well as to high levels of financial hardship due to severe unemployment and poverty" (Diaz et al, 2001:93).

Graham and Kiguwa found (2005:17-18) that within these communities, their respondents stated that their families would be unsupportive of their sexuality, and that they feared that if their family did know their sexual orientation, that they would be disowned or expelled from their homes. This is because it is seen as shameful to have a MSM member in their families. Complicating this is that if the family is supportive, the respondents feared that if the community knew their sexual orientation, there would be an anti-same-sex backlash against their family from the community.

2.3.Homophobia and its impact on MSM Health

"Living within a heterosexist society can result in homophobia" (Polders, 2006:6). It is this homophobia which has the potential to cause prejudiced behavior towards MSM, and it is this behavior that creates a significant amount of stress for MSM (Polders, 2006:7). This stress

[13] Homophobia is an irrational fear and a dislike for people who identify as homosexual (Butler, 2010:3)

has the potential to lower self-esteem, placing MSM at a higher risk for developing mental health problems (Polders, 2006:18).

Within South Africa, high levels of homophobia (Nel and Judge, 2008:19) is fueled by cultural, religious a general conservative attitude towards same-sex people (Reddy, Sandfort and Rispel, 2009: xv) with the result that the chances for MSM gaining employment, keeping employment or even furthering their careers are jeopardized (Samelius and Wagberg, 2005:39). Sometimes the silence in itself is a hostile response directed towards MSM (Reddy and Sandfort, 2008:30).

Often words such as "Moffie" are commonly used words to degrade MSM in South Africa. A common experience of MSM who continually face social stigmatization (as a result of this homophobia) may experience psychological stress and a lack of self-acceptance, thus causing them harm. This harm that is done to the MSM person is also then extended to their family and support system, fundamentally changing the relationships (Van Zyl et al, 1999:43). This social discrimination that MSM may face can either occur directly or indirectly (Samelius and Wagberg, 2005:19). International research has shown that people from sexual minorities are vulnerable to discrimination and victimisation (Reddy, Sandort and Rispel, 2009:36). An important consideration of this problem is that the victims of homophobia may also internalize it, as discovered by research (Reddy, Sandfort and Rispel, 2009:40; Polders, 2006:19).

In South Africa, research indicated that between 67% and 75% of same-sex people, such as MSM, had experienced homophobia, in the form of hate speech, while 22% had been punched, hit or even kicked, with between 17% and 22% being sexually assaulted (Polders, 2006:28).

It is therefore important to pay attention to the effects of homophobia on MSM health. Research has shown that there is an association between homophobia and poor mental health and an increase in HIV/AIDS and sexually transmitted infections (STI) risk behaviours (Lane et al, 2008a:430; Polders, 2006:29). Yet these MSM who have an increased risk to health problems also face harassment from healthcare workers (HCW) reducing MSM accessing healthcare services, or discussing same-sex sexual behavior (Lane et al, 2008a:431-432). This means that homophobia negatively impacts on MSM accessing non-stigmatising healthcare

services (Lane et al, 2008a:432). Fear of disclosure of their sexual practices not only effects accessing health care services, but also creates vulnerability to increased health risks (Polders, 2006:18).

2.4.MSM and Heterosexism within the Healthcare System

In the past, the approach taken by many western cultures in response to homosexuality was to view it as demonic possession, or a moral failing of the individual, and in the recent past as a psychological illness (Forstein, 2005).

It was only in 1973 that the American Diagnostic and Statistical Manual (DSM-IV) removed homosexuality as a listed mental disorder (other classification systems have since followed the DSMs lead) (Lewin and Meyer, 2002:166). Theunick, Hook and Franchi (2002) emphasise that without truly understanding the link between gay life experiences and their mental health, the possibility of re-pathologisation of homosexuality may occur. This could possibly be attributed to healthcare workers ascribing to the norms prevalent within the South African Society (Reddy, Sandfort and Rispel, 2009:44). The resultant behaviour of healthcare workers results in MSM being treated as second class citizens that creates further barriers to help seeking behaviours (Nel and Judge, 2008:20) and has the potential to cause secondary victimisation to the MSM person (Reddy, Sandfort and Rispel, 2009:47; Nel and Judge, 2008:28).

Within society today, many MSM face a multitude of stressful events. These events are commonly due to society's heterosexist oppression and reaction to them. In South Africa, a public survey in 2003 found that 63% of the population states that homosexuality should not be accepted by society, with only 33% agreeing that it should be accepted (Reddy, Sandfort and Rispel, 2009:26). As a result of these events and attitudes, MSM experience: forms of internalized oppression, fragmented identity and living a double life, poor mental health, psychological problems, social isolation, rejection, powerlessness, discrimination, harassment, violence and abuse. These problems are normally inter-related and not necessarily mutually exclusive, which results in them impacting on the MSM-person in a multitude of ways. Because of these problems, many studies have been carried out on the negative physical and psychological effects experienced by some MSM adolescents and adults due to their experiences of discrimination, harassment, and violence, by virtue of their sexual orientation (Polders, 2006:7; Nel and Judge, 2008:19,22).

To date there is no scientific evidence as to how homosexuality arises, nor that any psychopathology arises due to being inherently homosexual (Forstein, 2005). This is in stark contrast to the past where homosexuality was listed as a mental disorder within the Diagnostic Statistical Manual (DSM), until its removal in 1973. This was because it was found that the listing of homosexuality as a mental disorder was not supported by any scientific evidence. The further diagnosis of "ego-dystonic homosexuality" (this diagnosis had been kept to allow clinicians to treat homosexuals who could not accept their own sexuality) was also removed later in 1987.

Medicine and its related professions have had a long history in playing a part in the oppression of non-heteronormative sexualities (Lewin and Meyer, 2002:163). Oppression is a consequence of prejudice. Healthcare workers have also been implicated in violations against MSM (Lewin and Meyer, 2002:161), and poses concern that unless changes take place with respect to healthcare workers attitudes, further institutionalised homophobia and heterosexism within the healthcare sector may continue to contribute to the ill-health status of MSM (Lewin and Meyer, 2002:165), as continued viewing of heterosexuality as the norm can lead to and even promote: the use of treatments for homosexuality and same-sex behaviours, such as "reparative" or "conversion" therapies, despite these being condemned as a violation of basic human rights (Lewin and Meyer, 2002:166); marginalization and neglect of MSM health issues and further stigmatization (Lewin and Meyer, 2002:168).

In the South African environment, there is still a large prevalence of prejudice against MSM making it critically important that healthcare workers recognise that this prejudice and its resultant social isolation, has a detrimental effect on the physical and mental health of MSM (Lewin and Meyer, 2002:165). This was highlighted by a Constitutional Court judge in South Africa, "scarring comes…from invisibility. It is the tainting of desire, it is the attribution of perversity and shame to spontaneous bodily affection, it is the prohibition of the expression of love, it is the denial of a full moral citizenship in society because you are what you…" (cited in Lewin and Meyer, 2002:165). It is in understanding this that makes it important that healthcare workers should be driven to challenging such pathogenic environments (Lewin and Meyer, 165).

2.5.The Interplay between Homophobia and HIV/AIDS Spread among MSM in SA

Homophobia is acknowledged as a massive problem in South Africa (Thoreson, 2008: 695), and a factor in the spread of HIV among MSM. It is important to consider homophobia as a factor, as most African leaders (even many within South Africa) consider homosexuality as "un-African" which has an implication on discriminatory practices and treatment of homosexuals in society (Reddy, 2001:83-87).

Some of these discriminatory practices have spilled out into the media at times, as hate crimes perpetrated against homosexuals have resulted in deaths (Bosch, 2007:226). Homophobic violence is often a daily occurrence for MSM who are also not only marginalized for their sexuality, but also by poverty, sexism and often racism (Thoreson, 2008:695). This homophobic attitude within South Africa has been promulgated by President Zuma, the year before his election, when he addressed the Parliament stating that civil unions are a "disgrace to the nation and to God" and that "*unqingili* [homosexuals] could not stand in front" of him (Thoreson, 2008:696). This type of commentary is an extension of the view within many African communities, where homosexuality is seen as un-African, and thus necessitates the need for being "cured of evil" (Graham & Kiguwa, 2005:17).

Part of the homophobic problem in South Africa has been the stance of the Christian Churches, which have traditionally played an influential role in South Africa, where even Chaplains were used to maintain the government's ideological notion of MSM as deviant (Van Zyl et al, 1999:59), an ideological foundation based on Christian conservatism (Reddy, Sadfort and Rispel, 2009:16; Poldres, 2006:4). Often the values and notions of propriety within society are based on religious ideology with respect to morality (International Commission for Jurists, 2009:5), as was apparent within South Africa. With respect to MSM, many of the Christian Churches have generally based their treatment of homosexuality on the three following assumptions:

- That sexuality is generally sinful, as it is related to the lower instinct and should thus be controlled or even cut off in order to develop spiritual growth
- That the result of any form of sexual intimacy should be reproduction.
- That sexual attraction can only promote a sense of "wholeness" when directed at persons of the opposite sex (Nelson and Longfellow, 1994)

The African Christian Democratic Party (ACDP) often epitomises the fundamentalist Christian Church's views in the political arena of South Africa. Their biblical moralisms have often included homophobic rhetoric in the past, such as, "Nation-building cannot be possible while we try to legally destroy family values and the moral fibre of our society with clauses in the Constitution that promote a lifestyle that is an embarrassment even to our ancestors (Pastor Kenneth Meshoe, leader of the ACDP, Constitutional Assembly, 1995)" (Oswin, 2007:98). Often religious writings are used as an important source for condemnation of same-sex behaviours (Samelius and Wagberg, 2002005:21), while some church leaders either openly condemn homosexuality or express negative attitudes (Samelius and Wagberg, 2005:39).

Adding fuel to the fire in Africa, is the view that HIV and AIDS is a "white man's disease", with homosexuality being targeted as the decadent element within white culture that has brought HIV/AIDS to the continent. The further mythmaking and obfuscation that developed out of these views resulted in the initial denial that AIDS was a danger to "traditional" societies, who saw prevention campaigns as an "Afrikaner Invention to Discourage Sex" (Fourie, 2006).

2.6. Conclusion

Having looked at growing up and living as a MSM, as members of the LGBTIQ community within South Africa, and the possible resultant traumatic implications, it can be concluded that these events are psychological blows or wounds to the spirit that may irrevocably alter the path of a person's development (Hacking, 1995). These events can be linked to the experience of homophobia by MSM in South Africa, which is often a factor in the spread of HIV among MSM in SA.

This highlights the vulnerability of MSM to a variety of health concerns, including HIV/AIDS, a vulnerability that is compounded by: the very nature of being MSM; of having a sexual identity or sexual practice outside the perceived heterosexual norm; the reality of often living a "double life" and societal discrimination and prejudice (Reddy and Sandfort, 2008:37).

The Psychological Society of South Africa expressed in an open statement in 2009 to the Ugandan people that the effects of discrimination has been found to have negative effects on

psychological well-being and other harms, with correlating high risk behaviours, including substance abuse and attempting suicide.

Separation, rejection, exclusion and isolation appear to be critical features of vulnerability of MSM to HIV/AIDS and other health problems, as highlighted so far in this chapter. These are critical existential states of being that are important elements of care within Pastoral Therapy. Christ's role was to care for minorities and those in need. It appears that here is a minority that is in desperate need to experience inclusion, affirmation and acceptance in order to lower their vulnerability to health problems and the risk of HIV/AIDS.

HIV/AIDS risk of MSM and its impact cannot be fully understood, let alone addressed, without having understood the context of the MSM and the experiential dimension within South Africa. This context includes the daily life within the heterosexist and hetero-normative culture of South Africa, where experiences of stigmatization, discrimination, violence, substance abuse, as well as the socio-economic and cultural circumstances that are linked to these; as highlighted in this chapter (Reddy, 2011:6).

Chapter 3: The Impact of HIV/AIDS on MSM in South Africa

"AIDS today in Africa is claiming more lives than the sum total of all wars, famines and floods and the ravages of such deadly diseases as malaria ... We must act now for the sake of the world."
Nelson Mandela, in a closing address at the 14th International AIDS Conference in Barcelona, Spain, 2002.

3.1.Impact of HIV in SA

1982 saw its first AIDS victims in South Africa (Fourie, 2006), and by 2003 there were already approximately five million adults living with HIV. The country has one of the fastest growing HIV epidemics in the world and accounts for approximately 10% of the global HIV infection burden. Yet this epidemic is characterized by a lower HIV diversity[14] than is seen elsewhere in Africa. It has a large geographical variation with respect to the distribution of HIV infections, with the highest gradient of infection on the east coast and lowest on the west coast. Despite HIV infections being present in all racial groups in the country, it is the Black African population that shows the greatest prevalence[15] of HIV infection. One of the major factors playing a role in the spread of HIV is migration or population movement (Abdool Karim and Abdool Karim, 2008).

Research into HIV/AIDS in South Africa has recently indicated that the epidemic has started to plateau not due to intervention programmes, but due to natural saturation of the epidemic. In other words the prevalence is now stable due to the rate of new infections (the incidence rates[16]) being balanced by the number of deaths (mortality rates). This leveling off (steady state) will remain unless behaviour change or intervention strategies begin to take effect in reducing transmission and thus dropping the prevalence of HIV/AIDS. HIV/AIDS as an epidemic amongst heterosexuals, became the prevalent epidemic in South Africa, having

[14] HIV diversity relates to the diversity of HIV strains, which is the result of the extreme variability of genetics within HIV. Variations occur due to mutations introduced into the viral genomes.

[15] Prevalence can be defined as the proportion of individuals in the population who are infected.

[16] Incidence rate can be defined as the frequency of occurrence of new cases of infection within a time frame.

been linked to a corresponding epidemic in infants that are born to HIV-infected mothers. However, reliable vital statistics are lacking in South Africa (Abdool Karim and Abdool Karim, 2008).

The 2009 Joint United Nations (UN) Programme on AIDS (UNAIDS) statistics for South Africa reflect that:

- South Africa is one of the sub-Saharan countries where the HIV epidemic has either stabilized or is showing signs of decline
- There is an almost 90% coverage of treatment to prevent HIV transmission for mother-to-child in South Africa. However, South Africa is one of the very few countries in the world where maternal and child mortality has increased since 1990

It was during the late1980s and early 1990s that HIV gained a foothold in the heterosexual community, resulting in a major shift in the HIV and AIDS policy environment. Various sectors of South African society started to mobilize and take action. However it was a fractured response that mirrored South Africa's medical profession's focus and messaging with respect to HIV/AIDS. The private sector began drawing up policies to prevent the impact of AIDS by focusing on prevention and interventions in the workplace. Civil society started taking a stand and insuring that its voice was heard in comparison to the moralistic positioning of the government (Fourie, 2006).

The most significant shift in sentiment around HIV/AIDS in South Africa occurred in 2005 when the Medical Research Council of South Africa (MRC) announced the national mortality figures, which showed an increase in death by 60% from 1997 to 2003. They highlighted that the major reason for this increase was related to the under-reporting of deaths related to HIV/AIDS (Fourie, 2006). In 2003, of the estimated 37.8 million prevalent infections, approximately 87% of these were through heterosexual transmission (Abdool Karim and Abdool Karim, 2008).

Within the field of HIV/AIDS it has been made abundantly clear that HIV affects all aspect of our lives – including those people who are not infected. It affects the molecular level of the body, right through to the immune system, as well as to the emotional, psychological, spiritual, social and community levels of humanity. By its very nature, society is enmeshed

and entwined with the disease. Thus the disease has a vastly broad impact on South Africa. From the individual right through to the national level, there is no segment within society that has not been impacted upon in some way. These influences include impacts on: the economy, the practice of ethics, politics, healthcare, social and community structures. A few examples of these impacts are: the devastation and erosion of family structures (HIV/AIDS orphans, child-headed homes); overloading of healthcare services and the depletion of teachers and learners at schools; loss of productivity and products within the private and public sectors and the undermining of economic growth, yet the greatest impact still lies with those infected with HIV (Abdool Karim and Abdool Karim, 2008).

Research has found that HIV symptoms are related to negative effects on mental well-being and the functional health status of HIV/AIDS individuals (Coleman, 2003:457). Also, being diagnosed or living with HIV, a possible stigmatizing and life-threatening disease, may affect their sense of identity and reduce their self-regard. This is often associated with challenges in their ability to re-align to the changes within their interpersonal relationships, their physical appearance and even their cognitive functioning (Schwartzberg, 1993:483). If the person does not have an integrated sense of identity (an integrated sense of identity is defined as self-regard [Ulrich et al, 2004:183], or has a low self-esteem/self-regard, they may develop higher levels of distress as the disease progresses (Horowitz et al., 1996:382-385).

In order to deal with the progression of the illness, it is proposed that people with HIV need to develop some sense of meaning or purpose (Janoff-Bulman, 1992).

Compounding the issues of treating HIV/AIDS in South Africa it has been found to be difficult to treat a disease that has been stigmatized, and that the HIV-infected person lives in fear, silence and isolation (Cameron, 2005). “Stigma is an insidious, complicated phenomenon that feeds upon and reinforces and reproduces already present inequalities of class, race, gender and sexuality” (Abdool Karim and Abdool Karim, 2008:354). Cameron (2005: 53) explains that “stigma – [is] a social brand that marks disgrace, humiliation and rejection – remains the most ineluctable, indefinable, intractable problem in the epidemic. Stigma is perhaps the greatest dread of those living with AIDS and HIV – greater to many even than the fear of a disfiguring, agonizing and protracted death.” The extent of this stigma has reared its head in ways that have at times shocked this country; one such occasion was

when Gugu Dlamini, an AIDS activist, was stoned to death in Durban due to her openness about her HIV status (Cullinan and Thom, 2009).

The impact of this is that HIV-positive people are placed in a double bind when it comes to disclosure. When they do, they are faced with possible rejection and isolation, with its consequent loss of self-esteem. Yet if they don't disclose, they are likely to hinder the management and treatment of their condition, leaving them more vulnerable to other problems such as depression, fear and failing coping strategies (Abdool Karim and Abdool Karim, 2008).

Deaths due to stigma associated to HIV/AIDS are not the only victims of this epidemic. With the whole political debacle over the link between HIV and AIDS within post-Apartheid South Africa, research shows that 343,000 deaths, related to HIV/AIDS, occurred as a result of the delay in the rolling out of ARV therapy throughout South Africa, which finally occurred in 2004 (Nattrass, 2008). Needless deaths linked to a political debate that ravaged South Africa's communities that stemmed from President Mbeki and his Health Minister Manto Tshabalala-Msimang, who added fuel to the stigma by distributing a chapter of a book by William Cooper. This chapter by the AIDS dissident, talked about conspiracy theories linking AIDS to a plot to reduce Africa's population (Cullinan and Thom, 2009).

However, this has not been the only government to fail its people with respect to AIDS in South Africa. The National Party (NP) during the apartheid years had developed policies that failed to address HIV/AIDS appropriately, due to homophobic and racist assumptions with respect to the disease's vectors. However it was during 1986 that the MRC attempted to warn South Africans that AIDS might spread from MSM to the general population (Fourie, 2006).

Today the main driver of the HIV epidemic in South Africa is sexual behavior that exposes individuals to the risk of infection, thus necessitating a "solution" on prevention care that encloses a reframing of existing paradigms on sexuality. Sexual behavior is shaped by a number of factors: personal, interpersonal, environmental, cultural and structural. "The personal factors influencing sexual risk behaviour include feelings and cognitions related to sexuality, HIV/AIDS, and the self. Factors relating to interpersonal relationships, such as negotiating condom use, coercive male-dominated sexual partnerships and peer pressure to be sexually active, are also important. Cultural factors, such as traditions, shared beliefs, and the

norms of the larger society, also play a role. Unfortunately these often support an unequal distribution of sexual power between men and women and subordinate women's needs and rights" (Abdool Karim and Abdool Karim, 2008:143). Another driver is economic hardship, as it can change people's behaviours, making them more vulnerable to infection (Abdool Karim and Abdool Karim, 2008).

3.2.History of HIV among MSM in SA

In the 1980s, reports showed that an AIDS-like illness in Central Africa was not related to male-to-male sex or injection use as in the USA and Europe, instead HIV transmission was linked to the number and frequency of different heterosexual partnerships. Thus HIV transmission among MSM unfortunately became an obsolete discussion point within HIV/AIDS research (Lane et al, 2008:78).

It was during these years, that the media apportioned the blame to MSM, black people, commercial sex workers and intravenous drug users, for introducing HIV/AIDS to society (Fourie, 2006). It was however MSM who took the major brunt of society's scorn, with even politicians espousing that AIDS was God's punishment for MSM deviancy and unnatural acts. Thus AIDS became a solution to the Apartheid government's problem with MSM. Therefore legislation against MSM was seen to be supported by God's divine punishment (Fourie, 2006).

Apartheid gave a disproportionate exposure to the white MSM and women who have sex with women (WSW) communities, which is still indicative of post-apartheid era, where most of the groups are predominantly white, with other ethnic groups experiencing major shortage in facilities and services (Krouse and Berman, 1993:xx).

Despite Post-Apartheid South Africa having constitutional legal guarantees and a progressive approach to equality, many MSM still hold a marginal space in South African society, often facing discrimination and marginalization (Bosch, 2007:226). So when male-on-male sex re-entered the arena of HIV/AIDS research and debate, studies found that there was substantial risk of HIV infection among African MSM (Baral et al, 2009:1). The research has also shown that homosexuals are a key to the rising rate of HIV infection in many African and Middle East countries (CMAJ, 2007:177). In South Africa, part of the reason for this risk is the negative attitude towards condoms among men, who link masculinity to male pleasure. Their

arguments against condoms being based on the reduction of pleasure and that condoms are "unmacho" (Kauffman et al., 2008). Yet even up to today there is still a severe lack of research into HIV testing practices and prevalence in South African MSM. Compounding this is the lack of understanding of the various factors influencing same-sex sexual practices in South Africa (Sandfort et al, 2008:425).

An important step was made in South Africa where MSM were included in the government's strategic plan for HIV/AIDS in 2007 (Sandfort et al, 2008:425), to start addressing this lack of understanding and risk in this group. This is a vital step, as research is starting to discover that the risk of HIV infection among MSM is far higher than the general population (Rispel and Metcalf, 2009:133).

Often the debates in South Africa about same-sex practice is un-African, however Professor William Makgoba, a South African university vice-chancellor and former head of the Medical Research Council, states that "African culture countenanced man-man sexual relations long before Europeans colonized the continent" (cited in Cameron, 2005: 83). Research has also shown that same-sex sexuality is both indigenous and traditional in around 50 African societies (Cock, 2003:41). Murray (1998:35-36) found that records show that [*hlabonga*] has always existed within South Africa. The term [*hlabonga*] is used to refer to the situation where some young men were taken by other men for sexual purposes.
These views of same-sex practices being un-African, espoused in South Africa, and other parts of Africa, have often resulted in MSM being faced with resistance, resentment, emotional abuse and at times violence. Compounding this is the view that males need to portray the accepted male gender role of being "bread winners" who have children and partner women. This added viewpoint is an element of the norms in South Africa, as fashioned by ethnic, religious, cultural, historical and global influences, that continue to enforce the gender roles that MSM are confronted with (UNAIDS, 2009:2-4).

With South Africa's long history of prejudice towards minorities over the years, the disadvantaged groups, such as MSM, have slowly gained recognition for their human rights and, in so doing, have had their legal status protected and all forms of legal discrimination against them removed (Isaacs and McKendrick, 1992), despite the challenges of being seen as un-African.

3.3.Impact of HIV among MSM in SA

In South Africa the number of MSM people living with HIV is unknown, with even less being known about the discrimination and stigmatization that MSM living with HIV face (Cloete et al, 2008:1105). However what is known is that despite the increased access of MSM to HIV prevention programmes and services over the past few years, it is still inadequate as MSM are still among the most at risk populations (MARP) (UNAIDS, 2009).

The primary prevention strategy among MSM is still safer sex behaviour, especially not having penetrative sex that is unprotected (UNAIDS, 2009). This is a target prevention strategy as behavioural research shows that African MSM commonly practice unprotective anal sex (Smith et al, 2009:418). However preventative strategies for MSM cannot be considered, rolled out or assessed accurately as the data is lacking with respect to the HIV epidemic among MSM (AmFar, 2008).

The UNAIDS report (2009) refers to evidence that in sub-Saharan Africa, and in many other places in the world, the majority of MSM also have sex with women. It is believed that in sub-Saharan Africa, marriage is used to protect MSM from any prosecution and stigma.

This is a concern, as research has found that among MSM there are significantly higher levels of HIV infection than in men in general. In South Africa, available research information shows that the HIV prevalence among MSM who are 15 – 49 years old is 42.9% in Cape Town, 20.0% Durban and 25.0 in Pretoria, with an overall average for South African MSM being 35.1% (Parry et al., 2008:47). Other research carried out by Sandfort et al. (2008:427-429) found the HIV prevalence among MSM to be highest in KwaZulu-Natal at 31%, while in the Western Cape it was 15.1%. This research highlighted, however, that among the MSM in the Western Cape, the HIV prevalence was far higher than the 3.2% among the 15 – 49 year old group in the general population. In another study carried out by Lane et al (2009:4) the overall HIV prevalence was estimated to be around 13.2% which is comparable to the prevalence among men in the general population, however it was found to be 33.9% for self-identified gay men.

On average the studies show that between 1 and 4 out of every 10 MSM may possibly have HIV (Schreibe et al, 2010:7) and that MSM have a four times greater chance of having HIV than men in the general population (Lane et al., 2009:1). However, it is not known to what

extent this data can give a true indication of prevalence in the general MSM population in South Africa (Smith et al, 2009:418). Other issues around the data and research into MSM are the methodological challenges, the predominant being that of recruiting representative samples of MSM (Reddy and Sandfort, 2009:414). When coupling these statistics with the fact that MSM face increased vulnerability to HIV due to the levels of violence and stigmatisation perpetrated against them, the concern shifts from not only prevention of HIV transmission but on reduction of concomitant factors that increase MSM vulnerability to HIV (UNAIDS, 2009).

Important research done by Schreibe et al (2010:6-7), proposes that MSM vulnerability to HIV/AIDS and the disproportionate HIV/AIDS burden among MSM is often linked to a variety of factors:

- Legislation that is discriminatory
- Health policies that do not target MSM
- Lack of government support
- Cultural norms that are heterosexist
- Limited and restricted access to sexual health services
- Sexual risk behaviours that are high risk (including unprotected receptive anal sex)

These factors exist despite the South African Constitution protecting the rights of sexual minorities. In South Africa discrimination and prejudice towards MSM is still prevalent. It is often experienced by this population at an individual and structural level through behaviours, attitudes and policies. Other factors linked to the high burden of HIV among MSM are the increased incidence of substance abuse which is linked to risky sexual risk behaviours. This is because for many MSM, drug use is linked to the search for sex with other men. Research on sexual risk behaviour of MSM who are HIV-positive compared to HIV-negative has been found to be contradictory. Some research shows that HIV positive men show greater risk taking sex behaviours, while others show fewer risk taking sex behaviours, demonstrating further need for targeting research, interventions and healthcare services to this population (Parry et al, 2008:46).

Within South Africa, research into HIV/AIDS in the 1980s already showed that the two strains of HIV-1 were split between the predominant clade/subtype B strain within MSM and

the predominant clad/subtype C strain within the heterosexual population, highlighting that in the 1980s there were two independent epidemics that were unfolding – a chiefly white MSM epidemic and a black heterosexual epidemic (Fourie, 2006). However during the early phase of the HIV epidemic in South Africa, HIV was predominantly seen in a few hundred cases of MSM. It was the South African Medical Journal that described the first two cases of AIDS within the MSM population. It was among the MSM population, in the mid-1980s, that South Africa saw its first major peak in the AIDS epidemic, with a plateau being reached in 1989, while the epidemic in the heterosexual population began rising from 1989 and between 1990 and 1994 it was rapidly exceeding the MSM epidemic (Abdool Karim and Abdool Karim, 2008).

Present viral research now shows that the HIV transmission among white South African MSM have predominantly the subtype B strain which is linked with MSM in America and Europe; while on the other hand, African MSM have predominantly the subtype C strain, which resembles the same strain that is found within the heterosexual population (Smith et al, 2009:418).

An important link between the HIV epidemic among MSM and the heterosexual population is the practice of anal intercourse, commonly misperceived as an exclusive MSM sexual practice. Recently it has been indicated that anal intercourse among the heterosexual population is far more common than previously thought, with 10 to 30% of women and their male partners engaging regularly in this sexual practice. However research into anal sex and its role in HIV transmission in Africa is more or less non-existent, despite anal intercourse being associated with a far greater risk of HIV infection (Karim Abdool and Karim Abdool, 2008).

HIV/AIDS affects the self-perception of MSM, re-orientating their identity (Sollis, 2003:150). Compounding this, HIV positive MSM are exposed to a greater level of discrimination related to their HIV status than non-MSM. This discrimination can result in internalized AIDS stigma, which severely affects their emotional reactions and distress, resulting in further internalized feelings of shame and guilt, which have a negative effect on their health (Cloete et al, 2008:1106).

Discrimination can also be experienced from religious institutions which results in many MSM having to re-form their identities (Miller, 2005:35-36; Seegers, 2007). That is why few MSM turn to religion and spirituality to assist in coping with their illness. However, research has found that religion and spirituality are often of assistance to MSM to find meaning in their illness. Such practices as prayer have even been found to lower depression levels in HIV positive people (Schwartzberg, 1993:488-489).

The delayed research into MSM and HIV within South Africa, is not only linked to the country's past skepticism with respect to HIV/AIDS, but also to the fact that the proponents of this debate felt an unexpressed reluctance in promoting treatment options to those suffering with HIV/AIDS. Underlying this type of thinking is the unspoken assumption, made by many people, that these people do not "deserve" treatment as their plight is their own fault (Cameron, 2005).

Other possible reasons for delay in HIV prevention campaigns towards MSM are pointed out Reddy and Sandfort (2009:415), which include:

- Denial of the existence of same-sex relations
- Existence of stigmatization and the criminalization of MSM
- Shortage of data dealing with HIV transmission in MSM sexual practices
- Accessing MSM, especially self-identifying MSM
- Health professionals lacking MSM awareness or sensitivity
- Lack of support by donor organisations with respect to MSM programmes
- MSM needs not being addressed in national AIDS strategies

It becomes imperative that countries address these barriers to insure that the impact of HIV/AIDS on MSM is therefore addressed, so that the greater non-MSM community is also protected from the ravages of HIV/AIDS. This is because not all MSM identify as MSM and are also involved in sexual practices with women. Fourie (2006) therefore proposes that males in the South African culture, especially African males, need to take greater responsibility for their sexuality, sexual practices and social interaction. It is imperative that they no longer be able to hide behind customary practices and beliefs.

3.4.Conclusion

This chapter has highlighted the disproportionate vulnerability of MSM to HIV/AIDS than among heterosexual people, due to a variety of factors, including: legislation that is discriminatory; health policies that do not target MSM; lack of government support; cultural norms that are heterosexist; limited and restricted access to sexual health services and sexual risk behaviours that are high risk (including unprotected receptive anal sex).

However research is limited and the number of MSM in South Africa living with HIV/AIDS is unknown, with even less being known about the discrimination and stigmatization that MSM living with HIV face (Cloete et al, 2008:1105). However what is known is that despite the increased access of MSM to HIV prevention programmes and services over the past few years, it is still inadequate as MSM are still among the most at risk populations (MARP) (UNAIDS, 2009).

With primary prevention strategy aimed towards MSM being focused on safer sex behaviour, especially not having penetrative sex that is unprotected (UNAIDS, 2009) failing, as behavioural research shows that African MSM commonly practice unprotective anal sex (Smith et al, 2009:418). Preventative strategies for MSM cannot be considered, rolled out or assessed accurately as the data is lacking with respect to the HIV epidemic among MSM (AmFar, 2008), necessitating further research to develop improved strategies of addressing the vulnerability of MSM to HIV/AIDS and other health problems.

Often these vulnerabilities of MSM to HIV/AIDS are compounded by discrimination which can also be experienced from various religious institutions, causing many MSM to re-form their identities (Miller, 2005:35-36; Seegers, 2007). The impact of which causes many MSM not to turn to religion and spirituality to assist in coping with their illness, when confronted with HIV/AIDS. However, research has found that religion and spirituality are resources that can be of assistance to MSM to find meaning in their illness (Schwartzberg, 1993:488-489).

If MSM are not assisted in developing an integrated sense of identity (an integrated sense of identity is defined as self-regard [Ulrich et al, 2004:183], or with the possible resultant low self-esteem/self-regard, they may develop higher levels of distress as the disease progresses (Horowitz et al., 1996:382-385). Making it imperative to explore further the impact of

HIV/AIDS and being MSM on identity formation, and the implications for Pastoral Therapy with respect to prevention and treatment interventions.

Chapter 4: MSM – Fortigenesis and the Quest for Identity, Dignity and Meaning

"You can't get AIDS by hugging, kissing, holding hands. We are normal. We are human beings. We can walk, we can talk ... We have needs just like everyone else. We are all the same."
Nkosi Johnson, in a speech at the 13th International AIDS Conference, July 9, 2000.

"Life … is, despite the possible threats, about the fundamental and primary need for an intimate space for meaningful and hopeful existence" (Louw, 2012:12). So, with MSM being more vulnerable to HIV/AIDS, due to the simple fact of being MSM within South Africa, and the variety of heterosexist views people hold, and the various traumas they experience in their lifetimes, it becomes important to explore MSM identity formation within MSM, in the South African context, and how they are able to develop meaning and discover an inherent sense of dignity (as a relational issue [Louw, 62012:61]) and purpose.

In order to do this, it needs to be understood that at the core of all people are their basic beliefs or schemas that they hold, with respect to themselves and the world around them. These beliefs are confirmed by life experiences and dictate the experience and appraisal of stressors or events in life. The tendency is to maintain already held beliefs in the face of stressors or appraise them through these schemas. Any stressor that challenges these schemas is experienced as threatening to the identity (Janoff-Bulman, 1992:26-40), one of these being HIV/AIDS. A person, who experiences these threats to their inner world, becomes filled with a sense of "malevolence, meaninglessness and self-abasement" (Janoff-Bulman, 1992:63). Thus reappraisal is necessary in order to create meaning and develop greater self-worth (Janoff-Bulman, 199:118)

Often the vulnerability of MSM to HIV/AIDS is compounded by discrimination which can also be experienced from various religious institutions, causing many MSM to re-form their identities (Miller, 2005:35-36; Seegers, 2007). This is because these messages result in god-images that are inappropriate, resulting in negative and distorted identities within MSM (Louw, 2012:74). The impact of which causes many MSM not to turn to religion and spirituality to assist in coping with their illness, when confronted with HIV/AIDS. However,

research has found that religion and spirituality are resources that can be of assistance to MSM to find meaning in their illness (Schwartzberg, 1993:488-489).

If MSM are not assisted in developing an integrated sense of identity (an integrated sense of identity is defined as self-regard [Ulrich et al, 2004:183]), or with the possible resultant low self-esteem/self-regard, they may develop higher levels of distress as the disease progresses (Horowitz et al., 1996:382-385). Thus self-regard as an indicator of an integrated sense of identity is important when looking at such things as traumatic events (and consistent stressful events) and their impact on people (Ullrich et al, 2004:184).

When reviewing MSM schema's, it is important to note that part of these self-schema's involve the person's religious/spiritual identity, something that is often experienced as dichotomous to their sexual identity, due to the general homonegativity of religious institutions. This often results in MSM developing internalised homophobia (which is the internalization of societal negativity toward homosexuals) during the initial stages of their identity development, something that may follow them throughout the life course of their lives (Meyer, 1995); as well as negative views of religious institutions, when these men decide to turn to identification with their sexual identity as a predominant component of their overall identity. It is this internal struggle between sexuality and religion that often has negative mental health consequences to MSM.

Some MSM, however, have found that when they have turned to spirituality, it has aided in developing better psychological health (Heermann,Wiggins and Rutter, 2007:711-719), making spirituality a possible resource that is accessible when other coping mechanisms are exhausted (Dalmida, 2006:185-186).

4.1. MSM Identity Formation and the Impact of the South African Context

It is important for people to have a fully integrated sense of identity (an integrated sense of identity is defined as self-regard [Ulrich et al, 2004:183], otherwise they may express a low self-esteem/self-regard, leaving them predisposed to possibly developing higher levels of distress (Horowitz et al., 1996:382-385). For MSM to achieve a fully integrated identity, they must overcome a variety of social obstacles (Johns and Probst, 2004:82).

Fully integrated identities, lie on a continuum that is fluid process (Johns and Probst, 2004:88), are composed of well-constructed self-schemas, which are regulators of emotion by controlling perceived information and their relation with respect to concordance/dissonance to identity. Thus self-regard as an indicator of an integrated sense of identity is important when looking at such things as traumatic events and their impact on people. The diagnosis of life-threatening conditions could be considered as just such a traumatic event because traumatic events often result in a challenge to a person's basic understanding of themselves (Ullrich et al, 2004:184), often found in MSM.

Compounding identity formation difficulties for MSM is the lack of societal support which results in identification of MSM to MSM sub-cultures that emphasize "differentness" and "separateness," that create further crisis within the development of a person's identity (Isaacs and McKendrick, 1992). Adding to this, the subscription of various MSM to social labels as "gay" or "bi" is varied due to the socially imbedded meanings of these labels of identity in South Africa (Reddy, Sandfort and Rispel, 2009:4), this results in the variety of same-sex expressions and self-descriptions with respect to identity within South Africa (Reddy, Sandfort and Rispel, 2009:83).

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Discrimination can also be experienced from religious institutions which results in many MSM having to re-form their identities (Miller, 2005:35-36; Seegers, 2007). That is why few MSM turn to religion and spirituality to assist in coping with their illness. However, research has found that religion and spirituality are often of assistance to MSM to find meaning in their illness (Kubicek et al, 2009:15-16). Such practices as prayer have even been found to lower depression levels in HIV positive people (Schwartzberg, 1993:488-489).

MSM identity is, however, not pathological. It is one of a number of sexual identity alternatives that a person may be inclined towards, yet maintaining this identification to one's sexuality may have its consequences in a predominantly heterosexist society. This means that during development and life transitions, MSM experience these times in their life as inordinately stressful, unlike the heterosexual person where these life transitions and development fall within the usual coping capacities (Isaacs and McKendrick, 1992).

4.2. Identity Formation in MSM and Contextual influences

Research into the important stages in the development of a healthy identity within MSM, indicate that identity comparison (which is an attempt to resolve the feelings of being isolated and alienated that are caused by the disparity that exists between the self and non-MSM others) and identity pride (the development of positive beliefs and feelings towards a same-sex orientated identity and the development of positive relatedness to other MSM) are crucial to the development of a state of growth or dysfunction (Harawa et al, 2008:750; Johns and Probst, 2004:81-82). Various factors associated with identity comparison and/or identity pride are either negatively or positively correlated with the decision-making process that determines whether or not MSM engage in any sexual risk behaviours. Such factors include: environmental, socio-demographic and developmental, which can either positively or negatively impact self-perception (Crocker and Major, 1989:609-610); along with self-esteem levels (Crocker and Major, 1989:609-610) that exist among MSM; all of which provide for the potential to cause stress and psychological distress (Dohrenwend, 2000:2&12), increasing the possibility of MSM being involved in risk behaviour (Ross et al., 2000:249-250). These therefore impact on how MSM perceive their standing within the broader South African context, which may impinge upon the natural and healthy process of identity formation.

Within identity formation, every person establishes their own unique sexual identity which is a fundamental part of self-identity (Boles and Elifson, 1994:39) as it touches on "some of the most intimate and personal aspects of human existence" (Reddy, Sandfort and Rispel, 2009:32), which is comprised of three inter-related factors: biological sex, sexual orientation and gender. These are interpreted through the person's personal and cultural frame of reference (Reddy, Sandfort and Rispel, 2009:4).

Factor 1: Biological Sex

Male ⟷ (Intersex) ⟷ Female

All people are born somewhere along the above continuum of biological sex, indicating that biological sex is not as purely assumed as expressed by two polar opposites: male and female.

Factor 2: Sexual Orientation

Heterosexual ⟷ (Bisexual) ⟷ Homosexual

The predominant approach to sexual orientation is that there are only two: heterosexual and homosexual. However even Kinsey has warned against this, and research has expressed the need to look at sexual orientation as more of a continuum from heterosexual to homosexual.

Factors 3: Gender Identity

Feminine ⟷ (Transgender) ⟷ Masculine

Within MSM these three factors are combined in almost limitless combinations, allowing for the diversity of sexual identities that are found within MSM (Anova Health Institute, 2010:3).

In South Africa today, urban white MSM are predominantly concerned with respectability and social approval, valuing masculine gender identities (Swarr, 2004:82) which are centred on body consciousness. Making it important to focus on disturbed beliefs with respect to body image and dissatisfaction thereof (Garner, Garner and Van Egeren, 1991:263-264), these beliefs can have a huge impact on resultant behaviours. These behaviours are used to attempt to positively or negatively control external and internal stressors, such as poor self-image beliefs (Jerome et al, 2009:432&443), environmental factors, such as homophobia and heterosexism, and stigma, which ultimately impact on the MSM mental health and behaviours (Kalichman, Tannebaum and Nachimson, 1998; Kashubeck-West and Szymanski, 2008:595). Other maladaptive behaviours are further compounded by the important role that sexuality plays in the construction of MSM identity (Jerome et al, 2009:443).

Various researches confirms that MSM experience higher rates of mental health issues compared to their heterosexual peers, indicating that social status may negatively impact on access to social assistance and the development of personal self-esteem or self-identity (Meyer, 2003:674-675).

To understand the holistic impact of internal and external stressors on identity and psychosocial well-being (Szymanski, Kashubeck-West and Meyer, 2008:514), it is important to also look beyond the individual factors and look at the contextual factors (eg. situational, sexual and social) (Kelaher et al., 1994:101-102) that act as stressors, as the context plays an important role on the meaning and consequences of events (Thoits, 1995:80). Subculture development around MSM and same-sex sexualities and practices also come into play, which impact on identity and behaviour, an example of which is the correlation of high substance use and high risk behaviours (Halkitis et al., 2005:23-24). These could be impacted upon through negative self-perceptions (Kashubeck-West and Szymanski, 2008:596) developed as a result of a lack of identification as a member of a group, and a lack of connectivity and cohesiveness (Harawa et al., 2008:751).

4.3. Social Stress and Stigma

The social stress experienced by MSM, as a socially marginalised group, is linked to negative impacts on mental health (Meyer, 2003:674-675; Szymansk, Kashubeck-West and Meyer, 2008:514&517). This is because of the power relationships that arise out of imposed heteronormative societal standards, that result in stigma which add to the sense and perception of MSM that they are powerless and lack the ability to influence others and gain a sense of control of their own lives (Link and Phelan, 2006:528). The result being that many MSM hide their identities to prevent being stigmatized or facing prejudice. However, even just perceived stigma can have negative impacts on the person's sense of self, ending in increased high risk behaviours (Herek, 2007; Szymanski, Kashubeck-West and Meyer, 2008:510-513).

Minority stress theory, a theory that addresses stigma and the experience of social stress, proposes that the myriad of different health issues faced by MSM can largely be explained by the stressors that they experience as a result of living in a hostile, homophobic culture, which is linked to a lifetime of discrimination, harassment, victimization and maltreatment (Meyer, 2003:675). A person who is stigmatized and experiences this reality, questions their full humanity and dignity, they perceive themselves as being flawed and valueless in the eyes of others (Crocker, 1999:89). Part of this is due to the experience of MSM as being invisible within a heterosexist society (Szymanski, Kashubeck-West and Meyer, 2008:513), with a limited exposure to counter-messaging that is affirmative of MSM identities (Szymanksi, Kashubeck-West and Meyer; 2008:514).

This theory proposed that a variety of factors are associated with the stressors[17], with stressors being classified as either individual or social, and coping mechanisms and their positive or negative effects on mental health outcomes. The one predominant factor being internalised homophobia, which develops during the process of sexual identity formation, in which MSM develop negative attitudes about themselves whilst developing psychological conditions as a consequence of living in a heterosexist society (Meyer, 1995:39). Internalised homophobia within MSM is also thought to be linked to:

- Lower levels of connectivity to same-sex communities
- Lower self-esteem
- Feelings of shame
- Greater difficulty in developing intimate relationships
- Greater need for escapism

All of which leaves MSM prone to risky behavior and not protecting oneself, along with a tendency for self-destructive behavior (Kashubeck-West and Szymanski, 2008:596).

The socialization process ensures that the negative psychological adjustments of MSM identity formation are carried throughout their life (Nungesser, 1983 as cited in Meyer, 1995:41). The experience of social stigma thus not only results in issues such as low self-esteem, but also has other negative psychological impacts, such as a reduced and spoiled social identity (Crocker, 1999:89-90). This highlights that social interaction is crucial within the formation of identity.

Further lifetime adjustments are impacted on by MSM's individual and social coping resources that are put into play, some of which can have resultant psychological and physical impacts on the MSM individual (Link and Phelan, 2006:528).

[17] A stressor is any stressful event (Meyer, 2003:675)

4.4. Psychological Coping and Identity Formation in MSM

Peoples' coping[18] styles moderate the impact of stressors, either acting as protective buffers or as amplifiers of the stressor negative results. These coping mechanisms, though often related to personality styles, may be modified to improve their protective effects (Burgess et al, 2000:424). Social support is another factor that impacts on MSM ability to cope (Tate et al, 2006:237; Burgess et al, 2000:424), with low levels of social support being linked to self-destructive behaviours (Tate et al, 2006: 244) and poor mental health outcomes (Ueno and Adams, 2001:304).

Coping resources that are used include such things as: aggression, gay subculture acculturation (Ross et al, 2004:250); escapism or cognitive disengagement (Jerome et al, 2009:432) as seen in high levels substance use among MSM (Hampton; Halkitis and Matthis, 2010:417); fighting spirit (Penedo et al, 2003:203); avoidance and emotion-focusing (Ueno and Adams, 2001:396). These coping resources are engaged by either active or avoidant styles of coping by MSM. It is active coping that acts as a possible protective factor, along with spirituality and religiosity (Hampton, Halkitis and Matthis, 2010:418).

It therefore becomes important to understand how MSM cope with distress, especially with respect to HIV/AIDS, as research has indicated that any maladaptive coping styles are related to increased risky sexual behaviour and psychological distress, as well as reduced physical health (Tate et al, 2006:235-237; Kraaij et al, 2008:395-396).

Research into resources to cope with psychological distress found that spirituality is a possible resource in the case where coping mechanisms are exhausted (Dalmida, 2006:185-186). This is thought to be related to the ideas that people often turn to such things as religion/spirituality to provide hope through the divine or to the fact that it provides the ability to reframe negative events (Siegel and Schrimshaw, 2002:91) and develop new meaning (CIRA). This is because traumatic events and life stressors have the potential to cause a "crisis in faith" which results in the re-development of a new structure of faith, which is often described by people as being more spiritual than religious (Courtenay, Merriam and

[18] Coping is defined as cognitive or behavioural strategies that people use in order to manage demands that are believed to exceed existing resources (Tate et al, 2006:236).

Reeves, 1999:204), this is in line with the research that indicates that faith changes over a person's lifetime (Courtenay, Merriam and Reeves, 1999:203).

Reframing life experiences is an integral process of identity formation and the formation of beliefs about the world and others. An important part of this is the accessible coping resources and the approach that the MSM individual makes in synthesizing life experiences. These are done through the process of fortigenesis, so in order to understand psychological strengths and coping of MSM, it becomes necessary to understand the theory of how people are able to withstand social stress and life events, developing a state of well-being, where there is a perceived good quality of life.

Fortigenesis is a psychological concept that is developed out of salutogenesis, requiring one to understand salutogenesis. Strümpfer (cited in Barend, 2004) commented that salutogenesis and the pathologic view can be seen as a "health disease/ease continuum," which means that an individual's functioning will lie somewhere between the two poles of terminal illness and total wellness. However in order to conceptualise well-being, many constructs have been proposed. From these various constructs, he identified five as the core of salutogenic functioning, these were:

- *Sense of coherence (SOC)* - Antonovsky (cited in Barend, 2004) explains that SOC is crucial in developing an understanding of how people manage stress and stay well. SOC is a feeling of confidence about the predictability of an individual's internal and external environments, with a high probability that things will work out as well as can be expected. SOC is characterized by three major components, which contribute to the well-being of an individual. These are, *comprehensibility* (this is the extent to which an individual perceives an external stimulus as making cognitive sense), *manageability* (the extent to which an individual perceives their resource capacity in order to meet the stimulus) and *meaningfulness* (the extent to which an individual feels that the demands or challenges, to be worth the energy spent)
- *Stamina* – is assessed in "terms of capacity for growth, personal insight, life perspective, likelihood of functional breakdown and general competence" (Colerick, 1986, cited in Strümpfer, 1990, p. 272, cited in Barend, 2004:31)

- *Hardiness* – is considered by Roth, Wiede, Fillingim and Shay (cited in Barend, 2004) as a personality style, which is made up of three interrelated factors that are experienced in the face of inordinate demands: *commitment* (the tendency to involve oneself in whatever one is doing or encountering), *control* (a tendency to act or feel as if one can influence the stimuli that shape one's life) and *challenge* (the belief that change, not stability, is normal and is an incentive to grow)
- *Potency* - Ben-Sira (cited in Barend, 2004) defines potency as "a person's enduring confidence in his own capacities, as well as confidence in and commitment to his/her social environment, which is perceived as being characterized by a basically meaningful and predictable order and by a reliable and just distribution of rewards." It is a buffering variable, which aids in restoring homeostasis after an inordinate demand.
- *Learned resourcefulness* – is a set of well-learned behaviours and skills which is used by an individual to control or regulate their behaviour.

These core functionings were found to, in the case of a strong SOC, to maintain or improve a person's health compared to those people with a weak SOC (Lewis, Sperry and Carlson cited Barend, 2004). While hardy people tend to display a greater general sense of purpose meaning and commitment (Funck and Houston cited in Barend, 2004). It is this sense of meaning that is expanded upon within the realm of fortigenesis. It is the realm of meaning and meaning-making that this research is trying to explore, with respect to MSM in the face of HIV/AIDS.

4.5. Fortigenesis

Building upon salutogenesis, the term fortigenesis, which Strümpfer (2006:13-17) sees as a more embracing and holistic construct than salutogenesis, describes the situations in which individuals' base-line functioning surpasses their pre-challenged levels of functioning by converting the inordinate experiences they are faced with into personal growth, wisdom and more meaningful lives.

In order for this to occur, the challenge (referred to as an inordinate demand as it describes the stressor more neutrally) is subjected to appraisals by the individual (Strümpfer, 2007), which determine the person's fortigenic response and thus their placement on the continuum

of health between languishing and flourishing. Strümpfer (2006:13) had previously gone on to explain that it is the individual's "innate tendencies towards strength, and learned strengths growing out of overcoming the inordinate demands presented by developmental challenges, threats, adversity, and suffering" that highlight fortigenesis and flourishing.

He comments further that complete mental health can be viewed as an absence of mental illness and the presence of flourishing (Strümpfer, 2006:13). Thus fortigenesis' main focus is on the personality make-up of the person that allows them to overcome inordinate demands and develop a state of flourishing. Strümpfer believed that Fortigenesis provides a better understanding of an individual's psychological strengths which will point to new avenues to build capacity, improve prevention of reduced quality of life and rather enhance their quality of life. To enhance quality of life within an individual, it becomes important to understand fully how they respond to inordinate demands.

Inordinate Demands

Inordinate demands are events – which can range from positive or negative in nature that results in change. These inordinate demands are an ever-present part of reality, and which do not necessarily have to be a single event but could be a series of events that are usually not under the individual's control (McMillan as cited by Strümpfer, 2007). These events cause change through taxing an individual's psychological strengths (Strümpfer, 2007). Lazarus and Folkman (cited in Strümpfer, 2007) comment that it is therefore important to note that "how a person construes an event shapes the emotional and behavioral 'response'" (Strümpfer, 2007).

Fortigenesis involves the process in which an individual experiences an 'objective' event, which is then 'subjectively' experienced. Central to this process is appraisal (Strümpfer, 2007). Barends (2004) also states that this subjective understanding of the inordinate demand, combined with the success of previously used coping successes, determines whether the emotional state of the individual will be maintained or disturbed.

4.5.1. Appraisal of Inordinate Demands

Strümpfer (2007) quotes Grinker and Spiegel as describing the construct of appraisal of an inordinate demand as that it "requires mental activity involving judgment, discrimination, and

choice of activity, based largely on past experience." Appraisal is thus the method by which inordinate demands are assessed internally, as to the type of response that an individual will take to them. Barend (2004) cites Pretorius's research in stating that a person with fortitude displays positive appraisals.

There are two kinds of appraisal that take place Lazarus and Folkman (cited in Strümpfer, 2007) identified the two kinds as being primary and secondary appraisal. They are equally important with neither taking precedence. They are interdependent parts of a common process. They are not differentiated based on time, but on their content.

4.5.2. The Two Kinds of Appraisal

4.5.2.1. Primary Appraisal

The main concern of primary appraisal lies with the question: "What is at stake for me?" when an inordinate demand occurs. It is thus the answers to this question that determine the responses, either neutral, negative or positive (Lazarus and Folkman cited in Strümpfer, 2007).

Strümpfer (2007) lists possibilities to the question of primary appraisal and their impact:

- *Irrelevance* identifies that an inordinate demand has no implication on the individuals present or future wellness as it impacts on no need, value or commitment. This results in the inordinate demand being ignored.
- *Gainfulness* considers the event as favourable to an individual's well-being, or has the potential to be. Its meaning thus has to be weighed, despite the event not eliciting a coping demand.
- *Challenge* focuses on the potential for gain or growth. It tends to invite the individual to be involved, through the presence of pleasant feelings, such as excitement. It makes demands and requires effort to overcome the situation.
- *Threat* elicits the feelings of potential harm or loss, raising unease, fear and even dread. The extent of the threat is dependent on how the individual perceives themselves to be able to cope and overcome the situation. Threat and challenge are linked, as a challenge may elicit elements of threat yet bring about an opportunity.

- *Harm or loss* is the last possibility in which the inordinate demand results in traumatic stress that has negative implications for the future. Moving forward and adjusting requires one to overcome the harm and loss through resiling. These events even have the possibility to provide growth and flourishing.

4.5.2.2. Secondary Appraisal

Lazarus (cited in Strümpfer 2007) states that in secondary appraisal, three decisions need to be made:

- Who is responsible for the inordinate demand? (accountability)
- Do I have enough resources to meet the demand? (leading to problem-focused coping)
- Can I emotionally cope with the inordinate demand? (leading to emotion-focused coping)

In evaluating these questions, it implies that the individual will be concurrently assessing their coping strategies to the inordinate demand. It is thus difficult to separate out the secondary appraisal from the coping process.

This brings into light, the fact that a variety of variables will contribute to the appraisal process, from the 'bodily' level through to the cultural and life-span levels (Strümpfer, 2007). Pretorius (cited in Barend, 2004) adds that if an individual appraises an inordinate demand negatively, they will succumb to it, resulting in them reaching the-end point of 'languishing' (a state of being in which there is stagnation and sense of emptiness) on the wellness continuum, while a person who appraises the inordinate demand positively, will reach the end-point of 'flourishing' (state of functioning well and having high affective states) on the continuum, as they will experience a greater sense of belief in themselves and their ability.

This highlights that fortigenesis revolves around an individual's ability to appraise inordinate demands, which is done in two ways. It is through this, that one is able to fully construct fortigenesis.

4.5.3. Constructing Fortigenesis

Strümpfer (2006:13) highlights the concept of a bipolar continuum from languishing to flourishing, in which flourishing is a state of complete mental health where there is an absence of mental illness. It is the fortigenic processes, in response to the appraisal of inordinate demands that result in the individual moving along the continua between the poles of mental illness to the absence of mental illness, as well as from languishing to flourishing (Strümpfer, 2006:13).

Factors affecting the upwards progression towards flourishing, include eustress experiences such as "continuing education, self-directed work experiences, participation in socially valued decision making, a rejuvenating love relationship, the joys of parenthood, or psychotherapy; religious conversion and participation" (Strümpfer, 2006:25). However, movement towards languishing can be due to distressing experiences such as "serious illness or injury, bereavement, untoward work experiences without escape, retrenchment and unemployment, social isolation, persecution, imprisonment, political upheaval or repression, or war" (Strümpfer, 2006:25).

4.5.4. Flourishing/Thriving

Flourishing, or thriving as some refer to it, is derived out of the progression of an individual beyond resilience (the strength to recover from inordinate demands and return to baseline functioning) (Strümpfer, 2006:24-25).

Resilience is used to describe psychological strength (Nel, 2007), which was seen as the fortigenic ability of an individual to overcome inordinate demands and return to baseline functioning, or beyond to develop a new base-line functioning. Strümpfer (2002) cites McClelland in saying that resilience is "a recurrent concern about a goal state that drives, orients and selects behaviour." He also states that resilience has three different properties, namely:

- A system is able to resist shock without losing basic functioning
- A system is able to adapt to changing circumstances
- A system is able to transform to a new way of life

It is an innate capacity that is activated by an inordinate demand and is defined as a pattern of psychological activity made up of coping and rebounding, accompanied by emotions and cognitions (Strümpfer, 2002).

It can thus be said that in the case of flourishing, that flourishing occurs when an individual is able to positively grow and develop out of the challenge posed by an inordinate demand.

Flourishing has psychological, physical ("physiological changes that result from facing Stressors that leave individuals with greater physiological resilience than they had before the experience" Epel et al cited in Strümpfer, 2006:26) and social dimensions, which are inter-related and impact on the overall well-being of the individual.

4.5.5. Fortigenesis and Quality of Life of MSM

Adjustment to life stressors is implicated in a state of flourishing and the quality of life attained, along with the progression of any illnesses (Siegel and Krauss, 1991:17) and a person's personality (Burgess et al, 2000:424) and identity (Isaacs and McKendrick, 1992:207). Identity integration is thus important to resiliency, and MSM who can integrate sexual and spiritual identity show better resilience (Kubicek et al, 2009:15-17).

This highlights how research has indicated that those facing chronic illness, such as MSM in the face of HIV/AIDS (a difficult disease to deal with due to its unpredictable progression at times and stigma [Ueno and Adams, 2001:303]), need to address the following five tasks:

- "To reduce harmful environmental conditions and enhance prospects of recovery [complying with prescribed regimens, obtaining knowledge and skill for self-care, adjusting life-style]
- To tolerate or adjust to negative events and realities [dealing with stigma, confronting the inevitability of death, handling physical discomfort, grieving over losses]
- To maintain a positive self-image [maintaining a positive self-concept]
- To maintain emotional equilibrium [maintaining hope]
- To continue satisfying relationships with others [dealing with role change, adjusting to altered social relationships]" (Miller, 1993 as cited in Siegel and Krauss, 1991:18).

A major element in this process is centered on the search for meaning with respect to life stressors, such as HIV/AIDS; while attempting to gain mastery over the experienced stressors and improving self-esteem, as well as develop schemata with respect to their relationship with HIV/AIDS (Siegel and Krauss, 1991:18). The integration of life stressors into the meaning of life is an important element in trying to improve quality of life (Bloom, 2001:53).

What has been discovered is that during this process, high levels of knowledge are not directly connected to any changes in behavior (Bochow, 1990:186) and that behaviour is not reasoned or rational. An important behaviour to take note of is sexual behaviour as it is used as coping strategy. Often sexual acting out (Isaacs and McKendrick, 1992:9) or compulsive sexual behaviours are used to challenge anxiety and depression (Sandfort et al, 1995:220-221) and promote an affirmation and validity of self-identity (Isaacs and McKendrick, 1992:83). This affirmation and validation of MSM identity through promiscuous sexual behaviour is supported by the Cape Town MSM subculture (Isaacs and McKendrick, 1992:211).

MSM incorporate social networks into their process of stable identity formation (Isaacs and McKendrick, 1992:34) and adjustment, however the predominant basis of these networks are based on friendships, and limited family member involvement (Ueno and Adams, 2001:303). Whilst doing this, MSM also attempt to engage in the redevelopment of new life goals that are attainable to promote well-being and a better quality of life (Kraaij et al, 2008:399).

It thus becomes important that when approaching treatment and most importantly prevention, that MSM are assisted in facing stressors, by promoting better coping strategies and appraisal methods (Sandfort et al, 1995:225; Phaladze et al, 2005:126); while also assisting MSM to discover new meaning and purpose within life, which has been pointed out in research to aid quality of life; along with addressing such issues as spirituality/religion to aid this (Tsevat et al, 2009:931&935; Halkitis et al, 2009:261; Hsien-Chuan Hsu et al, 2009:385-386). Along with this, the promotion of the development of a fully integrated identity in the face of HIV/AIDS within MSM is paramount (Boles and Elifson, 1994:39) otherwise lowered self-regard will ensue and the consequential psychological and physical effects thereof (Ullrich et al, 2004:183-184). A positive self-esteem and self-regard are important elements of maintaining self-identity (Isaacs and McKendrick, 1992:35) and a state of well-being.

When looking at interventions for HIV/AIDS for MSM, it is important to be aware of fortigenesis, resilience and quality of life, as Herrick et al (2011:3) point out that "interventions …focused on deficits, gay men [or MSM] may perceive the negative focus as judgmental and they may therefore be less likely to accept, adhere to, and complete the intervention. Interventions that focus on strength and resilience rather than deficits could improve both intervention acceptability and efficacy." In other words health promotion interventions should be based on a strengths approach, that incorporate building spiritual fortigenesis through psychological fortigenesis, as is expressed by Helminiak (2008:184), "the key to transcendent living is the human spirit, the key to unleashing the spirit is the restructuring of psyche." It is thus important to focus on an inherently spiritual, yet human reality that is the meeting point of psychology and theology.

4.6. Conclusion

With the failure to understand and respond to the health needs of MSM, who face the greatest challenge and burden of HIV/AIDS in many countries, including South Africa. It is important to acknowledge the important step made in South African to include this marginalized group within the Governmental Strategic Plan for HIV/AIDS as a response to the findings that the risk of HIV infection among MSM is far higher than the general population.

This is an important step, as HIV positive MSM not only experience discrimination due to being homosexual in South Africa, but have far greater levels of discrimination towards them due to their HIV status than non-MSM people. The impact of this severely affects MSM emotional reactions and distress, resulting in deeper feelings of shame and guilt. These internalized emotions have far reaching impacts on their well-being. This is because many people diagnosed or living with HIV, find that the illness affects their sense of identity and results in a reduction of their self-regard. It thus becomes important to develop research into coping strategies employed by MSM in South Africa.

A commonly employed strategy of people living with HIV/AIDS is to achieve a greater sense of well-being and coping, through the exploration of the significance and meaning of HIV/AIDS in their lives, especially with respect to hope, faith, spirituality, purpose and meaning in life. This allows for MSM to fortigenetically flourish, by having the inordinate demand of HIV/AIDS viewed as a challenge that allows for them to move beyond resilience into flourishing by embracing their internal and external coping resources, such as

spirituality. This makes spirituality an important resource for coping. It is a resource that international research has shown that MSM do use as a means of coping, despite the historical exclusion and heterosexual bias expressed by many religious orders against them. This makes the interplay between spirituality and the improvement of MSM wellbeing in the face of HIV/AIDS and important field of research.

Chapter 5: MSM: The Cape Town Scenario

"In any holocaust, war, plague or pandemic, there were always one or two people who lived to tell the story and why couldn't one of those people be me? Somebody had to stay alive to tell the story for all those who had died with their song still in them, unsung."

David Patient, in an interview, with Jeanne Viall

There is very little epidemiological literature within South Africa on same-sex transmission of HIV in South Africa (Reddy, Sandfort and Rispel; 2009:xiii). This absence and silence on HIV/AIDS and MSM (an almost apparently deliberate silence [Reddy, Sandfort and Rispel, 2009:29]), is a glaring consequence of the cultural homophobia of the hetero-normative and heterosexist culture of South Africa (Reddy, Sandfort and Rispel, 2009:6).

It is important that this group of people is considered and focused upon when both looking at HIV/AIDS prevention and treatment. This was espoused by the UN General Assembly at a Special Session in 2001, where they stated that focus must be given to the needs of those who are vulnerable (Reddy, Sandfort and Rispel, 2009:4), making it necessary to enquire into MSM and their situatedness within the context of time and place (Reddy, Sandfort and Rispel, 2009:8), such as Cape Town, South Africa.

When looking at research done among MSM in Pretoria, it was found that one fifth of the young gay-identifying MSM are involved in risky sex behaviours that are influenced by substance use and bareback[19] sexual practices (Reddy, Sandfort and Rispel, 2009:196). Bareback sexual practices in Cape Town are alarmingly high, along with self-reported consumption of recreational drugs according to anecdotal reports. Along with these are the reported beliefs held by MSM in Cape Town that they are not at risk and that they are HIV-negative until they are tested HIV-positive (Reddy, Sandfort and Ripsel, 2009:201).

[19] Bareback sex is anal sexual penetration without protection.

This is concerning as Cape Town is a popular destination for international and domestic MSM travellers, which brings a greater expression of high risk sexual dynamics that are also increasing the risk of HIV/AIDS transmission (Reddy, Sandfort and Rispel, 2009:200).

The first study evaluating HIV prevalence and the associations of HIV infection among MSM within the peri-urban townships of Cape Town was carried out by Baral et al. (2011:2), who found that the overall HIV prevalence was 25%. This latest prevalence studies is higher than the previous prevalence studies done in Cape Town, which indicated a prevalence of 10.6% (Baral, et al, 2011:8) with other researchers estimating it at around 30% among gay identifying MSM (Samelis and Wagberg, 2005:42).

When this high prevalence is taken into account along with the high risk sexual practices that were uncovered, it is suggestive that the epidemic will only continue to increase (Baral et al, 2011:2). This is compared to the generalised HIV epidemic in South Africa, where it is "16.9% among adults 15 and older and 13.1 among men aged 15 and older" (Baral et al, 2011:3). These results show that MSM are extremely vulnerable to HIV/AIDS and interventions need to be developed to look into this sexual minority.

5.1. MSM in Cape Town: an Empirical Approach

This research is empirical and exploratory in nature, regarding the question of HIV/AIDS: Friend or Foe? It is an attempt to find what role Christian Spirituality can play in the development of the meaning by MSM in Cape Town's meaning-making frameworks around being HIV-positive. However, this cannot be done, without exploring empirically does determine what meaning HIV-Positive MSM develop in the face of the disease. Understanding and exploring their experiences is imperative, that is why a qualitative, interpretative phenomenological analysis (IPA) research approach was undertaken, within this chapter.

IPA is a version of the phenomenological method. It is thus important to understand what phenomenology is. "Phenomenology is concerned with the ways in which human beings gain knowledge of the world around them" (Willig, 2001:50) and the "phenomenological perspective includes a focus on the life world, an openness to the experiences of the subjects,

a primacy of precise descriptions, attempts to bracket[20] foreknowledge, and a search for invariant essential meanings in the descriptions" (Kvale, 1996:38).

IPA as a variant of Phenomenology, attempts to ascertain and gather the "quality and texture of individual experience" (Willig, 2001:3), which it believes is "never directly accessible to the researcher" (Willig, 2001:53). This means that the analysis that is produced is an interpretation of the individual's experience. The analysis that is produced is through engagement with the text produced from the interviews. This engagement is facilitated by a number of steps which allow for the determination and integration of a number of themes into "meaningful clusters, first within and then across cases." Because of the systematic nature of the analytic procedure, it is thus an ideal method to use within the psychological field (Willig, 2001:83).

Added to this, IPA as a research method within this exploration into meaning the meaning developed by MSM in the face of HIV/AIDS is ideal, as it agrees that "experience is mediated by thoughts and beliefs, expectations and judgments that the individuals bring to it. In other words, people attribute meanings to events which then shape their experiences of these events" (Willig, 2001:66). This approach thus will allow for an understanding of what are the meanings that MSM develop out of their experiences, especially HIV/AIDS and how spirituality is possibly associated to this.

Therefore the ability of the phenomenological method to focus on the lived experience of the subject, and elucidate the meaning through discovery, makes IPA a valuable research method in trying to understand the meaning developed by MSM in the face of HIV/AIDS. Schwartzberg (1993:488) describes this approach as creating a "map into the territory of people's attempts to forge meaning in a medical epidemic and psychological crisis." This concept links into fortology and the quest for meaning, and the development of positive mental health and well-being. It thus gives a picture of the person's state of being that would

[2020] Bracketing refers to "the putting out of play what we know about things in order to experience them freshly" (Giorgi, 1986:6). It is the process whereby the primary concern of the research is placed within these brackets, while simultaneously removing irrelevant concepts and ideas, which results in a research process that is completely grounded within the phenomenon being researched (Moustakas, 1994). Bracketing requires one to adopt a phenomenological attitude which ignores presuppositions of how things exist and attempts to represent things as they appear within the experience of the subject.

be dictated and experienced through the understandings as explained in theology of affirmation.

This is important to the field of exploration in this research, as highlighted by Louw (2008:17) the empirical dimension of human responses aids Practical Theology to improve on theological interpretations. This allows for improved focusing on approaching existential life issues more effectively and thoroughly, through aiding the care and counselling practices within pastoral hermeneutics. This is because it allows for a better understanding of approaching the "praxis of God as related to the praxis of faith within a vivid social, cultural and contextual encounter between God and human beings." Thus, by understanding the meaning-making of MSM in the face of HIV/AIDS in Cape Town, better frameworks, interventions and approaches can be developed within Practical Theology to breach the rift that has developed between many MSM and the Christian faith.

This is in alignment with the goals of this research which is interested in the candidate's subjective experience of their world. It is through this IPA that (in the terminology of IPA) meanings made by MSM who are faced with living with HIV/AIDS, may be discovered rather than constructed.

5.2. The Methodology and Research Project

The methodology used for carrying out the IPA into determining the meanings that MSM make within Cape Town, was governed by the stages as set out of Willig (2000:80-85):

1. Reading and re-reading and making any notes with respect to initial thoughts or observations
2. The identification and labeling of themes that characterize the text (see appendix 1)
3. The introduction of structure into the analysis, linking natural clusters of concepts and shared meanings. These clusters are given labels that capture the essence of the themes within the cluster (see appendix 2)
4. A summary table of the clusters was then drawn up (see appendix 2)
5. Integration of the cases are then carried out by investigating master themes across all the cases (see appendix 3)

The Research Techniques

In sub-Saharan Africa, where the HIV/AIDS epidemics have been found to have the most destructive effects, MSM are often overlooked (Smith et al, 2009:416). Because of this lack of research into HIV/AIDS and MSM, especially into meaning-making among HIV-positive MSM in South Africa as determined through doing analysis of current literature, it is necessary that empirical research be done to gain this understanding. This means that along with the literature research, an empirical research component needs to be included to assist in developing the understanding of what is the meaning MSM in Cape Town develop in the face of HIV/AIDS.

The empirical and exploratory nature of this research into developing an understanding and the creation of a framework for Practical Theology in approaching HIV/AIDS within MSM in Cape Town, makes it necessary that a phenomenological research design be used. The benefits of this approach allows for understanding the lived experiences and the linked existential states within MSM, and the resultant meanings that develop.

This design is a qualitative approach that is able to assist in determining the major meaning categories as expressed by the interviewees. These are then correlated and matched with the core concepts expressed within the theoretical framework. This assists in determining whether a Christian Spiritual perspective can aid MSM to reformulate these meaning units into new more well-being promoting ones, to be re-integrated into their lives through using a more holistic approach to spiritual healing which can overcome the schism of HIV/AIDS: Friend or Foe?

A literature review was carried out on the research done into the field of meaning and MSM and HIV/AIDS. With the following literature, acting as examples of the core articles:

- Schwartzberg, S.S. (1993). *Struggling for meaning: how HIV-positive gay men make sense of AIDS*. Professional Psychology: Research and Practice, 24(4), 483–490.
- Rispel, L.C. and Metcalf, C.A. (2009). *Breaking the Silence: South African HIV policies and the needs of men who have sex with men*. Reproductive Health Matters, 17(33), pp. 133 – 142.

- Cloete, A., Simbayia, L.C., Kalichman, S.C., Strebela, A. and Henda, N. (2008). *Stigma and discrimination experiences of HIV-positive men who have sex with men in Cape Town, South Africa*. AIDS Care, 20(9), pp. 1105 – 1110.
- Strümpfer, D. J. W., (2006). *The Strengths Perspective: Fortigenesis in Adult Life: Social Indicators Research,* Subjective Well-being in Mental Health and Human Development Research Worldwide, 77(1), pp. 11-36
- Louw, D.J. (2008). *Cura Vitae: Illness and the healing of life*. Cape Town: Lux Verbi

The primary tool used for the study was a semi-structured interview based on the questions as assessed and proposed by Schwartzberg (1993:487), that was analysed post hoc, rather than with any priori assumptions or hypotheses. This was to ensure that specific questions and topics are consistent across all the candidates and that the topics covered are consistent, yet allows for the free flow of conversation. Questions that were posed were generally open-ended and non-directed to provide the candidates with an "opportunity to share their personal experience of the phenomenon under investigation with the researcher" (Willig, 2001:54). Examples of such questions used were:

- "In what ways has AIDS and/or being HIV-positive affected how you feel about being gay?
- Has AIDS or being HIV-positive affected any spiritual or religious beliefs you have?
- Can you talk about any process or changes you've gone through in dealing with being HIV-positive since you've known?
- In what ways (if at all) are you a different person now than you were before you learned of your HIV status?" (Schwartzberg, 1993:487)

To improve the quality of the interviews, special attention was paid to developing rapport between the candidate and researcher. The researcher attempted to "bracket" off any preconceived ideas about the data, as required by the phenomenological design. This allowed for the interview to unfold without any tainting by the researcher (Schwartzberg, 1993:484).

This research gives a "snap shot"[21] of what some of the meanings that MSM in Cape Town ascribe to living with HIV/AIDS. This methodology takes note of the fact that meaning is an ongoing process that changes.

[21] A picture/idea of the categories at that specific time with respect to the phenomenon

5.3.Sampling

Within the empirical research, a sample of 5 HIV-Positive MSM candidates was selected through purposeful non-random sampling. The candidates were selected from clients that attend the City of Cape Town's CARE Programme. They were approached by the researcher indirectly through the CARE counsellor, having obtained approval by the City of Cape Town to do so. The CARE counsellor was informed of the research and its intents during the initial contact. The CARE counselor then asked potential participants if they would be willing to volunteer to take part in the research. The five that were willing to take part in the research and that had no objection to the researcher knowing their HIV status, were asked if it was possible for the researcher to approach them directly.

The candidates were informed that the following criteria were applicable to all possible candidates who were willing to volunteer to participate. They had to be:

- MSM
- HIV-positive no less than 18 months
- Not a minor
- Ethnically diverse

Emphasis was made that participation was voluntary.

5.4.Ethical Clearance

The researcher undertook to submit an application for ethical clearance to the Ethics Committee of Stellenbosch University before the research started. This application included (see appendix 4):

That informed consent would be gained from each candidate prior to the interviews, and the results would remain anonymous. The candidates were informed as to the general aim of the research, with respect to understanding the meaning developed by HIV-positive MSM in Cape Town. These interviews occurred once per candidate, and were audio-taped and transcribed verbatim. It was then analysed as laid out by Schwartzberg (1993:484).

Limitations

The limitation of this study, is that it was done with a small number of participants, of which all were from within the white MSM grouping within Cape Town. Also due to the

phenomenological nature of the empirical research, no causal relationships could be developed.

Results

Data Analysis 1: The specific representations of HIV/AIDS

The data analysis was split into two distinct phases, with the first phase being aimed at exploring one aspect of the meaning-making process: "attribution of specific qualities, traits, meaning units, or connotations to AIDS and HIV" (Schwartzberg, 1993:484). This was done to elucidate what the particular ideas are that MSM in Cape Town held about the impact of HIV/AIDS, as well as what metaphors, images and beliefs they have (Schwartzberg, 1993:284).

This phase of data analysis was modeled on the procedures laid out by Willig (2000:80-85):

- Interview transcription
- Individual Interview Analysis isolating meaning units (see appendix 1)
- Isolate Cluster Themes of meaning units per interview (see appendix 2)
- Summarise Cluster themes per interview (see appendix 2)
- Analysis of Cluster Themes across all interviews (see appendix 3)

As a result of these steps of data analysis, 10 distinct categories of meaning attributions/representations emerged, with all the participants yielding three of the same representations. Only one representation was yielded by two participants. The representations are listed below in descending order of the frequency with which they were mentioned by each of the different interviewees. The brackets contain the number of subjects expressing the representation.

1. HIV as Growth/Catalysis (5 of 5)

Many of the interviews expressed that their infection with HIV has presented them with an opportunity to grow within themselves. This growth expressed itself in various forms: no more pretense; more aware of self and others; an openness to new things; self-forgiveness; attitude shifts and improved relationships.

Example:

"I am fundamentally, enormously happier and I understand much better it is in my control and power. The way I was living before, was getting angry about the things that were

happening externally. Angry at the world. Even before diagnosis…Instead of concentrating on my own well-being. And in the changes I wanted to see, I can do that. It is in my grasp."

2. HIV and Spirituality (4 of 5)

Many interviewees expressed changes in their level of spirituality and how their spirituality assisted them in developing improvements within their lives, through connection to self and others; while also creating purpose and meaning. Also it allows them to live a good, moral life doing good things. Some expressed that though religion may have dropped or been unimportant, spirituality was more beneficial.

Example:

"I did a little soul searching and I've come across areas in my life which I think I needed to work on but then I have worked on them. I think I was bit of a selfish person beforehand and I'd like to think of myself as being less selfish. And so I am definitely spiritually more in touch with myself…I feel more in control of myself, more connected to myself, more connected to other people, and I am definitely more honest to myself, I really like that."

3. HIV as Stigmatization (5 of 5)

For all of the interviewees, there was an element of stigmatization around HIV/AIDS. It expressed itself as: shock, blame and other negative reactions from others, including rejection; that being gay means to get HIV/AIDS; that to be HIV positive is to be promiscuous or behave badly; and that stigma is linked to fear and a lack of education and understanding.

Example:

"And I told her husband, her husband is actually a great guy, you know he was a little bit shocked and accusing me of quite a lot of things. You know what it was like…know that it was out there and it was a risk and then why, why do you want to cry about it now that you've got it. That you're HIV positive…I should have known it was there and if I wanted to play – if I wanted to be gay and whatever it was just sort of part of the thing that."

4. HIV as Death (4 of 5)

Diagnosis with HIV resulted in many facing their own mortality, often resulting in the fear of an imminent death; of fearing death or how to plan for it; anger and a sense of shortened life; realisations that HIV/AIDS does not equate to a death sentence; acceptance of death as

normal and part of the cycle of life; and that death could become a metaphorical death of the old self.

Example

"I think he [dad] sort of knew what is happening and he just looked at me. It's like, Daniel, you are not going to die tomorrow. You don't have to do this right now, and it sort of sparked because then I sort of saw exactly. I am not going to die tomorrow."

5. HIV as Acceptance (3 of 5)

HIV for many interviewees' raises issues around acceptance: acceptance of self, the disease and by others. It also raised issues around support from work, family and friends; and knowledge about oneself; as well as acceptance of one's role in the transmission and risk of getting HIV/AIDS.

Example:

"I was at work when I found out that I'm positive…She was one of the very first people that I actually had contact with and…accepting about it. They have never raised any issue."

6. HIV Negative (5 of 5)

Among all the interviewees there was a presence of the perception that HIV/AIDS was a negative aspect of life. It was perceived has having negative impacts on lifestyle, removing sexual spontaneity or even creating a sense of directionless and futility of life. It was for some perceived as an enemy and that a person is best or even blessed that they are not infected with HIV. The infection with HIV meant a daily reminder and challenge to life.

Example:

"It is a daily process you know it is always easy to get up in the morning you have to find a reason to face yourself in the mirror again want to get up and face yourself, because it is just that it is like day to day you have to like find the little reasons, find the little things that is going to make it work for you that is going to improve your mood, that is going to just make your reality bearable for that day. And if you do through that they then the next day you know can repeat it."

7. HIV as Fear (2 of 5)

Two of the interviews had a high prevalence of meaning units within the category of fear. Fearing contaminating others with HIV or fearing the reaction, rejection and possible abandonment of those they disclose their HIV status to; with a loss in the sense of being able to be intimate with others or even self.

Example:

"The day I was diagnosed I decided this is where it stops, with me. And it is not going to go any further…Fear… [Fear of transmitting to someone else] absolutely, 100%...I lost the interest in intimacy. I just don't feel I may deserve it and just don't want to involve anybody in my life."

8. HIV as Responsibility (4 of 5)

Taking responsibility for oneself and others is another prominent meaning for 4 of the 5 interviewee's, where acknowledgement and acceptance of being a willing participant in becoming infected is important. It is also about taking responsibility of taking care of oneself after infection, and being responsible in limiting the impact of HIV on one's self and on others.

Example:

"One of the things is, first of all, I put myself in harm's way. Nobody made me have sex and get infected. I knew there was a risk. I may have put the reality out of my mind temporarily to follow certain desires. But I have to take responsibility for what happened."

9. HIV as Transmission/Infection/Medication (3 of 5)

HIV for many was about the transmission of HIV and being infected, as well as the need for medication. The need to use medication as a management of the disease and possible prevention was central to this meaning unit. The belief being that death is unnecessary if a person is adherent to medication regimes.

Example:

"He sort of started having unprotected sex and I said to him you realize what we are doing, and he said ja. You know he is absolutely fine with it. Look, I think, he also – at one point he said to me ag, you know I'm just making peace with this and I will probably get infected."

10. HIV as Life Review/Turning Point/Framework/Motivator (3 of 5)

HIV infection often prompted existential, metaphysical and spiritual questioning, with an attempt to review life and meaning; due to their changed circumstance and life context; as well as a questioning and re-evaluation of oneself. For some the resultant anger due to HIV acted as a motivating factor or even a framework for understanding life and shaping behaviours.

Example:

"I went through and am still busy with soul searching, sort of re-evaluating things."

Data Analysis 2: Overall Patterns for Ascribing Meaning to HIV/AIDS

Having explored the specific attributed meanings that the interviewee's have given to HIV/AIDS, the data was then re-examined to explore the broader question, as to whether the MSM in Cape Town, able to integrate HIV/AIDS into a coherent and encompassing framework in order to ascribe meaning to their lives, in other words, ascertaining if there were any general trends in the interviewee's attempts to find meaning in the face of HIV/AIDS (Schwartzberg, 1993:486).

The second phase involved reviewing the transcripts and the resultant themes and clusters, reviewing the individual quotes, the frequency and consistency or discrepancies of the reported themes. By re-examining the data in line with Schwartzberg (1993:486), comparison could be made with respect to the identified categories of: "high meaning, defensive meaning, shattered meaning and irrelevant meaning," that are ascribed to as an overall framework to providing meaning in the face of HIV/AIDS.

High Meaning (2 out of 5)

"Faced with the incontrovertible fact of their HIV infection…subjects were able to transform this information from despair to challenge, from psychological disequilibrium to catalyst for growth, from "death sentence" to a re-invigorated appreciation of life" (Schwartzberg, 1993:486-487). These were primarily represented by meanings of HIV as a catalyst for growth, acceptance and an opportunity to review their lives and a new development of spirituality, or new focus on a way of living, within their lives. This gave them a new sense of meaning and being in control. HIV/AIDS became something that needed to be accepted and become a normal part of life. It assisted in developing or focusing on a sense of new or important values, due to its' providing a means of unlocking unresolved issues, or the tapping of new insights into one-self and life (Schwartzberg, 1993:287).

Example:

"The question I eventually came to was "why me?"…Some things happen in life and it's the way we find meaning in it…. After diagnosis…the context had changed but also I felt that I really needed to resolve personal issues…HIV was a catalyst for me to go explore my spirituality… [which] changed my life."

Defensive Meaning (2 out of 5)

These men, instead of developing a new framework for meaning, have developed a superficial language of personal growth, without internalizing the new framework and growth.

With these men there was still the perception of HIV/AIDS as a negative factor in their lives (fear, death, denial and rejection being issues raised), with inconsistent and contradictory information between positive benefits versus the negative impacts of HIV/AIDS. These raise concerns that the lack of internalization of their utterances regarding growth could have a negative impact on their ability to sustain themselves in crisis (Schwartzberg, 1993:488).

Example:

"Well there was the stigma to start with, rejection, fear of being cast aside or thrown out. The fear of not being able to be treated. All of these accumulated. Built a huge fear in me..I don't know, I just don't feel, I will tell you what. It is I just don't feel that it is fair on anyone else. I don't feel it fair to basically burden anyone else with this thing. It is something I have to carry on my own… It was given to help me understand that there is a power greater than myself…I am in a better frame of mind. I have more contentment, feelings I am more serene…"

Shattered Meaning (1 of 5)

HIV/AIDS has resultant in the person being bereft of any meaningful framework in order to understand the world. The predominant meanings are about stigma, loss, isolation, fear, rejection and abandonment. The challenge of the existential, metaphysical and spiritual questionings around "why me?" have not been able to be resolved (Schwartzberg, 1993:488).

Example:

"Basically it has been… a process of destruction…it's certainly has made relationships more difficult…you still live under stigma. You have people not want to know you or consider sexual interaction or relationships of any kind, because they are not positive…"

Irrelevant Meaning (0 of 5)

None of the MSM interviewed, when it came to HIV, felt that it had neither transformed nor changed them or how they viewed the world. This category, Schwartzberg (1993:488) identified as being about denial, minimization and the compartmentalizing of HIV infection to prevent it becoming a prominent part of their identity. These people he felt lacked meanings that fell into the other 3 meaning categories (Schwartzberg, 1993:488).

Discussion

The empirical research creates an introductory exploratory map into the attempts made by MSM, within Cape Town, to formulate meaning in the face of HIV/AIDS. What was evident was that there was an enormously high number of meaning statements generated during their attempts to find meaning. This is in line with Schwartzberg (1993:488) who also found large numbers of meaning statements, and believed that this either directly or indirectly implied that meaning development was fundamentally important in coping with the trauma of being diagnosed with HIV/AIDS.

Along with these all the participants found some beneficial aspects out of contracting HIV/AIDS, with various levels of meanings relating to a sense of growth for each interviewee, while 4 out of 5 indicated that spirituality played an important role in assisting them in improving their lives. It aided in helping them to develop a sense of connection to themselves and others, something that many felt was missing within their lives. They felt that if it hadn't been for HIV, they would not have increased their levels of spirituality. This is an important empirical finding with respect to the research question and hypothesis, which hypothesized that HIV/AIDS promoted changes within MSM that results in spiritual growth and the development of internal strengths that allow them to transcend above the stressor of HIV/AIDS.

The fact that the majority of the interviewees experienced increased spirituality, and used spirituality as a coping resource is important to take note of. It opens the path to Practical theology to approach and support MSM in the face of extreme stressors, such as HIV/AIDS, where awareness is made of the separation MSM have between their understanding of their experiences of their subjective differences between religion and spirituality.

In looking further into the meaning and meaning categories, only 2 people could be classified as developing meaning that fell into the High Meaning category. These two candidates appeared to find a balance between the negative aspects of HIV/AIDS and the positive outcomes that could be developed, through internalized changes and a new approach to life. While another 2 interviewee's, in the Defensive Meaning category, spoke about personal growth and changes, however questions arise about the level of internalization, as the frequency of oppositional meanings were frequent, with high levels of negativity, fear, death and rejection being predominant against the perceived positive benefits of HIV/AIDS infection.

For one interviewee, in the Shattered Meaning category, there was a complexity of inconsistent and conflicting meanings that created a sense of superficiality and a lack of internalization. Combined with this, there is a sense of an inability to develop a resolution of a meaningful framework, with a predominance of life filled with isolation and loss.

Conclusion

These findings highlight what research has shown in the past, which Schwartzberg (1993:489) confirmed, that "ascribing meaning to illness is a basic human undertaking" and that "individuals ascribe meaning in a range of ways, influenced by cultural and personal factors" and "some people can discover beneficial, life-affirming aspects of coping with severe illness." Thus the development of an appreciation of how MSM ascribe meaning is vital, and what their experience of the role that spirituality played in this process was.

This would allow for the ability to review prevention campaigns, which have in the past attempted to create behavioural change, through HIV/AIDS education and awareness, which is insufficient to create the desired behavioural change and a change in the existential state of MSM. The lack of information is not the problem, it is best to take a complementary approach, looking at the broader social and environmental vectors or factors underlying the spread of HIV/AIDS (Fourie, 2006; Abdool Karim and Abdool Karim, 2008:151) and the impact it has on MSM, and address these. Along with these, it is important to explore the spiritual issues, such as isolation and separation that affect the meaning-making development process of MSM, as highlighted in this empirical research. This is because of the importance that MSM have placed on spirituality in HIV/AIDS.

This therefore makes it important to identify the meanings ascribed by MSM with HIV, such as ascertained in this empirical research among HIV-positive MSM in Cape Town, as being a catalyst for growth and High Meaning development and the association that the subjectively experienced increase in spirituality plays. It also highlights the need for the eradication of the negative meanings of stigma, death, rejection and fear by developing strategies that take the broader social and environmental factors into account, an example of which would be the poverty or the high use of drugs and its correlation to increased risk of HIV/AIDS (Abdool Karim and Abdool Karim, 2008). This is important for Practical theology, as MSM in the literature and the empirical research highlighted their negative experiences of Christianity, and that they have developed an understanding that separated religion from spirituality, with spirituality being what was important to them.

In order to do this Abdool Karim and Abdool Karim (2008:356) state the following, "the greatest headway in addressing stigma and discrimination has always been made through the power and action of the community when people take ownership of the challenges that HIV/AIDS brings at a community level. UNAIDS lists a number of multi-pronged interventions to address stigma and discrimination for a more effective response to the HIV/AIDS epidemic:

- Community mobilization and continuing advocacy with the support for social change of political and religious leaders in response to HIV/AIDS-related stigma and discrimination
- Broad-based action to counteract gender, racial and sexual in-equalities and stereotypes on which HIV/AIDS-related stigma and discrimination often feed
- Promotion of life-skills education, risk-reduction counselling and support groups to help HIV-infected and affected individuals cope with stigmitisation in the home, school and community
- Training and support for workplace initiatives, practical HIV-related training for health care workers and pre- and in-service training for teachers and religious leaders to promote better understanding and confidentiality and reduce unfound anxiety
- Ensuring that comprehensive care services with community partnerships and advocacy are available to:

- Provide voluntary counselling and testing (VCT) with follow-up care that gives support to individuals when they learn their serostatus and enables them to disclose their status to important persons in their life
- Raise awareness so that communities and women can access prevention of mother-to-child transmission care and support services and can hold government to account if these services are not available
- Ensure there is concrete action for greater access to, and uptake of, treatment and drugs
- Help people to understand that it is possible to live with HIV/AIDS and that treatment and wellness management promises real hope for the future; an important step in dissipating fear and anxiety about HIV/AIDS
- Expand access to anti-retroviral – treatment itself significantly reduces stigma and discrimination; community fears lessen as HIV/AIDS increasingly comes to be seen both by health service providers and by the community as a manageable disease; and there is also a greater impact on prevention strategies and condom uptake when there is hope for a longer life"

To address these, the empirical research of this thesis points to the meanings ascribed by MSM with HIV in Cape Town, as being a catalyst for growth and High Meaning development and the link that they make between HIV/AIDS to their increased level of spirituality. It also became clear through the meanings as well, that interventions are required to address broader social and environmental issues, to reduce the possibility of the development of the negative meanings around HIV/AIDS of stigma, death, rejection and fear. And that strategies need to be used in order to approach MSM where increasing levels of internal and external spiritual resources can be developed. These strategies also need to include spiritual understandings that can be developed within MSM to assist them in assessing the stressor of HIV/AIDS during the meaning-making process.

Due to this importance that MSM have placed on spirituality in dealing with HIV/AIDS during the meaning-making process, this thesis proposes that spirituality/religion, as linked to the realm of values and meanings, be harnessed to aid in self-realisation and transcendence, that characterizes well-being, when approached though psychological and spiritual fortigenesis.

Healing and wholeness therefore needs to be done through an approach of spiritual healing that affirms MSM and develops a sense of connectivity with self and others, thus enhancing self-identity and dignity. As described in chapter 4, it is important to develop an integrated identity, to better address the meanings that are developed out of experiences in life, such as HIV/AIDS.

The spiritual healing approach to address this, needs to develop a fuller understanding of these life experiences of MSM and the meanings they make and the meaning-making processes they use, and ultimately the resources they use in order to deal with their life experiences. In this case it has been shown that spirituality plays an important role in the face of HIV/AIDS.

The idea that MSM experience spirituality as something helpful and essential, makes it important to note that comments in the empirical research indicated that they tended to believe that if a Higher Power is involved, that it is unconditionally loving, kind and friendly. This is an important description of a God image within Christian Spirituality, a possible God-image of a Partner for Life or Friend. Thus, for Christian Spirituality to play a role within the healing of MSM and to better enhance spirituality and lay a better spiritual foundation, and develop better internal strengths and existential states, it thus becomes important to explore how Christian Spirituality will be able to address these needs of MSM.

Chapter 6: Wholeness and Spiritual Healing - Beyond the schism of HIV/AIDS: Friend or Foe?

"When will we learn that human beings are of infinite value because they have been created in the image of God, and that it is a blasphemy to treat them as if they were less than this and to do so ultimately recoils on those who do this? In dehumanizing others, they are themselves dehumanized. Perhaps oppression dehumanizes the oppressor as much as, if not more than, the oppressed. They need each other to become truly free, to become human."
Archbishop Desmond Tutu, Nobel Peace Prize Address in 1984

6.1. The Interplay between Spirituality and Religion

The previous chapter highlighted through empirical research that HIV-positive MSM in Cape Town developed the following meanings for HIV:

- HIV is a catalyst for growth, creating a greater sense of self and others, as well as a better subjective sense of control
- HIV promotes an increased sense of spirituality, where there is a greater sense of connectivity with self and others is experienced, and is beneficial in creating meaning and purpose

From this it was possible to ascertain that at least 2 of the 5 interviewee's developed a high meaning, and were thus able to transform their experience and existential state from that of despair to that of a sense of challenge, where there was a re-invigorating appreciation for life. This was promoted through acceptance, internal growth and development and the incorporation of spirituality. The other interviewees, despite not developing a high meaning, identified spirituality as a very important part of their developing meaning and purpose in their lives. They were able to grapple with the existential question of "Why me?" and find and develop understandings that were meaningful for them.

This therefore makes it important to identify the meanings ascribed by MSM with HIV, such as ascertained in this empirical research among HIV-positive MSM in Cape Town, as being a catalyst for growth and High Meaning development and the association that the subjectively experienced increase in spirituality plays. It also highlights the need for the eradication of the negative meanings of stigma, death, rejection and fear by developing strategies that take the broader social and environmental factors into account, an example of which would be poverty or the high use of drugs and its correlation to increased risk of HIV/AIDS (Abdool Karim and Abdool Karim, 2008). This is important for Practical theology, as MSM in the literature and the empirical research highlighted their negative experiences of Christianity, and that they have developed an understanding that separated religion from spirituality, with spirituality being what was important to them.

Healing therefore when addressing MSM and HIV/AIDS needs to address spirituality from a framework that is acceptable to MSM. In order to do this, the helping professional needs to be able to grapple with what healing means and what they themselves will be contributing. This is important, as where does pastoral care and counselling position itself in promoting healing of MSM (Louw, 2012:15)?

Within this research topic, the approach of understanding pastoral care and counselling is reflected within the Christian Spiritual perspective of what a "soul" means. A "soul is something more than the "psyche" or human "spirit." It is the whole human being which emanates from an understanding of Yahweh's presence within it; as well as the "qualitative stance before God determined by the source of wisdom: torah (to love God and other human beings)" (Louw, 2012:15). This means that spiritual healing is about wholeness and promoting meaning and human dignity.

Thus, when approaching spiritual healing and wholeness, with the attempt to move beyond the schism of HIV/AIDS: Friend of Foe. It is important to reflect on a few things before defining our understanding of concepts of: spirituality and religion, it is important to again return to our understanding of our Theological standpoint and framework (within pastoral care and counselling) used within this research.

This research has embedded itself in the theological affirmation framework as proposed by Louw, where a theology of affirmation refers to the ontic state of being. In other words it

refers to the very fact that human beings are affirmed in their being functions by eschatology. With eschatology being understood as an ontological category that defines being human in terms of the biblical events of the cross and the resurrection. In order to live as new beings in Christ, means that human beings are strengthened by the charisma (fruit) of the Spirit, so that they may live life in courage, with a vivid sense of hope (Louw, 2009:12). Affirmation theology is therefore able to ascribe dignity to all as it emanates from the ontological Yes in Christ to being human, which is "demonstrated in new patterns of pneumatic living (pneumatology and inhabitational theology)" (Louw, 2009:11).

A theology of affirmation thus embraces a theology of the cross (theologia cruces), a protest or lament of God against "woundedness, weakness, disfigurement, ailment, vulnerability, marginalization and stigmatization" (Louw, 2009:6), and moves beyond it, as a theology of affirmation entails more than the cross and suffering. It thus attempts to transcend it by also including the theology of resurrection (theologia resurrectionis), therefore affirming the faithfulness and fulfillment of God's promises through the resurrection of Christ.

Affirmation theology can therefore be ultimately understood to be about the "establishment, maintenance, transformation and transfiguration of life and hope." (Louw, 2009:6). In other words, human beings are able to perceive and celebrate God's promises to them (Cilliers, 2009:5) and that he is present with them at all times in compassion and love, lamenting along with them in protest against all forms of suffering (Cilliers, 2009b:11). This is important, as MSM in Cape Town, as highlighted in Chapter 5, have developed meaning frameworks in the face of HIV/AIDS as being that of opportunity for life review, growth and overall improvement of well-being through incorporation of spirituality and positive meanings. While some have developed meanings promoting negative and even states of negativity, promoting isolation, loss and a sense of directionless, often as a consequence of stigma and fear.

For many MSM a variety of psychosocial and environment factors (such as: stigma, heterosexism, heteronormativity, homophobia – internal and external, prejudice, minority stress and traumas) impact on their well-being, as reflected in the empirical research of chapter 5. It is the process of meaning attribution that can play a critical role, as with all humans involved in meaning-making processes when challenged with illness. The empirical research indicated that the meanings developed included HIV as fear and stigmatization,

resulting in a limited number of participants being able to develop High Meaning, where a sense of internal integrity and dignity could be achieved. It thus becomes important to understand how spirituality and religion play a role in this.

6.1.1. The Concept of Spirituality

Many researchers have defined spirituality and have identified that it has specific characteristics that include unfolding mystery, inner strengths and harmonious interconnectedness. It is also associated with well-intentioned forces that are related to various experiences of growth with one's soul and a connection to a higher power, the realm of transcendence (Barnum, 1996). Spirituality is thus understood by many to relate to a personal concept of God that includes one's attitudes and beliefs (O'Brien, 2003).

6.1.2. The Concept of Religion

Religion includes such things as attendance at religious services or prayer (Cotton et al, 2006b:14). James (1994:34) describes how religion is separated by one major divide that splits it into two fields, these being institutional religion and the other personal religion. Institutional religion is about "worship and sacrifice, procedures for working on the dispositions of the deity, theology and ceremony and ecclesiastical organisation" (James, 1994: 34); while personal religion is about the inner disposition of man and his relationship with his higher power, where the go-between and externals fall away. Personal religion is about the connection between the individual's soul and their higher power, which appears to correspond with the concept of spirituality. This means that distinctions need to be addressed between the understanding of spirituality and religion.

6.1.3. The Distinctions between Religion and Spirituality

Often religion and spirituality are used interchangeably. However, each is defined differently. Religion is more concerned with the social institutions, organisations and adherence to the set beliefs and practices or rituals that display our outward "expression of the sacred" (Cotton et al, 2006:5; Ridge et al, 2008:414; Brennan, 2008:55) involved in the belief system. Spirituality, on the other hand, is concerned with the individual's quest to understand and find meaning, purpose and value to life (Ridge et al, 2008:414; Frame et al, 2005:6; Cotton et al, 2006b:14). Spirituality also encompasses the domain of inner/soul growth and the individual's relationship and connection to a higher power or transcendent practices/beliefs (Dalmida, 2006:187-188). This means that spirituality incorporates the "internal, personal

and emotional expression of the sacred" (Cotton et al, 2006:5) and "the search for one's connection to the sacred" (Kremer, Ironson and Kaplan, 2009:368). Spirituality is usually seen as one's transcendence over one's immediate situations (Brennan, 2008:55). Over all, spirituality is seen to transcend personal and scientific boundaries, while religion is defined by boundaries (Miller and Thoresen, 2003). However in using James (1994) it can be said that spirituality (personal religion) falls within the realm of religion. Cotton et al (2006:5) get around the distinctions between religion and spirituality by using a construct of spirituality/religion that includes all forms of the internal and external expressions of the sacred.

6.1.4. The Spirituality/Religion Construct

With most recent research and literature focusing on the polarization of the constructs of spirituality and religion, of Smith (2007:4) points out that these conceptualizations can be considered unbalanced and unwarranted. In opposition to this polarization, Smith (2007:14-17) counters with a new proposal, a nascent convergence model of the two constructs that creates a new conceptual entelechy of spirituality/religion.

This spiritual/religious construct relies on the work of Wilber (as cited in Smith, 2007:15-16) who proposes two constructs: transformation (a "vertical movement, a holistic deepening wherein one's self is unified and integrated into a phenomenological experience that is deeply open, transcendently compassionate, and present") and translation ("the horizontal motion of the self, a movement by which the belief in the myths, rituals and doctrine consoles, fortifies and defends the self from the inherent angst and existential doubt of the human condition"), where the primary elements of spirituality and religion are translatable and transformative. As translation they provide: a schema or a filter of belief, through which to derive meaning; and legitimacy to a person's worldview and beliefs. Whereas, as transformative they provide an authentification to a person's beliefs and world view. Both are thus indispensable to all individuals and the whole of society.

Smith (2007:14-17) believes the constructs of translation and transformation are deeper phenomenological and ontological renderings; that are more precise with respect to spirituality and religion, yet are simultaneously incorporating both of these concepts within a broader and more balanced way. These constructs allow for the removal of assumptions about

the significant differences between spirituality and religion, and rather focus on them as qualitative variances of the same construct.

6.2. The Role of Spirituality/Religion in Health

There is a large body of empirically proven research that supports the beneficial effects of spirituality/religion on mental and physical health (Ridge et al, 2008:415; Frame et al, 2005:7; Joshi and Kumari, 2009:46; Dalmida, 2006:188-189; Coleman, 2003:457). Research has even shown that spiritual/religious practices are able to provide relief from symptoms and sometimes alter the illness outcome (Tuck et al, 2001:778), while also providing a meaningful way for a person to reincorporate well-being into their life (Adreescu, 2011:29). However, in some research spirituality/religion was negatively linked to health outcomes due to judgmental attitudes and other negative aspects of spirituality/religion (Ironson, et al, 2002:46).

In understanding the impact of spirituality/religion on health, it has been found that participation in spiritual/religious activities such as prayer and meditation promotes beneficial health effects through relaxation of the sympathetic nervous system (SNS) as well as improving the functioning of the immune system. It has been proposed that this is achieved through promoting improved coping abilities in the face of stress, including illness. These improved coping abilities are also found to be aided by the fact that spiritual/religious activities promote feelings of happiness and life satisfaction, that act to reduce depression (Dalmida, 2006:189).

What is important to note is that people with chronic illness often experience spirituality and religion as central issues (Cotton et al, 2006:5). This is because "chronic illness places unique stressors on one's mental health by affecting such psychosocial factors as coping, social support and overall health status" (Somlai and Heckman, 2000:57). Thus in order to adjust and cope with these stressors, various resources are drawn on, including spirituality and religious resources (Ironson et al, 2002:35-47). There is a significant amount of research that links psychological adjustment and spirituality/religion (Siegel and Schrimshaw, 2002:92). The effect of these coping resources and the adjustment to the stressors are measured by self-reported quality of life (Somlai and Heckman, 2000:57). Research also shows that people experiencing "spiritual struggles" have poorer health outcomes (Cotton et al, 2006b:14).

It is because of this that research has explored how spirituality/religion is linked to mental and physical health outcomes, in order to find interventions that can assist people to overcome "spiritual struggles." In overcoming "spiritual struggles," research has shown that spiritual/religious beliefs and practices that promote psychological well-being have the following benefits:

- The evocation of comforting emotions and feelings
- They offer strength, empowerment and control
- They assist in easing the emotional burden of illness
- The provision of a sense of belonging and social support
- A personal relationship with God that provides spiritual support
- The facilitation of acceptance and meaning of illness
- Preservation of health
- Provides relief from fear and uncertainty around death
- It is able to reduce self-blame and promote self-acceptance

These highlight possible potential mechanisms that spirituality/religion may have an impact on the process of psychological adjustment (Joshi and Kumari, 2009:50-52; Siegel and Schrimshaw, 2002:92).

6.3. MSM: Towards a Spiritual Approach in Well-being and Health

6.3.1. Spiritual/Religious and Psychological Adjustment

Research into the link between spirituality/religion and psychological adjustment to adversity has been well researched, with the methods and theory of Pargament (Pargament, 1997; Pargament et al, 2000) on spiritual/religious coping being predominant. These are corroborated by the works of Lazarus and Folkman (1984), and Park (1997).

Lazarus and Folkman in their work propose that the relationship between spiritual/religious resources and coping with adverse stressors was composed of a bi-directional process. This means that psychological adjustment and well-being is achieved through a process of cognitive appraisal of an external stressor and the person's sense of being able to respond adequately. These cognitive processes are influenced by the personal beliefs and values (including spiritual/religious beliefs) of the person (Lazarus and Folkman, 1994; Joshi and Kumari, 2002:50-52). In other words spirituality/religion influences how people appraise

stressors and events in their lives, and thus their response. These processes are integral to fortigenesis and the development of internal strength. Thus highlighting the importance of how spirituality/religion is linked to the field of fortigenesis.

Other researchers show that spiritual/religious coping may be intrinsic (internalized) or extrinsic (intercessory) when used to gain comfort or well-being (Somlai and Heckman, 2000:59), but is usually multi-dimensional and includes a "search for spiritual meaning and personal support; that faith congregations provide important social networks and support that facilitate personal coping and adjustment efforts; and that these congregations provide an array of instrumental, informational, and emotional support resources" (Somlai and Heckman, 2000:58).

In coping with chronic disease, some of the religious/spiritual practices that positively influenced their mental health were prayer, meditation, breathing exercises and spiritual activities (Somlai and Heckman, 2000:58); which improve one's "thoughts, feelings and even bodily sensations" (Ridge et al, 2008:423). Other spiritual/religious beliefs such as life after death; a higher power that is loving and caring; and the possibility of miracles also assisted in providing people with better abilities to cope with chronic illness (Somlai and Heckman, 2000:58).

This highlights how spirituality/religion facilitates adjustment to stressors through its influence on the cognitive appraisal within a person's fortigenesic processes (Pargament et al, 2004:1202). It is achieved through using spirituality/religious beliefs to be able to find meaning. One of these meanings was that God is benevolent and has a "larger plan." This gives a greater sense of control and emotional strength as God could be leant on, which assists in dealing with the existential feelings of helplessness. Spiritual/religious coping also facilitates social acceptance or support through participation in a religious community. Spirituality/religion also assists in the development of personal acceptance, through the development of a relationship with a higher power (Siegel and Schrimshaw, 2002:99; Ridge et al, 2008:413-426; Pargament et al, 2004:1202).

Attention needs to be drawn to the fact that spiritual/religious coping can be either positive (i.e. that is spiritual support or benevolent spiritual/religious appraisal of life events) or negative (i.e. that is the view of God/higher power as punishing; dissatisfaction with

organized religion), with positive spiritual/religious coping methods increasing well-being and mental health and negative spiritual/religious coping methods resulting in increased psychological distress and a negative appraisal of life events (Joshi and Kumari, 2009:51-52).

Spiritual/religious resources have been found to be "positively correlated with a sense of coherence and a sense of life as comprehensive, manageable and meaningful which in turn was negatively correlated with psychological distress" (Joshi and Kumari, 2009:47). This is because spirituality/religion is able to provide a certain sense of meaning during an existential crisis (Frankl, 1959:122-123; Mullen, Smith and Hill, 1993; Pargament and Hahn, 1995; Joshi and Kumari, 2009; Cotton et al, 2006:5).

6.3.2. HIV and Spirituality/Religion

The mental health impact of HIV/AIDS is correlated to an individual's spirituality/religion (Coleman, 2004:457). HIV/AIDS poses a challenge to a person on many levels: physically, socially, spiritually and psychologically. It threatens a person's sense of meaning and purpose in life (Joshi and Kumari, 2009:46; Tuck et al, 2001:777-778). This is because HIV/AIDS is a condition that is linked to a multitude of stressors that impact on the person's quality of life and their ability to cope (Tuck et al, 2001:777; Dalmida, 2006:185-186).

People affected by HIV/AIDS are often thrown into an existential crisis as they are confronted with a variety of issues including: "hope, death, grief, meaning/purpose and loss" (Cotton, et al, 2006:5). They also report feelings of being violated, alienated, hopeless, lonely, angry, guilty and shameful (Cotton et al, 2004; Joshi and Kumari, 2009:46). As a result of this, they search for guidance as they explore the meaning in their lives, in the attempt to find a new purpose and meaning. Research has found links between psychological stressors and the trajectory of the progression of HIV/AIDS (Tuck et al, 2001:777).

For some it becomes a turning point in their lives, or a moment of profound change or positive transformation in their personal beliefs, attitudes and behaviours (Kremer, Ironson and Kaplan, 2009:368). They were able to find a much deeper meaning in life and death, as well as an increased sense of hope, due to spirituality/religion.

However, for some people with HIV/AIDS, spirituality/religion has been undermining their well-being as, often, HIV/AIDS is linked to sinfulness and stigma (Ridge et al, 2008:426;

Cotton et al, 2004). Despite this, people have been found to retain their personal spiritual/religious beliefs (Cotton et al, 2004). They often seek transcendence or deeper understanding of the existential questions and feelings that arise due to HIV/AIDS (Cotton et al, 2006b:14). In a study by Cotton et al (2006b:18-19), more than two fifths of the participants stated that their levels of spirituality had increased. This increase in spirituality/religiosity has also been found by the WHO QOL HIV Group (2003). While in total, half of the participants were found to believe that spirituality/religion had assisted them in living longer (WHO QOL HIV Group, 2003). This highlights how spirituality/religion plays a vital role in improving the quality of life for people with HIV/AIDS (Joshi and Kumari, 2009:52; Cotton et al, 2006b:18-19; Frame et al, 2005:8), as research has shown that quality of life is severely impacted by HIV/AIDS (Tsevat et al, 2009:931-932; Phaladze et al, 2005:121).

Research has shown that people with HIV/AIDS use spirituality/religion as a means of coping, which allows them to reframe their lives and develop an improved sense of an increased quality of life (Cotton et al, 2006:5). Some of the spiritual/coping methods used by people with HIV/AIDS include, "spiritual transformation; belief in a higher power; prayer; belief in miracles; and collaboration between themselves and God/higher power" (Cotton et al, 2004:1203). This is because spirituality/religion is able to play a significant role in providing a new context for finding meaning in their lives (Cotton et al, 2004; Joshi and Kumari, 2009:52). A person's faith thus becomes an important coping resource, unless they believe that their future is totally in their higher power's hands, which makes it become a detrimental coping mechanism because of a possible sense of helplessness that may be induced (Cotton et al, 2006b:17-19).

Dalmida (2006:187) refers to Relf's idea that, in order for HIV-infected people to achieve a greater sense of holistic well-being, they need to explore the significance and meaning of HIV/AIDS in their lives, with respect to hope, faith, spirituality, purpose and meaning. Dalmida expresses the need for this as spirituality provides a resource for coping with HIV/AIDS and psychological distress. It is also used to reframe and aid in developing meaning and purpose (Cotton et al, 2006:5) and "stimulating psychological and spiritual growth (Joshi and Kumari, 2009:47). The tendency for people with chronic illness or even facing death and disability, to use religion or spirituality is much higher (Siegel and Schrimshaw, 2002:91). Dalmida's research is corroborated by other researchers in stating that

spirituality has been found to improve quality of life and psychological well-being (Dalmida, 2006:185-187; Siegel and Schrimshaw, 2002:99-101; Tate et al; 2006:243). This is often linked with the concept that spirituality/religion provides a framework to develop a sense of meaning and purpose (Coleman, 2003:462). It incorporates the understanding of spirituality to encompass the belief that an individual is on a journey and discovering the true essence of self (Tuck and Thinganjana, 2007:159).

In some studies, participants found that after contracting HIV/AIDS, they have become more spiritual. This is thought to be related to the raising of existential issues due to contracting the illness, which can be approached and understood through religious and spiritual means. (Cotton et al, 2006:5-6). Other research has suggested that, among peoples affected by HIV, there are three major themes of spirituality/religion:

- "The emergence of new spiritual meanings
- Incorporating illness into their self-concept of spiritual being
- A spiritual understanding of life" (Somlai and Heckman, 2000:58)

These themes are incorporated in the main spiritual/religious coping methods that have been identified among people with HIV/AIDS, which are:

- Spiritual transformation
- Belief in a higher power
- Miracles through a collaboration with a higher power and prayer
- Prayer

It is by using these positive resources for coping that people with HIV/AIDS are able to find hope, a sense of meaning and inner peace while developing the strength to deal with life (Joshi and Kumari, 2009:46-47). Other research concurs that for people living with HIV/AIDS, spirituality/religion is able to promote positive psychological states that improve health (Ironson et al, 2002:45-47).

Siegel and Schrimshaw (2002:94-99) noted that people living with HIV/AIDS believe that spirituality/religion was able to help them deal with their illness by promoting:

- Feelings of comfort
- Strength and a sense of control and empowerment
- A reduction in the emotional burden of HIV/AIDS
- A sense of belonging and social support
- The development of a personal relationship with God that offers spiritual support
- Acceptance and the facilitation of meaning of HIV/AIDS in their lives
- The preservation of health
- A relief from the usual fear and uncertainty around death
- Self-acceptance and a reduction in self-blame

For some people with HIV/AIDS however, spirituality/religion has had a negative impact through feelings of alienation, due to the stigma and the association of HIV/AIDS to "homosexuality, sexual promiscuity, and injection drug use" (Cotton et al, 2006b:19).

6.3.3. MSM and Spirituality/Religion

> *"Hate has no place in the House of God. No one should be excluded from our love, our compassion or our concern because of race or gender, faith or ethnicity or because of their sexual orientation." Desmond Tutu*

Historically, the relationship between MSM and spirituality/religion is a rich one. In the Christian tradition, this relationship has shifted with the change in the majority view towards MSM and the principle of celibacy (Nelson and Longfellow, 1994). In present times, due to the predominance of negative views towards MSM among most Western spiritual/religions, many MSM leave these institutions to find more affirming spiritual/religious paths. Yet other studies have shown that it is not only the personal spiritual/religious beliefs that impact on the person, but also the spiritual/religious culture of the country in which they live (Adamczyk and Pitt, 2009:339-340).

Within the empirical research of chapter 5, this was confirmed by MSM within Cape Town, who indicated the need to separate religion from spirituality, as a result of negative messaging and the resultant negative experiences of stigmatization from religious institutions

and society in general. This resulted in the MSM interviewed all having meanings of stigmatization and for some even fear.

The stance of some belief systems promote the concept of "love the sinner, hate the sin", which only results in MSM being ignored or having their partners/relationships rejected, thus isolating them within their own faith community. This impacts their spiritual/religious development and their participation in a non-affirming faith community can result in levels of increased internalized homonegativity (this is defined as negative attitudes to one's own homosexuality), causing poorer psychological health and lower self-regard.

Yet some MSM are able to move beyond this conflict between their belief and religious standpoint versus their sexuality, though the process is a very stressful developmental time for the individual. It is these individuals who have reconciled their identities who develop a strong relationship with their higher power and are able to differentiate between religion and spirituality (Heermann, Wiggins & Rutter, 2007:714). Many of these MSM, because of the hostility directed towards them, have tended to define themselves more in terms of spirituality, which includes the realm of finding the meaning in life, than religiosity (Ridge et al, 2008:414). This was seen with 4 of the 5 interviewees in the empirical research, that indicated that their level of spirituality/religion increased, and that they had a greater sense of connectivity with themselves and others. And that spirituality/religion promoted a sense of meaning and purpose in their lives, where they had a greater appreciation for life.

Often though, MSM experience their spiritual/religious identity and sexual identity as dichotomous due to the bias and homonegative messaging. This results in them being forced to choose one identity over the other, which is an outcome that is never healthy for the individual. In most cases, MSM opt for identification with their sexual identity over their spiritual/religious identity. However, reconciliation between these two identities is possible and, once achieved provides a deep level of self-awareness, that allows individuals to draw on their spirituality/religion as an added resource (Heerman, Wiggins and Rutter, 2007:714-715). This could be seen by the 2 interviewees within the empirical research that were able to develop High Meaning and had a greater sense of spirituality/religion within their lives. While another two interviews, though they had not developed a high meaning, they had found spirituality/religion as important to meaning development.

When it comes to HIV among MSM and research into spirituality/religion, Siegel and Schrimshaw (2002:100) showed that, despite exclusion from most organized religion, MSM do use spiritual/religious methods for coping. This was confirmed in chapter 5 of this research thesis, which showed that 4 out of 5 interviewees embraced and experienced an increase in their level of spirituality in the face of HIV/AIDS.

6.3.4. MSM, HIV and Spirituality/Religion

When it comes to MSM, HIV/AIDS and spirituality/religion, no research and/or discussion can be carried out if no consideration is made of the various issues that influence and impact upon the interpretations and meanings (Reddy and Sandfort , 2009:413) developed by MSM . So, with HIV/AIDS affecting the self-perceptions of MSM (Sollis, 2003:150), it becomes crucial to understand the interplay between spirituality/religion and HIV on MSM.

In a project run by Lubensky, Bradford and Bland (2008:1) for MSM living with HIV/AIDS, patients reported that spirituality/religion provided tools and resources that enabled them to cope with a variety of challenges in life (Miller, 2005:40-41), as is concurred within the empirical research carried out within this research project. Many MSM relate that their spiritual/religious beliefs emerged only after their HIV/AIDS diagnosis (Sollis, 2003:155).

However, some MSM who have been brought up within intolerant spiritual/religious traditions often internalize the homonegative biased messages, resulting in a number of adverse impacts on psychological health (Jeffries, Dodge and Sandfort, 2008). Often these messages are expressed by the leaders in authority at places of worship, which are supported by a culture that is normatively heterosexist. This results in a lack of acceptance of MSM by their friends and family (Miller, 2005:34-35). Among the MSM in Cape Town interviewed, this was highlighted by the important emphasis that they made in the need to separate religion and spirituality, because for them religion was synonymous to Christianity.

These messages are also reiterated by many cultures and communities in many countries throughout the world, where spiritual/religious beliefs strongly influence people's attitudes about MSM (Adamczyk and Pitt, 2009:339). The homenegative messaging often goes so far as to link HIV/AIDS and AIDS deaths to the consequences of sexual perversion (Sollis, 2003:159). These homonegative messages when internalized have also been proposed to be linked with high risk sexual behaviours among MSM. It is because of the encountered

condemnation that many MSM rely more on a personal relationship and understanding with God/Higher power, than with any specific spiritual/religious institutions, as a resource for coping with HIV/AIDS (Jeffries, Dodge and Sandfort, 2008; Miller, 2005:40-41). For others, this internalization may affect their self-perceptions and ability to formulate a spirituality/religion that may be a positive resource in aiding them to confront challenges (Miller, 2005:40-41). This makes it imperative that spiritual/religious approaches to MSM are affirming (Jeffries, Dodge and Sandfort, 2008).

This is important when considering such attitudes and experiences of Cape Town MSM, like David Patient, who expressed the following within an article in the OUT Magazine (2011:17).

"Then the religious right jumped on the band wagon and HIV messaging became morality based. And while many religious organisations are doing remarkable work in HIV, many are not."

Spirituality/religion provides people with the opportunity to confront their ability to control the consequences of significant threats in their life, such as HIV/AIDS. It is able to do this through the hope of divine intervention and a belief in a just world. MSM used spirituality/religion to adjust to HIV/AIDS through the use of coping methods (Siegel and Schrimshaw, 2002:99-101). MSM living with HIV/AIDS actively use these and other spiritual/religious coping methods, more so than HIV-negative MSM, to deal with HIV/AIDS and other life challenges (Hampton, Halkitis and Mattis, 2010:417), as found among the sample of MSM in Cape Town within chapter five .

Sollis (2003:159) points out that spiritual/religious institutions are able to learn from MSM with HIV/AIDS to gain an understanding of hope and appreciation of life in the face of death. When looking at the complex interplay between HIV, MSM and spirituality/religion, healthcare professionals would benefit from understanding the resilience that MSM show in developing a reconciled co-existence between their spiritual/religious and sexual identities (Heerman, Wiggins and Rutter, 2007:717-719).

6.3.5. The Challenge of MSM: Towards a Theology of Inclusive Caring

> *"Gay, lesbian, bisexual and transgendered people are part of so many families. They are part of the human family. They are part of God's family. And of course they are part of the African family."*
> *Archbishop Desmond Tutu in March 2010*

For the development of wholeness and healing, it is important that spiritual healing address the internalization of stigmatization and the altered self-perceptions that MSM have developed as a result of living within a heterosexist society in South Africa, as highlighted by the empirical research that showed negative meanings of stigmatization and fear being linked to HIV/AIDS.

This can only be done if the healing approach is affirming and promotes dignity, meaning and a sense of purpose. If it is to embrace the complexity and the interplay of HIV/AIDS, MSM and spirituality/religion, the healing approach needs to be able to promote spirituality/religion as a positive coping resource and internal strength, as within the MSM interviewed in this research, the majority used spirituality/religion as a coping resource. Making it imperative that the healing approach be spiritually based that is affirming.

As spirituality/religion provides people with the opportunity to confront their ability to control the consequences of significant threats in their life, such as HIV/AIDS. It is able to do this through the hope of divine intervention and a belief in a just world (Siegel and Schrimshaw, 2002:99-101).

Pastoral care and counselling, as a healing approach, is able to do this through the framework of affirmation theology. A theology of affirmation refers to the ontic state of being. In other words it refers to the very fact that human beings are affirmed in their being functions by eschatology. In order to live as new beings in Christ, means that human beings are strengthened by the charisma (fruit) of the Spirit, so that they may live life in courage, with a vivid sense of hope (Louw, 2009:12). It is therefore about the "constitution of the human identity in terms of ontology of salvation (the corporate reality of our new being in Christ) and our transformed status as children of God" (Louw, 2009:10). Thus human beings exist with spiritual fortigenesis and fortology due to their new state of being in Christ and the

indwelling presence of the Spirit (Dong Chan, 2009:189), with their being functions being linked to the concept of "soulfulness," which describes the quality of soul or the "aesthetics of the human soul" (Don Chan, 2009:190).

Theology of affirmation describes the status of human beings in terms of eschatology. With eschatology being understood as an ontological category that defines being human in terms of the biblical events of the cross and the resurrection. Affirmation theology is therefore able to describe ascribe dignity to all as it emanates from the ontological Yes in Christ to being human, which is "demonstrated in new patterns of pneumatic living (pneumatology and inhabitational theology)" (Louw, 2009:11).

A theology of affirmation thus turns to theology of the cross (theologia cruces) which points to the cross as a protest or lament of God against "woundedness, weakness, disfigurement, ailment, vulnerability, marginalization and stigmatization" (Louw, 2009:6), and moves beyond it, as a theology of affirmation entails more than the cross and suffering. It transcends it by also embracing the theology of resurrection (theologia resurrectionis) which affirms the faithfulness and fulfillment of God's promises through the resurrection of Christ. This allows affirmation theology to be about the "establishment, maintenance, transformation and transfiguration of life and hope." (Louw, 2009:6). In other words, human beings are able to perceive and celebrate God's promises to them (Cilliers, 2009:5) and that he is present with them at all times in compassion and love, lamenting along with them in protest against all forms of suffering (Cilliers, 2009b:11).

The theology of affirmation as an approach to theory and the practice of pastoral care to MSM does not intend to moralise or step into the theological ethical debates, but rather stay within the realm of aesthetics (quality of life or ethos). It is through the theological understanding of affirmation theology which affirms all human beings as new creations, with whom God stands in protestation against all forms of suffering, and the practice of pastoral care that is derived there from, that assists in preventing moralization and ethical debate. It is about bringing hope and declaring God's faithfulness and fulfillment of his promises and his very inhabitation through the Spirit within all people. Affirmation theology is thus able to address the lived experiences of all human beings and how God is related to these (Dong Chan, 2009:182). It allows for the ability to overcome the distance experienced by human beings in everyday life as compared to what it is meant to be (Louw, 2010:74). An example

of God's love in action is given as guidance by the Gospel of John 13:34 where Jesus expresses:

> "A new commandment I give unto you: love one another. As I have loved you, so that you must love one another. By this all men will know that you are my disciples, if you love one another."

This is the primary commandment of the Word, and there can be no other ethic for a Christian, but love (Kirkpatrick, 1988). Pastoral care then becomes about the practice of this ethic, and the influence of theory on praxis and praxis on theory. It is therefore important to understand the influence of practical theology, as the practice of pastoral theology through the actions of pastoral care.

It is about bringing the Gospel of unconditional love to humanity. It is the expression of the Word through action. The Word of God is thus understood and experienced through the action of the pastoral caregiver. Bringing closeness and the salvific action of Christ in the resurrection, creating a new creation in man and re-establishing a covenantal relationship with humanity, that emphasises the indwelling presence of Christ in each person. (Louw, 1998; Louw, 2008).

These sentiments are concurred by Frankl (1959:36) when he said: "The truth- that love is the ultimate and the highest goal to which man can aspire. Then I grasped the greatest secret that human poetry and human thought and belief have to impart: the salvation of man is through love and in love."

As practitioners of pastoral care, we need to be faithful in ensuring that we continue that pastorship of Jesus that embraced all, for pastoral practioners are ordained to humanise the embrace of God's love to all his people (Kirkpatrick, 1988). "This is the work of God in Christ and Christ in us. It is also the work of love's compassionate endeavouring towards all" (Kirkpatrick, 1988: 36). In practicing pastoral care in carrying out Jesus' pastorship, we acknowledge the Gospel of Mathew 18:20 where it says:

> "Where two or more are gathered in my name…I, Jesus, am present and my name is Love."

Pastoral care acknowledges this ministry of love above all else (Kirkpatrick, 1988). The human being is vulnerable and exposed to suffering, which "tests the quality of life within the essence of a person's being. Whether one succeeds depends upon whether one has an address to which to take one's need. This address could become the living and suffering God" (Louw, 2008:12).

Pastoral care acknowledges that every person is unique, and that they have to rely on their own resources. When these are taxed to the point of utter loneliness, the person begins the search for meaning and God (Louw, 2008). During this searching process, all people need a sense of genuine authentication that gives them a sense of being valued. This is the role of the carer. In caring for all people, there is no need for justification. However, justification is needed when there is lack of compassionate caring. It is this compassionate caring that demands the total presence of the pastoral practioners within the all-embracing unconditional love, acceptance and hope, which is nurtured by God's expression of love through Christ and Christ in each of us (Kirkpatrick, 1988). Pastoral care allows for the mutual experience and knowing that:

> "God loves us, as love loving us
> God embraces us, as love embracing us
> God reaches out to us, as love reaching out to us
> Through the frailties that are our common bond"
> (Kirkpatrick, 1988:37).

6.3.6. Pastoral care to MSM

When turning to the MSM debate and the "'definite references' (Leviticus 18:22, 20:13; Romans 1:26; 1 Corinthians 6:9; 1 Timothy 1:9, 10)…one issue to be decided is whether the authority of the Bible resides in the quotation of texts or whether texts should be interpreted within contexts in terms of sound exegetical analyses and interpretations" (Louw, 2008:374-375).

Louw (2008) proposes that the present theological paradigms need to move the homosexual and MSM debate "beyond the 'isms'" (Louw, 2008: 15). For this to occur, he expresses the need to turn to a theology of human affirmation, as he believes the task of theology is to

instill hope that engenders a sense of meaning and significance in life that keeps humans going. This can only be done through a theology of affirmation, that is framed within an eschatological approach to life and humanity's quest for meaning. This results in eschatology being related to ontology (i.e. the ontological state of a persons' being in Christ) and prevents pastoral theology ending up within the realm of moral pronouncements and legalistic interpretations to the requirements for human behaviour in life (Louw, 2008).

Human sexuality is a valuable and deeply spiritual encounter between human beings, as it is a spiritual space that enriches and fosters meaning (Louw, 2008). In exploring human sexuality, be it heterosexual, bisexual, homosexual etc. Louw (2008) states that it is a deeply-seated human drive that is an expression of human and gender identity, as a consequence of personal and existential needs. "It also represents the will to communion (the sensuous, erotic power to human fulfillment in bodily communion) and the quest for intimacy (developing intimacy with a partner is a lifelong process oscillating between the reality of fulfillment and disappointment) expressed by sexual love." (Louw, 2008: 353).

It is this understanding - that sexuality is sacramental - that emphasizes that homosexuality and the practices of MSM are a viable spiritual option. For it is the status in Christ (ontic identity) that is fundamental, rather than the sexual orientation. "In terms of re-creation (salvation; the indicative of the eschatological paradigm) the homosexual person must accept his/her position in Christ (the ontic yes to our being…and to realise the central purpose of human sexuality: responsible intimacy and sacrificial love (unconditional love)" (Louw, 2008:378-379).

6.4. Findings

This research paper set out to discover whether a Christian Spiritual perspective on basic threatening existential issues, such as HIV/AIDS Stigma, Homophobia, etc. can help MSM to reformulate the quest for meaning and be integrated in a holistic approach to spiritual healing in order to overcome the schism in HIV/AIDS: Friend or Foe?

Hypothesising that by using spiritual and religious resources, people with HIV/AIDS should be able to develop a new way of making meaning of events and how they react to them. That they should be able to make a transition from the view of a God/Higher Power that is judgmental to that of a loving God/Higher Power; one that is possibly a friend or partner for life, an important positive impact on coping and living with HIV/AIDS (Koss-Chiono, 2006:15-1).

Pointing out that for MSM, the development of God-images usually occurs during the process of growth and maturation as an individual, where a multitude of experiences are based primarily through the filter of belonging to a minority, which are seen predominantly from society as being sinful. The possible multitude of traumatic and often fearful life experiences, including the potentially highly stressful and difficult process of informing their parents and families of their sexuality, may influence their emotional experience and ultimately their God-image. The God-image of parental love, acceptance and caring may be impacted on by fear of rejection and the lack of acceptance. The development of ambivalence may strongly impact on MSM God-images, resulting in conflicted experiences and understanding of God, where the God-image could become distant and judgmental (Hoffman, 2009:15-18).

In order to understand this problem and determine the validity of this hypothesis in response to it, it was proposed that it was necessary to engage with the following questions:

1. In the case of the human quest for meaning, what is unique to this question within the realm of MSM?

Within the human quest for meaning, the unique question within the realm of MSM is that spirituality/religion has always had a powerful influence on a variety of spheres within the human context, especially on a variety of aspects of the private life spheres of

individuals, one of the most important being sexuality. With spirituality/religion and its variety of doctrines informing society's social norms with respect to what is considered acceptable and unacceptable sexual intimacy.

The understanding of the broader context of faith within the lives of MSM has been one of predominant silence and a resultant scarcity of information. This has resulted in little being known about how MSM conceptualise or frame spirituality/religion within their lives (Halkitis et al, 2009:251), and the impact this has on their identity formation, meaning-making processes and purpose in their lives

This research has shown that with church doctrine and ecclesiology playing such an important role within society and South Africa's past, it has had a major impact on how MSM embrace spirituality/religion as a coping resource in the face of HIV/AIDS, where separation between religion (perceived as doctrine) and spirituality (connection to a Higher Power) is developed, in order for MSM to embrace spirituality. By doing this they are able create the meaning and purpose that the majority of people experience. This was discovered and confirmed in the empirical research in chapter 5.

Schwartzberg (1993: 488) stated within his research into the question of the meaning within the face of HIV/AIDS by MSM, that MSM place a fundamental importance to creating meaning in order to cope with dealing with HIV/AIDS, with many gaining some special benefit from HIV-positive. He went on to describe that ascribing meaning to illness is a basic human undertaking, and the ascribed meaning may be powerfully influenced by cultural and personal factors, which in the case of MSM are often unique. This statement by Schwartzberg was corroborated within the empirical research carried out in chapter 5, that pointed to MSM in Cape Town, developing meaning and developing a sense of purpose and appreciation of life, that promoted a sense of control in their lives. This was achieved through an elevated sense of spirituality.

2. What are the characteristics of MSM with regards to the meaning question?

Schwartzberg (1993:486-489) identified four overall frameworks for ascribing meaning when researching HIV-positive MSM. These are: high meaning, defensive meaning, shattering meaning and irrelevant meaning. These four categories he expressed could be

beneficial in assisting the understanding of the style and success of an individual to negotiate creating meaning within the face of a crisis, such as HIV/AIDS.

MSM in Cape Town were found to embrace high meaning and a defensive meaning equally. Where better integration with high meaning, being among those who used spirituality/religion and indicated less negative meanings than those who use defensive meanings. The predominant meaning in both of these was that HIV/AIDS was seen as a catalyst of growth. However those who used defensive meaning development, were only able to integrate this superficially as a result of greater levels of negative meanings of stigmatization and fear with regards to HIV/AIDS.

Highlighting the need to address a variety of social and environmental factors, the predominant one being heterosexism. By approaching these, we are better able to promote integration and healing within MSM. As shown in this research healing and holistic integration can be approached through integrating the identity using a psycho-spiritual identity viewpoint that allows the ego to transcend and thus develop a far greater depth of resources.

3. How is this question related to the existential context of MSM and what are the unique spiritual needs of MSM?

When looking at the existential context of MSM, it is important to take note of the outcomes of social ridicule that is directed at them. Some of the possible outcomes are pervasive feelings of shame, unworthiness, self-debasement, intense need to atone (Carbone, 2008: 305), self-revulsion and hostility (Ross et al, 2008:548). With the use of religion/spiritual to legitimize this social ridicule, marginalization and stigmatization of MSM throughout history, making same sex intimacy sinful, it becomes important to realize that this group of people still persist with their faith and harness these beliefs to negotiate challenges such as HIV/AIDS. This highlights the fact that MSM, as a marginalized people, need to be able to break through society's barriers in order to achieve transcendent relationships with other people and with God (Halkitis et al, 2009:261).

These existential states are corroborated within this thesis, showing that disconnection, separation, isolation, internalized homophobia, anger, guilt, shame, anxiety, depression and anger are present among MSM within South Africa, and that it is spirituality/religion as part of their process of meaning-making, that is able to breach these, and assist in developing self-awareness, acceptance, understanding and a sense of connecting, purpose and a renewed appreciation of life, as empirically discovered among the MSM interviewees in Cape Town.

4. In order to establish a holistic approach to the spiritual healing of MSM, what is meant by healing and becoming whole in the case of MSM?

In the case of healing and becoming whole within MSM, the establishment of a holistic approach to spiritual healing needs to be cognizant of the interplay between theology and psychology and the strengths perspective. Widespread scientific literature and historical accounts of gay culture indicated that there is evidence for strength and resilience within MSM, which was corroborated in this research. By moving towards interventions that do not focus on the deficits of MSM, but rather on their strengths in order to address the deficits (Herrick et al, 2011:3), we will be better able to design pastoral care interventions to MSM.

These interventions have been proposed to use the framework of affirmation theology within pastoral care and counselling, which understands the quality of being functions of the person, and that caring for the soul of MSM, is about caring for the person as a whole being.

5. How is the human quest for meaning experienced, viewed and formulated by HIV-positive MSM?

   Within South Africa, statistics show that there is approximately 5.5 million people living with HIV/AIDS in the general population. However the risk of acquiring HIV among MSM is far higher. It is because of this disproportionate impact on MSM that it becomes necessary to focus research into this community (Rispel and Metcalf, 2009:133-134). The challenges faced by MSM in the face of HIV needs to be understood.

These challenges were those of a life of growing up in a predominantly heterosexist society, and the resultant traumas of being marginalized for being who you are. It is the interplay of lifelong trauma, its impact on identity and dignity, and the ability to assess the daily experiences of life in a way that promotes a state of flourishing that affects the experience of MSM when they are diagnosed or living with HIV/AIDS.

By embracing self-acceptance and spirituality/religion, MSM in Cape Town have shown that HIV/AIDS has the possibility of meaning growth and transcendence and a greater level of spirituality.

As well as the research questions as proposed by Schwartzberg (1993:483):

6. "What are the strategies HIV-positive gay men have developed to maintain or reconstitute the belief in a meaningful world? "

MSM in South Africa have often embraced their sexual identity over their spiritual identity, creating a sense of separation and disconnection. However by embracing spirituality, they found that they were able to create a sense of connectivity with themselves and others, and were able to create meaning and purpose in their lives, even in the face of HIV/AIDS. The best way to achieve this was by using the strategy of High Meaning, where HIV/AIDS was interpreted as an opportunity for self-growth, involving the acceptance of self and others, as well as forgiveness.

7. "How has AIDS affected beliefs about such issues as fate, religion, death, the meaning or purpose of life, and the degree to which people control their own destiny?" (Schwartzberg (1993:483):

MSM in Cape Town indicated a lessening fear of death and dying, and a better understanding and renewed belief and vigour in life. With a belief that there is a reason for having HIV/AIDS and that it was a catalyst for growth and a strengthening and development of a deeper sense of spirituality, meaning and purpose.

In attempting to understand these questions further, the research that has been done in this field, shows that people with HIV/AIDS often approach the existential issues that arise by a re-examination of their spirituality and religiousness. This makes spirituality and religion an important resource to tap into, to assist in coping with the illness and its impact on their lives, even among MSM who experience judgment, discrimination and exclusion from society in general and especially among religious institutions (Pargament et al, 2004:1204).

Within this research the stage was set for exploring the world's worst global challenge within the health sector, and how it relates to the South African context for MSM. The research uncovered that MSM face the greatest challenge and burden of HIV/AIDS in many countries, however little research has focused on MSM and HIV/AIDS in South Africa. Literature links this to the fact that throughout Africa, the predominant view of same sex relationships as being un-African, sinful and an abomination.

This predominant heterosexist viewpoint is a daily experience of MSM who are impacted upon by the trauma of existing as a minority in the South African society, a society which has had a history of oppression of minority groups. It is within this context of minority existence that MSM have to negotiate the fear of contracting HIV/AIDS and often the traumatic event of being diagnosed with the life threatening illness.

This results in the reframing of identity and the temporal reframing of their lives, with resultant changes in values, spirituality and life priorities. Along with this are the changes in meaning as life experiences, and the experience of being HIV-positive, impact upon the search for meaning. A process explained within the psychological field of fortigenesis. Fortigenesis expands the understanding of the human capacity to improve psychological well-being, an important psychological perspective that creates a better understanding of the development of resilience within MSM in the context of living in South Africa and their vulnerability to HIV/AIDS.

It is this strengths perspective that bridges the psychological well-being of MSM to their theological state of being, as described within affirmation theology, as their "courage to be," meaning that it bridges psychological well-being of the person, to the person's existential and ontological state of being.

It is this link that necessitated the exploration into the interplay between spirituality/religion, HIV/AIDS and MSM in order to uncover the meaning that MSM make in the face of HIV/AIDS, so better to provide better pastoral care interventions to this community within Cape Town, South Africa.

Approaching an understanding that Pastoral care to MSM is about the bringing of the Gospel of unconditional love and compassionate endeavour towards all of humanity. It is about the expression of the Word and the bringing of God to an encounter through human action. God's Word, love, fulfilled promises and grace are thus experienced through the actions of a pastoral caregiver. This means that pastoral care acknowledges that the ministry of love is paramount.

Within this understanding and approach to caring for humanity, including MSM, theological paradigms need to be rethought, so as to move the debates around MSM and homosexuality beyond the "isms" and to recognise that human sexuality is a valuable and deeply spiritual sacramental encounter between human beings. Through this understanding it becomes inherent that pastoral care acknowledges that the practices of MSM are spiritually viable (Louw, 2008).

This understanding and approach allows pastoral care to become about the mediation of God's love, grace and faithfulness to all, and moves it beyond any specific methods, techniques and skills.

The theological approach that is used to frame this approach is that of affirmation theology, which focus on the ontology of salvation, through the cross and resurrection, which results in a re-creation of the human body through God's enfleshment and embodiment through Christ (Louw, 2008).

This allows for pastoral care to embrace humanity through love and to transcend the mere use of interdisciplinary skills and techniques, ensuring it works within the realm of faith and spirituality. By incorporating psycho-pastoral models within affirmation theology, it allows for pastoral counselling to explore, more fully, the existential issues of MSM, relating to HIV/AIDS.

It is these existential issues (separation, fear, isolation, anger, depression, guilt and shame) and ontological states of being of MSM, as they relate to HIV/AIDS that are bridged by the psychological and spiritual framework of fortigenesis. Thus by developing an understanding of psychological and spiritual fortigenesis, exploration of the interplay between and psychology can give an understanding of the internal strengths present within MSM.

It is these internal strengths of MSM that are important to understand in order to properly address the main drivers of the HIV/AIDS epidemic in South Africa. The main drivers being sexual behaviour's that expose MSM to the risk of infection. It is because of this that a "solution" to prevention care should encompass a reframing of existing paradigms on sexuality. This would allow for the ability to work within the entangled realm of identity and sexuality with MSM in Cape Town, who have been found within the empirical research of this project, to embrace spirituality/religion as a coping resource in the face of HIV/AIDS that promotes meaning and purpose in their lives. Promoting new understandings that allow for a minimization of MSM vulnerability to HIV/AIDS, as the ability to promote internal resilience and fortigenesis and spiritual well-being, would alleviate MSM from the variety of factors that promote this vulnerabiltity, such as:

- Legislation that is discriminatory
- Health policies that do not target MSM
- Lack of government support
- Cultural norms that are heterosexist
- Limited and restricted access to sexual health services

An approach of healing and care using affirmation theology would alleviate MSM from experiencing discrimination, heterosexism and homophobia from society and especially from religious institutions that impact on their identities negatively (Miller, 2005:35-36; Seegers, 2007). This is why traditionally few MSM turn to religion and spirituality to assist in coping with their illness or other difficulties in their lives. Research, however, has found that religion/ spirituality is often of assistance to MSM to find meaning in their illness. Such practices as prayer have even been found to lower depression levels in HIV positive people (Schwartzberg, 1993:488-489).

Prayer allows the person to feel connected, something that is important within research in promoting well-being. Well-being that can only be achieved through a framework that promotes self-realization and transcendence, where positive self-regard becomes an indicator of an integrated sense of identity (sexual, spiritual etc.), which is important when looking at such things as traumatic events and the daily stress MSM experience in a heterosexist society.

Part of MSMs self-schema's involve their religious/spiritual identity along with their sexual identity, however as the research highlighted, that sexual identity takes precedence to spiritual identity due to heterosexist frameworks that separate MSM from being able to fully embrace religion/spirituality. This leaves MSM prone to not developing fully integrated identities and experiencing wholeness, thus leaving them prone to low self-esteem/self-regard and experiencing greater distress in the face of life experiences and stressors (Ulrich et al, 2004:183; Horowitz et al., 1996:382-385).

By addressing an affirmative framework when approaching MSM, prevention strategies for MSM are better able to not only address those MSM who do turn to spirituality/religion to assist them in dealing with life stressors (Heermann,Wiggins and Rutter, 2007:711-719), especially as spirituality has been found to be a possible resource in the case where coping mechanisms are exhausted (Dalmida, 2006:185-186). This is important because the MSM are better able to develop an integrated identity that results in an ego being able to draw on a greater capacity of internal resources to perform effectively. This identity needs to be an identity that is routed with a psycho-spiritual understanding of identity that is routed in grace (Louw, 2012:72), as continued identification of MSM with the social constructs of identity and HIV/AIDS results in continued sense of separation and stigmatisation.

By turning to a framework that uses a theology of affirmation, prevention strategies are able to address the disintegrated sense of identity and isolation experienced by HIV-positive MSM, by engendering and instilling hope that brings about a sense of meaning and significance that can aid MSM in continuing to keep living (Louw, 2008: 15). This framework also allows them to be approached in a manner that does not reinforce the social heterosexist constructs that promote stigmatization and separation. This means that within pastoral care and counselling, affirmation theology would allow for MSM in the face of HIV/AIDS to transcend the schemata of HIV/AIDS as a Friend of Foe, and identify

themselves by their position and identity within their position with God, something that can only be achieved through identification with a God-image of God as a Friend or Partner for life.

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Appendices

Appendix 1

Interview Transcripts and Analyses

Interview 1

Line No	Dialogue	Natural Meaning Units
1	I: Today is the 14th of August 2011 and I am doing my	
2	interview with participant 1. I have got a couple of	
3	questions which I have broken them down into different	
4	questions, informal. They call it a semi structured interview	
5	so that I have a couple of questions so that I can then ask	
6	questions off what you talk about.	
7	I: Could you tell me a bit about your process of coming	
8	out?	
9	P1: My process in coming out in gay life?	
10	I: Yes. When you first knew you were gay?	Always known was gay
11	P1: That is quite simple, I have known all my life I was gay,	Came out at 30
12	but I never came out until I was 30 years old. And then it	In closet due to time period
13	was still very much in the closet because of the time and	Apartheid
14	the period we were living in, in this country which was in	Victorian styled family/father
15	the apartheid era. Also because I had family and father	Father unapproachable
16	who was very Victorian, I was never able to discuss	Double life
17	anything with him, so I basically lived a double-life. But I	Came out at 30
18	only came out at around the age of 29 or 30 when I had my	First homosexual sexual
19	first sexual experience with a male, with another man.	encounter
20	I: When you say you knew all your life, did you know from	
21	young?	Knew was different, but not
22	P1: No, I just couldn't name it. I just knew I was different. I	how
23	understood that I was different. I couldn't name it. I didn't	Couldn't name difference
24	play with dolls, but I did prefer to be in the kitchen. You	Not into girl things
25	know what I mean? When you had the father that I had	Father wanted a real boy
26	who wanted me to be a real boy and everything else, which	
27	I didn't like. And as a result we never got on.	Father son relationship strained
28	I: what changed that helped you to put a finger on it?	
29	P1: I'll tell you what changed my whole attitude. When I	Attitude to gay changed due to
30	was about 29 I joined a theatrical society and with that,	exposure
31	there were gay people there. I got to know gay people; I	
32	got to know other guys. It was through that, that I actually	Realised being gay was why
33	realized this was the difference.	different
34	I: So it was through exposure you were able to identify…	
35	P1: It was through the exposure that I was able to put it in	Able to label being different
36	a box and say that this is what it is…	
37	I: So you could label it…	
38	P1: Yes I could label it, but before that, I really just didn't	Was naïve and ignorant about
39	know. In fact I was quite ignorant. Very naïve.	being gay
40	I: did knowing what it was make it easier, once you had	
41	named it	
42	P1: It became easier once knowing what it was, but it	Easier after identifying as gay
43	became more difficult as I didn't know how to not actually	Acting out on being gay difficult
44	act it out. That's where the difficulty came in. Living at	Living at home

45	home, I was still doing things at home, so to act it out was	Hiding gay at home hard
46	extremely difficult and there was a lot of guilt.	Guilt
47	I: What was the guilt about?	
48	P1: It was wrong? It was wrong because of my upbringing,	Being gay is wrong
49	although it was never discussed but then on the other	Gay or sex issues never
50	hand sex was never discussed in our family. It was always	discussed at home
51	behind closed doors.	Private issues
52	I: what helped you to make the transition away from	
53	feeling shame and guilt about it and come to some level of	
54	acceptance?	
55	P1:It was difficult, it only happened when I moved out of	Acceptance was difficult
56	home. When I actually went to live on my own. My mother	Began when lived alone
57	was very clever and perceptive. She said to me at that age	Mother aware I was gay
58	when I announced that I was leaving home. She said to me,	
59	“I am so glad you doing this because you can go and live	
60	with your own people”. That was her answer. My father	Father unhappy about me living
61	obviously hated the fact that I wanted to be on my own,	on my own
62	He couldn’t accept it. So with that move from the nest, at	Left home at 29
63	the tender age of 29…You can imagine, it was a big	Moving out was a transition
64	transition.	
65	I: When you made transition to yourself, what helped you	
66	to integrate your new identity as been a person who that is	
67	gay? What assisted you to integrating and accepting it,	
68	once you had moved to be by yourself?	Acceptance was a gradual
69	P1: I think it was just a gradual process, it was a process	process
70	that I had to go through.	
71	I: Can you name any of the processes, or anything along	
72	the processes that you can place where shifts occurred?	Exposure to gay people and
73	P1 : Getting to know people, getting to know other gay	culture
74	people. In my work situation it was not ever spoken about	
75	and when I went to join the airline I was exposed to more	
76	gay people and gay men, that became much easier and also	Outside country made easier
77	because I was out of my own country a lot of the time, I	Integrated into gay community
78	became more integrated within the gay community and	
79	that made it a lot easier.	
80	I: So it was basically meeting people that had accepted it,	
81	new it and lived that lifestyle?	Being accepted for me
82	P1: Accepted me as for who I was.	
83	I: Ok it was through other people accepting you that you	
84	learnt to accept yourself.	Envy out young gay people
85	P1: I envy people who come to me and say they have	
86	known or been involved in gay life since the age of 15 and	Cannot understand
87	16 I cannot understand it	
88	I: Because they knew from much younger?	Came out so late
89	P1: Because for me it took so long	
90	I: Do you think it was purely because of the upbringing, the	
91	era you were in?	Era delayed coming out
92	P1: The era that I was in I came from. In fact I was arrested	Arrested for being gay
93	twice in a gay club in Pretoria. We were all rounded up and	
94	thrown into jail.	
95	I: What was that experience like for you?	Terrible experiences

96	P1: It wasn't nice it was awful, it was terrible; I mean we	
97	used to go a gay club in Pretoria called The Butterfly which	Hide being gay at clubs by
98	was underground in a seedy part of town where we used to	having lesbian partners
99	take a lesbian girlfriend with and if the cops came in we	Snuggle in corner to prove
100	would go snuggle in the corner with the lesbian girl to try	legitimate
101	prove it was legitimate. It was terrible.	
102	I: An era that I don't know about	Many stories of living in
103	P1: It's an era you don't know about and I can tell you	apartheid era
104	many stories, many stories	
105	I: During that time when did the shift occur for you	
106	knowing now that you have moved into the gay arena,	
107	what happened with the relationships with people that you	
108	had? How did things change with respect to relationships	
109	with family, friends?	Never discussed being gay with
110	P1: It never really changed; my relationship with my late	mother
111	mother was always good and she understood but we never	Came out to dad 6 months
112	discussed it. I was asked 6 months before my father died,	before he died
113	he asked me why I never got married and I had to explain it	
114	to him, I never came out to him until that day so I kept it a	Rejected by brothers family
115	secret. My brother and his wife almost sort off didn't want	Children kept from me
116	to have much to do with me, they kept their children away	Pain due to familial separation
117	from me as a result today I don't know those children at all,	Excommunicated self from
118	it was all very difficult. I actually excommunicated myself	family
119	from my family.	
120	I: It still is a painful process of being separated from them?	Familial separation still painful
121	P1: Yes	
122	I: Has your diagnosis of HIV changed anything? Affected it	
123	any further? What?	Family immediately came when
124	P1: No, with me telling them that I was HIV positive they	diagnosed
125	immediately came down to Cape Town, but I was very ill in	Possibly dying in hospital
126	hospital and they didn't think I was going to live, so they	Don't talk about HIV
127	came to see me and.. but we don't talk about it. I am very	Not asked about health
128	seldom asked how are you. If there is anything I have to tell	Speak once a year
129	them I will tell them but we don't talk, we talk about once	
130	a year.	
131	I: So silent topic isn't referred to. And partners thing?	
132	P1: Sorry	
133	I: And with partners? If family is a silent topic - what about	No partner since diagnosis
134	with partners?	
135	P1: Partners that is another story, completely a different	
136	story because I hadn't had a partner since I was diagnosed.	Ex-partner did due to HIV
137	I: Specific reason?	Infected by ex-partner
138	P1: The reason was I do believe that the partner I had has	
139	passed away since from this disease and I do believe he	Faithful to partner and no
140	was the one who infected me, I can't blame. But I do	casual sex
141	believe it was the way it happened because I didn't have	Very few lifetime sex partners
142	anonymous sex, I didn't have casual sex not often and on	
143	my one hand, I can be quite honest with you, on one hand	
144	overall the years that I was gay I was only sexually intimate	
145	with about four people in my life - in that way.	
146		

147	I: So what has made you not move forward after your	Decided no sex as not going to
148	diagnoses and his death? What's made you …	ever risk others
149	P1: Just the day I was diagnosed I decided this is where it	
150	stops with me and it is not going to go any further	
151	I: Then no option for partnering with someone else who	Fear of transmitting to others
152	has it, what is the reason that you do not want to?	
153	P1: Fear	Fear of transmitting to others
154	I: Fear of transmitting to someone else?	
155	P1: Absolutely, 100%	Lost interested in intimacy
156	I: Taking medication not helping to alleviate that fear?	Don't deserve intimacy
157	P1: Still, I lost the interest in intimacy, I just don't feel that I	
158	may deserve it and I just don't want to involve anybody in	
159	my life	
160	I: What makes you feel that you don't deserve to have a	Not fair to burden another
161	relationship?	person with HIV
162	P1: I don't know I just don't feel , I will tell you what it is I	Must carry on own
163	just don't feel that it is fair on anybody else, I don't feel it	
164	fair to basically burden anyone else with this thing, it is	
165	something I have to carry on my own.	
166	I: When you talk about carrying it, what do you mean by	HIV is a burden or cross to bear
167	carrying it? Carrying this!	
168	P1: Maybe it's not the right word, it's a burden, it's a cross	
169	around my neck.	
170	I: So having HIV for you is a burden for you that you caring	Must learn to embrace burden
171	a cross around your neck?	Learn and managed to deal with
172	P1: Right, which I have had to learn to embrace, which I	it
173	have had to learn to deal with, which I have managed and	Daily remind reasons to live
174	with ARV's and whatever that I do take every day I still	
175	have to say to myself in the mornings when I get up there	
176	is a reason for taking these tablets.	
177	I: what are the ways it has burdened you? Let's go through	Burden: Lonely and isolated
178	the different ways it has burdened you.	
179	P1: Made life very lonely, isolated and I keep a distance	
180	I: Do you keep a distance from others or do others keep a	Put up own wall and keep
181	distance from you?	distance
182	P1: No I keep the distance, I put up a wall.	Fear
183	I: What is your reason for putting up the wall?	
184	P1: I am afraid	Fear of infecting others and
185	I: Afraid of infecting them?	being close
186	P1: I am afraid of infecting them, I am afraid of getting too	Fear of hurting self or others
187	close to them, because it could hurt, it could hurt them, it	
188	could hurt myself. Fear of hurting myself as well.	Fear rejection
189	I: Are you afraid of hurting yourself from would it be	
190	rejection	Fear being abandoned after
191	P1: Rejection	becoming intimate
192	I: What else would it be that you …	
193	P1: Getting to close to somebody, might get too involved,	
194	might bring to many complications and then eventually it	Fear
195	will turn and I just don't want to face it.	
196	I: The afraid of intimacy becoming possible relationships….	
197	P1: Ja	

198	I: That is how you managing to keep people distant from	
199	you, that's the burden that it's created for you, for you, for	Burden creates separation
200	you you would say the role it has played has been quite a	
201	strong burden that has kept you separated from others	
202	P1: Yes	
203	I: And I think we have covered in terms of if you look at HIV	
204	and you look at yourself as you said sexually you have	No sex due to fear
205	moved away from even thinking on sexual terms with	
206	others, and that is purely out of fear	
207	P1: Um purely out of fear	
208	I: And the same with intimacy. So for you sexuality is	
209	something that went out the door, from how long did it	Many years of chastity
210	take you to get to that decision or realization that this is	
211	how I am going to…..	8 years of living on medicine
212	P1: Ten years plus, I've been 6, 7 years now	
213	I: Is that how long you have been.. been with diagnosis	
214	P1: While it has been 8 years I think, when did the ARV's	Diagnosis prior to medicine
215	role out? Can you remember the date?	available
216	I: Was in not in 2003? I think it was 2003	Went into come due to lack of
217	P1: I was diagnosed before the role out started and	medicine
218	because I couldn't get any ARV's I had to wait, and because	
219	I had to wait that's why I became so very ill because I went	
220	into a comma and it was through going into this comma	
221	that they actually put me on just two months before the	
222	role out started	
223	I: How else have your attitude, ideas and believes change	
224	with respect to sex and HIV? How often has your ideas,	
225	attitudes, beliefs changed with respect to sex and HIV	
226	P1: What do you mean?	
227	I: Well if you think about it, since you have known about	Attitude completely changed
228	your HIV diagnosis it was right back almost as you have said	After diagnosis changed
229	it was around 2003 around there, how has your attitudes	behavior
230	changed in the time?	Lost interest in sexual things
231	P1: My attitude has changed completely. I was never how	
232	can I put it…promiscuous…I did do the whole steam baths	
233	thing and did thing most gay men do but it changed from	
234	that to absolutely nothing. I have just lost interest.	Asked to be killed if ever
235	I: What has the impact been on you on how you feel about	diagnosed with HIV
236	yourself and about life with respect to losing interest, is it a	
237	negative or positive impact?	AA helped deal with HIV
238	P1: Before diagnosed with HIV I used to say to friends and	AA saved life
239	people that if I have to be diagnosed with HIV I would kill	
240	myself. That was my statement. And when I was diagnosed	
241	I was fortunate to be in the AA program and that was	
242	incredible and it helped me to deal with HIV and it saved	Gave up alcohol
243	my life.	Incentive to look at life
244	I: What are the processes the AA gave you in dealing with	
245	your HIV.	
246	P1: I gave up alcohol. That gave me the incentive to look at	
247	my life to decide for myself that if it was not for the	Being sober could deal with HIV
248	program I definitely would have done something drastic. I	

249	probably would have drunk myself to death. The program	
250	taught me that by	Acceptance and taking action
251	Being sober I could deal with it.	Became a part of self
252	I: What are the processes the program taught you and	
253	allowed you to adapt into this diagnosis.	Had to have HIV
254	P1: Acceptance, and taking the necessary action to live	Incentive to go on in life
255	with it and for it to become part of me.	
256	I: What does acceptance mean to you?	
257	P1: Accepting that it was something that had to come my	In coma
258	way and give me incentive to go on because had it not	
259	come my way I would have just died.	Spiritual experience in hospital
260	I: What is the incentive it gave you?	
261	P1: I was in a coma and in hospital for a month. I was then	
262	transferred to hospital to die. And whilst there one night a	
263	beautiful light came through the window and I knew	Bathed in light
264	healing was coming, and I came out of that coma.	
265	I: What made you aware that you were bathed in light?	Spiritual turning point
266	P1: It was just this white bright yellow light that came	
267	through the window, I was completely awake and bathing	
268	in this light I knew it was a light of healing that came from	Been aware of something
269	somewhere and I could not explain that. It was a big	Hope of getting better
270	spiritual turning point.	
271	I: I f you had to name that event, what would you call it?	Most amazing experience in life
272	P1: It was a moment that made me aware that I have been	
273	aware of something that came to me and said you will get	
274	better. You can't die you will go on. Something gave me	
275	hope. I get emotional when I speak of it, it was the most	Stronger after experience
276	amazing experience of my life.	Outlook changed
277	I: How did your change take place of healing after that	Acceptance came
278	experience?	Belief in something greater than
279	P1: After that experience I just became stronger and	me
280	stronger and better . My outlook changed and that is	
281	where the acceptance comes in, accepting that there is a	Always cared for others
282	power greater than myself.	Need to give to others
283	I: How are you different as a person now knowing your	Very important to care
284	status, how are you different?	Used to be self-absorbed
285	P1: I have always been a care giver and wanted to help	
286	others but I just need to give something out to someone. It	
287	has become easier and more important to me. As in the	
288	past I was too involved in myself and now I started to be	Always had belief
289	more involved with others.	AA helped me understand
290	I: Was this confirmation part of your spiritual growth	better
291	coming out of AA or was it separate?	
292	P1: It certainly was – I have always believed in a power	Experience made it easier
293	greater than myself, but the AA program certainly helped	
294	me to get a better understanding of a greater than myself.	
295	Having had that experience certainly made me better.	Was motivational speak for HIV
296	I: Have you been involved with organizations or patience	
297	with HIV? Are you a member of a group or organization?	
298	P1: No, I did for a short while – somebody did approach me	
299	and I did a little motivational speaking. But I am not a talker	

301	and did not like it at all.	
302	I: What was the impact this had on you?	
303	P1: Well it is like being an alcoholic, you want to rush out	
304	into the world and tell everybody that you are an alcoholic	
305	and I suppose it was a bit of ego boosting. It was trying to	Sharing was a way of accepting
306	Be the big shot. And I did it to get it out there and no other	self
307	reason, to get it out for others and to get it out of myself.	
308	And it was a way of acceptance for me. I can't share it with	Fear of sharing HIV
309	the AA I do not need to do it.	
310	I: What is it that makes you not need to share it in AA?	
311	P1: Again fear	
312	I: How has your diagnosis change how you think about	
313	time?	
314	P1: That is a difficult one as well…I don't know how much I	Time is about living for today
315	have left and am almost 70yrs – I have had AIDS for last	Living in the present
316	seven or eight years. Who knows? Ten years? The only	
317	thing that has changed is that I have again due to the	
318	program and because of the program I am able to do things	No control over HIV
319	one day at a time. Living in the present. Not living in the	
320	past.	Death is part of process of life
321	I: Do you feel you have any control over the development	No fear of death
322	of HIV into AIDS?	
323	P1: No not at all	
324	I: How has your thought and feelings changed about AIDS,	Always affirmed no fear of
325	death and dying.	death
326	P1: I am not afraid of death or dying and it is part of the	Part of process of life
327	process.	
328	I: What has helped you not to have any fear?	
329	P1: Ever since a youngster I said I will not be afraid of death	
330	and it was a positive in my life. I have regarded it as a	Important to live a fulfilled life
331	process of life.	
332	I: If death is just a process, what is the meaning of that	
333	process for you?	Amazingly healthy
334	P1: When that time comes for me I have to face Pearly	Few health setbacks
335	Gates and I would like to know if I lived a fulfilled life	
336	I: How has having HIV affected your health thus far?	More well than ever
337	P1: I have been amazingly healthy. I have had a few	
338	setbacks and this thing I have with my skin now is worrying	
339	me a bit. I am not sure what it is and have not been giving a	Daily self care
340	diagnosis. But I have been more well as ever.	
341	I: What have you done to take care of yourself to be more	No changes in caring for self
342	well than ever?	
343	P1: Eat well, sleep a lot, rest, just taking life one day at a	Will not let HIV get me down
344	time.	
345	I: Anything changes you made after your diagnosis?	
346	P1: Nothing at all, just carrying on as normal	Won't give in to HIV
347	I: Was that a choice you made to carry on as normal?	
348	P1: My choice, I did decide that this thing is not going to	Positive mind set
349	get me down, whatever it brings me.	
350	I: What brought you to make that decision?	
351	P1: I've seen others give in – My father had cancer and he	Good support from healthcare

352	just gave up. And I was not going to repeat what I saw. I	team
353	took a positive frame of mind. I faced it.	
354	I: In terms of your healthcare workers, I have they been	
355	helpful in this process?	No alternative therapy
356	P1: Yes they have in terms of support, been there for me,	
357	been encouraging. They have always given me good advice.	
358	I: Have you ever been to any alternative or complimentary	Amazing dr
359	physicians?	
360	P1: No	Drs understand and can be
361	I: Any particular reason that you have stuck with the	open
362	standard physicians and western medicine?	
363	P1: It's because my first Dr I was treated by was amazing	
364	and I looked forward to visit her and see her. It is like going	
365	to Ivan Tom's – It is fun going there as they are	Openness between drs and self
366	understanding and I can be open with them.	
367	I: Is it just the ability of them to relate that makes it better	
368	for you going there?	Can be open as am understood
369	P1: It is that I can be more open when I go there and they	
370	can be open with me so it is a two way street.	
371	I: What allows you to be open to them?	Saw gay people die from HIV
372	P1: Just the fact that I know they will understand.	No Treatment
373	I: You had others die from the illness, what has been your	Curled up and turned to
374	experience of seeing people close to you die of AIDS?	vegetables and went crazy
375	P1: People I saw dying was also Gay people and they were	
376	there and under circumstances there was no treatment	
377	and they curled into bed and became vegetables and	
378	became crazy.	Feared dying from HIV
379	I: How many people them did you see?	Used to say I will kill myself first
380	P1: I would say about three or four	No longer will kill self
381	I: As the death has mounted did your way of grieving	
382	change?	
383	P1: No I don't think so I just feared it for myself and in the	HIV in past seen as a Gay
384	past I said I would put a gun against my head and not go	disease
385	through that but I do not feel like that now so yes it has	
386	changed. The initial fear has subsided. Something you don't	
387	know about is what the media was like in those day – it	New gay disease
388	was labeled the GAY DISEASE	HIV and gay disease in media
389	I: Tell me about the Media calling it the gay disease?	
390	P1: I can remember the very first report that came out in	
391	the Time magazine and it said "new gay disease" " new	Predominant news
392	homosexual disease" and it was on the front cover with	Terrified gay people
393	HIV in big letters like that	Added to my fear
394	I: What was the impact of this media on you?	
395	P1: Well it was spoken about and it was big hot news and	
396	everybody was absolutely terrified about it especially the	Despite HIV people carried on
397	gay people. So it added to my fear.	having sex
398	I: How else did this media impact on you besides fear, what	
399	were the other effects?	Media impacts the world
400	P1: I don't think it stopped any one from having their little	
401	encounters and ladida's. It certainly didn't stop me. I was	Stigma, rejection, fear
402	never promiscuous, though on occasions I went out. The	Cast aside and thrown out

403	media had a huge affect on the whole world.	Fear within
404	I: What were the fears that it added to?	
405	P1: Well there was the stigma to start off with, rejection,	
406	fear of being cast aside or thrown out. The fear of not	
407	being able to be treated. All of those things accumulated.	Drank due to fear
408	Built a huge fear in me.	
409	I: What was the other impact did this built up fear have on	Loneliness and isolation
410	you?	
411	P1: Yes, it certainly did, it increased my drinking	Escape through drinking
412	I:so had you already been drinking	Withdrawal from life
413	the loneliness set in, the isolation set in.	
414	I: Was it to numb feelings?	
415	P1: Yes to numb feelings , to get away from it all, to be not	
416	part of and to withdraw from life	
417	P1 I am getting very confused	
418	P1: I need to correct myself as I am getting very confused…I	Fear and anxiety caused more
419	was already in the program when I was diagnosed and	drinking
420	when all this had happened.	
421	P1 : I drank on all before I hit my rock bottom, this is when	
422	it all accumulated, the media hype the fear and anxiety I	
423	did drink on.	
424	I: The fear of developing HIV and the media hype made	
425	you withdraw.	Drank on fear
426	P1: BUT I was in recovery for 4 years before I was	
427	diagnosed.	
428	I: So it was the fear of developing HIV and what the media	
429	was creating.	
430	P1: YES that is what I drank on	
431	I; yes that is very clear in terms of the separation between	
432	the two	
433	I; Were there any changes or process that you have gone	
434	through, that have helped you to deal with AIDS and your	No contact with HIV positive
435	attitudes about AIDS.	people
436	P1: Let me think about that, I don't know.	Didn't like gay support groups
437	I: what has it been like to have contact with people who	
438	have AIDS?	
439	P1: it probably would have helped, I did considerate it once	
440	and went to one particular group that was organized, but I	
441	found it all very pretentious and gay. Witch I did not like at	
442	all, I just did not like the, I think I compared it to an AA	
443	meeting. That what I expected, but it was nothing like that	Don't mix with gay community
444	it was completely different. I only went once I did not	
445	bother to go again.	
446	I: In what way do you think that AIDS has changed the gay	
447	community?	Gay society based on youth and
448	P1: That is another difficult one because I do not mix with	looks
449	the gay society.	Am not part of this as am older
450	I; Is there a specific reason why you do not mix with the	
451	gay community?	
452	P1: Cape town is a strange place, again there it comes back	
453	to my age, if you not young gorgeous tanned and got white	Earlier generation was secretive

454	teeth, you are not on the books, so I have actually not	Out in the open now
455	wanted to be a part of	Gay life is exposed
456	I: How have things changed within your community and	People not shy to speak
457	peers?	
458	P1: I think it has changed a lot, if I take my generation,	Gay men care about their looks
459	which was all so secretive and in the closet and hidden	Self-care is important to gay
460	away and it is all so wonderfully open. I think that is the	men
461	change is that it has become exposed. Now everyone know	
462	about it they are not shy to talk about it. You get these	Open
463	young guys who are absolutely gorgeous, they looking	
464	good and they are well groomed and taking care of	Gay life was underground and
465	themselves they are doing body building and they are well	secretive in the past
466	groomed and have tattoos all over there bodies, I think its	
467	absolutely wonderful, its open, it opened it up wonderfully,	
468	where as in my time and you will hear lots and lots of	
469	people my age, it was so underground and so sectretive.	
470	And I think that change has just been phenomenal. Is that	
471	the answer you are looking for.	Better insight due to HIV
472	I: we will stick with that answer	
473	I: I want to ask you another question, has aids or being HIV	
474	positive effected any of your religious or spiritual beliefs	Belief greater than myself
475	you have had?	realized though HIV
476	P1: Only to the extent it has given me a better insight into	
477	my own understanding.	
478	I: what understanding would that be?	Not a victim
479	P1: That there is a power greater then myself as simple as	
480	that.	Received to help understand a
481	I: So it has helped you to come to an understanding that	Greater power than self
482	there is a power greater then you.	
483	P1; its not a skirt or something that has been beaten over	
484	the head with, I am not a victim. None of that stuff its just a	
485	thing that has helped me to understand. It has been given	
486	to me to help me understand that there is a power greater	
487	then myself.	
488	I: So the HIV has been given to you to help you understand	
489	that there is a power greater then you, and what would be	Trust in higher power
490	the qualities of this higher power that you talk about?	Communicate with a higher
491	P1:BE THE QUALITIES?	power
492	I: For and for your understanding in terms of what your	
493	high power is.	Prayers and being grateful
494	P1: The meer fact that I can put my trust into that higher	
495	power, I can speak to it communicate with it, I can talk to	Without I wouldn't be present
496	it.	
497	I: So what role does this religouse spirtitual belief play in	
498	helping you cope?	
499	P1: The daily process of me actually having to my prayers,	Aided in the changes
500	to just ask and thank to be greatful . To be greatful for	
501	what I have and who I am today. Had I not gone through	
502	this process I would not be here today. So it's the whole	
503	process from A to B to C.	
504	I: So it has helped you to get through theses changes.	

505	P:1 absolutely	Own personal beliefs
506	I: And it has been by talking being grateful and those sort	
507	of practices.	
508	I: So would you say so then how has your level of	Morning meditations
509	religiousness or spirituality changed since your diagnoses	
510	of HIV?	
511	P1: well my personal views on organized religion, its my	
512	personal thing I do not knock it or say that it is a lot of tripe	
513	or a whole lot of rubbish. But I have got my own ideas and	
514	that is it. I go down to the sea in the mornings and sit the	
515	sea I will do my meditations. Its fine for me I don't have to	Spirituality grew completely
516	do anymore.	
517	I: So then how would you say then the level of spiritual life	
518	changed since the diagnosis of HIV	
519	P1: I would say from if I had to put it on a scale from about	
520	5 to about 9	
521	I: It moved right up	
522	P1: YAH	
523	I: So how have these beliefs helped you in terms of your	Better frame of mind
524	healing process? In this move of your ratio form 5 to 9? Has	More contentment and serene
525	that increased in levels? How has that affected your	
526	healing process?	Given rest and sense of well-being
527	P1: IT affected me greatly, I can put it on a scale either, I	
528	DON'T KNOW	
529	I: If not scales do you have a sort of……	
530	P1: I just do know, that I am in a far better frame of mind, I	Greater sense of well-being
531	have more contentment, feelings I am more sort of serene	
532	I: So it has given you contentment and serenity	
533	P1: it has given me rest it has given me a feeling of well	
534	being in a way I suppose, not all the time, not right now,	
535	because I have this thing, this itch	
536	I: So it has given a greater sense of well being?	
537	P1: A greater sense of well being, that's exactly what it has	
538	done.	Giving up substance was important to survive HIV
539	I; Earlier you mentioned that you know have now have a	
540	greater sense of well being, before your diagnoses a fear of	
541	HIV and what was happening at the time was strongly	
542	linked to your use in alcohol, that obviously changed, what	
543	got you into change in your use in substance, catapulted	
544	you to actually giving up substance	
545	P:1 I knew that if I did not give up the substance I would be	
546	dead within weeks and that was just it, I had to give up	
547	substance, I had to give up alcohol it was my choice and I	
548	knew it was going to kill me and if I didn't do it I wouldn't	
549	be here today. It carried me into the clinic.	
550	I: It all had nothing to do with HIV, it was all completely	Death if not stopped drinking
551	where your life was at, at that point	
552	P:1 it had nothing to do with HIV at that time no	
553	I: It was the fear that escalated the use	
554	P:1 Absolutely ya	
555	I: And having now got separated from the substance it	

556	actually helped you in the process when your diagnoses	
557	came	
558	P:1 Completely. Had I not stopped drinking I wouldn't be	
559	alive, and then diagnosed on drinking I would not be	
560	around	
561	I: So one your health would not have allowed you and one	
562	is having found recovery it gave you the ability to deal with	Think before acting
563	it and gave you health to move forward	More compassionate
564	P:1 Ja	Need to heal self
565	I: Anything else you would like to share that I haven't	
566	questioned about your life around HIV – Aids or spirituality	Not to reject or judge others
567	or the role it played in your life	
568	P:1 It's a hard one, but what can I say I don't know where	A greater person
569	to start actually, what role has it played in my life?	A better person
570	I: Umm	
	P:1 Its made me very aware it's made me think before I act	Better person
	it's made me feel a lot of compassion to other people that	Nicer person
	has got the same disease, it's made me feel that I need to	
	heal myself before I can heal others , it has made me feel	
	that there is no need to reject anyone like that, no need to	
	judge people like that, all those things - ya there is a lot	
	there that I could say to do that. I think it made me a	
	greater person, a better person	
	I: So getting HIV has made you a better person	
	P:1 It's made me a better person, it's made me a nicer	
	person, I don't know I am just saying these things	
	I: Well thank you so much, thank you so much	
	P:1 Has this been any help	
	I: This is brilliantly – Thank you	
	[RECORDING ENDS]	

Interview 2

Line No	Dialogue	Natural Meaning Units
1	**I**: Okay, evening of the 24th of August and doing interview	
2	with participant (indistinct). Where I want, thought that	
3	we could start is to possibly look at coming out the coming	
4	out there.	
5	**P2**: I think I started – the first time that I really was sort of	Exposure to gay life after school
6	exposed really to gay life was when I was studying and a	
7	year after I left school and that's basically the first time you	
8	know that I sort of got in touch with gay people. And – but	Associated with gay people
9	I mean I've had male to male sex before that so I mean I've	M2M sex before meeting gay
10	always known that I'm gay it was not that I was in the	people / Always known was gay
11	closet or anything it was that I didn't know of any people. I	Didn't know gay people
12	suppose ja I'm hiding when I was studying far away from	Sexuality hidden from family
13	home I met a very big group of gay people and ja sort of	Out to gay group
14	came out to them. Early but surely I think the first person	Coming out to cousin
15	that I actually within family set-up was my second cousin	

16	they life in Port Elizabeth, but I also haven't known her for	Met cousin while studying
17	much of my life I basically met her when I to study in PE.	Coming out became easier
18	And ja ag I mean from there it's easier, but I never, never	Not out to family or parents
19	came out to my parents or to the rest of my family. It's	Never denied sexuality to
20	never – I was never – I never denied it and it was never	family
21	asked and it was never discussed, you know one or two	Family never asked about
22	occasions when I was still a student somebody sent me	sexuality
23	flowers, a bunch of flowers, and my parents just wanted to	Flowers from man
24	know where did this flowers come from, you know and I –	
25	because I think the guy actually signed his name although	
26	he – because they know his family by him send me the	
27	flowers and they wanted to know you know why I don't	Confusion over man sending
28	really know I mean I just met him I didn't actually know	flowers
29	why he was sending me the flowers. Because I just met	
30	him, I had an idea why he sent me the flowers, but um – ja	
31	you know so I was pretty sure that they actually they	Family realization of sexuality
32	realised what the hell was happening but it was now I met	HIV infection
33	– first of when I became positive just shortly after that I	Disclosed to sister
34	told my one sis – told them that I was gay and also you	Disclosed sexuality and HIV to
35	know by now there is more I'm not only gay but I'm also	family
36	HIV positive and that was a bit of a shock to them. But –	Family shocked over infection
37	because that sister of mine is actually the one that's the –	
38	she always you know ever since as children when we grew	Sisters homophobia
39	up always the one that hated gay people you know I mean	
40	and she often would almost tease me or say to me you	Teasing as a child by sister
41	know that you're gay or whatever you know and I – she	
42	had this thing, but you know she's I think often I think that	Belief sister and self in wrong
43	we should have actually been swopped around you know	bodies
44	that I should have actually maybe been the girl and she	
45	should have been the boy you know. Because she was like	Sister a tomboy
46	– she is actually quite a tomboy and a couple of my friends	Sisters sexuality questioned
47	have said to me you know but isn't your sister gay or a	
48	lesbian? (Indistinct) [3:41] or whatever it was her decision	
49	and she's – but I decided that I want to tell her.	
50	**I**: And why her?	Coming out to sister hardest
51	**P2**: I was thinking of telling my whole family, but she was	
52	like the one that I was having the biggest issue with telling	
53	because she was the one that was always making the	Conservative family
54	biggest issue, not even my parents, my father, you know	Parents have no sexuality issues
55	my father they are very conservative people, I grew up in	Sisters stigma to LQBTI people
56	the Northern Cape which is very conservative farm work	Coming out to sister hardest
57	community. But they never had as much issues or really	Coming out easier to rest of the
58	any issues with it as my sister did I mean she was always	family
59	like going on about it, so I just thought that I can get past	
60	her, or not past her, but if I can get that out and do it with	
61	her then it will just be easier to do it with the rest of them.	
62	**I**: Suppose, and then... [intervention]	Coming out was plain sailing
63	**P2**: Yeah, and then just get that over with and then the	Came out to sister and partner
64	rest will be like plain sailing. And I told her and her	Brother-in-law shocked
65	husband, her husband is actually a great guy you know he	Lifestyle an HIV risk
66	was as I say was a little bit shocked and accusing me quite a	

67	lot of things you know that it was like. I knew what I was	
68	looking for why should she be so bitty, and so bitty you	
69	know – know that it was out there and it was a risk and	Unsympathetic response
70	(indistinct) [5:10] then why – why do you want to now cry	Shocked by sisters reaction
71	about it that you've got it that you're HIV positive? You	
72	know, I didn't really know what to answer to that I mean I	
73	just said I don't know how you can really say that you know	
74	and ag we were very sort of had a lot of like a quite a tense	
75	not blamed me but just sort of said that you know I think	To be gay means getting HIV
76	she'd be sympathetic to me you know I should have known	
77	that it was there and if I wanted to play – if I wanted to be	
78	gay and whatever it was just sort of part of the thing	
79	that... [intervention]	To be gay means getting HIV
80	**I**: If you're gay you will get it.	
81	**P2**: Ja, you might get and you shouldn't cry about it	Sisters apology
82	afterward. But you know and then later in the afternoon	
83	she came back to me and said ah that is sorry about all the	Over reaction by sister
84	things she said she was just a little bit too shocked you	Sister offers support
85	know and that she did overreact and she think she did	No issue about HIV
86	overreact with the things she said and said that you know	HIV not talked about
87	whatever happens and if there is any problem that she will	Distant with sister
88	support me and there's no issue about it really. Ja, I mean	Sister has own life
89	since then we don't really talk about it I don't really see	
90	them all that often, but you know they've got their lives	
91	and I've got my live and we talk on the phone and	Sister concern over health
92	whatever. I went to visit them a little while ago and I got	situation
93	quite a bit thinner but it is not really there is nothing wrong	
94	with my health I started running a lot in the gym and	Concern over HIV progression
95	(indistinct) [06:45] my exercise basically you know I'm	
96	doing just a lot of overly running a lot and I've lost quite a	First concern over HIV
97	bit of weight from that. Why are you so thin? What's	progression by sister
98	healthy are you okay? I said to ja there is nothing wrong	
99	there you know it's just it's not – so that was sort of the	
100	first time that she acknowledged that there is anything	
101	happening but otherwise now and then you know I would	
102	say to her that I go for my test and everything is fine and all	
103	is good and whatever. She just sort of say okay never ask	Undisclosed about HIV to a
104	how it is or whatever so that was basically the first time.	sister
105	**I**: One being HIV and then the gay issue as well.	Distant relationship
106	**P2**: She is basically – my other sister I haven't even told	No opportunity to disclose
107	yet, but ag you know I've been – I don't see her all that	
108	often and I'm – I've never really had the opportunity to	Visiting parents
109	actually properly good and say listen this is it. They life	No opportunity to disclose
110	close to my parents so I usually either see her at my	No HIV disclosure to parents
111	parents or when I visit my parents I quickly pop in and just	Out for a short time to parents
112	– but we – been an opportunity for that. Our parents I only	
113	told that I'm gay I haven't told them and I also I mean I only	Had a partner
114	told my parents that I'm gay the past about a year and a	
115	half ago after I met my boyfriend because I also you know I	Shared relationship with
116	had a boyfriend for oh all that while and whatever and you	parents
117	know this boyfriend I just thought I would actually I'm so	Partner part of life

118	happy in that relationship and I just want to share with my	Parents unaware of partnership
119	parents how happy I am and also because he is part of my	
120	life you know I found with my other boyfriend that it was	
121	always that thing you know that sort of ja but my parents	Visits to parents
122	doesn't really know you know. It was always this – because	Hidden relationship
123	we used to go and visit my parents but there was always	
124	that you know that certain things you don't say or	
125	whatever in front of my parents because they don't really	Came out about being gay and
126	know that I'm gay and we're a couple and it was silly to do	being in relationship
127	that anymore. So, I basically sat them down and said to	Parents had suspected sexuality
128	them I'm gay and you know he's not just a friend but we	
129	are having a relationship. They were quite cool they just	
130	said they were sort of suspecting it, they haven't discussed	Never approached gay topic
131	it between them but they both sort of said that they	Parents supportive
132	realised a long time already, but just never approached it	Won't disclose HIV status to
133	you know. Ja, and they also I mean they are very	parents
134	supportive and quite cool with that as well. I won't tell	Fear of parents belief that HIV
135	them that I'm HIV positive… [intervention]	means death
136	**I**: (Indistinct)?	Protecting parents from fear
137	**P2**: Ag you know they're 75 they will think I'm going to die	
138	tomorrow and they will – they will not be well with taking	HIV too big a shock
139	care of me so as long as I can keep it away from them I will	HIV and imminent death
140	yes, ja, ja, no it's definitely, it's definitely just for their sake	
141	you know like I say they will be – I think that will be just too	
142	much of a shock for them. They will really think that	
143	everyday I'm going to die and how long is it still going to be	Parents lack HIV knowledge
144	before I die. So, I don't think they... [intervention]	HIV and death linked
145	**I**: Is that because they don't really know about the	
146	disease?	
147	**P2**: No, no, no, they don't know anything about it just the	Life due to medicine for HIV
148	little bit of TV that they see and they – the statistics that	Media depiction of HIV as death
149	you get on TV of how many people still die from it you	
150	know it might sound strange but a white man and being	Parents unaware of HIV reality
151	able to afford medicine and whatever we know what the	
152	situation is so (indistinct) [10:31] and it is a complete	Parents not likely to understand
153	different scenario to the one that you hear on the TV news	HIV and death linked
154	all the time. They are – they have absolutely no knowledge	
155	of the scenario that I'm in actually though and to try and	
156	explain that to them you know it is like I think they will hear	
157	but they will probably not register and they will just have	Partner awareness of HIV status
158	that picture that they have of HIV that I am going to die.	Partner unknowledgeable
159	And so ja that's why I…	about HIV
160	**I**: Your mom's and the two sister's relationship with your	
161	partner?	No exposure to HIV
162	**P2**: Look, when I met him he knew that I was HIV positive	
163	because he didn't know much about HIV, no not much, he	Partner a dedicated person
164	didn't know anything about it.	
165	**I**: Really?	
166	**P2**: You know because he said he was really confronted by	
167	it at all before because he's not a guy you know he doesn't	Pity by partner over HIV status
168	fuck around sort of – not sort of he is if he has got	HIV and death linked

169	somebody then he is like one hundred percent committed,	Fear of HIV by partner
170	one hundred percent you know and he also doesn't do	
171	things like that you know so when I met him he knew I was	
172	HIV positive and I think initially he really felt very sorry for	
173	me, but also I think because he also just had that idea that I	
174	have got this deadly disease and I'm going – in the	Unnecessary fear over
175	beginning you know when we started having sex I think the	transmission
176	first time that I actually came on his stomach I didn't know	
177	that he freaked out to a friend of his you know that I came	
178	on his stomach you know. And this guy also said to him but	HIV is normal
179	then you let's just go and have you tested which I also	
180	thought was so stupid of this friend you know that he	
181	should have known better, but anyway so he did go for a	No issue around HIV
182	test. But eventually you know I think... [intervention]	Unprotected sex
183	**I**: A fearful experience.	
184	**P2**: He just got to realise that I'm absolutely normal that	
185	there is nothing wrong with me, that I'm not sick, that I'm	Acceptance of transmission risk
186	more healthy that he is and then you know from being	
187	together for two years now there is absolutely now issue,	Fatality of getting infected
188	none at all, lots of unprotected sex or well he is (indistinct)	
189	[12:47] the issue with even you know he sort of starting	
190	having the unprotected sex and I said to him you realise	HIV not a death sentence
191	what we are doing and he said ja you know he is absolutely	
192	fine with it. Look, I think he also – at one point he said to	
193	me ag you know I'm just making peace with this and I will	Unprotected sex with partner
194	probably get infected, but why do you say that it is not	Viral load undetectable
195	going to happen I won't let that happen, let's not make it	Doctor neither condone or
196	happen. And I think he sort of was under the impression	promote unprotected sex
197	that if he gets it then it is also not the end of the world	
198	because he sees me living with it and so many people living	Partner aware of HIV status
199	with it and it is really not the end of the world. But, ja I	already
200	mean we do have unprotected sex but I'm undetectable	
201	and the doctor also said to me, but I raised the question	No need to discuss HIV status
202	with the doctor and said look I'm not going to say to you go	Nervous at regular testing
203	ahead but you can relate and you (indistinct).	Partner has regular HIV tests
204	**I**: Okay, so it is still coming?	
205	**P2**: Ja, ja, look it was easy I met him through a friend and	
206	this friend told him obviously before that I was HIV positive	Open about HIV status
207	so he knew when he met me that I was HIV positive so I	
208	didn't have to tell him you know. Look, I'm still a bit	
209	nervous you know when I go for my test he goes for a – ag	Usually disclose HIV status
210	when I you know when I have my blood work done and my	Open about HIV status
211	test then he goes for a HIV test. I'm still a little bit anxious	Accept others fears about HIV
212	and we sort of say okay we're doing this issue it's what…	
213	Uh, I'm not – no I don't think it has quite my – I'm not really	No fear of rejection
214	sure look if I – I'm very open with the fact that I'm when –	Had sexual encounters despite
215	before I met him very open about positive so I, I, not all the	being HIV+
216	time, but for ninety five percent of the – I've told people	Sense of impending death on
217	before that I'm HIV positive. I'm quite open about it and if	diagnosis
218	people have an issue with that I'm okay with that and I also	Fear of contaminating others
219	when they know they would rather not do it then I say look	

220	if I wasn't okay with you may be saying now then I wouldn't	In relationship when diagnosed
221	have told you so I'm really okay with if you say no sorry.	Unaware of HIV+ status
222	That's – no, but you know I still had lots of sex before I met	
223	him places like go to hot (indistinct) [15:21]. For a little	Both HIV+
224	while just shortly after you get diagnosed when you do feel	Partner knowledgeable about
225	that you have like a cloud around you that's going to if	HIV / Easier to accept HIV status
226	anybody comes near you are going to be infected and – but	No issues about HIV by partner
227	– and – but I mean it just takes a little – at the time when I	
228	(indistinct) [15:44] was in the relationship but I met him,	
229	but by the time I met him I was already positive but I didn't	Dealt with HIV with partners
230	know. After we were starting we both went to tests so he	help
231	was with me in that time when I tested, but he was also he	Touching does not mean
232	was with it or you know he was very knowledgeable about	transmission
233	HIV, totally, totally, totally cool. That also helped me to	
234	myself with regards to that you know they don't make such	Sex continued normally
235	an issue of... [intervention]	Relationship allowed for
236	**I**: Went through that helped you.	normalization of HIV
237	**P2**: A lot, if it wasn't for him it would probably would have	
238	been more difficult, but it just – I just realised that nobody	
239	can touch me that's still I do have this disease but it doesn't	HIV a part of life
240	necessarily mean that I'm going to infect however touches	Unclear if
241	me. Ja, I mean and I think just from the contact that we	Growth either through age or
242	had going on with your sex live basically it also grew	HIV
243	because I only knew him for three months but together for	
244	two years you know so it was the beginning of the	
245	relationship and it started we had a very physical	Open person
246	relationship as well.	No hiding or pretense
247	**I**: Knowing that it is just a part of life.	More open due to HIV
248	**P2**: Yes, ja, ja.	
249	**I**: Okay.	No issue disclosing
250	**P2**: Eight years ago I have – I'm eight years older as well	Initial disclosure hard
251	you know so I'm not sure how much of that has got to do	
252	with me being just older or how much of it is actually the	
253	cause of the HIV. I don't know you know I often thought	More honest due to HIV
254	about it. Something that – look I've always been fairly	
255	open about things to people I don't hide and don't pretend	No hiding or pretense
256	this thing, but one thing I think that the HIV done is just	
257	probably made me just that much more open. I don't,	Self acceptance
258	except for my parents, but for a reason, but I have	Good health
259	absolutely no issue in any conversation and to however of	Can be positive and not sick
260	disclosing the fact. So, ja I think and thinking back of the	
261	first people that I actually had to tell when I first tested	Positive lifestyle breaks stigma
262	positive how difficult it actually was to say it how the issue	
263	of – tuff. So, ja, but as I say you know I've always been very	HIV is normal
264	open but I may be it has just made me even more if you	No problem disclosing
265	want to call it honest, but just be open about things you	
266	know and not hide and not pretend about (indistinct)	
267	[18:30]. This is who I am and I think also a lot of it has also	
268	got to do with the fact that I – that I'm healthy, I know that	
269	it also can show people that even though I'm HIV positive	Lifestyle affected
270	that first of all you don't just showing that stigma that you	

271	know if you are HIV positive you don't have to look HIV	Same as before
272	positive and you don't have to be sick all the time and you	Not on the scene person
273	know like – so it's just like a normal thing that it is just very	
274	normal. And maybe while I have absolutely problem with	
275	telling people you know.	Being self
276	**I**: Just normal.	
277	**P2**: Ja, ja.	
278	**I**: And has – has it affected your…?	On website
279	**P2**: I think so. I think the only thing, but as I – I'm not sure	
280	if it has anything to do with being HIV positive really you	
281	know because of the way I was before I heard that I was	Expected to bond to to other
282	HIV positive, but I think that you do find a mentioned thing	HIV
283	you know, but I've never been out even more so you know	people
284	that there is no need to pretend or to for the sake of	
285	whatever. The reason just you have you can just be open	
286	(indistinct). Websites, the positive... [intervention]	HIV not reason for friendship
287	**I**: Websites.	
288	**P2**: Ja, the – one or two international ones, active ones and	Friendship based on liking
289	South African ones.	person
290	**I**: Any drawbacks?	HIV not a reason for friendship
291	**P2**: I don't I should necessarily be friends with people just	
292	because they are also HIV positive, and that's one thing	
293	that's a little bit sort of you know that I find the websites	Only artificial
294	that you we're now all supposed to be in this boat and we	
295	all have to stick together and you know I think I don't fall	
296	for that. If I don't want to be your friend and I don't really	Attend yoga group
297	like, not like you, but I mean there is just nothing…	
298	**I**: There.	
299	**P**: …there, why just because you know if it was any other	Gay HIV yoga group initial
301	reason we both have dark brown hair why the hell should I	now gay inclusive yoga group
302	be now your friend people have dark brown hair and	more natural interaction
303	whatever. So, that I find a little bit almost like too paused	
304	and little bit official and artificial, ja but on that's basically	friendship
305	just sort of on-line. I've had a little bit of more sort of	
306	physical contact with the – Nigel's group where you know	
307	we also get together and I don't know if you know we do	
308	the yoga thing.	friends are supporting
309	**I**: I've seen it at the time.	
310	**P2**: It started as first just HIV positive guys but then it sort	friends are there no matter
311	of opened up to just sort of gay people, but there are still a	what
312	lot of HIV positive guys in that group. And that was a little	no need for HIV support group
313	bit more – that was quite natural, but some of them also I	
314	found a bit like you know like we make contact with you or	
315	and not the same way you know if I don't like you but I also	not included in HIV group or
316	don't really like you that much to actually just be a friend	Organisation
317	you know and because we are both HIV positive you know	being HIV does not mean
318	change that. It doesn't have to change that. We did go to	involvement with other HIV
319	the groups and I – all my friends know that I'm positive and	social contact is gone
320	all of them are very supportive and anything would happen	
321	to me any of them will be there to do something, so I didn't	
322	really feel all that need for a specific HIV support group.	eat and not HIV group

323	**I**: Ja.	
324	**P2**: So, that's why I'm not really even trying actively to get	
325	involved in a specific HIV group or don't see why we should	
326	be forced into something that just because we're HIV	
327	positive. On the other hand you know I think it is a nice	
328	social thing to just have contact with people, but then you	Sharing ideals
329	know in terms – it shouldn't really be such a – it should be	Way of life
330	a forced thing it was just something more natural. I don't	Relate as friends
331	see whether it should just be HIV positive or just a nice	Open life and enjoyment of life
332	gathering likeminded gay people I would actually find it	
333	much more useful... [intervention]	Negative attitude and support
334	**I**: Together?	group
335	**P2**: Ja.	Negativity a problem
336	**I**: I mean you talk about live.	Life shouldn't be over serious
337	**P2**: I suppose it was not the same ideals and more like a	And inner answers
338	way of life you know somebody that I could actually more	Self-acceptance
339	relate to as a friend it's got a job that they like and have	People's problems due to
340	friends that they like and just have an open life and enjoy	unresolved inner issues
341	their lives. You know and also the little bit that I found in	
342	that is a group, support group, that we had is like you know	
343	people that were quite negative complaining about their	
344	HIV but just about life in general they were a little bit too	
345	negative for me. Also just way too serious about life as	
346	well, it's just life it's not – ja, ja. I think a lot has got to do	
347	you have to find a lot of that in yourself make peace for a	
348	lot of things. I think a lot of people liberty that people have	
349	is because of issues in themselves that they haven't really	Sense of urgency
350	resolved.	Sense impending death
351	**I**: (Indistinct) that you felt?	
352	**P2**: Well, I did tell me friends, my work, I like my work…	Not a death sentence
353	**I**: Sorry about that. Positive things in your life, what are	Likely to die of other causes
354	the positive things?	
355	**P2**: What is happening now?	
356	**I**: Okay. Okay, I wanted to ask just now like when you…?	
357	**P2**: I think shortly after I got diagnosed that I was positive	
358	it definitely did you know it was almost like they didn't	
359	know what the urgency, but you don't have all that much	
360	time left have to I mean shortly after that I went to some of	
361	my – my (indistinct) a little bit mad and talking about	Matured
362	pension and stuff (indistinct) you know but I probably be	
363	around you know or that long to really be that bothered	Confronted by death more
364	about pension and old age and what is going to happen to	
365	me when I'm 80, 90 whatever if I get there. And – but now	
366	I definitely I realised that you know I will probably get there	
367	but it is not going to be – it might not be HIV that is going	Death part of life
368	to kill me I might still have a heart attack, I might still get	
369	run over by a bus, I might still die in a car accident you	
370	know all these other things might kill me before I even get	
371	sick, if I get sick anyway you know. But, ja I think has, but	
372	then again as I say I'm eight years older I don't really know	
373	if that and my parents are also 75 you know they are	More peace with death

374	getting old and I realise that my dad is not very healthy	
375	okay so you get confronted more and people around me	
376	like sort of people that you know and just starting to die	Death doesn't have to be HIV
377	more and you're confronted much more by death and	related
378	(indistinct). Saying goodbye to people and also realising	Uncertain around cause of
379	that you know that it is just part of life that it is not – it is	attitude change
380	not new it happens to everybody it is going to happen to all	
381	of us and I'm not sure if he has really change but if it is just	
382	me growing older and I don't know wise. So, I don't believe	
383	if the HIV has any blame or any – it might you know it	
384	might subconsciously I might have made more peace with	Possibility medicine failure
385	the fact you know that I do have a disease that can possibly	
386	kill me that something might happen, some complication	Unconcerned
387	might happen and I get – and I still can die, but as I say I can	Faith in doctors
388	still get any other disease and I'm going to still die as well	
389	you know. So, I'm – maybe as I say I'm not sure if that has	
390	– if that is what changed my attitude.	
391	**I**: Allow to have any control.	Health focused unchanged
392	**P2**: Ja, ja, I do you know in as in the... [intervention]	
393	**I**: Full blown stage (indistinct).	Initially more health focused
394	**P2**: Ja, no as I say the only thing is that if something were	
395	to happen in (indistinct) or that I would get 'weerstand'	Healthy lifestyle
396	against the medicine, but then again I also know that I was	
397	Steve Andrews (indistinct) said that I'm not bothered	
398	because I know that he will whatever happens he will sort	
399	out, but I'm with (indistinct) I'll get to that I fully trust him	Tct limit stress
400	as well. You know if anything were to go wrong I'm 99%	
401	comfortable and sure that they will sort out whatever is if	Exercise and gym
402	there is a problem, so. I don't think I can really say that I'm	
403	healthier than what I was because I've always been fairly	
404	health conscience, but I'm not fanatical all of a sudden, I	
405	was a little bit in the beginning like stuffing myself full of	
406	vitamins and trying to boost myself, but then also	
407	afterwards I also I'm healthy I live a healthy life anyway so	Maintain positivity
408	what you need to a whole healthy and I live just a healthy	Remove negativity from life
409	life.	
410	**I:** What is the ways that you take care of yourself?	
411	**P2:** Look, I don't try and stress myself out too much so I try	
412	and limit my stress which I don't always get right, but I try.	
413	Gym, I do lot of exercise I really, but I mean I've been doing	
414	that even before I got HIV.	
415	**I**: Just maintained that?	Dr visit twice a year
416	**P2**: Yes, ja, and then ag I was at Curves I'm not really	
417	(indistinct) but as I say I'm not (indistinct) and not also then	
418	oh I got infected I just try and – ja and then also (indistinct)	By-yearly Dr visit even on ARV
419	it's because of the HIV also try and be positive you know	
420	because I believe that you know if you're always negative	
421	and you know that you all these issues and things and	Attempt to find right
422	things and things and you load it onto yourself with that as	medication
423	well. So, you know don't, don't do that just try and stay	
424	positive and stay calm.	

425	**I**: Okay, and as part of that, as part of staying calm and	Viral load undetected
426	(indistinct) physician working?	Past problem with medication
427	**P2**: Ja, well six months.	
428	**I**: Every six month?	
429	**P2**: When I started going onto my ARVs it was six months,	
430	but now you know I go – no I still go at six month you know	Experimentation with
431	because ALVs when I started that it was every three	alternative
432	months it was monitoring what exactly was happening	medicine
433	because there was a little bit of an issue getting viral load	
434	down. Like on the (indistinct) I was on this is (indistinct)	
435	from the notion on and so the thing is that you know that is	complimentary alternative
436	still Steve Andrews that is trying all that and died before I	lifestyle too demanding
437	got undetectable so he never even got to see me	health unaffected by
438	undetectable which is a little – there was a little bit of an	alternative approach
439	issue but now everything is fine you know, but I still go six	
440	month. I did yes before I went onto ARVs – no, no, just	
441	shortly after I did and we were trying to get this whole get	lack of faith in complimentary
442	the viral load undetectable I bought you know I was very –	medicine
443	I'm trying all these chemicals now there is never harm in	friend nearly died by not taking
444	just trying something else as well so I did it. But he just	meds
445	basically did a cleanse with some or other fowl tasting crap	
446	and massage and – but he was a little too way, way, way	content to take medicine
447	too much, too fanatical for me anyway you know. Not	
448	eating this and not drinking that and not ever touching that	
449	and I did that for a couple of months probably five, six	friend died of HIV
450	months and I still – nothing changed in my – I didn't go	
451	undetectable nothing changes in the viral load really there	HIV death an impact
452	was no really drastic change or anything. I don't really	
453	enjoy all of this and I didn't believe in it, but ja so I tried but	
454	ja I know of people that (indistinct) back and even now a	
455	friend that I know, you also know, tried the alternative	
456	thing and was not taking their drugs and they almost died,	
457	one did die and the other one almost died. I just decided	
458	no I am not doing that I am more than happy with taking	Unconscious link to HIV to
459	my drugs and they worked and… Not that close it was a	death
460	friend, but we were not like best friends but we were	
461	friends. But that was also that was a long time ago already	
462	that was way before I was infected. I think impact in what	
463	sense I mean obviously if a friend dies it has an impact on	
464	you but…	
465	**I**: Ja, but that it was…	HIV related death is
466	**P2**: Subconsciously I must have had that in my mind when	unnecessary
467	because he died and then another, he wasn't really a	
468	friend, but I know – I knew him and his boyfriend quite well	
469	you know because we're (indistinct), he also died from	
470	AIDS. So, I've had those two people that I know that died	Disbelief about why people die
471	(indistinct) so that must have been in my mind obviously	due to HIV
472	when I was in – I tested positive they died and I will	Past-belief HIV death sentence
473	probably die as well from AIDS because they both of them	
474	actually died.	
475	**I**: I'm wondering if there has been any changes?	Just a chronic illness

476	**P2**: I just think that that's why I was saying to you just now	Connected with HIV people
477	but does that still happen why the hell do you – why do you	
478	still have to die from it you know and even especially in	Researched HIV online
479	South Africa you just go to a provincial hospital and you will	
480	get (indistinct) and get healthy. But that's why I think that	
481	is the only thing I mean why do people still die from AIDS if	Relationship with HIV partner
482	you can do something about it. Ja, ja, which I didn't also	Unaware of partners status
483	realise you know that I was also initially when I was	
484	diagnosed I thought that it was going to kill me at some	Ex-partners status disclosed by
485	point but then I got more knowledgeable about it realised	friend
486	that it is just a chronic disease. No, I go onto internet	
487	online and I you know go to I think I spoke to quite a lot of	Passed ex-partner to Dr
488	people, positive people but also (indistinct) people and	
489	Steve Andrews was quite amazing, ja but I think a lot of	
490	(indistinct) just to that, that American website the Body	
491	(indistinct) quite a lot of that, but I haven't had – ja I	Ex-partner denies HIV status
492	haven't really suppose you would say that he (indistinct),	
493	but I didn't even know sort of had this on/off friendship	
494	and I wasn't even sure I didn't even know that he was	
495	positive and that he – he just – I just heard via the	
496	grapevine that he was sick and another friend of mine who	Apology by partner
497	is a friend of his phoned me actually (indistinct) do you	Partners fear of disclosure
498	realise this guy is positive and he got AIDS why is so sick	
499	which I didn't realise. And when I saw him and after	Little exposure to AIDS
500	because then I gave him this friend that phoned I gave him	
501	Steve Andrew's telephone number and took this other	
502	friend to Steve and whatever and – but I didn't see him in	
503	all this. And just after, not too long after that, I bumped	
504	into him in, in the shop somewhere, but just the two of us	People less concerned by HIV
505	and I said to him you know oh I believe you saw Steven and	
506	he said no he doesn't know what I'm talking about and he	People all have HIV friends
507	said you know and then afterwards like later he phoned me	If HIV infection happens it
508	one day and said you know he must apologise he obviously	happens
509	knows that I know that he is positive and that wasn't	
510	disclosing it to anybody yet you know. But that was the	Best to be un-infected
511	little bit of exposure that I had to somebody that had AIDS,	Not religious
512	but I mean he wasn't – I didn't even realise that it was AIDS	Less religious
513	and he wasn't – so that's it, that's…	
514	**I**: Didn't really bring up anything?	Maturity lead to reduced
515	**P2**: No, no, the contact that's all.	religiousness
516	**I**: What (indistinct)…	
517	**P2**: There was a lot of – a lot more awareness, but I think	Try live a good life
518	people are I wouldn't days not bothered by it at all but a lot	
519	less bothered by it because so many of their friends have,	Don't expect reward to live a
520	are HIV positive, and they see that (indistinct). They really	good life / desire to live good
521	you know if it happens then it happens... [intervention]	life
522	**I**: So, the general it is normal…?	No official belief
523	**P2**: Ja, like still number one is to not get it, but if you do	Life in earth is heaven
524	get it then it is also not (indistinct) you know that I've never	Making life good
525	(indistinct) or religious at all if maybe it has affected it me	
526	then it probably just made me even just less. I don't know I	Moral life

527	would say that has made me less religious but I think it is	Reared with morals
528	also just from getting older and just realising that for me it	Do to others as you want done
529	is just – it really is just – look I've been I don't but I mean I	onto you
530	as I mentioned before that I don't go around with a bad life	
531	in any way, but that is not because I feel that I – it is	
532	expected of me as a religious or a spiritual reward that I	Do recreational drugs
533	have to do this. It's just the way I want to live my life and I	
534	also believe this and still (indistinct) that it's I don't believe	
535	in that I (indistinct) so that I can get this is heaven for me I	Drugs to have uninhibited sex
536	have to have my heaven here and make it a good life.	
537	**I**: That's good. What gives…?	Unsafe sex due to drug sex
538	**P2**: I think it is just the way I was made my morals that I	No drug sex since diagnosis
539	was taught as a child and you grow older also get more of a	
540	mind then you also with experience see what things upsets	
541	you and you don't like when it happens to you by not trying	Drugs created increasing
542	to do that to other people. And I not abuse but I did hear	paranoia / drug use not
543	no I did I did smoke for years and years probably for eight,	pleasant
544	nine years and I was still smoking in the time that – but I	
545	also did other drugs and ja you know the drugs definitely I	Stopped drugs not only due to
546	can see that then it was - (indistinct) me very reserved if I	HIV
547	don't know people and with the drugs you go hours I did	Social phobia
548	take drugs to just sort of get high, but then it also makes	
549	you very uninhibited as well. So, probably I did things that I	
550	wouldn't have done if I wasn't under the influence, not a	Reduced immune system by
551	lot of it, but I definitely have done some of that before but	drugs
552	since I've been diagnosed I know. But that was also one	
553	thing that was happening to me sort of almost at the same	Drugs affected system badly
554	time the drugs was I was starting to get very paranoid it	
555	wasn't doing me – I wasn't feeling good on it anymore.	
556	Why I – I stopped taking them, but I don't think it was	Unwanting to compromise
557	merely the only thing that my, my – the HIV positive	system
558	influence has been me doing drugs now apart from the fact	
559	that I do still get very paranoid on social occasion	Work good about status
560	somebody passes stuff around and I still don't want to do it	
	because it also I know from when I was taking it you know	Work supportive around HIV
	if was taking E or my system would go down and for like	
	four or five days after that you get like very low and I get a	
	cold or some or other infection or something. And I don't	
	want to do that anymore even with dope, the smoking	
	dope as well you know I dope keeps me up for hours and	
	hours and go, go, go, go as well you know and I exhaust	
	myself. Now, also two three days later I'm – so I just don't	
	want to compromise my health by doing that anymore but	
	apart from the fact that it's – it doesn't – that I – I do get	
	very paranoid on it as well. Uh, so I was at work when I	
	found out that I'm positive (indistinct) work with are really	
	great it is a husband and – they – I started the firm with	
	them very close and they – she was there when I got the	
	news that I am positive. She was one of the very first	
	people that actually I had contact with and they have just	
	been – but they are really an incredible couple and I think	

	that has definitely had a great influence in totally honest and was also very acceptable about it because I mean they have never ever had raised any issue you know and even their children around me and when they were babies like (indistinct) anything to the babies and whatsoever. **I**: I'd like to thank you. **P2:** No, it's a pleasure	

Interview 3

Line No	Dialogue	Natural Meaning Units
1	I: Today I am doing an interview with participant 3 and it is	
2	the second of September 2011. To start with, could you tell	
3	me a bit about your coming out process?	
4	P3: It was a very, very long time ago. I came out when I was	
5	living at home and was about 14 years old. I had been reading	Young coming out
6	a lot about gay and lesbian issues in the newspapers. I was	LGBTI aware
7	physically and sexually mature and I was beginning to try and	Early maturity
8	understand my desires and then I began to realize these	
9	desire issues were linked to identity issues. I always felt very	Identity (ID) linked to sexual
10	different from people around me. There was this kinda fusion	orientation / Sense of difference
11	idea of this idea gay and lesbian people who were starting to	
12	became much more visible and vocal, and challenging of their	Sexual orientation and rights
13	rights issues. How these two things came together and the	
14	genesis of my coming out was to also link up to a youth	Youth organization involvement
15	organization. Admittedly I took it up at the same time as I was	
16	14. A high School student, living with my parents. I think I told	Living with parents
17	my parents either just before or just after I turned 15. People	Informed parents
18	have these ideas, maybe it is true, maybe it's not, but you	
19	know, just keep an open mind, obviously I wasn't going to	Own sexuality acceptance
20	accept any other answer. But anyway, on this life journey of	Gay ID acceptance
21	identity issues, I pretty much decided that I was on a gay	
22	identity, as a person, but obviously that was also my sexual	ID challenged social norms
23	orientation. The identity at the time was about challenging	
24	some of the dominant norms of society. The norm being held	American middle class norm
25	up at that time was that you grow up, get married, have	
26	children and live this middle class life, which was what North	Norm not the truth
27	Americans aspire to. The truth is, is that is not exactly the	
28	truth, as divorce rates were exceedingly high, in fact there	Series of new family types
29	were a whole series of new family types busy emerging. North	
30	America in particular was a post-industrial state by then, so	Sexual orientation and economics
31	later as I got older and went to University, I began to realize	linked
32	how much spaces around sexual orientation are influenced by	
33	economics. So once reproduction of labour became important	
34	in the western economy, so it became less important to	
35	physically breed, so that also raised a lot of questions about	
36	where gay and lesbian people fit in the economy. What rights	LGBTI place in society
37	we had to name our own rights and spaces. So being gay was	Claiming rights
38	also being about changing the silencing of these alternate	Un-silencing alternate identities
39	identities. Breaking silence and creating more voice, creating	
40	more visibility of the diversity of human experience. So	Visibility of diversity in human
41	challenging the hegemony of how the world was supposed to	experience / Challenging Hegemony
42	be. And also trying to create more voice and visibility around	/ Diversity voice and visibility
43	diversity.	
44	I: How does having HIV affect how you feel about being gay?	Gay ID separate from HIV
45	P3: Maybe the first thing to say is that I came out before HIV	
46	became a recognised issue. I'm 48m now. In practice we now	
47	realize that HIV was around for a number of years before it	Living in HIV epicenter

48	really emerged. And I was living in one, what turned out to be	Friends infected
49	an epicenter. Many of my friends got infected, and of course	
50	we were in a youth movement, so most people we are talking	Young dying
51	about were dying at 17 or 18. So I had not grown up with the	Gay ID separate from HIV
52	idea that gay identity was at all related with illness or disease.	Liberation ID
53	In fact it was very liberation orientated identity. But by the	
54	80s things had shifted so that a lot of identity issues around	Gay identity linked to HIV
55	being gay were closely being associated with, first of all with	
56	the disease that people didn't understand, and then it was	Stigmatization and fear
57	highly stigmatized, and that made it very scary as well. So we	Sexuality being fearful
58	went into maybe a 10 year phase where sexuality became	
59	increasingly scary. Men in particular had relationships with	Sexual encounters a risk
60	each other that every time you had a sexual relationship,	
61	there was a risk that someone would get infected. So I felt	Must get educated
62	strongly that we also had to also, on the one hand get	Be active and support
63	educated and be very active in this area and support people,	
64	HIV negative and positive people. But at the same time not	Gay ID and HIV
65	collapse the idea that a gay identity and HIV was the same	Gay ID and HIV NB in the West
66	thing. That became a very strong current, particularly in the	HIV a gay only issue
67	west, because HIV was not seen as a heterosexual issue, while	
68	in practice it was. Even where I grew up we were not only at	MSM HIV epicenter
69	the epicenter of male to male transmission, but because we	Heterosexual HIV epicenter
70	also had a large asian population, we were also in fact the	HIV racialised / Heterosexuals
71	epicenter of the heterosexual epidemic. People then again, it	ignore HIV
72	was racialised and the white media did not pay any attention.	HIV prevention involvement
73	They didn't see epidemiological what was going on. My	
74	intervention in the whole process was to get people to talk	Gay ID and HIV
75	about it, get educated, try to understand what you are doing,	
76	and make informed decisions yourself. But also try not to	Medically aware family
77	collapse these two ideas of ill health and identity. (unclear). I	Knew HIV origins
78	come from a very medical family, so I mean, I understood	
79	from early on that it was a virus causing the illness and how	HIV is epidemiological
80	the virus operated. From a medical background I knew this	
81	wasn't a sociological phenomenon, that it was an	HIV is worldwide
82	epidemiological one. And also I realised that it was spreading	Western gay militancy of HIV being
83	in other parts of the world. But what was very interesting,	a gay issue
84	was that a lot of gay men in the West, became militant about	
85	HIV being a gay issue. I never really bought into that. I thought	
86	it was obvious that men who have sex with men need to be	M2M medical respect and care
87	treated with respect when getting medical care, which wasn't	Rights not guaranteed
88	guaranteed at all. When treatment was available, obviously,	Treatment access / Ridiculous
89	we needed access. It was ridiculous how the Americans	reactions
90	reacted. But I also felt strongly, that there was a risk of	Linked HIV to pathology and low
91	pathologising and displacing a sense of low self-esteem and	self-esteem
92	marrying that to a medical phenomenon, they were naturally	
93	fitting with one another. That wasn't necessarily true, it	
94	became part of my work and intervention that recently men	Gay identity and HIV
95	that I met, gay men couldn't separate the idea of their	
96	sexuality from disease.	
97	I: how did the blurring of the lines of sexuality and disease	
98	affect you when you became HIV positive?	Sameness on Seroconversion

99	P3: Once I became HIV positive, nothing really interesting	Sex doesn't guarantee infection
100	happened actually. At first I was, after 17 years I had had	
101	protected sex and this far I had been very visible in saying,	
102	"You don't have to get infected. To be gay, you can be HIV	Non-judgement
103	negative. You really don't have to be judgmental about the	Support everyone
104	idea and epidemic. You need to be supportive to everybody,	
105	you can have sex with men who have AIDS, sex with men who	Don't need to be infected
106	are HIV positive and you don't have to get infected." And then	Got infected
107	I did get infected, but I got infected because I had	Unprotected sex caused HIV Status
108	unprotected sex obviously. So I felt very shaken by that	Shaken, guilt, shame
109	experience, I tried so hard. I had a lot of guilt and shame	
110	about the issue. But actually the first person I started having a	Serodiscordant partnership
111	relationship with after the diagnosis was HIV negative and	Good starting point
112	didn't know a lot about HIV. And that was a good starting	
113	point because it was like I believed all these things for the	Sex doesn't guarantee infection
114	past 20 years, that I could be a gay man, sexually active and	
115	not get infected. And it was true. So it is also true that you can	Serodiscordant partnership true
116	have sero discordant relationships. And it was something my	
117	therapist said to me, at which I have always thought was very	Virus demands
118	astute. He said, "the virus is already going to put a lot of	Maintain personal power
119	demands on you, don't hand over your power in the process.	
120	It is up to you to set how your life is going to be orientated	Set own life orientation
121	and what the priorities are; and the virus is going to have to	Set own priorities
122	fit into that. Sometime you are going to have to negotiate, but	Virus fits in
123	most of the time you don't. You just go ahead and do what	Occasionally negotiates with virus
124	you were going to do exactly anyway." She taught me to	Carry on same regardless
125	understand that it is your life and that there is also a viral	Your life
126	condition also. Centre your life, not the virus. So those were	Also viral condition
127	the eloquence that began to shape my relationship. In my	Shaped relationship
128	current relationship…I was previously involved with someone	HIV not an issue in relationship
129	who was HIV positive, it wasn't an issue you know.	
130	I: Did HIV play any role in how you behaved sexually?	Liberation from fear
131	P3: Well, ironically 19 years of worrying about getting infected	Lose fear of having sex
132	evaporated, so for the first time I didn't have to get worried	Now fear others status
133	about being infected with HIV. It was actually like shoo, that	Fear reaction
134	was quite nice. In fact, it was quite liberating, because it was	Disclosure
135	in fact like now actually I don't have to be scared of having	Fear easier than fear of HIV
136	sex. But then you still do have to worry about the other	
137	persons status is. How are they going to react? About	
138	disclosure issues, there is another whole bunch of things that	
139	come along with that, but in a way that is easier to deal with.	
140	The idea of being afraid of something, I realised after being	
141	infected that I carried around stressful issues. Now I don't	Carried stressful issues
142	have to carry them around any more. I think a lot of things	Not carrying stressful issues now
143	happened with the diagnosed. It was a watershed time	Diagnosis linked to a lot
144	psychologically in my life. And one of the areas was that I	Psychological watershed time
145	began to enjoy my sexuality more, to be less afraid of things	Sexual enjoyment
146	that could go wrong. This is my sexuality. This virus has been	Fear lessened of things gone wrong
147	around for the last years and now it is in my body, and not	Acceptance own sexuality
148	doing particularly much. Though I think I have matured	Virus present
149	sexually	Sexual maturation

150	I: what were the watershed areas?	
151	P3: The most obvious one, as you kinda already know already	
152	was in the area of spirituality. When I went to see my	Spiritual watershed
153	therapist after I was diagnosed, the question I eventually	
154	came to, was “why me? Why did I have to get infected after I	Questioning unfairness
155	had tried so hard to educate everybody, I tried so hard not to	
156	get infected. It wasn’t fair …” He said that it was a	
157	metaphysical question. I can’t answer that. There isn’t an	Metaphysical questioning
158	answer to that question…(unclear). Then I thought, actually	
159	he’s right. Some things happen in life and it’s the way we find	Life and meaning review
160	meaning in it. So I went off to a meditation centre, and I	Searching at meditation centre
161	always wanted to do meditation. I kinda thought Buddhism	
162	was interesting, but I was always to busy. Life had been too	Life was too busy
163	busy. So it was a bit, I still had that Western thing about being	
164	embarrassed about spirituality. I grew up as a child, an	Embarrassment over spirituality
165	Anglican, my parents, there was a death in the family when I	
166	was young and my parents had left the church. I had grown	Atheist childhood
167	up as a hard core atheist. So suddenly I’m facing this issue of	Facing own mortality
168	my own mortality, my own life. Trying to understand why this	Understanding infection
169	thing happened and then…so I was a bit like a bit shy of	metaphysically /
170	having to say like well now, I have a spiritual question a …..	Spiritual questioning
171	I: An existential question…	
172	P3: An existential question, that is a much better way of	Existential questioning
173	putting it. It is an existential question. So I found a path that	Found spiritual path
174	actually spoke to me a great deal. And it rapidly answered	Answered questions
175	that question. Buddhist teachings are very rich in psychology.	Buddhist rich in psychology
176	Many of the things taken as a norm in western psychology in	
177	the 20th century, were already discussed 2500 years ago. And	
178	one of the things is, first of all, I put myself in harms way,	Put self in harms way
179	nobody made me have sex and get infected. I knew there was	Sex and infection
180	a risk. I may have put the reality of that out of my mind	Reality suspension
181	temporarily to follow certain desires. But I have to take	Follow desires
182	responsibility for what happened, A. B, disease is a part of life	Taking responsibility
183	and death is a part of life, and everybody dies. It is an	Disease and death guarantee
184	absolute guarantee. Your body will fall apart. You will go blind	Body degrades
185	and your lungs will collapse, and eventually worms will eat	Cycle of life
186	your body. All of these things that will happen are	Death despite illness
187	guaranteed, regardless if you have virus’. You will have virus’,	
188	you will have bacteria, you will have fungi. That is the human	
189	experience. So the idea that the human body is perfect,	Human body not inviolate
190	inviolate, is absolutely…(unclear)…many other organism have	
191	genetic faults. We have a time clock due to run out. And it	Life will end
192	was through my experience of Buddhism that I started to	Learnt through Buddhism
193	understand these things, and God knows why I didn’t	Didn’t know before
194	understand them before. They are completely self-evident. I	Knowledge self-evident
195	don’t understand it. Then as I got deeper, then I really began	Spiritual path
196	to understand more of the structure of the teachings. I came	Deeper understanding
197	across a fascinating talk Tibok (spelling?) who was visiting	
198	Australia and I loved it. It was that classic moment. I was at an	Defining moment
199	actual monastic retreat at the time. Because it really set the	Difference in western self &
200	opposition between my own western background and asian	Buddhism

201	Buddhist teachings. Somebody said this in the talk that was	
202	transcribed, was that: this little girl, was the daughter of one	
203	of the people in our congregation, was busy dying of	Woman's daughter dying
204	leukemia. Isn't this wrong, that karma has to be because you	Karma and wrong doing
205	have to do something wrong. So how could a child die, its so	Child death wrong
206	wrong. How do you explain the death of an innocent person?	Death of the innocent
207	And the monk laughs, and the Australians are like, how can	
208	you laugh, we told you the child is dying. And he goes, who	
209	ever told you that sickness is a bad thing. Sickness in	Sickness is not bad
210	Buddhism, can be like a great shady tree on a hot day. The	Sickness as respite
211	more experience of reality can be the greatest teacher to	Greater reality experience teaches
212	liberation as possible. You decide if you are going to be	liberation / self decision if disease
213	oppressed bye disease or liberated by it. It is entirely up to	oppresses or liberates
214	you. If you want to make this disease your enemy, then good	Disease as enemy
215	luck to you. It is not going to work, it's not going to get you	Failure if see disease as enemy
216	anywhere. Or you can open your mind up and try to	Be open minded
217	understand what is going on, what your expectations of life is.	Understand processed & life
218	If you open your mind to the reality of suffering, then in fact	expectation / liberation through
219	you are liberated. The path of liberation only comes from	open mindedness to suffering/
220	recognition. I thought it was so interesting, because the	recognition leads to liberation
221	Australian audience didn't want to hear this. They wanted this	Audience deaf to message
222	idea of perfection, innocence, this perfect body. That ill health	Hold to perfection idea, illness
223	doesn't happen, and the monks approach was the opposite.	unreal / illness is real belief by
224	Whoever told you life was going to be like that. Life isn't like	monks / life is not perfect
225	that. The question is where does wisdom arise. Wisdom	How wisdom arises
226	either arises from facing the truth, but it isn't certainly going	Wisdom through facing truth
227	to arise from running away from it. What will arise from	
228	running away from the truth is misery, suffering and anguish.	Running from truth gives suffering
229	Liberation, happiness, joy in embracing our illness.	Embracing illness gives liberation &
230	I: what process assisted in your acceptance?	happiness
231	P3: There were many many steps. I started off with	Many steps to acceptance
232	meditation and through meditation I began to understand	Meditation
233	how to let go of stress. How to see when I was worried about	Letting go of stress
234	things. How to let go of being worried about them. How to	Identify worry & let go
235	move from negative mental states to positive mental states.	Negative to positive states
236	But then the actual structure of the Dharma in Buddhism is	
237	based on the idea. The beginning of it, is that the Buddha	
238	before he is enlightened he goes out and sees someone who	Reflecting on sickness
239	is sick and reflects on sickness. Then he sees someone who is	
240	old, and he reflects on old age. Then he sees someone who is	Reflecting on aging
241	dead, and reflects on it. And he realizes the human condition	Human impermanence & death
242	is an impermanent one, based on decay. Decay will always	Concept interesting to newly
243	happen. That is kinda interesting for someone just diagnosed	diagnosed
244	HIV positive. In a way you didn't, it's the last thing you want	Death is last thing
245	to hear. You want everything to be happiness, you will go to	Desire happiness sense of all will be
246	heaven and there will be angels and harps and things.	well
247	Buddhism is quite the opposite. Buddhism is, this body of	Buddhism opposite
248	yours will collapse, so will everybody else's. This is not new to	Buddhism believes body will decay
249	you, or this generation, or the next generation or at any other	Not new belief
250	time. But the question is, what you do with it. Then much	What to do with body decay belief
251	later I ran into this story by this monk, and I just thought it	no

252	summed up a lot of how my western cultural background had	Western culture and inability to
253	left me ill equipped to deal with the infection. Whereas there	deal with infection
254	are other paths of education which can strengthen one's	Acceptance strengthened by other
255	acceptance.	paths
256	I: You said that there were many things?	
257	P3: Yah, there were many things I had to do. One is to, learn	
258	the difference between what I want out of life and what I	Coming out similarity
259	intend out of life. Though not dis-similar to coming out,	
260	though the idea that you have only have one idea of what you	
261	life is going to have to be and accept there is going to be a	Acceptance to life possibilities
262	different one. Later I learnt and began to understand further,	different to own ideas
263	that the future is never what you think it's going to be. Never,	Future different to expected
264	ever and it doesn't matter what you think. It's always going to	
265	be different. So that I learnt. The issue is not so much about	Life want not important
266	what you want out of life. What is important to you and	
267	setting your intentions to be in the mental space you want to	Set intentions for wanted mental
268	be in and not to be in mental spaces you not supposed to be	space
269	in. Then to harness that process so that there is a constant	Harness process for wisdom
270	evolution of wisdom, so you are continuing to learn. So with	evolution
271	each phase of my experience of being HIV positive, treatment	
272	and immunity problems. One of those has been a journey of	Study what's going on
273	studying what is going on, trying to learn from that process.	Learn from HIV process
274	I: Would you say you are different as a result of being	
275	diagnosed with HIV?	
276	P3: So many things I have learned, it has been helpful. I am	Learnt many things, helpful
277	fundamentally, enormously happier and I understand much	Happier,understand better
278	better it is in my control and power. The way I was living	In my control and power
279	before, was getting angry about the things that were	Was angry at external in past
280	happening externally to me that occurred. Blaming other	Blaming others
281	people for things that were happening externally. Angry at	
282	the world. Even before diagnosis. Why was there poverty?	Anger at world
283	Why was there racisms? Why were there people being raped?	
284	Why were people not taking HIV seriously? Instead of actually	
285	concentrating on my own well being. And in the changes I	Not focuses on own wellness
286	wanted to see, I can do that. It is in my own grasp. And over	Self agency
287	the years I have also realised I can also teach that to other	Can teach others self agency
288	people. The other part of it was that I had a potential to help	
289	other people awaken to this sense of empowerment, of self	Awaken others self empowerment
290	value, the quality of life, of being realistic about the world and	Awaken Q.O.L
291	dealing with HIV or whatever your particular challenge is. I	Awaken ability to deal with HIV &
292	don't think HIV is any more challenging than other challenges	Life challenges / HIV equivalent
293	in life. In many ways we are very lucky, we have medication	challenge to other life issues / lucky
294	that I can live on. And also there is other stuff about , I had to	as have medication
295	get to some really core defences that I had built up earlier in	Break past old core defences
296	life as a child. I think to grow up gay you have to learn defence	Gay results in early defense
297	mechanisms very early on. Teased as school when I was a	mechanism development
298	child, issues with my father and brother, and you can	Teased; male family issues
299	internalize stuff like that. So after the diagnosis, it was also a	Internalized stigma
301	time to let go of that, liberated from all of that. To really value	Liberation from past post diagnosis
302	who I am. To forgive anyone else and what they had done to	Valuing self, forgiveness,
303	me and reconcile all that. Not to have to feel that I had any	reconciliation/ release past

304	burden from the past, to get into the present. To have	Live in present
305	reconciliation with the past. So, that was a very powerful	Powerful lesson
306	lesson. The diagnosis and the spiritual journey were catalytic	Catalytic – spiritual + diagnosis
307	to each other.	
308	I: What was the process you talked about?	
309	P3: I worked for many years, we set up the first gay and	Worked HIV field when HIV –
310	lesbian organisation in Zimbabwe, where we did HIV	
311	education. This was when I was still HIV negative. I worked for	
312	Asset. I worked for Triangle. I was then eventually the head of	
313	the prevention campaign. I did a lot of voluntary work	
314	already. After diagnosis, I made the decision not to do that	Stopped HIV work when diagnosed
315	any further. The context had changed but also I felt that this	Context changed
316	was that I really needed to resolve personal issues. I didn't	Resolve personal issues
317	feel that I wanted to be out about my HIV status in Cape	Wanting HIV status private
318	Town, even though I processed my feelings around the HIV. I	Processed own feelings around HIV
319	just thought that town has a lot of issues still around HIV still,	Cape Town has HIV issues still
320	and there would be a lot of consequences beyond what I	Possible unwanted consequences –
321	would appreciate or want. If I was very public about it. What I	fear
322	had done over the past few years was to organise a men's	Organized men's meditation and
323	meditation and yoga groups. Mostly focusing on HIV, but then	yoga groups / focus HIV & beyond
324	we kinda just grew into bigger things. So now it is now more	
325	than half the group is HIV positive, and we talk about HIV	HIV & wellness discussion
326	issues sometimes, but it is more generally about well-being.	
327	And growing well-being and wisdom in your life. That is kinda	Personal contribution
328	my contribution.	
329	I: Early you talked about death and dying?	
330	P3: First of all there has hardly been any change, other then	Self-care now
331	that I take more care about my health. You know that I work	
332	in a lot of rural contexts, extremely poor, some of the poorest	Really poor condition exposure
333	countries on the earth. I had to make a decision when I got	
334	infected, am I going to stop doing that and the answer was	Continue despite infection
335	no. So I thought about it and I decided I'd rather do what is	
336	important to me and die in the process. The goal is not to get	Die doing what's important to self
337	sick and die, but I would rather have a good life and do what	Have a good life
338	is meaningful to me, than sit at home and worry about it. In	Do what is meaningful
339	the process I did manage to get really sick several times, but I	Been really sick
340	don't actually think it had anything to do with my HIV status. I	HIV status not linked to illnesses
341	got amoebic dysentery in Indonesia. Gengen fever in South-	Got sick
342	East Asia while travelling, and I have been in extremely dodgy	Been to dodgy places
343	places: Central Africa, where you read about things like ebola	
344	virus and thus far I am still with us.	
345	I: Earlier on you said you take care of yourself, how?	
346	P3: I take care of myself by listening more carefully to my	Attention to body
347	body, except recently. I managed to get myself bronchitis. I do	Recent illness no attention
348	meditation, yoga, I take time out, I don't let my stress levels	Wellness practices
349	build up above a certain level. I know how to walk away from	Stress management
350	things that upset me. My partner and I talk a lot about well-	Letting go
351	being and he is better than I am. I am better at stress	Communication about wellness in
352	management, but he is better at knowing what his body is	relationship/stress manage not
353	doing. I've learnt a lot about that and just to pay more	body awareness /self awareness
354	attention, don't push yourself beyond your limits, eat wisely.	Healthy eating

355	Ya, that's the best you can do. I take my medication. There	Take medication
356	were no issues about taking the medication. I found the	No medication resistance
357	medication a bit harsh at the beginning. But I have met	Medication harshness
358	people who got all hit up about taking the medication, and	People medication resistant
359	almost died because they didn't want to. I have no hang-ups	Severe illness & non-medication
360	at all about it. I need air, I need nitrogen, I need oxygen. I	No medication resistant
361	need all sorts of things. I need food, why would I not need	Medication necessary
362	ARVs? If you know, I could live on a planet where everybody	
363	would inhale ARVs. There was no real hangup about that.	
364	Fortunately I have responded very well . I see the doctor	Good response to medication
365	when I need to. I am on a medical aid, so I am obliged to see	Visit Doctor
366	him quarterly for blood tests. Both of us think it's a waste of	Feel Dr's visit unnecessary
367	time, but I been doing it for years, so we obliged to do that.	
368	Uhhm, no, We not particularly, my idea of taking care of	Self-care is yoga
369	myself is to do yoga. In the week I do meditation about 5	Regular meditation
370	times a week. I am open to new things, massage; I went to an	Openness to new things
371	acupuncturist- that I thought was fascinating; I just haven't	Openness to complimentary
372	done anything about it.	practices
373	I: Earlier you talked about losing friends to HIV/AIDS?	
374	P3: Yes, yes, I lost many people close to me. Two of my	
375	boyfriends died of AIDS, both in Canada. Obviously I think of	Deaths due to HIV
376	both of them. People I have worked with here in HIV	
377	prevention died of AIDS. Friends in the organisation. When	Death and moving
378	Jonathan died, my second boyfriend, I just moved to South	
379	Africa. I got a letter from him after he died. He had written	Letter from dead partner
380	the letter, died, then his sister found the letter and posted it	
381	to me. I had a lot of anger around that. I had never had anger	Lot of anger
382	before. I was grieving. There was an immense amount of	Grief over loss
383	anger because he had not made it to 30. That for some reason	Anger of sheltered life of partner
384	bugged me. We were born just a week apart from each other,	
385	so, uhhm, that anger drove me to do 10 years of voluntary	Anger driven HIV voluntary work
386	work in HIV. And I learned to let go of that anger obviously	Released anger
387	and I have a very different approach today. Just my whole	Changed approach now
388	understanding of death is just so different from what it used	Death understanding now different
389	to be. Now, you know, uhm, now I very much see death as a	Death is cycle
390	cycle. What is also interesting in out tradition of Buddhism is	
391	that you de-emphasize the individual process. In Buddhist	Individual death de-emphasized
392	funerals you don't even mention the name of the person who	Person not mentioned at funeral
393	died. The time to love somebody is when they are alive.	Love in the present when alive
394	When they are dead, that corpse is not them. And it is that	Corpse not the person
395	whole thing about what is real and what is fantasy. To not	Reality v fantasy
396	accept death is complete craziness. I can understand that	Acceptance of death
397	feeling of not wanting to be alone. I can understand missing	Understanding loneliness & longing
398	somebody. For me, death is a lot easier to accept as I focus on	Focus on death
399	it more. I meditate on death. I do death meditations of my	Own death meditation
400	own. I think about my own death. I in act my own death in	Think of own death
401	meditation. You know, I am not from a Tibetan tradition. In	In act death in meditation
402	Tibetan tradition you spend your whole life preparing for	
403	death. You know, that is not quite my scene, but I do	
404	understand what they are saying. That if you don't	Understand death understand life
405	understand death, then you don't understand life. If you don't	

406	understand that you will stop breathing one day, then you	Understand not breathing
407	don't understand what it is to breathe each day. You really	Understand breathing
408	need to process that whole issue around what death is, and	Understand death and life
409	that makes you very alive. You are much more alive if you	
410	understand what death is. Does that make sense?	
411	I: Can you talk about …(unclear)…	
412	P3: In terms of HIV/AIDS?	
413	I: Yah	
414	P3: Well the part that was embarrassing is that when I got	Believed had no prejudices
415	diagnosed I thought I had no prejudices when it comes to HIV	Open minded
416	and AIDS. I thought I was the coolest guy, and I had had sex	Cool guy
417	with men who had AIDS. I had lost partners. I had been	
418	involved in this thing for 20 years. I thought I was the most	
419	open-minded person. And then suddenly it was me. And one	I was infected
420	of the things that came up, which I hadn't understood was I	
421	thought, as some very deep level which was unconscious to	Sleeping around leads to HIV
422	me, that only men who slept around and were foolish, would	Unconscious bias
423	get infected. But now I was infected, and I had been incredibly	Infected despite being responsible
424	responsible. So then I had to face the fact I did have a bias	Unconscious bias
425	that I had been dragging around with me, which I didn't even	
426	know I had. So I thought that was interesting. And	Interesting realization
427	subsequently I see that often in other gay men. That if I come	Same belief in other gays
428	out to somebody that I am HIV positive and they HIV negative,	
429	then it is not unusual that they should react, that you a slut.	HIV+ means slut
430	Only those people get HIV. Though this association with bad	Link between moralize illness
431	ethics or bad morality and disease is problematic, it is a little	
432	bit complicated. Under the Buddhist laws of karma, you do	Karma
433	generate it, what happens to you. The fact that I go infected	Get what you generate
434	with HIV was due to my own actions, it wasn't due to, and it	Infected due to self actions
435	was due to someone else's actions as well, but it was I who	Infections also due to others
436	created the conditions that allowed that to happen. But there	actions
437	is a big difference between accepting that responsibility,	Acceptance versus judgement
438	judging that, and becoming judgemental about that. So what I	
439	was trying to achieve at that moment had no ill intent in it,	Intention
440	that is the key thing. Is there ignorance? Yes, there was	Ignorance
441	ignorance. Was there harm? Did I do harm? No I did not do	Harm
442	harm. The other person did harm. The other person knew he	
443	was infected and infected me deliberately, so it was his	Deliberately infected
444	intention to infect me. But had I put myself in harms way?	In harms way
445	Well, yes. Did I, uhm, intentionally know this would happen.	Unintentional
446	No. So, so, I had to rework, I had to play and replay the tape	Responsibility
447	back to understand I had this prejudice. But what was my	Others responsibility
448	responsibility. What are other peoples responsibilities. And	Meaning of karma in practice
449	what does that mean in a karmic sense. But then what does	
450	that mean in practice. I know that that is a complicated	
451	discussion. The discussion I have had with other HIV positive	Belief in HIV as terrible occurance is
452	men, I think the idea, is that you have to say that this is	mistake
453	something terrible that has happened to me, is a mistake. You	
454	are an active participant, it is really important that you take	Active particiant
455	responsibility for that. Do you have to be judgmental about	Responsibility
456	that? No. That is extremely unhelpful and ignorant in itself. It	Acceptance v judgement

457	is what it is. Even if you do something that is harmful, heaven	Harmful actions happen
458	forbid you infect somebody else. It happens. The question, is	Moving on
459	what do you do now? How do you move on from any	
460	particular moment. The goal of the exercise is to act as	Ongoing mindful----------
461	mindfully and generously as you can at each stage of your life,	
462	wherever you happen to be. Part of that is also self-	Self forgiveness
463	forgiveness. And that true emotion is healthy emotion.	Self forgiveness
464	I: (unclear)	
465	You know, 10 or 15 years ago. I lived in Cape Town 20 years.	Past people wanted knowledge
466	When I first came here, people wanted to know. We ran HIV	Preventions workshops
467	prevention workshops. They very much started out with this	Epidemic due
468	basic idea that there is this epidemic coming and how you can	
469	avoid it. Later I began to run more workshops for people living	Living with HIV workshops
470	with HIV. There was an enthusiasm to understand what was	Enthusiasm for knowledge
471	going on and an enthusiasm to come together as a	Enthusiasm for community
472	community. Then speaking very frankly and very honestly	Open discussing
473	about those sexual practices, emotions, send of self-esteem.	
474	And that, all that ran out of energy. We were already picking	Energy ran out
475	up in research, particularly the work that Glen de Swardt was	
476	doing at Triangle Project, that there was a demographic shift	Attitude shifts
477	in attitudes. White gay men who had been very active in	
478	trying to self-educate, just switched off. They didn't want to	White gays switched off
479	hear. They felt they knew too much. There was no sign of	No behaviour changed
480	behaviour change on there part at all. There was a sign of	Info saturation
481	saturation of information. Black men were saying something	Black men different message
482	different. They were saying they are not getting access to	No access to information
483	information. They had high levels of anxiety and low levels of	High anxiety & low info – Black
484	information. While the white men where saying we have high	High anxiety & high info – White
485	levels of anxiety and high levels of information . Ergo, we	Stop
486	don't want to know any more. We don't know how to process	Cant process
487	the information. We are unable to move from information to	
488	behaviour change, therefore we are just going to shut off. You	Shut off
489	know, in my discussions with both mental health practioner's	
490	and physical health practioner's, our general view is that in	
491	this sexually active population in Cape Town, we are probably	Public visibility over CPT 50%
492	talking about a 50% infection rate. You don't see that	infection rate
493	publically. It is very invisible. I am always fascinated when I go	
494	to London or Amsterdam or New York. People often tell you	Openness of HIV status
495	their HIV status, unsolicited. People will quote you their CD4	
496	count, you know. People are blasé. They will chat about their	
497	treatment options. That is not always the case. But generally	
498	in the West, there is a lot of openness. In South Africa there is	HIV Stigma in SA
499	a huge amount of stigma. I am trying through the yoga and	Bypass stigma
500	meditation group, to some degree, I am trying to see if we	
501	can't get past that. But we are not obsessing about the HIV	
502	issues, but just talking about what it is to be a supportive	Supporting brotherhood
503	brotherhood. What it means to sleep with other guys, you	
504	must also respect them. You must care about them. Maybe	Respect sex partners
505	we just need to lower the defences just a little bit. Be a little	Be vulnerable
506	more vulnerable with each other. And in that sense,	
507	understand that we are saying, we are all in the same	All people the same

508	community.	
509	I: Considering you were saying…	
510	P3: I only have 5 minutes	
511	I: You have answered most of the other questions, so we will	
512	fly through them…Has HIV changed you?	
513	P3: Yes, enormously. HIV was the catalyst for me to go and	Catalyst
514	explore my spirituality. That lead me to adopt to a particular	Explore spirituality
515	path, Buddhist. To the point, that I spent some time in	Adopt Buddhism
516	Thailand. 10 years doing meditation and teaching Buddhism.	Involvement in path – spiritual
517	So it had a huge impact. That could have happened at any	Anytime but
518	point in my life, I had wanted to do that, but it was the	Diagnosis catalyst
519	diagnosis that was the catalyst.	
520	I: What role does your religion/spirituality play in helping you	
521	to cope?	
522	P3: Immenstrual, it has changed my life. I am a happier	Life change
523	person. I deal with stress much better than I did before. I try	Happier – deal with stress
524	to live more in reality than what I wish the world to be. Where	Live in reality
525	the stress doesn't come externally, but is a mental response	
526	to an external situation. Therefore it is in my power to	Control mental responses
527	change. I do believe, I would follow all this if I wasn't. If the	
528	fairy god mother came and waived her wand and I as no	
529	longer HIV positive, I would still follow this path. But, being	Not to manage stress
530	HIV positive, managing stress is pretty important. So, I…From	
531	what I have heard from other people and what I have seen	
532	with my own experience is if you manage stress and dissolve	Discover root of stress
533	it, go to the heart of it, go very deep into your own psyche,	In core of self
534	and figure out what is causing trouble. Right at that process.	
535	First of all, the quality of your daily life is going to get better.	Better QOL
536	Chances are that you are going to live longer is also higher.	Live longer
537	I: unclear…You've answered…unclear…process	
538	P3: Yes, it is always a debate whether Buddhism is a religion.	Buddhism and religion
539	There is no God in Buddhism, but there is all the other	
540	elements. There is a psychology behind it, there is a	Psychology
541	behavioural side to it, there is a philosophy behind it, and	Philosophy
542	there is a practice behind it. So, getting diagnosed lead me to	Practice
543	a path of practice that led to new convictions and new	Deepening each other
544	understandings that lead to deeper practices. So each of	
545	those things are a corollary of one another.	
546	I: at some levels are there differences?	
547	P3: In Buddhism, the way Buddhism is structured is that you	Practice Buddhism
548	practice, because for whatever reason brought you to it, and	
549	then you have to ask yourself, is this true what I have done? If	Delving depths of own psyche
550	it is true, then you have the opportunity to go to a deeper	
551	level and then another deeper level. Fundamentally it is a	
552	deeper level of your own psyche. So it is about, how willing	
553	are you to pierce into the structure of your own psyche to	
554	understand where the good parts and where the bad parts	Understanding good + bad self
555	are. And learn to let go of the bad parts and grow the good	Let go bad
556	parts. That isn't just fundamentally, a belief system, but a	Belief system
557	practice system.	
558	I: How have your beliefs supported/hindered your health?	

559	P3: Well, my beliefs and my practices have re-inforced each	
560	other. To show if I do these things, I am healthier. I am	Healthier happier
561	happier. Better relationships. Getting more quality out of my	QOL
562	life. Whether that has influenced my medical condition in any	
563	way I cannot say, but it certainly influenced my psychological	
564	reactions. I have just had an appauling flu. It's just a flu. A flu	
565	that people who are HIV positive are more particularly	
566	vulnerable to. And I got this bloody flu. You know, that's what	
567	I had, so I don't, I didn't sit there thinking, oh my God I am	
568	going to die. I did think I might die, that's interesting. You	
569	know, maybe it's now. What I am trying to say is, when there	Death is possible
570	are health crisis, I have a framework within which I process	Framework provided
571	these things.	
572	I: Do you, did you use recreational drugs and was it linked to	
573	your HIV?	
574	P3: Ok, Good question. I have a very odd history which is, I	
575	hadn't used recreational drugs throughout my whole growing	No prior recreational drug use
576	up period. I didn't drink either, I was one of those people that	
577	believed everything they told me in those advertisements	Conservative
578	about good health. I didn't smoke. I didn't drink. I didn't drink	
579	coffee and I didn't eat fatty foods. I didn't even eat butter. So	
580	I was one of those who grew up like that. So I didn't even start	
581	drinking alcohol till I was in my 30s. Then I got infected and	Infection
582	then I met some people who did a lot of recreational drugs	People using
583	and so I thought, hell, well I have HIV, I might as well try	Infected might as well
584	things. I have always been curious of all these things and what	Curiosity
585	it would be like. For two years, on and off, I did have	Fascinating experimentation
586	experiences with recreational drugs, a variety of them, and it	
587	was fascinating. And at the end of a two year period, I had a	
588	falling out with those particular people, partly because of	Falling out
589	their drug use. That relationship ended and I thought well you	Curiosity satisfied
590	know what that is about. But is that good for you? No. So, it is	
591	interesting, it did allow me a number of experiences of	Assisted understanding self
592	understanding my own psychology. In recreational drugs it	
593	triggers a lot of underlying psychological processes, so in that	
594	sense you can learn something from them. But I thought it	Opportunity to learn
595	was an unwise use of my energy and also my spirituality was	Incompatible to spirituality
596	growing at the time, and recreational drugs is very	
597	discouraged in the tradition. I have also come to the point	
598	now, that I like good wine and things, but I find with the ARVs	ARV & alcohol intolerance
599	I can't tolerate alcohol. Now I hardly drink, I kinda have got	
600	back to where I was before. No drugs. I hardly take any	Return to non-use
601	alcohol at all.	
602	I: Thank you so much. I really appreciate it.	
603	P3: It was my pleasure, good luck with this.	

Interview 4

Line No	Dialogue	Natural Meaning Units
1	**P4**: …I met him.	
2	**I**: Ja.	
3	**P4**: And obviously (indistinct) he's very – handling – well	
4	not handling as good but he is fine (indistinct) and then I	
5	still well you must go to the doctor with me and so that we	
6	can discuss issues and it doesn't help just one go it's we're	
7	(indistinct) together which we do. So, we went to – I used	
8	to go to Budnik... [intervention]	
9	**I**: Oh you're also Budnik okay.	
10	**P4**: So, so we asked him about you know the sex	
11	(indistinct) and we know the basics obviously, but you	
12	know you are in a relationship so sometimes the barrier it	
13	falls away of whatever you know and he was like really he	Lack of Dr + sex + HIV openness
14	was shy to talk about it. So, we walked out there and we	
15	were like okay we didn't really get what we wanted from	
16	this but not realising it as much then and then I felt	
17	(indistinct) and got all better took my IRVs and then my	
18	specialist said okay right maybe time to go and see your	
19	HIV doctor again to see if we need to put you back on IRVs	New Dr + sex + HIV openness
20	and he introduced me to Kevin. So, myself went to	
21	questions so the first question is not what must we do and	Sex + HIV openness
22	he was like a world of information which – and he wasn't	
23	shy to talk about it, it was – it's not a place where you can	
24	be shy in my opinion.	
25	**I**: No.	
26	**P4**: Anyway.	
27	**I**: No, okay, today is 8th or 9th?	
28	**P4**: 8th.	
29	**I**: Okay, so today is the 8th sorry you will be participant	
30	number four.	
31	**P4**: Okay, name of legal representative applicable?	
32	**I**: No, no, no.	
33	**P4**: Why not?	
34	**I**: The rest will be me. Okay, so when we start and do	
35	today is the 8th of August and I'll be doing my interview	
36	with participant four. Some of the things you were	
37	chatting about just now will actually come up again, but I'd	
38	like to start I think the easiest place to start out with is	
39	usually around tell me a bit about your coming out process.	
40	**P4**: I've got the funniest story, really. No, I mean I just – I	
41	mean I know ag from primary school that I was gay	
42	definitely and... [intervention]	
43	**I**: What made you know?	
44	**P4**: Just interest, I suppose playing around with some of	
45	the boys was a bit of a dead giveaway, but ja no ag it is just	Sense of always knowing own
46	something that I just always knew I never was ja I just knew	sexuality
47	it from day one. And I was in boarding school in high	Sexual experimentation at

48	school and experiments there with some of the other boys	school
49	at boarding school that is just how it goes. But anyway I	Work already out of school
50	finished high school and within my first week I started	
51	working because my Dad has a rule he doesn't buy any cars	
52	for kids so when I was at home after finishing matric for	Lack of freedom
53	two days and I figured out I definitely needed car because	
54	this is not working for me not being mobile. So, I got a job	Saving & purchase of car
55	as a waiter immediately and I saved every penny but by	Freedom to go out
56	January I bought … I bought a little beetle as we all did back	
57	then and – but now obviously having a car I started going	
58	out. So, I mean I obviously work in a restaurant and make	
59	friends with people and there was one guy Stefan, straight	Going out
60	guy, we went to in Sea Point, and I'm talking about early	
61	'90s, we went to a bar called the Blue Rock which was quite	
62	hectic and drinking and bizarre and all of that, a straight	Arrive home drunk
63	bar. And coming from there in the morning like at six	Parents upset over coming out
64	o'clock my Dad was waiting my in at home and as I – I	
65	couldn't unlock the door as we do and he opened the door	
66	and I mean like 'What the hell is wrong with you?' and I	
67	said 'I'm gay.' He just looked at me like it's like just go and	
68	sleep and like two or three hours later my Mom came and	
69	wake me put and it is like crying away and I'm like why are	
70	you crying it's like well what did you tell you Dad? I'm like I	Realization of coming
71	don't know what did I tell my Dad and it's like you told your	
72	Dad that your gay, I'm like oh that hmm, ja, no that's true	Difficult family time at onset of
73	because then I realised it cat was sort of like out of the bag.	coming out/own rebellious
74	But ja that was just that, we – me and parents went	behaviour
75	through a bit of a rough patch for about a year but I was	Family relationships smooths
76	naughty I went out late and didn't tell them and you know I	out
77	also initiated a lot of the arguments, but ja eventually it	
78	just sort of smoothed it all out and…	
79	**I**: What was the reason for you to initiate the arguments	
80	what had actually happened?	Staying hom
81	**P4**: Well, because I was – you know I was obviously still	
82	staying at home I was maar 'n first year student and you	Parents wanting to keep track
83	know I would go out and as parents you know want to	Stay out without caring
84	know what time you are going to come back or are you	
85	going out and I would come back the next morning at three	
86	and they would like sort of worry and that would lead to	
87	the argument. So, you know that and I mean at back then I	Realised I was being unfair
88	didn't think I was wrong but now I'm old enough to know	
89	that look I wasn't really playing by the rules and that is why	
90	we had a few fights and all that.	
91	**I**: And their response to your sexuality you stating being	
92	gay how did that go down?	Initial difficulty coming out
93	**P4**: Uh, at the beginning it was very raw, I mean I think like	Dreams of grandkids
94	everybody parent they want to see the grandkids and they	Ideal family
95	have got this you know little ideal world with a little white	
96	picket fence and a dog and a wife and the kids, but it's ja	Open family relationship
97	eventually it's brilliant and I've got a very open relationship	
98	with my parents, very, very open they know everything	Some info withheld from family

99	about me and more. Well, not much more, but they know	
100	everything they need to know and you know all my	
101	boyfriends throughout my – well at sometimes I had quite	Family meet serious
102	a bit, but the serious relationships always met my parents	relationship
103	and you know they it's like another son in the home that's	BF another son
104	just it. It is not even a topic that gets discussed anymore	Homosexuality no longer topic
105	because (indistinct) I mean my Dad is this real Afrikaans	Father a real man
106	Bulle kind of guy and when he sees me he hugs and then	Close father relationship
107	he kisses me and you know we've got a very, very, very	
108	good relationship and a solid and healthy relationship.	
109	**I**: Right, first let then me ask one questions how has HIV or	
110	being HIV positive changed the way you feel about being	
111	gay?	
112	**P4**: No, it's got nothing to do with that.	
113	**I**: Okay, and how has it affected your relationship with	
114	your parents?	HIV+ affected parent
115	**P4**: Positively, it affected it positively, on the day I found	relationship
116	out and I basically found out, I don't know if I'm jumping	
117	your question now, but... [intervention]	
118	**I**: No, no.	Life insurance application
119	**P4**: …I applied for more life insurance and you know as life	HIV test
120	insurance does the nurse come to do a HIV test and the	Feelings of unlikely HIV
121	nurse will ask me do I want any counselling and I still look I	infection due to boring life/turn
122	run such a boring life she really don't have to give me that	down HIV info/phone call to go
123	whole rundown and then she does the HIV the broker	see Dr
124	phoned look (indistinct) send you to a doctor and then you	Realization of HIV infection
125	just instantly know look obviously, but obviously that's	Finality of HIV infection
126	that. And which they've done and that was the morning	
127	and by the afternoon I just couldn't because I thought I'm	Home test confirmation
128	just going to go to the local chemist and get a quick test	
129	which I've done and it was positive and you know my Mom	Mom figured out result
130	works for me and I said to her look I'm just going to go out	
131	and I didn't come back and she sort of plotted the thing	
132	together and that evening at six she phoned she said look	Mom visited
133	I'm going to come over quickly to where I stay. And I said	
134	okay sure no problem and she you know came to visit and	
135	said look you didn't come back I know you took – wanted	
136	to have more life insurance and I know that our brokers	
137	phoned she said she just want (indistinct) she said like I	Admittance of HIV status to
138	take that you are HIV positive, I said yes it happened, she	mom/ acceptance by mom
139	said brilliant not a problem nothing changed. And oh she	Disappointed over HIV status
140	had a few tears obviously because it is a disappointment	
141	for everybody I suppose and then my Dad phoned and he is	
142	like so I just don't see why we are ever going to discuss this	Dad's acceptance of HIV status
143	again because I don't see the problem and his exact words	HIV just another disease
144	were 'I've got diabetes that's a bigger issue to life than	HIV more manageable than
145	with HIV your scenario is much better and manageable that	other diseases
146	diabetes,' and he just said it is the last time I'm going to	
147	talk about it just don't even and he's like that was – don't	No guilt over HIV
148	even try and feel guilty or this or that whatever nothing has	Family unchanged by HIV
149	to change but us as a family or whatever and that's it done,	

150	dealt with.	
151	**I**: How long ago was that?	
152	**P4**: It was last year just after the Easter weekend so it was	
153	like April ja.	
154	**I**: And, how has your partner – how has it affected your	
155	relationship with your partner?	Partner left due to HIV status
156	**P4**: At that stage I was seeing somebody and he ran for the	No support from partner
157	hills because I told him the same day, no support	Lack of surprise
158	whatsoever from him which to be quite honest it doesn't	Relationship was faltering
159	surprise me at, the relationship was going south in any	
160	events. So, whether it was that or any other reason you	
161	know it was not going to last so it was upsetting sort of the	New relationship
162	writing was on the wall. My current partner which I met	
163	the last bit of last year, last quarter of last year, very funny	
164	it my – actually of my parents' friend for I'm trying to think	Set up by family friend
165	how long they knew her, but many, many years I mean she	
166	knows me since I've been about seven or eight years old,	HIV+ disclosure to partner
167	introduced the two of us together and ja it's just worked	Acceptance of HIV+ by partner
168	and from day one I said look this is my scenario and	
169	Richard's response was just so that change your personality	
170	how? It doesn't. So, done.	
171	**I**: Okay.	Partner had previous HIV+
172	**P4**: Well, Richard also he has a – he's negative, but he have	partner
173	(sic) had a previous relationship, long-term relationship,	
174	with a positive partner so he is very well aware of the do's,	
175	dont's (sic) but management all of that.	Made things easier
176	**I**: Okay.	
177	**P4**: I suppose that made it much easier for me.	
178	**I**: For you?	
179	**P4**: Ja.	
180	**I**: So, making it much easier does the HIV take any role at	Responsibility for HIV important
181	all in the relationship?	HIV not a big thing
182	**P4**: It does because it has to because you need to be	Mutual support
183	responsible about it, but it is not like this big thing hovering	Reaction to ARV's
184	over us or anything, we, like I say, we manage together, we	
185	do the doctor's appointments together. Now because of	
186	my reaction I had on IRVs because I wasn't even supposed	
187	to go on IRVs because it wasn't necessary (indistinct) is	
188	going to do a little bit of an experiment where they are	
189	actually to go and treat Richard put him on IRV even he is	Protect partners health
190	negative on Truvada because there is a new study that's	Wanting children
191	been passed and we are going to be guinea pigs on that,	
192	because I just you know we want to look after his health	
193	and we both want kids so you know he would have to be	
194	the if we are going to do surrogacy you know somebody	
195	has to have healthy sperm, so ja that's where we're going if	
196	it.	
197	**I**: Okay, you talked about sex and being responsible, how	Always practice safe sex
198	has the HIV changed how you behave sexually?	Unsafe encounters
199	**P4**: It's – it didn't really because I've always been a very	Sense of distance in sex
200	safe sex kind of person, look obviously not all the time	

201	because I am infected, but it's – how – how do I answer?	
202	Yes it did because you think now a little bit further than	
203	what I used to, but in the – my normal general pattern not	
204	really because I know exactly who infected me, I know	One unsafe encounter
205	exactly when it happened, that person unfortunately is not	
206	honest enough to man up to it and the reason why I know	Request for HIV testing
207	was that person already starting seeing this guy and we	
208	one night had unsafe sex and I said to him look this has	Man disappeared
209	happened we've been seeing each other for two months or	
210	so, so I think the next step is just to go for a test and let see	
211	what the scenario is so we know how to manage it. And I	
212	never see him ever again – seen him ever again he	Assumption he was the person
213	disappeared from the earth, his cell phone number	
214	changed just gone, I promise you gone away off from	
215	Facebook it's just gone never, ever, ever seen him around	
216	in Cape Town, never walked into him again. So, I – look his	
217	assumption was I don't know but I assume that he did	Relief over not giving others HIV
218	know and because I said that he just ran for the hills and	
219	then I tested negatively but obviously it was in the sort of	
220	window period and a year and a half later when I tested	
221	again I was positive. And I only – I've only been with one	More cautious responsible
222	person thereafter, luckily he didn't get infected.	
223	**I**: Well, how has the HIV changed – having HIV changed	
224	your attitude?	Monogamous relationship
225	**P4:** My attitude may be a little bit more safer than what I	Manage HIV
226	used to be, not that I was unsafe a lot of times beforehand,	Concerned over other reason
227	but you know I do – well I do think about the other person,	
228	I mean now I'm a monogamous relationship so no it is	Upfront disclosure
229	different and we know about the scenario and we manage	Negative reactions over HIV
230	it, but before it you know it was you know you take care I	Pained but understand
231	sort of thought further for the other person. And in right in	reactions
232	the beginning obviously then you know you have disclose	
233	beforehand and there is people that have a total negative	
234	reaction against it, which is not nice, but it is the way is, it	
235	is just the way it is.	HIV removes sexual spontaneity
236	**I**: And, you said that your attitude has changed slightly, in	HIV removes spontaneity in sex
237	what way has it changed?	
238	**P4**: It takes a little bit of responti... [intervention]	
239	**I**: Spontaneity.	HIV – can be spontaneous with
240	**P4**: …away from it in terms of you know if you're negative	sex
241	often when you're negative and you are sort of a	
242	spontaneous sort of you know with your partner walking	Lack spontaneity
243	the mountain and you know you have a spontaneous	
244	rowdy moment you know you just sort of went for it where	
245	now it's a little bit different because now – so you that is	
246	you know I'm not as spontaneous what I used to be	Kit to assist possibilities
247	because now I go oh shit you don't have A, B, C and D with	
248	you so you know where – look there is still things you can	Spontaneity can improve over
249	do but now it just sorts of cuts it off because now it is sort	time/understand each other
250	of like you know I don't have my whole kit with me so now	
251	it is just not going to happen. And I think I will become	Commited relationship even

252	again more spontaneous about it especially with Richard	marriage
253	because we understand one another and it's a – you know	
254	it is a whole different level of relationship you know it's I	
255	know we're in for a long haul, we are going to get married,	
256	we are going to kids together you just know it is that	
257	person. So, it is very different so the longer we know each	
258	other you know it just involve more…	Changes person
259	**I**: But have you gone onto any changes or can you tell me	Re-evaluate life and self
260	about any processes you've gone through since you were	Look at life purpose
261	diagnosed?	Look at life meaning and take
262	**P4**: Ja, no definitely I mean you do I mean right in the	less for granted/regrouped
263	beginning you definitely sort of do a re-evaluation of	inner self/best thing HIV
264	yourself and you look at your purpose in life or you know	diagnosis
265	what's the reason for you being here, take less things for	
266	granted, so I mean in that event definitely it did make me	
267	sort of regroup of my inner self again which I think it is one	
268	of the best things that could of happened being diagnosed.	
269	But you know how it is you just sometimes say things for	
270	that's the way it is, ja, no.	
271	**I**: Well, when you re-grouped what will you say you talked	Internal happiness
272	about new purpose, meaning, what were – what did you	Purpose and meaning
273	evaluate for yourself?	
274	**P4**: Well, it's – you know for myself just to really be	Living unaware
275	internally happy and you know to have a purpose and a	
276	meaning for why I am roaming earth and I say it very	
277	lightly, but I mean very often I think people just get into	
278	this whole programme, this whole rut of get up, get to	
279	work, get home, have supper just do that for five days and	Changes – more aware
280	then you have to off days where you have many this same	
281	role programme where you know depending on who you	Desire to be remembered as a
282	are but that maybe go out on a Friday night and you know	good person
283	that's just in your programme. And for me it sort of just	Make a difference to people
284	changed, not that I had the programme, but I just I thought	
285	about it look if I – maybe if I pass away what is people	
286	going to say, not that they want them to go Oh (indistinct)	
287	the Great, but you know have a made a difference in	
288	somebody else's life you know or were I just one of those	
289	people that didn't do a difference. And I would like to – I	
290	would like to know that I did make a difference for	
291	somebody even if it is just the guy that collects the dirt and	
292	I gave a pair of shoes one day if, if you know that you	Am more helpful
293	know. So, ja, no, I definitely it wanted me to be a better	More awareness of little things
294	person.	
295	**I**: Okay, so since taken the evaluation how have you	
296	changed?	Notice things
297	**P4**: I do think I became definitely more helpful, no it's –	Help if able to
298	you know it's I'm seeing smaller things and acknowledging	No desire for acknowledgement
299	smaller things like I said you know the guy give him a pair	
301	of shoes or this or that, people that I know that's, and I'm	
302	sounding like bloody Mother Theresa, I'm not, but you	
303	know I just go I just see things, noticing things and if I can	

304	help I help and I don't want any acknowledgement of it it's	
305	just I feel better in doing it and some of the things I that I	Feel good making a difference
306	do people don't know that I've done it it's just it just	
307	happens and ja I mean I don't know how to really word it,	
308	but I'm happy with where I am.	
309	**I:** When you're doing these things without people knowing	
310	what is the impact on you?	
311	**P4**: It makes me feel good and it just you know it's – it just	
312	it's nice to know that you've made a difference for	
313	somebody else and something that they ready needed I	Desire for children
314	mean it's – and I'm talking about somebody that I've	
315	known for many, many years gone through a divorce and	Partner has same children
316	she's got three kids and she is struggling on her salary to	desire
317	feed her kids you know. Just to pack a box of groceries	
318	leave it at her front door tonight when she comes home it	Living for the moment
319	is just like there, you know little things and ja it is also I	Stopping putting things on hold
320	mean I've – one of the deeper things is I always wanted	
321	kids but it is sort of just put on the backburner, luckily now	
322	that I've met Richard and he wants the same thing you	
323	know now it is going to happen one day, hopefully sooner	
324	than later because I want to be young and enjoy it. But ja,	
325	so, living your life not put anything what you want sort of	
326	back and not getting to it.	
327	**I**: Okay, no longer putting things on hold you are actually	
328	doing it?	Not involved in HIV
329	**P4**: Yes, ja.	organizations
330	**I**: Okay, and have you been involved with any HIV	
331	organisations?	Not involved in gay
332	**P4**: No.	organizations
333	**I**: Not?	Gay identity not advertised
334	**P4**: Not, and I don't know why, but you know I'm also –	Not into gay culture
335	look also saying that maybe it is just something of my	
336	character because I'm not somebody I've never also – I've	Identity not same as gay culture
337	been involved in gay organisations. Just, I don't on the	
338	whole gay thing I also just I don't need to advertise who I	
339	am and what I am part of, don't have anything against it	
340	and I get the whole gay pride march, blah, blah, blah, I just	
341	never really done it, it's not how I tick. So, I think maybe in	Supported friends with HIV
342	that regard that's why I didn't really think of joining an	Assistance with HIV inf + help
343	organisation about that. I have had two instances of	
344	people that I've known for a good couple of years that's	
345	also been diagnosed positively and I've been there as a	
346	friend and a shoulder and I mean helping them to get the	
347	correct help with a clinic or this or that or whatever and	
348	answering some of their questions that they want to know	
349	that maybe I had the answer maybe I don't, but so in that	Impending shortening of life on
350	way being involved, but an actual organisation no.	diagnosis
351	**I**: No, that's perfect. I want to find out from you because	Chased dreams
352	you talked re-evaluating your life just now, has been	
353	diagnosed with HIV changed how you think about time in	
354	any ways?	

355	**P4**: It did in the beginning, it did in the beginning, that's	Urgency at beginning
356	why I sounded very silly, but in – it was like in the first	
357	week or two at that stage my dream car was Jeep	
358	Wrangler, I wanted a Jeep Wrangler with a passion okay	
359	and before I got diagnose... [intervention]	Awareness of acting out by
360	**I**: A nice car.	father
361	**P4**: Yes, so the first week or two and when that sort of like	
362	became sort of passed away or moved on but every time I	
363	drive passed a Jeep garage or any 4x4 sort second hand	
364	dealership I stopped and I looked and I was test driving all	
365	of them and it is was like or it was like it was almost	Death not tomorrow
366	something I needed to do and my Dad actually because I –	
367	my Dad and I always had we sort buy not guys together but	Realization of no impending
368	we between the two of us we have like a little fleet and we	death
369	sort of share our cars and bakkies and things. And my Dad	
370	sort of after like he – I think he sort of knows what is	Total material obsession
371	happening and he just looked at my it is like Daniel you are	
372	not going to die tomorrow you don't have to do this right	Obsessed initially
373	now and it sort of sparked because then I sort of saw	
374	exactly I am not going to die tomorrow. I don't have to	
375	because it was something that chased me like I had to get	Friends with HIV
376	this thing like now and I mean it's maybe a little bit silly	Can live long period with HIV
377	because it is a total materialist thing, but – and that sort of	
378	put onto the whole thing was (indistinct) it is like no shit it	
379	is not about that it's just not about that. So, ja time was	Realization that one can live
380	definitely it was definitely that whole I thought of time.	long life with HIV
381	Now I know, look and this whole journey you know I've I	
382	mean this one friend of mine that I've known for years has	
383	been living with HIV for 27 years he is as fit as a fiddle	Initial panic
384	there's not – nothing you know it is just life (indistinct)	
385	normally and he also came out that he is HIV positive after	
386	I was diagnosed and you know seeing him and just realising	
387	that you can manage it and you can have a perfect life,	
388	grow old and grey perfectly.	Close encounter with death
389	**I**: Okay.	
390	**P4**: But in the beginning definitely yes no it was like I was	Still have things to do
391	in a little bit of a panic.	Death now in perspective
392	**I:** Okay, well you talked about there of basically that sense	Sense of death as a reality
393	of dying, has your thoughts and feelings changed about	Thought of affecting others
394	death and dying?	
395	**P4**: It has I just really because I had very close encounter	Preparations
396	this year, very – way too close for my liking because I've	
397	still got things to do, but so it has changed and it is more it	
398	was put in perspective for me and it was made real	Reality of death faced
399	because I had you know that kind of experience and where	
400	it made me think of things should I die what is going to	Dealt with fear + death
401	happen to people you are going to leave behind and all of	
402	that, and well look I was in hospital and then suddenly I	
403	had to put a will together because that the it was going I	
404	had a business and all of that and I didn't have a will so	
405	there was things I had to do. And it was made a little bit	

406	more real because I always (indistinct) we all die one day,	
407	but and maybe also it made me deal with things that I was	
408	scared about if I should die which I'm now not scared	Death is another route
409	about anymore because now I sort of dealt with it and I	Spirituality move on
410	was maybe forced to think about it.	Spirituality being embodied
411	**I**: I want to understand about the process of death.	
412	**P4**: Very wide (indistinct) because it mean you can – you	
413	can answer it in a religious way, you can answer it in a	Spirit move on
414	spiritual way... [intervention]	
415	**I**: From your way, just your idea of death what is it?	
416	**P4**: I just think it is the beginning of another route, I mean I	
417	think we are on earth and spiritually I think you'll just move	
418	on I think we are just here a spiritual being in a human	
419	body and this is just really our little motorcar or vessel we	
420	move around in and I think if you pass away it is just really	
421	your body going away but your spirit will go somewhere	
422	else, where exactly I can't answer you. But you move on	Sense of control over AIDS
423	maybe to another dimension or to something else that you	
424	need to do but I don't think if you die on earth that's the	Self care
425	end it definitely it is going on and I think we had (indistinct)	
426	before we were here.	Irresponsible status life
427	**I**: Brings me to the idea of do you feel that you have any	
428	sense of control or not over whether or not you develop	
429	AIDS?	HIV affects immune system
430	**P4**: Yes, you definitely have some control.	
431	**I**: What ways?	
432	**P4**: I think you must be responsible you must – you have to	
433	look after yourself. If you're going to be somebody that is	
434	going to damage your immune system by either drinking	
435	way too much or taking recreational drugs or whatever	
436	then you are going to shorten your lifespan, well whether	Self care
437	you are HIV positive or not you are going to do it so, but I	
438	mean I think being HIV positive even more so because now	
439	there is already something fighting your immune system.	
440	So, you know if you are going to add to that then surely	Lack of responsibility leads to
441	you are going to have a problem, so yes you are in control	AIDS
442	and yes you have to look after yourself. No, you don't have	Take responsibility self
443	to put yourself on a pedicle and never go out in the rain or	
444	anything like that, but you must look after yourself. You	
445	know if you – ja definitely you're in control I don't – I – if	
446	you're not going to look after yourself if you are not going	
447	to go to the doctor three times a year to have your levels	
448	checked to see what is happening inside your body, if you	Initial poor reaction to HIV
449	are just going to leave it then you are going to have a	
450	disaster, but (indistinct) what you need to do then that's it.	Regrouped
451	**I**: Okay, well then there is this shall I ask is how has HIV	
452	affected your house so far?	Arrange Dr visit
453	**P4**: Well, now isn't that a story.	
454	**I**: Talking about (indistinct) and looking after yourself so	
455	let's see how has it affected you so far?	Early ARV treatment on
456	**P4**: Well, ja look that was my first instinct when I was	diagnosis

457	tested positively then I you know and I had my little	Poor Dr screening
458	wobbly, as we do, I – right so that is the scenario so this is	
459	now what are we going to do? So, phoned around, went to	Low CD4
460	a private practice because I thought that is where I am	High viral load
461	going to get the best help and that's what I did for almost a	Believed taking ARV's was right
462	year and I went every three months, went for my check-up,	ARV's worked
463	went for my blood test. I started on ARVs in less than a	More aware now
464	month I was diagnosed which I now know was the wrong	Possible initial infection
465	thing that they did because they didn't do two tests to see	
466	where my CD4 counts of viral loads what is happening to it,	
467	it was like one test and on that specific test my CD4 count	
468	was quite low it was 260 odd and my viral load was quite	
469	high and immediately oh right ARVs here we go and I	
470	though great that is what I need to do that is what I done.	
471	And my CD4 count my viral load dropped which should	
472	happen, but now that I know more is they – I personally	HIV impacted health
473	think they should have done two counts to see what is here	
474	maybe I'm just in that first period where your CD4 naturally	Poor reaction to ARV's
475	drops and your viral load goes higher and then eventually it	Deadly ill from ARV's
476	swopped over, that wasn't done. So, you know now	
477	without being on treatment I've got the CD4 count over	Huge weight loss
478	600 and I've been off treatment since March. So, want did	
479	I want to say?	Severe weakness
480	**I**: We're discussing how it affected your health.	Very recent illness
481	**P4**: Ja, so I think ja how it affects my health because I was	
482	taking ARVs which I should not have taken as yet that could	Dr not responsible
483	have possibly be part of why I had the reaction against the	Chance one takes
484	(indistinct) ja and then ja so that whole thing happened	
485	and I was deadly ill it was really real I mean I was as yellow	Very rare reaction to ARV's
486	as that folder. It was bad, it was really bad and I mean I've	
487	lost almost 20 kilograms in that period of time and I was	Reporting adverse effect to ARV
488	weak and there was a time where I could almost not eat by	
489	myself I was so weak. And it is quite strange to think that	
490	was only four months back, so ja it did affect hugely, but I	
491	can't say it's Pieter Goodnicks fault because I mean he	Some people have bad
492	would have not known either it's – unfortunately it is one	experience
493	of those trial and error things and not trial and success	Recovered
494	things and as far as I understand what happened to me is	Liver damage
495	one in a million and I mean it is so I mean Pieter Goodnick	Liver function good
496	has spoken to the manufacturers of (indistinct) and they	No other HIV related health
497	want all my information of this whole thing because I think	problems
498	I don't know how (indistinct) is used but they are going like	Regular Dr check ups
499	well then we need to know about this. So, - so ja, no I had	Prophylaxis for partner
500	– but I think it's – this about – this is what I know that some	
501	unfortunate people that a bit of a bad experience, hey	
502	luckily I recovered, my liver will never be a hundred	
503	percent but I've got a hundred percent liver function again	
504	so it's fine it's just how it's you know it is all good. Other	
505	than that no problems.	
506	**I**: Well how do you take care of yourself to make sure that	
507	you have no problems?	Double checking partners HIV

508	**P4**: Well, ja well now I mean I go for my every three	status
509	months check-up, in terms of Richard and myself the	Starting prophylaxis
510	relationship we are now going to try another route of	
511	protecting him to not become positive where he is going to	Excitement over study
512	take (indistinct) and there is a study it has got a name	involvement/change peoples
513	that's just been passed now a few months	lives
514	ago... [intervention]	Hope for study
515	**I**: Ja, I (indistinct) to that HIV Desmond Tutu Foundation I	Not a big drinker
516	interviewed (indistinct) one man (indistinct).	
517	**P4**: Ja, there's a name, but I've forgotten about that as	Not a club person
518	well, so we are going to go back actually not coming but	Used drugs recreational in past
519	the next week Monday because Richard had a HIV test and	Moved on from party scene
520	we're just doing or finish the window period to make	
521	double sure and then he is going to start that treatment	
522	which we're actually quite excited about because we – hey	
523	if we can be part of something that might change a lot of	Drugs not part of lives
524	other people's lives because we're going to be – I mean I	
525	think we're one of Kevin's only couples that are going to go	Opportunities to used passed
526	do this and hopefully it is going to be very successful.	over
527	Besides that and looking after myself I've never really been	
528	a big drinker, in my younger days when I was a student I	Decision not to use drugs
529	think we all had it, but I'm not that clubby kind of person	Not purely linked to HIV status
530	anymore and ja I've taken recreational drugs when I was	Moved on
531	younger I've done, I've dealt with it and moved on or many	Risk to self using drugs
532	years back already. So... [intervention]	
533	**I**: So, you're not involved with recreational drugs use or it's	
534	not your use hasn't changed?	Compromises immune system
535	**P4**: No, and look and the nice thing is with Richard he also	
536	he done it when he was younger and it's not part of our	
537	lives and we have had situations where you know at party	
538	at somebody's house or whatever where you know that	
539	scenario could have taken place and other people there	
540	took part in it and we just decided we don't want to. I	
541	don't know if it is purely just because I'm positive, I don't	Use of alternative treatment
542	think so I just think it's we've just sort of moved on and I	
543	also do know if I am going to do that then I am going to put	
544	myself in a more risky environment because my immune	Spiritual energy helping
545	system is going to be down for and I think your immune	
546	system is down for much longer what you really think	
547	thereafter. So, ja.	
548	**I**: Okay, referring back to the health have you – you've	
549	talked about the normal doctors et cetera, have you been	Meditation
550	involved with any alternative medicine or practices et	Turning point in health
551	cetera by taking care of yourself?	Shift in spiritual,body mind level
552	**P4**: If you say (indistinct) are you talking about…?	Shift in focus from – to +
553	**I**: Anything that the standard western medicine?	
554	**P4**: Not really medicine, but I have I've forgotten what this	
555	guy calls himself, but it actually while I was so ill now a very	Big turning point
556	good friend of mine send me this guy Steven was his name	Acupuncture therapy
557	and he is a sort of a like a spiritual healer kind of scenario.	
558	And he came... [intervention]	Mothers influence

559	**I**: Spiritual healing?	
560	**P4**: Hey.	
561	**I**: Spiritual energy healing?	
562	**P4**: Yes, and he came and he did like a meditation with me	
563	and it – but that was really a turning point in this whole	
564	health issue because I think mind, body and spirit just put	Use of comp meds and
565	on a totally different level and it took the focus because I	treatment
566	was focusing on this bad thing that was happening to me	
567	and he took the focus right away and there put it right on	Attending bodytalk
568	another place. I know a good, happy, positive place and it	
569	really did make a big, big turning point for me and before	Past abusive relationship
570	that acupuncture I love it. Ja, so I have – I'm all – I've been	
571	open to other ways of looking after yourself always not just	Bodytalk released past pains
572	the western way. I think it sort of comes from my mother	
573	as well she is not somebody if you ill you go to the doctor	Spirituality and mentally dealt
574	you get a bag of antibiotics and all that she will rather try	with a lot
575	and do it on a herbal doctors…	Good for me
576	**I**: Traditional or you get herbalists, you get	Dealing with things left undealt
577	homeopaths... [intervention]	with
578	**P4**: Homeopaths, she will go more that sort of route to try	
579	and put less chemicals in your body more to the nature	
580	side of things. So, ja and I've about three years back or so,	Psychologist treated after
581	four years back, I had a client and she did sort of bodywork	diagnosis
582	it is called (indistinct) and I went for quite a few session	
583	which was very good for me at that point because I had a	
584	very abusive bad relationship many – or not many years	Goodbye to old self (HIV-)
585	back six years back and that bodywork since she worked	
586	with all your connective tissue and all your pain basically go	New leaf new person
587	and sit in your connective tissue it sort of release all of that	
588	and actually spiritually and mentally I did had to deal with	
589	this whole experience was all of those things were released	Carrying no baggage
590	again which was very, very good because I think it was	Positively positive
591	good for me to – we always tend to certain things you just	
592	put on that file 13 and you think you've dealt with it but	
593	you actually haven't and that sort of made me deal with	
594	that as well. Oh, to jump back you asked earlier on how I	
595	sort of looked after myself, also after being diagnosed I	
596	went to go and see a very good psychologist which just it	
597	helped me deal with this whole thing because it is really	
598	about when you get diagnosed positively you must sort of	
599	say goodbye to the old you because that negative HIV	
600	negative person is gone it is dead it is not there anymore	
601	it's actually a new leaf or for me it was like you're like a	
602	new person and you've got a bit of a new identity. And ja I	
603	saw a very, very good doctor and dealt with that. But I	Greater awareness of others
604	think it was good because then it's – I don't have baggage	with HIV
605	about it I'm happily – I'm positively positive.	
606	**I**: Which is a good transition to make.	Meeting more HIV + people
607	**P4**: Ja.	
608	**I**: Well, let me move to the negative side have you lost	Not openly with HIV+
609	anyone close to you from AIDS, from AIDS (indistinct) with	People judge quickly

610	AIDS?	Open about HIV+
611	**P4**: I – people that's been ill and died because of AIDS or	Illness
612	because I am HIV positive that I don't have a connection	
613	with people?	Company management reacted
614	**I**: No, people that you have been close to that have had –	in ways to illness
615	that were HIV positive that have died of AIDS?	
616	**P4**: No, I haven't had that, no, no, I haven't had that.	
617	**I**: You're living positively with other perspectives.	Wont deny status
618	**P4**: I think it will I must be in it because now it is so weird	Don't advertise status
619	because it is like when you drive a certain brand car then	Don't fear reactions
620	you notice that sort of brand more often on the road, now	Unnecessary exposure to
621	that I'm positive I'm getting to know more people that is	reactions/responsible when
622	positive as well and maybe in a contradiction of a lot of	putting status at risk
623	things I said but I'm not an openly positive person and I	
624	chose to do that because people judge way too quickly and	
625	that's where also with my previous business I was quite	Open to healthcare
626	open to management of the holding company that I am	professionals
627	positive and when I now got ill that's when they started	Don't disclose if person not at
628	their whole thing and I know with, I mean I can't proof it	risk
629	because they haven't said it in so many words, but I know	
630	they reacted in a certain way because of they know things	Partner agrees not to advertise
631	about my health. It sort of filtered through on some	Stigmatized partner due to my
632	discussions and that's why I know it is like that. So, if	status/
633	somebody would ask I would never deny it but I don't go	
634	and put a sort of bumper sticker on my forehead and	
635	advertise it. Not that I – I'm not scared of the reaction I	
636	just don't think it is always necessary, you know if I am not	
637	going to interact with you positively of put in a scenario	
638	where I'm going to put you at risk I just don't think you	Stigma due to lack of education
639	have to know. I mean if you are a dentist or you know	Awareness about sexual
640	whatever you know I'm the first one to say look I am HIV	practices
641	positive so you need to do what you need to do to look	HIV over education
642	after yourself, or a whatever you know anybody in	
643	healthcare I would tell them. But if you a certain person	
644	whatever and it is not going to affect you then I just feel	HIV is bad
645	that you don't have to know, and it is also because of you	
646	know Richard and myself also decided to not to keep it at	HIV is manageable
647	bay but not to advertise it because people also look at him	HIV shouldn't control life
648	a little bit differently because people do and I know I did	
649	before I was positive. I mean sometimes you do – you do –	
650	did – I know I did have like a little bit of a barrier about it	
651	towards it and I don't I just don't think it is necessary.	
652	**I**: What was that tell me a bit about that barrier that you	If HIV+ you're promiscuous
653	feel people have.	Some have been promiscuous
654	**P4:** I think it is they don't – they are not educated well	
655	enough about it. I think they – we get educated about how	If HIV+ you are promiscuous
656	to be save sexually, which is good, but I think, it is going to	
657	sound really bad, but I think sometime it is over-education	
658	because they think if you're not – look if you are not save	People blame/assume HIV
659	you can be infected, but I think they are so over-educated	person behave poorly/no
660	that that people think it is such a bad thing you almost	separation of HIV + AIDS

661	can't speak to that person. What I said it is – I do think that	awareness
662	is maybe one thing, but you know it's actually it is so	People believe HIV+ will die
663	manageable that it should actually not – yes it is there, but	soon
664	it shouldn't take control.	
665	**I**: You talked about the barriers you also talked about	Partner typical reaction like
666	people jumping to making judgements, what type of	most
667	judgements do you feel that they will make?	Relief: die soon to HIV
668	**P4**: Well, I think immediately they think you are super	Abandoned due to status
669	promiscuous, which in many cases people has been, I don't	Non-monogomous relationship
670	say I've never been look I'm definitely the arch angel here	
671	standing on a white rock, but you know I do think people	Ex-partner now coming to
672	do that's the immediate connotation and you know we all	accept status
673	know it is mostly transmitted sexually so people go like	Warning of ex-partner to be
674	hmm what have you been doing? So, ja it's – and I think	safe due to promiscuity
675	besides that the other connection that people do have is	Please not get infected
676	that well HIV – well a lot of people don't make a difference	
677	between HIV and AIDS, I think which is the biggest problem	
678	and then when they hear HIV they thing that you are going	
679	to die sort of next week which it is not the case. And that's	
680	when you know the partner that I had when I found out	Stigmatized due to ignorance
681	that I was positive that was his immediate effect is like you	Ignorant about HIV
682	are going to die and I just can't deal with this so I'm leave	
683	bye. Funny, because he sort weren't monogamous	Limited disclosure linked to
684	towards me as I was towards him I mean ja it just came	lacking knowledge
685	out. Look now we sort of speak and he was in shock and all	Barrier to HIV+ people
686	of that and I tease him I say look you leaving was like the	
687	best thing ever happened I tease him about we've got a	Undercover barrier due to HIV+
688	good relationship now. And I said to him I said for the	people/sero-sorting sexual
689	naughty boy that you are you better be either very safe	behaviour thoughts
690	which I know you are not and be careful it's you've been	Now educator
691	blessed that you haven't been infected thus far you really	Awareness of HIV in body
692	have. I hope he took of it at heart.	Feared its takeover
693	**I**: One can see, but you came to with two areas is one is	Awareness of manageability
694	about your attitude to HIV just now have those changed?	
695	**P4**: Because now that I've you know I was very uneducated	
696	about HIV beforehand, the only thing I really know was	
697	wear condom, water base lube, body liquids problem,	
698	that's how far as it was, it really it is shocking but that is	
699	how little I knew and maybe that's partly of my decision of	Community split in 2
700	not being as open about it because I think you know I had a	
701	sort of barrier before I heard people were HIV positive. I	
702	never normally I don't think I've – well I think I didn't show	Promiscuous community
703	it but obviously I did and I know I've never if somebody	Don't care about of HIV
704	openly said that they were positive that I now wouldn't	Need education
705	have had sex with him. So, but in any case ja I educated	
706	myself a lot afterwards because now you have to because	
707	you need to know what is this thing in your body and in the	Concurrent
708	beginning I thought it was going to take over and now I	Multiple sexual partners
709	know it doesn't have to you can keep yourself healthy and	
710	keep it at bay, education about the issue that is what it	
711	was.	

712	**I**: So, that way you've changed, how do you think the gay	Must be careful
713	community the way it thinks about AIDS has changed?	I asked afterwards not before
714	**P4**: I don't – I think there is – I don't – I think I've multiple	
715	answers, I think there is a – I think you need to divide the	Past I would have sero-sorted
716	just the whole community whether it is straight or gay and	
717	I'm just going to bubble because I've got – I'm just thinking	
718	out load. But I think there is a promiscuous community	
719	and I think they – I think a lot of people just don't care and	Realize can have safe sex when
720	a lot of people think they are just immune to it, I mean I	HIV+/can have healthy sex
721	think I went through a whole big stage of my life where I	relationship
722	just through I was – I'm immune to it, but we're not. And I	Imperfect holistic partnership
723	think they need to be educated a little bit more, but on the	
724	other side if people that's promiscuous and they are into	
725	open sex with multiple partners at the same time or at – in	
726	– whether it is just one on one sex with a range of people	
727	within a let's call it a week I think they need to understand	
728	that people aren't always open and honest about it and	Bareback sexual fantasies
729	they must look after themselves, because that's what	No arousal unless sex is
730	happened to me I mean I asked the question afterwards	bareback
731	not beforehand. And maybe back then before I was you	
732	know positive I would have reacted differently and I	HIV not gay or straight
733	probably wouldn't have had sex with that person, but it	People need to be educated
734	would have been my maybe like defence mechanism	React badly to people's
735	instead of rather be just safe with that person. Now, that	ignorance
736	I'm on the other side of the line I understand that you can	
737	be safe about it and you can still have that healthy sex life.	Could have reacted better
738	I'm also fortunate enough to have the perfect partner in	
739	my life on every level, sexually, mentally, physically you	My offensive behaviour
740	name it we you know it is my man that's (indistinct). So,	reaction
741	I'm jumping around terribly, I think I must be the worst	
742	person to interview to take notes. So, ja that's one thing	People expect to die soon
743	and I think because promiscuous people have maybe have	
744	different outlook on it you know and there's – and I think	
745	there is people that you know their sexual fantasies you	
746	know there's people that only want to have unprotected	
747	sex and that's just that otherwise they just don't get	
748	aroused. So, ja that's just part of education then I guess, I	
749	don't think it's – ja I wouldn't put a gay or straight level on	
750	it, I just think – I think people in general needs to know	
751	more about it and (indistinct) I said quite hectically with	
752	somebody because she knew that I was HIV positive and	No contact previously with HIV
753	she said I have AIDS and I've had like my hair on my back	people
754	just went up and I should have reacted better I know it was	Wait for HIV results
755	like maybe it was a bad day in general for me, but I just got	
756	really offensive because she said I had AIDS and there is a	
757	difference and she didn't understand you know they just	Disclosed to partner first
758	go like oh shit you know you are going to sort of order your	Partner freaked
759	coffin next week, but ja like understanding that. I don't	Confusion on diagnosis
760	know did I answer that.	Partner needed to know
761	**I**: (Indistinct). What has it been like for you to have	Friends disclosed to other
762	contact with people actually with AIDS?	friends

763	**P4**: What has it been like?	
764	**I**: Been like ja?	Friends disclosed his HIV+
765	**P4**: I really haven't had... [intervention]	status
766	**I**: And opportunity.	
767	**P4**: …much. You know what I've – you know when after I	
768	mean I didn't have a lot of contact with people before I was	
769	positive then I became positive and then you know it was	Not much dealing with HIV+
770	very funny because when I – I told you earlier on you know	people/no experience of friends
771	the day I was waiting for those results to come from my	getting very ill or dying to
772	doctor I went to the nearest pharmacy and got tested and	AIDS/HIV
773	as I walked out there my very first thing was I phoned my	
774	partner then I said look this is what happened and he	
775	totally freaked out. And I said to him I'm telling you right	
776	now because I actually don't know what to do about it but I	
777	know you need to know so this is it. And one of our very	Soul searching
778	good mutual friends he put the phone down and	
779	immediately phoned this friend of ours and spilled the	
780	beans towards him and this phoned me back and I said	Was selfish
781	look I've just been to the phone with Brendan and he told	Grown less selfish
782	me this and I'm telling you know I'm HIV positive as well	More spiritually in touch
783	and I'm like what, we've know you for like three years and I	
784	didn't know this. So, what I'm trying to get is that I didn't	
785	really have much contact with people before so I haven't	Now more in control of self
786	dealt with somebody that passed away because of AIDS I	More conscious to self and &
787	really haven't been that whole process of somebody	others/more honest
788	getting that ill.	Like changes in self
789	**I**: So the route hasn't yet got there?	
790	**P4**: No.	Religiousness the same
791	**I**: Has, let's go back then to you and your experience is has	
792	being HIV positive affected any of your religious or spiritual	Problem with religious
793	believes that you have?	organizations
794	**P4**: Spiritually definitely because I did a little bit of soul	
795	searching and I've – did come across areas in my life which	Similar idea but own twist
796	I think I needed to work on but then I have worked on	
797	them. I'm and what I'm – I think I was a bit of a selfish	Belief religions shouldn't be
798	person beforehand and I'd like to think of myself being less	that way
799	selfish. And so no definitely spiritually I have been more in	Money linked to religion
800	touch with myself spiritually which I think I've – no not I	problem
801	think I know I did lose touch of myself for a period of time	
802	and that's been a very nice experience because I feel more	Buddhism maybe an exception
803	in control of myself, more connected to myself, more	
804	connected to other people and I am definitely more honest	
805	towards myself, I am most definitely more honest and I like	
806	that I really like that. Religiously I think it sort of stayed the	Spiritually connected
807	same because I've always been a person that I believe in	Explore spirituality
808	God and Jesus and that whole thing, I think it is great and I	
809	think it happened and it is definitely there, I've got a	Attended spiritual course
810	problem with religious organisations or	
811	believes... [intervention]	
812	**I**: Institutions.	
813	**P4**: Yes, and ja because I think if they all or a lot of them	

814	has got the basic thing but then they put their own sort of	Spiritualism
815	area on it for me which I don't think that's what it was	Understanding spirituality
816	intended to be. And I think as soon as people or as soon a	
817	religious organisation, institution whatever you want to call	More connected + open to
818	them connect money to it then I already have a problem	spirituality
819	with it because I don't think that's what religion was about.	
820	So, there all (indistinct) except maybe Buddhism I mean	
821	and Dali Lama himself said if – he would have been a	
822	Christian of it wasn't for the followers. So, ja, so, yes	
823	definitely there was an investigation with my inner self	
824	about it and I am spiritually definitely more connected and	
825	I want to explore a little bit more things spiritually, a couple	
826	of weeks back, I'm trying to think when, but it was after I	More spiritually connected
827	was in hospital I went with somebody that did a spiritual	
828	course and it was like their last even of that with this lady	
829	and it was sort of like an open class and they could bring	
830	like a mate or two or whatever. And me and Richard went	
831	and it was really nice because it was what she did like an	
832	intermediate course in spiritualism you know just all the	
833	terms and things so people can understand more and I'm	
834	seriously considering actually doing the next course when	
835	she would do it because I think if you understand the	
836	terminology of anything you understand the thing better.	Soul searching
837	So, and I think when I will do that it would obviously	Re-evaluation
838	connect or open or make me inquisitive about things more	Dropped defenses + defense
839	or introduce things to me which I either did not understand	mechanism
840	or didn't know about. So, ja there is some inquisitiveness	
841	there which I know I will do in my time. Religiously about	Investigated defense
842	the same throughout, but I did think about it.	mechanism
843	**I**: What role does spiritual or religious beliefs play in	More able to manage
844	helping you to cope?	relationships
845	**P4**: It definitely help, but like I say I'm more of a spiritual	Met match
846	connected person…	Special relationship connection
847	**I**: How does your spiritual beliefs helped you to cope?	with partner
848	**P4**: It does because it – I think it is a coping mechanism	Complete honesty and
849	and it makes you see your level of purpose and I think by	openness
850	having purpose you know how to cope with things.	Supportive partner
851	**I**: It makes sense to me, and how has your spirituality	Fully understand oneness with
852	changed in terms of the level your spirituality changed	partner
853	since your diagnosis?	
854	**P4**: I definitely gone a little bit (indistinct) like I said you	
855	know I went through and I'm still busy with still not soul	
856	searching but sort of evaluating things and – but I think – I	
857	think what – I think the best thing is I think I've dropped a	More balanced due to
858	lot of walls that I had previously in my life sort of what you	spirituality
859	call – not coping mechanism but sort of protective	Less eratic
860	mechanism and I've dropped that in many areas and I think	More calm
861	by dropping that and investigating some of it actually now	Smoothed things out
862	for the first time ever put me in a position to have I	Helped health wise
863	wouldn't say decent relationship, but I think I've now met	Changed mindset
864	my match. And it is the real thing and you know that is the	Couldn't cope

865	nicest thing to experience and it is great to just have this	Inner turmoil
866	person in your life and to share everything with them and it	Daily
867	is open and it is honest and it is true. And to have	
868	somebody sort of like a wing man and to understand you,	Spirituality brought focus
869	to read your mood without even saying anything and help	
870	you with things so ja.	Could cope
871	**I**: And (indistinct) is how besides helping to increase your	Coping creates improvement
872	level and lower some of those defences for you to connect	Mind is powerful
873	to a partner how else has your spiritual believes helped you	Mind can make healthier or
874	with your healing process?	sicker
875	**P4**: Well, it connected me to spiritualism again and ag I	
876	think it makes me a bit more balanced and I little bit more	
877	less erratic. But it definitely brings a calmness and ja do	
878	you know I think that is where it helped the most it sort of	
879	just sort of smoothed things out. Health wise it definitely I	Investigating spirituality
880	mean when I was ill the session I had with that person it	
881	made a – my mind set was just correct you know where	
882	before he came to visit me and I was like I want to get out	
883	of here I can't deal with this I don't know how to deal with	
884	it. And it was like this whole turmoil of everything because	
885	everything was going wrong and every day was just worse	
886	and worse and worse and worse. And you know after it	
887	was just like there was focus and there was peace and	
888	there was calm and I could deal with things because I could	
889	deal with things I got better and you know because of	
890	focusing on the downwards spiral I was focusing on the up	
891	and what's – and you know I think the mind is an amazing	Searched for spiritual
892	thing you can think yourself sicker than what you are and I	knowledge
893	think you can think yourself healthier is you think positively	
894	about thing.	
895	**I**: You talk about spiritualism or spirituality because you've	
896	mentioned a spiritualism course and you talked about	
897	spiritualism at the end.	
898	**P4**: Ja, look it's – I mean like I say I'm on a bit of this route	
899	where we, and I say we because Richard is actually doing it	
900	with me, where we sort of invest – or not invest we're just	
901	looking at things more often. I'm not busy watching the	
902	Abraham DVDs... [intervention]	
903	**I**: Are you ?	
904	**P4**: Yes, which I think is pretty amazing.	
905	**I**: Abraham ja.	Energy sensations
906	**P4**: Yes, Abraham, and I think that lady is... [intervention]	
907	**I**: Hicks.	
908	**P4**: Hey?	
909	**I**: Hicks.	Death possibly drug related
910	**P4**: Ja, she is really she is just something else in a good	
911	way. And we – ag what's this one's name? Her name is	Crystal healing
912	Dora, I don't know if you know her she is quite a big	
913	spiritual person in Cape Town and she is the lady that had	
914	this whole course of introduction and I really want to do it	
915	because I think there is I don't – it is not that I don't	

916 917 918 919 920 921 922 923 924 925 926 927 928 929	understand but there is a lot of terms and things that I don't know about because I was so disconnected for so long I'm like I'm a bit like a newbie. You know it's – but I – there is a lot of things I feel immediately I mean I was a little shop in Hout Bay two or three months back I was just I was sort of like let me think it was in my first or second week when I was back at work from sick leave and they – the shop is called Rock Chick in Hout Bay and they sell all crystals and minerals and stuff and I had this overwhelming feeling of this different energies and powers while I was there. And Richard my partner just lost his best friend from they were from pre-primary school and nobody know it happened his – they just found him basically on his bed, but he used recreational drugs and all that so there is influences, and. But nevertheless and I was there I was just experiencing all this energies and it was so amazing I picked up a piece of quartz and I'm just trying to think what name – ag I can't remember... [intervention] **I**: What colour? **P4**: Hey? **I**: Colour? **P4**: It was orangey yellow it was a sort of ocker sort of colour... [intervention] **I**: Was it – are you sure it was a quartz? **P4**: Sorry? **I**: Sure it was a quartz? **P4**: Ja. **I**: Did it say quartz? **P4**: Yes. **I**: Okay. **P4**: I'm just trying to think, but in any event and I picked this up and I just it was just this energy through me and I decided I wanted to buy it for Richard because I think it was something for him to keep in his pocket to help with you know with the things he is dealing and this lady at the counter said this is a relatively interesting choice is this for yourself or is it for somebody else? And I said no it is for my partner and he just lost you know his best friend and I just feel this energy that is something that will help him deal with this and she said well this was the perfect thing that you've just chosen it is like – so it was quite a nice experience and you know it did help Richard because you know I gave it him and you know he did carry it on him for about a month or so and the other day it was – smoky quartz I think, but anyway and it was lying on his bedside table and I said him you know are you not carrying it and he said you know he actually he parted with it now because he just feels that he now don't need that energy anymore and I mean that's how those things work it sort of comes and goes in our life I really – and it was just quite amazing…[RECORDING ENDS]	Energy from crystal no longer needed Things come and go in life

Interview 5

Line No	Dialogue	Natural Meaning Units
1	**I**: Okay, today is the 9th hey? The 9th of the 9th so I'll be	
2	doing – okay so what I want to do is just start out by ask –	
3	we're starting somewhere…	
4	**P5**: Well I denied – well I came out to myself – I think that	Denied own sexuality
5	there is other people out there that have points and needs.	Self acknowledgment – people
6	**I**: Was that also then family that followed that belief?	have needs
7	**P5**: Yes.	
8	**I**: Ja most definitely.	
9	**P5**: Well, there is an interesting story is that I decided at	
10	some point and I through a whole fucken process got my	HIV disclosure was a process
11	mother alone and told her that I was positive. My mother's	Disclosure to mother
12	reaction was oh my dad asked the other day whether I was	Coming out linked to HIV
13	gay. She was on holiday with my boyfriend and there's all	disclosure
14	sorts of incidences where she was I never like discussed it	Holiday with family and
15	but she was on holiday with my boyfriend, but the fact that I	partner/mother refused
16	was HIV positive that meant that I was gay and then the	child's sexuality
17	fucken other shoe dropped (indistinct).	
18	**I**: And how…?	
19	**P5**: Oh it didn't go well, I realised I was a difficult teen and	Difficult coming out to family
20	(indistinct) and sabotaged myself and got to the point of that	Difficult as a teenager
21	conversation where I realised there was no point because	Realised we couldn't connect
22	their frame of reference is just completely different they	Different frame of references
23	can't pretend to know what is going on in my life. So, our	Distinct relationship with
24	interaction had dwindled. You basically year from them…	family
25	**I**: I've heard you talked about…	
26	**P5**: (Indistinct) in my doctor telling me that I'm positive –	Diagnosed by Dr
27	boyfriend has been positive for – ja we were together I think	Partner had been unknowingly
28	like nine months – denied it all subsequently and – that in –	positive
29	well I find those complications whenever people get	Denied his HIV
30	(indistinct) – well through stigmas through people's own	Complications around HIV +
31	fears and perceptions. So, my previous relationship basically	stigma/fear + perception of
32	came to an end hear I was positive. Well, funnily enough	people/relationship ended
33	was quite a condom queen first boyfriend convinced me to	Persuaded by partner to be
34	do things so after not wanting to go for a test all of it I	unsafe at times
35	became positive. And after becoming positive a lot more	Became HIV+ and less safer
36	ever have sex (indistinct).	around sex
37	**I**: How did you get to that point?	Destruction process
38	**P5**: Basically it's been – gone through a process of	Giving up caring initially
39	distruction to get to that point of first of all not giving a fuck	Unravelling emotional layers
40	and then there was the initial phase to get out of it and then	Growth in understanding sex
41	layers of unravelling the emotional well in terms of sex has	Withdraw from LGBTI
42	moved away from (indistinct) to gay community, lesbian	community/HIV- people need
43	community. I would say that everyone that hasn't walked	to walk in HIV+ shoes
44	the shoes of being positive that they don't (indistinct) look	Fear+stigma
45	on their own (indistinct). I think it is just getting rid of the	Eradicate fear messaging
46	fear, the – and the fear I mean from insurance to condoms	People live in fear of HIB

47	constantly tell us to live in fear about every fucken thing	
48	that's (indistinct)…	Relationships difficult
49	**I**: Conversations we'll just start back at…	Interacting with people
50	**P5**: It's certain has made relationships more difficult made	difficult/stigmatized + people
51	interactions with people – well just because of stigma really	rejecting/rejected sexually by
52	you still live under stigma you have people not want to you	HIV- people
53	know consider sexual interaction of a relationship of any	HIV as a blessing
54	kind, they are not positive. The whole process of the plea –	
55	well one of the things that HIV did for me I still see it as a	Growth in happiness
56	blessing in disguise did for me specifically is what kind of	Self-acceptance
57	(indistinct) and people. The result of that it has made me – it	Lost superficiality
58	has made me very happy about myself not to worry to have	
59	to spend time not superficial. I think... [intervention]	Engaging people at deeper
60	**I**: And what does that mean?	levels
61	**P5**: I think it is fine you know engage with someone on a	Desire to connect at peoples
62	superficial level, but I don't see the point in engaging or	levels/reject superficial
63	wasting my time engaging with someone on a super –	interactions
64	therefore I would rather have (indistinct) have some loving	
65	behind the interaction or not react – interact at all.	Stronger person
66	**I**: Or are you (indistinct)?	Ability to face people issues
67	**P5**: Oh certainly yes and especially the results made me a	Stand up for self
68	stronger person by having to like face other people's issues	Stronger as a person
69	and having to stand up for myself and it was painful a lot of	More self aware
70	times, but it made me stronger in terms of who I am and	Respecting body
71	what I will and will not tolerate. Well, I'm not going out in	Healthy eating
72	the way I'm eating I mean whatever, though I've learnt to	
73	like respect my body in a way. Well, eating healthy, trying to	
74	avoid preservatives and all sorts of chemicals.	Changed lifestyle
75	**I**: And has that changed since…?	Ex-party culture
76	**P5**: Afterwards on occasion yes, but where it was a lifestyle	Occasionally see Dr
77	before it's well you know it was a rave culture we popped E.	
78	**I**: (Indistinct) taking care of yourself do you see…?	
79	**P5**: On occasion yes I do.	Issues with Drs
80	**I**: On occasion?	Confusion around beliefs and
81	**P5**: Ja. I have many issues with the doctor, I've gone	health
82	through several doctors in Cape Town, I don't know what to	
83	believe anymore when it comes to doctor that they actually	Drs only prescribe
84	know how your body works. Some of the comments I've had	Drs don't know human body
85	out coming out of doctor tells me that they simply are there	
86	to prescribe drugs they do not actually know how your body	Exploring alternative frequent
87	works.	treatment for HIV
88	**I**: Also (indistinct)?	
89	**P5**: Well, I'm on the brink of actually going into a very	
90	interesting where I don't know where they invented the	
91	machine actually and there is a whole thing about it. There	
92	is a frequency for every illness or – and I'm about to go into	Spirituality + healthy played a
93	that to work specifically on HIV.	part
94	**I**: Working for you…?	Coping somehow
95	**P5**: Ja, I've gone through the years I've gone through several	Changed perception
96	spiritual and health they've all played their part and ja health	Don't keep track of time
97	wise I'm still coping so and I must all – I would – ja my	

98	perception of time has definitely (indistinct) where I can't	Everything changes
99	keep track of time to the point where even when I'm a little	Living in present
100	bit foggy and faded and I go find (indistinct), but I don't	
101	know whether that relates to. Everything has changed but	Time focused within self
102	I've never like related – no, no the only thing I can say that	Fighting social structures
103	for me the past very typically living either in past whereas	
104	today I try much more day, so the timeline there for me is	
105	within myself. Okay, all right, buoyed and also trying to fight	Activistic lifestyle and
106	our social structures of in terms of alcohol and smoking and	alternative living
107	all of that, but comes (indistinct) oh God (indistinct)	
108	addiction to sugars, but all of that is so deeply ingrained in	Food changes
109	our social structure that trying to avoid them is a constant	
110	(indistinct) and try and go out for a weekend and not having	Avoid processed food
111	(indistinct) referring to there. Well, it depends on how	Fresh fruit and veg
112	deeply down the rabbit hole you go. The last 30 years our	
113	food supply has change – really actually good for you and	
114	you could try and avoid anything that is processed, fine you	
115	can buy fresh fruit and vegs, which is great, but then all of	
116	that is laced with fucken hormones and crap and shit as well.	
117	So, it depends on how healthy you really want to go or can	No fear of dying
118	afford to go at the end of the day.	Nothing to live for
119	**I**: But less of the commercial things. Okay, well if one looks	Fear of death was seeded
120	at that and the concepts of the time…?	Opened self up
121	**P5**: I said to that I'm not afraid of dying. Obviously you have	
122	nothing to live for. But no I can't think that far back I	More self aware
123	suppose fair of dying has think and seeded, but it's to say	
124	that I had the ability but I only explored it and opened myself	Spirituality linked to changes
125	up and stop blocking myself with chemical substances. It has	Spiritual healing fundamental
126	not change them, but it has made me bold in making me	Trained as a therapist
127	aware of them.	
128	**I**: (Indistinct).	Dealt with emotional daily
129	**P5**: Yes, absolutely. Well, this is not – getting at the end of	issues/released past
130	the day physical healing yes it's been fundamental and I did	Past victim behaviour
131	a (indistinct) healing course to become a therapist at some	Turning around now
132	stage, (indistinct) about becoming a therapist. So, yes	Stand for self and own rights
133	certainly on an emotional level it has made me deal with	
134	things on a daily basis therefore I tend to always have had in	Empowered
135	the past bolted on board and you know playing the victim	
136	card to myself and to others and that has turned around for	Lost at time of diagnosis
137	me in terms of where I would rather be for the lack of a	Had turned on religion
138	better word aggressive and stand on my rights than take on	Directionless
139	more shit because that is going to take more time to undo	Didn't view other limitations
140	again you know. It has empowered me.	
141	**I**: The level of relatives that spoke to you…?	
142	**P5**: Well, at the time that I was diagnosed I could pretty	Daily process of purpose
143	much say that I was pretty lost. I was at the end of a phase	finding
144	of turning my back against religion and I didn't know which	Face self daily process
145	direction because through it all I managed to – not to look	Small reasons
146	into other people's limitations.	Reasons to work
147	**I**: Lost hope?	Search to improve mood
148	**P5**: No, it is a daily process you know it is always easy to get	Find ways to make reality

149	up in the morning you have to find a reason to face yourself	bearable/repeats daily cycle
150	in the mirror again want to get up and face yourself, because	Self searching + awareness of
151	it is just that it is like day to day you have to like find the	uniqueness/purpose to make
152	little reasons, find the little things that is going to make it	a difference/purpose to life
153	work for you that is going to improve your mood, that is	No accidents in life
154	going to just make your reality bearable for that day. And if	Plan for existence
155	you do through that they then the next day you know can	
156	repeat it. I realised a lot of self-search that I am special	Denial around around HIV in
157	different, even in a small scale I do not have to even interact	LGBTI community
158	simply by on an (indistinct) level being I can make a	
159	difference, that's the reason why I am here I mean I do not	Stigma blocks unity
160	believe anything happens by accident there must be a	Instilled fear caused social
161	reason for that I can – I know that I am here for a reason.	issues
162	No.	Different social camps
163	**I**: What do you think AIDS…?	HIV not
164	**P5**: (Indistinct) it has (indistinct) the gay community. Well,	HIV a social issue
165	there is still a lot of people out there which are still within a	People lack understanding
166	dream world and denying and there are people that picture	Terminal illness creates ability
167	of unifying the gay community that it has become because of	to truly understand
168	the stigma, because of the fear that's been instilled through	futility of this world
169	us from the '80s has brought all sorts of social issues and	lost material attachment +
170	dramas have put us into different camps or we have to put	attachment to self
171	ourselves into those different – but the point is that it did	enjoy time now
172	not – has not encouraged unity because it is such a diverse	past material focus
173	socio- social issue that people that are not there can't grasp	
174	and they don't necessarily even want to grasp. And unless	ignored death but planned for
175	you've had a terminal illness you have to like get to that	it
176	point where you have to look at it in the mirror and	
	understand it. Realising this world is futile not getting too	
	attached about who you are, how much money you have,	
	what you drive, what you own, all of that. Life is enjoying	
	the moment. Well, I was in a very 3D world and where it	
	was about what you – gathering money and gathering stuff	
	so that you can survive old age and quite frankly at that	
	stage and in most of the cases not really wanting to think	
	about death, not really wanting, but yet in fear planning for	
	it. So, making you face that ja…	

Appendix 2

Natural Meaning Units and Interview Clusters

Natural Meaning Units for Interview 1

Cluster	Natural Meaning Unit	Line Number
HIV and Gay Link		
	Became a part of self	250
	Always cared for others	280
	Sharing was a way of accepting self	303
	HIV in past was seen as Gay disease	379
	New gay disease	382
	HIV and gay disease in media	383
	Predominant news	386
	Total	7
HIV and Stigmatization		
	Don't talk about HIV	125
	Stigma	396
	Total	2
HIV as Fear		
	Fear of transmitting to others	150
	Fear of transmitting to others	152
	Lost interest in intimacy	154
	Don't deserve intimacy	155
	Put up own wall and keep distance	179
	Fear	181
	Fear of infecting others and being close	183
	Fear of hurting self or others	185
	Fear of rejection	187
	Fear of being abandoned after becoming intimate	189
	Fear	193
	Fear of sharing HIV status	306
	Terrified gay people	387
	Added to my fear	388
	Fear	396
	Fear cast aside and thrown out	397
	Fear within	398
	Drank due to fear	402
	Escape through drinking	406
	Fear and anxiety caused more drinking	413
	Drank on fear	420
	Total	21
HIV as Growth/Catalyst		
	Attitude completely changed	226

	After diagnosis changed behaviour	227
	Had to have HIV	252
	Spiritual turning point	264
	Stronger after experience	274
	Outlook changed	275
	Need to give to others	281
	Very important to care	282
	Used to be self-absorbed	283
	Positive mind set	345
	Better insight due to HIV	465
	Not a victim	472
	Received to help understand a power greater than self	474
	Aided in the changes	493
	Spirituality grew completely	509
	More contentment and serene	518
	Given rest and send of well-being	520
	Greater sense of well-being	524
	Think before acting	556
	More compassionate	557
	Need to heal self	558
	Not to reject or judge others	560
	A greater person	562
	A better person	563
	A better person	565
	Nicer person	566
	Total	26
HIV as Support		
	Good support from healthcare team	348
	Amazing doctor	355
	Doctors understand and can be open	357
	Openness between doctors and self	361
	Can be open as understood	364
	Didn't like gay support groups	431
	Don't mix with gay community	438
	Total	7
Cluster	**Natural Meaning Unit**	**Line Number**
HIV and Disease as Negative		
	Not asked about health	126
	Speak once a year	127

	No partner since diagnosis	132
	HIV is a burden or cross to bear	165
	Must learn to embrace burden	169
	Burden: lonely and isolated	176
	Burden creates separation	198
	Diagnosis prior to medicine available	213
	No control over HIV	316
	Went into coma due to lack of medicine	215
	Few health setbacks	331
	Rejection	396
	Loneliness and isolation	404
	Withdrawal from life	407
	Total	14
HIV as Responsibility		
	Not fair to burden another person with HIV	159
	Must carry on own	161
	Learn and managed to deal with it	170
	Daily remind reasons to live	172
	8 years of living on medicine	210
	Daily self care	336
	No changes in caring for self	338
	Total	7
HIV and Illness as Positive		
	Gave up alcohol	241
	Being sober could deal with HIV	246
	Was a motivational speaker	293
	Amazingly healthy	330
	More well than ever	333
	Giving up substance was important to survive HIV	532
	Total	6
Cluster	**Natural Meaning Unit**	**Line Number**
HIV and Death		
	Family immediately came when diagnosed	122
	Possibly dying in hospital	124
	Partner died due to HIV	135
	Asked to be killed if ever diagnosed with HIV	233
	In coma	256

	Death is a part of process of life	318
	No fear of death	319
	Always affirmed no fear of death	322
	Part of process of life	323
	Saw gay people die from HIV	367
	No treatment	368
	Curled up and turned to vegetable and went crazy	369
	Feared dying from HIB	374
	Used to say I will kill myself first	375
	No longer will kill self	376
	Death if not stopped drinking	
	Total	
HIV and Spirituality		
	AA helped deal with HIV	236
	AA saved life	237
	Acceptance and taking action	249
	Spiritual experience in hospital	258
	Bathed in light	262
	Been aware of something	267
	Hope of getting better	268
	Most amazing experience in life	270
	Acceptance came	276
	Belief in something greater than me	277
	Always had belief	287
	Experience made it easier	290
	Belief greater than myself realized through HIV	468
	Trust in a higher power	483
	Communicate with a higher power	484
	Prayers and being grateful	487
	Own personal beliefs	499
	Morning meditations	502
	Total	18
Cluster	**Natural Meaning Unit**	**Line Number**
HIV and Sexual Practices		
	Infected by partner	136
	Faithful to partner and no casual sex	139
	Very few lifetime sex partners	140
	Decided no sex as not going to ever risk others	146
	No sex due to fear	203
	Many years of chastity	208

	Lost interest in sexual things	229
	Despite HIV people carried on having sex	391
	Total	8
Gay Identity		
	Always known was gay	10
	Double life	16
	First homosexual sexual encounter	18
	Knew was different, but not how	21
	Couldn't name difference	22
	Not into girl things	
	Attitude to gays changed due to exposure	29
	Realised being gay was why felt different	32
	Able to label being different	35
	Was naïve and ignorant about being gay	37
	Easier after identifying as gay	41
	Acceptance was difficult	54
	Began when lived alone	55
	Acceptance was a gradual process	67
	Exposure to gay people and culture	71
	Gay society based on youth and looks	442
	Am not part of this as am older	44
	Gay men take care of their looks	453
	Self care is important to gay men	454
	Total	19
Gay as Acceptance		
	Out in the open now	449
	Gay life is exposed	450
	People not shy to speak	451
	Open	456
	Total	4
Cluster	**Natural Meaning Unit**	**Line Number**
Coming out		
	Came out at 30	11
	Victorian styled family/father	14
	Father unapproachable	15
	Came out at 30	17
	Living at home	43
	Hiding gay at home hard	44
	Mother aware I was gay	
	Left home at 29	61
	Moving out was a transition	62
	Integrated into gay community	76

	Being accepted for me	80
	Came out so late	87
	Came out to dad 6 months before he died	111
	Total	13
Gay stigmatization and taboo		
	In closet due to time period	12
	Apartheid	13
	Father wanted a real boy	24
	Father son relationship strained	26
	Acting out on being gay difficult	42
	Father unhappy about me living on my own	60
	Outside country made easier	75
	Envy out young gay people	83
	Cannot understand	85
	Era delayed coming out	90
	Terrible experiences	94
	Arrested for being gay	91
	Hide being gay at clubs by having lesbian partners	97
	Snuggle in corner to prove legitimate	99
	Guilt	45
	Being gay is wrong	47
	Gay or sex issues never discussed	48
	Private issues	50
	Many stories of living in apartheid era	102
	Earlier generation was secretive	448
	Gay life was secretive and underground in the past	458
	Total	21
Cluster	**Natural Meaning Unit**	**Line Number**
Gay as separation		
	Never discussed being gay with mother	108
	Rejected by brothers family	113
	Children kept from me	114
	Pain due to familial separation	115
	Excommunicated self from family	116
	Familial separation still painful	119
	Total	6

Cluster order for Interview 1

Cluster order number	Cluster Theme	Quantity of Meaning Units
1	HIV as Growth/Catalysis	26
2	HIV as Fear	21
3	HIV and Spirituality	18
4	HIV and Death	16
5	HIV and Illness as Negative	14
6	HIV and Sexual Practices	8
7	HIV and Gay link	7
	HIV as Support	7
	HIV as Responsibility	7
8	HIV and Disease as Positive	6
9	HIV and Stigmatization	2
	Total Meaning Units	**132**

Natural Meaning Units and Clusters for Interview 2

Cluster	Natural Meaning Unit	Line Number
HIV and Stigmatization		
	Family shocked over infection	35
	Brother in law shocked	65
	Gay lifestyle and HIV risk	64
	Unsympathetic response	68
	To be gay means getting HIV	74/78
	Positive lifestyle breaks stigma	258
	Total	7
HIV as Ignorance/Denial		
	HIV not talked about	85
	No need to discuss HIV+ status	198
	Total	2
HIV as Disclosure		
	Disclosure to sister	32
	Disclosed sexuality and HIV to family	33
	Usually disclose HIV+ status	206
	Conservative family	52
	Ex-partners status disclosed by friend	475
	Total	5
HIV as Protection/Withholding		
	Won't disclose HIV status to parents	129
	Fear parents belief that HIV means death	131
	Protecting parents from fear	133
	HIV too big a shock	135
	Total	4
HIV as Concern		
	Sisters concern over health situation	90
	Concern over HIV progression	93
	First concern over HIV progression by sister	95
	Partner has regular HIV tests	200
	Total	4
HIV as Resignation		
	Resignation to getting infected	184
	People less concerned by HIV	495
	If HIV infection happens it happens	498
	Total	3
Cluster	**Natural Meaning Unit**	**Line Number**
HIV as Acceptance		
	Parents have no sexuality issues	53
	Sisters apology	80
	Overreaction by sister	82

	No issues about HIV	84
	No fear of rejection	210
	Open about HIV+ status	203/207
	Partner aware of HIV+ status already	195
	Dr neither condone or promote unprotected sex	192
	Easier to accept HIV+ status	222
	Parents had suspected sexuality	124
	Parents supportive	128
	Parents awareness of HIV+ status	154
	No issue around HIV	178
	Acceptance of transmission risk	182
	No issues about HIV by partner	223
	Dealt with HIV with partners help	226
	Self-acceptance	254
	Being self	272
	Friendship	299
	Friends are supporting	304
	Friends there no matter what	306
	Work good about status	548
	Work supportive around HIV	550
	Self-acceptance	333
	Total	25
HIV as Fear		
	Shocked by sisters fear	69
	Undisclosed about HIV+ to a sister	102
	No opportunity to disclose	104/107
	Fear of HIV by partner	166
	Nervous at regular testing	199
	Accept others fears about HIV	208
	Fear of contaminating others	215
	Partner fears disclosure	488
	Initial disclosure hard	267
	Total	10
HIV and Complimentary Medicine		
	Experimentation with alternative medicine	424
	Health unaffected by alternative approach	430
	Lack of faith in complimentary medicine	434
	Total	3
Cluster	**Natural Meaning Unit**	**Line Number**
HIV as a Bond		
	Expected to bond to other HIV+ people	278
	HIV not a reason for friendship	286/282
	Friendship based on liking a person	284
	Only artificial	289

	More natural interaction	297
	Being HIV does not mean involvement with other HIV+ people	312
	Social contact should occur unforced	315
	Gay and not HIV group	317
	Total	9
HIV as Lifestyle		
	Healthy lifestyle	390
	Try limit stress	394
	Always cared for body	399
	Positivity	402
	Remove negativity from life	403
	Dr visit twice a year	410
	Bi-yearly Dr visit are on ARVs	413
	Complimentary medicine	428
	Lifestyle too demanding	429
	Total	9
HIV and Drugs		
	Recreational drugs	522
	Drugs to have uninhibited sex	423
	Unsafe sex due to drug use	527
	No drug sex since diagnosis	528
	Drugs created increasing paranoia	531
	Drug use no pleasant	532
	Stopped drugs not only due to HIV	534
	Social phobia	536
	Reduced immune system by drugs	539
	Drugs affected immune system badly	547
	Unwanting to compromise system	545
	Total	11
HIV as Negative		
	Lifestyle affected	266
	Negative attitude in support group	328
	Negativity a problem	330
	Past problem with medication	420
	Best to be un-infected	561
	Total	5
Cluster	**Natural Meaning Unit**	**Line Number**
HIV as Growth		
	Unclear if growth either through HIV or age	238
	More open due to HIV	244
	More honest due to HIV	250
	No hiding or pretense	252
	Matured	356
	Uncertain around cause of attitude change	373
	Initially more health focused	388
	Researched HIV online	469

	Total	8
HIV as Normal		
	HIV is normal	175/260
	Viral load undetectable	419/191
	Relationship allowed for normalization of HIV	232
	HIV a part of life	236
	Good health	255
	No problem disclosing	261
	No issue disclosing	246
	No need for HIV support group	307
	Health focus unchanged	386
	Unconcerned	381
	Likely to die of other causes	348
	Not a death sentence	347
	Same as before	268
	Can be positive and not sick	256
	Just a chronic illness	466
	Total	17
HIV and Death		
	HIV and imminent death	136
	HIV and death linked	150/141/165
	Media depiction of HIV as death	145
	HIV not a death sentence	187
	Sense of impending death on diagnosis	213
	Confronted by death more	358
	Death part of life	362
	More peace with death	368
	Death doesn't have to be HIV related	371
	Friend nearly died from not taking meds	447
	Friend died of HIV	442
	HIV death an impact	444
	Unconscious link of HIV and death	457
	Past belief HIV is a death sentence	463
	Total	16
Cluster	**Natural Meaning Unit**	**Line Number**
HIV and Spirituality		
	Attend yoga group	292
	Gay HIV yoga group initial	295
	Now gay inclusive yoga group	296
	Sharing ideals	323
	Way of life	324
	Relate as friends	325
	Open life and enjoyment of life	326
	Life shouldn't be over serious	331
	Find inner answers	332
	Peoples problems due to unresolved inner issues	334

	Not religious	562
	Less religious	503
	Maturity lead to decreased religiousness	505
	Try to live a good life	508
	Don't expect reward to live a good life	510
	Desire to life good life	511
	No official belief	512
	Life on earth is heaven	513
	Making life good	514
	Moral life	516
	Reared with morals	517
	Do unto others as you want done unto you	518
	Total	22
HIV and Medicine and Life		
	Life due to medicine for HIV	144
	Possibility of medicine failure	379
	Faith in doctors	382
	Attempt to find right medication	416
	Content to take medication	439
	HIV related death is unnecessary	457
	Disbelief about why people die due to HIV	461
	Total	7
HIV and Sexual Practices		
	MSM sex before meeting gay people	9
	Unprotected sex	190/179
	Had sexual encounters despite being HIV+	211
Cluster	**Natural Meaning Unit**	**Line Number**
HIV as Ignorance/Denial		
	Parents lack HIV knowledge	140
	Parents unaware of HIV reality	147
	Parents not likely to understand	149
	Partner unknowledgeable about HIV	155
	No exposure to HIV	158
	Unnecessary fear over transmission	171
	Unaware of HIV status	218
	Unaware of partners HIV status	473
	Ex-partner denies HIV status	487
	Little exposure to AIDS	490
	Total	10
Gay Identity		
	Exposure to gay life after school	5

	Associated with gay people	8
	Always known was gay	10
	Never denied sexuality to family	19
	Family never asked about sexuality	20
	Family realization of sexuality	30
	Belief sister and self in wrong bodies	41
	Coming out easier to rest of family	56
	Shared relationship with parents	113
	Not on the scene	269
	No hiding or pretense	243
	Open person	242
	Came out about being gay and being in relationship	122
	Partner part of life	114
	Total	14

Cluster order for Interview 2

Cluster order number	Cluster Theme	Quantity of Meaning Units
1	HIV as Acceptance	25
2	HIV and Spirituality	22
3	HIV as Normal	17
4	HIV as Death	16
5	HIV and Drugs	11
6	HIV as Ignorance/Denial	10
	HIV as Fear	10
7	HIV as a Bond	9
	HIV as Lifestyle	9
8	HIV as Growth	8
9	HIV and Medicine and Life	7
	HIV and Stigmatization	7
10	HIV and Disclosure	5
	HIV as Negative	5
11	HIV as Protection/Withholding	4
	HIV as Concern	4
12	HIV and Complimentary Medicine	3
	HIV and Resignation	3
	Total Meaning Units	**175**

Natural Meaning Units for Interview 3

Cluster	Natural Meaning Unit	Line Number
HIV and Identity Link		
	Gay Identity separate from HIV	45
	HIV epidemiological not sociological	80-81
	Gay identity linked to HIV	55, 65,66,76, 77
	Gay Western militancy of HIV as gay issue	84
	Total	8
HIV and Stigmatization		
	Lack of understanding and fear	57
	HIV racialised	72
	Fear	320
	Heterosexuals ignored HIV	72
	Ridiculous reactions	89
	Fear reaction	137
	Fear easier than fearing HIV infection	139-140
	Sleeping around leads to HIV	421
	Unconscious bias	422, 424
	Same belief as other gay men	427
	HIV+ means you a slut	429
	Openness of HIV status in the West	494
	Stigma in South Africa	498
	Guilt, shame and shaken	108-109
	Link HIV to pathology and low self-esteem	91-92
	Cape Town has HIV issues still	319
	Wanting HIV status private	317
	Link between morality and illness	430
	Bypass stigma	499
	Fear others status	136
	Disclosure issues	138
	Public visibility over Cape Town 50% infection rate	491
	Total	23
HIV as Motivator		
	Anger driven voluntary work	385
	Total	1
HIV as a Framework		
	Framework provided	570
	Changed approach	387
	Shaped relationship	127
	Total	3
Cluster	**Natural Meaning Unit**	**Line Number**
HIV and Life Review		
	Maintain personal power	119
	Set life orientation	120
	Virus must fit in	122
	Carry on regardless	124

	Not an issue	128
	Set own priorities	121
	Fairness review	154
	Do what is meaningful	338
	Existential, Metaphysical and spiritual questioning	157, 168, 170, 172
	Life and meaning review	159
	Future different to expected	263
	Life want not important	265
	Context changed	315
	Continue despite HIV infection	334
	Be more vulnerable	505
	Total	**18**
HIV as Liberator		
	Liberation from fear	131
	Lose fear of sex	135
	Liberating	134
	Fear of HIV	140
	Released stressful issues	142
	Illness embracing gives happiness and liberation	229
	Happier	523
	Deal with stress	523, 560
	Live in reality	304, 523
	Greater reality experiences teaches liberation	211
	Self decision if disease is liberator or oppressor	212
	Liberation through open-mindedness to suffering	218
	Recognition leads to liberation	219
	Letting go	233, 234
	Break past old core defences	295
	Released past	303
	Total	19
HIV as Growth/Catalyst		
	Watershed	152, 144
	Found spiritual path	173, 195
	Understand death, understand life	405, 408
	Unknown knowledge became self-evident	193-194
	Self-forgiveness	462, 463
	Explore spirituality	514
	Catalyst	306, 513, 519
	Control mental responses	526
	Understand life processes and life expectations	217
	Move negative mental spaces to positive spaces	235
	Move on	450
	Self agency	286
	Attitude shifts	467-477
	Openness to new things	370, 371
	Life change	522

	Powerful lesson	305
	Resolve personal issues	316
	Delving depths of own psyche	549, 553
	Let go bad, grow good	555
	Good starting point	112
	Answered questions	174
	Knowledge self-evident	193-194
	Learn from HIV process	273
	Learnt many things	276
	Harness process for wisdom evolution	269
	Coming out similarity	259
	Awaken	289, 291, 292
	Self-awareness	353
	Total	38
HIV and Disease as Negative		
	Disease as enemy	214
	Enemy view leads to failure	215
	Hold to perfection and illness as unreal	221-228
	Running from truth gives suffering	228
	Virus demands	118
	Anger at world	282
	Blaming others	280
	Illness and fear	478 - 484
	Total	8
HIV and Responsibility		
	Reality suspension	180
	Following desires	181
	Taking responsibility	182
	Put in harms way	178, 444-445
	Acceptance versus judgment	456, 437
	Ignorance	440
	Others and self	447-448, 455
	Active participant	454
	Karma	432, 433
	Intention	439
	Total	14
Cluster	**Natural Meaning Unit**	**Line Number**
HIV and Illness as Positive		
	Embrace illness gains liberation and happiness	229
	Sickness is not bad	209
	Wisdom through facing truth	226
	Sickness as respite	210
	Belief in HIV as terrible occurrence is a mistake	451-453
	Healthier	277, 560
	Live longer	536
	Live in present	304

	Self care now	330
	Better quality of life	535, 561
	Wellness practices	348
	Total	13
HIV and Death		
	Friends	49
	Young dying	51
	Facing mortality	398-403
	Grief over loss	382
	Anger over shortened life	383
	Understand death, understand life	405, 408, 410
	Acceptance of death	396
	Disease and death are a guarantee	183
	Life cycle	185
	Body degrades	184
	Life will end	191
	Death of the innocent	206
	Death is last thing	244
	Deaths due to HIV	373-378
	Total	16
HIV and Spiritual practices		
	Meditation	369, 322
	Yoga	368, 323
	Ongoing mindful and generous actions	460
	Involvement in path and spiritual practices	547, 160, 556, 541
	Reinforce beliefs	542/ 515
	Total	11
HIV and Sexual Practices		
	Doesn't guarantee infection	100/ 114
	Don't have to be infected	106
	Sero-discordant partners	111
	Lose fear of sex	135
	Enjoy sex	145
	Unprotected sex caused HIV status	108/ 179
	Sexuality was fearful	58
	Sexual encounter a risk	60
	Total	10
LGBTI Identity		
	Linked to sexual orientation	9
	Acceptance of Gay identity	21

	LGBTI awareness	6
	Challenge to social norms	23/ 41
	Claiming rights	37
	Unsilencing alternate identities	38
	Liberation identity	53
	Diversity	42
	Visibility of human experience	40
	Series	29
	Norm not the truth	27
	Sense of difference	10
	Internalised stigma	299
	LGBTI place in society	36
	Total	14
Sexual Orientation Identity		
	Sexual orientation and rights	37
	Acceptance of own sexuality	19
	Early maturity	7
	Linked to economics	32
	Total	4

Cluster order for Interview 3

Cluster order number	Cluster Theme	Quantity of Meaning Units
1	HIV as Growth/Catalysis	39
2	HIV and Stgmatization	23
3	HIV as Liberator	19
4	HIV as Life Review	18
5	HIV and Death	16
6	HIV and Responsibility	14
7	HIV and Illness as Positive	13
8	HIV and Spiritual Practices	11
9	HIV and Sexual Practices	10
10	HIV and Disease as Negative	9

11	HIV and Identity Link	8
12	HIV as Framework	3
13	HIV as Motivator	1
	Total Meaning Units	**184**

Natural Meaning Units for Interview 4

Cluster	**Natural Meaning Unit**	**Line Number**
HIV as Acceptance		
	Realisation of HIV infection	121
	Finality of HIV infection	122
	Mom figured out the result	126
	Moms admittance of HIV+ status realisation	133
	Acceptance by mother	135
	Dads acceptance of HIV+	139
	Acceptance of HIV+ by partner	164
	Sero-discordant relationship	167
	Partner had previous HIV+ partner	168
	Made things easier	172
	Mutual support	179
	Pained but understanding of reactions	227
	Understand each other	245
	Supported friends with HIV	331
	Death now in perspective	383
	Dealt with fear and death	392
	Helped deal with being HIV+	574
	Open about HIV+	602
	Don’t fear reactions	611
	Ex-partner coming to acceptance of	660

	HIV+	
	Friend disclosed his HIV+ status	751
	New Dr - sex and HIV openness	192
	Total	22
HIV as Life Review		
	Re-evaluate life and self	823/255
	Regrouped	442
	Could have reacted better	725
	My offensive behaviour	727
	Dealing with things left un-dealt with	568
	Goodbye to old self (HIV-)	575
	New leaf and new person	578
	Carry no baggage	581
	Greater awareness of others with HIV	595
	Soul searching	822/763
	Inner self investigation	791
	Total	**13**
Cluster	**Natural Meaning Unit**	**Line Number**
HIV as Stigmatization		
	Negative reactions over HIV+	226
	People judge quickly	601
	Company management reacted in ways due to illness	605
	Undercover stigma	607
	Unnecessary exposure to reactions	612
	As partners, agreed not to advertise	621
	Stigmatise partner due to my HIV status	622
	Used to stigmatise people	623
	Used to have barrier to HIV+ people	624
	Stigma unnecessary	626
	Stigma due to lack of education	629
	HIV over education	632
	HIV is bad	635
	HIV+ people unapproachable	635
	If HIV+ you're promiscuous	646/643
	People blame/assume HIV+ behave badly	648
	Stigmatised due to ignorance	669
	Barrier to HIV+ people	674
	Undercover barrier to HIV+ people	676
	Sero-sorting sexual behaviour	677
	Community split in two	688
	Past I would have sero-sorted	704
	No sex rather than safer sex with HIV+ people	706

	Total	24
HIV as Discomfort		
	Lack of doctor – sex and HIV openness	13
	Total	1
HIV as Transmission		
	Knowledge who infected	198
	One unsafe encounter	201
	Assumption he was the person	209
	Starting prophylaxis	506
	Awareness of sexual practices	630
	Some have been promiscuous	646
	Non-monogamous relationship	658
	Warning of ex-partner to be safe due to promiscuity	662
	Concurrent multiple partners	697
	I asked afterwards not before	702
	Total	10
Cluster	**Natural Meaning Unit**	**Line Number**
HIV as Ignorance/Denial		
	Feelings of unlikely HIV infection due to boring life	118
	Person no honest	199
	Man disappeared	205
	Living unaware	269
	No separation of HIV/AIDS awareness	650
	Ignorant about HIV	670
	Limited disclosure linked to lacking knowledge	672
	Now educated	679
	Promiscuous community	691
	Don’t care about HIV	692
	Past belief invincible to HIV	694
	Need education	695
	People aren’t open or honest about HIV	700
	Promiscuous people have different outlook on HIV	715
	People need to be educated	721
	React badly to peoples ignorance of HIV/AIDS	723
	No contact previously with HIV+ people	739
	Not much dealing with HIV+ people	755
	Total	18
HIV as Protection/Withholding		
	Some into withheld from family	97
	Protect parents health	186
	Not openly HIV+	660

	Don't advertise HIV status	610
	Open to healthcare professionals	617
	Don't disclose if person is not at risk	618
	Unaware of friends status	753
	Total	7
HIV and Spiritual practices		
	Meditation	846
	Religiousness still the same	776
	Problem with religious organisations	778
	Similar idea but own twist	781
	Belief religion should not be that way	783
	Money linked to religion a problem	785
	Buddhism maybe an exception	788
	Total	7
Cluster	**Natural Meaning Unit**	**Line Number**
HIV as Negative		
	Disappointed over HIV	136
	Reaction to ARVs	180
	Anger for ARV intervention as unnecessary	181
	HIV removes sexual spontaneity	233/231/238
	HIV affects immune system	421
	Initially poor reaction to HIV	440
	HIV impacted health	464
	Poor reaction to ARVs	466
	Deathly ill from ARVs	467
	Some people have bad ARV experience	483
	Blessed not yet infected	664
	Feared its takeover	681
	Gay community view of HIV unchanged	687
	Confusion on diagnosis	746
	Couldn't cope	847
	Inner turmoil	848
	Total	18
HIV and Responsibility		
	Responsibility of HIV impact	177
	Prophylaxis ARVs for partner	183
	Always practiced safer sex	194
	Relief over giving others HIV	214
	More cautious and responsible	218
	Monogamous relationship	221
	Manage the HIV	222
	Concern over the other person	223
	Must be careful	701
	Plan and aware of necessities	239
	Assistance with HIV info and help	334
	Sense of control over AIDS	414

	Take responsibility of self	433
	Prophylaxis for partner	491
	Double checking partners HIV status	499
	Responsibility when putting others at risk	613
	Total	16
HIV and Illness as Positive		
	Best thing my diagnosis	259
	Total	1
Cluster	**Natural Meaning Unit**	**Line Number**
HIV as Death		
	Impending shortening of life on diagnosis	341
	Chase dreams	343
	Urgency at beginning	347
	Awareness of acting out by father	351
	Death not tomorrow	357
	Obsessed initially	375
	Initial panic	375
	Close encounter with death due to HIV	380
	Sense of death as a reality	384
	Preparations	387
	Reality of death faced	390
	Death of HIV- self	576
	People believe HIV+ will die soon	652
	Partner typical reaction like most people	655
	Belief people will die soon due to HIV	656
	People expect die soon	729
	Total	16
HIV and Sex		
	Few unsafe encounters	195
	Sense of distance in sex	196
	HIV+ can be spontaneous about sex	235
	Kit to assist possibilities	242
	Spontaneity can improve with time	244
	Can have healthy sex relationship	709
	Bareback sexual fantasies	717
	No arousal unless sex is bareback	718
	Total	8
HIV as Disclosure		
	Admittance of HIV status to mom	134
	HIV disclosure to partner	163
	Upfront disclosure	225

	Won't deny status	609
	Disclosed to partner first	766
	Partner needed to know	747
	Friend disclosed to other friends	748
	Total	7
HIV and Living in the now		
	Living for the moment	312
	Stop putting things on hold	313
	Things come and go in life	928
	Total	3
Cluster	**Natural Meaning Unit**	**Line Number**
HIV as Normal	HIV just another disease	140
	HIV more manageable than other diseases	141
	No guilt over HIV	144
	HIV not a big thing	178
	Sex not really changed HIV+ status	193
	Realization of no impending death	359
	Realization that one can live long life with HIV	377
	Not being over cautious	426
	No other HIV related health problems	487
	HIV is manageable	637
	HIV shouldn't control life	638
	Awareness of HIV manageability	682
	Now realize can have sex if HIV+	708
	HIV not Gay/Straight	720
	Can live long periods with HIV	368
Gay Identity	**Total**	15
	Lack of freedom	52
	Saving and purchase of car	54
	Freedom to go out	55
	Own rebellious behaviour	73
	Realised I was unfair	86
	Ideal family (Parents lose dream)	93
	Committed relationship and even marriage	247
	Total material obsession	364
	Not into gay culture	326
	Identity not same as gay culture	328
	Gay identity not advertised	325
	Total	15
Coming out		
	Arrive home drunk	62
	Admittance of sexuality to father	68
	Parents upset over coming out	66

	Difficult family time at onset of coming out	72
	Initial difficult at coming out	91
	Family relationships smoothed out	75
	Open family relationship	95
	Family meet serious relationships	100
	Boyfriend another son	101
	Total	9
Cluster	**Natural Meaning Unit**	**Line Number**
HIV as Rejection		
	Partner left due to HIV status	152
	No support from partner	153
	Lack of support	154
	Still upsetting though	157
	Partner abandoned due to HIV status	657
	Partner freaked	745
	Total	6
HIV as Growth/Catalyst		
	HIV positively affected parent relationship	112
	Changes	254
	Internal happiness	266
	Changed – more aware	274
	New awareness of little things	288
	Notice things	291
	Spiritually and mentally dealt with a lot	565
	Areas in life to work on	764
	Was selfish	766
	Grown less selfish	767
	Now more in control of self	771
	More connected to self and others	772
	More honest	773
	Like changes in self	776
	Spiritual change	790
	Dropped defences and defence mechanisms	824
	Investigated defence mechanisms	827
	More able to have relationships	828
	Total	18
HIV as Purpose		
	Look at life purpose	256
	Look at life mean and take less for granted	257
	Desire to be remembered as a good	276

	person	
	Make a difference to people	275
	Still have things to do	382
	Thought of effect on others	385
	Change people's lives	504
	Have purpose due to spirituality	815
	Cope due to sense of purpose	816
	Total	9
Cluster	**Natural Meaning Unit**	**Line Number**
HIV and Spirituality		
	Regrouped inner self	258
	Purpose and meaning	267
	Help if able to	292
	No desire for acknowledgment	293
	Feel good making a difference	299
	Death is another route	400
	Spirituality moved on	461
	Spiritual beings embodied	402
	More spiritually in touch	768
	Spiritually connected	812/804/712
	Explore spirituality	795/793/800/863/875
	More balanced due to spirituality	841
	Less erratic	842
	More calm	845
	Smoothed things out	844
	Helped healthwise	845
	Changed mindset	846
	Spirituality brought focus	852
	Coping created improvement	855
	Mind is powerful	856
	Mind can make healthier or sicker	857
	Total	27
HIV as Lifestyle		
	Self-care	427/416
	Irresponsibility will shorten life	418
	Lack of responsibility leads to AIDS	432
	Early ARV treatment in diagnosis	467
	Health status good	460
	Regular Dr check-ups	690
	Moved on	527
	Risk to self, using drugs	523
	Positively positive	582
	Awareness of HIV and body	680
	Total	11

Cluster	Natural Meaning Unit	Line Number
HIV and Drugs		
	Not a big drinker	507
	Used drugs recreationally in past	510
	Moved on from party scene	511
	Drugs not part of lives	515
	Opportunities to use passed over	517
	Decision not to use drugs not purely linked to HIV status	520
	Compromises immune system	526
	Total	7
HIV and Alternative medicine		
	Use of alternative medicine	533
	Spiritual energy healing	536
	Turning point in health	542
	Shift in spiritual, body, mind level	543
	Big turning point	547
	Acupuncture therapy	548
	Openness to complimentary treatment	556/569
	Attended bodytalk	559
	Good for me	567
	Crystal healing	894
	Total	11

Cluster order for Interview 4

Cluster order number	Cluster Theme	Quantity of Meaning Units
1	HIV and Spirituality	27
2	HIV as Stigmatization	24
3	HIV as Acceptance	22
4	HIV as Ignorance/Denial	18
	HIV as Growth/Catalyst	18
	HIV as Negative	18
5	HIV as Responsibility	16
	HIV as Death	16
6	HIV as Normal	15
7	HIV as Life Review	13
8	HIV as Lifestyle	11
9	HIV as Transmission	10
10	HIV as Purpose	9
11	HIV and Sex	8
12	HIV and Spiritual Practices	7
	HIV as Disclosure	7
	HIV and Drugs	7
	HIV as Withholding/Protection	7
13	HIV as Rejection	6
14	HIV and Illness as Positive	1
	HIV as Discomfort	1
	Total Meaning Units	**261**

Natural Meaning Units for Interview 5

Cluster	Natural Meaning Unit	Line Number
HIV as Acceptance		
	Self-acknowledgment	5
	People have needs	5
	Self-acceptance	56
	Terminal illness ability to truly understand	166
	Total	4
HIV as Stigmatization		
	Complications around HIV and Stigma	29
	Fear and perceptions of people	30
	HIV- people need to walk in HIV+ peoples feet	42
	Fear and stigma link	46
	Eradicate fear messaging	45
	People live in fear of HIV	46
	Relationships difficult	48
	Interacting with people difficult	49
	Stigmatised and people rejecting	50
	Rejected sexually by HIV- people	51
	Denial around HIV in LGBTI community	156
	Stigma blocks unity	159
	Instilled fear caused social issues	160
	Different social camps	162
	HIV not unifying	163
	HIV a social issue	164
	Total	16
HIV as Ignorance/Denial		
	Partner had been unknowingly HIV+	27
	Denied his HIV+	28
	People lack understanding	165
	Total	3
HIV as Disclosure		
	HIV disclosure was a process	10
	Disclosure to mother	11
	Coming out linked to HIV disclosure	12
	Total	3
HIV as Responsibility		
	Condom queen	32
	Total	1
HIV as Blessing		
	HIV as a blessing	53
	Total	1
Cluster	**Natural Meaning Unit**	**Line Number**
HIV as Negative		
	Lost at time of diagnosis	136
	Destructive process	37

	Giving up caring initially	38
	Nothing to live for	119
	Had turned on religion	133
	Directionless	138
	Face self a daily challenge	146
	Futility of this world	168
	Total	8
HIV as Growth/Catalyst		
	Unraveling emotional layers	39
	Growth in understanding sex	40
	Growth in happiness	55
	Lost superficiality	57
	Engage people at deeper level	59
	Desire to connect at deeper levels	61
	Reject superficial interactions	67
	Stronger as a person	68
	Past material focus	172
	More self-aware	122/69
	Everything changed	98
	Opened myself up	120
	Dealt with emotional and daily issues	128
	Released past	129
	Stand for self and own rights	137
	Empowered	134
	Search to improve mood	147
	Total	18
HIV as Infection		
	Diagnose by doctor	16
	Became HIV+	34
	Total	2
HIV and Sexual Practices		
	Persuaded by partner to be unsafe at times	33
	Less safer sex	35
	Total	2
Cluster	**Natural Meaning Unit**	**Line Number**
HIV as Lifestyle		
	Respecting body	70
	Healthy eating	71
	Changed lifestyle	74
	Occasionally see doctor	77
	Coping somehow	94
	Total	5

HIV as Death		
	No fear of dying	117
	Fear of death was seeded	119
	Ignore death, but plan for it	174
	Total	3
HIV and Spirituality		
	Enjoy the now	176
	Less material attached and attached to self	169
	Spirituality and health played a part	97
	Changed perception	98
	Don't keep track of time	96
	Living in the present	99
	Time focused within self	101
	Spirituality linked to changes	124
	Trained as a therapist	126
	Spiritual healing fundamental	125
	Didn't view others limitations	139
	Purpose to make a difference	151
	Plan for existence	154
	No accidents in life	153
	Total	14
HIV as Purpose		
	Daily process of purpose finding	142
	Purpose to life	153
	Small reasons	145
	Reasons at work	146
	Find ways to make reality bearable	148
	Repeated daily cycle	149
	Self-searching and awareness of uniqueness	150
	Total	7
HIV as Turning Point		
	Turning around now	131
	Total	1
Cluster	**Natural Meaning Unit**	**Line Number**
HIV as Non-conforming		
	Issues with doctors	79
	Confusion around beliefs and health	80
	Doctors only prescribe	83
	Doctors don't know human body	84
	Exploring alternative frequency treatment for HIV	86
	Fighting social structures	102
	Food changed	108
	Avoid processed food	110
	Fresh fruit and vegetables	111
	Total	9

Cluster order for Interview 5

Cluster order number	Cluster Theme	Quantity of Meaning Units
1	HIV as Growth/Catalyst	18
2	HIV as Stigmatisation	16
3	HIV and Spirituality	14
4	HIV as Non-conforming	9
5	HIV as Negative	8
6	HIV as Purpose	7
7	HIV as Lifestyle	5
8	HIV as Acceptance	4
9	HIV as Ignorance/Denial	3
	HIV as Disclosure	3
10	HIV as Infection	2
	HIV and Sexual Practices	2
11	HIV as Blessing	1
	HIV as Responsibility	1
	HIV as Turning Point	1
	Total Meaning Units	**94**

Appendix 3

Across Interview Cluster Theme Analysis

Table: Top 10 Cluster Themes across Interviews

Cluster Theme	% Quantity of Meaning Units 1	% Quantity of Meaning Units 2	% Quantity of Meaning Units 3	% Quantity of Meaning Units 4	% Quantity of Meaning Units 5	% Total	Average	Cluster Order
HIV and Spirituality	13.3	12.57	0.00	10.34	14.89	51.50	10.22	2
HIV as Stigmatization	1.51	4.00	12.50	9.20	17.02	44.23	8.85	3
HIV as Acceptance	0.00	14.29	0.00	8.43	4.26	26.98	5.40	5
HIV as Ignorance/Denial	0.00	5.71	0.00	6.90	3.19	15.80	3.16	
HIV as Growth/Catalyst	19.70	4.60	21.20	6.90	19.15	71.55	14.31	1
HIV as Negative	10.60	2.86	4.89	6.90	8.51	25.25	5.05	6
HIV as Responsibility	5.30	0.00	7.61	6.13	1.06	20.10	4.02	8
HIV as Death	12.12	9.14	8.70	6.13	0.00	36.09	7.22	4
HIV as Normal	0.00	9.71	0.00	5.75	0.00	15.46	3.09	
HIV as Life Review/ Turning Point/ Framework/ Motivator	0.00	0.00	11.20	4.98	1.06	17.24	3.45	10
HIV as Lifestyle	0.00	5.14	0.00	4.21	5.32	14.67	2.93	
HIV as Transmission/ Infection/ Medication	0.00	5.71	0.00	3.83	2.13	11.67	3.89	9
HIV as Purpose	0.00	0.00	0.00	3.45	7.44	10.89	2.18	
HIV and Sex	0.00	0.00	5.43	3.07	2.13	10.64	2.13	
HIV and Spiritual Practices	6.06	0.00	5.98	2.68	0.00	14.72	2.94	
HIV as Disclosure	0.00	2.86	0.00	2.68	3.19	8.91	1.78	
HIV and Drugs	0.00	6.29	0.00	2.68	0.00	8.97	1.79	
HIV as Withholding/Protection	0.00	2.29	0.00	2.68	0.00	4.97	0.99	
HIV as Rejection	0.00	0.00	0.00	2.30	0.00	2.30	0.46	

HIV and Illness as Positive/Blessing	4.55	0.00	7.07	0.38	1.06	13.06	2.61	
HIV as Discomfort	0.00	0.00	0.00	0.38	0.00	0.38	0.08	
HIV as Non-conforming	0.00	0.00	0.00	0.00	9.57	9.57	1.91	
HIV as Liberator	0.00	0.00	10.33	0.00	0.00	10.44	2.07	
HIV and Identity Link	5.30	0.00	4.35	0.00	0.00	9.65	1.93	
HIV as Bond/ Support	5.30	5.14	0.00	0.00	0.00	10.44	2.07	
HIV as Fear	15.90	5.71	0.00	0.00	0.00	21.61	4.32	7

Table: Top 10 Cluster Themes across Interviews

Order	Cluster Theme	% Quantity of Meaning Units 1	% Quantity of Meaning Units 2	% Quantity of Meaning Units 3	% Quantity of Meaning Units 4	% Quantity of Meaning Units 5	No of interviews represented by across Cluster Theme
1	HIV as Growth/Catalyst	19.70	4.60	21.20	6.90	19.15	5
2	HIV and Spirituality	13.3	12.57	0.00	10.34	14.89	4
3	HIV as Stigmatization	1.51	4.00	12.50	9.20	17.02	5
4	HIV as Death	12.12	9.14	8.70	6.13	0.00	4
5	HIV as Acceptance	0.00	14.29	0.00	8.43	4.26	3
6	HIV as Negative	10.60	2.86	4.89	6.90	8.51	5
7	HIV as Fear	15.90	5.71	0.00	0.00	0.00	2
8	HIV as Responsibility	5.30	0.00	7.61	6.13	1.06	4
9	HIV as Transmission/ Infection/ Medication	0.00	5.71	0.00	3.83	2.13	3
10	HIV as Life Review/ Turning Point/ Framework/ Motivator	0.00	0.00	11.20	4.98	1.06	3

Appendix 3

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jou kennisvennoot • your knowledge partner

19 July 2011

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LETTER OF ETHICS CLEARANCE

With regards to your application, I would like to inform you that the project, *Searching for meaning in the face HIV among men who have sex with men (MSM) in Cape Town, South Africa,* has been approved on condition that:

1. The researcher/s remain within the procedures and protocols indicated in the proposal;
2. The researcher/s stay within the boundaries of applicable national legislation, institutional guidelines, and applicable standards of scientific rigor that are followed within this field of study and that
3. Any substantive changes to this research project should be brought to the attention of the Ethics Committee with a view to obtain ethical clearance for it.

We wish you success with your research activities.

DIE UNIVERSITEIT VAN STELLENBOSCH
19 JUL. 2011
THE UNIVERSITY OF STELLENBOSCH

Best regards

MR SF ENGELBRECHT
Secretary: Research Ethics Committee: Human Research (Humanora)