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Overcoming Adversity: A Grounded Theory of Health Management Among Middle-Aged and Older Gay Men

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Abstract
This article presents findings from a grounded theory study in which we explored how self-identifying gay men between 40 and 76 years of age manage their health in the context of homophobia, heteronormativity, and discrimination. Data were collected with 25 men over a 6 month period in a large urban setting in Western Canada. A preliminary theory of health

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management is discussed, consisting of the central phenomenon of overcoming adversity. Three thematic processes are considered that illustrate how adversity and health management are situated within the interrelationships of historical and ongoing discrimination inclusive of and external to the health care encounter, the complexity of men’s illnesses, and the temporal aspects of HIV epidemics and treatments that occurred throughout their lives. These themes include: advocating for health needs, knowing about health issues and treatments, and engaging in health promoting practices. These findings help to address a gap in knowledge concerning health management among older gay men and support that initiatives aimed at health care with gay men must appreciate the systemic role of discrimination, while supporting men’s individual efforts in actively managing their health.

Keywords: Inequalities/social inequalities in health status, health behaviour, gay/lesbian, social determinants of health, men’s health

Introduction

It is well established that middle-aged and older gay men experience health inequities that are influenced by homophobia and heteronormativity (Aggarwal and Gerrets, 2014; Ferlatte, Dulai, Hottes, Trussler and Marchand; Mustanski, Andrews, Herrick, Stall and Schnarrs, 2013). Despite evidence that gay men experience significant health concerns rooted in discrimination, little is known about the processes they use to manage their health. Without an adequate understanding of how middle-aged and older gay men manage health, clinicians do not have adequate tools to enhance men’s capacities to promote and protect their health.

Health management, the term for men’s individual practices to promote their health and manage acute exacerbations of chronic illness (Cameron and Leventhal, 2003), has gained increasing attention within the health literature. Historically, much of this work emphasized gay men’s sexual health practices including condom use, attendance to sexual health services and adherence to HIV treatment regimens (Eaton, Kalichman, and Cherry, 2010; Gastaldo, Holmes, Lombardo and O’Byrne, 2009; Klein, 2012) to the extent that these foci were critiqued as

1 Homophobia refers to discrimination at the interpersonal level (including violence and name calling) by individuals who harbour fear and/or hatred towards those who are not heterosexual (Kitzinger, 2001)
2 Heteronormativity represents macro-level discrimination via oppressive practices and attitudes directed towards those who do not identify as heterosexual (Aguinaldo, 2008)
privileging neoliberal public health approaches that prioritized personal responsibility and constructed gay men’s sexual practices as ‘risk’ (English and Rourke, 2015; Lupton, 1995; Scarce, 1999). Little attention has been paid to gay men’s management of other health issues such as depression, anxiety, suicidality and substance overuse, which disproportionately affects this population (Aggarwal and Gerrets, 2014; Blackwell, 2015; Conron, Mimiaga and Landers, 2010; Ferlatte et al., 2015; author, 2017; Wang, Hausermann, Ajdacic-Gross, Aggleton and Weiss, 2007; Wright, LeBlanc, de Vries and Detels, 2012). Overwhelmingly, gay men’s health management is situated within the context of illness such that there is little understanding as to how men go about promoting and protecting their health more generally.

Interventions to foster health management as a consequence of neo-liberal perspectives of ‘risk’ have focused on individual behaviours, with minimal attention given to the social, economic and personal contexts of men’s lives and the intersections between context and behaviour (Bogowicz et al., 2016; Siconolfi, Halkitis and Moeller, 2015; Smith, White and Ross, 2017; van den Boom et al., 2018). Homophobia is a documented proven contributing factor to health inequities among gay men and their health management (Aggarwal and Gerrets, 2014; Ferlatte, Dulai, Hottes, Trussler and Marchand, 2014; Mustanski et al., 2013) with direct negative effects on the resources necessary for health such as income security, access and receipt of health care and freedom from violence; all of which can detrimentally affect men’s opportunities for effective health management (author, 2018; Ferlatte et al., 2015; Yep, 2002).

**Gay Men, Discrimination and Health Management**

Within the burgeoning field of health management among gay men, men’s health management interventions have focused on emphasizing how men’s sexual practices and condom use are influential for sexually transmitted infection (STI) and HIV susceptibility (e.g., Dickinson and Adams, 2008; King and Richardson, 2016; Mustanski, Newcomb, and Garofalo, 2011; Goldhammer and Meyer, 2011; Rhodes et al., 2015; Wirtz et al., 2014). The influence of discrimination on health management strategies within sexual encounters, and consequently men’s HIV and STI susceptibility, has become increasingly integrated into this work. Findings indicate that discrimination—and its resulting stigma and negative consequences for self-worth—was correlated with an increased number of sexual partners, substance use, and unprotected anal intercourse (Gastaldo, Holmes, Lombardo and O’Byrne, 2009; Goldhammer and Mayer, 2011;
Ferlatte et al., 2014;). However, the exact mechanism by which discrimination shaped health management was unclear.

Health management scholars have also focused on social supports used by gay men of diverse ages, particularly in contexts including homophobic violence and harassment experienced (Harper et al., 2015; author, 2018; Mustanski et al., 2011). Mustanski and colleagues (2011) found, for example, that support from family members and peers contributed to decreased psychological distress associated with sexual orientation-related victimization among gay youth. The negative health consequences of discrimination experienced by gay men over 65 years of age were reportedly mitigated by the development of strong supportive networks consisting of partner(s), friends and/or family (Kushner, Neville and Adams, 2013). Dickinson and Adams (2014) also demonstrated that having social connections, and engaging in personal reflection, having interests and hobbies, and seeking counseling were key contributors to mental health among gay participants.

Other studies about health management have focused on men’s engagement with STI- and HIV-related health services, particularly help-seeking, which refers to men’s willingness to engage health services (author, 2012). Discrimination was reported as a significant issue for engagement with, and receipt of, effective health services. Men felt uncomfortable accessing services as gay men, and expressed a discomfort in disclosing sexual identity in clinical encounters (Guy et al., 2010; Maulsby et al., 2018; Tong, Lane, McCleskey, Montenegro, and Mansalis, 2013; Quinn et al., 2012; Wall, Khosropour, and Sullivan, 2010). Both structural-level discrimination (heteronormativity) and homophobia have been cited as barriers to help-seeking (Aguinaldo, 2008; author, 2018), with substantial evidence illustrating how gay men were constructed by health care providers as the “risky other, in opposition to heterosexual men as the (hetero)normal” (author, 2012 p. 1).

Discrimination, and the homophobic and heteronormative assumptions about gay men being hypersexual, risk-taking, and deviant, have created a significant bias in health service provision that further compounds men’s disengagement with health services (Dean et al., 2000; Meyer and Northridge, 2007; Quinn et al., 2015). Studies illustrate, for instance, that gay men are less likely to report a recent medical visit when compared to heterosexual men (Alvy, McKirnan, Du Bois, Jones, Ritchie and Fingerhut, 2011) despite the evidence of a disproportionate burden of illness. Gay men also report an inability to access essential primary care services for sexual and
non-sexual health concerns; a situation compounded by heteronormative ideologies that conflate being gay with illness, risk, and hypersexuality (Adam, 2005; Adam, Corriveau, Elliott, Globerman, English and Rourke, 2015; author, 2018; Race, 2010). The overemphasis by health providers on HIV and other STIs has contributed to gay men’s other health concerns going untreated, and feelings of disrespect and shame, which limits their capacity for positive health management (author, 2018).

Currently, there is a dearth of information about gay men’s health management strategies, particularly as situated within the broader social and historical contexts of their everyday lives including the HIV era of the 1990’s, relentless discrimination and the complexity of the health concerns they may experience. This is especially true for middle-aged and older gay men. Consequently, this article details how 25 self-identifying gay men between 40 and 76 years of age manage their health in the context of homophobia, heteronormativity, and discrimination. In doing so, we sought to grasp how men’s experiences moved from the individual to the community, fueled mobilization, and shaped new social worlds (Plummer, 1994). After reviewing our research design, we specifically discuss the core phenomenon of overcoming adversity as a preliminary theory to managing health. We conclude with implications of this work that illustrate how understanding men’s health management strategies is a necessary precursor to developing appropriate interventions for this population.

**Research Aims**

The research question being addressed in this study was: *What are the processes by which middle aged and older gay men manage their health?* The findings have the potential to generate evidence-informed recommendations for public health and primary care interventions to foster gay men’s health management capacities and tackle health system barriers for health management.

**Methods**

This study was conducted in Victoria, British Columbia, Canada; the provincial capital with a population of 85,000 (Government of BC, 2015). Inclusion criteria were: men who self-identified as gay, age 40 and over (i.e., middle-aged and older), English speaking and residing in the Victoria area. The sampling process was aided by several men, connected to networks of other gay men, and who were known to the first author and expressed support for the project. A recruitment flyer was developed and distributed by these individuals at social and educational community events. In doing so, a snowball sample evolved whereby participants furthered recruitment efforts by
passing along the recruitment flyer to prospective individuals within their social, educational, and community circles. This approach introduces limitations via the potential exclusion of men who are not necessarily connected to other gay men or who are not openly gay. The need for future investigations to capture these potentially excluded men is indicated as the similarity across social location of participants can lead to homogeneity in experiences.

**Data Collection**

Data were collected over an eight-month period via semi-structured, one-on-one interviews held in locations and at times convenient for the participants. Congruent with grounded theory methodology, the interviews were used as a means to encourage storytelling with depth and breadth without interruption (Mischler, 1991). A semi-structured interview guide, informed by the literature on health management, gay men’s health and the experience of the research team was used to assist in storytelling. The questions included topics such as men’s general health, health issues experienced throughout their lives, and how they managed or engaged with these health issues. As the study emphasized the process of health management for men over 40, we were also interested in how men’s engagement with health and illness occurred over time and what if any factors contributed to how men developed and implemented these strategies. Specific probes to explore if and how their experiences were situated within a nexus of homophobia were included. Interviews lasted approximately 60 minutes, were audio recorded and transcribed verbatim by an experienced transcriptionist.

Verbal consent was obtained prior to each interview, and interviews were conducted by the first author. Each participant was offered the choice of $30 CDN in cash or coffee shop gift card for to acknowledge their contribution to the study. To ensure voluntary consent, participants were informed that they could withdraw from the study at any time without needing to offer any reason for doing so (TCPS, 2014). Twenty-five men ranging in age from 40 to 76 years old (average age 54 years old) took part in the study. Twenty-three self-identified as White and most had completed some post-secondary education. The participants maintained a variety of occupations spanning architecture, teaching, various roles in local government and non-profit organizations, finance and accounting.

**Data Analysis**

As per the iterative nature of grounded theory methodology, data were collected and analyzed simultaneously (Bryant and Charmaz, 2007). The first step was a broad read of each
interview transcript to establish familiarity with the text and an opportunity to reflect on the information as a whole (Charmaz, 2006). Next, open coding commenced wherein large portions of data were compared and patterns were summarized by assigning a short phrase (Charmaz, 2006). For example, open codes included “exercising three times per week to boost energy”, “telling physicians about side-effects of the medication” and “being bullied in high school”. We also specifically sought to identify potential differences in experiences throughout the interviews by integrating specific probes concerning details of experiences for instance, ‘please elaborate on the challenges you faced?’ or ‘explain how you made that decision and what influenced your decision? As analysis progressed and became more focused, we paid particular attention to the how men’s health management practices evolved over time and intersected with their experiences of discrimination as gay men in society generally and in the context of health care encounters specifically.' Memo writing was integral and included notations about how the codes being identified related to one another and the participants’ overall health management practices (Charmaz, 2006).

As the data reached saturation on key processes, coding was refined to three overarching analytic categories that illustrated core processes in health management. Finally, theoretical coding was undertaken to identify how the analytic categories related to each other and how these could be integrated into a theory of health management that considered the temporal personal and social factors shaping these practices (Charmaz, 2000, 2006). To enhance accuracy, feedback and guidance were elicted from participants to clarify data interpretation throughout the analysis. Participants were provided with a short summary document via email, twice during the analyses, which outlined preliminary themes and final categories (Charmaz, 2006; Sandelowski, 1986). Participants were in agreement with the analysis, which are detailed in the subsequent results section of this paper.

**Results**

Drawing on the interview data a preliminary theory of older gay men’s health management as *overcoming adversity* was identified. Overcoming adversity represents the central phenomenon expressed in the three interrelated thematic processes, advocating for health needs, knowing about health issues and treatments, and engaging in health promoting practices. To contextualize these findings, a brief overview of the participants and their perspectives on health follows.

**Participant Overview**

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The participants experienced an array of acute and chronic health issues. Twelve men were living with HIV and 16 reported struggling with varying degrees of anxiety, depression, suicidality and/or substance use. Participants were predominantly well-educated White men whom demonstrated profound recognition of the complexity of their health, and all were invested in living a long and healthy life. Health was described as a process of living a life full of possibility versus a static state of physical wellness or absence of disease. Men described how they came to see health as a life of possibility. This perspective came as a result of their experiences during the 1980s and 1990s, where they witnessed substantial suffering and death of their peers and partners as a result of HIV and AIDS. The men discussed how loss illuminated the fragility of life, shifting the emphasis to health, and even moreso their perception of health as not only the means to survive, but the opportunity to enjoy, engage and live life to the fullest:

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

Participants engaged in an array of practices to help them achieve their wish to live a long and healthy life. These practices were developed over the course of their 40-plus years and shaped by the need to manage the everyday complexities associated with being a gay man in a predominantly heteronormative society. Consequently, our findings represent a nascent theory of gay men’s health management as a series of social processes and individual practices that we collectively termed “overcoming adversity.”

Overcoming Adversity: A Theory of Health Management

Historical and ongoing discrimination contributed to harm and poor health for all of the participants, particularly by means of the biological consequences of exposure to toxic stress throughout their lives. The men described frequent occurrences throughout their lives of bullying, assault, loss of job opportunities, denial of visitation rights with intimate partners in hospital settings, and refusal for residency in apartment buildings. Men also recounted the lack of public health response to the HIV crisis in the 1980s and 1990s and the overwhelming loss of friends and partners as a quintessential example of discrimination. This discrimination contributed to the development of numerous health problems, particularly HIV and mental health issues such as anxiety, depression, suicidality, and substance use. Discrimination further percolated into the
health services context, where participants reported mistreatment by health professionals, including assumptions that gay men are hypersexual, and/or deviant and therefore at risk for HIV and STIs. Many participants expressed that health professionals had a sole focus on HIV, which distracted from having unrelated health issues addressed. The interconnected evolving nature of these experiences—historical and ongoing discrimination, multiple acute and chronic health challenges, problematic engagement with the health care system, and living through pre-treatment HIV (the term used to describe a time where the care for HIV and AIDS was primarily palliative)—was recognized as adversity in the lives of the middle-aged and older gay men who took part in this study. As one participant noted:

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

Ultimately, adversity created multiple barriers to men’s health. Their health management therefore necessitated overcoming this adversity, which they did by developing and implementing a series of practices represented analytically within three overarching categories: (1) advocating for health needs, (2) being knowledgeable and (3) engaging in health promotion practices. Employing these processes provided men with the means to overcome adversity, as evidenced by the overwhelmingly enthusiastic stance men communicated about the current state of their well-being. These three processes, detailed in Figure 1, were interconnected and multidirectional.

figure 1. Overcoming Adversity
Advocating for Health Needs

The complexity of men’s acute and chronic health issues over many decades necessitated their regular engagement with health services, especially a primary care provider such as a family physician or nurse practitioner. Experiences of discrimination and pathologization due to being gay were frequent in health settings, and these incidents were compounded by traditional patient-provider hierarchies. Men recounted being made to feel “uncomfortable, dirty, or simply wrong” in their sexual identity within health care settings. Additionally, numerous harmful assumptions were made by health providers that contributed to marked oversights in care. In fact, the most profound insight gained from descriptions of health encounters was the frequency of men who described being pathologized whereby clinicians’ conflated gay identity with HIV and/or STIs:

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

The discriminatory incidents within health settings illustrate the adversity gay men faced in managing their health: essential health services were, and remain, potential sites of harm. Health management therefore, required tackling discrimination in the care encounter, which was
exemplified in men’s stories of building their capacity to advocate to have their health needs addressed.

Being gay was fundamental to building and enacting their capacity to advocate for themselves during a health encounter. Participants talked about developing confidence over time to simply deflect negative comments or ignore intrusive and inappropriate questioning about sexual identity and to focus on the health issue at hand. Being marginalized cultivated strength and a belief in oneself that aided the ability to speak up and contest their subordination:

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

This advocacy also required being actively involved and informed about health matters and treatment options, discussed in more detail in the subsequent theme. By positioning themselves as responsible and informed, men maintained a level of confidence in deliberating with health professionals and were in a position to speak up and question approaches to care. However, at times advocating for oneself could lead to tensions with health professionals and contribute to an additional obstacle in care provision as eloquently described in the following excerpt:

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

Contesting discrimination in other aspects of their life was also integral to building confidence in advocating for one’s needs in health care. For many, having lived through the pre-treatment HIV era was a tremendous influence for building capacity in health management as men rallied together and supported one another. During this time, for example, participants noted that accessing vital information about transmission required a collaborative effort among gay men, since much of what was known about prevention was obscured from public knowledge due to societal assumptions that HIV was caused by “deviant sexual practices.” As one man noted:

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

By rallying together, men fought for access to information and care. It was these experiences of community advocacy that men noted contributed to their confidence to advocate within individual health care encounters. Men described how those experiences “taught us” to speak up and learn from one another and that they had a right to health care, which further enabled them to advocate for their health care needs.

**Being knowledgeable about health concerns and treatments**

Intricately connected to the ability to advocate for one’s health needs in overcoming the adversity associated with discrimination was the process of being knowledgeable including having essential knowledge about physiology, illness management strategies, and medical treatments. It also included being recognized by health care providers as a “responsible man” deeply invested in his health. They were well informed about their health and illnesses and demonstrated proficiency in assessing information from diverse sources, allowing them to gauge their health situation and match information resources appropriately.

Family and friends were also a key source of information, and regularly the first supplier of information before accessing health care. These trusted individuals were considered safe, which referred to non-judgmental and non-discriminatory interactions. Many of these individuals were allied or regulated health professionals and their support was invaluable:

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

Eliciting information from family and friends enabled empowerment: the men became more informed about their bodies, illness processes and health promotion strategies, which they used to facilitate conversations with health care providers. Maintaining an arsenal of knowledge was an essential strategy for the participants to engage with health providers, which functioned to both advocate for their needs and, as they noted, refute providers’ perceptions of gay men as unaware, irresponsible and/or reckless with their health.
For the participants living with HIV, being knowledgeable added specific dimensions concerned with avoiding stigma and demonstrating their proficiency as responsible health care consumers that were directly related to treatment regimens and the necessary blood testing. Many participants noted that they had copies of their bloodwork sent to them for assessment prior to meeting with their “HIV specialist.” This enabled them to take an active role in their health management by reviewing the information and preparing questions prior to the appointment. Participants emphasized that involvement to this degree was a learning process over time. The commitment to being a knowledgeable health care consumer was regularly described as the responsibility of “all gay men.” Not doing so was seen as irresponsible.

A couple of our members at (organization) right now are so lackadaisical about seeing physicians. They don’t know what their blood test results are before they go in…I have copies mailed to me so I can be prepared. I have questions, ‘what’s the relationship of these two tests?’ Because you learn (over time) it’s not going to be 20 minutes of discussion and there’s everything you have to know. It’s very slow going. It doesn’t happen overnight.

You have to work at it. (Men need to) take that attitude. (70 years old)

Participants expressed that showing up to appointments with knowledge of test results and other health information demonstrated to their health care providers that that they are informed and committed to health matters. The level of dedication to this reputation was evident in participants’ comprehension of immune function, the meaning of cell counts in relation to health and illness, and how the virus and medications influence these markers. Participants expressed that the information was complex and required additional learning and effort; but that being knowledgeable was essential to navigating a health care encounter. For these men, being informed was not simply about managing an illness: it refuted discriminatory stereotypes about gay men and facilitated dialogue with health professionals about health issues and treatment options. Ultimately, knowing about health issues and treatments was an essential element in health management as overcoming adversity.

Engaging in Health Promotion Practices

Men’s health management processes in overcoming adversity were further shaped by their everyday health promotion practices that were regularly described in terms of “lifestyle activities” by the participants. Men discussed the importance of eating well and getting exercise and these health promoting practices were uniquely positioned in the adversity associated men’s desire to
refute damaging homophobic stereotypes as “reckless gay men”, while simultaneously navigating complex, acute, and chronic mental and physical health issues. Assuming responsibility and control were central tenets of men’s health promoting practices in addressing this adversity. Men spoke about how the work of “being healthy” resided within themselves as noted in the following excerpt:

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

The goal of health enabled a life rich with possibility; therefore, men dedicated tremendous effort and attention to health promoting practices. Most participants emphasized the importance of dietary choices and exercise. A “healthy diet” meant limiting processed foods, refined sugars, alcohol and red meat while increasing vegetable, fruit and water intake. Exercise referred to a continuum of activities on a near daily basis, including high impact (e.g., running, swimming) and less intense (e.g., walking the dog, gardening) activities. Adherence to discipline, restriction, and the vigilant weighing of pros and cons were evident throughout their stories:

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

Participants aimed to live in good health, which they construed as their own responsibility and which necessitated control and restriction. Men discussed the importance of not adhering to stereotypes about gay men as reckless and hedonistic that they perceived general society assumed about them, but instead focused on being a “good health citizen.”

For many of the men, health management to navigate significant mental health issues was seen as a crucial element of being healthy. Men recounted early life experiences with mental health issues such as depression and suicidality. Their stories were situated within a nexus of isolation (e.g., disapproval of family members), violence (e.g., bullying and physical assault - defined as “gay bashing” by participants), and grief:

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

Participants broached conversations about mental health without reticence, and they emphasized the importance of seeking counseling. Further, they described how they developed varied and unique strategies to promote mental health. Men stated that exercise had a tremendous impact on their emotional well-being, and they saw it as a health promoting practice, encompassing physical and mental wellness. This positive impact on mood was the biggest motivator as articulated by this participant:

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

Participants discussed strategies such as dancing or crying as being “different” from typical masculine ways of coping and how, by virtue of non-adherence to dominant masculine norms, they drew upon their own unique strategies as a means to facilitating health. Committing to “healthy living” both helped men feel better on a daily basis and provided the means to alleviate some of the symptoms of multiple mental health issues that many participants grappled with. Diligent engagement in health promoting activities contributed gay men being recognized as actively engaged and invested in their health matters with health care providers, but also served as a powerful tool to bolster their physical and mental health.

**Discussion**

In the current study we examined how health management was situated within the larger context of discrimination associated with sexual identity among Canadian middle-aged and older gay men. By moving beyond the current research focus on individual behavior and expanding upon age to include older gay men, we developed a nascent theory that illustrates how the adversity associated with discrimination, loss, and interpersonal violence over their 40-plus years necessitated unique processes for managing their health. While there is ample research illustrating
the negative health effects of discrimination generally (e.g., Krieger, 2014), and among gay men in the context of HIV and STIs or mental health (Ferlatte et al., 2014; Ferlatte et al., 2015; Mustanski et al., 2013), conspicuously absent are theories about gay men’s health management that pay particular attention to older gay men or how they engage with and respond to both historical and ongoing discrimination, grief, or violence to promote and protect their health. The current findings and theory speak to the lasting effects of discrimination, violence and loss for men’s health and how these factors must be included in research, programs, and practices aimed at health promotion among middle-aged and older gay men. Understanding gay men’s health management as a temporally bound process of overcoming adversity associated with loss, violence, and discrimination through the interconnected processes of being knowledgeable about health issues and treatments, advocating for health needs, and engaging in health promoting practices is a critical first step to informing innovative health service reforms to support the health of gay men. This study, therefore, contributes to a body of evidence challenging dominant discourses that conflate gay men’s health with risky behavior, stemming from neoliberal-informed public health approach that conflate sexual practices with ‘risk’ (Lupton, 1995; Scarce, 1999; Sicinolfi, Halkitis and Moeller, 2015) detracting from informed, meaningful understandings as to how health is conceptualized and managed by gay men associated with HIV susceptibility (Adam, 2005; Adam et al., 2014; Aggarwal and Gerrets, 2014). Although the adversity that men described in health care encounters, such as dismissal of health concerns, threatened refusal of care, and fear of disclosing sexual identity are similar to gay men of all ages (Knight et al., 2012), these participants experienced historical and ongoing grief, trauma, and violence that has not yet been fully examined as influential for health management. Engagement with the health care system was a regular occurrence and a vital part of men’s health management; a situation brought about by their complex health issues. The oversight in trauma-informed approaches to care—defined as care that is sensitive to historical and ongoing violence and discrimination and does not cause harm or re-traumatize (Browne et al., 2016)—contributed to significant harm. Men described health providers’ insensitivity to historical and ongoing discrimination through an overemphasis on HIV, which reminded them of their losses and their feelings of unworthiness during the meagre public health response to the crisis. The intersecting strategies of becoming knowledgeable about health issues and enacting health promoting practices could be a consequence of mitigating against these harms, although further research to test and refine the theory for the motivations underpinning
these practices is required. At a minimum, the responsibility for health and building health knowledge was paramount to advocating for one’s needs being recognized as a responsible “health citizen” was, as has been shown elsewhere (Adam, 2005; English and Rourke, 2015; Lupton, 1995), tantamount to overcoming stereotypes of gay men as irresponsible and hedonistic and having a more effective, albeit perhaps still discriminatory, health care encounter.

The study’s findings suggest the need for a series of highly actionable recommendations to promote gay men’s health management and reduce the likelihood of discrimination in the context of the health care encounter. There is a continuing need for more patient-centred and trauma-informed approaches to health care with gay men. Additionally, there is an urgent need to debunk stereotypes concerning gay men’s health practices and instead to emphasize enhancing the capacity of gay men to effectively manage their health. The men in this study demonstrated tremendous capacity and active involvement in their health. They moved beyond tolerating adversity to overcoming it, through their commitment to developing and implementing facilitative strategies. These findings are congruent with other research in gay men’s health related to men’s protective practices to promote and protect their health (Herrick et al., 2012; Lyons, Hosking, and Rozbroj, 2014; McLaren, Jude, and McLachlan, 2008). These findings also highlight how collectively produced stories of strength can contribute to social change. As Plummer (1994) articulated, stories move from the individual to the community, fueling mobilization and creating new social worlds. Participant’s accounts advanced the gay civil rights movement and resisted HIV/AIDS discrimination and stigma. These participants, by virtue of having lived at least forty years, have contributed to powerful narratives of change and witnessed change within their communities and society.

To our knowledge, this study is one of the few that explore middle-age and older gay men’s health management. There are, however, limitations to the study. The purposive sample, while in keeping with grounded theory research, was largely drawn from related social networks and therefore not necessarily representative of the population of gay men residing in Victoria. Additionally the snowball sampling approach had the potential to inadvertently exclude men who were not necessarily connected to other gay men or who are not openly gay. The sample also consisted of predominantly well-educated White men. There is an urgent need for future investigations to capture potentially excluded men and for further theory testing and development that may avoid problematic assumptions of homogeneity among men. However, this article
contributes to a growing understanding of middle-aged and older gay men’s health management as a series of social processes that are highly effective in supporting men to manage their complex health and illness issues. The findings illustrate men’s strength and capacity to manage health in a system that imposes significant limitations through discrimination in care encounters as well as the perpetuation of the harmful discourse about gay men being irresponsible. Moving forward, investigations into gay men’s health necessitate a focus on health management generally, in the absence of a disease context. We draw attention to men’s strengths and capacity but do not wish to detract from the foundational issue of historical and ongoing discrimination that has given rise to tremendous adversity for gay men.

**Conclusion**

Recognizing that overcoming adversity is central to how gay men manage their health is essential to developing effective health supports for men in this age group. The theory of health management developed in this investigation—overcoming adversity—and the temporally bound processes inherent to the theory illustrate the ongoing nefarious effects of trauma, adversity and discrimination and the ever present need for health services to adapt and be supportive of men’s capacities for health management in non-discriminative and person-centred ways. The findings from this investigation highlight key processes that gay men use in health care settings. Understanding these processes as ongoing (and ideally evolving further) is the first step to designing tailored patient-centred resources that respect the historical contexts while attempting to reduce the adversity that this population currently faces. In essence, the longstanding effects of historic and ongoing discrimination must be concurrently acknowledged and addressed to best serve these discriminated sub-groups.

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