Developing Resilience: Gay Men's Response to Systemic Discrimination

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Abstract

Gay men experience marked health disparities compared to heterosexual men, associated with profound discrimination. Resilience as a concept has received growing attention to increase understanding about how gay men promote and protect their health in the presence of adversity. Missing in this literature are the perspectives and experiences of gay men over 40 years. This investigation, drawing on grounded theory methods, examined how gay men over 40 years of age develop resilience over the course of their lives to promote and protect their health. In-depth interviews were undertaken with 25 men ranging between 40 and 76 years of age who experienced an array of health concerns including depression, anxiety, suicidality, and HIV. Men actively resist discrimination via three interrelated protective processes that dynamically influence the development of resilience over their life course: (a) building and sustaining networks, (b) addressing mental health, and (c) advocating for respectful care encounters. Initiatives to promote and protect the health of gay men must be rooted in the recognition of the systemic role of discrimination, while supporting men's resilience in actively resisting discrimination.

Gay men experience marked health disparities when compared to heterosexual men (Brennan, Ross, Dobinson, Veldhuizen, & Steele, 2010; Eaton, Kalichman, & Cherry, 2010). The body of knowledge that comprises gay men's health research has emphasized illness with a focus on risk factors that include the deleterious effects of discrimination across the life span (Aguinaldo, 2008; Brennan et al., 2010). In particular, homophobia and heteronormativity have been identified as discriminative processes that collectively contribute to poor health outcomes among gay men (Aguinaldo, 2008; Brennan et al., 2010; Rosenberger et al., 2011). Homophobia represents discrimination at the individual or interpersonal level and is often described as constituting a range of negative attitudes and feelings toward individuals who are not heterosexual (Kitzinger, 2001). Homophobia is observable in hostile behavior such as acts of physical violence and derogatory name calling and, as such, situates discrimination firmly within the psychology of specific individuals: the manifestation of harbored fear and/or hatred toward those who are not heterosexual (Aguinaldo, 2008; Kitzinger, 2001). Heteronormativity, however, represents discrimination at the macro or structural level via oppressive practices and attitudes directed toward those who do not identify as heterosexual (Aguinaldo, 2008). Heteronormativity represents an ideological system that denies, derogates, or penalizes any nonheterosexual form of behavior, identity, relationship, or community (Kitzinger, 2001).

There is a growing body of literature, however, that highlights factors associated with fostering health and well-being and shows how gay men are actively involved

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in an array of health and illness practices to promote and protect their health and navigate illness. Resilience has been central to investigations of men's active engagement in health promotion and is regularly positioned by scholars as an effective means to appreciate how gay men promote their health and wellness in the face of adversity (Herrick et al., 2012; Herrick et al., 2014). Definitions of resilience vary, but there is wide recognition that it entails a process of individual adaptation within the context of significant adversity to overcome the negative effects of risk exposure (Harper, Bruce, Hosek, Fernandez, & Rood, 2014). Integral to resilience is the presence of both risk(s) in the individual's environment and internal and external protective processes (Fergus & Zimmerman, 2005; Luthar, Sawyer, & Brown, 2006; Masten, 2007; Zimmerman, 2013). Protective processes are defined as strategies that are key to the development of resilience and that encompass social/relational dynamics such as family/peer support, mentors, and community-based organizations (Luthar et al., 2006; Masten, 2004, 2007; Smith & MacKenzie, 2006). Internal processes refer to personal processes or perspectives such as optimism; external processes, however, draw on tenets of social ecology and refer to processes situated within social environments such as social support networks (Fergus & Zimmerman, 2005). Due to the recognition of resilience as a developing process, research efforts have focused on external protective processes.

Most research into resilience with gay men has drawn on quantitative designs, yielding a wealth of knowledge and the foundation for the current work (Lyons, Hosking, & Rozbroj, 2014; McLaren et al., 2008; Ngamake, Walch, & Raveepatarakul, 2014). There is a dearth of research employing qualitative methods to provide nuanced understandings about the unique stressors and life circumstances gay men experience and the protective processes integral to cultivating positive health outcomes over their life span. At present, three qualitative investigations of resilience specific to gay men were identified, but none was specific to middle-aged and older gay men (Fenaughty & Harre, 2003; Harper et al., 2014; Kushner, Neville, & Adams, 2013). In particular, how middle-aged and older gay men develop resilience to promote health and wellness is poorly understood. Information pertaining to resilience in this demographic group is needed, given the propensity of chronic illness (Conron et al., 2010; Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013). The investigation reported here was part of a larger study on health and illness practices of gay men. Permeating the men's experiences were multiple forms of discrimination, which shaped their state of well-being. Consequently, discrimination emerged as a risk, and the focus was on identifying protective processes integral to the development of resilience in middle-aged and older gay men. In focusing on resilience, the impetus was to emphasize men's strength and capacity amid formidable obstacles perpetuated by discrimination as opposed to encouraging individual adaptation to a heteronormative society, which can be an unintended interpretation of the use of a resilience framework. The specific research question was

> How have middle-aged and older gay men developed resilience over the life course to promote health and wellness?

Background

Resilience and Gay Men's Health

Over the course of the past decade, there has been an increasing interest in the concept of resilience and how it can facilitate understanding of gay men's capacities for health and illness across their life spans (Herrick et al., 2014; Lyons, 2015) with a particular emphasis on HIV, other sexually transmitted infections (STIs), and mental illness (Dickinson & Adams, 2014; King & Richardson, 2016; Mustanski, Newcomb, & Garofalo, 2011). Within these studies, resilience is often examined in relation to the protective processes or factors that can foster positive health outcomes (e.g., family/peer support, mentors, and community-based organizations). Mustanski et al. (2011), for example, identified that support from family and peers (described as potential resilience processes) contributed to decreased psychological distress associated with sexual orientation–related victimization among gay youth. Another investigation reported that the risk of depression was mitigated among gay men who belonged to a gay community and had strong social ties when compared to those who did not (McLaren et al., 2008). Dickinson and Adams (2014) demonstrated that resilience processes (described as having social connections, engaging in personal reflection, having interests and hobbies, and seeking professional support such as counseling) were key factors contributing to mental well-being among gay participants. Similarly, Toro-Alfonso, Varas-Diaz, Andujar-Bello, and Nieves-Rosa (2006) showcased the facilitative role of building strong ties within a social support network in mitigating levels of depression within a sample of gay Puerto Rican youth.

The few qualitative investigations of resilience and gay men have also emphasized protective processes associated with resilience, reinforcing the importance of such processes for gay men's health. Harper and colleagues (2014) studied young gay and bisexual men living with HIV and identified resilience processes such as seeking support and providing support to others as integral to developing resilience. Kushner et al. (2013) demonstrated that building a strong social support network—comprising a partner,

friends, and/or family—was foundational to facilitating the aging process of older gay men amid homophobia and heteronormativity. What is less clear in the literature is a nuanced understanding of how gay men have developed these protective processes, what reinforces these processes, and what creates barriers. Only one published study was found (Kushner et al., 2013) that has addressed resilience in the context of the life course. Men over 40 years experience a marked burden of illness (Conron et al., 2010; Fredriksen-Goldsen et al., 2013) and they have historically experienced pervasive discrimination by virtue of sexual identity and the generation-specific risk or adversity in the form of the pre-treatment HIV era (additional discrimination via association of HIV with being gay, suffering, grief, and trauma; Adam, 2005; Forstein, 2013). Ultimately, information about how gay men develop resilience and engage in processes to promote and protect their health is needed to inform service development and health provider strategies toward effectually supporting the health of gay men.

Methods

Research Design

A qualitative descriptive design drawing on grounded theory methods (Charmaz, 2000) was used. The intention was not to develop a theory of resilience per se, but rather to describe how men, over the life course, developed resilience in the face of discrimination and how this process may have shifted over time. Grounded theory methods were employed to examine these problem-solving practices and processes central to the development of resilience. Charmaz (2006) asserts that discovered reality arises from the interactive processes and their temporal and structural contexts. By applying grounded theory methods in this way, it was possible to examine the impact of contextual, historical, and socio-structural elements on men's experiences of discrimination and the development of resilience.

Setting and Recruitment

Ethics approval for this study was granted by the University of British Columbia Behavioural Research Ethics Board (UBC BREB H14-01112). The study setting was the city of Victoria, British Columbia, the provincial capital situated on Vancouver Island with a population of approximately 85,000 (BC Statistics, 2015). A total of 25 participants were purposefully sampled based on specific inclusion criteria to enhance understandings of the phenomenon of interest (Polit & Beck, 2008). 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 interest in the project. These men

distributed the recruitment flyer at social, educational, and community-based events. At the outset of the project, men were required to self-identify as gay, be currently residing in Victoria, and be 40 years of age or older.

Data Collection

Data were collected over an 8-month period via conversational, one-on-one interviews held in public spaces, including cafes, in the city of Victoria. Each interview was conducted by the lead author (IH), and verbal consent was obtained from each participant and audio-recorded prior to initiating the interview. Verbal consent was obtained in keeping with the Canadian guidelines for ethical research with people (Tri-Council Policy Statement-2, 2011). Verbal consent was an appropriate method of consent with men who may be reticent to provide a written signature. Such reticence is reportedly associated with previous breaches in men's privacy and confidentiality within health services during the HIV/AIDS epidemic and consequent discrimination within specific health encounters (Adams, McCreanor, & Braun, 2013; Aguinaldo, 2008; Flicker et al., 2015). Each participant was offered the choice of $25 cash or a gift card for Starbucks's coffee of equal value. To ensure voluntary consent, participants were informed that they may withdraw from the study at any time and need not offer any reason for doing so (TCPS, 2014).

A total of 25 men between the ages of 40 and 76 years, with a mean age of 54 years, took part in the study. Of the 25 men, 23 identified as Caucasian, 12 self-disclosed their positive HIV status, and 22 had a primary care provider (defined as a family physician or nurse practitioner). Participants maintained a variety of occupations including architecture, teaching, various roles in local government and nonprofit organizations, finance, and accounting. The majority of men had relocated to Victoria from other parts of Canada, which many men described as a process to escape discrimination in smaller communities. Stories of being bullied or simply being regarded as "different" were pervasive when they discussed their childhoods.

To gain an understanding of how gay men developed resilience over the life course to promote health and wellness, the questions focused on the men's everyday life experiences. As the interviews progressed, questions focused on health issues over the life course, for example, how issues were experienced and navigated and how sexual identity potentially impacted these experiences. To adequately capture resilience, questions were of a temporal nature addressing experiences at different time points over their life (e.g., youth, 20s, 30s, present day). By gathering information that spanned many years, the practice of resilience was made visible. Interviews were loosely

structured by a topic guide comprising several questions and probes. Conversations, however, frequently expanded beyond the specifics of health and illness into a variety of personal experiences and stories that shed light on the processes that contributed to the development of resilience. Reflexive practice was employed by journaling thoughts, impressions, and potential biases after each interview. The interviews were approximately 60 min in duration, and all were audio-recorded and transcribed verbatim.

Data Analysis

Data were collected and analyzed simultaneously, reflecting the iterative nature of grounded theory approaches (Charmaz, 2006). Beginning with several broad reads, the focus shifted to identifying recurrent similarities and differences followed by open coding, which assigned a short name or phrase to summarize sections of data (Charmaz, 2006). The preliminary open codes drew attention to recurrent concepts requiring additional exploration, namely, the prominence of men's reactions to discrimination. Constant comparison fueled recognition of discrimination as embedded in men's resilience and, more importantly, that much of what men were doing to foster health and wellness was in reaction to discrimination.

As more data were collected, focused coding—which entailed comparing newer codes to earlier ones—commenced and memos were kept to chronicle possible connections between codes and what participants were experiencing and/or expressing through the codes (Charmaz, 2006). Memos provided an analytical account of the forms of discrimination, what men did and how this impacted their approaches to health and wellness (Charmaz, 2006). Feedback was then elicited from participants to ensure effective and accurate representation (Sandelowski, 1986). Analysis culminated in axial coding, which entailed identification of the relationship between categories and subcategories. It was at this time that three main categories that illustrate the interrelated processes of developing resilience were identified (Charmaz, 2006).

Feedback from participants was obtained by providing men with a short summary document that outlined preliminary themes and asking for their thoughts and reflections on the analysis thus far. This feedback process occurred twice during the analysis. Permission to contact men for feedback was solicited at the beginning of each interview and each participant noted that e-mail was the most effective way for follow-up.

Findings

Three categories of protective processes were identified to illustrate the interrelation of these processes in developing

resilience: (a) building and sustaining networks, (b) addressing mental health, and (c) advocating for self. Described in the following text is how men employed these protective processes over their life course.

Building and Sustaining Networks

Most men talked about their early life experiences and provided candid accounts of pondering their sexuality and the consequent discrimination faced when living an openly gay life. Being openly gay was defined as voluntary disclosure of sexual identity, such that being gay was made known to the myriad individuals, groups, and communities in a person's life including family members, friends, peers, and employers. For many participants, one of the first strategies employed to combat adversity and buffer the harmful effects of discrimination was building supportive networks, most often with other gay men. Building these networks frequently involved leaving their home communities, particularly for those who experienced extensive bullying in their hometowns. Men described moving to larger centers as enabling connection to a supportive community, an essential aspect of "coming out."

> P1: In High School we never talked about it (sexual identity) much you know, especially I grew up in Northern Ontario you never talked about it. . . . I was conditioned, and grew up with the same notions that (gay people) "those people are disgusting, those people do horrible things.". . . When I first came out in university, I went from having zero gay friends, not knowing a single gay person, to suddenly having 200 friends. Like that . . . that's like a real fundamental shift, to suddenly have people. (50 years old)

The emotional benefit derived from building friendships with other gay men and the level of comfort and safety bestowed by involvement in an established gay community was described as emancipatory. Nevertheless, participants spoke of the overarching socio-structural inequities that remained an ever-present obstacle. This was especially the case for participants who were young men during the 1970s and 1980s, an aggressively discriminative time period for gay men (Forstein, 2013; Lyons, 2015). During these decades, men faced significant discrimination by virtue of sexual identity in every facet of life: from the threat of eviction from housing, to fear of losing employment, to denial of visitation rights in hospital settings. To resist this discrimination, participants described facing and fighting adversity by building networks to advocate for their rights, despite the aforementioned risks that included to their personal safety.

> P1: We were marching for equal rights and public accommodation, hospital visitation I think, and employment

non-discrimination because back then I still could've been fired from my job for being gay, kicked out of my apartment for being gay. This was the early 80s so like it was really complicated. You needed to be really cautious back then, with the apartment, being kicked out, or being fired. I wanted to be a school teacher and knew there was no way. (50 years old)

When discussing their teenage and early adult years specifically, the men frequently addressed living through the pretreatment HIV era. The powerful impact of HIV on the lives of participants was clearly evident by the prevalence of this topic in conversations, despite any questioning on the matter. Men experienced confounded discrimination: discrimination for being gay aggravated by the arrival of HIV. The sense of foreboding was overwhelming due to the uncertainty about the disease and the lack of treatment options. The persistent loss and grief culminated in a belief that death was certain for many.

P12: I mean for me, coming out in the 80s when, that decade was, it had a lot of unfortunate circumstances with HIV and AIDS and all that. . . . Going into the 90s as a 20-year-old it's very much in your mind and it is something you never forget. We talk about this actually quite regularly, [name] and I, with other friends, and say "Oh, remember in the 80s, or remember in the early 90s?" It was like, "Oh God, you were going to die" . . . so it took a long time to pass. (42 years old)

The fear, suffering, and grief dealt with on a daily basis were wrapped in the realization that little support was available, for example, support in the form of medical treatment, information, or grief counseling. There was no responsive push to develop treatment, vaccines, and supportive organizations until the virus reached heterosexual communities. In developed nations out of this despondency, however, arose one of the most profound displays of resilience in the form of collective efforts: the multitude of grassroots movements that combated the complacency around HIV service development (Adam, 2005; Forstein, 2013). These movements are an exemplar of the resilience demonstrated amid seemingly unsurmountable challenges. Gay men not only fought discrimination in the form of homophobic discourses and heteronormative assumptions amid devastating loss and suffering, they remained perseverant in their action for care, services, and resources. Several participants described their involvement in HIV/AIDS grassroots initiatives as an attempt to alleviate the sense of helplessness that permeated that time period. Some participants described how, in moving to action, men effectively contributed to a healing process.

P3: When really the deep rationality of it was how community came together in the face of any crisis, but certainly the

AIDS crisis, and we made it up. In doing so, we had meaning, purpose and belonging. Which induced health, which induced a sense of mobilization. (48 years old)

Many participants acknowledged that working through the effects of the pretreatment HIV era was an ongoing process. Due to the lack of resources to address this specific need, gay men had again come together to develop supportive networks to work through the guilt and sorrow that for many accompanied survivorship. One participant shared a community-led event that was developed to provide men the opportunity to share their experiences and emotionally support one another in various dimensions, including addressing the grief and loss incurred from HIV/AIDS. The visible, lasting impact of that loss was evident to men in a very literal way.

P1: So [name] and [name] and like 34 gay men who went to Salt Spring Island for the weekend. You're immersed . . . a wonderful experience . . . I remember us all standing around in a circle in order of age. We kind of started with the youngest one, and that gap that existed because of AIDS. There was that actual gap in ages, whereas like these are the people we lost. People should be in this age range right here. That's who we lost. (50 years old)

The building of supportive networks developed by men served to further spur advocacy efforts and is recognized as a powerful protective process in shaping resilience. In connecting with one another, gay men derived a sense of community, emotional support, and well-being that facilitated their efforts to resist and transcend discrimination. Over time, many men became more actively involved in communities, and their efforts for supporting one another grew. The passing of time served to fortify networks and facilitate advocacy as men derived strength and support from one another, fueling their confidence as individuals and their collective efforts in fighting for equity.

Addressing Mental Health

Despite participants describing their health optimistically, a multitude of health issues were disclosed and included mental illnesses spanning anxiety, depression, bipolar disorder, post-traumatic stress disorder (PTSD), and suicidality. These mental health challenges were directly connected to discrimination and how it is interpersonally, institutionally and structurally played out in the day-to-day lives of gay men, a finding substantiated in other studies concerned with gay men's mental health (Ferlatte, Dulai, Hottes, Trussler, & Marchand, 2015; Mustanski, Andrews, Herrick, Stall, & Schnarrs, 2013). Substance use, reported as directly related to discrimination by other scholars (Aggarwal & Gerrets, 2014;

Mustanski et al., 2013), was an additional persistent challenge and most often included alcohol, marijuana, and "party drugs" (e.g., methamphetamine, cocaine, and Ecstasy). Most participants shared that mental health challenges and substance overuse eventually necessitated the involvement of health services. Initiating contact for health services, however, was described as extremely exigent because many men had faced multiple discriminations within health settings. Consequently, the potential for discrimination was a major obstacle to seeking help, but one that participants surmounted due to recognition of their need for support.

Men often talked about mental illness throughout their lives as occurring amid emotionally challenging situations, such as acknowledgement of sexual identity and living through the pretreatment era of HIV. Anxiety was commonly discussed in the context of the coming-out experience and was often debilitating and all consuming; for some, it was incited by recognition of sexual identity and identified as the greatest health challenge faced.

> P12: I felt sick and insecure, and I felt so scared, terribly scared. And the insecurity is just, it's beyond description, it's just this vacant, void feeling in the pit of your stomach that is just so hollow . . . it is exhausting . . . it wears you down. It kills your spirit. It forced me to go [to see a psychologist]. . . . It was helpful to admit that I was gay and I had never admitted it aloud up until that point . . . it took like five sessions to say it. Once it was said there was a portion of weight that was lifted off my shoulders, and yet the journey continues but that was the first step. (42 years old)

For this participant, garnering the support of a health professional was incumbent to fostering health. Through the process of regularly meeting with a trained therapist, he was able to address and, to some degree, alleviate the crippling anxiety that was taking a marked toll on his well-being.

Depression was stated as a significant concern, perhaps even the most prominent and debilitating health issue currently affecting gay men.

> P2: It's micro-crises. We're seeing it in depression. Not that I, I don't identify as being depressed but because so many people around me, certainly so many gay men in the context of our conversation here, it's like, that is a cultural miasmic state. (48 years old)

Homophobia and heteronormativity are recognized as discriminative processes that contribute to depression (Choi, Paul, Ayala, Boylan, & Gregorich, 2012; Lyons, 2015). For many participants, depression was perceived as stemming from deeper sources, an issue rooted in unaddressed emotional conflict and trauma. For example, the disruption of family relationships after disclosing

sexual identity was a major source of sadness for a number of participants. In some cases, men had not spoken to family members for years because of the conflict that emerged on the premise of sexual identity.

> P8: Yeah, because even when I went back home my Dad, I haven't seen my parents for 18 years, so, and I just talked to my mother through the phone. And my Dad basically disowned me, so, because I was gay and he just couldn't accept it. (49 years old)

For many, seeking the support of others was greatly facilitative to addressing and working through depression. In creating dialogues about depression within social networks, men described how the prevalence of depression became evident and they no longer felt alone in their struggles. Having established relationships within which men felt cared for and safe enabled conversations about depression and further set the stage for potentially asking for professional help and connecting with health services. Of key importance was men's acceptance of depression and no longer viewing the need to ask for help as weakness. For these men, their networks served to provide support that was twofold: emotional support that was beneficial for addressing depressive symptoms and relationships that created a space for conversations about getting connected to health supports, as articulated by this participant.

> P21: Ask for help. Have an advocate. Peer navigation. People taking care of people. It's a gift. My need for help doesn't mean there is anything wrong with me. It actually means we're in a help and healing process together. (48 years old)

This participant delineated how, in asking for help, he actually served to further strengthen his support network. In asking for help, he contributed to a greater supportive process that illuminated the fact that many others had, or were currently experiencing, similar challenges. The strength derived from support networks fostered many men's ability to voice their health issues and seek help because they felt cared for, highlighting the mutual help obtained from supportive communities: the affirmation of struggles as real and common coupled with the sharing of strategies for identifying cause(s) and addressing depressive symptoms.

Many participants identified that they and other gay men continued to suffer from depression because of a dearth of appropriate resources. This was especially evident in the case of depression stemming from living through the pretreatment HIV era. Some 30 years later, the lasting effects of the pretreatment era were evident in the men's narratives. Loss became a fixture of daily life that persisted for many years and was only truly understood by those who lived during this time period. The

need for a space to express the feelings rooted in the trauma experienced during pretreatment HIV was identified as a crucial need.

> P2: There's also this culturally induced shame of long-term survivorship which is such a blanket statement that hasn't necessarily been mapped out . . . that's where there's a lot of depression out there. We're still carrying the burden. A lot of conversations and experiences people haven't talked about. There's no space to talk about it. (48 years old)

Several men spoke to the value of individual and/or group counseling, but it often took years to connect with such a resource. In almost all cases, men instigated connecting to a service because the sorrow had become overwhelming, and even the support of friends, peers, and partners was insufficient in alleviating the grief. Supportive networks, however, played a critical role in the development of resilience by facilitating community acknowledgment that depression exists widely and by facilitating men's propensity to reach out for help.

Mental illness was often intertwined with substance use as participants sought to obtain what they described as obtaining "relief" from debilitating anxiety, fear, and depression. Alcohol was the most commonly cited substance used in this context. For some men, it allowed for a level of functioning and normalcy by blunting depressive symptoms. Alcohol consumption as a relief strategy usually continued until it was no longer effective or a health crisis situation arose.

> P6: I wasn't asking for help, I was in active addiction. I tried to take my own life on several occasions. Damn near did it right the last time. . . . If you can't ask your doctor for help, ask a friend, ask somebody you know because they might know something . . . don't be afraid to ask for help, because you'll get it. There's lots of it out there if you're willing to seek it out. (56 years old)

How participants conceptualized "addiction" was a major barrier to seeking help. Individuals with substance use problems were often described as street involved and impoverished, which was not the case for most participants. Even after reaching out for help, some men struggled with their perceptions of addiction and stereotypes about individuals who use substances.

> P6: Even walking in the door at the addictions outpatient treatment centre on [street], I didn't think I belonged there. I had until recently been employed, I'm a professional, in my own mind I didn't think I was an addict. I don't know how I couldn't recognize that, but to me those were the people you find living under a bridge or on the street, but I guess I was a functional addict, until I wasn't. With the PTSD, the drugs lower your PTSD symptoms until you stop using and your PTSD symptoms take off again so it's a vicious cycle. (56 years old)

For many men, an individual or a supportive network was crucial to cultivating self-acceptance with regard to viewing substance use issues. For some, it helped coming to terms with recognizing that use can affect anyone, regardless of social positioning, and thereby prompt getting the necessary support(s). Substance use, however, was entrenched as a means of reprieve: Substances diminished some of the feelings associated with acts of discrimination during youth and proceeded to address the symptoms of depression later on. Substance use was, however, a double-edged sword in the development of resilience. There was temporary relief of mental health symptoms, but this was coupled with the risk of exacerbating those same illnesses. Furthermore, "recreational" substance use was frequently regarded as the norm in many social circles/supportive communities; therefore, ceasing use could run the risk of a degree of separation from those supportive networks. Substance use is entrenched as a means of reprieve. Men experienced relief from discrimination during their youth and currently from the debilitating symptoms of depression (rooted in discrimination) when using substances. Substances ultimately continue to provide temporary relief but pose the danger of exacerbating mental illness and potentially disrupting resilience.

Advocating for Self

Developing the strength to stand up and advocate for oneself was a process that developed over time and was largely influenced by experiences within health settings. In particular, advocating for the self was strongly developed in relation to discrimination within the health system and, more importantly, to how gay men resisted discrimination. Ultimately, these incidents were foundational to the development of resilience. As stated earlier, in many cases despite men connecting to health services by their own volition, discrimination in these settings enacted by health professionals was a persistent issue. Many men resisted this discrimination by confidently advocating for their health needs. According to participants, the discrimination within health settings drew on stereotypes, wherein health-care professionals pathologized HIV risk as entwined with sexual identity, as outlined by this participant who reflected on an interaction with a physician.

> P5: So if I keep hearing things about venereal diseases, and I've told you already I'm not promiscuous, I have a partner. That should be the end of it. If I was a straight woman, would you be having this same conversation? So I question that when it happens, and it has happened in the past. (56 years old)

To combat these assumptions, men would, as this participant did, question the conduct of health professionals.

Such assertiveness necessitated a level of confidence to address the health professional's approach and inappropriate and harmful judgment. This self-advocacy was the product of confidence and proficiency that had developed over time. Men recognized that if they wanted their needs met, they would have to make it happen.

Some discrimination was more blatant, wherein some participants explained in the interview that they exited health interactions due to mistreatment. Ultimately, men wished to have their health issues dealt with and did so by accessing a different health provider. A number of these situations involved HIV being broached in a flippant, insensitive manner, without any consideration as to how referencing this chronic illness might affect the individual in question.

> P14: It became really chronic tonsillitis and by that time I had informed my family doctor of that, of my sexuality . . . and he goes, well, either you have tonsillitis or you have AIDS. . . . I never questioned him on his statement to me . . . so I went in after my checkup and pulled out my file and flipped it open. I am at the receptionist desk and I flip it open . . . and on one page unto itself is the word HOMOSEXUAL in big letters. . . . I didn't confront him, I just moved on. (51 years old)

For participants living with HIV, many described obstacles when dealing with health professionals. The most prominent issue was the shaming of gay men who disclosed HIV infection, which remains an ongoing issue for many. In particular, recurrent among participants who had HIV were accounts of providers insinuating their recklessness and lack of responsibility in contracting the virus. Initially, these incidents left men feeling shamed and embarrassed. Over time, however, men reflected and recognized these episodes for what they were: exemplars of glaring discrimination.

> P7: I didn't get tested until 1995 and I came down with shingles and thrush at the same time and shingles was on my face. So I went to the hospital, so this is homophobia, I went to the hospital. Lying on the gurney and waiting for the doctor, waiting, waiting, waiting and finally the doctor shows up . . . I say, I'm a gay man. . . . It's 1995 it's most likely HIV. And he just looked at me and all he said was "Well, you know as a gay man you should be using condoms when you're having sex." (53 years old)

The incident had occurred over 20 years ago, but at the time, he did not view the interaction as discriminatory; rather, his reaction was embarrassment and shame over his HIV status. Over time, however, he was able to critically reflect on this interaction as a flagrant example of discrimination. Many men described their engagement with supportive communities, advocacy, and connection to meaningful health resources as

facilitative to confidence building, which in turn helped enable recognition of discrimination. In this way, several protective processes were recognized as fortifying men's confidence and ability to self-advocate. In addition, the passing of time was crucial: Over the years, men built and engaged with supportive networks and received effective support with health issues. This served to build and fortify their confidence as individuals, which then permeated all facets of life, including health service settings.

Confidence and proficiency was demonstrated not only by the ability to advocate for their health needs but also by actively gaining knowledge of various health issues to enable informed conversations with health providers. This proficiency with health services and health knowledge was a particularly marked shift for older men who had grown up in the 1960s, 1970s, and even 1980s—a time when health provider approaches (viz, physicians) were seldom questioned (Goodyear-Smith & Beutow, 2001; Parsons, 1951). Due to the confounding effects of discrimination and a strained health system (that frequently translated into shorter windows of time with primary care providers), participants stressed the importance of being informed and organized in order to have their health concern(s) adequately addressed.

> P11: I have, and both doctors that I went to, my old GP and the new one, they laugh because I always have a list. . . . You certainly get the sense of how much time they're going to have or how chatty they are and you prioritize the list . . . some of the stuff, if it's really important then I bring it up, or at least say I want to talk to you next time, or I need to make another appointment . . . so you learn to prioritize, re-evaluate, or evaluate or whatever. (60 years old)

The participant outlined being organized and informed as essential to having his health needs met. Here he took the initiative to gather information and maintained awareness of time constraints on the part of the provider, a factor that he recognizes directly affects his care. By being informed and engaged, he maximized the health visit and ensured his concerns were addressed, in turn fostering his health and well-being.

Though remarkable proficiency was demonstrated in health service settings, the lasting impact of adversity was evident in the importance placed on the need for safety. Countless years of discrimination necessitate a safe place for care delivery. This is also evidenced by the many participants who continued to see primary care providers in Vancouver due to established rapport and acceptance. When asked to describe a safe place, simply an indication that the health service was open and accepting of individuals who identify as gay would suffice, as articulated by this participant, involved with a local AIDS Service Organization (ASO).

P4: People I think are afraid to come out, like in the health care system, like the doctors, you don't see anything that advertises diversity welcome in the community. So people are kind of scared to approach. . . . I think a lot of people are being missed in the gay community because of that factor. Sure, if we've lived here for years we know where all the places are, but someone new coming in doesn't know that. (46 years old)

Preference of a gay health provider was indicated by some; However, most men stated that providers must simply be open-minded and express genuine concern for the health needs of the consumer. Being prompted by discrimination to speak up, resilience was bolstered by the ability to not only advocate for health needs but also insist on a respectful provider. By refusing to engage in a negative and potentially harmful environment, men set a precedent for their health that ensured meaningful and effective health delivery in the form of a respectful provider. In doing so, participants greatly contributed to the cultivation of their own wellness.

Discussion

The purpose of this investigation was to explore how middle-aged and older gay men developed resilience over the life course, specifically, identifying the external protective processes that comprise resilience to promote health. The extensive discrimination experienced by gay men solely by virtue of their sexual identity is recognized as a structural risk factor that played out over the course of life. Ultimately, resistance to discrimination in the form of the three interrelated protective processes prompted developing resilience. In the following section, four key insights are discussed: the contributions of this study to the gay men's resilience literature, discrimination as a determinant of health, the utility of equity-oriented primary health care (PHC) for health service delivery, and the integration of safety into an equity-oriented PHC design.

This is potentially the first qualitative investigation into resilience development among middle-aged and older gay men. The sample, however, was predominantly comprised of White educated men, representing a particular social location that bears influence on the development of resilience. Currently, gay men's resilience research has focused on young men, emphasizing the extensive adversity faced during adolescence (Herrick et al., 2014; Herrick et al., 2011). The findings highlight that discrimination continues to be a current fixture in gay men's lives, necessitating the ongoing development and implementation of protective processes. In particular, building and sustaining networks was identified as a central protective process to resilience, as stated in the literature (Herrick et al., 2012; Herrick et al., 2014).

The findings indicated that involvement in formal networks (e.g., HIV grassroots initiatives) in early adulthood was integral to health promoting by laying the foundation for continued engagement with networks of gay men throughout life. The protective process of addressing mental health offers preliminary insight into how gay men promote their mental health and signals the importance men placed on mental health. This is a key finding, given the dearth of information on gay men's mental health promotion, despite extensive documentation of mental illness and emotional distress among gay men (Conron et al., 2010; Wright et al., 2012). The integral role of time to resilience development was also identified: Over time, discrimination directly contributed to health inequities, but time also enabled experience and confidence through years of learning how to respond and ultimately thrive. Advocating for respectful care encounters speaks to ongoing discrimination in health settings and recognizes gay men to be informed, responsible health-care consumers, in opposition to the discourses that position gay men as irresponsible (Adam, 2005; Forstein, 2013). Attention is paid to the shift in confidence that accumulated over time, especially for older men who had grown up in the 1960s, 1970s, and even 1980s—a time when health provider approaches (viz, physicians) were seldom questioned (Goodyear-Smith & Beutow, 2001; Parsons, 1951).

Despite recent societal strides toward equity for individuals of diverse sexual orientations and genders (Berg, Ross, Weatherburn, & Schmidt, 2012) being greatly driven by individuals from within these specific communities, discrimination remains a pervasive obstacle to health. The historical and ongoing experiences of discrimination directly contribute to health inequities for gay men (Ferlatte et al., 2015; Mustanski et al., 2013). To fully support the health of gay men, discrimination must be situated as a determinant of health (Krieger, 2014). Several major pathways have been theorized that link discrimination and health inequities, including economic and social deprivation, social trauma, health-harming responses to discrimination, and inadequate medical care. These insights have been drawn from ecosocial theory to demonstrate specifically how exposures (e.g., discrimination) from our societal contexts are biologically embodied, creating the potential for health issues (Krieger, 2014). Fundamental to this framework is recognition of the individual's power and ability to act in response to risk exposure to enable understanding how health inequities are monitored, analyzed, and addressed. Active resistance of discrimination was a key finding in this study: Gay men are not passive victims of discrimination, but rather they actively resisted historical and ongoing systemic discrimination to develop resilience over the course of their lives. Essentially, gay men

responded to discrimination with tremendous strength and tenacity to overcome the adversity present in their everyday lives.

The pervasiveness of discrimination behooves socio-structural-level change to ensure people of various sexual and gender identities enjoy the same civil liberties as everyone in society. Dismantling the structures that perpetuate discrimination is a huge undertaking that will require more time; therefore, practical strategies to support individual efforts are needed in the interim (Browne et al., 2016). One such approach gaining momentum is equity-oriented PHC (Browne et al., 2016), which has been demonstrated as an effective means to support the health of individuals within groups that have been subject to systemic disadvantage (Starfield, 2006; WHO, 2008). For gay men, an equity-oriented PHC approach would necessitate recognition of historical and ongoing discrimination as the fundamental systemic contributor to the health inequities many gay men face.

An equity-oriented PHC framework would take knowledge of systemically induced inequities among gay men and integrate this information into practical strategies via four general approaches: partnerships with gay men, action at all levels (patient–provider, organizations, systems), attention to local and global histories, and attention to unintended and potentially harmful impacts of each strategy (Browne et al., 2016). Allied health professionals must advocate for the development of needed policies and processes within their organizations to support the development and implementation of equity-oriented PHC services. Findings from this study showcase that health providers are in need of guidance to meaningfully support the health of gay men. Discrimination toward gay men by health providers was prominent in this study and although possibly unintentional, was nonetheless harmful, a finding well substantiated in the literature (Alvy et al., 2011; Knight et al., 2012). Furthermore, the need for support guidance for providers regarding HIV treatments and health needs of individuals with HIV is indicated. The findings showcased that men with HIV face unique challenges in the health setting, namely, preoccupation with HIV status on the part of health providers. Many concerns were overlooked or ignored because of the emphasis on HIV, a finding that is supported in the literature (Robinson, Petty, Patton, & Kang, 2008). The need for updated knowledge for providers regarding HIV treatments and training to address health issues for individuals who are HIV positive is indicated to ensure health issues and concerns are not overshadowed by HIV.

Equity-oriented PHC would also support the resilience demonstrated by gay men: Despite the numerous challenges and unfavorable health-care experiences the participants shared, the overwhelming majority of men displayed an unwavering dedication to maintaining and bettering health. In accordance with the resilience literature specific to populations that are diverse sexually and with regard to gender identity, men's development of supportive social networks is integral to cultivating wellness and optimism (Harper et al., 2014; Kushner et al., 2013). Appreciating the value of supportive networks as fueling resilience via complex interactions at the personal and interpersonal level necessitates additional research to inform the development of meaningful support services for gay men. The findings from this study indicate that men in Victoria would benefit from established, community-based peer networks to be able to connect and engage with other gay men. Such community-based services would also prove beneficial in addressing health issues, most notably, those that were prevalent in this investigation: anxiety, depression, and substance use. Of specific note is the need for such a service to support men experiencing depression rooted in HIV pretreatment trauma, and men who lived the experience are in the best position to determine what will be most effective in terms of service design and delivery (Bates & Berg, 2014; Im & Rosenberg, 2016; Thupayagale-Tshweneagae & Mokomane, 2014). The literature is rife with support for the effectiveness of such services for gay men, principally with regard to HIV and sexually transmitted infections (STI) prevention (Harris & Alderson, 2007; Veinot, 2010; Yun Gao & Wang, 2007).

The development of primary care services inclusive of and sensitive to men of varying sexual and gender identities is indicated and would benefit from an equity-oriented PHC design. Drawing attention to the impact of systemic discrimination is fundamental; for example, the importance of establishing the health setting as a safe place was a finding of key importance to middle-aged and older gay men. Mostly, this translated into something as simple as a rainbow flag placed conspicuously to indicate an acceptance of diversity. Other men stated that a listing to identify gay-friendly health services would greatly improve men's access, especially when considering newcomers to the city. Considering that access to health has been identified as a key determinant of health (World Health Organization, 2013), this finding is integral to the health and well-being of gay men. In particular, it has been reported that older gay men are five times less likely to seek health care and social services out of fear of discrimination (Sharma, 2006). If men do not feel safe, then they will not access services, as described at length in the gay men's health service literature (Alvy et al., 2011; Quinn et al., 2015). Unfortunately, the generalized dearth of primary care options in Victoria currently (specifically, family physicians) confounds this issue. Many participants expressed their discontent with walk-in clinics, primarily due to the inconsistency with regard to health providers: In essence,

you rarely see the same provider twice, creating difficulty in developing rapport and communicating health issues of a more sensitive nature (e.g., sexual health issues). Consequently, several participants who relocated to Victoria from relatively nearby areas maintain a family physician in their former place of residence (in these cases, other cities or small coastal islands), which incurs travel costs and is impractical. The need for appropriate, meaningful primary care services for gay men equipped with respectful, open-minded health professionals is greatly indicated to provide support and guidance to gay men.

This study has a number of limitations. First, the snowball sample entails potential exclusion of men who are not necessarily connected to other gay men or who are not openly gay. Data were not collected pertaining to relationship status, socioeconomic status, or age of "coming out," all of which could influence the development of resilience. Also, the sample predominantly consisted of White, well-educated men, which necessitates further investigation of ethnicity, education, and socioeconomic status on the development of resilience. The study was also limited to gay men, meaning that investigations into other sexual identities such as bisexual are needed. Finally, all the men in this sample were facing health issues, warranting further investigation into how the absence of health issues potentially differs with regard to resilience development.

Conclusion

The findings from this investigation highlight the profound discrimination faced by middle-aged and older men and the remarkable resilience participants cultivated through actively resisting discrimination. Discrimination continues to be a tremendous stumbling block to health. Dismantling structural discrimination is a priority but a massive undertaking. In the meantime, equity-oriented PHC is a possible approach to providing practical strategies to support men's resilience while addressing the overarching structural discrimination that warrants investigation. The need for health services provided by health professionals aware of the health issues that affect some groups of gay men, coupled with open-mindedness and respect in care delivery, is significant. This sample of men demonstrated, despite various health complications and challenges, a tenacious commitment to maintaining and improving health and well-being. Health support services for gay men must be developed upon a foundation that recognizes systemic discrimination while supporting men's resilience.

Acknowledgments

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