The association between minority stress and oppression in the lives of MSM in Cape Town, South Africa

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INTRODUCTION

The mental health outcomes of men who have sex with men (MSM) are understudied in resource-poor settings. African MSM are members of those understudied populations, as their lived experiences and psychiatric outcomes are rarely explored in scientific literature. The lack of research persists despite growing networks of same-sex activity throughout the continent, high estimates of disease burden caused by psychiatric disorders, and an overarching "culture of denial" regarding same-sex behavior among most Africans (1, 2, 3). When people are members of stigmatizing and discriminating societies, the conflict between them and the dominant culture can result in minority stress, which can lead to internalized negative self-regard and adverse mental health outcomes (4). Amongst MSM in South Africa, where 80% of the population considers MSM behavior to be "always wrong", the paucity of targeted research interventions on the population is especially pronounced and the population's mental health outcomes are unexplored (5).

The objectives of this study were to determine the degree to which a sample of MSM in Cape Town, South Africa experienced elements of minority stress due to discrimination. Researchers explored the experiences MSM had with the primary constructs in Ilan Meyer's Theory of Minority Stress: Physical attack, internalized homophobia, perceived discrimination and stigma. Participants were asked to describe how those experiences were associated with their mental wellness, daily activities, identity constructions, relationships and coping strategies.

METHODS

Recruitment and methodology

Between May and August 2010, 22 MSM took short mental health surveys and participated in in-depth interviews (IDI), which examined their experiences with violence, discrimination, perceived stigma, trauma, and related mental health outcomes.

Participants were recruited utilizing venue-based sampling that focused on community-based organizations with strong connections to various MSM sub-populations. To participate, men had to be 18 or older, self-report a recent sexual relationship with another man, and live or work in Cape Town or its surrounding townships. At the conclusion of ongoing interviews, participants were given referral cards, so that others who were interested could be screened for and enrolled in the study. The aim was to have a racially heterogeneous sample that also varied in age and relationship statuses.

In-depth interviews were conducted at venues participants considered safe spaces for MSM. Each respondent gave his written consent to participate, was assigned a study identification number, given a three-page survey and underwent a one-hour interview. Interviews were conducted in English, and survey questions and answer options were read aloud to control for error. At the conclusion of each interview, men received an envelope with a "Thank You" card, their travel compensation in cash (ZAR80, USD$10), and a mental health resource guide. The guide was created in partnership with local agencies to ensure cultural appropriateness and to address the needs of men who experienced psychological distress while participating in the interview. It listed contact details for local, easily accessible, affordable mental health services targeted toward MSM.

Data collection and analysis

The quantitative mental health survey comprised questions on participant demographic data, history of abuse and physical violence, and four scales related to the primary constructs of the Minority Stress Theory – a 20-item Internalized Homphobia Scale (6), a 7-item Short-Form Screening Tool for Post Traumatic Stress Disorder (7), a 6-item Perceived Stigma & Discrimination Scale (8), and a shortened 26-item Interpersonal Relationship Scale (9). Each scale had an alpha of .85 or higher. The IDI question guide was created with a phenomenological lens, and both it and the quantitative instrument were field-tested three times before they were given to study participants. Themes in the IDI question guide included participants' comfort with their sexuality, comfort and levels of trust in their most recent relationships, experiences telling others about their sexual preferences, experiences with discrimination, and their coping strategies.

The researcher utilized SPSS 18.0 to conduct descriptive statistical analysis of the survey data. Scores for scales measuring internalized heterosexism, trauma, and perceived stigma were averaged across items. The qualitative in-depth interviews were analyzed using latent thematic analysis. The researcher looked for prevalent patterns across the data set and within each data item. The validity of all results was examined by comparing them to similar studies published on the mental health of MSM.

RESULTS

Findings from the study support aspects of the Minority Stress Theory, and refute others. Most respondents reported experiencing direct or indirect stress and negative life events due to their status as sexual minorities. Negative life events were compounded when study participants were living at an economic disadvantage or were members of historically disadvantaged racial groups, specifically low-income black and coloured communities. The average age of the sample was 32 (range: 18-55, SD=11.81), and there was an even racial distribution (8 black participants, 8 coloured participants, and 6 white participants).

Experiences with prejudice events were common, and were described as either enacted by people close to the participant like friends, family, or peers, or enacted by institutions and authority figures like public clinics, employers, teachers and police. In this study, prejudice events took the form of hate speech, violence, expulsion from homes

and communities, and corrective therapy. In this sample, intimate partner violence was more prevalent than violence as a discriminatory act.

Experiences with prejudice events shaped participants' expectations of stigma, their constructions of sexual identity, their comfort in certain places in the city, how they met their partners, relationship functioning, and their daily activities and interactions. The mean score on the Perceived Discrimination and Stigma Scale indicated that most respondents perceived slightly elevated levels against MSM in the Cape Town area. In interviews, all men reported that they perceived black South Africans and white Afrikaners to be least accepting of MSM behavior while white English and non-Muslim coloured South Africans were perceived to be most accepting. These perceptions shaped the way respondents moved within the city, with MSM reporting avoiding public clinics and shebeens in black areas, and Afrikaner venues they deemed unfriendly to gays.

Reports of concealing one's sexual preference were common and levels of perceived stigma and discrimination were higher than levels of internalized homophobia, violence and trauma. Most men said they preferred to conceal their sexual preference and "act straight," in settings they perceived to be unfriendly or high-risk. Men tied financial independence and economic privilege to their level of comfort telling others about their sexual preferences. The more financially independent men reported themselves to be, the less impact societal stigma had on their personal lives. Participants who self-reported being financially dependent on others, black Xhosas, white Afrikaners, and coloured Muslims reported having more experiences with incidents of direct prejudicial events and concealing their sexual preference in public settings. These were also the groups who participants perceived to be least tolerant to homosexuals.

Coping strategies for managing these stressful experiences were diverse. Most respondents reported coping by attaching themselves to a group of MSM peers, becoming advocates for the MSM community, hiding their sexual identity and relationships, abusing substances, engaging in high-risk sexual behaviors, or participating in individual or group counseling. The work of existent and emerging MSM support agencies and networks is promising, but is also limited in its ability to meet the psychosocial needs of the growing community and reach out to resource-poor neighborhoods in ways that are salient to members of the community.

CONCLUSION

The findings from this study illustrate the importance of examining the lived experiences of MSM in South Africa as they relate to societal oppression and minority stress. Though South African MSM have lived with certain legal protections for years, oppression and minority stress still pose a threat to their mental and emotional wellness, and contribute to the uptake of undesired avoidant coping strategies. Study limitations included the fact that study participants were closely affiliated with MSM support groups or HIV prevention organizations and interviews were conducted by a foreign, heterosexual identified woman in English, a second language for most participants in the study. These findings have the potential to shape myriad public health issues including HIV prevention strategies, mental health infrastructure, and attitudes toward disempowered minorities. The lack of research on this topic and the diversity within South African MSM communities demand further exploration of these experiences to develop tailored, successful, and comprehensive mental health promotion, stigma reduction, risk prevention, and sexual minority support interventions.

Works Cited

1. World Health Organization (2005). Mental Health Atlas – 2005. Country Profile: South Africa.
2. Cloete, A., Simbayi, L.C., Kalichman, S.C., Strebel, A., Haida, N. (2008). Stigma and discrimination experiences of HIV-positive men in Cape Town, South Africa. *AIDS Care*. 20(9): 1105-10.
3. Reddy, V. & Sandfort, T. (2008). Researching MSM in South Africa: Some preliminary notes from the frontlines of a hidden epidemic. *Feminist Africa*, 11:29-54. HSRC Library: shelf number 5646. ICASA
4. Meyer, Ilan H. (1995). Minority Stress and Mental Health in Gay Men. *Journal of Health and Social Behavior*, 36: p. 38-56
5. Roberts, B. & Reddy, V. (2008). Pride and prejudice: Public attitudes toward homosexuality. *HSRC Review.* 6(4): 9-11.
6. Wagner, G., Brondolo, E., Rabkin, J. (1996). Internalized homophobia in a sample of HIV+ gay men, and its relationship to psychological distress, coping and illness progression. *Journal of Homosexuality*. 32 (2): 91-106.
7. Bresleau, N., Peterson, E.L., Kessler, R.C., Schultz, L.R. (1999). Short Screening Scale for DM-IV Posttraumatic Stress Disorder. *American Journal of Psychiatry*, 156: 908-911.
8. Martin, J. and Dean, L. (1987) Ego-Dystonic Homosexuality Scale. School of Public Health, Columbia University.
9. Garthoeffner, J. L., Henry, C. S., & Robinson, L. C. (1993). The modified Interpersonal Relationship Scale: Reliability and validity. *Psychological Reports,* 73**:** 995-1004.