

Sexual Anxiety Among Non-Monogamous Men Who Have Sex with Men: A Phenomenological Study

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LIST OF ABBREVIATIONS

ASA	Adulthood Sexual Abuse
AIDS	Acquired Immunodeficiency Syndrome
CBT	Cognitive Behavioural Therapy
CDC	Centre for Disease Control and Prevention
CSA	Childhood Sexual Abuse
ESTEEM	Effective Skills to Empower Effective Men
GBM	Gay and Bisexual Men
gbMSM	Gay, Bisexual and other Men Who Have Sex with Men
HIV	Human Immunodeficiency Virus
IH	Internalized Homophobia
LBG	Lesbian, Bisexual and Gay
LGBT	Lesbian, Bisexual, Gay and Transgendered
MSM	Men Who Have Sex with Men
MSSCQ	Multidimensional Sexual Self-Concept Questionnaire
OHRI	Ottawa Hospital Research Institute
OHSN-REB	Ottawa Health Sciences Network Research Ethics Board
PrEP	Pre-exposure Prophylaxis
PTSD	Post-traumatic Stress Disorder
SD	Sexual Dysfunction
U=U	Undetectable = Untransmittable
WHO	World Health Organization

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Abstract

Sexual anxiety is a prevalent issue among men who have sex with men (MSM) that negatively affects sexual satisfaction and wellbeing. However, research investigating sexual anxiety among MSM has been scarce. This descriptive phenomenological study was conducted to address knowledge gaps and identify the predominant underlying causes of sexual anxiety among non-monogamous MSM. Using purposive sampling, eleven sexually active, non-monogamous MSM were recruited for this study (N=11). Data were collected using audio recorded, semi-structured interviews, and analyzed using Moustakas' (1994) structured approach to data analysis in phenomenological research. Participant descriptions of their lived experiences of sexual anxiety identified six prevalent causes among MSM individuals. These included performance anxiety, fear of HIV, fear of bacterial STIs, internalized homophobia, body image dissatisfaction and history of sexual abuse. Not surprisingly, fear of HIV was the dominant cause of sexual anxiety among most participants. Recommendations to prevent and reduce sexual anxiety among MSM are provided.

CHAPTER ONE: INTRODUCTION

Introduction

Sexual anxiety among men who have sex with men (MSM) is common. A recent online cross-sectional survey of men who have sex with men living in Ontario (N=1960) found that 37% of participants reported feeling stressed or anxious during sex at least half of the time or more, and 24% reported feeling stressed or anxious after sex at least half of the time or more.¹ These findings highlight the prevalence of sexual anxiety among MSM and raise questions as to how this may impact quality of sex life, sexual risk taking, as well as overall quality of life. Notably, there has been limited research conducted that explores the experiences and causes of sexual anxiety among MSM, and what does exist in the literature has largely been focused on negative physical health outcomes, including sexual dysfunction and human immunodeficiency virus (HIV) infection.² As a result, there are gaps in our knowledge regarding the underlying psychosexual factors contributing to sexual anxiety and dissatisfaction among MSM.

The current study uses a descriptive phenomenological design to investigate some of the root causes of sexual anxiety among non-monogamous MSM by exploring lived experiences of sexual anxiety. This study provides a detailed description of the phenomenon through the perceptions and experiences of MSM whose sex lives are currently or have previously been negatively impacted by sexual anxiety. Health care professionals and men within sexual minorities can benefit from the findings of this research, as a greater understanding of the causes of sexual anxiety can inform preventative measures and development of coping

mechanisms aimed at reducing sexual anxiety, thus improving the quality of life for gay, bisexual, and other men who have sex with men (gbMSM).

Statement of Research Problem

The evolving field of sexual health research has established a significant link between sexual health outcomes and overall health and quality of life.³ Correspondingly, satisfying sexual activity has been linked to favourable health outcomes, such as reduced depression and anxiety,⁴ and greater life satisfaction.⁵ However, sexual health may be impaired by experiences of sexual anxiety, which is defined as the tendency to feel tension, discomfort or worry about the sexual aspects of one's life.⁶ Sexual anxiety has been found to be associated with adverse outcomes among MSM, including negative self-image, depression and substance abuse.⁷⁻⁹ Therefore, mitigating the frequency and degree of sexual anxiety among MSM may lead to more favorable overall health outcomes. Our ability to address this is limited however, as most research on sexual anxiety and wellbeing has predominantly been conducted among heterosexual populations.¹⁰ In addition, the limited number of sexual anxiety studies conducted among MSM populations have largely focused on negative health outcomes related to HIV and sexual dysfunction (SD).^{2,7} This has led to paucities in the literature regarding the broader psychosocial determinants of sexual health and well-being among MSM, including knowledge on the causes and preventative measures for sexual anxiety. Research into the determinants of sexual anxiety is thus warranted to identify factors that undermine quality of sex and overall sexual health of MSM, and promote positive health outcomes in this population.

Research Question

The underlying research question for this study is:

What factors contribute to the experience of sexual anxiety among men who have sex with men?

Purpose of Study

The purpose of this descriptive phenomenological study was to identify the predominant underlying causes of sexual anxiety among non-monogamous men who have sex with men. This was achieved through semi-structured interviews with eleven sexually active, non-monogamous MSM living in Ottawa, Canada.

Objectives of Study

1. To explore how perceptions of healthy and satisfying sex lives effect experiences of sexual anxiety among men who have sex with men.
2. To explore men who have sex with men's perceptions and experiences of sexual anxiety before, during and after sexual activity in order to develop an understanding of the factors that contribute to sexual anxiety.
3. To explore the preventative measures and coping mechanisms utilized by men who have sex with men to mitigate sexual anxiety and improve sexual satisfaction in order to provide implications for health services and promotion.

Positionality Statement

The descriptive phenomenological technique of bracketing was practiced throughout data collection and analysis in this study. Bracketing is the process by which researchers set

aside, or bracket off, their own previous experiences, understandings and assumptions of the phenomenon of interest in order to prevent bias during the collection and interpretation of the data.¹¹ Therefore, the role of the primary researcher necessitates the identification of personal values, assumptions and biases at the beginning of the study.

There are a number of reasons why I have an interest in the study phenomenon, sexual anxiety among non-monogamous MSM. I identify as a bisexual male, and have numerous gay and bisexual male friends within my social circle. In addition, one of my ongoing extracurricular activities is playing on a competitive volleyball team in the Gay Ottawa Volleyball league. These factors have allowed me to maintain an active social life within Ottawa's MSM community, and have facilitated a personal interest in the target population. I have also previously volunteered at GayZone, a weekly anonymous sexual health testing clinic for guys into guys, which helped establish an interest in sexual health. Furthermore, I have assisted on various research projects while working as a research assistant under the supervision of Dr. MacPherson, one of my thesis co-supervisors. In particular, I was a content developer for online medical learning modules on delivering healthcare to MSM patients, as well as online information pages on MSM health. Both of these resources are available at cometohugo.ca, an Ottawa Hospital affiliated website that provides MSM and health care professionals with relevant health information, tools and resources. This employment experience was my introduction into clinical research, and influenced my interest in MSM health.

I understand that each reason for my interest in the thesis topic stated above provides presuppositions of the study phenomena that would need to be bracketed off. For example, my employment as a research assistant and content developer facilitated a strong foundation of

knowledge regarding MSM mental and sexual health. In addition, my own experiences of sexual anxiety, such as periods of sexual activity avoidance due to a negative body image, have provided personal understandings of the causes and effects of sexual anxiety. Given these factors, I attempted to set aside and bracket off any prior knowledge, understandings and assumptions I had of the study phenomenon throughout the conduct of this study. This was done to mitigate bias during data collection and analysis, and improve the methodological rigor of this study.

Summary of Thesis

This thesis presents a comprehensive report of the research inquiry in six chapters. The chapters were selected based on recommendations by Moustakas (1994) for writing phenomenological studies of this nature.¹² The introduction, literature review and methodology chapters formulate the research, providing the background and design for the study. Chapters four and five present the data analysis and findings as a descriptive phenomenological account of the experiences of sexual anxiety among men who have sex with men. The final chapter provides an in-depth discussion of the research findings and their implications, the limitations of the study, and recommendations for future research arising from this thesis.

Chapter One: The introduction of the thesis presents the research problem and question, purpose and objectives of the study, a positionality statement, and a summary of the thesis chapters.

Chapter Two: The literature review chapter provides an analysis of the existing literature regarding the experience of sexual anxiety among MSM, including potential underlying causes

and its effect on quality of life and sexual wellbeing. This review highlights gaps in the current literature, and illustrates how the present study relates to previous research.

Chapter Three: The research methodology chapter examines phenomenology as a methodology of qualitative research. This chapter provides a brief explanation of qualitative research before presenting an overview of phenomenology, including a discussion of the underpinning philosophical assumptions of phenomenology, and an analysis of the two fields of phenomenological research, Husserlian (descriptive) and Heideggarian (interpretive). Descriptive phenomenology, otherwise referred to as transcendental phenomenology, provides the philosophical and methodological framework for this study.

Chapter Four: The methods chapter describes the research strategies utilized in this study. This chapter discusses the study population, participant recruitment, ethical considerations, and data collection and analysis procedures.

Chapter Five: The results chapter presents the research findings, which include the participants' experiences of sexual anxiety. This chapter provides an overview of the meaning units and themes that emerged from the data. The emergent themes found in this study were: healthy and satisfying sex lives, performance anxiety, fear of HIV and bacterial sexually transmitted infections (STIs), body image, internalized homophobia, and history of sexual abuse.

Chapter Six: The final chapter discusses the findings that confirm and oppose the information available in the existing literature, and presents new knowledge that has emerged from this study. This chapter also considers the significance of the study findings, while providing recommendations for future research and implications for health services. Lastly, the study limitations are described, and a conclusion to the research presented in this thesis is provided.

Appendices: Contains the thematic guide, English and French recruitment flyers, informed consent form, the coded significant statements and formulated meanings that pertained to the study objectives, and the meaning units and emergent themes that explained the study phenomenon.

Summary of Chapter

Chapter one introduced the study inquiry and the utilization of descriptive phenomenology to develop an understanding of the experiences and causes of sexual anxiety among men who have sex with men. The introductory chapter presented the research problem and question, and the study purpose and objectives. In addition, a positionality statement describing the researcher's interest and relationship with the research project was provided. This was followed by a synopsis of the content of the thesis chapters. The subsequent chapter is the literature review, which discusses the available literature relating to sexual anxiety among MSM.

CHAPTER TWO: LITERATURE REVIEW

Introduction

The goal of this literature review was to examine current research conducted on sexual anxiety among MSM in order to ascertain the knowledge gaps and inconsistencies in the existing literature. This assisted with the development of arguments to justify conducting the present phenomenological study, and with the generation of questions for the thematic guide (Appendix 1). An online search was conducted using electronic academic journal databases, which included PubMed, PsychINFO, and Google Scholar. The search was restricted to publications in the English language. Due to the limited amount of literature published on MSM's experiences of sexual anxiety, no time frame restriction was placed on the searches in order to capture the greatest number of publications. There are a limited number of studies that have explored factors associated with sexual satisfaction and anxiety among MSM, as the bulk of the literature is focused on HIV-related outcomes. However, the literature review unveiled several potential underlying mechanisms of sexual anxiety among MSM, which are discussed in this chapter.

Sexual Health Research

Historically, the field of sexual health has largely focused on the negative health outcomes associated with sexual activity, including sexually transmitted infections (STIs), sexual dysfunction, and sexual coercion and violence.¹³ However, sexual health has more recently been recognized by both physicians and policy makers as an important aspect of overall health and quality of life.¹⁴ In the 1975 publication, *Education and Treatment in Human Sexuality*,¹⁵ the

World Health Organization (WHO) first defined sexual health as: “the integration of the somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love.” Since its first articulation, definitions of sexual health have evolved to be progressively more holistic and health-focused, with researchers emphasizing its importance for well-being across multiple health domains, and not simply the absence of sexually-related disease or dysfunction.¹⁶⁻¹⁷ Correspondingly, sexual activity and satisfaction have been found to be positively associated with a reduced risk for mental health problems, physical disability and mortality.^{3,18} Hence, the promotion of healthy and satisfying sex lives has become an increasingly important measure to improve health outcomes and prevent adverse health events.¹⁹

Despite a general shift in focus towards overall well-being, sexual satisfaction and the positive aspects of sexuality, sexual health research among gbMSM still remains largely focused on negative health outcomes, and more specifically, on HIV.^{2,7} Gay, bisexual and other MSM are at an increased risk for HIV, accounting for 41.4% of incident infections in Canada in 2018.²⁰ Given this public health issue, research into the sexual health of MSM has reasonably been conducted to understand sexual risk behaviours and prevention needs,^{7,21} as well as to develop risk management techniques.²²⁻²³ While HIV research among the MSM population has been widespread, there are paucities in the literature regarding the broader psychosexual health outcomes of MSM. Moving forward, research into the determinants of sexual wellbeing is warranted to identify factors that undermine quality of sex and overall sexual health among MSM, and to promote positive health outcomes in this population.

Sexual Anxiety

Defined as the tendency to feel tension, discomfort and anxiety about the sexual aspects of one's life,⁶ sexual anxiety may play a critical role in the impairment of sexual satisfaction and overall quality of life. Anxiety and unhappiness around sex have in fact been associated with increased sexual compulsivity and frequency of unprotected sex,^{7,24} as well as decreased self-esteem, reduced sexual pleasure and lower sexual autonomy.^{8,25} These in turn increase the risk for negative sexual, physical and mental health outcomes. Therefore, preventing and treating sexual anxiety become important to overall healthcare.

In an effort to better diagnose and treat sexual anxiety, previous studies have been conducted to construct and validate quantitative measures of the phenomenon. Janda and O'Grady (1980) developed the Sex Anxiety Inventory, a 25-item questionnaire consisting of dichotomous response choices, with one of the responses to each item reflecting sexual anxiety.²⁶ The scoring system ranges from 0-25, with higher scores being indicative of greater sexual anxiety, and one-point being awarded for each item in which the response associated with sexual anxiety is selected. The Sex Anxiety Scale's scoring system is limited in its utility however, as it does not allow for a measure of the degree of anxiety on individual items, which can increase the risk for misclassification.²⁷ For example, a participant who feels a mild degree of anxiety on a large number of items would score as highly anxious. Whereas, someone who feels an extreme degree of anxiety for a small number of items may be rated as only having mild sexual anxiety.

Another questionnaire developed to measure sexual anxiety is the SOMA (Sexual Orientation Method and Anxiety) scale.²⁷ This scale was developed to assess sexual anxiety in

patients presenting with sexual dysfunctions, such as erectile dysfunction. This scale then is not useful in detecting or measuring sexual anxiety rooted in psychosocial domains, such as trauma or abuse. In addition, items and scoring parameters of the SOMA are drawn from the Sexual Orientation Method, a questionnaire developed to assess relative levels of homo- and heterosexual orientation during “treatment” of homosexuality.²⁸ Therefore, the SOMA may be considered homophobic, or otherwise inappropriate and inadequate for application in non-heterosexual populations.

The most common measure of sexual anxiety utilized in research is the sexual anxiety subscale of the Multidimensional Sexual Self-Concept Questionnaire (MSSCQ).⁶ The MSSCQ is a 60-item questionnaire measuring psychological tendencies associated with human sexuality, with items scored on a Likert-type scale ranging from 0 (“Not at all characteristic of me”) to 4 (“Very characteristic of me”). The MSSCQ produces scores for 12 subscales, including one for sexual anxiety. The sexual anxiety subscale consists of 5-items assessing anxiety around the sexual aspects of one’s life, with a higher overall score suggesting greater levels of sexual anxiety. Examples of items include, “I feel anxious when I think about the sexual aspects of my life” and “I usually worry when I think about the sexual aspects of my life.” A small number of studies using the MSSCQ’s sexual anxiety subscale in MSM samples have found positive associations between sexual anxiety and internalized homophobia,²⁹⁻³⁰ body image dissatisfaction,³¹ and fear of HIV.³² While these reported findings provide insight into the correlates of sexual anxiety among MSM, other factors, such as sexual abuse,³³ have yet to be investigated. In addition, the questions of the sexual anxiety subscale of the MSSCQ are designed to measure the level of general sexual anxiety experienced, and thus do not provide insight into

what is being experienced with sexual anxiety and how it affects one's sex life. Future research into the causes and effects of sexual anxiety is needed to develop an understanding of the prevention and treatment needs of MSM.

Sexual Anxiety and Satisfaction Among MSM

Interest in the thesis topic, sexual anxiety among MSM, came from preliminary results from a cross-sectional study of 1960 gbMSM living in Ontario. Data for this study were collected from an anonymous online survey conducted between June 2018 and March 2019. Respondents came from all regions in Ontario and were recruited via network and snowball sampling. The mean age of the participants was 38.1 years (SD=15.2). Among all participants, 37% reported feeling stressed or anxious during sex at least half of the time or more, and 24% reported feeling stressed or anxious after sex at least half of the time or more.¹ The research presented in this thesis is a subsequent investigation of factors associated with experiences of sexual anxiety among MSM, with a focus on how sexual anxiety impacts sexual satisfaction and wellbeing.

Research exploring sexual satisfaction among MSM populations has largely focused on the effects of HIV serodiscordant sexual partnerships and homosexual couple dynamics,^{29,34-35} as well as on sexual dysfunction (decreased libido, erectile difficulties and premature or delayed ejaculation).^{7,36} Serodiscordance and relationship dynamics studies are often limited in the generalizability of their findings, as participants tend to be HIV-positive or partnered, respectively, and thus may not be representative of the general MSM population. As for sexual dysfunction studies, SD has been found to be associated with negative mental health outcomes among both heterosexual and homosexual males, including anxiety and depression.³⁷⁻³⁸ In

addition, sexual dysfunction among MSM has been found to be associated with performance anxiety.³⁴ In regards to the directions of these relationships, it is theorized that underlying psychological issues, such as depression and sexual anxiety, have a greater causal effect on sexual dysfunction than sexual dysfunction does in the reverse direction.³⁶⁻³⁹ For example, in a Dutch study on sexual health, Kuyper and Vanwesenbeeck (2011) found that gay and bisexual men (GBM) with higher levels of internalized homophobia reported lower levels of sexual satisfaction and greater sexual dysfunction.³⁹ Therefore, psychological and social factors may contribute more to sexual anxiety and well-being among MSM than the negative health outcomes related to sexual dysfunction. Moreover, results and conclusions drawn from studies conducted on the frequency and effects of sexual dysfunctions among MSM have been ambiguous, yet well-documented. They are presented, among others, in publications by Bancroft et al (2005), Jern et al (2010), Hirshfield et al (2010), Kuyper and Vanwesenbeeck (2011), and Shindel et al (2012).^{36,39-42} Due to the contribution of underlying psychological factors in the experience of sexual dysfunction, and the saturation of the topic in the existing literature, this study did not explore sexual dysfunction as a mechanism of sexual anxiety among MSM. Instead, greater emphasis was placed on examining the experiences and causes of sexual anxiety that are more specific to sexual minority men, which will be discussed later in this chapter.

In a study comparing affective states during sex between heterosexual and homosexual men and women, Peixoto and Nobre (2016) found that homosexual men are more likely to report greater negative affect and lesser positive affect compared to both heterosexual men and women.⁴⁶ These findings suggest that sexual minority males may experience greater dissatisfaction and heightened worry about their sex life than heterosexual individuals. However,

results from studies comparing sexual satisfaction between homosexual and heterosexual populations have been contrasting and inconclusive. In a large cross-sectional study, Flynn, Lin and Weinfurt (2017) found that compared to straight men, GBM report lower satisfaction and greater discomfort with sex.⁴⁴ Conversely, Holmberg and Blair (2009) found no significant differences in general sexual satisfaction between men in different-sex and same-sex relationships,³⁴ and Sánchez-Fuentes and Sierra (2015) reported similar findings in their study of heterosexual and homosexual Spanish couples.⁴⁵ However, these latter two studies were conducted in samples of partnered-individuals, thus the results may not reflect experiences and rates of sexual satisfaction in non-partnered persons. Regardless of potential differences in sexual satisfaction between sexual orientations, sexual dissatisfaction is an important issue that negatively impacts the wellbeing of MSM.⁴⁶ Furthermore, in a recent study of sexual satisfaction among lesbian, gay and bisexual (LGB) adults, Shepler et al (2018) found that sexual anxiety was negatively correlated with sexual satisfaction in partnered gay and bisexual men (and women).²⁸ While it is unknown if this association exists in non-partnered GBM, the reported correlation suggests that preventing and mitigating sexual anxiety is important to improve sexual satisfaction, and thus quality of life, among MSM.

Previous sexual health research provides some insight into the psychosocial correlates of sexual anxiety among MSM. A UK study of the sexual issues among GBM found that 71% of 1199 participants reported one or more problems with sex in the past-year, including poor self-image or low self-esteem, loss of libido, low frequency of sex, performance anxiety, and fear of acquiring/transmitting HIV.⁷ In addition, a European survey of more than 18,000 MSM reported that over one-third of participants (37%) were unhappy with their sex life, and that being

“closeted” to one’s social network about their same-sex attraction was correlated with a greater degree of sexual dissatisfaction.⁴⁷ These findings demonstrate that sexual dissatisfaction is a prevalent concern among sexual minority men, and suggest that psychological and social factors greatly influence sexual anxiety and well-being in this population. As mentioned earlier in the chapter, research conducted among MSM using the sexual anxiety subscale of the MSSCQ have found positive correlations between sexual anxiety and internalized homophobia,²⁹⁻³⁰ body image dissatisfaction,³¹ and fear of HIV.³² The following sections of this literature review chapter will discuss these factors as mechanisms of sexual anxiety among MSM, as well as additional potential causes, including fear of other (bacterial) STIs and sexual abuse.

Internalized Homophobia

Meyer’s minority stress model was the first to theorize that mental health problems among lesbian, gay, bisexual and transgender (LGBT) individuals develop from minority stress.⁴⁸ The term “minority stress” refers to the process by which the chronic and socially-based stressors related to one’s minority status negatively influence minority individuals.⁴⁹ Individuals belonging to minority groups, such as gay men and other sexual minority males, experience additive stress due to frequent prejudice, discrimination and stigmatization related to their minority status.⁴⁸⁻⁴⁹ According to Batchelder et al (2017), minority stress among sexual minority individuals can result in negative psychosocial outcomes, including expectations of rejection, repressing/concealing sexual identity, internalized homophobia or homonegativity, and maladaptive coping strategies.⁵⁰ Moreover, several studies have demonstrated that minority stress influences sexual health. For example, higher levels of internalized homophobia are

related to negative sexual health outcomes, including sexual compulsivity⁵¹⁻⁵² and decreased sexual satisfaction.^{39,53}

Internalized homophobia (IH) is defined as negative feelings and homophobic attitudes a sexual minority individual has towards oneself and others who are also within sexual minorities.⁵⁴ According to Grabski et al (2019), IH is a strong predictor of the sexual quality of life in non-heterosexual men.⁵⁵ Not surprisingly, internalized homophobia contributes to a number of psychosexual outcomes among sexual minority males. In a study of internalized homophobia and psychosexual adjustment among gay men, Dupras (1994) reported that men who are less accepting of their homosexuality rate themselves higher on sexual anxiety, sexual depression, fear of sexuality, and concern about sexual image.⁵⁶ In addition, a study of Chinese gay and bisexual men found that higher levels of internalized homophobia were significantly associated with greater psychological distress, increased sexual compulsivity, and greater frequency of unprotected sex.²⁴ Furthermore, results from other studies conducted among MSM have demonstrated significant associations between IH and inability to decline unwanted sex,⁵³ decreased sexual satisfaction^{39,53} and greater sex guilt (feeling of remorse associated with thoughts about or participation in sexual activity).⁵⁷ More specific to the thesis topic, Shepler et al (2018) and Moody et al (2019) reported significant positive associations between internalized homophobia and sexual anxiety among their samples of LGBT and MSM individuals, respectively.²⁹⁻³⁰ These findings highlight internalized homophobia as an important factor that contributes to sexual health outcomes in MSM, and suggest that IH may be an underlying domain of sexual anxiety among sexual minority males. Additional research is needed to provide

understanding of how internalized homophobia contributes to and affects experiences of sexual anxiety among MSM.

Body Image Dissatisfaction

The term “body image” describes the subjective image that one has of their anthropometric measurements, contours, and shape of the body, regardless of their actual appearance.⁵⁸⁻⁵⁹ According to Rucker and Cash (1992), body image is a construct composed of perceptual (assessment of one’s own size, including distorted views and comparison to an ideal body) and attitudinal (i.e., thoughts, behaviours, and emotions related to one’s bodily size and appearance) components.⁶⁰ One’s perception of their body and physical appearance significantly influences their sex life, as a negative body image can deter sexual confidence and satisfaction.^{29,61-62} According to Blashill et al (2016), “Individuals who are dissatisfied with their appearance may find sex challenging and anxiety provoking, as attention is focused on their body/body parts.”³¹

Existing research on body image has established gender differences in body satisfaction, with men consistently reporting a more positive body image than women.^{61,63-65} This suggests that male gender is a protective factor against negative body image. However, this effect does not appear to be true for sexual minority men. A meta-analysis of 20 studies comparing the body satisfaction of homo- and heterosexual males reported that homosexual men have a significantly worse body image than heterosexual men,⁶⁶ a finding confirmed by more recent studies since the original publication.^{61,65,67-68} Furthermore, in a large study of body image satisfaction among heterosexual and LGB adults, Peplau et al (2009) found that compared to heterosexual men,

GBM experience increased rates of body image dissatisfaction, yet there were no significant differences in body satisfaction between homosexual men and homosexual women, and heterosexual women.⁶¹ Thus, there appears to be a negative association between male sexual minority status and body image. In comparison, this negative relationship has only been observed among men, as homosexual women have been found to report either significantly greater levels of body satisfaction compared to heterosexual women,^{61,66,69} or no significant differences in body satisfaction.⁷⁰⁻⁷²

Differences in body image between heterosexual and homosexual men may partially be explained by reactions to media portrayals of the male body. According to Fredrick and Essayli (2016), homosexual men are significantly more likely to report pressure from the media to look attractive compared to their heterosexual counterparts.⁶⁵ For men, media images depict fit and muscular bodies as the most attractive and desirable.⁷³⁻⁷⁴ However, in an analysis of muscularity and body fat depictions in magazines that target straight and gay men, Lanzieri and Cook (2013) found that while both types of magazines depict muscularity as an ideal, gay-targeted magazines depicted men who were thinner than magazines targeting straight men.⁷⁵ Moreover, additional studies into the content of gay male targeted magazines have reported frequent use of images that depict having high levels of muscle tone and low levels of body fat as the ideal,⁷⁶ and images that exhibit high levels of physical objectification, focus on specific body parts, and emphasize the importance of having the ideal body.⁷⁷ Given that media images for gay men depict a less realistic or unattainable body ideal than those for heterosexual men (similar levels of muscle tone but lower levels of body fat), it is likely that MSM, compared to heterosexual men, experience a greater negative influence on their body image as a result of the media.

Objectification theory may also help explain the disparities in body image satisfaction between heterosexual and homosexual males.⁷⁸ Research on partner preferences has found that men, regardless of sexual orientation, place stronger emphasis on a partner's physical attractiveness than women.⁷⁹⁻⁸⁰ Therefore, according to Objectification theory, sexual minority men experience increased pressure to achieve an idealized (thin and muscular) body than heterosexual men, as they attempt to attract other men, who are more appearance-discriminating than women.^{61,81} This pressure can lead to self-objectification and constant monitoring of one's body and physical appearance, resulting in a negative body image.³¹

Body image satisfaction is intimately tied to the sexual health and quality of life of sexual minority men. Compared to lesbian and bisexual women, as well as straight men and women, GBM report the worst sex quality of life as a function of their body image, with 42% of gay and bisexual male participants stating their body image negatively impacted the quality of their sex life.⁶¹ Studies conducted among MSM have found negative body image to be significantly associated with depressive symptoms,⁸²⁻⁸⁴ lower sexual health efficacy (belief an individual has regarding their ability to effectively negotiate sexual decision-making) and increased sexual anxiety.³¹ The results of these studies underscore body image as a key variable contributing to sexual and psychological health outcomes among men who have sex with men, and suggest it as an underlying mechanism of sexual anxiety in this population.

Fear of HIV and Other STIs

It is challenging to fully comprehend homosexual male sexuality without first understanding the issues associated with HIV.⁸⁵ In Canada, it is estimated that MSM comprise

over half (52.5%) of prevalent cases of HIV,⁸⁶ and make up the greatest proportion of annual incident infections (41.4%).²⁰ Given the high-risk of HIV acquisition among the MSM population, there is a complicated relationship between HIV and the sex lives of sexual minority men.

According to McNally and Adams (2001), for HIV-negative MSM, fear of HIV infection is a reason for avoiding sexual activity, which makes it difficult to gain sexual experience.⁸⁷ In addition, sexual behaviours that increase the risk of HIV acquisition, such as condomless anal sex, may cause feelings of guilt or self-accusations in men worried about HIV. Moreover, prioritizing and necessitating condom usage may interfere with sexual function and satisfaction, as the condom serves as a symbolic reminder of the potential risk of HIV infection. Since fear of HIV infection may lower sexual satisfaction and influence MSM to avoid sexual activity, it is likely that fear of HIV is an underlying cause of sexual anxiety among men who have sex with men.

The Pleasure and Sexual Health study conducted in Australia (2012) reported a strong desire among its gay male participants to have satisfying sex while avoiding HIV infection,⁸⁸ suggesting that fear of HIV may direct sexual attitudes and behaviours in this population. Correspondingly, a New York-based study of GBM found that approximately half of participants (49%) reported thinking about HIV most or all of the time during sex,⁸⁹ highlighting fear of HIV as an intrusive anxiety during sexual activity. Moreover, results from pre-exposure prophylaxis (PrEP) studies suggest that fear of HIV contributes to reduced sexual desire and pleasure. PrEP has been demonstrated to prevent HIV infection with high efficacy – an estimated 90% reduction in HIV acquisition when PrEP is used consistently and correctly.⁹⁰ However, it may also be an effective intervention for reducing fear of HIV and improving sexual satisfaction, as PrEP use among MSM has been reported to be significantly associated with decreased sexual anxiety,^{32,91}

greater sexual autonomy,²⁵ and increased willingness for sex and sexual satisfaction.^{25,32} These findings underscore fear of HIV infection as a potential domain of sexual anxiety, as GBM report preoccupations with HIV-related thoughts during sexual activity, and report experiencing increased sexual desire and satisfaction when the risk of HIV is mitigated by pharmaceutical intervention. Interestingly, perceptions and experiences of sexual anxiety among MSM may differ based on HIV serostatus. Sexual anxiety may result from fear of HIV acquisition among HIV-negative MSM, whereas among HIV-positive MSM, it may come from a fear of transmitting HIV to a sexual partner.⁹²

HIV is not the only sexually transmitted infection that may cause sexual anxiety among MSM, as there are relatively high rates of bacterial STIs, such as gonorrhea, chlamydia and syphilis, in this population. Correspondingly, province and nation-wide data suggest that up to 85%,⁹³ 41%,⁹⁴ and 11%,⁸⁶ of yearly diagnoses of syphilis, gonorrhea, and chlamydia, respectively, are among the MSM population. As PrEP protects against HIV but not other STIs, concerns have emerged among physicians and researchers regarding the potential for increased incident infections of STIs among PrEP users due to low condom use. Correspondingly, a recent Canadian study observed increased incidence rates of chlamydia, gonorrhea, syphilis and Hepatitis C among MSM in the 12 months after starting PrEP relative to the 12 months prior.⁹⁵ Furthermore, in a longitudinal study of MSM, Chen et al (2016) found that PrEP use was correlated with an increased reporting of condomless anal sex and a decreased frequency of consistent condom use.⁹⁶ Despite PrEP's effectiveness as an intervention to prevent the transmission of HIV, these findings suggest that as PrEP becomes more widely accessible, it may result in the increased incidence of other STIs among the MSM population. With the incidence (and thus risk) of STIs

currently on the rise among MSM in Canada,⁹⁷ fear of bacterial STIs may well contribute to sexual anxiety in this population, especially among those on PrEP who may place greater emphasis on their concerns regarding bacterial STIs due to a reduced fear of HIV. Further research is needed to provide understanding of how fear of both HIV and bacterial STIs affects sexual wellbeing and contributes to experiences of sexual anxiety in men who have sex with men.

Sexual Abuse

Experiences of childhood sexual abuse (CSA) and adulthood sexual abuse (ASA) have both been found to be correlated to negative psychological outcomes, including substance use, depression and post-traumatic stress disorder (PTSD).⁹⁸⁻¹⁰⁰ Research into the effects of sexual abuse on sexuality of have shown CSA and ASA to be associated with sexual avoidance, sexual aversion, decreased sexual satisfaction, and low sexual desire,¹⁰¹⁻¹⁰⁴ underscoring sexual abuse as a potential mechanism for sexual anxiety among adults. Consistent with this, studies in heterosexual populations have found that sexual abuse is positively correlated with sexual anxiety.¹⁰⁴⁻¹⁰⁵ However, is it unknown if sexual abuse influences sexual anxiety among MSM, as researchers have yet to assess this association in a non-heterosexual male population. Information on the repercussions and psychosexual effects of sexual abuse among women is widely available in the literature (for a review, see Abbey, Jacque-Tiura and Parkhill 2010),¹⁰⁶ but research lags behind in understanding these experiences among men, especially among sexual minority males.¹⁰⁷ This is because the majority of sexual abuse research among MSM has largely focused on implications for HIV-prevention. For example, positive associations between a history

of CSA and condomless anal sex, and greater number of casual partners among MSM are well-documented.^{99-100,108-110}

Population-based surveys on sexual abuse have most often been female-targeted, or rarely assess differences in sexual orientation.¹⁰⁷ As a result, currently available knowledge regarding sexual abuse prevalence among MSM is limited. In the previously mentioned online study of 1960 MSM in Ontario, 16.3% and 19.5% of participants reported a history of CSA and ASA, respectively.¹ According to a systematic review performed by Rothman, Exner and Baughman (2011), the median estimated prevalence of lifetime sexual assault among gay and bisexual men is 30%³³. More specifically, the authors distinguished that the median estimated prevalence of CSA and ASA among GBM is 22.7% and 44.7%, respectively.³³ Xu and Zheng (2015) later reported similar rates in a meta-analysis of CSA prevalence among LBG adults, with a median estimated prevalence of 23.6% and 21.4% for gay and bisexual men, respectively.¹¹¹ These rates are higher than those found in the recent Ontario survey, which is likely due to fact that studies included in the two meta-analyses relied on data from non-random, purposive sampling.^{33,107,111} These rates are much higher than those reported for heterosexual males, especially for CSA, which has been observed to be under 5% across the limited number of studies conducted,¹¹²⁻¹¹⁴ indicating that MSM are at an increased risk of experiencing sexual abuse than heterosexual males. Consistent with this, a meta-analysis of sexual orientation disparities in childhood sexual abuse found that sexual minority individuals were 3.8 times more likely to report CSA compared to heterosexuals.¹¹⁴ Given the elevated risk of sexual abuse among sexual minority males, and the negative mental and sexual health outcomes associated with CSA and ASA, sexual abuse may be an underlying domain of sexual anxiety among MSM populations.

Additional research is required to develop an understanding of how previous experiences of sexual abuse contribute to experiences of sexual anxiety and affect current sexual wellbeing among MSM.

Summary of Chapter

The literature review discovered knowledge gaps in sexual health research related to the experiences of sexual anxiety among men who have sex with men. This is because the majority of sexual health research and research on sexual anxiety conducted among MSM populations has largely focused on HIV-related outcomes. As a result, there is a lack of data explaining the experiences of sexual anxiety and its effects on sexual wellbeing among MSM. Nonetheless, reviewing the literature in a broader scope highlighted several correlates and potential underlying domains of sexual anxiety in this population. These include internalized homophobia, body image dissatisfaction, fear of HIV and other STIs, and sexual abuse. However, how these factors contribute to the experience of sexual anxiety among these men has yet to be investigated.

Through a qualitative design, the present study sought to explore experiences of sexual anxiety related to the above factors, and identify the predominant causes of sexual anxiety among non-monogamous MSM. The findings of this study will add to the gbMSM sexual health literature by addressing existing paucities, and provide a framework to approach sexual anxiety among MSM, and recommendations for preventative measures and positive coping mechanisms aimed at reducing sexual anxiety. Therefore, study results will be of interest to both health care professionals and patients. The research presented in this thesis will investigate the

phenomenon (sexual anxiety) by describing the lived experiences of sexual anxiety among eleven HIV-negative identified MSM. The following chapter will provide an overview of the research methodology, phenomenology, which is the methodological framework for this study.

CHAPTER THREE: RESEARCH METHODOLOGY

Introduction

This chapter introduces phenomenology as a methodology of qualitative research. Phenomenological methods aim to articulate and understand the details of participants' lived experiences with the study phenomena, as well as the participants' interpretation of their experiences. Phenomenology is recognized as an appropriate methodology for research in sexuality, as it assists investigators in developing an understanding of sexuality (the phenomenon) as it is experienced in daily life.¹¹⁵ Two prominent fields of phenomenological research are examined in this chapter, Husserlian (descriptive) and Heideggerian (interpretive). Arguments for applying descriptive phenomenology as the methodological framework of this study are discussed.

Qualitative Research

For the purpose of answering the proposed research question, a qualitative study design was chosen to explore perceptions and experiences of sexual anxiety among men who have sex with men. Qualitative research uses "a systematic, subjective approach to describe life experiences and give them meaning."¹¹⁶ It allows researchers to explore perspectives, feelings, behaviours and experiences in depth and through a holistic framework.¹¹⁷ In contrast, quantitative research is a formal systematic investigation of empirical data via statistical or computational techniques.¹¹⁶ As discussed in chapter two, the use of quantitative research methods has uncovered correlates of sexual anxiety among MSM, which included internalized

homophobia, body image dissatisfaction, and fear of HIV. However, statistical inferences in quantitative research do not address causation, and also do not explain the processes participants experience (what is being experienced), the contexts in which participants experience a phenomenon of interest (why it is being experienced), how participants are affected by and react to their experiences, and the perceptions and behaviours that underpin participant reactions to their experiences.¹¹ A qualitative research design was thus chosen for this study to explore the potential contributions of a number of correlates to sexual anxiety among MSM,¹¹ as identified in several quantitative studies.

Phenomenology

Phenomenology is an approach to qualitative research that aims to understand and describe the common meaning/experience of a phenomenon for group of individuals.¹¹ The word phenomenology is derived from two Greek words, *phainómenon*, meaning “appearance” or “to show oneself”, and *logos*, meaning “thought or concept.”¹¹⁸ Thus, phenomenological research can be seen as the study of what people reveal and how they react to a given experience (how phenomena appear) and their perceptions of these experiences.

Phenomenologists set out to describe the commonality of a lived experience of a particular group, with the purpose of reducing individual experiences to a description of the universal “essence” of the phenomenon (i.e., what is the phenomenon and how it is being experienced).¹¹⁹ The essence, or essential, invariant structure, is a composite of the experiences of all participants in the study.¹¹⁻¹²

There are two prominent fields of phenomenological investigation within sexual health research, descriptive and interpretive phenomenology. These methodologies are rooted in the works of Edmund Husserl (descriptive) and Martin Heidegger (interpretive).¹²⁰ Koch (1995) noted that there are distinct differences between these two approaches which have implications for the phenomenological methodology utilized in a study.¹²¹ Briefly, descriptive phenomenology focuses on epistemological inquiries (study of knowledge), whereas interpretive phenomenology focuses on ontological inquiries (study of being and temporality). The following sections will examine the underlying philosophical assumptions of these two fields of phenomenological research.

Husserl's Descriptive Phenomenology

Husserl's philosophical ideas gave rise to the field of descriptive phenomenology, which is also referred to as transcendental phenomenology. His philosophy emphasized the equal value of both objective and subjective human experiences, thus rejecting positivism's focus on objective observations of external reality.¹²² According to Neubauer (2019), "Husserl argued that phenomena, as perceived by individual's consciousness, should be the object of scientific study."¹²⁰ Moreover, Husserl believed that, "Ultimately, all genuine and, in particular, all scientific knowledge, rests on inner evidence," with inner evidence (i.e., thoughts and perceptions of consciousness) being where the phenomenon is studied.¹²³ Therefore, Husserl's descriptive phenomenology examines the essence of consciousness, placing emphasis on the descriptions of an individual's lived experience, which are free of interpretation. His approach

attempts to provide understanding of phenomena of daily life via the investigation of people's experience using a rigorous scientific methodology.¹²⁴

For a researcher conducting a descriptive or transcendental phenomenological study, the goal is to achieve transcendental subjectivity.¹²⁰ Lopez and Willis (2004) describe transcendental subjectivity as a state where "the impact of the researcher on the inquiry is constantly assessed and biases and preconceptions neutralized, so they do not influence the object of study."¹²⁵ In other words, a researcher must not let their individual subjectivity bias data analysis and interpretations, which is known as phenomenological reduction. Phenomenological reduction is a key epistemological approach of phenomenology,¹²⁶ and relates to the Husserlian concept of epoche, otherwise known as bracketing. This is the process by which researchers set aside, or bracket off, their own previous experiences, understandings and assumptions of the phenomenon of interest in order to "take a fresh perspective towards the phenomenon under investigation," as if for the first time.¹¹ Therefore, the goal of phenomenological reduction is to isolate the "pure phenomenon" from what the researcher already knows about the phenomenon. According to Ashworth (1996), there is a wide array of personal opinions, experiences and previous understandings, including scientific theories, knowledge or explanations, that must be bracketed off by the researcher.¹²⁸ Researchers embracing the idea of bracketing in phenomenology should describe their own experiences with the phenomenon and bracket out their views before proceeding with the experiences of others.¹¹

Moustakas (1994) describes that in transcendental-phenomenological reduction, each participant's experience is considered individually, and an exhaustive description of the phenomenon's essence is constructed from these experiences.¹² This is achieved via imaginative

variation of the data, in which all participant descriptions of lived experiences of the phenomenon are extracted into “a unified synthesis of essences through the process of free variation.”¹²⁰ Free variation relies on the researcher’s intuition, and requires them to imagine multiple variations of the phenomenon in order to determine the essences of the phenomenon.¹²⁹ For instance, if the imaginative elimination of a particular factor or aspect causes the phenomenon to collapse, then it was essential to the essences of the phenomenon.¹³⁰ These intuited essences become the foundation for all knowledge regarding the phenomenon of interest.

Heidegger’s Interpretive Phenomenology

Interpretive phenomenology, also referred to as hermeneutic phenomenology, originates in the works of Martin Heidegger, a German philosopher. As a student and colleague of Husserl, Heidegger was influenced by Husserl’s work, and initially, their philosophical inquiries and assumptions coincided.¹²⁰ However, Heidegger later challenged and altered some of the key aspects of transcendental phenomenology. The most notable being a foundational break of the focus of phenomenological inquiry. Husserl’s descriptive phenomenology focuses on epistemological inquiries (study of knowledge), whereas Heidegger’s interpretive phenomenology focuses on ontological inquiries (study of being and temporality). Heidegger rejected Husserl’s emphasis on “acts of attending, perceiving, recalling and thinking about the world,” the importance of description, and the notion that human beings are knowers of the phenomenon.¹²² Instead, Heidegger was interested in understanding the human experience and how it is lived, i.e., the way humans exist and act in the world.¹¹⁹ He posited that human beings

were not knowers of the phenomenon, but rather were actors in the world, and thus he focused his inquiries on the relationship between individuals and their everyday lives.¹²⁰ In addition, Heidegger disagreed with Husserl's concept of epoche, or bracketing, believing it was impossible to dissociate one's mind from previous knowledge, experiences and assumptions about the phenomenon.¹³² Even Moustakas, a transcendental phenomenologist, admits that bracketing is infrequently a perfect process.¹² Moreover, Geanellos (2000) suggested that the interpretive phenomenologists value a researcher's personal knowledge and experience, and view it as a necessity to phenomenological studies.¹³² After all, it was the researcher's prior knowledge and experience that led them to consider a particular phenomenon worthy of investigation.¹²⁰ Therefore, bracketing is an unwarranted process in interpretive phenomenology. However, researchers conducting an interpretive phenomenological study should state any preconceptions and experiences they have with the phenomenon of interest, and describe how this subjectivity will influence and be utilized in the collection and interpretation of the data.¹²⁵

The Methodological Framework: Descriptive Phenomenology

Lopez and Willis (2004) note that a lack of transparency regarding a study's methodology can facilitate difficulty in understanding how data are to be interpreted and utilized.¹²⁵ Thus, it is critical to state which phenomenological approach provides the philosophical and methodological framework for this study. The research presented in this thesis uses Husserl's transcendental/descriptive phenomenological methodology. This involves the exploration, analysis and description of a particular phenomenon, as free as possible from any existing preconceptions, so as to ascertain the essence (composite description) of the phenomenon.¹³³

Correspondingly, the present research is a descriptive study investigating the lived experiences of eleven HIV-negative identified men who have sex with men.

The selection of descriptive phenomenology as the methodological framework of this study was based on a previous descriptive phenomenology study conducted in a sample of gay men. Parrish and Frieden (2008) used a descriptive phenomenological methodology to investigate the lived experiences of gay identity development, gaining a rich understanding of the experiences that facilitate movement towards self-acceptance and adaptation for gay men.¹³⁴ Likewise, the current study sought to use descriptive phenomenology in order to develop a deep understanding and derive an exhaustive description of the lived experiences of sexual anxiety among men who have sex with men. Moreover, according to Matua, Van Der Wal and Mostert (2015), “Descriptive phenomenology seeks to emphasize the pure description of subjects' experiences, while interpretative phenomenology considers contextual features as they relate to influences that affect the subjects of the study.”¹³⁴ Due to the current study's focus on developing a pure, exhaustive description of the study phenomenon (sexual anxiety), a descriptive phenomenological approach was chosen.

Summary of Chapter

This chapter on research methodology discussed the philosophical assumptions that underpin the investigative approach used in this study. Justifications for the use of qualitative methods were presented, and were followed by an overview of phenomenology. This included an exploration of the two prominent fields of phenomenological research, Husserlian (descriptive) and Heideggerian (interpretive). Descriptive, or transcendental, phenomenology

provides the philosophical and methodological framework for this study, with the goal of obtaining a rich understanding and developing a composite description of the lived experiences of sexual anxiety among non-monogamous MSM. The following chapter will describe the precise methods utilized in conducting the research presented in this thesis.

CHAPTER FOUR: RESEARCH METHODS

Introduction

The methods chapter summarizes the research strategies employed in this descriptive phenomenological study of the lived experiences of sexual anxiety among non-monogamous MSM. This chapter describes the study population, outlining the inclusion and exclusion criteria, as well as the participant recruitment strategies that were used. This is followed by a discussion of the ethical considerations of the study, and an overview of the data collection procedures and data analysis techniques that were utilized, which included Moustakas' method of data analysis.¹²

Sample Size

In contrast to quantitative research where a large sample size is sought to increase statistical power and the generalizability of study results, sample sizes in qualitative research are significantly smaller. Unlike in quantitative research, qualitative studies do not investigate variables and correlations, but rather explore events and experiences that are informative and specific to the research question and study objectives.¹³⁵ Therefore, the depth and richness of information provided by participants of a qualitative study justifies the use of a small sample size, as a large volume of information is generated and collected from each participant.¹³⁶ Consistent with this, participants in qualitative studies are continually recruited until the data are theoretically saturated.

Theoretical saturation, or data saturation, refers to the phase in qualitative research in which sampling and data analysis is continued until little or no new data appear.¹³⁷ It is a concept applied in qualitative research as a criterion for when to stop data collection and analysis.¹³⁸ Urquhart (2013) defines data saturation as “the point in coding when you find that no new codes occur in the data. There are mounting instances of the same codes, but no new ones.”¹³⁹ At that point, the collection and analysis of additional data will not lead to any new emergent themes.¹⁴⁰ Based on Polkinghorne’s (1989) recommendations for phenomenological research, a sample size of 5-25 participants was expected to achieve saturation in this descriptive phenomenological study.¹⁴¹ Accordingly, after the ninth interview conducted in this study, there were no new themes emerging in the data analysis. Therefore, it was deemed that theoretical saturation was achieved. Data collection and analysis continued for two more participants to confirm that no new themes would emerge from additional data collection. The final study population consisted of eleven HIV-negative identified, non-monogamous men who have sex with men (N=11), four of whom reported being on PrEP at the time of data collection. Participant characteristics are described below in Table 1:

Table 1. Participant Characteristics.

Participant Number	Participant Pseudonym	Age Range	PrEP Use
1	Ash	20s	No
2	David	30s	Yes
3	Damon	20s	No
4	James	30s	Yes
5	Marc	20s	Yes
6	Mark Mountain	20s	No
7	Raf	30s	No
8	Vanje	20s	Yes
9	Joseph	60s	No
10	Migel	30s	No
11	David	20s	Yes

Participant Eligibility

Study participation was open to HIV-negative identifying gay, bisexual and other men who have sex with men aged 18 years and older. Eligible participants had to self-identify as a male, have had sex with another man in the last 6-months, and not be in a mutually exclusive, monogamous relationship at the time of participation. The last criterion was considered important as we hypothesized that for the two populations, monogamous and non-monogamous, roots of sexual anxiety could markedly differ. According to Stephenson et al (2015), monogamously partnered MSM are at higher odds of perceiving a zero-risk for HIV infection and being very confident of staying HIV-negative compared to MSM who are single or in an open-relationship.¹⁴² Therefore, partnered MSM may be at a reduced risk of sexual anxiety rooted in a fear of HIV. In addition, sexual anxiety within an established relationship may be confounded by relationship stressors, including anxiety around relationship permanence,¹⁴³⁻¹⁴⁴ body image dissatisfaction but relative to one person as opposed to general self-perception,¹⁴⁵ power or financial differentials,¹⁴⁶ and possible intimate partner violence.¹⁴⁷

For these reasons, MSM currently in a mutually monogamous relationship were excluded from this study as they were viewed as a different population. Lastly, due to linguistic limitations of the researcher and the method of data collection chosen for this study (semi-structured interviews), only English speaking MSM were eligible to participate.

It is important to note that this study had planned to include HIV+ and older MSM in its sample in order to explore potential differences in the causes and experiences of sexual anxiety between HIV-negative and HIV positive MSM, and between younger and older MSM. However, due to the COVID19 pandemic, and because data collection for this study involved face-to-face

contact with participants (described later in this chapter), data collection was stopped early due to social distancing measures. Based on Public Health directives, the University of Ottawa ordered the cessation of all in person interviews for research purposes, which forced the researcher to end data collection. This limited data collected among HIV-positive and older MSM participants, thus preventing the aforementioned planned data comparisons. Limitations resulting from this sampling bias are discussed in chapter six.

Participant Recruitment

Purposeful sampling was employed for recruitment in this study. This method of sampling is frequently utilized in qualitative research, as it is a researcher's goal to purposefully select participants who will provide information that is relevant to the research question and study objectives.¹⁴⁸ Therefore, the participants in this study must have had experiences of sexual anxiety that negatively affected sexual satisfaction and wellbeing, and be willing to reflect on and share these experiences with the researcher. Although non-random sampling introduces bias in qualitative research, using purposeful sampling to recruit relatively small, data-rich samples is critical to develop a thorough understanding of study phenomena.¹³⁶ This allows researchers to distinguish data related to study phenomena from "surrounding conceptual noise" during data analysis.¹⁴⁹ This may in turn improve the validity of the study, as it prevents the analysis and reporting of data unrelated to the study objectives.

Participant recruitment occurred in Ottawa, Ontario over a period of 4 months. In order ascertain different perceptions and experiences of sexual anxiety as they relate to fear of HIV, purposeful sampling was used to ensure the study sample included men on and not on PrEP.

Two men currently taking PrEP were recruited from the Ottawa Hospital's HIV Prevention Clinic. Dr. Paul MacPherson, who runs this clinic and is one of the thesis co-supervisors, identified potentially eligible participants, and explained the rationale and goals of the study in order to assess potential interest. Patients who consented to have their contact information given to the researcher were contacted via telephone. During these phone calls, the researcher clarified the rationale and goals of the study, explained the commitment requirements, and assessed participant eligibility and interest.

The additional nine participants (three of whom were on PrEP) were recruited indirectly through information flyers geared towards potential participants (English Version: Appendix 2; French Version: Appendix 3). The recruitment flyers were posted in community organizations that provide health and outreach services to MSM (e.g., AIDS Committee of Ottawa and MAX Ottawa), and in LGBT-oriented bars/pubs, and bathhouses in Ottawa's Centretown and downtown areas. The flyers contained study contact information, allowing participants to make initial contact via telephone or email. Potential participants who contacted the researcher via phone or email were assessed for eligibility and explained the rationale, goals, and commitment requirements of the study.

Individuals from all recruitment methods who were eligible and expressed a desire to participate in the study were scheduled for an interview with the researcher within a private room at the Ottawa Hospital General Campus. All participants were provided a \$30.00 cash honorarium following participation (a single interview session) in order to compensate them for travel costs/parking and to cover their time away from other tasks.

Ethical Considerations

Formal ethical approval for this research study was obtained from the Ottawa Health Sciences Network Research Ethics Board (OHSN-REB) and the University of Ottawa Health Sciences and Science Research Ethics Board. Recruitment and data collection did not commence until after formal ethical approval was obtained. Prior to commencing study interviews, the purpose and objectives of the study were reiterated to all participants, and then each participant was asked to sign the informed consent form (Appendix 4). A copy of the consent form was given to each participant for their reference. All participants were informed that they could withdraw from the study and terminate the interview at any time without repercussion.

As the interview questions and discussion had the potential to evoke painful feelings and emotions, the researcher was to terminate the interview if a participant was distressed and offer immediate referral to a social worker or psychotherapist at the Ottawa Hospital. Fortunately, no participants exhibited emotional distress during the interviews, and no referrals to a mental health professional were required.

Privacy and confidentiality were maintained at all times throughout the study. The researcher has ensured that no personal or potentially identifiable information was recorded or printed in this study. Direct quotes from participant interviews are utilized in this research but are not identifiable. With participant consent, the interviews were audio recorded and transcribed verbatim by the researcher to ascertain an accurate report of the interview discussions. Since interviews were transcribed verbatim, participant pseudonyms were used during interviewing to prevent recording of identifiable information. Following each interview, the audio file was encoded by the researcher and stored on a password protected and encrypted

USB. All interviews were transcribed verbatim by the researcher within two days of data collection, and the digital recordings were deleted after confirming an accurate transcription. Transcript data were stored in password protected folders with restricted access, which were contained on an encrypted USB that was only accessible by the researcher. The signed consent forms were stored in a locked filing cabinet, which was only accessible by the researcher, and separate from the interview transcripts.

Data Collection

For the purpose of the proposed study objectives, face-to-face, open-ended, semi-structured interviews were conducted. In qualitative research, it is the researcher's role as the data collection instrument to obtain an understanding of the participants' experiences and to engage with participants to facilitate the sharing of information-dense descriptions.¹¹ Open-ended interviews are frequently utilized for data collection in qualitative research as they allow participants to control the discussion with regards to the issues and experiences that are explored throughout the interview.¹²⁷ By not restricting participant responses in the interviews, rich and relevant data are collected by the researcher.¹⁴⁹ In addition, a semi-structured interview format was selected to allow the researcher to prepare a framework in which open-ended questions related to pre-identified themes are posed to encourage participants to freely discuss their opinions and experiences.¹⁵⁰⁻¹⁵¹ According to Robinson (2000), "the formal qualitative interview is an unstructured conversation with purpose that usually features audiotape and verbatim transcription of data and the use of an interview guide rather than a rigid schedule of questions."¹⁵² Based on findings from the literature review, a thematic

framework (Appendix 1) was developed by the researcher and used as an interview guideline in this study. The interviews thus consisted of a number of themes uniquely developed to obtain an understanding of the lived experience of sexual anxiety among non-monogamous MSM, and identify causal mechanisms and healthy coping strategies in this population.

Each interview began with questions that pertained to perceptions and definitions of healthy and satisfying sex lives (Appendix 1). During the interviews, the researcher limited his responses to those that sought clarification of participants' thoughts and experiences, or prompted participants to provide more information. Examples of responses and prompts used by the researcher during the interviews include, "Can you please elaborate more on that point?" and "Can you please describe in more detail how that experience affected your sex life?" The interview process for each participant lasted an average of 34 minutes, with interviews ranging from 22 minutes to 52 minutes in duration.

At the end of each interview, participants were asked if they consented to being contacted and sent the composite structural-textural description of the phenomenon in order to validate the essence of the lived experiences of sexual anxiety among non-monogamous MSM. This was not a requirement of study participation and was requested on a volunteer basis. Eight (N=8) of the eleven participants agreed to be contacted in order to validate the study's findings.

Data Analysis

Moustakas' (1994) structured approach to data analysis in phenomenological research was utilized and deemed most appropriate for this study.¹² Moustakas' method modifies that originally proposed by Colaizzi, and emphasizes the development of a composite description that

captures the essence of the phenomenon of interest.^{12,153} While, each transcribed interview in this study was analyzed using Moustakas' structured approach, in order to improve methodological rigour, the analysis also incorporated some methods of data analysis suggested by Colazzi: (1) the researcher actively listened to each participant's audio recording twice and read each transcript three times before extracting significant statements. This was done to facilitate a greater understanding of the participant's lived experiences of the study phenomenon. (2) formulated meanings were constructed from significant statements in order to improve the researcher's ability to accurately interpret perceptions and meanings from the participants' lived experiences of sexual anxiety. And (3), the researcher returns to the participants in order to validate the composite description of the phenomenon and improve the reliability of this study. Figure 1 below presents a summary of the sequential stages of data analysis undertaken in the current study:

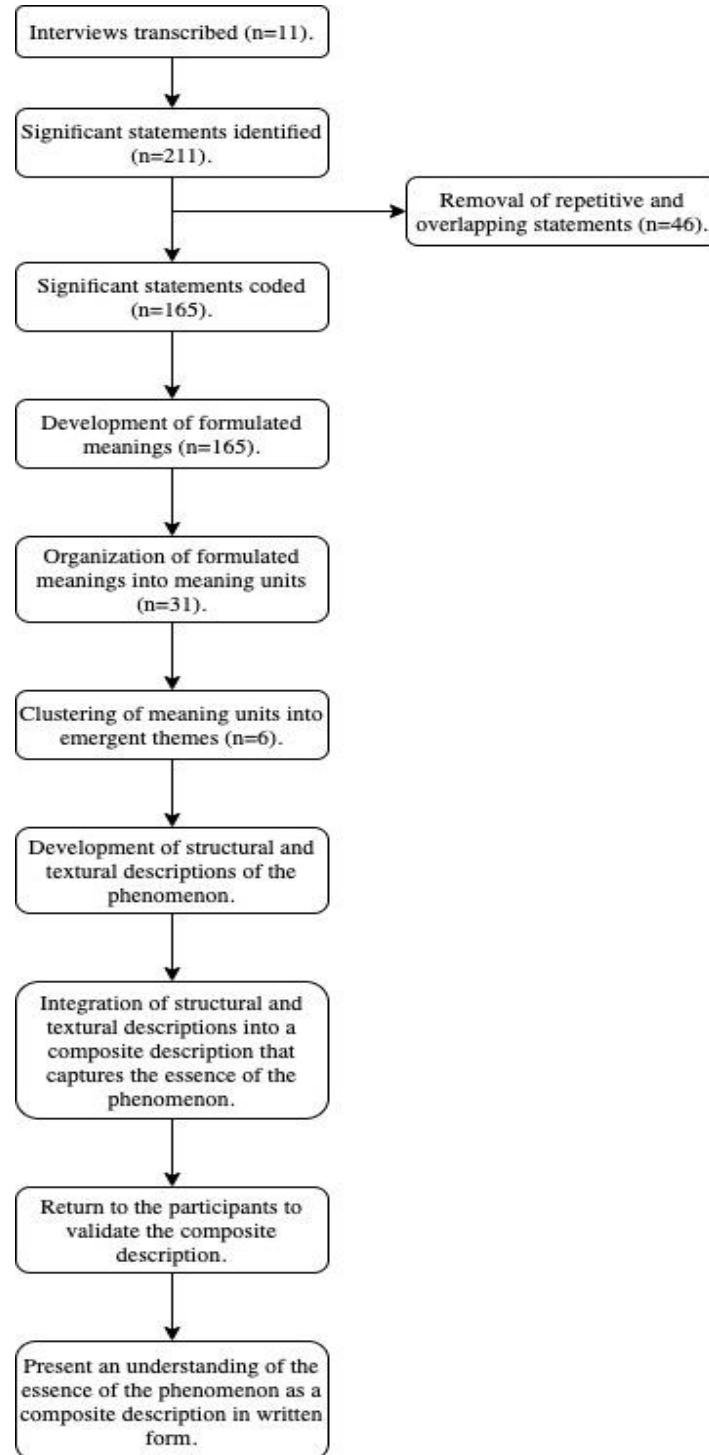


Figure 1. Sequential stages of data analysis.

Significant Statements and Formulated Meanings

Through the horizontalization process, significant statements and phases pertaining to the phenomenon of sexual anxiety among non-monogamous MSM were coded from the interview transcripts. Every transcript was read three times to identify significant statements, and all statements were reviewed by the researcher to ensure they related to the study objectives. Two hundred and eleven significant statements were originally identified. Overlapping and repetitive statements were removed so that only the most rich and descriptive statements were included in the analysis. Forty-six repetitive and overlapping statements were removed from the analysis, resulting in a total of 165 significant statements being coded and given equal value. Table 2 below provides an example of how significant statements were identified and distilled from the interview transcripts. The bolded sentences in Table 2 indicate the significant statements that were extracted.

Table 2. Example of the horizontalization process from an interview transcript (Participant 7; Lines 220-242).

Participant 7: Yes. **Many people say, “If you are ugly, you cannot be gay.” In the beginning, I was pushed to work out, and to pay attention to my face, my fashion, and my physique because I’m gay.** But with time, I feel like there can be ugly gay people. Like physically, not very attractive gay people. **I also think it’s a media thing. Like only beautiful, white, Caucasian, Anglo-Saxon gay people are pictured in the media.** It’s funny. On Tuesday, there were librarians talking about queer catalog in libraries. I could tell she was very supportive of gay people, but all those pictures in the catalog of lesbians and gay guys, those pictures, they were all white. So, I was like, “Girl, thank you! But can you try to include some diversity?” **That’s the thing, you look around on**

media and all the gay people are white, muscular and pretty. Or at least not overweight. So, like, that was one motivation that pushed me to change. And then, I'm just interested in looking pretty. I enjoy looking pretty, so that too. And also, you know, exercise and weightlifting are ways to relieve pressure or stress. So, speaking of my body image, I would say it's not the best and not the worst. Many people are worse than me so I cannot complain. At least, I will never get overweight because it's so hard for me. My family members are all skinny, so yeah

Interviewer: Okay, so given how you just described your body image, how do you think that perception has impacted your sex life over the years?

Participant 7: Well it's sad but it's true. Like when you look in the mirror naked, you are going to have more confidence. I think I personally enjoy sex more right now because I have more confidence, and second, with more muscle there is more to play with. Also, you receive more compliments, like regarding your thighs, your butt, your chest, and stuff like that.

The next step in data analysis involved formulating meanings for each of the extracted and coded significant statements. This was performed to enhance the researcher's understanding of the data, as well as his intuitive ability. Morrow, Rodriguez and King (2015) describe the creation of formulated meanings as the process by which "the researcher identifies meanings relevant to the phenomenon that arise from careful consideration of the significant statements."¹⁵⁴ This involved reviewing the statements surrounding each identified significant statement in order to maintain the contextual significance of the verbatim transcriptions. One

hundred and sixty-five (165) formulated meanings were derived from the 165 significant statements, and each formulated meaning was coded with the same number as its corresponding significant statement. Table 3 below demonstrates the process utilized in this study to develop formulated meanings from significant statements. Appendix 5 presents all coded significant statements and respective formulated meanings that were relevant to the study objectives.

Table 3. Examples of coded significant statements and corresponding formulated meanings.

Participant Number	Lines	Coding Number	Significant Statement	Formulated Meaning
1	207	1	Other STIs yeah for sure. I already had chlamydia, but also gonorrhoea, syphilis.	Previous history with chlamydia influences current worry about contracting another STI.
3	210-211	37	But for now, if you contract HIV, you'll be taking meds for the rest of your life, and I don't want to be weighed down by that.	Fear of HIV influenced by its permanence and that you have to take meds the rest of your life.
5	303-305	76	But in the middle of sex, it might have been with my ex or with some other random person, but in the middle of it, I had this random thought of, "This is weird and wrong". Like just randomly.	Unexpected internalized homophobia experienced during sex with a man.
10	178-179	136	I'll make something up. I would say I'm tired, I don't feel good, or whatever because I don't feel comfortable naked.	He will make excuses to avoid sex if he is not feeling confident with his body.

Meaning Units and Emergent Themes

The next step in the data analysis is to collate the formulated meanings into broader meaning units, which are then clustered into emergent themes that are common across all accounts.¹⁵⁴ The 165 formulated meanings were organized into thirty-one (31) coded meaning units. Table 4 below illustrates how the formulated meanings were aggregated into meaning units in this study. Subsequently, Table 5 describes which meaning units were clustered to form the six emergent themes found during data analysis. These two tables demonstrate the researcher’s intuitive process to arrive at the emergent themes reported in this thesis. To review the full listing of the formulated meanings, meaning units and emergent themes in this study, see Appendix 6.

Table 4. Examples of the development of meaning units and emergent themes from formulated meanings.

Formulated Meanings (Coded Number)	Meaning Unit(s)	Emergent Theme
Despite always practicing safe sex and not being sexually selective to keep himself safe, he still contracted an STI. This contributes to why he has a large concern for STIs, because his safety mechanisms have failed in the past. (40)	History of STI	Fear of HIV and Bacterial STIs
Fear of STIs influenced by previous history of STI and internalized stigma. (41)		
Always has a fear of STIs despite practicing safe sex and being knowledgeable about STIs. This is due to previous history with an STI, and worry about being stigmatized by others. (46)		
Body image issues may stem from not meeting depictions of what gay men look like in the media, which is often white and fit/muscular. (63)	Media Representations	Body Image
Media images of gay men put pressure on MSM to try to conform to the gay mold that		

is depicted in media, which is often white, muscular and attractive. This can cause body image issues for MSM who do not feel like they meet that beauty standard, whether it be ethnicity, body type, etc. (103)

Thoughts and anxieties about his experience with sexual abuse are pervasive, and still affect him multiple times a day. (141)

Pervasive Thoughts

Sexual Abuse

If he is triggered during sex or foreplay, and is reminded of his sexual abuse, then he will lose interest in sex and need to stop. (142)

Table 5. Emergent themes and clustered meaning units.

Emergent Theme	Meaning Units
Definitions of Healthy and Satisfying Sex Lives	Frequency Consent, Comfort and Trust Informed and Safe
Performance Anxiety	Bottoming Anxieties Partner Perceptions Penis Size
Fear of HIV and Bacterial STIs	Fear of HIV Stigma History of STI Open Relationships HIV Permanence Position Choice PrEP and Condom Use Prevalence Testing History and Health Status U=U and Positive Partners
Internalized Homophobia	Culture, Family and Religion Heteronormativity Identity Avoidance Position and Partner Choice Pressure to Have Sex Taboo Sex

Body Image	Perceived Gay Beauty Standards Issues with Aging Media Representations Muscularity and Fitness Overweight Partner Opinions and Comparisons Sexual Avoidance
Sexual Abuse	Internalized Homophobia Loss of Autonomy and Desire for Control Intrusive and Pervasive Thoughts

Developing a Composite Description of the Phenomenon

The goal of data analysis in descriptive phenomenological research is to produce an exhaustive or composite description that captures the essence of the phenomenon, i.e., the common underlying structure(s) of lived experiences of the phenomenon. First, structural and textural descriptions of the participants' lived experiences with the study phenomenon are developed based on the emergent themes and significant statements. These are descriptions of what is being experienced with the study phenomenon (structural), and the contexts or settings that influence how participants experience the phenomenon (textural).¹¹ Next, these structural and textural descriptions are incorporated into a composite description that reports the essence of the phenomenon.

While not a requirement of Moustakas' methodological approach to data analysis in qualitative research, Colaizzi's method states that the researcher should return to the participants for validation of the composite description reported in the study.^{12,153} This step was undertaken to maintain methodological rigor and ensure the trustworthiness the study's findings. Eight of the eleven participants in this study agreed to be contacted and sent the final composite description of the study phenomenon for validation purposes. All eight consenting

participants were sent the exhaustive, composite description of the study phenomena (see page 108 for the composite description) in order to validate that it accurately represented the participants' lived experiences of sexual anxiety. All eight of the participants confirmed that the researcher's composite description of sexual anxiety among non-monogamous MSM corresponded with their own lived experiences, and accurately reported the essence of the phenomenon. Therefore, participant validation of the composite description of the phenomenon yielded no new or relevant data.

Methodological Rigor

The goal of methodological rigour in qualitative research is to ensure that researchers accurately depict and interpret the experiences of the participants involved in the study.¹²⁷ Without rigour, qualitative research findings can become falsified, insignificant and irrelevant to clinical practice, policy change or everyday life.¹⁵⁵ Earlier approaches to methodological rigor and validation in qualitative research insisted on the use of parallel equivalents to quantitative research. This included internal validity, external validity, reliability, and objectivity.¹⁵⁶ However, Ely et al (1991) argued that the use of quantitative terms and positivist research language "is not congruent with or adequate to qualitative work."¹⁵⁷ Similarly, Lincoln and Guba (1985) suggested the use of alternative terms in qualitative research that apply to more naturalistic concepts. They stated that trustworthiness in qualitative research entails four aspects: credibility, transferability, dependability, and confirmability.¹⁵⁸ The following strategies were utilized to maintain methodological rigor throughout this study.

Prior to the commencement of the study, the researcher identified and acknowledged any presuppositions with the study phenomenon so as to not compromise the analysis and interpretation of the data. These included previous experiences, understandings and assumptions regarding the study population (MSM) and the phenomenon of interest (sexual anxiety). Phenomenological researchers are required to be consciously aware of how their personal preconceptions and previous experiences can impact the conduct and interpretation of the research,¹¹ and ensure they do not impose their own ideas or agenda during data collection and analysis. The Husserlian technique of bracketing, which was discussed in chapter 3, promotes rigor by identifying, listing and reflecting on the researcher's presuppositions before commencing data collection and analysis. These are discussed in the researcher's positionality statement in chapter one of this thesis.

Purposeful sampling was selected as the recruitment strategy in this study. The inclusion criteria required participants to have had sex with another male within the last 6-months of the interview date. This was done to ensure that all participants were sexually active and identified as MSM, so that they would yield information that was relevant to the research question and necessary for the study objectives. Additionally, all interview audio files were transcribed verbatim by the researcher to ascertain an accurate report of the interview discussion. This is considered fundamental to the management, analysis and interpretation of verbally generated data in qualitative research.¹⁵⁹ However, a dangerous flaw of transcribing data is the potential for transcription error. In order to prevent transcription error in this study, all transcripts were proof read and cross-referenced (with the respective audio file) three times in order to accurately represent the participants' experiences.

Participant validation was employed in this study in order to confirm the accuracy and trustworthiness of the research findings. Interestingly, Colazzi's method (1978) is the only approach to data analysis in phenomenological research that requires returning to the participants for validation to ensure that their lived experiences are accurately captured and articulated by the composite description of the study phenomenon.¹⁶⁰ Therefore, participant validation was used to ensure methodological rigor in this study.

To ensure the credibility of the current study, an audit trail, or auditable trail of decisions, was recorded throughout data collection and analysis. According to Wolf (2003), "the audit trail helps to establish the credibility of qualitative research and serves to convince the scientific community of their rigor."¹⁶¹ Briefly, an audit trail is a document that allows researchers to retrace the process by which they arrived at their final findings.¹¹ In order to ensure that a rigorous and auditable process was adhered to throughout this study, all coded significant statements, formulated meanings, meaning units and emergent themes were reviewed by the thesis supervisors. Appendices 5 and 6 illustrate the researcher's auditable trail of decisions for the extraction of significant statements, creation of formulated meanings, and the development of broader meaning units and emergent themes.

Summary of Chapter

This methods chapter described the research strategies utilized for conducting this descriptive phenomenological study. Participants were recruited using purposeful sampling, and data collection was performed using a series of face-to-face, open-ended, semi-structured interviews. The Moustakas and Colazzi approaches to data analysis in phenomenological

research were used. Data in this study were analyzed via the extraction of significant statements, formation of formulated meanings, and development of meaning units and emergent themes. Ethical considerations including participant safety, confidentiality, anonymity and consent were also addressed. Lastly, the chapter concluded with a discussion of the methodological rigor of the research presented in this thesis. The following chapter will present the findings from this study, providing an understanding of sexual anxiety through the experiences of eleven HIV-negative identifying men who have sex with men.

CHAPTER FIVE: RESEARCH FINDINGS

Introduction

This research findings chapter focuses on the major themes that emerged from participants' descriptions of their lived experiences of sexual anxiety. From eleven interviews that were transcribed verbatim, 165 significant statements that pertained to the study objectives were identified, distilled and coded. Subsequently, 165 formulated meanings were derived from the coded significant statements (Appendix 5). These formulated meanings were then clustered into thirty-one meaning units, which were further merged into six emergent themes (Appendix 6). The findings reported in this chapter will be discussed thematically, with each emergent theme being defined and supported using direct quotes from participant transcripts. This is followed by a composite structural-textural description of the phenomenon, which illustrates the essence of sexual anxiety among non-monogamous MSM.

Healthy and Satisfying Sex Lives

As part of the study objectives, this research sought to understand perceptions of healthy and satisfying sex lives among MSM. The emergent theme of *healthy and satisfying sex lives* was defined as the factors that participants deemed critical to sexual satisfaction and fulfillment. These included pleasure, frequency of sex, being informed and safe, and consent, comfort and trust.

Most men in this study emphasized that a certain frequency of sex is required for a satisfying sex life. When asked what, in their opinion, is a healthy and satisfying sex life, one participant stated:

“When you are having sex on like a regular basis with partners that you have some kind of connection with.” (Participant 4; Lines: 11-12).

Another participant also iterated a desire for sex on a regular basis:

“... a healthy sex life is when you’re having sex on a regular basis, with people you like and are presumably attracted to.” (Participant 9; Lines: 9-11).

Moreover, some participants provided a specific frequency of sex that would be satisfying for them:

“In my own opinion, a satisfying sex life is one where I’m having sex regularly. So, three times a week would be regularly. Maybe like where I’m getting to do all the things I enjoy doing as well.” (Participant 8; Lines: 20-22)

“I would say having sex on a semi-regular basis. What that means, personally for me, I prefer to be in a monogamous relationship. And in that monogamous relationship, I would say sex three times a week, maybe more.” (Participant 5; Lines: 19-21)

Mutual consent, comfort and trust were described by participants as key aspects of a healthy sex life. Among MSM, healthy sex occurs when all parties agree to what happens during sexual activity, and when neither feels judged for their sexual interests. One participant noted:

“Healthy sex would be first of all, consenting from both parties. And sex that fits into what everyone is comfortable with in every situation... So, for me, as long as everyone is comfortable with the situation and what is going on, then it’s healthy.” (Participant 2; Lines 15-19)

Another highlighted the importance of being able to openly communicate one’s sexual interests and desires with a partner, and feeling comfortable enough with them to explore new things:

“What that means to me is being able to be open to your partner about your preferences, your interests. Being able to explore things with your partners, and also feeling safe in the choices that you do make with your partner, even if they don’t particularly pertain to your interests.” (Participant 6; Lines 4-9).

The same participant then explained that he desired confidentiality between him and his partners in order to achieve comfort and satisfaction in his sexual relationships:

“Like if that person were to kiss-and-tell, that’s also a concern, right? Cause that’s also part of a healthy sex life for me is that if I wish for it to be confidential, it remains confidential between those who I choose to share with.” (Participant 6; 17-19).

For some participants, feeling sexually fulfilled (pleasure) and free of harm highlighted their perceptions of a healthy and satisfying sex life. One participant stated:

“A healthy sex life is where your sexual needs are met, and you feel satisfied, and there’s no harm to you, physical or emotional.” (Participant 8; Lines 6-7)

Furthermore, another suggested that pleasure and the ability to achieve orgasm defines satisfying sex, while also echoing other’s opinions about desiring mutually consenting sex:

“Oh, satisfying sex? Um first you are able to achieve orgasm. Second, the whole process is comfortable, and whatever you do is mutually agreed.” (Participant 7; Lines 24-25).

Lastly, the majority of the study’s participants described a healthy sex life as one in which everyone involved is informed about their sexual health status (regarding HIV and other STIs), and presumably can make decisions to prevent the transmission or acquisition of STIs.

Correspondingly, some participants broadly defined a healthy sex life as one that is mutually informed about each other’s health status:

“And healthy in terms of being informed about their sexual health, them knowing my sexual health, and knowing what I am getting into and agreeing to.” (Participant 3; Lines 18-19).

“...personally, sex with a partner in a relationship where you know each other’s status, or at least have an idea that you know each other’s status, that’s healthy.” (Participant 5; 35-37).

Whereas, other participant opinions were more specific, and stressed the importance of using condoms and regular testing to a healthy sex life:

“Healthy sex would be safe sex, or at least like PrEP, condoms, getting tested regularly.” (Participant 11; Line 18).

“...being safe, like using condoms, especially if it’s a one-night stand. If not, making sure you are being tested regularly.” (Participant 5; Lines 8-9

This was further supported by one participant’s focus on testing frequency and his emphasis on discussing sexual health with a partner before engaging in sexual activity:

“... you should be constantly aware of your sexual health situation. Like you get tested, every 3-months, 6-months, or at least every year. You know like your testing frequency.

Third, every sex you have should be based on mutual consensus. And enough communication with the partner about what you are going to do, if one of you have any STDs, and like whatever you want to talk about. Like there has to be a pre-sex discussion.”
(Participant 7; Lines 10-15).

Among participants in this study, prominent factors that defined a healthy and satisfying sex life included having frequent mutually consenting sex that is free from both self-judgement and judgement from sexual partners. In addition, participants expressed a desire to be informed about their own and their partner’s sexual health status in order to facilitate decisions to reduce exposure to HIV and other STIs. It is likely that that sexual anxiety among MSM is experienced when a sexual encounter, or one’s overall sex life, deviates away from what is perceived as healthy and satisfying.

Performance Anxiety

The second emergent theme in this study, *performance anxiety*, centred around participants’ concerns over being judged by sexual partners. Performance anxiety in this study was defined as negative thoughts and disbeliefs regarding one’s ability to perform well during sexual activity. This theme corresponded to a decrease in sexual confidence among the study population, and was found to influence preferences for sexual activities and positions. The meaning units that contributed to the development of this emergent theme included bottoming anxieties, penis size, and partner perceptions.

Lack of experience with receptive anal sex (bottoming), was a concern for some men in this study who felt their lack of experience would prevent them from being able to perform well. For this reason, some MSM may prefer being the insertive partner (topping) during anal sex. One participant explained:

“Yeah, I’m more confident with topping for sure. I don’t think I know how to bottom very well. But maybe that’s the thing, like you only learn how to do something is by doing it and I’m not all that much experienced. So, I’m more comfortable topping.” (Participant 8; Lines 290-292).

In addition, lack of experience with receptive anal sex can also be anxiety provoking due to potential discomfort or pain, as a participant noted:

“I learned to enjoy both because before I would only top. But as I grew older and slept with more people, some people have helped me experience or experiment. So now I find both will bring me pleasure, but I more naturally tend towards topping just because sometimes I’m worried that I won’t be a good bottom... Let’s say I’m out of practice, then it will be more difficult or hurt more, for example, until it gets into the right feeling.” (Participant 2; Lines 279-287).

Moreover, another participant suggested that receptive anal sex can be anxiety provoking out of fear of having a feces-related accident:

'However, it is more anxiety provoking. Cause like I'm always afraid I'm going to have an accident when bottoming, so there's that anxiety.' (Participant 1; Lines 285-287).

He then elaborated that he has to prepare if he knows he will be the receptive partner, which causes some anxiety in comparison to when he knows he will be the insertive partner:

"... when you are bottoming, you can't do it on the fly. I have to watch what I eat, prepare myself mentally right? Like "Oh I'm going to bottom today", I need to wash up and get myself ready. Whereas topping, it can happen in the moment. I don't really need to prepare, watch what I eat or anything like that." (Participant 1; Lines 289-292)

Interestingly, one participant explained how his previous negative experiences with feces-related accidents during anal sex has influenced his sexual preferences. He expressed his preference for sexual activities other than anal sex:

"So other things that cause me anxiety that you haven't mentioned, and I'll just be forthcoming, is shit. Like literally human excrement. Because I, as a top and as a bottom, this has been an issue. And it makes me not prefer anal sex." (Participant 3; Lines: 532-534).

While not a popular topic of conversation during the interview discussions, one participant described how his penis size contributes to performance anxiety. He explained that while he may like to be in the insertive role, because of his penis size, he is often assumed to be and accepts the role of the receptive partner:

“Well I feel like this is kind of personal, but I don’t have a large penis. And if I had a larger penis I would top a lot more. So, um sometimes I feel like because I have a smaller penis, I get positioned in the bottom role.” (Participant 1; Lines 356-358).

Concern over partner judgement was also found to contribute to the experience of performance anxiety among the participants. One participant clarified that performance anxiety can stem from sex with new or unfamiliar partners, as there may be expectations as to the quality of sex:

“I would say anytime it’s someone new or just a hook up, I definitely have a sense of like unease. I think we always go into these situations with a set of expectations, on like both sides. And especially in gay culture, there is a certain expectation that when you hook up, it’s going to be like certain things. It’s going to be super hot, super intense and all these things. I’ve had other conversations with other gay friends about this and similar ideas, and it gives you more of a sense of why there’s a sense of anxiety, because sex is supposed to go a certain way.” (Participant 4; Line 150-156).

A different participants' narratives highlighted that partner perceptions can cultivate sexual anxiety or confidence, depending on if it's negative or positive, respectively. He explained that his history of positive feedback and reactions from partners has helped him not worry about how he is performing during sex:

“And you know, from feedback; I’m not saying I’m good all the time, but I haven’t had any bad feedback, whereas I have had really good feedback. Which again doesn’t mean that everyone I had sex with thought I was amazing, because in some cases I probably wasn’t, but it’s not something that worries me.” (Participant 2; Lines 413-415).

Moreover, the small size of the MSM community in Ottawa itself may also breed performance anxiety as it relates to partner perceptions. As one of the participants explained, there is an onus to perform well with a hook up or casual partner, lest negative rumors spread about one's sexual abilities:

“I think that, especially if it’s a hook up, and let’s say you live in a smaller place, well people talk. So, it’s always about like, having a good performance.” (Participant 4; Lines 162-164).

In summary, participant descriptions suggest that experiences of performance-related sexual anxiety among non-monogamous MSM are largely focused on partner perceptions of one's sexual performance. This can result in sexual reluctance and reduced sexual satisfaction.

Fear of HIV and Bacterial STIs

The emergent theme of *fear of HIV and bacterial STIs* was critical to the lived experiences of sexual anxiety among MSM in this study. This theme was defined as anxiety or worry regarding the transmission or acquisition of HIV or bacterial STIs, such as chlamydia, gonorrhea and syphilis, during sexual activity. Fears of HIV and bacterial STIs were found to influence many aspects of the sex lives of the participants, including partner choice, position preferences, and decisions to avoid or engage in sex. The meaning units that comprised this emergent theme were fear of HIV stigma, history of STI, HIV permanence, prevalence, PrEP and condom use, open relationships, position choice, and U=U (undetectable = untransmittable) and positive partners.

For gay, bisexual and other men who have sex with men, fear of stigma from within and outside the MSM community is a major contributing factor to their fear of HIV acquisition. As one participant admitted, stigma against HIV has become internalized over time and causes him anxiety around contracting HIV:

I guess just the stigma is still there within the community and even within myself. It's kind of like the fear that's been instilled in me right, like growing up? (Participant 1; Lines 233-235)

There was also held beliefs in the sample that HIV stigma from outside the community is a unique experience to MSM, as heterosexual individuals do not understand or need to worry about the risks of HIV to the same degree as sexual minority males do. One participant noted that his heterosexual friends tend to associate sex between men with HIV:

“...even from straight friends sometimes. Like even when I go on a gay cruise. I haven’t been on one, but I was telling a friend about my interest in one, and she’s like, “Oh be safe though, and take the PrEP.” And I’m like, “Oh shut up, you wouldn’t say that if I wasn’t gay.” I know they wouldn’t.” (Participant 8; 240-243)

This was supported by another participant who felt that, unlike with heterosexuals, stigma toward HIV and anxieties around HIV acquisition are a large part of the gay male sexual experience:

“Because there is such a stigma with attached to HIV, even though you are totally fine to live with it. It’ll influence your life but not to the same degree that it would in 1993. But I would say there is always something at the back of your head. Like compared to my heterosexual friends, they are not worried about HIV in the same way that I worry about it, or my gay friends do.” (Participant 5; Lines 164).

Some participants voiced concern that HIV stigma stemming from the AIDS (acquired immunodeficiency syndrome) crisis of the 1980s has instilled negative thinking and misbeliefs in their family members. Because of this, they expressed anxieties around either being stigmatized by their family if they were to contract HIV, or having the disease be burdensome on their family:

“So, HIV concerns me a lot because there is a huge stigma about it. Like if I contract HIV, I would tell my parents, I’m very open with them. And they would be fucking terrified because they grew up through the 80s, right? They lived through the AIDS crisis. I know it’s not a death sentence anymore, I know it’s not as big of a deal any more. But it’s not a good thing to have, HIV.” (Participant 3; Lines 199-203)

“So, there was the HIV/AIDS scare that came and that has a huge stigma that carries with it within the community and outside. One of the biggest things, well I don’t have to disclose my family, but declining health or a drastic change in lifestyle will definitely begin to bleed towards my family and the likes, and that’s a conversation I would not like to have. So, there’s social stigma and stigma within the community you would have to worry about.” (Participant 6, Lines 198-202).

In addition, a participant who is not a Canadian citizen discussed how policies regarding immigration and work/study permits stigmatize against HIV and gay men. He explained that his anxieties around HIV are exacerbated by worries of being sent back to his home country if he were to contract HIV while in Canada:

“I feel like, if you are not Canadian, you are going to be extra worried. Because you have to stay inactive for HIV anti-body if you want to keep your school or work period effective.” (Participant 7; Lines 113-115).

For the majority of men in this study, the fear of HIV was greater than the fear of bacterial STIs. This was attributed to the permanent nature of HIV infection. When asked what concerns them more, HIV or bacterial STIs, most participants stated HIV given there is no cure:

“Yeah. I think HIV is my main concern... Like other STIs are more preventable. Not preventable sorry, treatable.” (Participant 1; Lines 167-169).

“Well other STIs are treatable in a sense that, you know, you get chlamydia, get the treatment and then it’s gone. So that’s why I am less concerned with catching chlamydia or gonorrhea. That’s basically it, the treatable thing.” (Participant 2: Lines 176-178).

“I think HIV. Because once you are positive for HIV, you are non-convertible to be negative again. So, it’s the permanent thing. And also, most STIs are more like visible and more possible to cure.” (Participant 7; Lines 203-205).

Another reason for greater fear of HIV that was cited by participants in this study is the requirement to be on medication for the rest of your life in order to maintain a low viral load and prevent the development of AIDS. One of the participants broadly stated:

“But for now, if you contract HIV, you’ll be taking meds for the rest of your life, and I don’t want to be weighed down by that.” (Participant 3; Lines 210-211)

And another discussed his concern of being reliant on medication access that may not always be guaranteed:

“I know that there are good ones out there, but having my life reliant on this system is not what I want. And I know it’s no longer the cocktail that you have to take every day, which is good. So, it’s great that we’re advancing, but it’s scary to think that if I lose my access to the medical or medication system, then that could shorten my life span drastically. So, I guess I don’t like the permanence of it, and it’s very scary to think about.” (Participant 6; Lines 210-215).

Interestingly, permanence of disease was not unique to just fear of HIV in this study, as one participant mentioned that antimicrobial resistance in bacterial STIs has increased his anxieties around contracting one:

“...I think its chlamydia or gonorrhoea that’s becoming “super”. Like antibiotic resistant STIs because it’s been so common and treated that I guess the bug has evolved to the point where it’s harder to treat. So that concerns me. And then there are STIs like Herpes that are incurable. So, I’m concerned less about chlamydia, and I’m concerned less about crabs, but HIV and the super gonorrhoea are concerns of mine.” (Participant 3; Lines 212-216).

Not surprisingly, the prevalence of HIV and bacterial STIs among MSM contributed to the experience of sexual anxiety in the study sample. One participant stated that due to how common HIV is among MSM, he has a fatalistic view of HIV despite being as safe as he can:

“Getting HIV, I feel like it actually is a manifest destiny. Like it’s going to happen to me at some point... I just feel like, I can be as safe as I can, and I am very safe, and I’m choosy about who I sleep with. But I just feel like it’s so common. Like I know people who are 18 and have HIV.” (Participant 3; Lines 587-590).

However, like with permanence, the meaning unit of prevalence was not unique to just fear of HIV, as another participant express concern regarding the rise of syphilis among the MSM community:

“I started talking to my friends about it and everybody would say, “Syphilis is a thing in our community, it’s on the rise.” They did a study, and the rates have increased by like 400% in the last 5 years. I couldn’t believe it! So, I am so cautious because I know how easy it is to be transmitted during sex.” (Participant 8; Lines 101-104).

Moreover, fear of bacterial STIs was often expressed by participants in this study who reported a history of STIs or STI scares. For one participant, his previous experience with a chlamydia infection has caused him to reevaluate his safe sex practices and decisions:

“I feel like I could be safer sometimes. I don’t use protection for oral. And I did end up catching chlamydia in my throat.” (Participant 1; Lines 36-37).

Another participant discussed his frequent concern regarding STI infections during sex due to having his usual safety mechanisms fail him in the past:

“I never bareback. If I were to have sex with somebody, I need to know a bit about them. I’m not a straight to it kind of guy, I’m not a one-night-stand type of guy, or an anonymous type of guy. However, I still got something. So, it’s kind of like a roll of the dice.” (Participant 3; Lines 271-274).

Furthermore, for some participants, STI scares, and not actual diagnoses, were enough to increase their anxiety around contracting bacterial STIs. As one participant explained, an STI scare caused him greater worry and led him to start using PrEP:

“And last year I got a call from the sexual health clinic, from the city, and they said I was exposed to syphilis. Like through secondary contact. I freaked out, and that’s when I went on PreP after. I went down to the city, got the penicillin shots, got tested, and I didn’t have it. But needless to say, it made me more worried about sexual health or contracting an STI.” (Participant 8; Lines 97-101).

Due to the impact that fear of HIV and bacterial STIs can have on the sexual satisfaction and wellbeing of MSM, participants had developed coping mechanisms to decrease sexual anxiety and improve autonomy over their sexual health. Pre-exposure prophylaxis, condom use, and being informed of one's own and their partner's sexual health status, through regular testing and having pre-sex discussions, respectively, were described as preventative measures for sexual anxiety among the study's participants. In regards to PrEP use, participants currently using PrEP explained how it has helped reduce their concern for contracting HIV during sexual activity:

"But right now, I don't really feel like I have any HIV concerns because PrEP is like a perfect iron shield around it. And then condoms add... well it's a perfect second wall behind the wall of having a condom." (Participant 11; Lines 181-183)

"I'm more concerned with other STIs. Because I'm on PreP, my main partner's on PrEP, my compliance with taking it every day is really, really strong, and I've been on it for two years. So, I feel like PrEP is pretty good." (Participant 4; 138-140)

"I would say that it helped, at least practically. Because it does lower you chances of getting HIV. I'm less hypochondriac than I used to be." (Participant 7; Lines 94-95).

For the participants who were not on PrEP at the time of the interview, PrEP use appeared as an enticing option that would likely allow them to forego condoms more often. As one of the

participants not on PrEP suggested, PrEP is helpful in directing decisions to use a condom or not during anal sex:

“I usually try to use protection when I am doing anal, since I’m not on PrEP or anything like that.” (Participant 1; Lines 158-159).

“So usually if there isn’t a condom then I won’t do anal sex, unless they are like, “oh I’m on PrEP.” (Participant 1; Lines 175-176).

Another participant expressed interest in PrEP in order to not have to use condoms, thus improving his sexual satisfaction. However, he feared this may increase his concern surrounding other STIs:

“Um I use condoms, so it’s not as enjoyable for me. So, I feel like maybe I should get on PrEP and bareback? But then I have a concern about the other STIs. But I feel like maybe I’ll like it much more, right?” (Participant 3: Lines 550-551).

Correspondingly, PrEP may make it more difficult to use condoms and protect oneself from bacterial STIs due to pressure from sexual partners to have unprotected anal sex. As one participant explained:

“It’s just hard because more and more people are getting on PrEP. And I guess since I’m on PrEP and they are on PrEP, the most frequent question I get asked is, “Well why not?” They’d be like, “you’re on PrEP, I’m on PrEP, we both get tested and go to the doctor every 3 months. Why don’t you just do bareback?” (Participant 7; Lines 73-76)

The same participant then expressed that even in a situation where he knows he is safe from STIs, sex without a condom still causes him concern and sexual guilt following the sexual encounter:

“If they are on PrEP and they can verify like when they got tested, an exact date that’s pretty recent, I might give in. But after I may sometimes feel bad, like bad that I gave in. And after, I might have some concerns because I took a risk” (Participant 7; Lines 84-86).

Similarly, a different participant stated that he always uses condoms, regardless of the partner or situation, as it is one of the only ways he can help mitigate his worries around contracting a STI:

“I always use a condom, I never bareback. Like the last time I barebacked, I don’t remember. There was one time I can remember since I moved to Ottawa a few years ago. And then before that, I don’t know. So, I always use a condom for the large majority of my sex. But that’s because I am scared of, or I worry about STIs...” (Participant 3; 154-157).

For some participants in this study, fear of HIV affected their position preferences and choice of sexual practices during a sexual encounter. As one participant explained, he prefers to be the insertive partner during anal sex in order to reduce his risk of HIV acquisition:

“...the one piece for me that I feel awkward or have a mental block is that usually I’m a top, but I’m somewhat verse. But I’d still rather, at this point, not bottom for someone because the risk is higher. Even though if I know that they’ve been recently tested, that I’m on PrEP, and things like that, there’s still like, I don’t know, a mental block.” (Participant 4; Lines 306-309).

Another stated that he will refrain from engaging in anal intercourse if he feels he may be at risk of catching an STI, such as when he has casual sex with an unfamiliar partner:

“I also don’t often don’t penetrative sex with a hook up because there’s a bit of an anxiety of catching something.” (Participant 5; Lines 139-140).

Furthermore, for MSM in this study who were in open relationships (a relationship where two people are each other’s primary romantic and sexual partners, but are mutually allowed to have sex with other people), a rule of consistent condom use was implemented to prevent the risk of HIV or other STIs coming back into the shared bedroom:

“Well we talked about that. We discussed certain rules and wearing condoms when having sex with someone who isn’t our partner.” (Participant 2; Lines 156-157)

“Well we have safe sex [with an outside partner]. It’s always with a condom.” (Participant 9; Line 95).

Another way that MSM protect themselves from HIV and bacterial STIs is to get tested regularly, and discuss sexual health with a partner before engaging in sex. By being aware of their own health status, as well as their partners’, participants in this study felt that they are able to make informed choices that protect their sexual wellbeing. One participant noted that frequent testing helps him not to worry about bacterial STIs:

“And syphilis, it can wreak havoc on your body, but I get tested frequently enough that it’s not a concern.” (Participant 3; 217-219)

However, he also expressed concern over the testing history of his sexual partners, as those who don’t get tested frequently may carry an STI. This causes him anxiety and leads him not to trust the information a partner may provide him:

“Also, because the people I’m sleeping with, not everyone gets tested after every sexual partner they have. They don’t always wait after the incubation period. So, you never

know, 100% for sure if someone is negative if they say they are. And some people may not get tested every 6 months, they may get tested only once a year.” (Participant 3; 71-74).

Correspondingly, another participant suggested that getting tested together and mutually sharing results with a sexual partner is one method of improving trust and quelling anxieties in a sexual relationship:

“Like some partners we’ve actually gotten tested. Like there are free health clinics, and we’d arrange a time to go and share our results.” (Participant 6; Lines 152-153).

In addition, having a pre-sex conversation about sexual health was imperative for some participants in this study, as it affected their decisions on whether to use condoms, or even to have sex in general. As one participant explained, discussing sexual health is necessary if he is going to have sex with someone:

“Whenever someone messages me asking to bareback, it’s like, “No stranger! You’re attractive but good-god that’s terrifying.” Like if you’re not even asking if I’m on PrEP or something, which is not on my Grindr profile, then no. I don’t even want to go near that if you’re not going to have that conversation.” (Participant 11; Lines 163-166).

Interestingly, men in the study agreed that online avenues of finding romantic or sexual partners, such as gay dating apps like Grindr, help facilitate discussions about sexual health and

may make it easier to navigate decisions around condom use. One participant suggested that the sexual nature of dating apps provides the confidence to ask potential partners about their sexual interests and sexual health status:

“Online it’s interesting because you end up more sexual. I think the conversations are way more sexual online. Everything is sexualized, you are not afraid to ask for pictures, nude pictures, you’re not afraid to ask about sexual preferences, or ask somebody about their HIV status and all those question like that.” (Participant 8; Lines 115-118).

And another said that the information that can be provided on dating app profiles promotes conversations about sexual health and condom use:

“I will say that I think it is easier online. The thing is that a lot of apps and stuff will have like certain information listed. You can put your status, you can put your safe sex practices. Some people put their testing date, and things like that. So, I think that’s really great and sort of facilitates the conversation.” (Participant 4; Lines 277-279).

Despite a prominent fear of HIV acquisition among the sample population, participants in this study expressed willingness to have sex with a HIV positive partner provided they had an undetectable viral load. For men in this study, knowing that an undetectable viral load corresponds to an exceedingly low risk of HIV transmission to a negative partner (undetectable equals untransmittable, or U=U) helped reduce anxieties around HIV acquisition. That said, some

participants stated that while they would have sex with a positive and undetectable partner, they would still use a condom to help ease their anxiety:

“...cause I know if someone has an undetectable viral load, then I can have sex with them and not worry about infection. But, I would still treat that person the same way as I would with any other person I meet and use a condom.” (Participant 8; Lines 360-363)

“Usually though, I would just use a condom. I think it’s better for me and for them too to not get any STI. I don’t have like a strong opinion about it, but I guess I’d prefer to use a condom.” (Participant 7; Lines 152-154).

Similarly, regardless of comprehending the extremely low risk of HIV transmission when having sex with a positive and undetectable partner, some participants reported that they would still need to use multiple methods of HIV prevention to quell anxiety sufficiently to have sex:

“If someone is HIV positive but undetectable, they can’t pass it on, they are essentially negative at the time. So also, with me being on PrEP and using a condom, then it’s like a whole extra level.” (Participant 4; Lines 301-304).

“I know that [U=U], and with our activities, especially if I’m on PrEP and we use a condom, there’s practically no chance of transmission.” (Participant 11; Lines 213-214).

Interestingly, other participants indicated that they are more confident having sex with someone who is HIV positive and undetectable than having sex with someone who says they are negative. According to one of these participants, this is because they believed that positive and undetectable individuals are more likely to be tested recently, and thus be aware of their sexual health status:

“If someone says that they are positive and undetectable, that I trust as well. Because they are aware of the status and have it under control. I’m a believer in the U=U, undetectable equals untransmittable. It’s usually people who like don’t get check often that worry me.” (Participant 1; Lines 188-191).

This view was supported by another participant who added:

“...there’s a theory or reality that people who are HIV positive and undetectable, are constantly in touch with their doctors, constantly tested, are on medicine to keep their viral load low and their HIV in check and make sure it does not transition into AIDS. And because they are so connected with their doctors and everything, they are more informed about their sexual health. Whereas people who are HIV negative, may get tested only every 6 months or every year, and then they are not getting tested as frequently, and therefore might contract something and unknowingly have it in their body and pass it on to other people, which is less healthy.” (Participant 3; 180-187).

In conclusion, fear of HIV and bacterial STIs is likely to be a predominant cause of sexual anxiety among most non-monogamous MSM. Fear of HIV appears to be a unique and multifactorial anxiety, rooted in HIV stigma, HIV permanence, and the prevalence of HIV within the MSM population. PrEP use, increased STI testing frequency, and engaging in pre-sex discussions about sexual health helped mitigate sexual anxiety related to fear of HIV and/or bacterial STIs among MSM in this study.

Internalized Homophobia

The emergent theme of *internalized homophobia* in this study was defined by the harmful effects that heteronormativity and homophobic messages have on participants' sexual identities, and their perceptions of sex with other men. In their narratives, participants who were affected by internalized homophobia described how this contributed to a repression of sexual identity, negative attitudes towards gay sex, and the development partner and position preferences. The meaning units that were clustered to form this emergent theme included culture, family and religion, heteronormativity, identity avoidance, taboo sex, pressure to have sex, and position and partner choice.

During the interviews, participants often cited two causes for their experiences of internalized homophobia: (1) cultural, religious or familial opinions, and (2) heteronormativity. For reference, heteronormativity is defined as the "cultural understanding in which heterosexuality is the norm and the resulting social institutions are based on the assumption that men are sexually and romantically attracted to women and women are attracted likewise to

men; the possibility of same-sex attraction is neither acknowledged by the public at large nor recognized by its social institutions.”¹⁶²

For participants who experienced a traditional or conservative upbringing, exposure to homophobic messages while growing up was not uncommon, and created a barrier they had to overcome in terms of self-acceptance. In some cases, this led to adverse mental health outcomes. One participant explained how his religious upbringing and feelings of family disappointment greatly impaired his mental wellbeing:

“When I was 18, I really struggled accepting myself because I did identify as a [member of a religion]. And according to [religion], being gay is a sin, right? So, I didn’t understand why I was gay and I didn’t want to be gay. I was like, ‘I’m the eldest son in my family. My parents expect me to have kids, and get married to a woman. How could I do this to my family? How could I betray them?’ So yeah it even came to the point where I was suicidal. And I was trying to find purpose, like why am I gay? Why am I this way? So, I’d ask myself a lot of questions like that. And I would take to umm, I would inflict physical pain on myself as well.” (Participant 1; Lines 527-533).

Another participant also iterated how his family and traditional upbringing caused him to struggle to accept his identity as a gay man:

“So, my family was very traditional in the scope that they did not accept homosexuality. And it took me a long time to first accept it myself because of the way I was taught

growing up that homosexuality was not a good thing. Like I was told that they are going to hell, that they were not of God's creation. So, I think that I definitely internalized, and took that in, right? When you're young, you idolize those around you, and when they express those thoughts and those feelings, you take them because you think it's coming from a good person and all of that. So, I had to overcome that first."

The same participant later mentioned that upon coming out to his parents, he was given false information which, at first, he internalized and that this dissuaded him from having sex with another man:

"It was understanding that when I first came out to my family, my mom expressed that if I were to have sex with another man, and I'm not joking I mean any kind, oral, anal or whatever the fuck you want to describe, that it would create AIDS." (Participant 6; Lines 314-317).

Others in this study discussed being unable to understand or accept their sexual identity while growing up due to low exposure to homosexuality. One participant explained how his heteronormative upbringing prevented him from understanding what it meant to be gay:

"I was so disconnected from anything homosexual. I didn't know what being gay meant. No one would talk about it. I didn't have any friends that would talk about it. The only time people would talk about it would be like making jokes. You know like, 'Ha-ha you're

gay.’ And I don’t remember what I felt back then about gays because it just wasn’t around. My parents and my family never talked about it.” (Participant 2; Lines 322-331).

Similarly, another participant stated that he faced internal hardships when he came out to himself, as he didn’t know what life outside the traditional, heteronormative husband-wife family dynamic meant for him:

“... when I first realized I was gay, I definitely went through period of depression. And I didn’t really know what to do because in my mind, my entire life was going to go a certain way... I always had this kind of expectation that my life had a course: I was going to university, then get a masters, and I was going to get married and have a kid. You know, live in the suburbs with a wife and kid. It was this whole thing. And when I suddenly realized that it was not my path, that it was no longer my path, I wasn’t happy about it. Like in my mind, my life was going to go a certain way and this very much derailed it. I guess I couldn’t see another life except for that. And that’s probably because I grew up in the suburbs, it was very upper-middle class, everyone was white, everything was heteronormative.” (Participant 4; Lines 474-484).

Heteronormativity appears to produce environments with low exposure to LGBT people and information, which may heighten the feeling of minority status among MSM. One participant equated his visible minority status to his minority status as a gay man, stating that there are

always going to be difficulties navigating the world when you are comparing yourself to the majority:

“It’s just like being [visible minority], you know what I mean? Like, why am I different from the people around me? Or like why am I different from those people on TV?... It’s because I’m different. And it’s hard. It’s hard in every country” (Participant 7; Lines 308-311).

Interestingly, despite most participants coming to accept their identity as MSM, for some, heteronormativity continues to affect their sex lives. In particular, this was true for those who reported being in an open relationship. According to these participants, they feel forced to hide the dynamics of their relationship from heterosexual individuals out of fear of judgement or misunderstanding. One of the participants in an open relationship stated:

“I think that sometimes as a gay man, a lot of anxiety from being in an open relationship actually comes from like, if people outside the queer community find out and certain aspects of that.” (Participant 4; Lines 37-39).

“I find anytime a cis- or like heterosexual person finds out, there are a lot of question because I think they don’t really get it or are judgmental.” (Participant 4; Lines 43-44).

This view was similarly held by another participant in an open relationship who felt that open relationships may be unique to sexual minorities, which prevents heterosexual individuals from understanding and accepting that type of relationship dynamic:

“Also, it eliminates that risk of, or it puts that spice of variety into the relationship. I know that’s sort of exclusive to gay men. I know heterosexuals aren’t as receptive to that. And I get that because they mate for different reasons, and we are a different species sexually than they are.” (Participant 9; Lines 68-71).

Because of this, that same participant explained that he feels the need to conceal the open-dynamic of his relationship from his heterosexual friends and neighbours:

“In my neighbourhood, we’re accepted as just another couple on the street. But I would never tell my neighbours. We would never tell my neighbours we do three-ways. As for my friends, as liberal as they are, maybe a couple of them know. I don’t think they would judge, I just think they would have a difficult time processing.” (Participant 9; Lines 80-84).

As previously mentioned, internalized homophobia can cause MSM to struggle to accept their identity. For some, this manifests as wishing to not be gay, and avoidance or denial of one’s homosexuality. For example, one participant described how societal attitudes towards homosexual relationships at the time he realized he was gay caused him to deny his sexual orientation and wish he was straight:

“I think growing up it was sort of understood that it was a thing, but it was bad. It was not desirable. And I had that sort of sexual awakening experience when I was young with my friend. That was like in 2002, so the Defensive Marriage Act was the big thing in the states. And even the gay marriage was very unpopular in 2005 when it was legalized at the federal level. So, for me, I knew it was something that was not desirable. I knew it was something that was kind of bad, or at least for other people who begrudgingly started having to accept gay people. So, once I realized that I would fall into that category, I wondered how I could wish this away and not be the case.” (Participant 11; Lines 280-283).

Others admitted to adopting homophobic attitudes and actions in order to deflect attention away from themselves and not appear as being gay:

“Oh yeah, I used to be super homophobic. Like I used to say a lot of homophobic things growing up just to deflect the attention off myself, right? To not come off as gay.”

(Participant 1; Lines 514-515).

“Well when I was younger, yes. Like I used to just walk away. Like if any gay man was getting close to where I was, I would move myself. And I would try to show myself as a different person. Like I would be more rude or cold just to avoid people seeing it.”

(Participant 10; Lines 244-246).

And for one of those participants, he stated that he is still greatly affected by internalized homophobia, and currently hides his homosexuality out of fear of being stigmatized by others:

“I never stop to say I’m gay. I can’t. I just can’t do it. I tried to go with the flow and just talk, but I just don’t say it. Like nobody at work knows... I’ve always been scared for people to know because I came from a country where still today bullying is okay, like to bully gay people.” (Participant 10; Lines 205-212).

This concealment of his sexual orientation has negative effects on his social and sex life, as it prevents him from being able to socialize with other gay men, thus hindering him from making new friends and meeting potential sexual partners:

“I don’t want to be associated with them [other gay men], you know? Sometimes I feel like, you know, if I’m off one day, I should to go out and have a couple drinks. I want to go to a gay club, and maybe hang out as a gay guy. And sometimes I get there, get to the building and then I turn around and go home.” (Participant 10; Lines 346-349).

For some men in this study, internalized homophobia caused sexual anxiety as it led to them to believe that sex with a man is wrong or “taboo”. As one participant noted, despite having sex with men, he remains uncomfortable with it:

“I guess I started feeling anxious when I started having it. So, I started having sex when I was 24. Just because it was such a taboo thing, like I was always on edge.” (Participant 1; Lines 85-86).

Furthermore, another participant described having invasive homophobic thoughts during sexual activity with other men:

“But in the middle of sex, it might have been with my ex or with some other random person, but in the middle of it I had this random thought of, ‘This is weird and wrong.’ Like just randomly.” (Participant 5; Lines 303-305).

And when this participant was questioned on why he believes this experienced occurred, he answered:

“It’s just that internalized homophobia and heteronormativity is so all encompassing that like, sometimes it will happen I guess.” (Participant 5; Line 309-312).

Interestingly, internalized homophobia was also found to influence partner preferences and position choices among some of the study participants. For instance, one participant explained how forced masculinity when he was younger has affected his taste in men:

“Yep, in choice of partners. Naturally, I’ll immediately flock to more masculine men, because feminine men are not quote, ‘a good thing’... I often had to present as more masculine than I was. So, you naturally start to associate that ‘masculine gay men are good, feminine gay men are bad...’ (Participant 6; Lines 328-334).

Moreover, in regards to sexual position preferences, experiences of internalized homophobia may impact these decisions. When discussing sexual practices and preferences, a participant stated:

“But I’ve noticed that there is a certain homophobia towards anal sex when you are the receiver, the bottomer. For example, when I told my brother that I enjoy both, I can tell he was, there was a bit of disgust around the receiving of anal sex. So, I think maybe on some level, that does sometimes impact how often I’m going to receive over how often I’m going to give.” (Participant 8; Lines 273-277).

Lastly, sexual anxiety resulting from internalized homophobia may also stem from messages and attitudes within the MSM community. Correspondingly, some participants felt gay culture may pressure MSM to emphasize sex, and lead to anxiety in men who are less sex-focused. For example, one participant reported worrying that he would be unable to find a monogamous partner due to the emphasis on sex among MSM, which has resulted in internalized messages that all gay men are promiscuous:

“But there is sort of a feeling that gay sex works differently from straight sex, biology withstanding. But it’s sort of like, the sex is first and then everything else follows afterwards. So, to a certain extent that I wonder if it would count as homophobia because you are presuming that all guys are like that. And that’s internalized from the message that men are just after sex with each other, and are not interested in relationships, or not capable of relationships. And it concerns me because if it’s true, then maybe I’ll never find what I’m actually looking for [a monogamous partner].” (Participant 11; Lines 329-335).

In addition, as one participant explained, his feelings that men were only interested in sex has caused him to worry about his appearance and desirability to other men:

“I think that gay culture, and perhaps we’ve moved slightly away from this as time has gone on, but there’s a big gay culture that is very much about sex. Especially if you go back in time a bit to when gay people weren’t as open and we were more repressed, sex was seen as one of the only things you could really do to be gay in a way. And since sex is so body focused, and everyone wants to be desired, so you want to look a certain way, so you can have more sex and attract a certain type of people and things like that.”
(Participant 4; Lines 420-425).

Among participants in this study, internalized homophobia was found to cause sexual anxiety, as it incited feelings of guilt and prevented some from having sexually satisfying experiences with other men. In addition, participants often cited heteronormativity as a key

contributor to the development of internalized homophobia among GBM. In order to overcome internalized homophobia-related sexual anxiety, some MSM may adopt coping mechanisms to increase comfort and confidence around sex with other men, such as partner selectivity.

Body Image

The emergent theme of *body image* in this study was defined by how participants' perceptions of their own physical appearance affects their sexual satisfaction and willingness to engage in sex. As expected, body image among MSM can play a large role in the experience of sexual confidence or sexual anxiety, depending on one's perception of their body and overall attractiveness. Contributing factors to body image-related sexual anxiety and/or confidence included perceived gay beauty standards, media representation, being overweight, muscularity and fitness, issues with aging, partner comparisons and opinions, and sexual avoidance.

Among the study participants, there was a common perception that one's physical appearance is tied to their identity as a sexual minority male. As one participant explained, there is an expectation for gay men to appear well-dressed and well-groomed, and those that are not may be stripped of their gay identity or presumed not to be gay by other members of the community:

"I think because we are very appearance-focused group at the moment, looking gay often comes with a status, right? You have to be rich, able bodied, often white..." (Participant 6; Lines 340-341).

“I’ve definitely been not perceived as gay because I dress down or don’t get a haircut sometimes. Which is kind of like, if I’m associated with a lower class, I’m also stripped of my identity of being gay. Which I find very fascinating because I’ve had gay men also ask me if I’m gay. They’ll be like, “Oh I never would have assumed.” And I always press the question, “How the hell do you look gay?” (Participant 6; Lines 352-355).

In addition, for some men in this study, they have internalized messages that the ideal gay male body is that of a young, slim, and muscular white man. This can cause MSM who feel that they do not fit this idealized “mold” to have negative body images and perceive themselves as less attractive. One participant stated that he felt he is often seen as less attractive because he is not Caucasian:

“Hmm I feel like sometimes people, like I don’t know how to say this. It’s like, especially in Ottawa, like the community perceives if you are more Caucasian or white, you are more attractive. So sometimes, or most times, I feel like my skin colour works against me.” (Participant 1; Lines 385-387).

Other participants commented on how they felt pressure to work out and prioritize their appearance in order to conform to the muscular and attractive image of what they believed a gay man is supposed to look like:

“Many people say, ‘If you are ugly, you cannot be gay.’ In the beginning, I was pushed to work out, and to pay attention to my face, my fashion, and my physique because I’m gay.” (Participant 7; Lines 220-222).

“Well I think like those messages that I said I was giving to myself are actually from the community. I think in the gay men’s community, there is a lot of messages we get about the chiselled body, the Adonis look. Youth it also privileged, and there is a hierarchy it seems with groups that are favoured in the community. Like white gay men with great bodies and stuff are at the top, and then it progresses down right? So, there’s that pressure to kind of fit in.” (Participant 4; Lines 183-187).

Not surprisingly, media representations of gay men were cited by participants as a common source of beauty standards and unrealistic body ideals among MSM:

“...the media itself puts pressure on people. If you look at any gay focused media, especially when I was younger, like late 1990s or early 2000s, it depicted the white, muscular, hairless mold of gay guy. And if you don’t fit that then you aren’t as desirable I suppose.” (Participant 4; Lines 425-428).

“I also think it’s a media thing. Like only beautiful, white, Caucasian, Anglo-Saxon gay people are pictured in the media... That’s the thing, you look around on media and all the

gay people are white, muscular and pretty. Or at least not overweight. So like, that was one motivation that pushed me to change.” (Participant 7; Lines 223-229).

Moreover, one participant described the potential negative effects on body image caused by gay porn and how the industry represents the male body. He noted this may be something that is unique to the MSM experience. Unlike with straight porn, the focus of gay porn is not on the opposite sex, but instead on other men who are often thin and muscular. This leads to body comparisons between oneself and the porn stars on the screen, and can cause harmful self-objectification. According to this participant:

“Think about straight porn for a second, there’s a guy but presumably you are looking at the girl. So, you are looking at something that is not you, your object of desire is not someone like yourself. Whereas when you are looking at another guy, or like two men having sex together, it’s like, “Okay I need to live up to an ideal.” Even though like, tops and bottoms are different, and might have different muscular structures and all that kind of stuff. But there’s like one symbol for sexual attraction, it’s the one that you yourself have to live up to. Whereas for a straight guy watching straight porn, they’re looking at the woman, it’s completely other. It’s not a same comparison.” (Participant 11; Lines 64-68).

For some MSM in this study, negative body images centered around being overweight. As one participant explained, he often perceives himself to be larger than he actually is:

“I’ve been struggling with this. I’ve started doing this fucking spin class every day for like a couple weeks. And it’s good, but it’s because I feel like I don’t look as good as I would like to look, like physically. I probably think I’m bigger than I actually am.” (Participant 51 Lines 192-194).

In addition, another participant discussed feeling shame when disclosing his sexual orientation because he did not feel his physique fits his own and others’ perceptions of what a gay man should look like:

“Absolutely, and embarrassingly enough, I think that’s one of the reasons I get more scared to say that I’m gay. It’s not that I’m afraid of being gay, it’s that I’m not fit, or not physically in the proper shape or physique that gay men are supposed to have.”

(Participant 11; Lines 87-89).

And a different participant described how being overweight is deemed unattractive among the gay community, even more so compared to society in general, as it is associated with femininity. Furthermore, he believed that MSM will go to the gym to put on muscle in order to avoid being perceived as feminine:

“So, like I’m overweight and I feel like in the gay community that’s even like a... I think in society itself that generally being overweight is considered with like not being attractive. And I feel like it’s even more so in the gay community” (Participant 1; Lines 324-326).

“And I think most guys try to think, like they associate being overweight with being feminine somehow. Umm it’s like a more feminine trait for whatever reason... Um and people I think because of their own insecurities, they don’t want to be identified as more feminine. Cause like growing up like being gay is associated with being feminine so they might have been teased for that or whatnot. So, I feel like now a good percentage of gay guys try to go to the gym and be more masculine. Or like try to define themselves as more masculine. So, something like that’s being more feminine, or like not fitting that definition, it’s unappealing.” (Participant 1; Lines 331-342).

Interestingly, another who felt he was overweight but preferred sexual partners who are thin and muscular discussed sexual anxiety and low sexual satisfaction as a result. He indicated he did not understand why sexual partners would find him attractive, as he perceives himself to be undesirable. This participant stated:

“... it’s feeling like that’s not desirable. Or at least I don’t find it attractive. And in fact, it’s almost a turn-off if others find it attractive. Like I’ve internalized that it’s not attractive, but I have it. And I still want to enjoy sex and enjoy others, but I find I’m turned off by

them if they're enjoying it. It's such a backwards way of thinking about it. I wonder what's underlying or going on underneath. It's disconcerting." (Participant 11; Lines 78-82).

The same participant later described a sexual encounter in which he experienced sexual anxiety and decreased sexual satisfaction as a result of his negative body image:

"There was another guy, he was very attractive but I just could not find myself aroused because we went into it like super quickly, as a matter of fact. And again, I felt this internal, "Why are you finding this attractive? Why are you enjoying this" And he clearly was, and he clearly enjoyed it. But I guess I felt reluctance, yes. Or like a shame about being naked, which may have contributed to feeling like I wasn't attractive." (Participant 11; Lines 135-139).

Furthermore, men in this study who felt that they were overweight experienced sexual anxiety resulting from their body insecurity. For one participant, this manifests as reluctance to undress in front of a sexual partner:

"I'm probably more reticent to be undressed, or quickly undress in front of somebody... I don't want to be objectified by them, or compare myself and feel like I'm fat, even though I'm not very large." (Participant 5; Lines 198-200).

And for others, their body insecurity sometimes causes them to avoid sex altogether:

“I think mostly it’s like, if I’m not looking hot, then I won’t have sex... I just feel like if I’m not looking good, who’s going to want to have sex with me?” (Participant 1; Lines 613 and 618).

I don’t want anybody. Like I’ve never been rejected by anybody for my body type or anything like that. But I still don’t like certain parts of my body and I don’t want to show it at first. (Participant 10; Lines 164-166).

I’ll make something up. I would say I’m tired, I don’t feel good, or whatever because I don’t feel comfortable naked. (Participant 10; Lines 178-179).

Intriguingly, some of these self-perceived overweight men mentioned experiencing greater sexual anxiety related to their body image after a sexual encounter compared to before or during sex. This appeared to be due to participants feeling increased vulnerability after sex and comparing their bodies to their sexual partners. As two of the participants stated:

“Not during the moment, but sometimes right after it. Like “oh look at him and then look at me.” It’s like I become more aware of what my body looks like afterwards. Like I feel shame sometimes in that regard.” (Participant 1; Lines 642-644).

“I feel like I’m more vulnerable after sex. Because when you’re into it, you’re into it and you’re not really paying attention. And then afterwards it’s like all the attention. You’re fucking naked and like cleaning up. You’re looking at him and he’s looking at you. So, I feel like you are a lot more vulnerable in that moment than you were before... Usually I’ll think that they are not as attracted to me afterwards than they were before or during.”

(Participant 5; Lines 204-212).

However, this experience was not unique to overweight MSM in this study. Another participant, one who exercises regularly and expressed relatively higher levels of body confidence, reported feeling insecurity and sexual anxiety when having sex with thinner men:

“Even now I go to the gym all the time and I’m still not 100% happy with my body. I think everybody, period, feels that way. I’m healthier and happier than I was, and I do think I am more attractive now than I was in the past, but it’s not like I’m 100% confident. But then I guess it does come into play because when I am having sex with people who are thinner than I am. I feel a bit insecure or self-conscious about my own body in comparison to them.” (Participant 3; Lines 324-329).

Exercising or going to the gym appeared to relieve some degree of sexual anxiety, or facilitate sexual confidence. Those that exercised regularly described improvements in their sex life as a result. The following statements illustrate the positive effects that working out had on body image and sexual satisfaction among the study’s participants:

“But I work-out a lot more now and am a lot happier with my body. I used to be like super twinkie, and now I am, well not that much muscular and then I got super hairy... but yeah, I’m much happier with my own appearance, and I think that’s translated to me being more confident over time. Especially when I think back to the past 4 or 5 years... Now I have more sex outside my relationship than I did before even though we were open. And I think it’s because I’m more willing now, or less shy to ask.” (Participant 4; Lines 184-194).

“Like when you look in the mirror naked, you are going to have more confidence. I think I personally enjoy sex more right now because I have more confidence, and second, with more muscle there is more to play with. Also, you receive more compliments, like regarding your thighs, your butt, your chest, and stuff like that.” (Participant 7; Lines 239-242).

“I think I as a person enjoy having sex more if it’s with a person that I am more attracted to. And maybe because I consider myself more attractive now, and that I’m fitter now... then I am able to get people who are more attractive. So maybe then that’s why I enjoy it more now.” (Participant 3; Lines 307-310).

Lastly, a couple of participants in this study discussed appearance and body image issues related to aging as a gay man. For one of these participants, he described how his appearance has

become increasingly important to him as he ages, stating that with gradually fading youth, he must work hard to maintain a level of attraction in order to continue to have sex:

“But I do know that as I’m aging, my body image seems to be more important to me. Do you know what I mean? Cause it’s like, ‘Oh I have less youth, so you better do something to balance it out or you’re not going to get to have sex.’ That’s the message I tell myself.”

(Participant 8; Lines 172-174).

This perception was supported by the narratives of an older participant who explained that he has experienced sexual anxiety as he has aged because he is no longer perceived to be as attractive as he used to be, and thus feels less desired and has less sex than he used to in his youth:

“So, my concerns are, um, learning to adjust to the fact that I’ve gone from somebody who is highly sexed to someone who is not... I think a lot of men defined themselves more in terms of their sexuality. I’m not saying that’s right, I’m not saying that’s wrong, it just is what it is. And I definitely did too. A lot of my social life and a lot of my pleasure came from my ability to have as much sex as I want.” (Participant 9; 162-169)

“So yeah, your perception of your body changes, and you’re also not as virile. So, it’s changed, and there’s definitely an element of sadness about it. In terms of wishing you

look now how you did back then so you can have sex whenever you want and with whoever you want again. But that's just the reality of it." (Participant 9; Lines 230-234).

In conclusion, body image dissatisfaction was found to cause experiences of sexual anxiety among participants in this study. Consistent with this, some men discussed experiencing reduced sexual satisfaction or willingness to engage in sex due negative perceptions of their own physical appearance. Most participants expressed that certain physical characteristics have become idealized in gay culture, and created a "mold" that MSM feel pressured to conform to in order to be able to have sex. These include youth, Caucasian ethnicity, and low body fat and high muscle density. Notably, MSM who feel they do not fit this mold may develop a negative body image, thus leading to experiences of sexual anxiety.

Sexual Abuse

The final emergent theme in this study, *sexual abuse*, was defined as negative thoughts or attitudes towards sex resulting from a history of being sexually abused or assaulted. For the men in this study who reported a history of sexual abuse (4 of 11), these experiences were associated with adverse and pervasive thoughts, a loss of sexual autonomy, and increased internalized homophobia. Correspondingly, the meaning units that were clustered to form this emergent theme were internalized homophobia, intrusive and pervasive thoughts, and loss of autonomy and desire for control.

MSM in this study who were sexually abused as either children or adults described sexual anxiety following the event, which resulted from a loss of sexual autonomy. As one participant

explained, being sexually assaulted impaired his self-efficacy to provide consent with future partners:

“I have been sexually assaulted, so that definitely changes my perception on sex, and availability of my body to other men, and the consent I can give. Because once it’s taken away from you, it’s difficult to gain that autonomy again. So, I definitely feel that, and looking back at it, I’m realizing that it’s kind of pervasive. It’s a desire to control what’s going on, control what’s happening.” (Participant 6; Lines 407-411).

In order to overcome this loss of sexual autonomy, participants described a desire for control during sexual situations, so as to prevent being hurt again. One participant mentioned that he now ensures his friends know where he is and that he has an escape plan if he feels unsafe or threatened by a sexual partner:

“Some precautions occur, or like I try to let a friend know where I’m at or I try to get to know them more before I go over now. So, like I have a strategy.” (Participant 1; Lines 127-129).

For another participant, he described ensuring control over sexual situations by taking things slow with new partners, and enforcing boundaries until he felt he was able to have satisfying sex that he consented to:

“Once I started having satisfying sex that I consented to, it became easier. I began by taking it slow though and making sure that if I was going to have a romantic or sexual relationship with a new guy, it would be on my terms and within my boundaries. I know it doesn’t seem like much, but it helped. After a while, I felt more and more liberated from those fears that I will be harmed again. There’s something really empowering about being able to retake charge of your own sexuality and sex life.” (Participant 8; 328-333).

Similarly, a different participant stated that enforcing his own boundaries with new partners was helpful to begin having satisfying sex again. He also revealed that reaching out to others for social support was beneficial in overcoming his trauma and sexual anxieties:

“I think actually having satisfying and safe sex has allowed me to work through some of that. Understanding that that’s not all I am. Practicing those boundaries and practicing safe sex has helped. Just reaching out to others who have also had those experiences and understanding that you are not alone in it. And to have somebody to just reaffirm that it wasn’t your fault helps too. Yeah, I guess it’s just looking for empowerment.” (Participant 6; Lines 456-460).

However, it should be noted that one participant who was sexually abused as a child reported that the event had little effect on his sexual autonomy or confidence. According to this participant, he had repressed or forgotten the memory to the point that when he finally

remembered years later that he was assaulted as a child, he was already sexually confident enough to not be affected by it:

“Because I didn’t know anything back then. And I kind of forgot about that. I was not able to remember that until like #metoo movement. They were saying everyone more or less, at one point in their life, they may have been sexually harassed. And I was like, ‘yeah that happened to me too, but only once.’ Now I think that’s kind of like harassment, but it doesn’t get to me very much. I feel confident it won’t happen to me again, you know?”

(Participant 7; Lines 355-359).

Despite utilizing coping mechanisms to regain control over their sex lives following sexual abuse, participants in this study described ongoing sexual anxiety in the form of intrusive thoughts or memories of the event. As one participant mentioned, he currently experiences memories of the event multiple times a day despite it being many years since he was sexually abused:

“And all this kind of stuff is always going inside, inside, inside. And it’s repeated in my mind. I think about it probably, 3 or 4 times a day. It’s still coming to me and it’s been so many years.” (Participant 10; Lines 281-283).

Correspondingly, another participant elaborated on how sex can sometimes trigger negative thoughts or memories of being sexually abused, resulting in him becoming disconnected from the moment and subsequently experiencing performance anxiety in the middle of having sex:

“Like sometimes I feel like I’m out of it, I’ll be thinking of it if I get a flashback. When you’ve been sexually assaulted, often having sex can trigger memories of that. And you get unfocused. I guess it’s like, you can’t have a conversation while you are distracted. I keep thinking of sex as a conversation between bodies, right? Like if one person is on their phone during the conversation, then they aren’t giving 100% into it, right? So, then you get caught up in this anxiety loop of “oh fuck, I’m not here”, so then you have to over-perform, but then maybe you aren’t listening fully now, and it’s a lot that just gets to you, and can cause a spiral.” (Participant 6; Lines 439-446).

Furthermore, the concept of being triggered during sexual activity was also iterated by the previous participant, who explained that experiencing memories of his sexual abuse during foreplay or sex can cause him to either lose interest or avoid sex altogether:

“It’s happened both. Depends if it’s at the start or in between. If it’s during sex and I feel that something that we are doing can bring me to that memory, then I can completely go and lose interest in everything and stop or avoid having sex.” (Participant 10; Lines 296-298).

Lastly, experiences of sexual abuse were also cited by participants as adding to feelings of internalized homophobia. According to one of the participants, being sexually harassed by an

older man when he was younger served to confirm false messages he was taught about gay men:

“I think early on you are taught that, like the way homosexuality is viewed is that gay men are perverts, in terms of inside [his family’s culture]. And that example kind of like fed into that image.” (Participant 1; Lines 575-577).

In addition, for some participants, their experiences of sexual abuse led to periods of repressed sexuality and avoidance of gay sex out of fear of being triggered or harmed again by another man:

“But for a while I avoided sex or thoughts of sex with other men because it could be triggering. Like I even tried to watch straight porn for a while because I feared watching two guys fuck may bring up a painful memory, you know? Like cause me to relive it. So, I guess there was a period afterwards where I was avoiding gay sex, but not anymore.”
(Participant 6; Lines 465-469).

“It happened when I was younger around when I was first coming out. And I think it shaped my perception of gay men and of my own identity. Well, at least for a bit. It made me scared to trust other men. I started to dislike myself for being gay and putting myself in a situation where I could be harmed by another man like that. I put up walls from

myself and others, and repressed my sexuality, repressed myself, for over year afterwards.” (Participant 8; Lines 316-320).

In one case, the experience of sexual abuse led to prolonged self-loathing, internalized homophobia, and repressed sexuality:

“And I hated myself, I hated my sexual organs for some time in my life. It made me feel ashamed about being gay and I think that’s why I’m still uncomfortable around other gay men, or having others perceive me as gay.” (Participant 10; Lines 275-277).

In summary, a history of sexual abuse, either CSA or ASA, was found to cause sexual anxiety among participants in this study. For some MSM who were sexually abused by another man, these experiences caused adverse memories and flashbacks, leading them to avoid sexual activity, or deny or repress their sexual orientation altogether. Moreover, a history of sexual abuse may result in increased sexual anxiety among MSM, as participants described experiencing a loss of sexual autonomy after the event. These findings are concerning given approximately 1 in 5 MSM report a history of sexual abuse.^{1,111}

Composite Structural-Textural Description of the Phenomenon

The goal of descriptive phenomenological research is to develop an exhaustive description that captures the essence of the study phenomenon. This is done by integrating both textural and structural descriptions of the phenomenon into a composite description. Textural

descriptions explain what is experienced with the phenomenon of interest, and structural descriptions discuss the contexts or settings that influence how participants experience the phenomenon.¹¹ The composite description is thus an amalgamation of the structural and textural descriptions, which explains the essence, or common underlying structures of the phenomenon.¹¹ The following is a thematic composite description of the lived experiences of sexual anxiety among eleven HIV-negative identifying, non-monogamous men who have sex with men.

The first emergent theme explored MSM's perceptions of healthy and satisfying sex lives. According to the study participants, there are common factors that contribute to this. Participants described desiring mutually consenting sex on a regular basis (e.g., at least three times/week) that is free from both self-judgement and judgement from sexual partners. In addition, participants expressed the importance of being informed about one's own and one's partner's sexual health status in order to make decisions to keep themselves safe from risks of HIV and other STIs. Given these findings, it appears that sexual anxiety is experienced among MSM when a sexual encounter, or one's overall sex life, deviates away from what is perceived as healthy and satisfying. Moreover, depending on the context that facilitated experiences of the phenomenon, sexual anxiety among non-monogamous MSM is experienced in a variety of ways. Most commonly, these included lower sexual satisfaction, loss of arousal, and sexual avoidance.

Participants in this study who suffered from performance-related sexual anxiety explained that negative thoughts about one's perceived ability to perform well during sexual activity causes sexual reluctance and decreased satisfaction. Sexual reluctance was related to avoidance of or preference for certain sexual positions (i.e., insertive vs. receptive positions

during anal intercourse) due to fears of being unable to perform well, and thus having a sexual encounter reflect badly on them. Notably, performance-related sexual anxiety among participants was centred around partner perceptions of one's sexual performance.

The third emergent theme, fear of HIV and bacterial STIs, contributed most to the experience of sexual anxiety among participants in this study. Specifically, fear of HIV largely influenced sexual anxiety and sexual satisfaction among the study sample. The disproportionately high incidence and prevalence of HIV among the MSM population, and persistent stigma against HIV from within and outside the community, facilitate heightened sexual anxiety among MSM. In addition, the permanence of HIV largely contributes to anxieties around HIV acquisition. Sexual anxiety is experienced as avoidance of anal sex out of fear of HIV transmission, or as pervasive worrying thoughts about HIV during sexual activity. Interestingly, PrEP was described as an effective preventative measure for sexual anxiety due to its efficacy in preventing HIV transmission. However, PrEP may increase fear of bacterial STIs among users who use condoms less during anal intercourse. Given the high proportion of other STIs among the target population, anxieties regarding bacterial STI acquisition are not uncommon. Again, this can lead to pervasive thoughts during sex, or for some, undesired condom use, both of which decrease sexual satisfaction. Moreover, fear of HIV and bacterial STIs may be exacerbated by unfamiliarity with a sexual partner due to potentially being uninformed or misinformed about their sexual health status. Because of this, it is important for some MSM to engage in pre-sex discussions about sexual health and history. These discussions appear to provide a sense of autonomy and sexual safety, thus reducing sexual anxiety.

The fourth emergent theme in this study, internalized homophobia, explored the relationship between negative attitudes towards one's own homosexuality and experiences of sexual anxiety. For MSM burdened by internalized homophobia, sexual anxiety may be experienced as repression of sexual identity, or negative thoughts regarding sex with other men, which result in sexual reluctance and decreased sexual satisfaction. Participants with lower levels of self-acceptance (either currently or previously) discussed periods where they repressed or denied their same-sex attraction. Correspondingly, identity repression and avoidance resulted in sexual anxiety, as it prevented participants from engaging in satisfying sex with other men. Furthermore, heteronormativity and homophobic messages in society were observed to impact perceptions of gay sex among MSM, and facilitate sexual reluctance and decreased satisfaction among the study population. For example, some participants described experiencing decreased willingness to engage in sex, or general anxiety around their sex life, as a result of perceptions that gay sex was wrong or taboo. Because of this, some MSM adopt coping mechanisms to increase confidence and comfort with gay sex, such as partner selectivity, or preferences for being the insertive partner during anal sex, which may be perceived as a more masculine role.

The emergent theme of body image was related to experiences of sexual anxiety resulting from a participant's perception of their own physical appearance. For MSM in this study, body image dissatisfaction was associated with experiencing decreased sexual satisfaction and unwillingness to engage in sex. Participants felt gay men as a group are overly focused on the appearance of other men, and that representations of gay and bisexual men in the media emphasize physical characteristics such as youth, Caucasian ethnicity, low body fat and increased muscle density. Most participants felt these physical characteristics have become idealized, and

create a “mold” that MSM feel pressured to conform to in order to be able to have sex. MSM who feel they do not fit that description may develop a negative body image, leading to experiences of sexual anxiety. In particular, MSM who perceive themselves as overweight appeared to experience decreased sexual confidence and satisfaction, and several participants indicated a reluctance to be naked in front of a partner. Weight lifting and other forms of exercise were coping mechanisms for many participants with body image-related sexual anxiety. Men who perceived themselves as muscular discussed experiencing increased levels of sexual satisfaction, sexual confidence, and willingness to initiate sex compared to a time when they were not working out and felt they were less muscular. Given these findings, body image appears to be directly related to experiences of sexual anxiety and sexual confidence among MSM.

The final emergent theme in this study, sexual abuse, explored how a history of childhood or adult sexual abuse is related to experiences of sexual anxiety among non-monogamous MSM. This is particularly relevant given the prevalence of sexual abuse among MSM, with nearly one in five gay men having been sexually abused as a child. For men who were sexually abused or assaulted in their youth, these experiences can generate adverse memories and flashbacks, leading them to avoid sexual activity, or deny or repress their sexual orientation altogether. Some participants with histories of sexual abuse experienced sexual anxiety in the form of intrusive thoughts or memories triggered by sexual activity. Other participants described a loss of sexual autonomy, which is the ability to refuse sex or request a partner use a condom.¹⁶³ Coping mechanisms described by participants included desiring and asserting control over sexual situations so as to prevent future harm to their physical health and emotional

wellbeing. A history of sexual abuse among MSM may thus result in decreased sexual satisfaction, increased general anxiety, a loss of arousal and sexual avoidance.

Summary of Chapter

In this chapter, the research findings from semi-structured interviews with eleven HIV-negative identifying MSM were presented. Results pertaining to the study phenomenon, sexual anxiety among non-monogamous MSM, were discussed thematically, utilizing direct quotes from participant interviews to support the researcher's intuitive process and validate the reported findings. An exhaustive, composite description that incorporated structural and textural understandings was also provided. The objective of this composite description was to describe the essence of the lived experience of sexual anxiety among non-monogamous MSM. As hypothesized, a number of factors contributed to sexual anxiety among this population. These included performance anxiety, fear of HIV and bacterial STIs, internalized homophobia, body image dissatisfaction, and a history of sexual abuse.

CHAPTER SIX: DISCUSSION AND CONCLUSION

Introduction

This purpose of this descriptive phenomenological study was to identify the predominant underlying causes of sexual anxiety among non-monogamous men who have sex with men. This was achieved by utilizing a Husserlian (descriptive) phenomenological methodology to explore lived experiences of sexual anxiety among a sample of eleven HIV-negative identifying, sexually active, non-monogamous, predominantly younger MSM. Data collection was conducted via semi-structured interviews, which were audio recorded and transcribed verbatim by the researcher. Moustakas' structured approach to data analysis in phenomenological research was used to analyze interview transcripts. This allowed for the development of meaning units and emergent themes that described the phenomenon of interest. Notably, the study's findings demonstrated that there are multiple causes of sexual anxiety among non-monogamous MSM. In this chapter, the major findings from this study are discussed in relation to the relevant literature, and implications of the findings and recommendations for further research are provided. This is followed by an overview of the limitations of the study, and a conclusion to this research project.

Discussion of Findings and Recommendations for Future Research

The findings of this study are significant for several reasons. There is very limited information regarding sexual anxiety among MSM in the existing literature. Previous research has focused on sexual anxiety as a risk factor for HIV infection and sexual dysfunction, resulting

in significant knowledge gaps related to potential causes.² Although quantitative studies have found a few correlates of sexual anxiety among MSM, including internalized homophobia and body image dissatisfaction,²⁹⁻³¹ these factors had yet to be investigated as causal mechanisms. The research presented in this thesis attempted to address these gaps through a phenomenological inquiry of the lived experiences of sexual anxiety among younger sexually active, non-monogamous MSM. This allowed the researcher to develop a rich understanding of the phenomenon, while investigating the causes and effects of sexual anxiety in this population.

Six themes associated with sexual anxiety were found in this study, five of which may be underlying causes. These included fears of HIV and bacterial STIs, performance anxiety, body image dissatisfaction, internalized homophobia, and a history of sexual abuse. A composite structural-textural description of the study phenomenon was presented thematically in the previous chapter (page 108). In this composite description, what was experienced with the phenomenon, and the contexts within each of the above themes that influenced how participants experienced the phenomenon, were discussed. By providing an explanation of how the above themes result in experiences of sexual anxiety and reduced sexual wellbeing, this study clearly supports the idea that sexual anxiety among MSM is rooted in multiple causes and may provide a way forward to address and help reduce or resolve sexual anxiety for these men.

Sexual anxiety among the study sample was experienced when a sexual encounter, or a participant's overall sex life, was not congruent with their perception of healthy and satisfying sex. For MSM in this study, sex that is mutually consented to, occurs on a regular basis, and is free of emotional and physical harm, including risks of HIV and other STIs, was perceived as healthy and satisfying. Similarly, in a study of subjective factors that constitute the best sex life

among a large sample of GBM (N=12,129), Bourne et al (2013) reported that participants expressed desire for volume and variety in their sex lives, as well as for sex that is free from social, emotional and physical harm.⁹² These results, coupled with findings from the present study, highlight frequency and avoidance of harm (risk-free sex) as important factors for sexual satisfaction among MSM. By gaining an understanding of what individual MSM value for their sexual satisfaction and wellbeing, researchers and health care professionals may be able to engage MSM and help them achieve a more satisfying sex life that is congruent with their goals, and in turn, prevent sexual anxiety.

In a recent study of 1,443 MSM, Grabski and Kasperek (2020) found that performance anxiety significantly increased the odds of experiencing discomfort or pain during receptive anal intercourse.¹⁶⁴ This suggests that performance-related sexual anxiety may prevent men from fully engaging in sex and lead to reduced sexual pleasure and comfort. This was also found to be true among the current study's population. In this study, lack of experience with receptive anal intercourse was found to cause worries related to personal pleasure/discomfort and more prominently, concerns regarding partner perceptions of one's sexual performance and cleanliness. This led to sexual reluctance and decreased satisfaction among study participants.

According to Rich et al (2016), drug-use among MSM is linked to sexual roles, with amyl nitrates (poppers) being significantly associated with receptive anal sex.¹⁶⁵ It is suggested that MSM may use substances, such as poppers, before or during sex to alleviate anxieties, thus facilitating, enhancing or prolonging sexual pleasure.¹⁶⁵⁻¹⁶⁶ However, substance use among MSM is also associated with condomless sex and multiple sexual partners.¹⁶⁷ Interestingly, alcohol or substance use as a means of relieving sexual anxiety was not reported by participants in this

study. This may be due to the thematic guide not including questions pertaining to sex-related drug and alcohol use. As a result, discussions of alcohol or substance use were not prevalent or rich enough to constitute a meaning unit for one of the emergent themes. However, questions on the thematic guide (Appendix 1) were broad enough to allow participants to discuss whatever topics or contexts they felt were relevant to their experiences of sexual anxiety. Therefore, it is posited that if alcohol or substance use were important to the experience of sexual anxiety among the study sample, then this theme might have emerged whether or not it was directly addressed by the thematic guide. Regardless, several causes and effects of performance-related sexual anxiety were reported in this study, providing an increased understanding of the factors that undermine sexual satisfaction and wellbeing among MSM.

Performance anxiety in this study was found to be rooted in a fear of being judged and concern over a sexual partner's perception of one's sexual performance. In contrast, performance anxiety in the literature often refers to maintaining an erection long enough to satisfy a partner.^{7,92} Based on current findings, it is posited that partner perceptions contribute more to performance-related sexual anxiety among non-monogamous MSM than issues related to sexual dysfunctions or expectations of pain/discomfort during sexual activity. Future research should investigate performance anxiety and sexual confidence among MSM in order to better understand this issue, and develop strategies to address performance anxiety and the negative impact it can have on sexual and overall wellbeing.

Fear of HIV acquisition was a prominent cause of sexual anxiety in this study. This was due to participants' concerns regarding HIV stigma, HIV permanence, and the prevalence of HIV among MSM. HIV stigmatization from other MSM may facilitate a fear of HIV among

seronegative men for a number of reasons, including social exclusion, rejection, and discrimination based on health status. Indeed, a Dutch study found that over 70% of gay men living with HIV reported experiencing discrimination and rejection by HIV-negative gay men in the past year.¹⁶⁹ In addition, in another study, over 80% of MSM living with HIV reported worries of being rejected by sexual partners due to their positive serostatus.¹⁷⁰ These results support findings in the present study, which demonstrated that HIV stigma from other MSM contribute to a fear of HIV acquisition and to sexual anxiety.

Another factor cited by participants as contributing to their fear of HIV was the current prevalence of HIV among Canadian MSM. Considering that over half of prevalent HIV cases in Canada are among the MSM population,⁸⁶ it is understandable that HIV-negative men may experience anxieties around HIV acquisition. Moreover, prevalence of disease also contributed to fears of bacterial STI acquisition among participants in this study, as the high incidence of gonorrhea and chlamydia among MSM,^{86,94} as well as the increasing incidence of syphilis,⁹⁷ contributed to concerns regarding one's sexual health. As the present study is the first to explore both fear of HIV and fear of bacterial STIs among MSM, the researcher is limited in his ability to compare current findings to previous research. Interestingly, men in this study reported greater concern for HIV compared to bacterial STIs due to the incurability or permanence of HIV, which is a novel finding.

Koester et al (2018) reported that PrEP use among MSM may help reduce or alleviate fears of HIV, resulting in a decreased frequency of serosorting (practice of selecting a partner based on a perception that they are of the same HIV status).¹⁷¹ This was also observed to be true among participants in the present study. However, willingness of HIV-negative men to have sex

with a seropositive partner may be more strongly influenced by the partner's HIV viral load than by their own use of PrEP. Participants in this study, regardless of PrEP use, expressed a willingness to have sex with an HIV-positive man provided he had an undetectable viral load (defined as <50 copies/mL)¹⁷² and is therefore very unlikely to transmit the virus during sex. These findings highlight the early success of Canada's endorsement of the U=U (undetectable = untransmittable) campaign.¹⁷³ The increased willingness for serodiscordant (different HIV statuses) sexual relationships among MSM indicates reductions in HIV-related stigma. It should be noted, however, that some participants required multiple modes of HIV prevention, including PrEP, condom use and being the insertive partner, in order to have sex with an HIV-positive man despite the positive partner having an undetectable viral load. These findings demonstrate that fear of HIV drives the sexual experience of some MSM, as these men still required additional mechanisms to reduce sexual anxiety despite an exceptionally low risk of HIV transmission.¹⁷² Moving forward, improving the delivery of up-to-date knowledge of HIV and bacterial STI transmission risks to MSM individuals, as well as reducing barriers and increasing access to HIV prevention strategies, are recommended to facilitate informed sexual decision making and reduced sexual anxiety in this population.

Geosocial networking smartphone applications (apps), such as Grindr, are a popular means of meeting sexual partners among MSM. Correspondingly, Holloway et al (2014) found that meeting casual sexual partners ("hook ups") was the most frequently reported reason for using Grindr or online dating sites among MSM.¹⁷⁴ In a recent systematic review and meta-analysis, Wang et al (2018) reported that MSM using smartphone dating applications, like Grindr, are at significantly higher odds of having chlamydia, gonorrhoea and syphilis compared to MSM

that do not use these apps.¹⁷⁵ This may be posited to more frequent unprotected sex and a larger number of sexual partners among MSM app-users compared to non-users.¹⁷⁶⁻¹⁷⁷ It has thus been established in the literature that dating-app use is associated with greater STI risk among MSM. For this reason, it was expected that dating app use among study participants would be associated with concern for STIs and sexual anxiety. However, findings from the present study suggest that dating-app use may help reduce sexual anxiety by decreasing perceived risk of STI acquisition. Participants in this study reported that the general sexual nature of MSM dating applications, and the information that can be provided on app profiles, such as HIV serostatus, PrEP use or testing history, facilitate pre-sex conversations about sexual health and interests. This allows MSM to be more informed in their decision-making regarding condom use, sexual practices and partner selection, thus helping to reduce their perceived risk of HIV or bacterial STIs, and in turn, alleviate sexual anxiety. As this is a unique and novel finding, additional research investigating the effects of using dating-apps, such as Grindr, on perceived STI risk and sexual satisfaction among MSM is warranted to further increase understanding and confirm this conclusion.

This study also found that internalized homophobia was associated with experiences of sexual anxiety, which included repression or denial of sexual identity, sexual reluctance, and decreased sexual satisfaction. These findings are supported by results from quantitative studies, which have reported significant correlations between internalized homophobia and both increased sexual anxiety²⁹⁻³⁰ and decreased sexual satisfaction.^{39,53} Most men in the present study reported higher levels of identity acceptance, and thus could only describe past lived experiences of sexual anxiety linked to internalized homophobia. However, participants who still

suffered from internalized homophobia were able to describe how this led to experiences of current sexual anxiety. These findings illustrate that greater identity acceptance may reduce or prevent sexual anxiety.

Body image dissatisfaction was also found to cause sexual anxiety in this study. For example, some participants who believed themselves to be overweight experienced decreased sexual desire and satisfaction due to self-perceptions of being unattractive. It has been posited that values and norms among MSM place an emphasis on physical appearance, which may influence body image satisfaction, as men may feel pressured to conform to an idealized image.^{67,178} Findings from the current study support this, as well as demonstrate that media representations of gay and bisexual men have resulted in the cultural idealization of youth, Caucasian ethnicity, low body fat and high muscle density. Correspondingly, MSM who feel they do not fit this “mold” of a gay man may experience body image dissatisfaction and sexual anxiety. These findings were expected, however, as previous studies have found that that body image ideals among MSM are greatly influenced by media and social factors,^{65,67} and that media images of GBM frequently depict low-body fat and high muscle density as critical features of the gay male appearance.⁷⁵⁻⁷⁶ Interestingly, the present study also found that representations of the male body in gay porn may contribute to body image dissatisfaction and sexual anxiety. MSM viewing porn may identify with and compare their bodies to the porn stars they watch as opposed to being focused on the bodies of the opposite sex, as in the case with heterosexuals. This is likely due to the high number of mesomorphic, muscular and highly athletic looking men within pornography oriented towards gay men.¹⁷⁹ This may cause viewers to internalize beliefs that they need to possess a similar physique in order to be desired by other men.¹⁸⁰

MSM in this study further discussed internal and external pressures to conform to the idealized gay image. For example, in order to be perceived as attractive and be able to have sex, some participants reported feeling obligated to work out and obtain a thinner and more muscular appearance. This may be partly explained by Objectification Theory,⁷⁸ which posits that MSM experience pressure to conform to gay male beauty standards as they are attempting to attract other men, who in contrast to women, place greater preference on physical attractiveness.¹⁸² This can lead to self-objectification and constant monitoring of one's body and physical appearance, resulting in a negative body image.³¹ Moreover, participants also discussed feeling pressured to be muscular so that they are perceived as being masculine or less feminine. These findings are supported by those of Sánchez et al (2009), who reported that there is increased pressure among gay men to be physically attractive and appear masculine in order to be accepted by society and to be perceived as desirable by other gay men.¹⁸¹

Previous studies conducted among MSM have similarly found body image dissatisfaction to be significantly associated with negative sexual health outcomes, including sexual anxiety.³¹ However, some MSM with a negative body image address this through consistent exercise and weightlifting. In a study of 379 men (48% MSM), Mor et al (2014) reported that MSM believed the results of their training improved their confidence and desirability, and that men who participated in >4 hours of resistance training per week were significantly more likely to report a greater number of sexual partners in the last six months.¹⁸¹ Similarly, it was found in the present study that MSM experience greater sexual satisfaction and sexual confidence after increasing muscle density through regular exercise. However, due to the qualitative nature of this study, these findings may not be generalizable, particularly to MSM who are overweight or are

older.^{31,83,183} Further research is warranted among these groups of MSM to better understand the effects and mitigating strategies of body image dissatisfaction.

Prior to this study, it was unknown if a history of sexual abuse contributed to sexual anxiety specifically among MSM. This study found that MSM who are victims of either childhood or adult sexual abuse experience a loss of sexual autonomy. This loss of sexual autonomy, or one's ability to refuse sex or request a partner use a condom,¹⁶³ causes sexual anxiety, and leads to decreased sexual arousal and satisfaction among MSM. These findings are supported by results from studies conducted among heterosexual samples, which found that a history of sexual abuse is associated with sexual avoidance, low sexual desire, and decreased sexual satisfaction.¹⁰²⁻¹⁰⁴ Moreover, participants in the present study described experiencing intrusive and adverse thoughts or memories of an abusive event during subsequent sexual activity. These thoughts or memories resulted in a loss of arousal, sexual avoidance, or decreased sexual satisfaction for study participants, which highlights that sexual abuse causes subsequent sexual anxiety among MSM.

Brewin, Dagleish and Joseph (1996) suggested that PTSD symptoms among sexual abuse victims subside overtime, as the individual becomes less preoccupied with blame towards oneself and others, and regains a sense of safety and control.¹⁸⁴ Findings from the current study support this, as some participants reported developing temporary sexual avoidance/experiential avoidance, and an indefinite desire to control sexual situations following experiences of sexual abuse. This desire to control, however, may have been developed as a coping mechanism to help reduce initial PTSD symptoms, and mitigate ongoing sexual anxiety. Participants described establishing sexual boundaries, such as consent or avoidance of certain sexual

practices/positions, and enforcing them with sexual partners, as effective means of increasing sexual desire and satisfaction and preventing future harm to one's physical and emotional wellbeing. Therefore, practicing sexual boundaries may reduce sexual abuse-related sexual anxiety among MSM, as it helps men to re-establish a sense of safety and control over their sex lives.

It should be noted that this study did not ask participants to discriminate between childhood and adult sexual abuse, so it is uncertain if participants who described sexual abuse-related experiences of sexual anxiety were victims of one, the other or both. It is thus unknown if experiences of sexual anxiety differ among MSM who experienced sexual abuse as children or adults, as well as among those who experienced revictimization. Regardless, the common structures of sexual abuse-related sexual anxiety among the study's participants were reported, which highlight a history of sexual abuse as a cause of sexual anxiety among MSM. Further research investigating differences in sexual anxiety and sexual satisfaction among MSM of differing sexual abuse histories is recommended to better understand the effects of sexual abuse on the sexual wellbeing of MSM.

Several contexts in which performance anxiety, fear of HIV, fear of bacterial STIs, internalized homophobia, body image dissatisfaction, and history of sexual abuse can cause sexual anxiety were reported in this study. In addition, participant reactions to experiences of sexual anxiety were also discussed. Sexual anxiety among non-monogamous MSM was found to be experienced in numerous ways, and was more often associated with participant reports of reduced sexual satisfaction, loss of arousal, decreased sexual desire and sexual avoidance. It is interesting that no participants described sexual anxiety as leading to sexual compulsivity or

sexual abandonment. These findings highlight the negative effects of sexual anxiety on the sexual wellbeing of MSM, and help explain associations between sexual anxiety and negative mental health within this population.⁷⁻⁹ Since sexual anxiety was found to cause decreased sexual satisfaction and desire among study participants, and satisfying sexual activity has previously been found to be associated with a reduced risk for mental health problems, such as depression,¹⁸ it is posited that sexual anxiety may be associated with depressive symptoms and other mental health problems among MSM. Future research is warranted to investigate the strength of associations between sexual anxiety and mental health outcomes, such as depression, general anxiety and PTSD among MSM.

Implications for Health Services and Promotion

It has been established in the literature that MSM desire sex that is free from risks or worries of STIs.⁹² Findings from this study confirm this statement, and suggest strategies MSM can use to help mitigate their fears. The Centre for Disease Control and Prevention (CDC) in Atlanta has recommended that non-monogamous MSM who are sexually active undergo testing for HIV and other STIs a minimum of every three months.¹⁸⁵ However, the optimal periodicity of testing is unclear, and likely should be determined by the frequency of new partners. An Ottawa-based study found that over 30% of MSM patients with chlamydia or gonorrhea were asymptomatic.¹⁸⁶ This highlights the importance of routine sexual health screening to prevent inadvertent transmission of STIs. Consistent with this, being informed of one's sexual health status is important to personal and public health, as it facilitates early treatment of STIs, prompts notification of one's sexual partners who may have been exposed, and prevention of onward

transmission.¹⁸⁷ In addition, frequent STI testing, and thus being informed about one's sexual health status, can facilitate pre-sex conversations about sexual health and help MSM to make informed decisions regarding condom use, sexual practices and partner selection.

Correspondingly, these pre-sex conversations were found to help reduce perceived risks of HIV or bacterial STI acquisition, and in turn, mitigate sexual anxiety. Given these findings, it is posited that increased STI testing frequency among sexually active, non-monogamous MSM may not only reduce the risk of incident STI infections within this population but also help mitigate sexual anxiety and improve sexual wellbeing.

Due to its efficacy in preventing HIV transmission, PrEP was found to be an effective preventative measure for sexual anxiety. This was evident from participants' descriptions of less frequent concern and lower levels of anxiety regarding HIV acquisition since starting PrEP. These findings are supported by results from a recent study, which found PrEP use was significantly linked to reduced sexual anxiety among GBM.³² Therefore, physicians should consider prescribing PrEP to non-monogamous sexually active MSM in their practice as an effective means of reducing both HIV risk and sexual anxiety. However, it is critical that health care providers also provide PrEP patients with adequate information about reducing risks of other STIs. With the present and previous studies finding that PrEP use may lead to more frequent unprotected anal sex,⁹⁶ and since PrEP only protects against HIV and not bacterial STIs, MSM on PrEP may be at an increased risk of bacterial STIs. Correspondingly, sexual anxiety may persist or increase due to greater fear of bacterial STIs. Therefore, non-monogamous, sexually active MSM should be encouraged by the health care provider(s) to utilize various preventative measures to help decrease perceived risks of bacterial STIs, which may subsequently lower sexual anxiety and

improve sexual well-being. Preventative measures include condom use, increasing testing frequency and screening sexual partners (pre-sex discussions about sexual health and history).

In addition to HIV prevalence and permeance, HIV stigma was found to contribute to fear of HIV among the study sample. Notably, however, study participants reported willingness to have sex with an HIV-positive man provided he had an undetectable viral load. These findings suggest that knowledge of U=U may help lower HIV stigma and decrease the frequency of serosorting among MSM. This may improve sexual willingness and satisfaction among MSM experiencing sexual anxiety due to a fear of HIV acquisition. Moreover, these findings underscore the significance of delivering up-to-date knowledge about HIV and other STIs to the broader MSM population as a means of lowering both sexual health risks and sexual anxiety. Public health campaigns are encouraged to focus on delivering information regarding U=U, PrEP (effectiveness and accessibility), and STI transmission rates and sexual health testing (frequency and accessibility). Geosocial networking apps directed towards MSM, such as Grindr and Scruff, are popular avenues for MSM to search for sexual partners.¹⁷⁴ Given that Grindr use is associated with greater sexual risk behaviours and PrEP uptake,¹⁸⁸ these apps may be effective platforms for delivering healthcare information to the target population, non-monogamous, sexually active MSM, through advertisement campaigns. According to Hoenigl et al (2019), “PrEP promotional messages and linkages to care on the Grindr platform could enhance PrEP uptake, as well as increase testing for HIV and STIs.”¹⁸⁸

Based on study findings, which demonstrated that internalized homophobia may lead to sexual anxiety among MSM, men with internalized homophobia may benefit from greater social support and therapeutic intervention.¹⁸⁹⁻¹⁹¹ For men with internalized homophobia and minority

stress, developing healthy coping mechanisms through LBG-affirmative cognitive behavioural therapy (CBT) may help increase self-efficacy and decrease sexual anxiety. For example, Effective Skills to Empower Effective Men (ESTEEM), which is an LBG-affirmative CBT model designed for use among MSM, has been shown to significantly reduce depressive symptoms, problem alcohol use, sexual compulsivity, and condomless anal sex with casual partners compared to participants in a waitlist control condition.¹⁹² Moving forward, it would be nice to see future studies investigate the impact of sexual anxiety and internalized homophobia among MSM on overall wellbeing and sexual satisfaction, as opposed to simply number of partners and condom use.

Long term outcomes of sexual abuse victimization include substance use, depression, and PTSD.^{99-100,193} According to Chivers-Wilson (2006), symptoms of PTSD among sexual assault survivors include increased general anxiety and experiencing flashbacks or nightmares of the event.¹⁹⁴ Furthermore, Gold, Marx and Lexington (2007) found that a history of sexual abuse among MSM is associated with PTSD symptoms, experiential avoidance, and increased internalized homophobia,¹⁹⁵ which was consistent with participant narratives in the present study. Therefore, it is likely that MSM who are triggered by current sexual activity, and experience pervasive thoughts or memories of past sexual abuse, and/or increased general anxiety, suffer from PTSD and experiences of sexual anxiety. In addition, other studies investigating sexual abuse among MSM have found a history of sexual abuse to be prospectively associated with problematic alcohol or substance use, condomless anal sex and greater number of sexual partners.^{107,196-197} This may in turn increase the risk of revictimization, as both childhood sexual abuse and alcohol use are linked to adult sexual abuse among MSM individuals.^{107,196-197} Given these findings, and those found in the present study, early

intervention for all sexual assault victims is recommended to prevent negative mental health outcomes and future physical and sexual harm. Sexual assault victims may benefit from cognitive behavioural therapy, and in particular, trauma-focused CBT, which has been found to be effective in reducing negative outcomes associated with trauma exposure, including anxiety, depression and PTSD symptoms.¹⁹⁸⁻¹⁹⁹

Lastly, it is important for healthcare providers to become more informed about sexual anxiety, which is prevalent issue among MSM.¹ The present study found that sexual anxiety can lead to decreased sexual satisfaction and desire, and ultimately, impair quality of sex life. These findings highlight the importance of addressing this issue at the provider level in order to prevent the development of adverse health outcomes associated with sexual anxiety and dissatisfaction, including negative self-image, anxiety, depression and substance abuse.⁷⁻⁹ Based on findings from this research, sexual anxiety among MSM patients may be rooted in multiple causes and difficult experiences. Healthcare providers should be ready to enquire about sexual anxiety if sexual health and activity are issues among their patients, and be prepared to engage in open discussions on difficult topics such as internalized homophobia, body image, unprotected sex and sexual abuse.

Limitations

Due to the small sample size in this study (N=11), the research findings cannot be generalized to the wider population of men who have sex with men.²⁰⁰ However, the focus of qualitative research is on the quality and depth of data obtained from participants, and not on the number of participants that provide data.¹³² Therefore, purposive sampling was utilized to

recruit participants who could provide data pertaining to the study objectives.¹⁴⁸ This method of sampling introduces bias, however, as the subjective and non-probability-based nature of participant selection may lower the representativeness of the sample.¹⁴⁸ In order to reduce this bias, the researcher interviewed all individuals who expressed interest in the study, were eligible to participate, and were able to attend an in-person, audio-recorded interview. Moreover, investigating sexual anxiety among a relatively small, data-rich sample of MSM facilitated a thorough understanding of the study phenomenon, thus allowing the researcher to reliably discern and interpret data pertaining to the study objectives. This improved the validity of the study findings, as it prevented the analysis of data unrelated to the study phenomenon, thus ensuring that the pure essence of phenomenon was reported.²⁰¹

This study may have also been limited by the researcher's personal relationship with the target population. The researcher identifies as a bisexual male, and has been an active member within Ottawa's MSM community for multiple years. While the researcher believes his experiences as a bisexual male assisted him in establishing rapport with the study participants, it is possible his perceptions and biases influenced data collection and/or interpretation. Although bracketing of the researcher's presuppositions of the study phenomenon was performed to reduce bias in data collection and analysis, bracketing is not often a perfect process,¹² and thus may have not been fully successful in this study. In addition, it is also possible that, despite reassurances of confidentiality, participants may have felt the need to reserve or filter their responses out of potential concern for confidentiality and anonymity within the Ottawa MSM community. In hindsight, this study may have been strengthened by offering participants a choice of interviewers.

It should be noted that due to the COVID19 pandemic, and because data collection for this study involved face-to-face contact with participants, data collection was halted due to social distancing measures. Based on Public Health directives, the University of Ottawa ordered the cessation of all in person interviews for research purposes. While theoretical saturation was achieved in this study among a population of HIV-negative MSM, interviews with self-identifying HIV-positive men were ongoing, and theoretical saturations was not reached at the time in which data collection needed to be stopped. As a result, this thesis reports on the experiences of sexual anxiety among HIV-negative identified, non-monogamous MSM. Perspectives and experiences of HIV-positive MSM were not reported in this thesis. Future research is warranted to develop an understanding of the lived experiences of sexual anxiety among HIV-positive MSM, whose experiences may differ from those of HIV-negative MSM. For instance, sexual anxiety may be experienced as fear of HIV transmission among HIV-positive men, compared to fear of HIV acquisition among those that are HIV-negative.⁹²

Another limitation resulting from having to stop data collection early due to COVID-19 was that the study sample skewed young in terms of age – all but one participant (n=10) were aged 20-39. As a result, the experiences and perspectives of sexual anxiety among older MSM may not be fully represented in this study, and thus the study findings may be more applicable to younger MSM. Nonetheless, discussions regarding body image issues associated with aging across participant interviews were similar and frequent, which saturated the meaning unit, issues with aging, within the emergent theme of Body Image. Study findings suggested that as MSM age, they may feel that they are no longer as sexually desirable due to youth being idealized as an attractive characteristic within the MSM community. This can lead to sexual

anxiety and increased pressure to weightlift and exercise so as to maintain a certain level of perceived attractiveness in order still be able to have sex. However, it is possible that there are additional age-related factors that influence experiences of sexual anxiety among non-monogamous MSM which were not able to be explored in the present study. Future qualitative research comparing experiences of sexual anxiety between younger and older MSM is recommended to better understand how aging contributes to sexual anxiety among MSM.

Lastly, due to potential differences in sexual anxiety attributed to lower perceived-risks of HIV (i.e. fear of HIV acquisition) among monogamous MSM compared to non-monogamous MSM,¹⁴² and that sexual anxiety among monogamous MSM may be confounded by relationship stressors,¹⁴³⁻¹⁴⁷ this study excluded monogamously partnered MSM. It is likely that there are contributing factors to sexual anxiety that are unique to monogamously partnered MSM which were not reported in this thesis. These may include anxiety around relationship satisfaction and permanence,¹⁴³⁻¹⁴⁴ body image dissatisfaction but relative to one person as opposed to general self-perception,¹⁴⁵ power or financial differentials,¹⁴⁶ and possible intimate partner violence.¹⁴⁷ Future research comparing experiences and perceptions of sexual anxiety between monogamous and non-monogamous MSM is recommended to explore how relationship status contributes to experiences of sexual anxiety among MSM.

Conclusion

This descriptive phenomenological study sought to identify the predominant causes of sexual anxiety among men who have sex with men. Semi-structured interviews were used to explore the potential contributions of a number of correlates to sexual anxiety among non-

monogamous MSM. Data were collected from eleven HIV-negative identified, sexually active, non-monogamous, predominantly younger MSM, which allowed the researcher to obtain a rich understanding of the participants' lived experiences of sexual anxiety. This provided valuable insight into the causes and effects of sexual anxiety among MSM, and facilitated the development of a composite structural-textural description which explains the essence of the study phenomenon.

As part of the study objectives, this study investigated how perceptions of healthy and satisfying sex lives among MSM contribute to experiences of sexual anxiety. For men in this study, sex that is mutually consented to, occurs on a regular basis, and is free of emotional and physical harm, including risks of HIV and other STIs, was perceived as healthy and satisfying. Interestingly, it appears that sexual anxiety among MSM may be experienced when a sexual encounter, or one's overall sex life, deviates away from what is perceived as healthy and satisfying.

Another objective of this study was to develop an understanding of the factors that contribute to sexual anxiety among non-monogamous MSM. Performance anxiety, fear of HIV, fear of bacterial STIs, internalized homophobia, body image dissatisfaction, and history of sexual abuse were common factors associated with the lived experiences of sexual anxiety among MSM in this study. While these findings support results from quantitative studies, which reported positive correlations between sexual anxiety and fear of HIV,³² internalized homophobia,²⁹⁻³⁰ and body image dissatisfaction³¹ among MSM, they also demonstrate that there are additional factors associated with sexual anxiety among MSM. These include fear of bacterial STIs and a history of sexual abuse, both of which had not been investigated by prior research. Therefore,

this study established that sexual anxiety among MSM is multifactorial, as various underlying causes were found among the study participants. Moreover, several contexts in which each of the above factors can cause sexual anxiety were reported, and participant reactions to experiences of sexual anxiety were also discussed. Sexual anxiety among MSM was found to be experienced in a variety of ways, and was more often associated with reports of reduced sexual satisfaction, loss of arousal, decreased sexual desire and sexual avoidance, as opposed to sexual compulsivity and increased risk taking. These findings highlight specific negative effects of sexual anxiety on the sexual wellbeing of men who have sex with men.

The last study objective was to explore the preventative measures and coping mechanisms utilized by MSM to decrease sexual anxiety and improve sexual satisfaction. Given the negative psychosexual outcomes of sexual anxiety, along with the high prevalence of sexual anxiety among MSM,¹ mitigating the frequency and degree of sexual anxiety among MSM is critical to promote positive health outcomes in this population. Consistent with this, data from the current study can help inform and enrich strategies used by health care professionals to prevent or reduce sexual anxiety among MSM patients. Based on study findings, it was concluded that fear of HIV is a predominant cause of sexual anxiety among most MSM. This fear was found to be rooted in multiple factors including HIV permanence, HIV prevalence, and HIV stigmatization, which may be greater for MSM.¹⁶⁸ In addition, findings from the current study support previously reported associations between PrEP use and decreased sexual anxiety among MSM.^{32,91} Therefore, physicians should consider prescribing PrEP to patients as an effective method of both HIV prevention and sexual anxiety reduction. PrEP prevents HIV transmission with high efficacy, thus helping to alleviate fear of HIV acquisition and lower sexual anxiety.

Additional strategies that may reduce sexual anxiety related to fears of HIV and bacterial STIs among MSM include engagement in sexual healthcare. Increased frequency of STI testing and engaging in pre-sex discussions with sexual partners about sexual health and practices appeared to help mitigate sexual anxiety.

Notably, mechanisms to prevent or reduce sexual anxiety among MSM in this study were observed to be cause specific. For example, greater identity acceptance and belonging were found to lower sexual anxiety related to internalized homophobia, whereas becoming thinner and gaining muscle were reported to reduce sexual anxiety related to body image dissatisfaction. Correspondingly, recommendations for preventative measures and/or coping mechanisms were provided in this study for each proposed cause of sexual anxiety among MSM. However, since sexual anxiety was found to be multifactorial among MSM, health care professionals treating sexual anxiety should consider multiple underlying causes among their patients. MSM presenting with sexual anxiety should be screened to discern the underlying cause(s), and prevention and treatment options should be discussed accordingly, which may include behavioural, psychological, or pharmaceutical intervention(s). Although the present study provided insight into various methods of reducing sexual anxiety, the effectiveness of these strategies among the MSM population is unknown. Future quantitative research is warranted to investigate the measure of association between potential preventative factors, such as PrEP use and STI testing frequency, with reduced sexual anxiety among MSM. This will allow investigators to develop a greater understanding of the prevention needs among MSM, and recommend evidence-based interventions to reduce sexual anxiety and improve sexual wellbeing.

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Thesis Project – Thematic Guide

Study: Sexual Anxiety Among Men Who Have Sex with Men: A Phenomenological Study

Research Question: What factors contribute to the experience of sexual anxiety among men who have sex with men?

Time of Interview:

Date:

Location:

Interviewer:

Questions

- I. What does having a healthy sex life mean to you?
- II. What does having a satisfying sex life mean to you?
- III. How would you describe your sex life?
- IV. What are your biggest concerns regarding sex?
- V. How does your familiarity with a sexual partner contribute to your sense of confidence or unease and experience of sex?
 - a. Do you feel more or less trusting of a potential partner than you meet online vs. in person?
- VI. Does your sense of confidence or unease about sex change depending on the location in which you engage in sexual activity?
- VII. What are your thoughts on practicing safer sex (i.e., using a condom during sex)?
 - a. What factors contribute to your decision to either use or not use a condom during sex?
- VIII. Based on your current sexual practices, do you perceive yourself to be at risk for contracting/transmitting HIV? Why or why not?
 - a. Are you on PrEP? Why/why not?
 - b. Do you perceive yourself to be at risk for other STIs (ex. Syphilis, chlamydia or gonorrhoea)? Why or why not?
 - c. Do you find you are more concerned about HIV or about other STIs? How come?
 - d. Can you please describe how your worries about HIV and/or other STIs have affected your sex life and overall wellbeing (either currently or in the past)?
- IX. How do you feel about your body and physical appearance?
- X. How does your perception of your body and physical appearance affect your sex life?
- XI. How does being gay/bisexual contribute to your self-identity? Who are you out to?
- XII. Do you ever experience negative feelings or homophobic attitudes about yourself or towards other men who have sex with men?
- XIII. How do your perceptions of homosexuality and your identity as a man who has sex with men affect your attitudes towards sex?
- XIV. Do you have a history of sexual abuse?
 - a. If yes, can you please describe how that experience has affected your sex life?
- XV. Are there any other things that cause you to feel anxious or concerned about sex, or interfere with your confidence to engage in sex?



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PARTICIPANTS NEEDED FOR RESEARCH IN MEN WHO HAVE SEX WITH MEN (MSM)

We are looking for volunteers to take part in a study of sex-related anxieties and worries in men who have sex with men who meet the following criteria:

- Aged 18 or older
- Self-identify as a male
 - Have had sex with another male in the last 6-months
 - Are not currently in a mutually exclusive relationship
 - Ability to read and comfortably communicate in English

If you are interested and choose to participate, you would be asked to attend an interview session at the Ottawa Hospital, General Campus. Your participation would involve one study visit, which will be about one hour long.

In appreciation for your time, you will receive a \$30.00 honorarium in order to compensate you for travel costs and to cover time away from other tasks.

For more information about this study, please contact
the Research Coordinator, Cayden Peixoto.

Phone:

Email:



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PARTICIPANTS REQUIS POUR ÉTUDE AVEC HOMMES AYANT DES RELATIONS SEXUELS AVEC DES HOMMES (HSH)

Nous sommes à la recherche de bénévoles pour participer à une étude sur l'anxiété et l'inquiétude liées aux relations sexuelles chez les hommes ayant des rapports sexuels avec des hommes qui correspondent aux critères suivants :

- Âgés de 18 ans ou plus
- S'identifient comme homme
- Ont eu des rapports sexuels avec un homme dans les derniers 6 mois
- Ne sont pas présentement dans une relation mutuellement exclusive
 - Capacité de lire et communiquer confortablement en Anglais

Si vous êtes intéressé et choisissez de participer, vous devrez assister à une session d'entrevue à l'Hôpital d'Ottawa, Campus Général. Votre participation comprendra une visite d'étude d'une durée d'une heure.

En guise de remerciement pour votre participation, vous recevrez une rétribution de 30,00 \$ pour compenser votre temps et vos déplacements.

Pour plus d'information au sujet de cette étude, veuillez contacter le coordonnateur de recherche, Cayden Peixoto.

Téléphone:

Courriel:



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Minimal Risk Informed Consent Form for Participation in a Research Study

Study Title: A qualitative study of sexual anxiety in men who have sex with men.

OHSN-REB Number: 20190653-01H

Study Doctor:

Dr. Paul MacPherson, MD, PhD, Associate Professor, Department of Medicine, University of Ottawa.
(t): 613-737-8899 ext. 73896

INTRODUCTION

You are being invited to participate in a research study. You are invited to participate in this study because you are aged 18 or older, self-identify as a gay or bisexual male, have had sex with another male in the last six months, and are not currently in a mutually exclusive relationship. This consent form provides you with information to help you make an informed choice. Please read this document carefully and ask any questions you may have. All your questions should be answered to your satisfaction before you decide whether to participate in this research study. Please take your time in making your decision. You may find it helpful to first discuss it with your friends and family.

Taking part in this study is voluntary. You have the option to not participate at all or you may choose to leave the study at any time. Whatever you choose, it will not affect any current or future medical care that you receive outside the study. In addition, your decision will not affect your employment, volunteering, or extra-curricular activities.

IS THERE A CONFLICT OF INTEREST?

There are no conflicts of interest to declare related to this study.

WHY IS THIS STUDY BEING DONE?

We hope this study's results will help inform targeted interventions aimed at reducing or preventing experiences of sexual anxiety in men who have sex with men (MSM). The purpose of this study is to:

- Explore men who have sex with men's (MSM) perceptions and experiences of sexual anxiety before, during and after sexual activity in order to develop an understanding of the factors that contribute to sexual anxiety.
- Explore perceptions of healthy and satisfying sex lives among MSM.
- Explore coping mechanisms utilized by MSM to reduce sexual anxiety and improve sexual satisfaction.



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HOW MANY PEOPLE WILL TAKE PART IN THIS STUDY?

It is anticipated that about 30 people will take part in this study, from research sites located in Ottawa, Ontario. This study should take 4 months to complete and the results should be known in approximately 6 months.

WHAT WILL HAPPEN DURING THIS STUDY?

You will be asked to attend one 45-60- minute interview for this study. During the interview, you will meet with a member of the research team (Cayden Peixoto) at The Ottawa Hospital, General Campus. The interview will be conducted in a private room in order to ensure your anonymity and privacy. You will be asked to speak about your sexual health and practices, your perceptions of healthy and satisfying sex, and your experiences of anxiety or worry around the sexual aspects of your life. You will be audio recorded during the interview in order to obtain an accurate transcript of the interview discussion. The interview will be transcribed verbatim (word for word), so if you use anyone's name during the discussion, it will be replaced with a pseudonym (fake name) in the written transcript.

The information you provide in this study is for research purposes only. The questions are of a sensitive nature and the interview discussion may explore painful experiences, emotions or feelings. You can choose not to answer questions if you wish.

HOW LONG WILL PARTICIPANTS BE IN THE STUDY?

Your participation in this study will consist of attending a single 45-60-minute interview session.

CAN PARTICIPANTS CHOOSE TO LEAVE THE STUDY?

You can choose to end your participation in this research (called withdrawal) at any time without having to provide a reason. If you choose to withdraw from the study, you are encouraged to contact the research team.

You may withdraw your permission to use information that was collected about you for this study at any time by letting the research team know. However, this would also mean that you withdraw from the study. If you decide to leave the study, you can ask that the information that was collected about you not be used for the study. However, any data that has been combined with other participant's data for the purpose of analysis cannot be removed.

CAN PARTICIPATION IN THIS STUDY END EARLY?

Your participation on the study may be stopped early, and without your consent, for reasons such as:

- The research team decides to stop the study



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- The Ottawa Health Science Network Research Ethics Board withdraws permission for this study to continue.
- The University of Ottawa Health Sciences and Science Research Ethics Board withdraws permission for this study to continue.

If you are removed from this study, the research team will discuss the reasons with you.

WHAT ARE THE RISKS OR HARMS OF PARTICIPATING IN THIS STUDY?

There are no medical risks to you from participating in this study, but taking part in this study may make you feel uncomfortable. The interview questions and discussion can explore painful feelings, emotions, and experiences, as you may be confronted with problems or anxieties. This may result in increased levels of emotional distress, or worsening of symptoms related to mental health disorders. However, these effects are expected to be temporary. You may choose not to answer questions or leave the interview at any time if you experience any discomfort. If you experience significant emotional distress or poor mental health outcomes during the interview session, an appointment can be made with either a social worker or psychotherapist. They can also refer you to additional mental health services as needed.

WHAT ARE THE BENEFITS OF PARTICIPATING IN THIS STUDY?

You may not receive direct benefit from participating in this study. However, study findings will be of interest to both physicians and patients. We hope the information learned from this study will help inform targeted psychological or behavioural interventions aimed at reducing or preventing experiences of sexual anxiety in MSM, thus improving their overall health and quality of life.

HOW WILL PARTICIPANT INFORMATION BE KEPT CONFIDENTIAL?

If you decide to participate in this study, the research team will only collect the information they need for this study. Records identifying you at this centre will be kept confidential and, to the extent permitted by the applicable laws, will not be disclosed or made publicly available, except as described in this consent document.

Authorized representatives of the following organizations may look at your original (identifiable) study records at the site where these records are held, to check that the information collected for the study is correct and follows proper laws and guidelines.

- The Ottawa Health Science Network Research Ethics Board and the University of Ottawa Health Sciences and Science Research Ethics Board, who oversee the ethical conduct of this study.



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- The Ottawa Hospital Research Institute, who oversees the conduct of research at this location.

Information that is collected about you for the study (called study data) may also be sent to the organizations listed above. Your name, address, email, or other information that may directly identify you will not be used. The records received by these organizations may contain your pseudo-initials or pseudonym, sex, and partial date of birth (month and year).

Privacy and confidentiality will be maintained at all times throughout the study. Even though the likelihood that someone may identify you from the study data is very small, it can never be completely eliminated. Since interviews are to be transcribed verbatim (word for word), if you use anyone's name during the discussion, they will be replaced with a pseudonym (fake name) in the written transcript. If names or other identifying information is shared during the discussion, it will not be included in the written records.

The audio recordings and transcript data will be stored in password protected folders on an external hard drive that is only accessible to members of the research team. The audio recordings will be kept until they have been transcribed, and then they will be destroyed.

If the results of this study are published, your identity will remain confidential. All findings will be portrayed in a confidential manner, and no personal or identifiable information will be recorded or printed in the study. The information collected during this study will be used for the purpose of the researcher's Master's dissertation. In addition, it is expected that study findings will be published in academic journals and presented to the scientific community at conferences.

WHAT IS THE COST TO PARTICIPANTS?

There are no direct costs associated with participating in this study.

ARE STUDY PARTICIPANTS PAID TO BE IN THIS STUDY?

If you decide to participate in this study, you will receive a \$30.00 cash honorarium in order to compensate you for travel costs and to cover time away from other tasks.

WHAT ARE THE RIGHTS OF PARTICIPANTS IN A RESEARCH STUDY?

You will be told, in a timely manner, about new information that may be relevant to your willingness to participate in this study.

You have the right to be informed of the results of this study once the entire study is complete. If you would like to be informed of the results of this study, please contact the research team.



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Your rights to privacy are legally protected by federal and provincial laws that require safeguards to ensure that your privacy is respected.

By signing this form, you do not give up any of your legal rights against the researcher, study doctor or involved institutions for compensation, nor does this form relieve the researcher, study doctor or their agents of their legal and professional responsibilities.

You will be given a copy of this signed and dated consent form prior to participating in this study.

WHOM DO PARTICIPANTS CONTACT FOR QUESTIONS?

If you have questions about taking part in this study, you can talk to your study doctor, or the doctor who oversees the study at this institution. That person is:

Dr. Paul MacPherson

Principal Investigator Name

613-737-8899 ext. 73896

Telephone

If you have questions about your rights as a participant or about ethical issues related to this study, you can talk to someone who is not involved in the study at all. Please contact The Ottawa Health Science Network Research Ethics Board, Chairperson at 613-798-5555 extension 16719.



Study Title: A qualitative study of sexual anxiety in men who have sex with men

OHSN-REB Number: 20190653-01H

SIGNATURES

- All my questions have been answered,
- I understand the information within this informed consent form,
- I agree to be audio recorded during the interview session for data collection purposes as explained in this consent form,
- I do not give up any of my legal rights by signing this consent form,
- I agree to take part in this study.

Signature of Participant

Printed Name

Date

Signature of Person Conducting
the Consent Discussion

Printed Name and Role

Date

Appendix 5. Formation of formulated meanings from significant statements.

Participant Number	Lines	Coding Number	Significant Statement	Formulated Meaning
1	207	1	Other STIs yeah for sure. I already had chlamydia, but also gonorrhoea, syphilis.	Previous history with chlamydia influences current worry about contracting another STI.
1	613	2	I think mostly it's like, if I'm not looking hot, then I won't have sex.	If he doesn't not feel confident about his appearance, then he will avoid looking for or having sex.
1	618	3	I just feel like if I'm not looking good, who's going to want to have sex with me?	If he doesn't not feel confident about his appearance, then he will avoid looking for or having sex as he doesn't feel like anyone else is going to want him.
1	127-129	4	Some precautions occur, or like I try to let a friend know where I'm at or I try to get to know them more before I go over now. So, like I have a strategy.	I order to lessen anxiety about potentially being harmed by a sexual partner, he informs a friend of his location before meeting for a sexual encounter, and will also try to get to know the person better before sex to better screen out their personality and motives.
1	158-159	5	I usually try to use protection when I am doing anal, since I'm not on PrEP or anything like that	Tends to use condoms when having sex since he is not on PrEP. Suggests that largest concern is HIV, and that he may bareback more if he was on PrEP
1	167-169	6	Yeah. I think HIV is my main concern... Like other STIs are more preventable. Not preventable sorry, treatable.	HIV is scarier than other STIs, because unlike most other STIs, HIV is permanent/less treatable.
1	175-175	7	So usually if there isn't a condom then I won't do anal sex, unless they are like, "oh I'm on prep	Protects self from HIV by refusing anal sex if a condom isn't available. However, if a partner is on PrEP, it's a green light for him to be able to bareback because he assumes the partner is HIV negative.
1	188-191	8	...If someone says that they are positive and undetectable, that I trust as well. Because they are aware of the status and have it under control. I'm a believer in the U=U, undetectable equals untransmittable. It's usually people who like don't get checked often that worry me.	Would have sex with someone who is positive and undetectable because they are more likely to be aware of their health status (since they are seeing doctors more regularly) and are likely to have their health under control. It's anxiety relieving to know that they see doctors and are tested often compared to those who may only test once or twice a year.

Appendix 5 | Formation of formulated meanings from significant statements

1	233-235	9	I guess just the stigma is still there within the community and even within myself. It's kind of like the fear that's been instilled in me right, like growing up?	Fear of HIV is partly contributed to stigma against HIV from other MSM, and from false messages about HIV/AIDS while growing up.
1	246-249	10	...Just cause if I do end up being HIV positive, it's something that I would have to get treatment for. Treatment that would last me my life... Whereas when I caught chlamydia, I kept it under wraps. It was treatable...	His fear of HIV is caused by concerns of having to take treatment for entire life (i.e., not curable), and of having to disclose health status and sexuality to family
1	285-287	11	However, it is more anxiety provoking. Cause like I'm always afraid I'm going to have an accident when bottoming, so there's that anxiety	Bottoming can be anxiety provoking as worries about having an "accident" (i.e., poop) is there. No previous history of such accidents though, but he needs to prepare and clean up if he knows he's going to be bottoming
1	324-326	12	So like I'm overweight and I feel like in the gay community that's even like a... I think in society itself that generally being overweight is considered with like not being attractive. And I feel like it's even more so in the gay community	Has body image issues due to being overweight. This is an issue as in generally society, being overweight is deemed unattractive, and this is even more pronounced among gay men.
1	331-333	13	And I think most guys try to think, like they associate being overweight with being feminine somehow. Umm it's like a more feminine trait for whatever reason.	Being overweight is considered unattractive among gay men because it's associated with femininity
1	337-342	14	Um and people I think because of their own insecurities, they don't want to be identified as more feminine. Cause like growing up like being gay is associated with being feminine so they might of been teased for that or whatnot. So, I feel like now a good percentage of gay guys try to go to the gym and be more masculine. Or like try to define themselves as more masculine. So, something like that's being more feminine, or like not fitting that definition, it's unappealing.	Due to societal associations between femininity and being gay, there is an anxiety of appearing more feminine, as this may be considered unattractive. As a result, gay men try to appear more masculine in contrast to stereotypes. However, this may cause body image or physical appearance insecurities for those who appear more "feminine" in their physical traits.

Appendix 5 | Formation of formulated meanings from significant statements

1	356-358	15	Well I feel like this is kind of personal, but I don't have a large penis. And if I had a larger penis I would top a lot more. So umm sometimes I feel like because I have a smaller penis I get positioned in the bottom role.	Anxiety about small penis size - performance anxiety while topping as he doesn't feel like his penis size is adequate enough to pleasure a partner. Also, some anxiety about being assumed to be a bottom due to penis size.
1	36-37	16	I feel like I could be safer sometimes. I don't use protection for oral. And I did end up catching chlamydia in my throat.	Previous history of STI causes concern that he should be safer with his sexual practices.
1	385-387	17	Hmm I feel like sometimes people, like I don't know how to say this. It's like, especially in Ottawa, like the community perceives if you are more Caucasian or white, you are more attractive. So sometimes, or most times, I feel like my skin colour works against me.	There is a standard of beauty of being white/Caucasian in the gay community, and that can cause body image/appearance issues for racialized MSM or MSM of different ethnic backgrounds.
1	448-450	18	Just cause like, the Afghan community is pretty small in Ottawa, so everyone knows everyone. And like homosexuality is seen as something that is taboo, so if someone catches wind of it, everyone will know.	Anxiety around his sexuality being disclosed/found out by his family or members of his community, as being gay is seen as a sin and he would be stigmatized (since word will travel fast in a small community).
1	514-515	19	Oh yeah, I used to be super homophobic. Like I used to say a lot of homophobic things growing up just to deflect the attention off myself, right? To not come off as gay.	In his youth, when he was still trying to conceal his sexual identity, he would say homophobic comments just so he wouldn't come across to others as gay.
1	527-533	20	When I was 18, I really struggled accepting myself because I did identify as a Muslim. And according to Islam, being gay is a sin, right? So, I didn't understand why I was gay and I didn't want to be gay. I was like, "I'm the eldest son in my family. My parents expect me to have kids, and get married to a woman. How could I do this to my family? How could I betray them?" So yeah it even came to the point where I was suicidal. And I was trying to find purpose, like why am I gay? Why	Internalized homophobia stemming from a religious upbringing that classified homosexuality as a sin. Also, often questioned why he was different from his family, and despised that he was different as he didn't want to let them down/didn't want to be a disappointment. This led to an identity crisis, self-hate, suicidality and self-harm

Appendix 5 | Formation of formulated meanings from significant statements

			am I this way? So, I'd ask myself a lot of questions like that. And I would take to umm, I would inflict physical pain on myself as well.	
1	54-56	21	I feel like if know the person, I am more self-conscious. If it's someone I like randomly met, I'm not really concerned about how I look too much, because I'm never going to see that person after.	He feels less self-conscious about his body if he is with someone he doesn't know since he won't see them again. i.e., doesn't have to leave a good impression.
1	575-577	22	I think early on you are taught that, like the way homosexuality is viewed is that gay men are perverts, in terms of inside the Afghan culture. And that example kind of like fed into that image	History of sexual abuse from an older man when he was in his early teens. This experience fed into the idea he was taught growing up that gay men are perverts. i.e., history of sexual abuse contributed to internalized homophobia.
1	642-644	23	Not during the moment, but sometimes right after it. Like "oh look at him and then look at me." It's like I become more aware of what my body looks like afterwards. Like I feel shame sometimes in that regard.	Body image issues and related negative thinking are experienced more after sex than before or during sex; comparing himself to his partner
1	85-86	24	I guess when I started having it. So, I started having sex when I was 24. Just because it was such a taboo thing, like I was always on edge.	Felt anxiety about his sexuality and sex life at first due internalized homophobia ("because it was such a taboo thing").
2	15-19	25	Healthy sex would be first of all, consenting from both parties. And sex that fits into what everyone is comfortable with in every situation... So, for me, as long as everyone is comfortable with the situation and what is going on, then it's healthy.	Health sex is sex that is consensual from all parties. Everyone is okay with what is going on

Appendix 5 | Formation of formulated meanings from significant statements

2	156-157	26	Well we talked about that. We discussed certain rules and wearing condoms when having sex with someone who isn't our partner.	Rule for open relationship: wear a condom when having sex with someone who isn't the primary partner. This reduces anxiety as it lowers the chances of someone bringing an infection into the shared bedroom.
2	176-178	27	Well other STIs are treatable in a sense that, you know, you get chlamydia, get the treatment and then it's gone. So that's why I am less concerned with catching chlamydia or gonorrhoea. That's basically it, the treatable thing	Is more concerned with HIV than other STIs as unlike most other STIs, HIV is non-curable.
2	279-287	28	I learned to enjoy both because before I would only top. But as I grew older and slept with more people, some people have helped me experience or experiment. So now I find both will bring me pleasure, but I more naturally tend towards topping just because sometimes I'm worried that I won't be a good bottom... Let's say I'm out of practice, then it will be more difficult or hurt more, for example, until it gets into the right feeling.	He is more sexually confident when topping compared to bottoming due to performance anxiety, potential pain/discomfort
2	322-331	29	I was so disconnected from anything homosexual. I didn't know what being gay meant. No one would talk about it. I didn't have any friends that would talk about it. The only time people would talk about it would be like making jokes. You know like, "Ha-ha you're gay." And I don't remember what I felt back then about gays because it just wasn't around. My parents and my family never talked about it.	Had very little exposure to gay men growing up, due to being in a white, suburban, non-diverse neighbourhood. i.e., upbringing was heteronormative. This resulted in him not being exposed to anything gay or even knowing what gay meant. Led to some internalized homophobia and identity issues
2	413-415	30	And you know, from feedback; I'm not saying I'm good all the time, but I haven't had any bad feedback, whereas I have had really good feedback. Which again doesn't mean that everyone I had sex with thought I was amazing,	Positive feedback from most previous sexual partners have contributed to him being confident/less anxious with sex. This likely relates to not experiencing performance anxiety.

Appendix 5 | Formation of formulated meanings from significant statements

			because in some cases I probably wasn't, but it's not something that worries me.	
2	65-66	31	Well trying to always ask the other person's recent history. Although that can be difficult if it's like a one-night stand. You're not going to really delve into that.	Asking a partner's recent sexual and testing history is a way of protecting oneself and of reducing anxiety around HIV and STIs
3	154-157	32	I always use a condom, I never bareback. Like the last time I barebacked, I don't remember. There was one time I can remember since I moved to Ottawa a few years ago. And then before that, I don't know. So, I always use a condom for the large majority of my sex. But that's because I am scared of, or I worry about STIs...	Always has protected sex when engaging in anal intercourse. The reason why is because he worries about STIs.
3	16-18	33	Active, so having sex because I enjoy it. With people who I am attracted to, that I have a comfortable relationship or that I trust, and I enjoy their company.	A satisfying sex life is one that is active, and that involves people whom there is a level of trust and some sort of relationship.
3	18-19	34	And healthy in terms of being informed about their sexual health, them knowing my sexual health, knowing what I am getting into and agreeing to it	A healthy sex life is one where you are informed of your own sexual health, and know what you are getting into in terms of risks to your sexual health (HIV/STIs) and the sexual activities that happen
3	180-187	35	...there's a theory or reality that people who are HIV positive and undetectable, are constantly in touch with their doctors, constantly tested, are on medicine to keep their viral load low and their HIV in check and make sure it does not transition into AIDS. And because they are so connected with their doctors and everything, they are more informed about their sexual health. Whereas people who are HIV negative, may get tested only every 6 months or every year, and then they are not getting tested as frequently, and therefore might contract	Belief that it may be safer to have sex with someone who is positive and undetectable compared to someone HIV-negative, because the positive person is more likely to be tested frequently and be aware of their sexual health status.

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			something and unknowingly have it in their body and pass it on to other people, which is less healthy.	
3	199-203	36	So, HIV concerns me a lot because there is a huge stigma about it. Like if I contract HIV, I would tell my parents, I'm very open with them. And they would be fucking terrified because they grew up through the 80s, right? They lived through the AIDS crisis. I know it's not a death sentence anymore, I know it's not as big of a deal any more. But it's not a good thing to have, HIV.	Worried about contracting HIV because of the stigma against it (society and within community). Also scared because he'd have to tell his parents who would be very worried for him, and he doesn't want to feel like a burden on their emotions. Even if it's not fatal anymore.
3	210-211	37	But for now, if you contract HIV, you'll be taking meds for the rest of your life, and I don't want to be weighed down by that.	Fear of HIV influenced by its permanence and that you have to take medications the rest of your life.
3	212-216	38	...I think its chlamydia or gonorrhea that's becoming "super". Like antibiotic resistant STIs because it's been so common and treated that I guess the bug has evolved to the point where it's harder to treat. So that concerns me. And then there are STIs like Herpes that are incurable. So, I'm concerned less about chlamydia, and I'm concerned less about crabs, but HIV and the super gonorrhea are concerns of mine.	Frequent testing helps mitigate the anxiety of STIs that are curable and more easily treated, such chlamydia, crabs and syphilis. However, his anxieties appear centred around the permanence issues of some STIs, as highlighted by concerns about HIV, Herpes and AMR in STIs.
3	217-219	39	And syphilis, it can wreak havoc on your body but I get tested frequently enough that it's not a concern	Frequent testing helps mitigate the anxiety of STIs that are curable and more easily treated, such chlamydia, crabs and syphilis.
3	271-274	40	I never bareback. If I were to have sex with somebody, I need to know a bit about them. I'm not a straight to it kind of guy, I'm not a one-night-stand type of guy, or an anonymous type of guy. However, I still got something. So, it's kind of like a roll of the dice.	Despite always using condoms and being sexually selective to keep himself safe, he still contracted an STI. This contributes to why he has a large concern for STIs, because his safety mechanisms have failed in the past.

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3	271-276	41	It's frustrating, and makes me not want to have sex as much after getting an STI. It just feels like it's a dirty thing and I'm this dirty person for having it. So, it's internalized stigma, but it's there.	Fear of STIs influenced by previous history of STI and internalized stigma
3	307-310	42	I think I as a person enjoy having sex more if it's with a person that I am more attracted to. And maybe because I consider myself more attractive now, and that I'm fitter now... then I am able to get people who are more attractive. So maybe then I enjoy it more?	Since he started going to the gym and becoming more fit/muscular, he has finds himself more attractive and is more confident. This has translated into him attracting more attractive guys, which made his sex life more satisfying.
3	324-329	43	Even now I go to the gym all the time and I'm still not 100% happy with my body. I think everybody, period, feels that way. I'm healthier and happier than I was, and I do think I am more attractive now than I was in the past, but it's not like I'm 100% confident. But then I guess it does come into play because when I am having sex with people who are thinner than I am. I feel a bit insecure or self-conscious about my own body in comparison to them.	Despite going to the gym and feeling more confident, happy and attractive, he does still experience body image concerns if having sex with someone who is thinner.
3	532-534	44	So other things that cause me anxiety that you haven't mentioned, and I'll just be forthcoming, is shit. Like literally human excrement. Because I, as a top and as a bottom, this has been an issue. And it makes me not prefer anal sex.	Previous history of issues with feces during anal sex causes him to worry now when having anal sex, and causes him to prefer other sexual activities to anal sex
3	550-551	45	Um I use condoms, so it's not as enjoyable for me. So, I feel like maybe I should get on PrEP and bareback? But then I have a concern about the other STIs. But I feel like maybe I'll like it much more, right?	Because he doesn't like anal sex due to loss of sensation with a condom, he is considering going on PrEP and barebacking. However, this may increase his worry about other STIs.

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3	56-59	46	Nonetheless, I have had STIs in the past, and they are not enjoyable. There is a lot of stigma associated with it. I don't want to have another mark on my record (medical) as it were. I don't want to have to tell people about it, and that can be like friends or people that I had slept with.	Always has a fear of STIs despite practicing safe sex and being knowledgeable about STIs. This is due to previous history with an STI, and worry about being stigmatized by others.
3	587-590	47	Getting HIV, I feel like it actually is a manifest destiny. Like it's going to happen to me at some point... I just feel like, I can be as safe as I can, and I am very safe, and I'm choosy about who I sleep with. But I just feel like it's so common. Like I know people who are 18 and have HIV.	He feels he is destined to get HIV, no matter how safe he is
3	71-74	48	Also, because the people I'm sleeping with, not everyone gets tested after every sexual partner they have. They don't always wait after the incubation period. So, you never know, 100% for sure if someone is negative if they say they are. And some people may not get tested every 6 months, they may get tested only once a year.	Anxiety around HIV and other STIs risk because you never know how often a potential sexual partner gets tested, and don't know if they are actually aware of their health status. People getting tested less than once every 3 months causes him to worry
4	11-12	49	When you are having sex on like a regular basis with partners that you have some kind of connection with.	Satisfying sex is when it's on a regular basis (frequent enough) and with someone you're connected to
4	102-104	50	Am I at risk of HIV? I would say no. Like the only way to completely remove the risk is to not have sex since we know that any sexual contact can result in the transfer of something. But I'm on PrEP, and am usually safe, so I would say that I am at a low risk.	Perceived risk of HIV is low due to being on PrEP
4	138-140	51	I'm more concerned with other STIs. Because I'm on PrEP., my partner's on PrEP, my compliance with taking it every day is really, really strong, and I've been on it	He is more concerned with other STIs than with HIV because both he and his partner are on PrEP

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			for two years. So, I feel like PrEP is pretty good.	
4	150-156	52	I would say anytime it's someone new or just a hook up, I definitely have a sense of like unease. I think we always go into these situations with a set of expectations, on like both sides. And especially in gay culture, there is a certain expectation that when you hook up, it's going to be like certain things. It's going to be super hot, super intense and all these things. I've had other conversations with other gay friends about this and similar ideas, and it gives you more of a sense of why there's a sense of anxiety, because sex is supposed to go a certain way.	He is more anxious about hooking up with someone new than with someone he's experienced with because he feels there are expectations put on that sex, and he feels like he will let the person down if those expectations don't happen or aren't met. Therefore, there's greater performance anxiety around sex with a new person.
4	162-164	53	I think that, especially if it's a hook up, and let's say you live in a smaller place, well people talk. So it's always about like, having a good performance.	Has more performance anxiety if he's hooking up with someone new because he feels pressured to perform well to prevent negative rumors spreading about him
4	184-188	54	But I work-out a lot more now and am a lot happier with my body. I used to be like super twink, and now I am, well not that much muscular and then I got super hairy.. but yeah, I'm much more happy with my own appearance, and I think that's translated to me being more confident over time. Especially when I think back to the past 4 or 5 years.	Improved confidence and body image since going the gym regularly and gaining muscle.
4	193-194	55	Now I have more sex outside my relationship than I did before even though we were open. And I think it's because I'm more willing now, or less shy to ask.	In comparison to before he started going to the gym, he now has more sex outside of his relationship, despite also being open then.. This is because he is more confident now and is more willing to engage or seek out sex outside his relationship.
4	205-213	56	I feel like I'm in this age-generation where I grew up and when I was first coming out and we'd talk about safe sex, we could not have imagined a world with	Explains that over time, his concern for and perceived risk of HIV has diminished as there is now PrEP to prevent him from getting HIV, and even if he does get it, it's no longer

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			PrEP or anything like that. Because medication has changed a lot for people with HIV and now preventing it too, so I think earlier, let's say in my 20s, HIV was a bigger worry. So, when you asked how concerned I am, I think I am making my answer relative to how I used to feel, when I was like 19 years old. Back then it seemed like if you got HIV, it was then end of your life. So, I think that maybe when I say that I'm not concerned, it's more that we've come so far that you can take so many steps now to reduce your chances of contracting it. So that's why I feel like the risk is so low for me.	fatal like it used to be. You can still live a happy and healthy life if you are HIV-positive, and that helps take away some of the anxiety around it
4	277-279	57	I will say that I think it is easier online. The thing is, is that a lot of apps and stuff will have like certain information listed. You can put your status, you can put your safe sex practices. Some people put their testing date, and things like that. So, I think that's really great and sort of facilitates the conversation.	It's easier to have conversations about safe sex and sexual health with someone you meet online vs. in-person because the platforms allow for information sharing which facilitates those conversations.
4	29-32	58	I am in a relationship model that I am very happy with. I'm with my primary partner, and we both explore outside that, which is something that is important to both of us. I also feel like the frequency of sexual occurrences is something I'm satisfied with.	Currently in a satisfying open relationship since both enjoy exploring outside the relationship, and he's happy with the frequency of his sex
4	301-304	59	If someone is HIV positive but undetectable, they can't pass it on, they are essentially negative at the time. So also, with me being on PrEP and using a condom, then it's like a whole extra level.	He would have sex with someone who is HIV-positive and undetectable, but would use a condom. With the combination of using protection, being on PrEP, and the person being undetectable, there's very little risk for or concern of HIV acquisition.
4	306-309	60	...the one piece for me that I feel awkward or have a mental block is that usually I'm a top, but I'm somewhat verse. But I'd still rather, at this point, not bottom	Still would have some anxiety having sex with a positive but undetectable partner if he was bottoming. The greater risk of contracting something while bottoming vs. topping is a

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			for someone who is positive because the risk is higher. Even though if I know that they are undetectable, that I'm on PrEP, and things like that, there's still like, I don't know, a mental block.	mental block for him to engage as a bottom.
4	37-39	61	I think that sometimes as a gay man, a lot of anxiety from being in an open relationship actually comes from like, if people outside the queer community find out and certain aspects of that.	Stigma against open relationships from people outside the community causes anxiety around being in one
4	420-425	62	I think that gay culture, and perhaps we've moved slightly away from this as time has gone on, but there's a big gay culture that is very much about sex. Especially if you go back in time a bit to when gay people weren't as open and we were more repressed, sex was seen as one of the only things you could really do to be gay in a way. And since sex is so body focused, and everyone wants to be desired, so you want to look a certain way, so you can have more sex and attract a certain type of people and things like that	Perceived sex-focused gay culture puts pressure on gay men to have sex and to look a certain way so that they can have sex. In addition, since sex is so body-focused, he feels pressured to go to the gym, in order to look more attractive
4	425-428	63	...the media itself puts pressure on people. If you look at any gay focused media, especially when I was younger, like late 1990s or early 2000s, it depicted the white, muscle hairless mold of gay guy. And if you don't fit that then you aren't as desirable I suppose.	Body image issues may stem from not meeting depictions of what gay men look like in the media, which is often white and fit/muscular.
4	43-44	64	I find anytime a cis- or like heterosexual person finds out, there are a lot of question because I think they don't really get it or are judgmental.	Stigma against open relationships from people outside the community causes anxiety around being in one. Heteronormative society doesn't tend to understand in his experience
4	474-484	65	... when I first realized I was gay, I definitely went through a period of depression. And I didn't really know what to do because in my mind, my entire life was going to go a certain way... I always had this	Heteronormative upbringing with low exposure to LGBT contributed to the anxieties around the unknowns of a gay life path

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			kind of expectation that my life had a course: I was going to university, then get a masters, and I was going to get married and have a kid. You know live in the suburbs with a wife and kid. It was this whole thing. And when I suddenly realized that it was not my path, that it was no longer my path, I wasn't happy about it. Like in my mind my life was going to go a certain way and this very much derailed it. I guess I couldn't see another life except for that. And that's probably because I grew up in the suburbs, it was very upper-middle class, everyone was white, everything was heteronormative.	
4	49-50	66	But I think it's still like.. like professionally, or in a professional setting, I'm in a monogamous relationship, you know?	Feels like he needs to hide his open relationship status in certain situations, so that he won't be judged by straight people
4	59-63	67	So we usually use condoms if we are hooking up with someone else. We both have a couple of regular other partners who are also on PrEP. For example, I have a friend with benefits who is on PrEP and his partner is also on PrEP, so there's like a level of trust there, we're all trusting	In order to keep himself and his partner safe, both use condoms with other people outside the relationship. In addition, their regular partners are also on PrEP, which mitigates anxieties around HIV.
4	73-74	68	But we always disclose to one another that we are thinking of not using a condom with another person.	Disclosure done to maintain trust within the open relationship since the general rule is to wear condoms. Helps lessen worry about STIs being brought back into the bedroom, since you know who your partner has been with, and what they have been doing.
5	198-200	69	I'm probably more reticent to be undressed, or quickly undress in front of somebody... I don't want to be objectified by them, or compare myself and feel like I'm fat, even though I'm not very large.	Body image issues creates hesitance in undressing in front of a sexual partner as sex is body focused
5	8-9	70	...being safe, like using condoms, especially if it's a one-night stand. If not, making sure you are being	A healthy sex life is one where you are using condoms, and are testing regularly for STIs.

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			tested regularly	
5	139-140	71	I also don't often have penetrative sex with a hook up because there's a bit of an anxiety of catching something.	Anxieties around catching an STI so he doesn't have anal intercourse with someone he doesn't know well.
5	19-21	72	I would say having sex on a semi-regular basis. What that means. Personally, for me, I prefer to be in a monogamous relationship. And in that monogamous relationship, I would say sex three times a week, maybe more.	A satisfying sex life is one where he is having a certain frequency of sex, and preferably with a monogamous partner.
5	192-194	73	I've been struggling with this.. I've started doing this fucking spin class every day for like a couple weeks. And it's good, but it's because I feel like I don't look as good as I would like to look, like physically. I probably think I'm bigger than I actually am.	He is struggling with body image issues and perceives himself to be larger or heavier than he actually is.
5	204-207	74	I feel like I'm more vulnerable after sex. Because when you're into it, you're into it and you're not really paying attention. And then afterwards it's like all the attention. You're fucking naked and like cleaning up. You're looking at him and he's looking at you. So, I feel like you are a lot more vulnerable in that moment than you were before.	Body image issues are usually felt more often or heightened after sex due to increased vulnerability from being naked and having attention focused on your body.
5	211-212	75	Usually I'll think that they are not as attracted to me afterwards than they were before or during.	Body image issues causing reduced confidence in physical appearance after sex.
5	303-305	76	But in the middle of sex, it might have been with my ex or with some other random person, but in the middle of it, I had this random thought of, "This is weird and wrong". Like just randomly.	Unexpected internalized homophobia experienced during sex with a man.
5	309-312	77	It's just that internalized homophobia and heteronormativity is so all encompassing that like sometimes it will happen I guess.	Feelings of internalized homophobia and messages of heteronormativity are encompassing and interfere sometimes during sex.
5	35-37	78	...personally, sex with a partner in a relationship where you know	Awareness of your own and your partner's status in regards to STIs/HIV

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			each other's status, or at least have an idea that you know each other's status, that's healthy.	contributes to a healthy sex life.
6	4-9	79	What that means to me is being able to be open to your partner about your preferences, your interests. Being able to explore things with your partners, and also feeling safe in the choices that you do make with your partner, even if they don't particularly pertain to your interests.	A healthy sex life is one where you and your partner are capable of having an open conversation about sexual versa, and where you feel safe exploring and trying new things or things you may not enjoy for the benefit of your partner
6	152-153	80	Like some partners we've actually gotten tested. Like there are free health clinics, and we'd arrange a time to go and share our results.	Knowing each other's sexual health status (HIV/STIs) factors into the decision to use condoms or not during sex. One way of knowing is to get tested together and share results.
6	17-19	81	Like if that person were to kiss-and-tell, that's also a concern, right? Cause that's also part of a healthy sex life for me is that if I wish for it to be confidential, it remains confidential between those who I choose to share with.	Healthy sex is sex that is free of social stigmas (won't be judged by partner), and stays between the consenting parties.
6	198-202	82	So, there was the HIV/AIDS scare that came and that has a huge stigma that carries with it within the community and outside. One of the biggest things.. well I don't have to disclose my family, but declining health or a drastic change in lifestyle will definitely begin to bleed towards my family and the likes, and that's a conversation I would not like to have. So, there's social stigma and stigma within the community you would have to worry about.	Stigma from within and outside the gay community contributes to fear of HIV. Also, he would not want to have to disclose being positive to his family, as it would cause them worry and burden them with his health
6	202-205	83	As well, a lot of the other STIs are treatable nowadays. Like they can be removed. Or curable is the way to put it. But then with HIV, we haven't discovered that yet. You can't cure it. So, if you are positive, for now, you are positive for life.	He is more concerned with HIV than other STIs as HIV is non-curable
6	210-215	84	I know that there are good ones out there, but having my life	Permanence of HIV - having to take pills every day and having your life

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			reliant on this system is not what I want. And I know it's no longer the cocktail that you have to take every day, which is good. So, it's great that we're advancing, but it's scary to think that if I lose my access to the medical or medication system, then that could shorten my life span drastically. So, I guess I don't like the permanence of it, and it's very scary to think about.	reliant on a health care system - contributes to the fear of HIV.
6	293-299	85	So, my family was very traditional in the scope that they did not accept homosexuality. And it took me a long time to first accept it myself because of the way I was taught growing up that homosexuality was not a good thing. Like I was told that they are going to hell, that they were not of God's creation. So, I think that I definitely internalized, and took that in, right. When you're young, you idolize those around you, and when they express those thoughts and those feelings, you take them because you think it's coming from a good person and all of that. So, I had to overcome that first.	A traditional/religious upbringing bred internalized homophobia when he was younger due false and homophobic messages he was getting from his family and the church.
6	314-317	86	It was understanding that when I first came out to my family, my mom expressed that if I were to have sex with another man, and I'm not joking I mean any kind, oral, anal or whatever the fuck you want to describe, that it would create AIDS.	The false and homophobic information his mom gave him about gay sex stimulated some internalized homophobia. i.e., traditional/conservative upbringing as a causal agent for internalized homophobia
6	328-334	87	Yep, in choice of partners. Naturally, I'll immediately flock to more masculine men, because feminine men are not quote, "a good thing"... I often had to present as more masculine than I was. So you naturally start to associate that "masculine gay men are good, feminine gay men are bad"...	Having to put on the appearance of a masculine man during his upbringing facilitated some internalized homophobia towards more feminine men. This manifest itself in choice of sexual or romantic partners, as he naturally goes for more masculine looking men.

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6	340-341	88	I think because we are very appearance-focused group at the moment, looking gay often comes with a status, right? You have to be rich, able bodied, often white...	The gay community is appearance-oriented and therefore there is pressure to look a certain way, and conform to the look of a rich(well-dressed/well-groomed), fit and white gay man.
6	352-355	89	I've definitely been not perceived as gay because I dress down or don't get a haircut sometimes. Which is kind of like, if I'm associated with a lower class, I'm also stripped of my identity of being gay. Which I find very fascinating because I've had gay men also ask me if I'm gay. They'll be like, "Oh I never would have assumed." And I always press the question, "How the hell do you look gay?"	There is pressure from within the community to maintain a certain image/appearance (well-dressed and well-groomed) because that's what a gay guy is "supposed to look like"
6	407-411	90	I have been sexually assaulted, so that definitely changes my perception on sex, and availability of my body to other men, and the consent I can give. Because once it's taken away from you, it's difficult to gain that autonomy again. So, I definitely feel that, and looking back at it, I'm realizing that it's kind of pervasive. It's a desire to control what's going on, control what's happening.	History of sexual abuse /assault has changed his perceptions on sex, as he experienced a loss of sexual autonomy and has to work to get that back or to feel it again with a partner. Thoughts or memories of the sexual abuse are described as pervasive, and the anxiety manifests itself as a desire to control what's going on in a relationship and with sex. The control allows him to feel autonomous and like he can consent to what is happening and who he's doing it with
6	428-430	91	Exactly, it's a defence mechanism. And I think it's in part a healthy one, although maybe I'm considered prudent for that. But it's not something I'm willing to comprise I guess. Because at the end of the day, it's MY conversation to have with MY partner.	In order to protect himself and his sexual autonomy, he now takes it slow with partners (doesn't rush into sex) and establishes frequent and open conversation with his partners about sex. This helps him feel more in control of his sex life and sexual practices, which mitigates anxieties around his history of sexual abuse
6	43-46	92	So at one point one of my partners disclosed that they may have been positive for syphilis. Which at the time was kind of scary, but realizing that there is modern medicine and modern advances, I felt that it was scary at the time	Had a syphilis scare, but modern medicine (testing and treatment) helped mitigate fear or worry around the STI, which allowed him to feel like the situation was under control.

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			but it ultimately paved out and it ended up being a mole hill and not a mountain in my life.	
6	439-446	93	Like sometimes I feel like I'm out of it, I'll be thinking of it if I get a flashback. When you've been sexually assaulted, often having sex can trigger memories of that. And you get unfocused... I guess it's like, you can't have a conversation while you are distracted. I keep thinking of sex as a conversation between bodies, right? Like if one person is on their phone during the conversation, then they aren't giving 100% into it, right? So then you get caught up in this anxiety loop of "oh fuck, I'm not here", so then you have to over-perform, but then maybe you aren't listening fully now, and it's a lot that just gets to you, and can cause a spiral.	Since he was assaulted, he sometimes gets triggered during sex and the thoughts/worries can be anxiety provoking. This can either lead to stopping sex/avoiding sex due to potential, "spiralling", or it can cause performance anxiety as he feels he is no longer fully present with is partner and is no longer pleasuring them/attentive to their needs
6	456-460	94	I think actually having satisfying and safe sex has allowed me to work through some of that. Understanding that that's not all I am.. Practicing those boundaries and practicing safe sex has helped. Just reaching out to others who have also had those experiences and understanding that you are not alone in it. And to have somebody to just reaffirm that it wasn't your fault helps too. Yeah, I guess it's just looking for empowerment.	Practicing safe sex and sexual boundaries (i.e., exhibiting control over sex life/re-establishing autonomy) has helped reduce the anxieties caused by the sexual abuse. In addition, having satisfying sex showed him that sex can be good again even after his autonomy was taken away, helped him not fear having sex. And talking to people and realizing he wasn't alone in his struggle was helpful too in overcoming the anxiety and pain.
6	465-469	95	But for a while I avoided sex or thoughts of sex with other men because it could be triggering. Like I even tried to watch straight porn for a while because I feared watching two guys fuck may bring up a painful memory, you know? Like cause me to relive it. So, I guess there was a period afterwards where I was avoiding gay sex, but not anymore.	He avoided gay sex, seeing gay sex, and thoughts of gay sex for a period after being sexually assaulted so as to not get triggered

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6	57-58	96	Another thing too is that you don't have any idea about their current status. Positive or negative when it comes to STIs.	It's more difficult to know a partner's sexual health status if you are less familiar with them, thus it is more anxiety provoking.
7	10-15	97	... you should be constantly aware of your sexual health situation. Like you get tested, every 3-months, 6-months, or at least every year. You know like your testing frequency. Third, every sex you have should be based on mutually consensus. And enough communication with the partner about what you are going to do, if one of you have any STDs, and like whatever you want to talk about. Like there has to be a pre-sex discussion.	A healthy sex life is one where you don't feel shame in your sexual activities or desires. Getting tested frequently and knowing your sexual health status is also part of a healthy sex life, as well as having conversations (pre-sex discussions) with sexual partners about each other's statuses.
7	113-115	98	I feel like, if you are not Canadian, you are going to be extra worried. Because you have to stay inactive for HIV anti-body if you want to keep your school or work period effective.	His worries about HIV and STIs are influenced by policies requiring him to be HIV-negative and syphilis free for the duration of his student Visa, lest he not be able to renew his visa and forced to go back to his home country.
7	152-154	99	Usually though, I would just use a condom. I think it's better me and for them too to not get any STI. I don't have like a strong opinion about it, but I guess I'd prefer to use a condom	Despite a fear of HIV, he would be okay having sex with someone who is HIV-positive but undetectable as long as a condom is used. This is mostly to protect himself and the partner from other STIs
7	203-205	100	I think HIV. Because once you are positive for HIV, you are non-convertible to be negative again. So, it's the permanent thing. And also, most STIs are more like visible and more possible to cure.	He is more concerned with HIV than other STIs because HIV is permanent/non-curable
7	210-212	101	I'm at more peace with it than before. Before I was like pretty skinny. Well I'm still skinny, because that's like a family thing, but now I have some muscle. That's kind of a compromise to the gay culture.	Since going to the gym, his body image and confidence has improved as he put on more muscle. However, he does admit that he started going to the gym because he feels pressured to look muscular in order to attract other gay guys.
7	220-222	102	Many people say, "If you are ugly, you cannot be gay." In the beginning, I was pushed to work out, and to pay attention to my face, my fashion, and my physique	Due to being gay, he felt pressure to conform to a certain look, which is being fit, well-groomed and attractive.

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			because I'm gay.	
7	223-229	103	I also think it's a media thing. Like only beautiful, white, Caucasian, Anglo-Saxon gay people are pictured in the media... That's the thing, you look around on media and all the gay people are white, muscular and pretty. Or at least not overweight. So, like, that was one motivation that pushed me to change.	Media images of gay men put pressure on MSM to try to conform to the gay mold that is depicted in media, which is often white, muscular and attractive. This can cause body image issues for MSM who do not feel like they meet that beauty standard, whether it be ethnicity, body type, etc.
7	239-242	104	Like when you look in the mirror naked, you are going to have more confidence. I think I personally enjoy sex more right now because I have more confidence, and second, with more muscle there is more to play with. Also, you receive more compliments, like regarding your thighs, your butt, your chest, and stuff like that.	He is more sexually confident and his sex life has improved since he started working out. This is because he finds himself more attractive to others, and has received more positive feedback about his body since he started working out regularly.
7	24-25	105	Oh satisfying sex? Um first you are able to achieve orgasm. Second, the whole process is comfortable, and whatever you do is mutually agreed.	A satisfying sex life is one that is pleasurable (able to achieve orgasm with partners) and one in which the sexual activities are mutually agreed (consensual).
7	308-311	106	It's just like being Asian, you know what I mean? Like, why am I different from the people around me? Or like why am I different from those people on TV?... It's because I'm different. And it's hard. It's hard in every country.	He experienced some internalized homophobia when he was younger due to minority status, i.e., wondering why he was different from the majority of those around him (i.e., straight people).
7	355-359	107	Because I didn't know anything back then. And I kind of forgot about that. I was not able to remember that until like #metoo movement. They were saying everyone more or less, at one point in their life, they may have been sexually harassed. And I was like, "yeah that happened to me too, but only once." Now I think that's kind of like harassment, but it doesn't get to me very much.	Is not affected by thoughts or worries of his history of being sexually harassed by another man, because he repressed the memory until the #metoo movement made him remember. But at that point, he was mentally and sexually mature enough to not be affected.
7	61-64	108	Because if you are on PrEP, it's supposed to be very unlikely that you would get positive. But like	Still has anxieties about catching HIV despite being on PrEP because there are strains of HIV that Truvada doesn't

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			after you get on PrEP, and I'm always doing social work and outreach like that, so gradually you get to know.. there are like very slight chances of getting infected by some types of HIV-virus, like ones PrEP doesn't cover.	cover.
7	73-76	109	It's just hard because more and more people are getting on PreP. And I guess since I'm on PrEP and they are on PrEP, the most frequent question I get asked is, "Well why not?" They'd be like, "you're on PrEP, I'm on PrEP, we both get tested and go to the doctor every 3 months. Why don't you just do bareback?"	If you are on PrEP, there is pressure to bareback from others, especially if they are also on PrEP. This causes anxiety around being safe and other STIs as it makes it difficult to use condoms consistently.
7	84-86	110	If they are on PrEP and they can verify like when they got tested, an exact date that's pretty recent, I might give in. But after I may sometimes feel bad, like bad that I gave in. And after, I might have some concerns cause I took a risk	Provides an example of unprotected sex under safe conditions (partner is on PrEP and recently tested) to highlight anxieties around sexual health and STIs. He feels guilty after and worries about his health if he barebacks, even if it is with someone who is "safe"
7	94-95	111	I would say that it helped, at least practically. Because it does lower you chances of getting HIV. I'm less hypochondriac than I used to be..	PrEP isn't fully helpful. But it's useful for relieving some anxiety around HIV acquisition during sex
8	161	112	Because I love getting naked in front of partners.	His positive body image improves his sex life as he is confident getting naked in front of partner.
8	6-7	113	A healthy sex life is where your sexual needs are met, and you feel satisfied, and there's no harm to you, physical or emotional.	A healthy sex life if one where your sexual needs are met/you are sexually satisfied, and is free of emotional or physical harm (i.e., STIs risk and violence)
8	101-104	114	I started talking to my friends about it and everybody would say, "Syphilis is a thing in our community, it's on the rise." They did a study, and the rates have increased by like 400% in the last 5 years. I couldn't believe it! So, I am so cautious because I know how easy it is to be transmitted during sex.	The high and rising prevalence of syphilis in the MSM community is a cause for concern and leads to anxiety around catching syphilis

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8	115-118	115	Online it's interesting because you end up more sexual. I think the conversations are way more sexual online. Everything is sexualized, you are not afraid to ask for pictures, nude pictures, you're not afraid to ask about sexual preferences, or ask somebody about their HIV status and all those question like that.	The sexual nature of online gay dating platforms, such as Grindr, provides confidence to initiate or engage in sexual conversations. This helps facilitate conversations about sexual health prior to meeting.
8	172-174	116	But I do know that as I'm aging, my body image seems to be more important to me. Do you know what I mean? Cause it's like, "Oh I have less youth, so you better do something to balance it out or you're not going to get to have sex." That's the message I tell myself.	He feels pressured to fight the signs of aging and maintain a fit physical appearance or else he won't have sex. Concern around becoming less attractive and sexualized as he ages.
8	183-187	117	Well I think like those messages that I said I was giving to myself are actually from the community. I think in the gay men's community there is a lot of messages we get about the chiselled body, the Adonis look. Youth it also privileged, and there is a hierarchy it seems with groups that are favoured in the community. Like white gay men with great bodies and stuff are at the top, and then it progresses down right? So there's that pressure to kind of fit in.	Messages from within the gay community put pressure on him to try to fit a standard of attractiveness, which is being young, white, and muscular/chiselled.
8	20-22	118	In my own opinion, a satisfying sex life is one where I'm having sex regularly. So, three times a week would be regularly. Maybe like where I'm getting to do all the things I enjoy doing as well.	A satisfying sex life in one in which sex happens at least a desired frequency, and one in which he can partake in the sexual activities he wants to
8	240-243	119	...even from straight friends sometimes. Like even when I go on a gay cruise. I haven't been on one, but I was telling a friend about my interest in one, and she's like, "Oh be safe though, and take the PrEP." And I'm like, "Oh shut up, you wouldn't say that if I	Example of stigma against gay sex and HIV from those outside the community, in this case his friend

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			wasn't gay." I know they wouldn't.	
8	273-277	120	But I've noticed that there is a certain homophobia towards anal sex when you are the receiver, the bottomed. For example, when I told my brother that I enjoy both, I can tell he was.. there was a bit of disgust around the receiving of anal sex. So, I think maybe on some level, that does sometimes impact how often I'm going to receive over how often I'm going to give.	Stigma against gay sex/bottoming is internalized, and it sometimes impacts his sexual practices.
8	290-292	121	Yeah, I'm more confident with topping for sure. I don't think I know how to bottom very well. But maybe that's the thing, like you only learn how to do something by doing it and I'm not all that much experienced. So, I'm more comfortable topping.	Has performance anxiety when bottoming due to lack of experience. Prefers to be a top because he feels like his experience makes him better at it
8	316-320	122	It happened when I was younger around when I was first coming out. And I think it shaped my perception of gay men and of my own identity. Well, at least for a bit. It made me scared to trust other men. I started to dislike myself for being gay and putting myself in a situation where I could be harmed by another man like that. I put up walls from myself and others, and repressed my sexuality, repressed myself, for another year after.	Previous history of sexual abuse led to internalized homophobia and repression of sexuality following the event
8	328-333	123	Once I started having satisfying sex that I consented to, it became easier. I began by taking it slow though and making sure that if I was going to have a romantic or sexual relationship with a new guy, it would be on my terms and within my boundaries. I know it doesn't seem like much, but it helped. And after a while, I felt more and more liberated from those fears that I will be harmed again. There's something	Taking it slow with a new partner and controlling the pace at which a romantic/sexual relationship progressed helped him regain autonomy over his sex life

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			empowering about being able to retake charge of your own sexuality and sex life.	
8	360-363	124	...cause I know if someone has an undetectable viral load, then I can have sex with them and not worry about infection. But, I would still treat that person the same way as I would with any other person I meet and use a condom.	If someone was HIV+ but undetectable, he knows he couldn't get HIV from them, but would use a condom anyways as he has concerns about other STIs.
8	71-73	125	Oh very cautious. I'll use condoms all the time. I was on PrEP for like 5 weeks. It didn't change my sexual behaviour at all. So, I was like, "Why am I on it? I have to get my enzymes tested routinely, so what's the point?" So I decided to just go off it	He uses condoms consistently during sex. He even went off PrEP because he was still using condoms just as regularly. He saw no point of taking a daily pill and getting his regular blood work if his practices didn't change from before being on PrEP.
8	97-101	126	And last year I got a call from the sexual health clinic, from the city, and they said I was exposed to syphilis. Like through secondary contact. I freaked out, and that's when I went on PrEP after. I went down to the city, got the penicillin shots, got tested, and I didn't have it. But needless to say, it made me more worried about sexual health or contracting an STI.	His previous syphilis scare and the treatment needed contributes to his fear of bacterial STIs
9	95	127	Well we have safe sex. It's always with a condom	They mitigate the risk of STI or HIV transmission when having threesomes with others by always having protected sex
9	9-11	128	... a healthy sex life is when you're having sex on a regular basis, with people you like and are presumably attracted to.	A healthy sex life is one where you are having a satisfying frequency of sex with people you are attracted to
9	162-169	129	So, my concerns are, um, learning to adjust to the fact that I've gone from somebody who is highly sexed to someone who is not... I think a lot of men defined themselves more in terms of their sexuality. I'm not saying that's right, I'm not saying that's wrong, it just is what it is. And I definitely did too. A lot of my social life and a lot of my pleasure came from my	His sexuality was a large part of his identity, which he felt was true for most gay men. So, as he has aged and become less "youthful", he had to adjust to not having as much sex and not being as desired. He had to adapt and find a new identity, including new avenues of socializing and finding pleasure in other activities

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			ability to have as much sex as I want.	
9	173-174	130	And I've had straight men say to me, "you guys are so lucky, you can have sex whenever you want." And it's like yeah, we can, but it's a double-edge sword, I realize that.	When you're older and no longer as virile and desired as you were in your 20s-40s, you have to be able to adapt to not being able to have sex whenever you want, your sexuality has to change
9	19-20	131	...where you have sex as many times as it satisfies both. Because it shouldn't be all about one partner.	A healthy sex life is about mutual satisfactions in terms of frequency and sexual gratification
9	194-204	132	Well I can intellectualize it. And I'm really happy, like I'm a really happy person. And I have had a lot of advantages in life... So, I'm not going to focus on the fact that I'm not having sex as much as I used to. I focus on that this is a transition, and you have to adapt to getting older. You need to focus on everything else that brings you happiness and satisfaction instead.	Part of overcoming the sadness or anxiety around aging and sexuality is realizing that he is fulfilled in many other aspects of his life. He has had and currently has a very good life and is happy, so he focuses on that instead of on not having as much sex as he used to
9	68-71	133	Also, it eliminates that risk of, or it puts that spice of variety into the relationship. I know that's sort of exclusive to gay men. I know heterosexuals aren't as receptive to that. And I get that because they mate for different reasons, and we are a different species sexually than they are	Belief that openness in relationships, whether fully open or bringing in a third for threesomes, isn't understood as well by heterosexuals as it is by bisexuals. And maybe that's because heterosexual form partnerships for other or additional reasons.
9	80-84	134	In my neighbourhood, we're accepted as just another couple on the street. But I would never tell my neighbours. We would never tell my neighbours we do three-ways. As for my friends, as liberal as they are, maybe a couple of them know. I don't think they would judge, I just think they would have a difficult time processing?	Explains that he has to hide his sexuality/openness from his neighbours and heterosexual friends because they wouldn't understand as well as another gay person would.
10	164-166	135	I don't want anybody. Like I've never been rejected by anybody for my body type or anything like	Anxiety around body image sometimes causes him to not want sex, so either not initiate or engage in sex, and

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			that. But I still don't like certain parts of my body and I don't want to show it at first.	makes him reluctant to be undressed.
10	178-179	136	I'll make something up. I would say I'm tired, I don't feel good, or whatever because I don't feel comfortable naked.	He will make excuses to avoid sex if he is not feeling confident with his body.
10	205-212	137	I never stop to say I'm gay. I can't. I just can't do it. I tried to go with the flow and just talk, but I just don't say it. Like nobody at work knows... I've always been scared for people to know because I came from a country where still today bullying is okay, like to bully gay people	He is uncomfortable with being gay and doesn't like talking about his sexuality or for people to know. He is scared to tell people he's gay or be seen as gay because he had a homophobic upbringing where he had to hide his sexuality.
10	244-246	138	Well when I was younger, yes. Like I used to just walk away. Like if any gay man was getting close to where I was, I would move myself. And I would try to show myself as a different person. Like I would be more rude or cold just to avoid people seeing it	Would act homophobic in order to deflect attention off himself and not come off as gay.
10	254-256	139	So like I said, I was so worried about people getting to know what it is or a person hearing a rumour or anything like that, I would stop anything that is going on. Like I'd avoid talking or being around any gay guys so no one else would know.	His concern about people finding out he is gay affects his current romantic and sex life and he will avoid approaching or being approached by other guys so people don't know he's gay. This has prevented him from having sex
10	275-277	140	And I hated myself, I hated my sexual organs for some time in my life. It made me feel ashamed about being gay and I think that's why I'm still uncomfortable around other gay men, or having others perceive me as gay.	His experience of being sexually assaulted in his youth has caused him to repress his sexuality
10	281-283	141	And all this kind of stuff is always going inside, inside, inside. And it's repeated in my mind. I think about it probably, 3 or 4 times a day. It's still coming to me and it's been so many years.	Thoughts and anxieties about his experience with sexual abuse are pervasive, and still affect him multiple times a day.
10	296-298	142	It's happened both. Depends if it's at the start or in between. If it's during sex and I feel that	If he is triggered during sex or foreplay, and is reminded of his sexual abuse, then he will lose interest in sex

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			something that we are doing can bring me to that memory, then I can completely go and lose interest in everything.	and need to stop.
10	339-342	143	I don't think I have done it completely, you know? Because I still hide it, like I said. I know at work there is at least two people that are openly gay, and I avoid those persons. I really avoid them, like really bad. Like I don't want to work with them, I don't want them to come to my area.	Still is battling internalized homophobia as he still doesn't want people to know. For instance, he hides it at work despite two co-workers being openly gay. He avoids them so others don't think he is gay.
10	346-349	144	I don't want to be associated with them, you know? Sometimes I feel like, you know, if I'm off one day, I should go out and have a couple drinks. I want to go to a gay club, and maybe hang out as a gay guy. And sometimes I get there, get to the building and then I turn around and go home.	Will stop himself from going out to socialize with other gay men because he does not want people to see that he is gay.
11	18	145	Healthy sex would be safe sex, or at least like PrEP, condoms, getting tested regularly.	Outside of a relationship, a healthy sex life is one where you are protecting yourself from STIs and HIV (PrEP and condoms) and are frequently tested so you are aware of your sexual health status
11	12-14	146	... it's being able to enjoy having the type of sex you want without any concerns for your physical health. And also, no concerns regarding the emotional intimacy. Trying to be as barrier free as possible, if that makes sense.	A healthy sex life is one that is free of risk of STIs and emotional harm/trust issues. It should be one where you can be completely open about your sexuality with your partner.
11	135-139	147	There was another guy, he was very attractive but I just could not find myself aroused because we went into it like super quickly, as a matter of fact. And again, I felt this internal, "Why are you finding this attractive? Why are you enjoying this" And he clearly is and he clearly enjoyed it. But I guess I felt reluctance, yes. Or like a shame about being naked, which may have contributed to feeling like I wasn't attractive.	Could not get fully aroused and enjoy sex with a guy he was very attracted to because he kept having pervasive thoughts about feeling unattractive.

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11	161-163	148	Fairly low because one, having gone through the whole rigmarole about having to worry about being safe, I know what safe sex is and how to have it, as well as how to prioritize it.	Previous experience prioritizing safe sex with a HIV positive partner has made him confident in his ability to protect himself from HIV
11	163-166	149	Whenever someone messages me asking to bareback, it's like, "No stranger! You're attractive but good-god that's terrifying." Like if you're not even asking if I'm on PrEP or something, which is not on my Grindr profile, then no. I don't even want to go near that if you're not going to have that conversation	Discussing sexual health and safe sex before meeting up is important in protecting yourself from STIs/HIV
11	181-183	150	But right now, I don't really feel like I have any HIV concerns because PrEP is like a perfect iron shield around it. And then condoms add.. well it's a perfect second wall behind the wall of having a condom.	Does not worry about HIV because he is on PrEP and regularly uses condoms.
11	197-202	151	Because I feel like it's virtually impossible for me to get right now. PrEP, condoms, topping; unless you tell me otherwise, I'm pretty sure I covered the bases that I can. And my ex, we keep in good, regular touch. He's on medication and is totally fine. So even if the worst is going to happen, it's very different from a time where you get diagnosed and the proper meds weren't invented yet and you have nothing. He was diagnosed like 9 years ago now, and he's fine.	He is currently more concerned about other STIs than HIV because he does not feel like he is at risk of catching HIV. This is due to a combination of preventative measures the he uses (PrEP, condoms, and topping). In addition, knowing that HIV is not fatal, and that you can live a happy and healthy life with HIV, helps relieve worries around HIV acquisition.
11	208-216	152	I know that [U=U], and with our activities, especially if I'm on PrEP and we use a condom, there's practically no chance of transmission.	Due to U=U, condom use, and PrEP, he would be willing to have sex with a HIV positive partner.
11	280-288	153	I think growing up it was sort of understood that it was a thing, but it was bad. It was not desirable. And I had that sort of sexual awakening experience when I was	When he realized he was attracted to men, he understood that public opinion towards homosexuality was negative and undesirable. He internalized this message when he

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			<p>young with my friend. That was like in 2002, so the Defensive Marriage Act was the big thing in the states. And even the gay marriage was very unpopular in 2005 when it was legalized at the federal level. So, for me, I knew it was something that was not desirable. I knew it was something that was kind of bad, or at least for other people who begrudgingly started having to accept gay people. So, once I realized that I would fall into that category, I wondered how I could wish this away and not be the case.</p>	<p>was younger and tried to hide and run away from the fact that he was gay</p>
11	30-36	154	<p>So it was like, get into it right away, a good relationship for the first month and a half, and then next 3 years it became an issue of negotiating, “okay you have it, but now do I have it, and how do we navigate this?” So I never really learned what it meant to have a good, satisfying or healthy sex life because it was always about how do we make sure we are being as safe as possible, which can lead to it just being dull as well. The only time we were adventurous was the two times I was on post-exposure anyways.</p>	<p>He never learned what good sex was when he was in a relationship for 3 years with a positive partner because he was always anxious about catching HIV. Always worrying about being safe took away the pleasure</p>
11	319-322	155	<p>I was more the one who didn’t care about being able to be PDA with my ex at the start. But then later on I got a little more skittish with it. But again, I think that’s tied to body image issues. Like, “Oh you’re not fit, you’re not fitting the image. You should be ashamed, so keep that private.”</p>	<p>He felt like they weren’t going to be accepted as a gay couple by others because of how he looked (not fitting the image of a fit gay man).</p>
11	329-335a	156	<p>But there is sort of a feeling that gay sex works differently from straight sex. Biology withstanding. But it’s sort of like, the sex is first and then everything else follows afterwards. So to a certain extent that... I wonder if it would count as</p>	<p>He feels increased pressure to emphasize sex and to have sex because he is gay, and feels like he's internalized messages that gay men are promiscuous. He worries that this will prevent him from finding a monogamous partner.</p>

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			<p>homophobia because you are presuming that all guys are like that. And that's internalized form the message that men are just after sex with each other, and are not interested in relationships, or not capable of relationships. And it concerns me because if it's true, then maybe I'll never find what I'm actually looking for.</p>	
11	47-49	157	<p>But now, I think my issues are more body image issue related. For me that's been something that's been a struggle my whole life. Like gain weight, lost weight, gained weight, lost weight, etcetera.</p>	<p>His main worries around sex are body image related. This is likely due to a him struggling with is body image for many years</p>
11	64-68	158	<p>Think about straight porn for a second, there's a guy but presumably you are looking at the girl. So, you are looking at something that is not you, your object of desire is not someone like yourself. Whereas when you are looking at another guy, or like two men having sex together, it's like, "Okay I need to live up to an ideal." Even though like, tops and bottoms are different, and might have different muscular structures and all that kind of stuff. But there's like one symbol for sexual attraction, it's the one that you yourself have to live up to. Whereas for a straight guy watching straight porn, they're looking at the woman, it's completely other. It's not a same comparison.</p>	<p>Porn causes him to feel body inadequacy as the focus of gay porn and the porn he watches is on two presumably fit/thin/muscular males/male bodies, and not on a female like it is in straight porn. So, it makes him compare his body to that of the porn stars which makes him feel like he doesn't live up to the ideal set by porn, and the standard of his own attractiveness</p>
11	78-82	159	<p>... it's feeling like that's not desirable. Or at least I don't find it attractive. And in fact, it's almost a turn-off if others find it attractive. Like I've internalized that it's not attractive, but I have it. And I still want to enjoy sex and enjoy others, but I find I'm turned off by them if they're enjoying it. It's</p>	<p>Since he doesn't find himself attractive due to his weight, it's hard for him to enjoy sex because he doesn't understand why the person finds him attractive, and thinks they are just lying to him. And if they do find him attractive/are enjoying sex with him, he feels turned off by the fact that they are attracted to something he</p>

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			such a backwards way of thinking about it. I wonder what's underlying or going on underneath. It's disconcerting.	himself has deemed undesirable.
11	87-89	160	Absolutely, and embarrassingly enough, I think that's one of the reasons I get more scared to say that I'm gay. It's not that I'm afraid of being gay, it's that.. cause I'm not fit, or not physically in the proper shape or physique that gay men are supposed to have.	He has internalized messages that gay men are supposed to be fit/in shape. Therefore, he feels like he doesn't meet the standard of what a gay man is supposed to look like, and will refrain from informing others that he is gay because of it.
11	40	161	It was always there. So that was kind of an overriding issue	The fear of HIV was always present during sex with his positive ex, and it blocked his ability to have good sex/fully enjoy sex.
6	232-233	162	Um I really haven't had any complaints. I often don't get turned away. So, when I choose to have that conversation with somebody, it seems there is 100% success.	One of the reasons he is confident with his body and appearance is because he's received either positive or no negative feedback from his partners, which is evident by not being turned down by other guys
1	289-292	163	... when you are bottoming, I can't do it on the fly. I have to watch what I eat, prepare myself mentally right? Like "Oh I'm going to bottom today", I need to wash up and get myself ready. Whereas topping, it can happen in the moment. I don't really need to prepare, watch what I eat or anything like that	Bottoming can be more anxiety provoking than topping as there is more preparation needs to be done in comparison to topping.
5	153-157	164	Because there is such a stigma with attached to HIV, even though you are totally fine to live with it. It'll influence your life but not to the same degree that it would in 1993. But I would say there is always something at the back of your head. Like compared to my heterosexual friends, they are not worried about HIV in the same way that I worry about it, or my gay friends do.	Fear of HIV is a pervasive anxiety during sex, and an anxiety that is unique to the MSM experience.
9	230-234	165	So yeah, your perception of your body changes, and you're also not as virile. So, it's changed, and there's definitely an element of	Becoming less youthful or attractive with aging can be anxiety provoking as you need to transition and accept that you may not be able to have as much

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			sadness about it. In terms of wishing you look now how you did back then so you can have sex whenever you want and with whoever you want again. But that's just the reality of it.	sex as you used to.
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Appendix 6. Formulated meanings, meaning units and emergent themes.

Formulated Meanings (Coded Number)	Meaning Unit(s)	Emergent Theme
<p>A satisfying sex life is one that is active, and that involves people whom which there is a level of trust and some sort of relationship. (33)</p> <p>Satisfying sex is when it's on a regular basis (frequent enough) and with someone you're connected to. (49)</p> <p>Currently in a satisfying open relationship since both enjoy exploring outside the relationship, and he's happy with the frequency of his sex. (58)</p> <p>A satisfying sex life is one where he is having a certain frequency of sex, and preferably with a monogamous partner. (72)</p> <p>A satisfying sex life is one in which sex happens at least at a desired frequency, and one in which he can partake in the sexual activities he wants to. (118)</p> <p>A healthy sex life is one where you are having a satisfying frequency of sex with people you are attracted to. (128)</p> <p>A healthy sex life is about mutual satisfactions in terms of frequency and sexual gratification. (131)</p>	<p>Frequency</p>	<p>Definitions of Healthy and Satisfying Sex Lives</p>
<p>Healthy sex is sex that is consensual from all parties. Everyone is okay with what is going on. (25)</p> <p>A healthy sex life is one where you and your partner are capable of having an open conversation about sex, and where you feel safe exploring and trying new things or things you may not enjoy for the benefit of your partner. (79)</p> <p>Healthy sex is sex that is free of social stigmas (won't be judged by partner), and stays between the consenting parties. (81)</p>	<p>Consent, Comfort and Trust</p>	<p>Definitions of Healthy and Satisfying Sex Lives</p>
<p>A satisfying sex life is one that is pleasurable (able to achieve orgasm with partners) and one in which the sexual activities are mutually agreed. (105)</p> <p>A healthy sex life if one where your sexual needs are met/you are sexually satisfied, and is free of emotional or physical harm (i.e., STIs risk and violence) (113)</p>	<p>Pleasurable</p>	<p>Definitions of Healthy and Satisfying Sex Lives</p>
<p>A healthy sex life is one where you are informed of your own sexual health statuses, and know what you are getting into in</p>	<p>Informed and Safe</p>	<p>Definitions of Healthy and Satisfying Sex Lives</p>

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<p>terms of risks to your sexual health (HIV/STIs) and the sexual activities that happen. (34)</p> <p>Awareness of your own and your partner's status in regards to STIs/HIV contributes to a healthy sex life. (78)</p> <p>A healthy sex life is one where you don't feel shame in your sexual activities or desires. Getting tested frequently and knowing your sexual health status is also part of a healthy sex life, as well as having conversations (pre-sex discussions) with sexual partners about each other's statuses. (97)</p> <p>Outside of a relationship, a healthy sex life is one where you are protecting yourself from STIs and HIV (PrEP and condoms) and are frequently tested so you are aware of your sexual health status. (145)</p> <p>A healthy sex life is one that is free of risk of STIs and emotional harm/trust issues. It should be one where you can be completely open about your sexuality with your partner. (147)</p> <p>A healthy sex life is one where you are having safe sex, and are aware of your sexual health status. (70)</p>		
<p>Bottoming can be anxiety provoking as worries about having an "accident" (i.e., poop) is there. No previous history of such accidents though, but he needs to prepare and clean up if he knows he's going to be bottoming. (11)</p> <p>He is more sexually confident when topping compared to bottoming due to performance anxiety from lack of experience, and from potential pain/discomfort. (28)</p> <p>Previous history of issues with feces during anal sex causes him worry now when having anal sex, and causes him to prefer other sexual activities to anal sex. (44)</p> <p>Has performance anxiety when bottoming due to lack of experience. Prefers to be a top because he feels like his experience makes him better at it. (121)</p> <p>Bottoming can be more anxiety provoking than topping as there is more preparation needs to be done in comparison to topping. (163)</p>	<p>Bottoming Anxieties</p>	<p>Performance Anxiety</p>
<p>He is more anxious about hooking up with someone new than with someone he's experienced with because he feels like there are expectations put on that sex, and he feels like he will let the person down if those expectations don't happen</p>	<p>Partner Feedback</p>	<p>Performance Anxiety</p>

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<p>or aren't met. (52)</p> <p>Positive feedback from most previous sexual partners have contributed to him being confident/less anxious with sex. This likely relates to not experiencing performance anxiety. (30)</p> <p>Has more performance anxiety if he's hooking up with someone new because he feels pressured to perform well to prevent negative rumors spreading about him. (53)</p>		
<p>Anxiety about small penis size - performance anxiety while topping as he doesn't feel like his penis size is adequate enough to pleasure a partner. Also, some anxiety about being assumed to be a bottom due to penis size. (15)</p>	<p>Penis Size</p>	<p>Performance Anxiety</p>
<p>Fear of HIV is partly contributed to stigma against HIV from within the MSM community, and from false messages about HIV/AIDS while growing up. (9)</p> <p>Worried about contracting HIV because of the stigma against it (society and within community). Also scared because he'd have to tell his parents who would be very worried for him, and he doesn't want to feel like a burden on their emotions. Even if it's not a death sentence anymore. (36)</p> <p>Stigma from within and outside the gay community contributes to fear of HIV. Also, he would not want to have to disclose being positive to his family, as it would cause them worry and burden them with his health. (82)</p> <p>His worries about HIV and STIs are influenced by policies requiring him to be HIV-negative and syphilis free for the duration of his student Visa, lest he not be able to renew his visa and forced to go back to his home country. (98)</p> <p>Example of stigma against gay sex and HIV from those outside the community, in this case his friend. (119)</p> <p>Fear of HIV is a pervasive anxiety during sex, and one that is unique to the MSM experience (164)</p>	<p>Fear of HIV Stigma</p>	<p>Fear of HIV and Bacterial STIs</p>
<p>Previous history with chlamydia influences current worry about contracting another STI. (1)</p> <p>Previous history of STI causes concern that he should be safer with his sexual practices. (16)</p> <p>Despite always using condoms and being sexually selective to keep himself safe, he still contracted an STI. This contributes to why he has a large concern for STIs, because his safety mechanisms have failed in the past. (40)</p>	<p>History of STI</p>	<p>Fear of HIV and Bacterial STIs</p>

<p>Fear of STIs influenced by previous history of STI and internalized stigma. (41)</p> <p>Always has a fear of STIs despite practicing safe sex and being knowledgeable about STIs. This is due to previous history with an STI, and worry about being stigmatized by others. (46)</p> <p>His previous syphilis scare and the treatment needed contributes to his fear of bacterial STIs. (126)</p>		
<p>Rule for open relationship: wear a condom when having sex with someone who isn't the primary partner. This reduces anxiety as it lowers the chances of someone bringing an infection into the shared bedroom. (26)</p> <p>Disclosure done to maintain trust within the open relationship since the general rule is to wear condoms. Helps lessen worry about STIs being brought back into the bedroom, since you know who your partner has been with, and what they have been doing. (68)</p> <p>They mitigate the risk of STI or HIV transmission when having threesomes with others by always having protected sex. (127)</p>	<p>Open Relationships</p>	<p>Fear of HIV and Bacterial STIs</p>
<p>HIV is scarier than other STIs, because unlike most other STIs, HIV is permanent/less treatable. (6)</p> <p>Fear of HIV contributed to having to take treatment for entire life (i.e., not curable), and because it would mean having to disclose health status and sexuality to family. (10)</p> <p>Is more concerned with HIV than other STIs as unlike most other STIs, HIV is non-curable. (27)</p> <p>Fear of HIV influenced by its permanence and that you have to take meds the rest of your life. (37)</p> <p>Frequent testing helps mitigate the anxiety of STIs that are curable and more easily treated, such chlamydia, crabs and syphilis. However, his anxieties appear centred around the permanence issues of some STIs, as highlighted by him being concerned about HIV, Herpes and AMR in STIs. (38)</p> <p>He is more concerned with HIV than other STIs as HIV is non-curable. (83)</p> <p>Permanence of HIV - having to take pills every day and having your life reliant on a health care system - contributes to the fear of HIV. (84)</p>	<p>Permanence of HIV</p>	<p>Fear of HIV and Bacterial STIs</p>

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<p>Had a syphilis scare, but modern medicine (testing and treatment) helped mitigate fear or worry around the STI, which allowed him to feel like the situation was under control. (92)</p> <p>He is more concerned with HIV than other STIs because HIV is permanent/non-curable. (100)</p>		
<p>Still would have some anxiety having sex with a positive but undetectable partner if he was bottoming. The greater risk of contracting something while bottoming vs. topping is a mental block for him to prefer or suggest bottoming. (60)</p> <p>Anxieties around catching a STI so he doesn't do penetrative sex with a hook up (someone he doesn't know well). There's less chance of catching a STI from non-penetrative sexual activities. (71)</p>	<p>Position Choice</p>	<p>Fear of HIV and Bacterial STIs</p>
<p>Tends to use condoms when having sex since he is not on PrEP. Suggests that largest concern is HIV, and that he may bareback more if he was on PrEP. (5)</p> <p>Protects self from STIs/HIV by refusing anal sex if a condom isn't available. However, if a partner is on PrEP, it's a green light for him to be able to bareback because he assumes the partner is HIV negative. (7)</p> <p>Always uses a condom when having anal intercourse. The reason why is because he worries about STIs. (32)</p> <p>Because he doesn't like anal sex due to loss of sensation with a condom, he is considering going on PrEP and barebacking. However, this may increase his worry about other STIs. (45)</p> <p>Perceived risk of HIV is low due to being on PrEP. (50)</p> <p>He is more concerned with other STIs than with HIV because both he and his partner are on PrEP. (51)</p> <p>Explains that over time, his concern for and perceived risk of HIV has diminished as there is now PrEP to prevent him from getting HIV, and even if he does get it, it's no longer fatal like it used to be. You can still live a happy and healthy life if you are HIV-positive, and that helps take away some of the anxiety around it. (56)</p> <p>In order to keep himself and his partner safe, both use condoms with other people outside the relationship. In addition, their regular partners are also on PrEP, which</p>	<p>PrEP and Condom Use</p>	<p>Fear of HIV and Bacterial STIs</p>

<p>mitigates anxieties around HIV. (67)</p> <p>Still has anxieties about catching HIV despite being on PrEP because there are strains of HIV that Truvada doesn't cover. (108)</p> <p>If you are on PrEP, there is pressure to bareback from others, especially if they are also on PrEP. This causes anxiety around being safe and other STIs as it makes it difficult to use condoms consistently. (109)</p> <p>Provides an example of unprotected sex under safe conditions (partner is on PrEP and recently tested) to highlight anxieties around sexual health and STIs. He feels guilty after and worries about his health if he does bareback, even if it is with someone who is "safe." (110)</p> <p>PrEP isn't fully helpful. But it's useful for relieving some anxiety around HIV acquisition during sex. (111)</p> <p>He uses condoms consistently during sex. He even went off PrEP because he was still using condoms just as regularly. He saw no point of taking a daily pill and getting his regular blood work if his practices didn't change from before being on PrEP. (125)</p> <p>Does not worry about HIV because he is on PrEP and regularly uses condoms. (150)</p> <p>He is more concerned about other STIs than HIV because he does not feel like he is at risk of catching it right now. In addition, knowing that HIV is not fatal, and that you can live a happy and healthy life with HIV, helps relieve worries around HIV acquisition. (151)</p>		
<p>He feels like he is destined to get HIV, no matter how safe he is. (47)</p> <p>The high and rising prevalence of syphilis in the MSM community is a cause for concern and leads to anxiety around catching syphilis. (114)</p>	<p>Prevalence</p>	<p>Fear of HIV and Bacterial STIs</p>
<p>Anxiety around HIV and other STIs risk because you never know how often a potential sexual partner gets tested, and don't know if they are actually aware of their health status. People getting tested less than once every 3 months causes him to worry. (48)</p> <p>Asking a partner's recent sexual and testing history is a way of protecting oneself and of reducing anxiety around HIV and</p>	<p>Testing History and Health Status</p>	<p>Fear of HIV and Bacterial STIs</p>

<p>STIs. (31)</p> <p>Frequent testing helps mitigate the anxiety of STIs that are curable and more easily treated, such chlamydia, crabs and syphilis. (39)</p> <p>It's easier to have conversations about safe sex and sexual health with someone you meet online vs. in-person because the platforms allow for information sharing which facilitates those conversations. (57)</p> <p>Knowing each other's sexual health status (HIV/STIs) factors into the decision to use condoms or not during sex. One way of knowing is to get tested together and share results. (80)</p> <p>It's more difficult to know a partner's sexual health status if you are less familiar with them, thus it is more anxiety provoking. (96)</p> <p>The sexual nature of online gay dating platforms, such as Grindr, provides confidence to initiate or engage in sexual conversations. This helps facilitate conversations about sexual health prior to meeting. (115)</p> <p>Discussing sexual health and safe sex before meeting up is important in protecting yourself from STIs/HIV. (149)</p>		
<p>Would have sex with someone who is positive and undetectable because they are more likely to be aware of their health status (since they are seeing doctors more regularly) and are likely to have their health under control. It's anxiety relieving to know that they see doctors and are tested often compared to those who may only test once or twice a year. (8)</p> <p>Belief that it may be safer to have sex with someone who is positive but undetectable compared to someone HIV-negative, because the positive person is more likely to be tested frequently and be aware of their sexual health status. (35)</p> <p>He would have sex with someone who is HIV-positive and undetectable, but would use a condom. With the combination of using protection, being on PrEP, and the person being undetectable, there's very little risk for or concern of HIV acquisition. (59)</p> <p>Despite a fear of HIV, he would be okay having sex with someone who is HIV-positive but undetectable as long as a</p>	<p>U=U and Positive Partners</p>	<p>Fear of HIV and Bacterial STIs</p>

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<p>condom is used. This is mostly to protect himself and the partner from other STIs. (99)</p> <p>If someone was HIV+ but undetectable, he knows he couldn't get HIV from them, but would use a condom anyways. (124)</p> <p>The fear of HIV was always present during sex with his positive ex-boyfriend, and it blocked his ability to have good sex/fully enjoy sex. (161)</p> <p>Previous experience prioritizing safe sex with a HIV positive partner has made him confident in his ability to protect himself from HIV. (148)</p> <p>Due to U=U, condom use, and PrEP, he would be willing to have sex with a HIV positive partner. (152)</p> <p>He never learned what good sex was when he was in a relationship for 3 years with a positive partner because he was always anxious about catching HIV. Always worrying about being safe took away the pleasure. (154)</p>		
<p>Anxiety around his sexuality being disclosed/found out by his family or members of his community as being gay is seen as a sin and he would be stigmatized (since word will travel fast in a small community). (18)</p> <p>A traditional/religious upbringing bred internalized homophobia when he was younger due false and homophobic messages he was getting from his family and the church. (85)</p> <p>Internalized homophobia stemming from a religious upbringing that classified homosexuality as a sin. Also, often questioned why he was different from his family, and despised that he was different as he didn't want to let them down/didn't want to be a disappointment. This led to an identity crisis, self-hate, suicidality and self-harm. (20)</p> <p>The false and homophobic information his mom gave him about gay sex stimulated some internalized homophobia. i.e., traditional/conservative upbringing as a causal agent for internalized homophobia (86)</p>	<p>Culture, Family and Religion</p>	<p>Internalized Homophobia</p>
<p>Had very little exposure to gay growing up, due to being in a white, suburban, non-diverse neighbourhood. i.e., upbringing was heteronormative. This resulted in him not being exposed to anything gay or even knowing what gay meant. Led to some internalized homophobia and identity issues. (29)</p>	<p>Heteronormativity</p>	<p>Internalized Homophobia</p>

<p>Stigma against open relationships from people outside the community causes anxiety around being in one (61)</p> <p>Stigma against open relationships from people outside the community causes anxiety around being in one. Heteronormative society doesn't tend to understand in his experience. (64)</p> <p>Heteronormative upbringing with low exposure to LGBT contributed to the anxieties around the unknowns of a gay life path. (65)</p> <p>Feels like he needs to hide his open relationship status in certain situations, so that he won't be judged by straight people. (66)</p> <p>Feelings of internalized homophobia and messages of heteronormativity are encompassing and interfere sometimes during sex. (77)</p> <p>He experienced some internalized homophobia when he was younger due to minority status, i.e., wondering why he was different from the majority of those around him (i.e., straight people). (106)</p> <p>Belief that openness in relationships, whether fully open or bringing in a third for threesomes, isn't understood as well by heterosexuals as it is by bisexuals. And maybe that's because heterosexual form partnerships for other or additional reasons. (133)</p> <p>Explains that he has to hide his sexuality/openness from his neighbours and heterosexual friends because they wouldn't understand as well as another gay person would. (134)</p>		
<p>When he realized he was attracted to men, he understood that public opinion towards homosexuality was negative and undesirable. He internalized this message when he was younger and tried to hide and run away from the fact that he was gay. (153)</p> <p>In his youth, when he was still trying to conceal his sexual identity, he would say homophobic comments just so he wouldn't come across to others as gay. (19)</p> <p>He is uncomfortable with being gay and doesn't like talking about his sexuality or for people to know. He is scared to tell people he's gay or be seen as gay because he had a homophobic upbringing where he had to hide his sexuality.</p>	<p>Identity Avoidance</p>	<p>Internalized Homophobia</p>

<p>(137)</p> <p>Would act homophobic in order to deflect attention off himself and not come off as gay. (138)</p> <p>His concern about people finding out he is gay affects his current romantic and sex life and he will avoid approaching or being approached by other guys so people don't know he's gay. This has prevented him from having sex. (139)</p> <p>Still is battling internalized homophobia as he still doesn't want people to know. For instance, he hides it at work despite two co-workers being openly gay. He avoids them so others don't think he is gay. (143)</p> <p>Will stop himself from going out to socialize with other gay men because he does not want people to see that he is gay. (144)</p>		
<p>Having to put on the appearance of a masculine man during his upbringing facilitated some internalized homophobia towards more feminine men. This manifests itself in choice of sexual or romantic partners, as he naturally goes for more masculine looking men. (87)</p> <p>Stigma against gay sex/bottoming is internalized, and it sometimes impacts his sexual practices. (120)</p>	<p>Position and Partner Choice</p>	<p>Internalized Homophobia</p>
<p>Perceived sex-focused gay culture puts pressure on gay men to have sex and to look a certain way so that they can have sex. In addition, since sex is so body-focused, he feels pressured to go to the gym, in order to look more attractive. (62)</p> <p>When you're older and no longer as virile and desired as you were in your 20s-40s, you have to be able to adapt to not being able to have sex whenever you want, your sexuality has to change. (130)</p> <p>He feels increased pressure to emphasize sex and to have sex because he is gay, and feels like he's internalized messages that gay men are promiscuous. (156)</p>	<p>Pressure to Have Sex</p>	<p>Internalized Homophobia</p>
<p>Felt anxiety about his sexuality and sex life at first because he internalized messages of gay sex being taboo. (24)</p> <p>Unexpected internalized homophobia experienced as a homophobic thought during sex with a man. (76)</p>	<p>Taboo Sex</p>	<p>Internalized Homophobia</p>
<p>There is a standard of beauty of being white/Caucasian in the gay community, and that can cause body image/appearance issues for MSM of different ethnic backgrounds. (17)</p>	<p>Gay Appearance and Beauty Standards</p>	<p>Body Image</p>

<p>The gay community is appearance-oriented and therefore there is pressure to look a certain way, and conform to the look of a rich(well-dressed/well-groomed), fit and white gay man. (88)</p> <p>There is pressure from within the community to maintain a certain image/appearance (well-dressed and well-groomed) because that's what a gay guy is "supposed to look like." (89)</p> <p>Due to being gay, he felt pressure to conform to a certain look, which is being fit, well-groomed and attractive. (102)</p> <p>Messages from within the gay community put pressure on him to try to fit a standard of attractiveness, which is being young, white, and muscular/chiselled. (117)</p> <p>He felt like they weren't going to be accepted as a gay couple by others because of how he looked (not fitting the image of a fit gay man). (155)</p> <p>He has internalized messages that gay men are supposed to be fit/in shape. Therefore, he feels like he doesn't meet the standard of what a gay man is supposed to look like, and will refrain from informing others that he is gay because of it. (161)</p>		
<p>He feels pressured to fight the signs of aging and maintain a fit physical appearance or else he won't have sex. Concern around becoming less attractive and sexualized as he ages. (116)</p> <p>His sexuality was a large part of his identity, which he felt was true for most gay men. So, as he has aged and become less "youthful", he had to adjust to not having as much sex and not being as desired. He had to adapt and find a new identity, including new avenues of socializing and finding pleasure in other activities. (129)</p> <p>Part of overcoming the sadness or anxiety around aging and sexuality is realizing that he is fulfilled in many other aspects of his life. He has had and currently has a very good life and is happy, so he focuses on that instead of on not having as much sex as he used to. (132)</p> <p>Becoming less youthful or attractive with aging can be anxiety provoking as you need to transition and accept that you may not be able to have as much sex as you used to. (165)</p>	<p>Issues with Aging</p>	<p>Body Image</p>
<p>Body image issues may stem from not meeting depictions of</p>	<p>Media Representations</p>	<p>Body Image</p>

<p>what gay men look like in the media, which is often white and fit/muscular. (63)</p> <p>Media images of gay men put pressure on MSM to try to conform to the gay mold that is depicted in media, which is often white, muscular and attractive. This can cause body image issues for MSM who do not feel like they meet that beauty standard, whether it be ethnicity, body type, etc. (103)</p> <p>Porn causes him to feel body inadequacy as the focus of gay porn and the porn he watches is on two presumably fit/thin/muscular males/male bodies, and not on a female like it is in straight porn. So, it makes him compare his body to that of the porn stars which makes him feel like he doesn't live up to the ideal set by porn, and the standard of his own attractiveness. (158)</p>		
<p>Due to societal associations between femininity and being gay, there is an anxiety of appearing more feminine, as this may be considered unattractive. As a result, gay men try to appear more masculine in contrast to stereotypes. However, this may cause body image or physical appearance insecurities for those who appear more "feminine" in their physical traits. (14)</p> <p>Since he started going to the gym and getting more fit/muscular, he has finds himself more attractive and is more confident. This has translated into him attracting more attractive guys, which has improved his sex life. (42)</p> <p>Improved confidence and body image since going to the gym and gaining muscle. (54)</p> <p>In comparison to before he started going to the gym, he now has more sex outside of his relationship, despite also being open then. This is because he is more confident now and is more willing to engage or seek out sex outside his relationship. (55)</p> <p>Since going to the gym, his body image and confidence has improved as he put on more muscle. However, he does admit that he started going to the gym because he feels pressured to look muscular in order to attract other gay guys. (101)</p> <p>He is more sexually confident and his sex life has improved since he started working out. This is because he finds himself more attractive to others, and has received more positive feedback about his body since he started working out</p>	<p>Muscularity and Fitness</p>	<p>Body Image</p>

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<p>regularly. (104)</p> <p>His positive body image improves his sex life as he is confident getting naked in front of partner. (112)</p>		
<p>Has body image issues due to being overweight. This is an issue as in generally society, being overweight is deemed unattractive, and this is even more pronounced in the gay community. (12)</p> <p>He is currently struggling with body image issues and perceives himself to be larger or heavier than he actually is. (73)</p> <p>His main worries around sex are body image related. This is likely due to him struggling with is body image for many years. (157)</p> <p>Since he doesn't find himself attractive due to his weight, it's hard for him to enjoy sex because he doesn't understand why the person finds him attractive, and thinks they are just lying to him. And if they do find him attractive/are enjoying sex with him, he feels turned off by the fact that they are attracted to something he himself has deemed undesirable. (159)</p> <p>Being overweight is considered unattractive in the gay community because it's associated with femininity. (13)</p>	<p>Overweight</p>	<p>Body Image</p>
<p>Body image issues and related negative thinking are experienced greater after sex than before or during sex; comparing himself to his partner. (23)</p> <p>Despite going to the gym and feeling more confident, happy and attractive, he does still experience body image concerns if having sex with someone who is thinner. (43)</p> <p>Body image issues are usually felt more often or heightened after sex due to increased vulnerability from being naked and having attention focused on your body. (74)</p> <p>Body image issues causing reduced confidence in physical appearance after sex. (75)</p> <p>One of the reasons he is confident with his body and appearance is because he's received either positive or no negative feedback from his partners, which is evident by not being turned down by other guys (162)</p> <p>Could not get fully aroused and enjoy sex with a guy he was</p>	<p>Partner Opinions and Comparison</p>	<p>Body Image</p>

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<p>very attracted to because he kept having pervasive thoughts about feeling unattractive himself. (147)</p> <p>He feels less self-conscious about his body if sex is with someone he doesn't know since he won't see them again. i.e., doesn't have to leave a good impression. (21)</p>		
<p>If he doesn't not feel confident about his appearance, then he will avoid looking for or having sex. (2)</p> <p>If he doesn't not feel confident about his appearance, then he will avoid looking for or having sex as he doesn't feel like anyone else is going to want him. (3)</p> <p>Body image issues creates hesitance in undressing in front of a sexual partner as sex is body focused. (69)</p> <p>Anxiety around body image sometimes causes him to not want sex, so either not initiate or engage in sex, and makes him reluctant to be undressed. (135)</p> <p>He will make excuses to avoid sex if he is not feeling confident with his body. (136)</p>	<p>Sex Avoidance</p>	<p>Body Image</p>
<p>History of sexual abuse from an older man when he was in his early teens. This experience fed into the idea he was taught growing up that gay men are perverts. i.e., history of sexual abuse contributed to internalized homophobia. (22)</p> <p>He avoided gay sex, seeing gay sex, and thoughts of gay sex for a period after being sexually assaulted so as to not get triggered. (95)</p> <p>Previous history of sexual abuse led to internalized homophobia and repression of sexuality following the event. (122)</p> <p>His experience of being sexually assaulted in his youth has caused him to repress his sexuality. (140)</p>	<p>Internalized Homophobia</p>	<p>Sexual Abuse</p>
<p>In order to lessen anxiety about potentially being harmed by a sexual partner, he informs a friend of his location before meeting for a sexual encounter, and will also try to get to know the person better before sex to better screen out their personality and motives. (4)</p> <p>History of sexual abuse /assault has changed his perceptions on sex, as he experienced a loss of sexual autonomy and has to work to get that back or to feel it again with a partner. Thoughts or memories of the sexual abuse are described as pervasive, and the anxiety manifests itself as a desire to</p>	<p>Loss of Autonomy and Desire for Control</p>	<p>Sexual Abuse</p>

<p>control what's going on in a relationship and with sex. The control allows him to feel autonomous and like he can consent to what is happening and who he's doing it with. (90)</p> <p>In order to protect himself and his sexual autonomy, he now takes it slow with partners (doesn't rush into sex) and establishes frequent and open conversation with his partners about sex. This helps him feel more in control of his sex life and sexual practices, which mitigates anxieties around his history of sexual abuse. (91)</p> <p>Practicing safe sex and sexual boundaries (i.e., exhibiting control over sex life/re-establishing autonomy) has helped reduce the anxieties caused by the sexual abuse. In addition, having satisfying sex showed him that sex can be good again even after his autonomy was taken away, helped him not fear having sex. And talking to people and realizing he wasn't alone in his struggle was helpful too in overcoming the anxiety and pain. (94)</p> <p>Taking it slow with a new partner and controlling the pace at which a romantic/sexual relationship progressed helped him regain autonomy over his sex life. (123)</p>		
<p>Since he was assaulted, he sometimes gets triggered during sex and the thoughts/worries can be anxiety provoking. This can either lead to stopping sex/avoiding sex due to potential, "spiralling", or it can cause performance anxiety as he feels like he is no longer fully present with is partner and is no longer pleasuring them/attentive to their needs. (93)</p> <p>Is not affected by thoughts or worries of his history of being sexually harassed by another man, because he repressed the memory until the #metoo movement made him remember. But at that point, he was mentally and sexually mature enough to not be affected. (107)</p> <p>Thoughts and anxieties about his experience with sexual abuse are pervasive, and still affect him multiple times a day. (141)</p> <p>If he is triggered during sex or foreplay, and is reminded of his sexual abuse, then he will lose interest in sex and need to stop. (142)</p>	<p>Pervasive Thoughts</p>	<p>Sexual Anxiety</p>