COMMUNICATING SOCIAL SUPPORT FOR THAI MEN WHO HAVE SEX WITH MEN WITH HIV/AIDS

COMMUNICATING SOCIAL SUPPORT FOR THAI MEN WHO HAVE SEX WITH MEN WITH HIV/AIDS

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By

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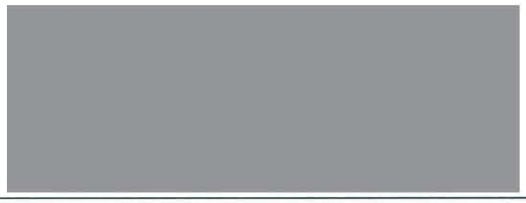

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ABSTRACT

This study aims to examine the communication of social support for Thai men who have sex with men (MSM) with HIV/AIDS. It is believed that this study can help the researcher and society better understand what sorts of social support promote health and safety among HIV/AIDS infected MSM facing stigma and discrimination related to both sexuality and disease. Also, it is to discover communicative patterns used to socially support those MSM living with HIV/AIDS and to know how these communication strategies are successfully employed.

Social support has been studied extensively in the context of HIV/AIDS, but this work tends to ignore nuances of such support in the Thai culture in particular. These nuances, which involve gender/sexuality and privacy management, can complicate the stress-coping strategies and social constructionism in relation to health in the Thai cultural context. Additionally, as these factors in the present research are interrelated, the three research questions were developed: (1) How do sexuality, culture, and concerns about privacy management intertwine as Thai MSM with HIV/AIDS construct meaning in the experience of social support? (2) What patterns and processes of communication have Thai support networks employed to socially support MSM living with HIV/AIDS? (3) How successful are communication strategies used for social support?

The research participants from the three HIV/AIDS organizations consisted of gay patients and healthcare staff infected with HIV and straight healthcare staff without HIV infection. All of them living in Bangkok and vicinity were over 18 years of age with different social support experiences. Observations of support groups (46 key informants including patients and healthcare providers at the two support organizations) and semi-structured interviews (23 care receivers and 14 staff members of the three support organizations) were carried out for a period of four months. Interpretive analysis of observations of support group meetings and in-depth interviews supplemented with the field notes recorded during the research process yielded fifteen themes that emerged from the four universal dimensions of social support: emotional, informational, instrumental, and positive reappraisal support.

The findings revealed that the themes of emotional support reflected the importance of Theravada Buddhism and the collectivist culture in Thailand, which helped form sympathy, empathy, and privacy shared between support networks (i.e., family and friends) and Thai HIV/AIDS infected participants in contrast with the Western individualistic privacy. On the other hand, consistent with previous research on privacy and support groups in the Thai health context, the themes of informational support explained reliance on information mainly from self-help groups of HIV/AIDS infected MSM that possessed knowledge and experience with this disease. In addition, rather than separate functions of social support, it was seen in the study that one main theme of informational and emotional support can be integrated in order to promote commiseration so that the misery caused by social stigmatization among the Thai HIV/AIDS infected support group members can be reduced with use of Theravada Buddhist altruism. In this way, they were assured that other group

members were also in the same or even worse situation, making one another feel validated.

As for instrumental support, unlike other cultures focusing on trust relationship, direct assistance and embracing acceptance from support networks (e.g., siblings and relatives) in the Thai cultural context can strengthen interpersonal bonds that can foster physical and mental well-being. Finally, support for positive reappraisal involves not only spiritual care through use of Buddhism associated with parental and karmic issues, but also the use of Socratic questioning, which encourages HIV/AIDS infected individuals to have "sati" or Buddhist mindfulness for holistic healing, which is in contrast to Western mindfulness.

The limitations of the study are discussed, and future research ideas are proposed to identify problems and improve the ways the research can be conducted to gain more valid research results with use of methodological approaches (e.g., observations and interviews). Further, theoretical implications involving other related theories (e.g., group identity and identity models) can be used so that this important issue of Thai MSM living with HIV/AIDS will be more extensively examined. Finally, regarding practical implications, research contributions can help Thai government, HIV/AIDS organizations, educational sectors, and not only healthcare providers but also the family or society to become aware of the true nature of Thai MSM with HIV/AIDS condition and then find some ways to enhance better understanding and effective communication for social support.

Approved:

Signature of Advisor

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CHAPTER 1

INTRODUCTION

1.1 Introduction to the Problem

As one of the most stigmatized diseases, HIV/AIDS has greatly affected public health at the global and local level. Recent statistics on the global HIV/AIDS pandemic are staggering. According to the Joint United Nations Program on HIV/AIDS (UNAIDS), "36.7 million [30.8 million-49.2 million] people globally were living with HIV infection in 2016," with approximately 1 million people dying and 1.8 million newly infected in the year (UNAIDS, 2018). Figures for Thailand are also distressing. In 2016, approximately 450,000 people were living with infection (hereafter, HIV+), 6,400 people were newly infected, and there were "16,000 AIDS-related deaths" (Avert, 2018).

HIV first came to Thailand in 1984, and by the end of 1988, the number of infected people had steadily increased by 30% (TYAP, n.d.). Since the late 1980s, almost all early AIDS cases in Thailand were related to homosexual or bisexual men, but the main focus of surveillance and prevention was on the heterosexual populations (Nelson et al., 2002). According to the National AIDS Committee of the Ministry of Public Health, Men who have Sex with Men (MSM) were the largest single group acquiring new HIV infections in Thailand, accounting for over 40% of new infections in 2013. Also, the Thai Red Cross Anonymous Clinic, the largest HIV testing center in the country, found that 92% of acute HIV infections identified were MSM (De Souza et al., 2015), and in Thailand, the majority of new infections had been occurring among gay men and men who have sex with men (MSM) (FHI 360, 2008).

A recent study revealed an “explosive epidemic” of HIV prevalence among Bangkok MSM between 2006 and 2012 (Van Griensven et al., 2013, p.830). In 2014 the prevalence of HIV among MSM was 24% in Bangkok, 23% in Chiang Mai, 14 in Phuket, and 9.67% in Chonburi (Chamroonsawasdi, Promsart, Kittipichai, Yodmai, & Rujanavej, 2017). It was also reported that, during this time, MSM population had more infection rates than other at-risk Thai populations (i.e., transgendered people, people who injected drugs and female sex workers) (Avert, 2018). Then, in 2016, the Royal Thai Government estimated the number of at - risk MSM in Bangkok was at least four times larger than the number in Chonburi, the province with the second - highest MSM population size estimate. Moreover, according to a deputy governor of the Bangkok Metropolitan Administration, there were a total of 77,970 people living with HIV in Bangkok and 2,205 registered in 2017 or about six persons a day (“Number of people with HIV in Bangkok reaches almost 78,000”, 2017). These higher figures strongly suggest that MSM have not been aware of or understood the dangers of unprotected sex. In addition, they are blamed for their illness; some people in Thailand believe homosexual people have excessive sexual desires and, compared to heterosexuals, participate in unnatural sexual activity which has led to the spread of HIV/AIDS (Jackson, 1995).

Fortunately, there have been great advances in the efficacy and availability of therapy. Globally, UNAIDS (2018) estimates that “20.9 million people were accessing antiretroviral therapy in June 2017.” In Thailand, 68% of adults and 86% of children infected with the disease were receiving antiretroviral treatment in 2016 (Avert, 2018.). Despite these successes, the disease and associated stigma are exceptionally stressful challenges (Logie, Newman, Weaver, Roungkraphon, & Tepjan, 2016; Sapsirisavat et al., 2016). On the latter point, from the earliest stages of

the pandemic, infection has been strongly linked with homosexuality (Shilts, 1987/2007). It can be said that, while MSM carry a greater HIV disease burden than other groups in Thailand, they also experience discrimination due to the disease and their same-sex preference.

There have been efforts to educate Thais about the disease, and sexual mores are evolving in Thai culture, but ignorance and prejudice persist (Liamputtong, Haritavorn, & Kiatying-Angsulee, 2009). Thus, many infected Thais must cope with the double stigma of infection and counter-normative sexuality. Social support can be a lifeline for the afflicted (Cunningham & Barbee, 2000).

1.2 Overview of the Study

Social support plays a crucial role in alleviating the suffering associated with HIV/AIDS (Thoits, 1995). Social support involving psychological and behavioral adjustment can be very beneficial in conditions with chronic high stress, like HIV/AIDS (Wilson, Washington, Engel, Ciol, & Jensen, 2006). Although coping with stress is essential for people living with HIV/AIDS (PLWHA), social support is not always easy to obtain. People in need of the support might be reluctant to seek it because the ability to talk about problems depends on levels of intimacy, and certain types of stress might not be easy to discuss or resolve. These communicative barriers can be made more complicated when networks intended to provide helpful forms of social support are perceived as unhelpful by support-seekers (Goldsmith, 2004). Consequently, there is need for improvement in both the quantity and quality of support in this domain.

Social scientists have cataloged many challenges in social support (reviewed below). However, in an effort to capture the causal structure of social support, the approach taken in past post-positivistic research reduces what appears to be a highly

dynamic phenomenon to a relatively static causal matrix. By contrast, the approach taken in this dissertation is social constructionist. Although the support for this position is detailed below, it is appropriate at this point to note that a wide range of research indicates that human expectations and desires are constructed in ongoing, situated interaction, as people agree, disagree, and experience uncertainty, frustrated desires, ambivalence, and so on. Similarly, Gergen (1991) explained that all human intelligibility is generated within relationships in which humans derive their conceptions of what is real, rational, and good. Therefore, views of reality should not be assessed in terms of some abstractly conceived standard of "Truth" but rather by pragmatic outcomes that result from constructed views of reality. In this way, "enacted social support" (Goldsmith, 2004, p. 31) arises in these communicative co-constructions of meaning. The co-construction of social support can be more complicated in the context of HIV/AIDS, a stigmatized disease thought to be related to promiscuity or drug use (Green & Sobo, 2000). Consequently, support-seeking and provision, or efforts to construct supportive interactions, are likely to be hindered by uncertainty. In short, whereas post-positivist social support research looks for a stable causal structure, the constructionist approach sensitizes the researcher to highly context-dependent, situated meaning-making processes such as those that are likely to characterize social support for Thai PLWHA.

Thai culture constructs homosexuality and gender identity in complex ways, which can affect the co-construction of HIV/AIDS and support. Uncertainties and ambivalence are highly likely to arise. This is particularly true in the process of disclosure, as will be discussed more in Chapter. 2. Further, gender identity and sexuality are both implicated in the connections between the disease and the men who have sex with men, and this introduces still other uncertainties. The meanings of

gender identity and sexuality, which are themselves ambiguous and dynamic, are learned from the social environment. Further, this issue can be more complicated in Thailand because it is not only a collectivistic but also a high-context culture (Hall, 1976). In the Thai collectivistic culture, people focus more on the "we" identity than the "I" identity; the former involves interdependence and harmony, as opposed to individualism that prefers individual needs and goals in loose social relationships (Ting-Toomey, 1988; Triandis, 1995). In addition, high-context culture is characterized by less explicit verbal communication and greater reliance on implicit contextual knowledge (Hall, 1976). Explicit support seeking might be rare in a high-context culture where support might be mostly implicit and subtle. These subtleties might give rise to a mismatch between desired and received support, causing unsolicited support and other difficulties. Hence, in all of the aforementioned ways and more, social support is likely to be a challenging co-construction in the experiences of Thai people living with HIV/AIDS (PLWHA).

Social support in these challenging situations inevitably takes on the character of individual, relational, and cultural resources, as communication creates and reproduces (Giddens, 1984) not only conceptions of the stressor but also participants' identities, relationships, group and organizational memberships, and encompassing culture (Babrow, 1992, 2016; Shi & Babrow, 2007). Most extant social support research on Thai gay PLWHA has been conducted from a post-positivist perspective assessing a number of variables, such as prescribed social support scales or types of social support as identified in previous investigations. Although such work has value, it does not give a clear picture of the challenges and range of possible meanings that arise in these complex interactions, including variables determined between characteristics of social network and social support. Furthermore, most qualitative

research in Thailand has focused on sexual behaviors (Chemnasiri et al., 2010; Li et al., 2009), treatment, care, and prevention (Logie et al., 2016; Li, Murray, Suwanteerangkul, Wiwatanadate, 2014; Tam, Ho, & Sohn, 2014; Tangmunkongvorakul et al., 2013), or disclosure and discrimination (Obermeyer, Baijal, & Pegurri, 2011; Wilson & Yoshikawa, 2004). Therefore, there has been little systematic study of experiences with the communication of social support among infected Thai MSM. Furthermore, even though there have been many studies of universal forms of social support, the likelihood that these dimensions of social support play out differently depending on cultural context has been ignored. As a result, both subtle and profound aspects of social support that area distinctive in the Thai cultural contexts may have been neglected.

My research has examined communication processes between support providers and receivers. Leatham and Duck (1990) stated that, rather than conceiving of social support as the process of exchange or cause and effect interactions, social support should be examined in terms of interpersonal and contextual interactions. In this respect, supportive communication is not accomplished simply by transmission of a well-intentioned message to a passive receiver. Rather support is worked out interactively, co-operatively, collaboratively (Ford, Babrow, & Stohl, 1996; Mattson & Hall, 2011; Rashid, Rahman, & Rahman, 2016), or "co-constructed" (Jacoby & Ochs, 1995). Also, Gottlieb and Sylvestre (1994) have stressed that social support is co-constituted as part of a system of meaning that is mutually shaped; in other words, support should not be regarded as "a commodity that is extracted from people's societal ties as an aspect of the [routine] process of conducting human relationships" (p. 53). In fact, social support inherently involves culturally specific patterns of social relationships among individuals; therefore, people from different cultural

backgrounds may use support and be treated from others differently even if they have equally supportive social networks (Kim, Sherman, & Taylor, 2008). As can be seen, whereas post-positivist social support research looks for a stable causal structure, the constructionist approach sensitizes the researcher to highly context-dependent, situated meaning-making processes such as those that are likely to characterize social support for Thai PLWHA.

Hence, to examine social support in this Thai cultural context, three research questions will be addressed: (1) How do sexuality, culture, and concerns about privacy management intertwine as Thai MSM with HIV/AIDS construct meaning in the experience of social support? (2) What patterns and processes of communication have Thai support networks employed to socially support MSM living with HIV/AIDS? (3) How successfully are communication strategies used for social support?

1.3 Objective and Significance of the Study

The main objective of this research is to help the researcher and the society understand better what makes social support helpful and what inhibits effective social support in this complicated Thai health context involving family members and those working in the healthcare field. Further, it is to find out what patterns of communication have been used to socially support those MSM living with HIV/AIDS and how successful these communication strategies are.

Improving social support among Thai MSM with HIV/AIDS can, therefore, help members of this community live more healthfully and safely, decrease the likelihood of disease progression to full-blown AIDS, and perhaps contribute to lower rates of infection as infected MSM learn communication skills for more effectively managing their illness.

1.4 Summary of the Research

This dissertation first defines social support, which is associated with HIV/AIDS and MSM in the Thai context. Given that this dissertation will investigate features of communication support for Thai MSM living with this disease, I review past literature that involves the tenets of social support (i.e., types of social support, coping strategies), social construction of illness, gender and sexuality, and communication privacy management. These research topics are examined in order to find whether or to what extent communication support for HIV+MSM in the Thai context is different from that of other cultural contexts. In order to achieve this objective, I attempt to observe naturally occurring supportive interactions as Thai MSM with HIV/AIDS participate in social support groups. I supplement these observations of actual, naturally occurring, face-to-face interactions with in-depth interviews of selected group members and staff at Thai HIV/AIDS organizations providing support group meetings. Finally, the dissertation proposes results, summary of the findings, and limitations and future research.

1.5 Definitions of Key Terms

MSM as a public health term encompasses "gay-identified men and youth, bisexual males (males who have sex with males and females), male-to-female transgenders, male partners of transgenders, male sex workers, and other males who engage in same-sex sexual activity" (Käng, 2011, p. 186). However, as noted above, surveys of MSM with HIV/AIDS often distinguish gay from transgendered and bisexual people. My research will include only MSM who self-identify as gay and who are infected with HIV/AIDS. These MSM experience discrimination both because of their homosexuality and HIV/AIDS infection.

HIV stands for “Human Immunodeficiency Virus” (UCSF, 2014, para. 1). This virus attacks the immune system, thereby weakening one’s ability to fight infections and disease (CDC, 2018).

AIDS stands for “Acquired Immune Deficiency Syndrome” (UCSF, 2014, para. 3). AIDS is the final stage of HIV infection when the body can no longer fight life-threatening infections. With less effective immune system, AIDS sufferers are much more vulnerable to infections and diseases (CDC, 2018).

Social Support features the social structure of an individual’s life and various interpersonal relationships and messages. The latter involve “verbal and nonverbal communication between recipients and providers in order to reduce uncertainty about the situation, the self, the other, or the relationship, and functions to enhance a perceptions of personal control in one's experience” (Albrecht & Adelman, 1987, p. 19).

Communication Privacy Management is a rule of privacy management that explains the regulations of disclosing and protecting private information when others are involved (Child & Petronio, 2017).

CHAPTER 2

REVIEW OF LITERATURE AND RATIONALE FOR THE STUDY

Social support occurs at the intersection of a wide range of potentially significant processes. These processes occur throughout the stages of illnesses dealt with by patients and their social support networks. This chapter will overview some of the theories that are likely to be useful to illuminating the meaning of support.

2.1 Social Psychological Theory of Stress and Coping

Stress can be classified into three categories: life events, daily hassles, and chronic strains (Thoits, 1995). Life events involve severe changes that need significant readjustment within quite a short time, such as divorce, marriage, or retirement (Settersten & Mayer, 1997). On the other hand, daily hassles are minor events that lead to smaller adjustments within a day or two, such as traffic jams or unexpected visitors (Wethington, 2000). Finally, development of diseases, like HIV/AIDS, is associated with chronic strains that produce high-intensity threats and more persistent demands; therefore, longer readjustment is needed (Wethington, 2000).

Coping processes are needed for this wide range of stresses. These coping processes arise in nearly constant efforts in thought, communication, and other actions to manage specific demands (Lazarus, 1993). Coping can be classified into emotion-focused and problem-focused strategies (Lazarus & Folkman, 1984). Emotion-focused coping involves internal psychological adjustment in attempts to manage emotional reactions or reduce negative emotional states (Lazarus & Folkman, 1984). Emotion-focused coping can be classified into active and passive strategies. The former entails emotional social support and positive reappraisal of the stressor,

while the latter includes distancing (by denial, avoidance, and escape) and wishful thinking (fantasizing or daydreaming) (Maes, Leventhal, & DeRidder, 1996; Wong, Reker, & Peacock, 2006). By contrast, rather than changing just internal psychological adjustment, problem-focused coping is an attempt to deal with the stressor by changing person–environment reality (Lazarus & Folkman, 1984). For example, problem-focused coping can take the form of planning (finding a way to alleviate or solve a problem), suppression of competing activities (avoiding distractions to cope with stress more effectively), restraint coping (withholding oneself in order to think before taking actions), and seeking informational and/or instrumental social support (Carver, Scheier, & Weintraub, 1989).

Emotion-and problem-focused coping entail nearly continuous (re)appraisals or evaluation of the stressor ("primary appraisal") and potential lines of response ("secondary appraisal") in relation to the individual's well-being (Krohne, 2002). Primary and secondary appraisals result in perceptions of a stressor as either a threat or a challenge (Lazarus & Folkman, 1984). Perception of threat arises in response to forthcoming or past loss/harm and can result in passive emotion-focused coping. By contrast, appraisal of a stressor as a challenge arouses eagerness or excitement about encountering the stressor and can thus activate emotion-focused coping or problem-focused coping (Lazarus & Folkman, 1984; Smith & Kirby, 2011). Over time, appraisal and coping processes intertwine with social support (Thoits, 1995).

2.2 Social Support and Coping with Stress

2.2.1 Social Psychological Theory of Social Support and Coping with Stress

As a means of coping with stress, social support is associated with "psychosocial" functioning, which is an important part of the social side of individual health conditions (Cohen, 1998, p. 271). In part, this social connection entails the

sense of belonging and of being accepted, the “affectual ties” that maintain not only the integrity of the self but also of the group (Bharadwaj & Wilkening, 1980, p. 338). Foucault (1986) adds texture to this view through his postulation that the care of the self becomes “an intensification of social relations” (p. 53). The individual uses care of the self to fit in with society; through this self-care, the individual demands that others in her or his social network also participate in care of the self. In this way, Foucault argued, care of the self involves “the whole bundle of customary relationships or kinship, friendship and obligation” (pp. 52–53) that allows society to function. Individuals, thus, use their knowledge of self-care not only to care for themselves but also others in their community.

The reciprocity of social support involves both social integration and a social network. The former involves the existence of a social relationship, while the latter is related to the structure of social relationships and the interrelationships among individuals (Keeling, Price, Jones, & Harding, 1996). Both social integration and social networks contribute to the functionality of social support through their influence on perceived or anticipated availability of support and the actual receipt of support from other social members (Schwarzer, Hahn, & Schroder, 1994).

To understand the importance as well as the challenges of these dynamics, we must recognize that not all ostensibly supportive actions are experienced as supportive (Albrecht & Adelman, 1987; Ford, Babrow, & Stohl, 1996; Wethington & Kessler, 1986). The reason for this is rooted in variations in the ways that people make sense of stressors (as discussed above) and the sorts of verbal and behavioral messages that are potentially meaningful as forms of support. Therefore, social support is not a linear but an interactional process in which participants struggle with troublesome constructions of their stressor and situation, such as uncertainty about

highly valued desires and dreads, ambivalence, diverging expectations and desires, and unpleasant certainties and impossibilities (Babrow, 1992; Dennis, Kunkel, & Keyton, 2008). In such circumstances, "even well-intentioned support efforts can produce negative outcomes" (Dennis et al., p. 416). For example, a study of 42 adults with HIV/AIDS examined their perceptions of interactions in which others thought they were being supportive and found that these ostensible support receivers rated only 55% of the others' actions as supportive (Barbee, Derlega, Sherburne, & Grimshaw, 1998; also see Goldsmith, 2004).[1]

According to the classic framework developed by House (1981), social support messages/actions can be classified into four types: emotional, instrumental, informational, and appraisal support. Emotional support consists of reassurance, caring, and understanding. Cunningham and Barbee (2000) averred that emotional support is vital for both psychological and physical well-being for people coping with illness. Providing emotional support to a distressed person requires "listening to, empathizing with, legitimizing, and actively exploring their feelings" (Burleson, 2003, p. 2; also see Albrecht, Burleson, & Goldsmith, 1994). Informational support involves provision of information or general advice (House, 1981). Rees, Smith and Sparkes (2003) further stated that knowledge- or fact-based informational support constitutes "advice or guidance concerning possible solutions to a problem" (p. 137). Third, instrumental support involves the provision of direct and tangible aid (e.g., money, goods) and services (e.g., taking care of patients, doing household chores for the patient) that directly assist a person in need. Therefore, instrumental support which is associated with tangible assistance has been related to positive health

[1] Hence the English idiomatic expression, "The road to hell is paved with good intentions."

outcomes under very stressful circumstances (Cutrona & Russell, 1990; Jennings & Britt, 2017). Therefore, the major difference between instrumental support and informational support is that the former involves direct involvement or assistance, while the latter involves providing individuals with the information necessary for them to help themselves or make their tasks easier. Finally, appraisal support involves not only constructive feedback as defined by House (1981) but also communication of key information relevant in self-evaluation situations (Langford, Bowsher, Maloney, & Lillis, 1997). This is related to positive reappraisal, which embodies adaptability to stress and distress (Park & Folkman, 1997).

These kinds of social support are also associated with coping strategies (Horowitz et al., 2001). In other words, emotion-coping strategies involve emotional support, while problem-focused coping strategies involve informational support and instrumental support. On the other hand, appraisal support is clearly related to positive reappraisal in terms of meaning-focused coping, which aims to change the evaluation of a situation and to make beliefs, goals, and stressful situations more consistent so that individuals are more open to dealing with stressful situations (Pearlin, 1991).

With these distinctions in types of support and their associations with stress and coping in mind, it is possible to understand one of the major determinants of whether ostensibly supportive acts are experienced as helpful or unhelpful. The value of "enacted support," or specific actions undertaken with the intention to be helpful, often depends on corresponding aims: a match between the support-seeker's needs and desires and the design of the support-provider's message (Goldsmith, 2004, p. 3). For example, a support-seeker who seeks emotional support is likely to experience messages designed to provide emotional validation or comforting reappraisal as

supportive (Albrecht, Burleson, & Goldsmith, 1994). By contrast, messages designed to meet needs or wants (e.g., information or advice) that clash with the support-seeker's desires (e.g., to obtain emotional support) are likely to be experienced as unsupportive (Albrecht, Burleson, & Goldsmith, 1994).

Matching supportive actions with the recipient's needs and wants, thus, involves the ability to take the perspective of the support-seeker (Burleson, 1990) and/or understand the situation or context (Vanderbilt & Adams, 2001). Both perspective-taking and situational understanding foster coordinated support actions and meanings (Goldsmith, 2004); in turn, this influences whether an interaction is functional (supportive) or dysfunctional (unsupportive) (Albrecht & Adelman, 1987).

The foregoing considerations help us to understand how support is possible not only in close relationships (e.g., intimates, family/kin, significant others, friends) but also in "weak ties" or less intimate relationships (e.g., acquaintances, co-workers) (Albrecht & Goldsmith, 2003), as well as in both informal and formal networks of professional support systems (Waddell & Messeri, 2006). In all of these contexts, knowledge of the other, the stressor, or the specific situations/contexts can contribute to a support-provider's ability to understand the support-seeker's needs and wants and thereby formulate appropriate messages. Of course, a host of factors (e.g., uncertainty, ambivalence, over-protectiveness, enmeshment, defensiveness, unwanted repetitive patterns, role rigidity, role conflict) can interfere with even the richest background of shared intimacies or contextual understandings. Hence, social support remains at the same time a vital human need and a challenging communicative accomplishment. The challenges are most evident when we attempt to understand social support in concrete contexts, such as living with HIV/AIDS, and even more so

in the context of gender identity and sexual orientation complexities in the high-context culture of Thailand (Hall, 1976).

2.2.2 Social Support in the Context of HIV/AIDS and Thailand

In collectivistic families, such as those composing the Thai culture, interdependence, harmony and awareness of in-group goals among family members is prevalent. Knodel and Saengtienchai (2005) found that not only mothers but also fathers communicated emotional (encouragement) and instrumental support (financial assistance or help with household chores) with their sons infected with HIV. Also, they became the link to the healthcare system for their sons with AIDS by telling them to attend medical appointments even though these parents encountered time and financial constraints (Saengtienchai & Knodel, 2001). Further, with the sense of filial responsibility, these children with HIV might feel obligated to repay their parents for raising and caring for them. For example, Uphold, Shehan, Bender, and Bender (2012) found that, after aging mothers in collectivistic Asian cultures provided instrumental support in terms of completing household chores (e.g., cooking and cleaning) for their sons with HIV/AIDS, these children, in turn, helped their mothers who had limited economic resources and physical ability with some money or transportation services. This filial responsibility in the Thai culture can be explained by the concept of "katanyu katawethi," or goodness that should be reciprocated to their parents who have always looked after them (Knodel, Saengtienchai, & Sittitrai, 1995, p.84). Therefore, MSM with HIV in Thai collectivistic culture could also have reciprocal relationships with their parents.

Even though the Thai collectivistic culture focuses on such "interdependence, affiliation, and co-operation among family members as a strong source of social support," this ethic is conditioned by the value of "machismo" similar to that present

in the Latino collectivistic culture (Ortiz-Torres, Serrano-Garcia & Torres-Burgos, 2000, p. 861). This social value entails strong masculine heterosexual dominance and often leads to homophobia (Ortiz-Torres, Serrano-Garcia & Torres-Burgos, 2000). In this case, when MSM are negatively regarded by other people, they can feel pessimistic about themselves. In this respect, Jackson (1995) explained that MSM are expected to maintain a masculine identity and conform to heterosexual norms by both non-heterosexual family members and family members who do not want this sexual stigma to be known publicly. Nevertheless, despite a male-dominated and patriarchal Thai society, Jackson (2016) claims that the value ascribed to maleness and masculinity in Thailand, unlike other extreme masculine-dominated societies (e.g., Latin America, etc.), is "tempered by a parallel valuing of a range of other status-and -prestige-conferring qualities that can be achieved by both women and non-masculine males" (p. 60). In other words, attitudes toward sexualities in Thailand appear to be more accepting than some other cultures. Even so, stigmatization of sexuality is still deeply rooted in Thai society; as Likhitpreechakul (2016) said, "homophobia isn't the exclusive terrain of any particular religion or country. Those who think that Thailand is immune to such homophobia and violence against lesbians, gays, bisexuals and transgenders (LGBT) have been fooled by the myth of "acceptance"" (para.2). Consequently, with their illness, MSM are likely to internalize not only their sexual but also their HIV stigma, which can discourage them from seeking social support from family members, resulting in passive emotion-focused coping.

Because of such inhibitors of family support, infected MSM might turn to their friends as another source of social support, since friendships are sometimes more easily ended, and this can provide an "emergency exit" when the issues for emotional support are too disturbing (Albrecht & Adelman, 1987). Also, friendship networks are

"less densely connected than" family networks, so confidentiality can be more securely kept (Albrecht & Adelman, 1987). Consistent with the research conducted by Rongkavilit et al. (2010), Thai male youth who ever had sex with men were more likely to disclose their HIV status to friends and less likely to disclose to immediate family members. This is because homosexuality is viewed in Asian culture as deviant, contrary to family values that prioritize expectation of marriage in order to continue the family name and progeny (Matteson, 1997). Therefore, in collectivistic Asian societies such as Thailand, those with gay and HIV status can bring disgrace and shame to family, so concealing this kind of information is necessary.

In addition to friends, another informal network that HIV+ MSM depend on is that of religious institutions. According to Kubotani and Engstrom (2005), Buddhist monks in Thailand provide male PLWHA both emotional and appraisal support with Buddhist teachings about natural phenomena of death and birth. In this way, male PLWHA were not only able to feel calmer but also self-effective to continue their life (Kubotani & Engstrom, 2005). Consistent with Kubotani and Engstrom's study, Bechtel and Apakupakul (1999) found that Thai Buddhist people focus on "self-meditation" and "deprivation" to overcome suffering (p. 471); the monks at Buddhist temples (Wats) serve not only as spiritual leaders but also educators and healers for community members (Bechtel & Apakupakul, 1999, pp. 471-472). Similarly, this crucial role of Buddhist temple was identified in a study of "Wat Phra Bat Nam Phu," where PLWHA were provided with Buddhist teachings through chanting or talking with monks, sermons, and psychological counseling (Yamamoto, 2009). In addition, Phra Alongkot Tikkhapanyo, the abbot of this temple, educated visitors on HIV/AIDS in order to promote the development of compassion for and understanding of PLWHA (Yamamoto, 2009, p. 11). However, some religious communities might not

be as supportive of those infected with HIV due to its association with homosexuality, sex, and drug use (Vaddhanaputi, 1999). For instance, some Buddhists believe that homosexuals not only deserve to suffer HIV/AIDS but should be blamed for spreading this disease to others. As discussed in Chapter One, some view infected MSM as having excessive sexual desires and lacking "moral control over sexual drive" (Isaramuni, 1989). Moreover, those monks who became involved in this kind of activity and received a great deal of publicity were not seen in a positive light (Darlington, 2012). With no hope for assistance from religious institutions, MSM with HIV could thus become more spiritual rather than being religious. Spirituality involves "individual subjective experiences," while religion is considered as "an organized social entity more focused on prescribed beliefs, rituals, and practices" (Tarakeshwar, Pearce, & Sikkema, 2005, p. 180). Therefore, HIV+ MSM could rely on their own beliefs (e.g., superstitions or their own consciousness of what is right or wrong) in order to cope with their illness and consequently develop greater self-esteem and life satisfaction.

Apart from those informal networks (family, friends, and religious institutions) mentioned, MSM with HIV might also rely on formal networks, like HIV support groups, which can help improve PLWHA's mental health through providing information about specific medical treatment rather than "general subsistence care" or basic support needs from the informal networks (George et al., 2009, p.1012). In this case, support groups of the same sex could provide gay PLWHA a safe environment with people of same sexual background and HIV experience (Hays, Catania, McKusick, & Coates, 1990). Therefore, in support groups, they could feel more comfortable sharing their experiences and communicating support with each other (Cawyer & Smith-Dupre, 1995). In addition to promoting a sense of belonging,

Tanabe (1999) found that support groups in Thailand also assist PLWHA in ‘‘self-fashioning their existence as an ethical subject” (p. 17). In this way, emotional and appraisal support with holistic care promotes a harmonious relationship between the minds and the bodies of PLWHA (Tanabe, 1999). Further, the purpose of the support groups was to provide emotional support with human dignity among group members and informational support about how to sustain self-care and live their daily life (Lyttleton, 2004). Thai society still deems HIV/AIDS as the disruption of social harmony associated with the Buddhist holistic perspective that disease with its physical symptom is the expression of the disturbed harmony in our life as a whole (Ratanakul, 2004). Because of this, the Thai support groups can be safe venues to help PLWHA to communicate with one another more comfortably than in the public where they need to carefully consider others’ feelings or “krengjai” and, meanwhile, preserve appropriate manners or “kalatesa” to prevent interpersonal conflicts (Lyttleton, 2004, pp. 19-20). In these ways, access to a similarly gendered/sexed support group can help Thai MSM with HIV to adjust to their illness and to live normally in their society.

Despite their values, support groups might be under-utilized due to a variety of barriers (Bui et al., 2002). MSM with HIV in Thailand might use passive emotion-coping when they have low self-esteem, similar to some individuals identified in previous Asian and Western literature. For example, Pakenham and Rinaldis (2001) revealed that HIV infected gay or bisexual men preferred to use “passive-avoidant” coping strategies that depended on wishful thinking or self-blame when they had higher levels of depression. In addition, individuals who experienced high internalized HIV stigma were less likely to ever have attended an HIV support group (Lee, Kochman, & Sikkema, 2002). The more accepting respondents were of being

gay, the more satisfied they were with their current support and the more likely they were to experience an increase in social support from their support groups (Turner, Hays, & Coates, 1993). HIV-positive gay men who concealed their sexual identity exhibited a faster progression of their HIV disease and AIDS than those who did not (Cole, Kemeny, Taylor, Visscher, & Fahey 1996). Consequently, MSM with HIV with low self-esteem could be discouraged from seeking social support and instead use passive emotion-focused coping, like self-blame, which can contribute to their feeling more depressed. Relatedly, stigma could have a variety of negative effects on Thai PLWHA, including delay in access to care and feelings of isolation (Busza, 2001; Vanlandingham, Im-em, & Saengtienchai, 2005). On the other hand, those with higher self-esteem might be more willing to participate in support groups.

Another complication involves other Thai collectivistic issues. Mesquita (2001) found that Thai PLWHA tried to avoid interpersonal conflicts by not bringing personal problems to the attention of others; they avoided such talk because they did not want to burden their social networks. Similarly, McCarty et al. (2012) reported that, in dealing with hypothetical social situations, Thai children, aged 6 to14 years, were twice as likely as American children to report covert coping (i.e., inwardly directed, emotion-focused responses). The use of covert coping by Thai children was said to be motivated by the strong collective and interdependent norms of the Thai culture in order to preserve social harmony with important others (McCarty et al., 1992). This finding of avoidance is similar to observations by Siegel, Lune, and Meyer (1998). Their study documented collectivistic African gay and bisexual PLWHA who used concealment in order to maintain and protect social relations by pretending to appear normal despite visible illness. It can be said that implicit social support or emotional forms of support, which do not require disclosure or explicit

acceptance of one's problem, might be used more frequently than explicit social support in Asian cultures (Taylor, Welch, Kim, & Sherman, 2007). In this relationship context, a person is expected to avoid bringing his or her personal problems to the attention of others to enlist their help because such an act can undermine harmony or make inappropriate demands on the social group (Kim, Sherman, Ko, & Taylor, 2006). Specifically, in the Thai culture, this avoidance of disclosure that potentially leads to negative reactions is related to the importance of "krengjai" based on Buddhism as the active reluctance to impose upon or bother another person (Klausner, 1993). Given this collectivistic consideration of interpersonal conflict, when MSM with HIV/AIDS need social support, they might implicitly rather than explicitly request it. Therefore, the informal and formal networks in Thailand should consider this barrier and communicate with PLWHA in order to promote mutual understanding.

Further, Thai MSM with HIV might also expect helpful support but find that they received unhelpful social support instead. According to Albrecht and Adelman (1987), social support attempts include not only functional (helpful) but also dysfunctional (unhelpful) forms. Gottlieb and Wagner (1991) found that parents of chronically ill children could become overprotective by telling their children to strictly follow their suggestions about medical practices since they were obsessively worried about their children's well-being. Similarly, Barbee, Derlega, Sherburne and Grimshaw (1998) revealed that family members were seen as providing unhelpful support despite good intention by asking too many personal questions. In this case, gay men with HIV/AIDS were not happy with the social support provided by health care providers who were forceful in dispensing advice. This overprotectiveness made PLWHA feel uncomfortable (Pakenham, 1998). In addition, according to Song and

Ingram (2002), HIV participants could receive “forced optimism” from support groups and health care professionals. This kind of optimism was an attempt to impose the positive and minimize the obstacles of living with HIV/AIDS (Song & Ingram, p.79). In other words, individuals might be told to look on the bright side. In a similar vein, with the sense of strong ties among Thai collectivistic members, support providers (e.g., family members, healthcare providers) could be too concerned about PLWHA and provide social support that MSM regard as unhelpful. This can be explained by strong root in Thai Buddhism which teaches to care for others more than to care for oneself (giving more than one takes) (Niffenegger, Kulviwat & Engchanil, 2006). Also, this is consistent with the research conducted by Prasomsuk, Jetsrisupap, Ratanasiri, and Ratanasiri (2007) who explained that Thai mothers can sometimes be overprotective and overconcerned with their children living with thalassemia. This can make children become stressed and, in turn, affect their self-development.

In sum, although there have been a number of studies of social support for PLWHA, most of it, including studies conducted in Thailand, has come in the form of traditional psychological studies; social constructionist perspectives have generally not been applied to communicative phenomena pertaining to social support. In fact, a social constructionist lens promises to enhance our understanding of social support in the unique context of Thai MSM with HIV.

2.3 Social Construction of Meaning in the Health Context

2.3.1 Theories of Social Constructionism

Social constructionism rejects the essentialism characteristic of traditional social scientific studies of health, health care, and health communication. For example, the seemingly essential categories, “normal” and “abnormal,” might be applied anywhere apart from statistical distributions (Delamater & Hyde, 1998).

Outside of the context of statistics, the meaning of these terms is, nevertheless, shaped by the sociocultural context, and the interactions in which the meanings of these terms are negotiated. Similarly, health and illness are socially and culturally produced rather than naturally determined. There could be the impact of cultural meanings embedded in illnesses. For instance, the current school textbooks in Thailand still describe homosexuality as an illness or abnormality, and some Thai school textbooks even go as far as warning students to stay away from LGBT "sexual deviants" in school (UNDP, 2014). In fact, a "real" division of categories, for example, in terms of normal vs. abnormal, does not exist; the ways we understand the world are historically and culturally specific, and knowledge is collectively shared and validated in our social interactions and relationships. Therefore, in contrast to the biomedical model, which assumes that diseases are universal and invariant regardless of time or place, social constructionists emphasize how the meaning and experience of illness are shaped by cultural and social systems (Conrad & Barker, 2010). These systems constitute realities that are learned.

The preceding is consistent with Berger and Luckman's (1967) argument that social reality is not a social fact in its own right but is something produced and communicated. In other words, the meaning of reality is derived through the knowledge systems of communication (Berger & Luckman, 1967). These systems of communication depend on "objectivation and internalization" (pp. 60-61). Objectivation is the process through which the externalized products of human action are objectivated or attain the character of objectivity (i.e., they are seen not as products of human action but as existing independently of such action); in this way, the objectivity of the externalized world is a humanly produced, constructed objectivity (Berger & Luckman, 1967). In terms of internalization, individuals who

have experienced objectivated events within the institutionalized social world immediately interpret them and find personal meaning. This internalization is also involved with different kinds of socialization. In primary socialization, which occurs largely during childhood, people first become a member of a society, and this kind of socialization ends when the concept of "generalized other" (abstraction of roles and attitudes from concretely visible significant others) occurs. As for secondary socialization, this is the process of internalizing institutional or institution-based "subworlds," which means acquiring role-specific behaviors and knowledge. This process of secondary socialization is characterized by formality and anonymity. It can be seen that, through socialization, “the sociology of knowledge “must concern itself with everything that ‘passes’ for knowledge in society” (Berger & Luckman, 1967, p. 14). In this respect, it is important that people know what is constructed as reality in their life (Berger & Luckman, 1967).

More specifically, this sociology of knowledge can be better understood in different contexts of social construction associated with power and freedom of discursive use (Burr, 2003). Social constructionist theory and research, according to Burr (2003), can be classified into two forms: “micro” and “macro” (pp. 21-23). Influenced by Foucault, macro social constructionists are more concerned with discourses as wholes and cultural patterns of communication in which institutionalized power and practice always function to marginalize and oppress people everywhere (Burr, 2003). On the other hand, micro social constructionists focus on the structures in which language is used in social interaction (Burr, 2003). They are interested in what particular people say in specific sequences of turn-taking; therefore, micro social constructionism celebrates the agency of individuals to create the world in which they live (Burr, 2003).

For the current dissertation project, the focus will be on micro social constructive processes. One useful way to study these processes is through narrative research that focuses on narrative constructions. Narrating provides us with knowledge of the realities people presuppose in defining themselves and enacting their social and relational identities (Harter, Japp, & Beck, 2005). Nevertheless, similar to Berger and Luckman's objectivated reality, knowledge becomes, according to Burr (2003), fabricated in ways that people want to construct through their daily interactions in the course of social life through language as opposed to "the nature of the world as it really is" (Burr, 1995, p. 3). In this process of fabrication, constructions of the world create asymmetric relationships by sustaining some patterns of social action and excluding others (Burr, 1995). Our constructions of the world are, therefore, bound up with power relationships because those power relationships have implications for what is permissible for different people to do, and for how individuals might treat one another (Burr, 2003).

In a similar vein, Gergen (1985) argued that social construction is a discursive, social, and relational process that constitutes knowledge of the self and others. This co-construction of meaning positions narrativity as "situated knowledge" and as "shifting knowledge" in the mutual interplay of telling and listening (Harter et al., 2005, pp.26-27). In this respect, understanding is actively and cooperatively co-created in relationships, such as the interactions that physicians use to understand patients' physical and psychological conditions in order to promote health care (Harter et al., 2005). This interaction is dependent on the changing context in human activities, as Gergen (1991) contended that there are as many realities as there are cultures, contexts, and ways of communicating. Each of us has "multiple, multiphrenic selves, which are socially constituted within the boundaries of culture,

context, and language" (Gergen, 1991, p. 79). In other words, it is impossible to have all our lived experiences in an integrated, harmonious, bounded whole. In addition, the concept of relational being is a still open and unfinished concept. As Gergen (2009) stated, we live with incompleteness and uncertainty. That is to say, the more we become engaged or immersed in interaction, the more we can feel that we are not sure what we, as a communicator, know about each other's experience due to the forever unfolding of ongoing interactions. Unlike Burr's fabricated knowledge that involves asymmetry relationships and Berger and Luckman's objectivation, Gergen's concept of social construction focuses more on contextual and dynamic nature of human beings. This human nature of interactive communication is still evolving, and might ultimately allow the (im)possibility of achieving more mutual understanding between individuals. Consistent with Williams (1984), "teleological form" in narrative reconstruction involves not only the liberation from the semantic restriction but also interaction between the individual and society in an unfolding process.

2.3.2. Social Constructionism and the Healthcare Context

The suffering of patients (particularly those who have chronic conditions with depression) is complicated. Narrative reconstructions of patient experiences can promote mutual understanding. Sharf and Vanderford (2003) postulated that social construction has emerged as a reaction to the predominant biomedical perspective. Rather than focusing on "traditional, biomedical information conveyed in the authoritative voices of physicians and other healthcare providers," social constructionist research examines the subjective language associated with "the internal, nonverifiable experience of illness, of being in dis-ease" (Sharf & Vanderford, 2003, p. 11). In this view, the unfolding process of interaction between

the individual and society gives rise not only to the self and social relationships but to our experience of illness.

Sharf and Vanderford (2003) identified five functions of health/illness narratives that help to promote human agency: “sense-making, asserting control, transforming identity, warranting decisions, and building community” (p. 16). Sense making involves the use of narratives to create meaning of disconnected events, people, and action. Individuals can interpret, justify, and make links in retrospect that are less likely to be discerned in real time. In this respect, meanings are found in interpretation of phenomena, not in objective observation (Vanderford, Jenks & Sharf, 1997). Garro and Mattingly (2000) asserted, “narrative is a fundamental human way of giving meaning to experience. In both telling and interpreting experiences, narrative mediates between an inner world of thought-feeling and an outer world of observable actions and states of affairs” (p.1). In other words, through narratives, we construct and understand our lives by creating and shaping ourselves in some particular ways. Secondly, rather than obeying orders of others, the narrators assert themselves as agents in order to recover the voices that illnesses and their treatments often take away (Sharf & Vanderford, 2003). Thirdly, narratives help wounded storytellers to reshape their identities either in practical, enabling ways or with a focus on loss or trauma (Sharf & Vanderford, 2003). Stories that serve this function can include identification of critical life-changing incidents, presentations of multiple perspectives and adaptation to illness (Vanderford et al., 1997). Fourthly, narratives affirm storytellers’ decisions and reasons for their actions, such as routine activities and medical decision making (Vanderford et al., 1997). Finally, in building community, narratives encourage ill individuals to provide support to each other, raise

public awareness about specific issues of illness, and involve discourses for advocacy (Sharf & Vanderford, 2003).

Narrative reconstruction is, thus, essential for both construction of illness experiences and for analysts interested in studying social support. The illness context involves highly subjective phenomena "including various perceptions, conceptions, and experiences of health status related to age, race, sex, or education" (Brown, 1995, p. 39). Illness often involves not only fluctuations of pain, distress, and suffering but also ensuing medical treatment (Martin & Peterson, 2009). The body should not, therefore, be seen as "a machine that constitutes separate parts and replaceable parts, controlled by one's physiology" (Petersen, Heesacker, & Schwartz, 2001, p. 214). Rather, we should consider the body in relation to ongoing narrative and dialogic sense making of disease progression, recovery, and dying (Petersen et al., 2001). In a nutshell, other "selves" are created (or lost) in the course of narratives as "past selves" and "new selves" come and go in relation to the changes brought on by illness (Potts, 2000, p. 116).

These narrative functions have been shown in some previous studies. According to Bueno (2009), medical therapists and support groups co-construct problems and solutions about living with HIV by recreating past stories in order to plan future living. In another study conducted by Briggs (2010), healing through a cancer journey was viewed as a multi-layered process with several intertwining dimensions, each of which serves to connect the mind, body, and spirit. In this respect, human bodily reactions not only involve "physical effects, but also . . . mental, emotional, social, spiritual, and environmental" realities (Briggs, 2010, p. 7). In order to keep the balance of thriving and healthy bodies, volunteers at the Keep A Breast Foundation encouraged women with cancer to share co-constructed stories;

they promoted empowerment and holistic healing by communicating and fostering every kind of social support, promoting active emotion-focused coping and problem-focused coping in terms of lifestyle adjustments which ranged from diet and nutrition, to exercise, to spiritual practice (Briggs, 2010). Similarly, Mathieson and Stam (1995) explored the identity-altering self-narratives of 27 cancer survivors. The identity of the cancer survivors went through changes in interpersonal relationships, their sense of autonomy, and visions of the future. The transformation of narrative and the telling and sharing of narrative has multiple effects for the teller and the audience. Evidently, these narratives are related to the use of the rhetoric of identification that Thelen (2007) more specifically explained in his study of people living with HIV/AIDS. The analysis began with the guilt each suffered, followed by how they purified that guilt and concluded with redemptive acts by recontextualizing HIV/AIDS as something that is to be treated rather than blaming the patient for his/her condition (Thelen, 2007).

The emphasis on the notion of guilt in this western research is, nevertheless, in contrast to the notion of shame in Thai collectivistic culture that values relational interdependence and conformity to group norms (Steven, 2013, p. 250). This difference between shame and guilt also corresponds to “shame cultures” and “guilt cultures”, respectively (Shulich, 2009, p. 234). The former regulate social behavior in reference to what others will feel or think rather than “one’s inner sense of right and wrong”, whereas the latter involves the strong superego as “the self-punishing enforcer of social norms” that mediate the desire to do right and wrong (Shulich, 2009, p. 234). Moreover, shame in Thai culture is much influenced by Theravada Buddhism which restricts inappropriate behavior, while shame of other Asian cultures

is related to the Confucius concept emphasizing human relationship in the society (Steven, 2013).

Even though the shame caused by HIV/AIDS can make Thai people suffer and feel painful, this negative feeling can be lessened during exchanges at support groups in the Thai context. Liamputtong, Haritavorn, and Kiatying-Angsulee (2013) found that the strategies shared within the support groups of women living with HIV/AIDS could construct discourse of positive living which helped to boost a sense of optimism in order to avoid stigma and shame of the HIV epidemic among the women (Liamputtong, Haritavorn, & Kiatying-Angsulee, 2013). Furthermore, less isolation and loneliness are associated with the importance of "puag diew kan" (our group of people) and "sai luat deaw gan" (belonging to the same bloodline) through the process of the support group meetings (Liamputtong, Haritavorn, and Kiatying-Angsulee, 2013, p. 389). Similarly, Lyttleton (2004) showed that this sense of belonging in support groups can "take specifically mandated forms to reverse the shame and stigma associated with HIV infection" (p.7). These studies again show how co-construction of meaning through narratives can promote holistic healing through having each individual tell his/her story and, simultaneously, convince other HIV participants that receiving social support can help improve their lives.

As can be seen, stories bring peoples' experiences and perspectives to the conversation in a powerful way that is qualitatively different from discussions of logical objective facts with reasons and evidence supporting a claim rather than shared subjective feelings and thoughts (Polletta, 2006; Young, 1996). In a nutshell, communication obviously involves storytelling about one's experience that is connected in space and time in order to create identification that involves belief sharing. This social construction is thus related to the "dialogic mode" in which

participants are actively involved in the construction of meanings through a dialectic process in which both meanings and identities are co-determined and focus on the context rather than the speaker only (Molinari, 2010, p. 15). The world is neither predetermined nor chaotic, but, instead, is a collective production, created in the processes of interactions (Bakhtin, 1981).

The dialogic mode can be disrupted by fear of rejection after disclosure of HIV/AIDS. Daftary (2012) examined the perspectives of South Africans infected with both HIV and TB diseases in order to analyze how they think about their dual illness. Daftary found that these patients deflected the stigma of HIV "through concurrent processes of HIV 'othering'" (p. 1512). In other words, they avoided disclosing their HIV/AIDS status but disclosed that they were infected with TB, which was less stigmatizing than HIV. In terms of face loss, they might have felt shame or embarrassment and feared social rejection and loss of social support. Similarly, this face loss related to the Thai shame culture as discussed earlier can be found in a study conducted by Liamputtong and Haritavorn (2014). It was found that a Thai female participant did not directly tell her daughter about her real HIV/AIDS condition but obesity as she said, "My daughter often asks me why I take a lot of medications. I told her that I have gained a lot of weight and the doctor prescribed the drugs to get rid of cholesterol in my blood" (Liamputtong & Haritavorn, 2014, p. 28). As can be seen, social construction of illness can be complicated by individual and cultural preference for disclosure. Therefore, dialogues that promote co-construction of meaning and relief of HIV/AIDS-related suffering can be stymied. Given the significance of face in the Thai collectivistic culture (Hofstede, 2018), some Thai people with HIV/AIDS tend not to share their stories of HIV/AIDS with their networks but talk about other

kinds of less stigmatized diseases (e.g., allergies) that are the side effects of HIV/AIDS itself.

In addition to face loss, asymmetrical power relations between the interlocutors, who rarely have the same socio-economic background (e.g., the patient and healthcare provider), can hinder communicative understanding (Molinari, 2010). In this way, both parties could have different access to communication due to the authority (power) held by the healthcare provider (Molinari, 2010). Corresponding to high power-distance in the Thai context (Hofstede, 2018), MSM with HIV could also experience this kind of asymmetrical power relation; this power distance can discourage these Thai MSM from sharing their HIV/AIDS stories with healthcare providers. In short, a high-context, high power distance, and collectivistic culture could complicate the collective accomplishment of support in the Thai healthcare context.

2.4 Social Construction of Gender and Sexuality

The gender and sexuality of MSM with HIV/AIDS, as discussed in Chapter One, adds stigma to their health challenges. As such, in the construction of health, gender and sexuality complicate the way we understand the process of social support.

Gender identity refers to "the degree to which persons see themselves as masculine or feminine given what it means to be a man or woman in society" (Stets & Burke, 2000, p. 997). Butler (1997) observed that authorities categorize people who are given identity as a masculine man or a feminine woman. Those who do not conform to gender norms can feel guilty and perceive themselves as being outside the mainstream of society (Butler, 1997). As opposed to such essentialism that assumes an unchangeable reality or essence, Butler (1988) argued for the significance of the body that "becomes its gender through a series of acts which are renewed, revised,

and consolidated through time…rather than a predetermined or foreclosed structure, essence, or fact, whether natural, cultural, or linguistic" (p. 523). In addition, drawing on Bourdieu's work, Butler explained that, across cultural fields (or social positions), choices of practice involve a notion of temporality that allows the potential for change (Butler, 1988). Butler emphasized the significance of the human body as a cultural site related to gender norms rather than a static condition. These views suggest that gender is a social construction that can be developed in different ways, apart from the heteronormative convention.

Rubin (1992) argued that gender cannot be the direct expression of sexuality; sexuality is even more dynamic than gender and cannot solely be explained by the lens of gender even though gender influences the pattern of sexuality. In other words, sexuality, which is comprised of "erotic desires, fantasies, acts, identities, and politics," cannot be reduced to gender dynamics (Seidman, 2003, p. 23). The sexual self is "a fluid, complex entity consisting of various forms of self-relevant knowledge" (Daniluk, 1998, p. 15). Furthermore, Simon and Gagnon (1987) found that the most individual and unique conceptualization of the sexual self can be found in "intrapsychic scripts" that involve internal and mental rehearsals of sexual scenarios, memories, arousals, or preferred ways of engaging sexuality (p. 364). These intrapsychic scripts convey desire and expectations about sexual relations to people of different sexes (Gagnon, 1990). Unlike an appetite, drive or instinct, desire does not create the self but is "part of the process of creation of the self" (Simon & Gagnon, 1986, p. 100). In addition, in "cultural scenarios," instructional guides in social norms at the collective level determine sexual behaviors that must either directly or indirectly reflect appropriate cultural scenarios (Simon & Gagnon, 1987, p. 364). These appropriate cultural scenarios are related not only to objects, aims, and

desirable qualities of the self and other in relationship but also to sequences of gestures and utterances in times and places (Simon & Gagnon, 1986). It can be said that, if there is congruence between the sexual act as defined by "prevailing cultural scenarios and experienced intrapsychically," the resultant behavior is symbolic (Simon & Gagnon, 1999, p. 30). With the exchange of symbolic elements in the cultural scenario, "interpersonal scripts" that represent "the self and the implied mirroring of the others that facilitate the occurrence of a sexual exchange" occur (Simon & Gagnon, 1999, p. 31). In this way, individuals have to deal with their personal sexual desire that might or might not be accepted by others in their relationships as determined by social conventions. Therefore, uncertainty about sexual expression can be lowered or heightened, depending on both social and cultural factors. These prior experiences of sexuality can shape sexuality attitudes and values. In this way, the sexual scripting theory applies Burke's (1968) "metaphor of drama" that describes the ways people express and experience their sexuality (Gagnon 1973, Simon, 1996). Theatrical elements (e.g., scene, stage, script, audience reactions, actor's performances) are essential to the construction of sexual activity, as sexual scripts can be interpreted and performed differently by actors depending on their "unique life histories, experiences and backgrounds" (Whittier & Melendez, 2004, p. 131).

Some studies have shown this sociocultural construction of sexuality. According to Bailey and Zucker's meta-analysis (1995), in all three cultures (i.e., Turkey, Brazil, and Thailand), pre-gay boys were less aggressive and less interested in sports than pre-straight boys. They were more likely to have associated with girls and to have participated in typical girls' activities. Related to this, Ford and Kittisuksathit (1994) found that sexual lifestyles, particularly of Thai young people,

were dynamic, developing in relation to a wide range of social, personal, and cultural factors. In this respect, from the beginning of life, children's sexual identity is shaped within and among families, schools, play, and in relationship to media through language, action and silence (Ford & Kittisuksathit, 1994). Similarly, McRobbie and Thorton (1995) found that children were hindered from becoming aware of being competent as erotic and desirable and are instilled with the discursive construction of the sexual predator "folk devil"—especially "the homosexual"—as Other. In this way, sexuality is considered an "adults only" site of knowledge; therefore, children are perceived to be "too young" to understand (Robinson, 2008, p. 121). They are denied access to the media and interaction with peers and queer family members and friends (Robinson, 2008). If gay children grow up in a society that says that they should not exist and certainly should not act on their feelings, these societal feelings can be internalized. Burr (2003) succinctly identified the constraints of current sexuality discourse:

> ...the discourses of sexuality on offer in our present society offer a limited menu for the manufacture of sexual identity. However, two well established discourses in particular call upon us to identify ourselves with respect to them: "normal" sexuality and "perverted" sexuality. (p.107)

Further, during adolescence, while Thai male adolescents are encouraged to tell stories of sexual conquest as a way of boosting their status in society, Thai females are encouraged to keep their traditional submissiveness, which leads to insufficient negotiating skills (Vuttanont, Greenhalgh, Griffin, & Boynton, 2006). Clearly, the construction of sexuality can be referred back to the sociology of knowledge or social constructionist theory, which is concerned not only with "empirical knowledge," but also the way knowledge is "established as social realities" (Huber & Gillaspy, 1998, p.190). Consistent with the notion of essentialism, the

sociology of knowledge posits the social construction of a finite number of fixed forms that crucially possess “constancy and discontinuity” (DeLamater & Hyde, 1998, p. 10). Constancy is concerned with fixed ideas that are understood to be unchanging across time, while discontinuity refers to the division or classification of human beings in order to emphasize the difference (DeLamater & Hyde, 1998). Of course, social constructionism does not take these fixed ideas or constructions of discontinuity as “real” independent of societal sense-making; rather, the world’s finiteness is expressed and experienced in the confines of these constructions.

Similar to “dividing practices” in panopticonism (prison system that closely observes and separates the normal (sane, healthy) from the abnormal (mad and unhealthy)), Foucault explained that individuals become victimized in both social and spatial areas (Madigan, 1992). In other words, people with counter-normative identities, like homosexuals, tend to be objectified and spatially isolated from the mainstream of heterosexuals (Madigan, 1992). Related to governmentality or the way of governing that affects people’s beliefs and ideology, not only the mechanisms of the legitimization but also the rationalization of practices use power to dictate what is reasonable or possible for certain actions (e.g., sexuality) through discourses (Foucault, 1995). Foucault viewed this production of discourses about sexuality as a means of social control, and individual identity, in this way, is no different from an inhuman subject that is an isolated and objectified puppet (Foucault, 1975). In this respect, president of LGBT rights group Anjaree, told Phuket News in 2013, “I think it’s true that Thai people can only accept gay and lesbian people in superficial ways, such as the way they act or dress. But when it comes to the meaningful circumstances, Thai people tend to be biased against them” (para.32). In addition, while there are no shortages of gay and kathoey personalities in the media, there are very few prominent

LGBT figures in influential fields like politics, justice, medicine or education as "There are no openly gay people in high-ranking offices who can influence the change in both law and attitude", said Suppakorn Chudabala, a gay rights researcher (Thanthong-Knight, 2015, para. 17).

With the regulation of this sexual system, internalization can occur. Meyer and Dean (1998) defined internalized homophobia as "the gay person's direction of negative social attitudes toward the self, leading to a devaluation of the self and resultant internal conflicts and poor self-regard" (p. 161). Nevertheless, after they accept their stigmatized sexual orientation, LGB people can begin a process of coming out. Correspondingly, Sattler and Lemke (2017) found that when Thai gays felt stigma, this internalized homonegativity predicted lower satisfaction with life; on the other hand, being able to disclose their sexual orientation can help to increase their life satisfaction.

2.5 Sexuality and Gender Constructionism in Thailand

Even though Thai culture adopts the universal concept of sexuality and gender, there are distinctive nuances of these aspects associated with Thai linguistic diversity. Unlike the Western notion that differentiates sex from gender, the Thai way of representing sex, gender, and sexuality encompass the notion of "phet" in Thai (Käng, 2014, p. 414). In other words, this category "phet" can simultaneously refer to "sexual difference (male vs. female), gender difference (masculine vs. feminine) and sexuality (heterosexual vs. homosexual)" (Jackson & Sullivan, 1999 p. 5). These varieties reflect that "sexual desire is an extension of gender identification rather than separate domains of gender and sexual orientation" (Käng, 2014, p. 415).

Nevertheless, compared to sexuality, the term "phet" is more related to gender issue as Jackson (2003) stated, "while having distinctive erotic interests and objects of

sexual fascination, each of the modern Thai identities is a gender more than it is a sexuality" (p. 86). In addition, Jackson (2000) and Sinnott (2004) argue that Western sexual identities become localized with conceptualizations of gender, thereby multiplying gender categories in the Thai cultural context. In this respect, Jackson (2000) uses the term "eroticized genders" (p. 351) and Sinnott (2004) uses the term "gendered sexualities" (p. 28) which refers to the ways in which we experience our sexuality based on the interaction of our biological sex and gender socialization (Crane, Towne, & Crane-Seeber, 2013). Further, Jackson (1995) explains that

> The linguistic conflation of the domains of biology, gender and sexuality in Thai leads to a common tendency to "naturalise" both ascribed gender and sexuality to biology. For example, in Thai discourses on gender and sexuality the categories *chai*, *ying* and *kathoey* are typically conceived in terms of performance of masculine, feminine and transgender roles, respectively, which in turn are believed to be biologically based in maleness, femaleness and hermaphroditism (p. 218)

This very important role of gender in Thai culture could be explained by the traditional Thai culture of collectivism that places great emphasis on interconnectedness of social members. Therefore, conformity to the Thai mainstream gender norm is necessary. Even though Western discourses of sexuality have been borrowed to name some Thai discourses in terms of "phet" that have emerged in the modern era in Thailand, it seems that Thai society has not incorporated the Western sexual/gender system underlying these labels (Jackson & Sullivan, 1999). Jackson (2000) asserts that there are at least ten gender terms commonly used in contemporary Thai discourse. He explained how the three categories of (1) man, (2) *kathoey* (transgender), and (3) woman have proliferated into ten categories from the 1960s to the 1980s:

> (1a) man, (1b) *seua bai* (male bisexual); (2a1) *gay king*, (2a2) *gay queen*, (2b1) *kathoey*, (2b2) *kathoey plaeng phet* (transsexual), (2b3) *khon sorng phet*

(hermaphrodite), (2c) *tom*; (3a) *dee* and (3b) woman, respectively. These terms refer to seven common *phet* categories: "man," *gay king*, *gay queen*, *kathoey*, *tom*, *dee*, and "woman" (p. 414).

As can be seen, Thai gay populations have drawn creatively on foreign idioms to label local sex-cultural patterns and often use English in ways that are alien in English-speaking countries. Moreover, in Thailand the "top/bottom" or "actif/passif" pairing is labeled with the borrowed terms "gay king"/ "gay queen", or often simply "king/queen" (Jackson, 2009, p. 18). While "queen" has historical associations with effeminate homosexuality in English-speaking countries, its use with "king" indicating preferred variety of homosexual activity is unique to Thailand (Jackson, 2009). Therefore, these sub-gay identities are reflected by the degree of masculinity and femininity.

Moreover, all of these terms mentioned above can also be referred to "a third-gender category" which exists alongside the categories 'men' and 'women or all non-normative gender presentations and sexualities in The Thai culture (Ocha & Earth, 2013, p. 196). However, this needs to be treated with caution as this term can sound discriminatory to some who do not want to be viewed as outside Thai heteronormative society (Sinnott, 2004). Soontravaravit, Boonprakarn, and Banthomsin (2010) stated that sexual behavior of "the third gender", called gay, is different from the acceptance of social norm or the dominant discourse of ideology (p. 1). Evidently, the numbers of people in this gender which are rapidly increasing reflect the complication and the fluidity of sexual identity. It can be said that these various Thai terms mainly associated with gender are consistent with Clarke, Ellis, Peel, and Riggs (2010) who stated that "whereas western cultures tend to privilege

sexuality over gender, many non-Western cultures privilege gender over sexuality" (p. 32).

The emergence of new sexual identities in Asia and non-Western societies also corresponds to "global queering" coined by Altman (1996). The research on global queering in Asia can also confirm Appadurai's account of cultural globalization as a multifaceted phenomenon, "globalization is itself a deeply historical, uneven, and even *localizing* process. Globalization does not necessarily or even frequently imply homogenization or Americanization" (Appadurai, 1996, p.17). Therefore, the Thai sex/gender system is rather historically and contextually uncommon to the Western model

Even though these various sexual and gender identities have evolutionarily and culturally been created, Thai people still discriminate against these MSM who publicly express their sexual/gender identity but are nonetheless tolerant of private space for them. Morris (1994) stated, "virtually any [sexual] act is acceptable if it neither injures another person nor offends others through inappropriate self-disclosure" (p.32). Morris (2002) explained that Thai contemporary society has a mode of power that works horizontally rather than vertically like in the panoptic or "all-seeing" mode that Foucault (1980) described in the Western cultures in which power is more totalizing (p. 152). Those in power in Western cultures seek to prohibit non-normative sexual expression in the private as well as the public domain (Jackson, 2004). In other words, there is the gap between having sexual desire and living within the specified category of that sexuality.

As can be seen, discriminatory power in Thailand is exercised when MSM are forced by Thai society to freely express their identity only within their private space, such as saunas, gay bars, or chat rooms for gay communities. In addition, private

space, for example, space within family, can be defined differently for Thai homosexuals (Soontravaravit, Boonprakarn, & Banthomsin, 2010). For example, some feminine gays prefer expressing their feminine identity to their female family members who have more compatible behavior with them, whereas masculine gays conceal their identity in the family by acting like unmarried men by being silent or avoiding the topic of their girlfriends (Soontravaravit et al., 2010).

In sum, there could be some difficulties of trying to infer sexual and gender norms, associated social dynamics and categories of behavior without understanding the Thai social context (Jackson & Duangwises, 2017). Fluidity, ambiguity, uncertainty, ambivalence about gendered and sexual subjectivities, all mean that gendered sexuality is an ongoing meaning construction that can be related to homosexuals' disclosure of HIV as a double stigma. Also, some chronic illnesses and sexuality are linked to social stigma or "unrealized norms" in social interactions (Goffman, 1963, pp. 137-138). Consequently, it can be hard to make societal perceptions more open to and reasonably accepting of diverse sexual or even gender identities and their practices.

2.6 Communication Privacy Management

Privacy concerns, motivated by desires to avoid embarrassment or discomfort, can obstruct disclosure in any culture, although the reasons for embarrassment or discomfort, as well as norms related to privacy, differ across cultures. Communication privacy management (CPM) theory is used to study the phenomena of individual and collective boundaries that determine the extent to which information can be gained and shared in various contexts (Petronio, 2002). However, rather than using the term "self-disclosure," which conveys "the unilateral act of the discloser," Petronio expressed a preference for the term "disclosure of private information," which focuses

more on the content of what is said and how private information is handled (Griffin, Ledbetter, & Sparks, 2012, p.169). According to CPM, people both actively make choices to disclose or withhold the information about the self as well as reactively responding to those choices by their conversational partner (Petronio, 2002). Therefore, CPM seeks to explain not only how people use rules to reveal or conceal private information in order to "best protect personal privacy" (Metzger, 2007, p. 336) but also how rules "become defined anew" (Petronio, 2002, p. 38). CPM further explains three rule management processes: "privacy rule foundations, boundary coordination operations, and boundary turbulence" (Petronio, 2002, pp. 23-33), as summarized in Table 2.6.1

Table 2.6.1

Three Rule Management Processes

Privacy rule foundations	Five criteria: Cultural, gendered, motivational, contextual, and risk-benefit ratio
Boundary Coordination Operations	Boundary linkages, boundary permeability, and boundary ownership
Boundary Turbulence	Violation or failure of boundary rules

Privacy rule foundations involve attributes and development of rules; in these ways, people obtain rules of privacy and understand the properties of these rules through different social situations that determine the particular type of disclosure (Petronio, 2002). As rules for managing privacy are learned over time, they can then be developed to fit the situation (Petronio, 2002). The five decision criteria are: "cultural, gendered, motivational, contextual, and risk-benefit ratio criteria" (Petronio,

2002, pp. 24-26). First, culture involves certain norms for privacy that influence decisions of disclosure, varying from one culture to another culture (Petronio, 2002). For instance, Thai culture, with its preference for high-context communication values, can encourage people with HIV/AIDS to make more implicit disclosures than would be true of individuals residing in a low-context culture. As can be seen, privacy "differs among cultures in terms of the behavioral mechanisms used to regulate desired level of privacy" (Altman, 1977, p. 66). More specifically, in terms of gendered behavior, the gender criteria determine the nature of male and female privacy; in other words, men and women tend to use different sets of criteria to define the way private information is co-owned (Petronio, 2002). Also, the criteria of gay gender and sexual orientation are used to judge whether to reveal or conceal something private, like HIV/AIDS; for example, gay men were cautious about decisions on disclosure of HIV positive which is believed to be associated with their gayness (Collins, 1998). Third, motivational criteria are concerned with the needs for private disclosure associated with reciprocity. In this case, reciprocity, based on social exchange theories, involves trust, liking, and attraction between individuals (Petronio, 2002). For example, people might be more willing to disclose private information if they trust or like one another. Fourth, contextual criteria are dimensions of disclosure decision-making, such as setting (e.g., where to disclose), timing (e.g., when to disclose), and message features (directness vs. equivocality) (Greene, Derlega, Yep, & Petronio, 2003). Finally, risk and benefit ratios involve the evaluations of the advantages and disadvantages of revealing or concealing.

Secondly, the term boundary coordination refers to "how individuals co-own and co-manage private information" (Petronio & Durham, 2008, p. 314). In this case, there are three elements: boundary linkages, boundary ownership, and boundary

permeability (Petronio, 2002). Boundary linkages involve the connections of boundary with collective others in the communicative network who are involved in private information sharing (Petronio & Durham, 2008). For example, in one study, depending on intimacy, the secure participants disclosed more information to a high discloser partner than to a low discloser partner (Mikulincer & Nachshon, 1991). As can be seen, the participants collectively share private information with the high discloser partner in this intimate communication. On the other hand, avoidant participants did not show any disclosure to their partner (Mikulincer & Nachshon, 1991). Also, with higher trust, these boundary linkages can be unified in the sense that every social member, as a collective other, is eligible to have access to private information (Petronio, Jones, & Morr, 2003). In addition, boundary ownership is the right of individuals to own private information and perceive how they will permit others to be co-owners (Petronio & Durham, 2008). The degree of boundary ownership can reach to the extent that the private information belongs to everyone (Petronio, Jones, & Morr, 2003). Finally, boundary permeability allows private information to be known either completely or partially (Petronio & Durham, 2008).

As the last element of CPM, boundary turbulence literally refers to the violation of ownership expectations or failure of communication coordination that is complex and related to imperfect boundary regulation (Petronio, Jones, & Morr, 2003). In this case, people use different criteria to develop rules and perceive levels of risk concerning revealing and concealing differently, and this causes turbulence (Petronio, 2002). However, when boundary turbulence occurs, rules can be changed to fit individual needs so that a certain level of control over privacy can be maintained (Petronio, 2002).

2.6.1 Privacy Management of HIV/AIDS Status and MSM in Thailand

One of the biggest potential barriers to disclosure of Thai MSM is HIV-related stigma and discrimination as well as AIDS phobia, compared with HIV-positive MSM in the West, where HIV-related stigma is less severe (Wei, Lim, Guadamuz, & Koe, 2012). Wei et al. (2012) found that non-disclosure to others was associated with meeting partners at public cruising spots, sex parties or gay saunas, places where sexual encounters were casual or anonymous. Similarly, Korner (2007) found that many Thai people perceive that HIV/AIDS is considered a fatal disease related to homosexuality and promiscuity, and they have a gossip culture that makes PLWHA feel uncomfortable (Korner, 2007). Even though Thai MSM, as discussed earlier, might feel free to disclose to each other in their private space, the HIV/AIDS stigmatized condition can obstruct disclosure. According to Yoshioka and Schustack (2001), Asian and Thai patients experienced self-imposed barriers to disclosure that are rooted in cultural values. With Asian cultural values of harmony and avoidance of unpleasant interaction, many of the participants chose not to disclose to family members due to the desire to protect themselves from the inherent shame and fear of the stigma attached to their sexual orientation or their parents' lack of information and understanding of HIV (Yoshioka & Schustack, 2001). Similarly, Lee et al. (2010) found that the positive benefits of HIV disclosure in Thailand are becoming more salient. While HIV disclosure can lead to positive outcomes (e.g., more support from family members, sense of relief, linkage to care), there are also potential negative consequences to disclosure (e.g., stigma and discrimination) (Lee et al., 2010). According to Udomkhamsuk, Fongkaew, Grimes, Viseskul, & Kasatpibal (2014), Thai youth living with HIV/AIDS were fearful of being rejected by their friends even though society currently accepts patients with HIV living among healthy people, perhaps fearing discrimination and bias. Similarly, it has been found from a study

conducted in 2014 that anticipated and perceived stigma from more than half of the adult Thai population discouraged those living with HIV/AIDS from making disclosure (Srithanaviboonchai et al., 2017). Apart from feeling of shame, Oberdorfer et al. (2006) found that, in Asian countries, particularly in Thailand, society is more rigidly stratified than in Western countries. Unlike in Western countries where public confession is more common among people even of the more privileged strata of society, in Asia the concept of not losing face is commonly practiced (Oberdorfer et al., 2006). Also, another issue is avoidance of interpersonal conflict that, as discussed earlier in relation to Mesquita's (2001) study, can affect the decision to disclose.

Given the aforementioned considerations, it appears that four CPM criteria, namely cultural (collectivistic), gender ("phet" encompassing sexual difference: male vs. female, gender difference: masculine vs. feminine and sexuality: heterosexual vs. homosexual) that can obstruct disclosure, contextual, and risk and benefit criteria pertaining to disclosure might be particularly important in Thailand. Also, in terms of boundary turbulence, fear of information leakage can affect face saving and provoke shame among HIV participants or family members. In the latter case, according to the study of collectivistic Chinese culture like in Thailand where HIV/AIDS is highly discriminated against, boundary was co-owned and coordinated between close family members and HIV members due to social shame. In addition, even though disclosure of MSM has been promoted in Thailand, Thai culture with high context-dependence can still make disclosure or request for social support implicit, thus causing difficulties of understanding about support provision. These difficulties can further lead to passive emotion-focused coping (e.g., avoidance, denial) that makes HIV participants feel more depressed.

Based on the preceding review of literature, the study detailed in following chapters was designed to answer the two research questions:

1. How do sexuality, culture, and concerns about privacy management intertwine as Thai MSM with HIV/AIDS construct meaning in the experience of social support?
2. What patterns and processes of communication have Thai support networks employed to socially support MSM living with HIV/AIDS?
3. How successful are communication strategies used for social support?

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CHAPTER 3

METHODOLOGY

Human communication is complicated because human learning, thinking, and sense-making are contextual. These dynamics make meaning and action hard to predict. Qualitative researchers study meaning and action using "naturalistic inquiry": in real world settings without manipulation of the phenomenon of interest (Patton, 2002). As human communication is dynamic and thoroughly contextual, inquiry that is interpretive and naturalistic is warranted. The interpretive perspective will be explained further in the following section.

3.1 Interpretive Perspective: Hermeneutic Phenomenology

Interpretation is the process through which people assign meaning to things that they observe or experience. Phenomenological inquiry requires gaining access to the phenomenon and achieving a thorough understanding and full elaboration of the phenomenon, to make its meaning or "essence" clear (Griffiths, 2009, p. 36). The task of phenomenology is to identify the subjective experience, describe it and thus understand it. When the goal of the research is to understand a phenomenon or process, or explore or describe what is under investigation from the point of view of the participants, the researcher is expected to develop an interactive relationship with the participants in the study to accurately and reliably describe their perspectives. In this regard, hermeneutic phenomenology is concerned with the life world or human experience as it is lived. The focus is toward illuminating details and seemingly trivial aspects within experience that may be taken for granted in our lives, with a goal of creating meaning and achieving a sense of understanding (Wilson & Hutchinson, 1991). In this way, it is also important that the researchers should have flexibility to

follow and explore unexpected ideas during research with in-depth and longitudinal explorations in order to develop new ideas and theories.

Furthermore, Parker and Carballo (1990) explained that qualitative approaches are appropriate for investigating homosexual behavior within a broader social and cultural context. As given behavioral patterns are not necessarily translated into the construction of a sense of sexuality, qualitative inquiry can examine precisely the way sexual behaviors and identities are linked (Parker & Carballo, 1990). In addition to aiding my study of sexuality, qualitative research would help me to investigate social support related to participants with HIV from different backgrounds who can share the experience of the social support they have gained from and/or provided to their social support networks. Qualitative researchers can achieve rich and thick description (detailed description of research data) by bringing various representations of phenomena to light (Denzin & Lincoln, 2005).

In order to make the situations of social support more understandable, I employed two qualitative methods (i.e., observation of social support groups and individual interviews). At the early stage, I observed multiple social support group sessions that helped me to know more about collective experiences of social support from MSM with HIV/AIDS. Also, after a period of initial observations or at the same period of observations, not only MSM with HIV/AIDS but also the staff members were interviewed separately and individually in order that I might learn more about the experiences of both MSM with HIV/AIDS and the staff as their support providers. Complementing both observational data from the support groups and interviews has helped to me to gain more vivid insights into how support is given to MSM with HIV/AIDS.

3.2 Research Participants

Participants were mainly comprised of members of the MSM community as the most at-risk population infected with HIV/AIDS. I selected MSM participants who were over 18 years old with a wide range of infection periods so that I was able to learn from them a number of different experiences of social support and disclosure. People of these different infection periods may have different motives for disclosure and encounter different kinds of social support networks. These participants came from Bangkok and its vicinity where HIV/AIDS incidence, as discussed earlier, is the most prevalent.

At that time, I chose three organizations (names have been changed to protect confidentiality), as well as their social workers and nurses: Organization A, Organization B, and Organization C for my study. These three organizations have focused on social support provision to MSM and transgendered individuals with HIV/AIDS in Bangkok, while other support organizations (e.g., Rainbow Sky Association of Thailand or hospitals) were responsible for HIV/AIDS prevention and medical treatment.

Organization A is “the first care and support community-based organization” for MSM and transgender. It also offers a series of workshops with clients, volunteers and staff of the center and other services, such as HIV/AIDS telephone consultation services, home visits, personal and close supervision with assistance calls between friends and other recreational and cultural activities that promote social support.

Similarly, Organization B is for a peer support group of people living with HIV. After their regular meeting for the examination at the immunization clinic on every Tuesday morning with social workers and nurses, the patients usually meet again on the third Wednesday of the month. In this way, it is believed that those who

share the same HIV/AIDS experiences can give better comfort or advice to each other than doctors or psychologists.

Like Organization A, Organization C is an independent, non-profit organization that is committed to assisting MSM most affected by HIV since rates of HIV among these people are critically high in the Asia region, including Thailand. The staff of Organization C provides one on one personal care with MSM with HIV/AIDS in order that individual problems related to this disease can be closely tracked for social support.

In order to gain entry, I made contact with the directors of Organization A, of Organization B, and of Organization C as the gatekeepers who could direct me not only to MSM with HIV/AIDS within their organizations but also other staff members taking care of MSM with HIV/AIDS. As Organization A, Organization B, and Organization C deal with social support for MSM, collecting data from these organizations has enabled me to find more information on social support and disclosure associated with MSM with HIV/AIDS.

A document confirming that I had completed the IRB process from the Ohio University Office of Research Compliance was required for the research process (See Appendix A). Before the collection of data, participants (HIV+ Thai MSM and the staff of three HIV/AIDS organizations) were asked to complete a consent form that explained the general purpose of research, my research procedures (use of two main qualitative approaches: observations and interviews), potential harms and benefits, information concerning anonymity (the use of pseudonyms for research participants), confidentiality (people eligible for access to the information of this research), and compensation (See Appendix B, C, D, and E). After explanation of the study, 46 people from the three organizations eventually returned signed consent forms. The

participants included gay 43 patients and healthcare staff who had AIDS or were HIV+ but had not progressed to the full syndrome; in addition, three non-infected care providers, who are two straight men from Organization B and C and one woman from Organization C, participated (See Appendix F).

In total, there were ten patients of Organization A, fourteen of Organization B, and six of Organization C, respectively. On the other hand, there were six staff members of Organization A, six of them of Organization B, and four of them of Organization C (See also Appendix F). The participants from Organization A and Organization B joined both support groups and interviews, while those from Organization C agreed to have only the interviews. The whole research process of observation and interview took approximately four months, from June to September, 2014.

3.3 Observation

Typically, observation refers to all observation activities in which field work occurs; however, observation depends on the roles and duration of fieldwork (Wolcott, 1999). Consistent with this idea, Patton (2002) proposed a continuum of observational strategies, ranging from "full participants to complete separation from the setting as spectator" (p. 265). However, Gold (1958) offered clearer delineations of four types of observation roles. First, complete participants pretend to be a member of the scene and do not want to be recognized as a researcher; in this way, natural activities of the group will not be disturbed or interrupted (Merriam, 2009). Second, participants as observers focus more on the participating role than observation and allow group members to know about their research intent (Wolcott, 1999). Third, observers as participants primarily observe group members but can occasionally and informally interact with them; in other words, the role of information gatherer is more significant than that of participation (Gold, 1958). Finally, complete observers neither

disclose themselves to public members nor participate in the observed activities, so participants are unaware of being observed and the observer has minimum impact on the naturally occurring events (Glesne, 2011).

3.3.1 Observation Process

For four months, I worked as an observer-as-participant who mainly observed six support groups from various backgrounds at the two HIV/AIDS organizations (Organization A and Organization B) except Organization C where most MSM participants were newly infected and did not want to see other HIV+ members in group meetings. The regularly scheduled support group meetings were moderated by the staff of the organizations. As Organization B held the meetings at the beginning of every month, I managed to participate in observations for four months. On the other hand, during that time the moderator of Organization A was available for the group meetings only in the second and third month. All the participants wanted to join group conversations, so I could observe different groups held at Organization B (four support groups) and at Organization A (two support groups). Some participants of Organization A also joined the observations of Organization B, and vice versa. Each session of group observation generally conducted with 8 to 13 group participants in 1 hour. With the observations of these support group sessions, I was able to know more about communication of social support in relation to disclosure in the Thai cultural context.

Due to ethical concerns, I worked neither as a complete observer nor complete participant, as both of these roles would require hiding my researcher role and aims from natural actors. At the beginning of each observation session, the moderator introduced me to other support group participants. Then, they introduced themselves to me and each other. Before the conversations of the groups started, I explained to

the participants about the information in the consent form again to ensure that they understood the research purpose and procedure. After that, during the observations, I audio-recorded their conversations and wrote field notes marked with key words or phrases of necessary information during my observation. Immediately after leaving the field, I made revisions by writing more comprehensive notes and organizing these notes so that they could be used to complement the interview transcripts (Glense, 2011). Field notes are considered a main instrument for observers. Van Maanen (1988) explained that field notes are "shorthand reconstructions of events, observations, and conversations that [take] place in the field" (p. 123), while Sanjek (1990) defined them as "a body of description, acquired and recorded in chronological sequence" (p. 99). In field notes, not only did I write down verbal important messages (e.g., If you are 'rook', you could tell your partner as 'rub' or "This kind of gossip is responsible for labeling"), but I also recorded participants' nonverbal communication (e.g., squirming, smiling or frowning) conveying subconscious messages that indicate a possible different intent of the speaker. In this case, the support group members might not want to reveal all their information and feelings; therefore, nonverbal messages that contradict verbal communication were also interpreted and analyzed (Berg, 2009). In order to minimize biases and promote reflexivity (ongoing conversation about what "the researcher knows and how the researcher came to know this"), my feelings and thoughts (e.g., speculations, likes or dislikes, confession of mistakes, etc.) were included in the field notes (Berg, 2009, p. 198). For example, I commented on why I liked or disliked the ways moderators facilitated peer support groups; alternatively, I speculated on how some participants reacted to some questions or preceding remarks given by other participants. Further, I interviewed these MSM participants for more information on social support and

disclosure to ensure that what I had observed from verbal and non-verbal communication in support group conversations confirmed or corresponded to the interview responses. In this way, matched data between support groups and interviews can warrant accuracy of data that MSM participants give. The interviews will be explained more below.

3.4 In-Depth Interviews

Another kind of qualitative method is the semi-structured interview that is non-standardized and is not intended to test a specific hypothesis (David & Sutton, 2004). Similar to the structured interview, I had a list of specific questions as an interview guide (See Appendix G and H). This interview schedule might not be followed exactly as originally outlined (Gordon, n.d.). As interviews gave rise to new and unanticipated issues, some questions that were not included on the original guide might be added while questions that were part of the original guide, if they prove to not be productive, will be dropped (Gordon, n.d.). Clearly, the strengths of the semi-structured interview are that the topic guide ensures that a core list of questions is asked in each interview; in addition, the interviewer can investigate the interviewees' motives with probing and follow-up questions (Hardon, Hodgkin, & Fresle, 2004). By asking for further examples and evidence, probing is used to elicit more details in responses that lack clarity and depth (Rubin & Rubin, 2012). Common probing questions, called "tour" or "grand tour" questions, prompt participants to tell interviewers not only how things are generally done (e.g., social support gained from support networks) but also develop insights as to how they interpret aspects of social support experiences (Lindlof & Taylor, 2011, p. 202). In addition, "mini-tour questions" are used to investigate parts of the "grand tour question" by dealing with smaller episodes of experience, such as a distinctive experience that might be a first

experience or turning point (Lindlof & Taylor, 2011, pp.202-203). For example, I might ask how they began to feel that a particular overture of social support was not right for them. On the other hand, follow-up questions examine whether the answers given are relevant to the researcher's questions (Kvale, 1996). In this case, follow-up questions are used with some relevant but untold information, for example, answers that are superficial, too broad, or too narrow, interviewees' contradictory and ambivalent statements, stories rather than direct answers, abstract and complex ideas, themes, and new and unanticipated ideas (Rubin & Rubin, 2012, pp. 153-159).

3.4.1 Interviewing Process

After the observations of some group sessions, I employed convenience sampling by asking if any of those support group participants, including staff members, were free for the interviews. Then, the date and time were set for them. Therefore, a variety of support experiences could be observed. I audio-recorded individual interviews of MSM with HIV/AIDS and the staff members at Organization A and at Organization B with their consent. During the observations at the other two HIV/AIDS organizations, the interviews were also conducted with care receivers and the staff at Organization C. I used semi-structured, one-on-one interviews with not only 23 MSM participants with HIV/AIDS to ask about support from informal and formal networks but also 14 staff members of these three support organizations. Initially, I strived to establish rapport (building a degree of comfortableness in being together and of trust in one another) with interviewees, so I knew more about formal support (e.g., consultation, support groups, etc.) that can be either helpful or unhelpful to MSM with HIV/AIDS. Establishing rapport also promoted non-defensive interactions by showing my empathy and understanding of HIV/AIDS as an illness that is not as socially threatening as widely believed since it cannot be easily

transmitted to other people except through blood transfusion or sexual activity without protection. Meanwhile, I expressed to participants my concern about the significance of social support.

The interviews ran from 50 minutes to 1 hour and were open-ended in order to elicit responses from both HIV infected participants and staff members so that I was able to gain a deeper understanding of social support and participants' disclosure with follow-up and probing questions. These questions helped me to discover more, for example, about ways of providing and receiving support of different kinds from support networks in the Thai context, conflict during communication/disclosure, or strategies of handling any communicative difficulties. In this way, the occurrence of contextual-based communication had an impact on support providers and receivers in ways that previous literature has not investigated. Separate interviews of MSM with HIV/AIDS and the staff at the healthcare support organizations also generated different versions of the same story and allowed disclosure of more in-depth details similar to a study conducted by Hertz (1995) that explored on "separate but simultaneous interviewing of husbands and wives." In addition, the interviewee felt more comfortable without the presence of the other who might have influenced his opinion(s) on some issues related to social support and disclosure of HIV/AIDS status. In this respect, I employed the separate interviews with MSM with HIV/AIDS and the staff of Organization A, Organization B, and Organization C. Then, I used the points that the MSM participants mentioned to ask their staff members. However, I did not directly refer to what these participants had said but rephrased their points in a more objective tone with open-ended questions that allowed the staff to think and answer. For example, I made questions on how the staff communicated to make some

HIV/AIDS infected participants, especially those with great suffering and distress, feel more relieved or helped them to turn from negative attitude to positive one.

In this way, not only would I help to protect MSM's information or feelings towards the staff from being revealed but I would also learn social support incidence from the other party who provided social support to MSM with HIV/AIDS. In sum, researchers guided by reflexivity should convey neutrality or non-judgmental reactions toward interviewees' responses by actively acknowledging their own actions and decisions that can influence the meaning and context of interviewees' experience under investigation (Horsburgh, 2003). Also, in terms of empathetic interviewing, as researchers should care more about interviewees' feelings and emotions, I was aware of the feelings and emotions of MSM and the staff participants during interviews (Rubin & Rubin, 2012). Finally, I transcribed what I recorded into interview scripts.

3.5 Data Analysis

Transcribing the audio-recorded data and revisiting field notes are essential for data analysis process. After collecting the data, I transcribed all recordings both from support groups and interviews; then, the transcripts were checked against the taped messages to mark verbal messages and non-verbal messages (e.g., tones of voice, pause, and facial expressions). In addition, I organized my written field notes after observing support groups and interviewing by typing up whatever observations struck me as the most noteworthy or the most interesting. This not only facilitated my immersion in the data but also allowed me to ensure that field notes were carefully matched with these two research methods.

Next, thematic analysis, which is a method for systematically identifying, organizing, and offering insight into patterns of meaning (themes) across a dataset,

can allow me to see and make sense of collective or shared meanings and experiences. For this analysis, I relied on a widely cited interpretive method described by Braun and Clarke (2006)[2]. Based on "semantic themes", the themes are identified within the explicit or surface meanings of the data and the analyst is not looking for anything beyond what a participant has said or what has been written (Braun & Clark, 2006, p. 13). Therefore, semantic coding is related to the descriptive rather than the interpretive analysis which belongs to latent coding. Based on an inductive orientation, this form of thematic analysis is called data-driven; in other words, themes emerge directly from the data during analysis, and it helps to truly explore and reflect participants' views and experiences on the process of social support, disclosure, and privacy. As such, this semantic coding helps to prevent the researcher's subjective views that can cause bias interpretations of the data. This semantic analysis is not a linear process which moves from one phase to the next; instead, it is a more recursive process, where I had to move back and forth as needed, throughout the phases.

Based on the outline of Braun and Clark (2006), process entailed six phases of thematic analysis: (a) "familiarizing yourself with the data", (b) "generating initial codes phase", (c) "searching for themes", (d) "reviewing potential themes", (e) "defining and naming themes", and (f) "producing the report" (pp. 16-23).

Initially, I familiarized myself with the data by reading and re-reading textual data (i.e., support group and interview transcripts and field notes) and listened to audio-recordings at least once, as well as reading the transcripts. This phase of familiarization encouraged me to make "causal observational notes" (Terry, Hayfield,

[2] According to a Google Scholar on March 10, 2018, this article had been cited 37,589 times.

Clarke, & Braun, 2017, p. 23); in this way, I took notes of some information on the margin of the support group and interview transcripts relevant to the potential findings that could answer the research question. Also, these notes were used for the subsequent phase of finding codes.

Then, at the phase of generating initial code phrase, using line-by-line coding, I underlined relevant words or phrases of different types of social support, disclosure, and privacy (e.g., comforted, gently patted, making gradual disclosure, then I said just listen to him...) during the open coding. Also, for classification of the relevant data, these categories were highlighted with different colors, numbers and some notes; meanwhile, file cards were used to separate the coded data. Therefore, throughout the process, the labels were meaningfully and systematically created. I chose to use manual coding over electronic coding because normally the use of computer software in qualitative data analysis is limited due to the nature of qualitative research itself regarding “the complexity of its unstructured data, the richness of the data and the way in which findings and theories emerge from the data” (Wong, 2008, p. 2). Although it has been argued elsewhere that NVivo does not take over the analysis process from the researcher, computer-based qualitative and data analysis software, like NVivo, could determine rules for specific procedures, such as nodes which is a leading sign to the researcher to split his/her data into those containers (Zamawe, 2015). Moreover, despite the useful function of queries, arguably it might also serve to distance the researcher from the context of the data (St John & Johnson, 2000). As such, coding based on query's searches can obviously reduce thickness of the data. In this respect, since qualitative research is context-bound, the researcher needs to be context-sensitive in order to detect and be aware of any misrepresentation in the data. Moreover, use of manifold synonyms might lead to partial retrieval of information in

the computer software; in other words, not all results of the word being searched will appear (Zamawe, 2015).

Later, I searched for the potential main themes related to social support, which was done by reorganizing the codes I had developed from the data during open coding in new ways by making connections between categories. In this way, after examining codes and their associated data, I combined and then clustered codes into meaningful patterns by finding similarity and a range of different codes that can be clustered into a possible theme. This is also called a "clear core idea or concept that underpins a theme" (Braun & Clarke, 2015, p. 102). Nevertheless, the themes, at this stage, were still the candidate ones, some of which were discarded later.

At the phase of reviewing, I checked if those candidate themes matched and captured the coded data relevant to the meaning of the central organizing concept of the theme which can answer the research question on sexuality, culture, and concerns about privacy management intertwining as Thai MSM with HIV/AIDS construct meaning in the experience of social support. Through refining themes, I ascertained whether the themes work in relation to the data set and coded any additional data within themes that had been missed in earlier coding stages so that the range of meanings and each candidate theme were distinctive. Furthermore, in order to ensure this refining process, testing the coding reliability is essential. In the test-retest method, I coded the themes, but for the second time I did not look at the results and re-coded the same themes in order to check the agreement of the first and second coding.

Then, I tried to find the appropriate names for themes, which can fit in each of these four dimensions of social support. I identified the essence of what each theme is about by going back to reread the data extracts and determined what aspect of the data

each theme captured. Essentially, thorough examination of the patterns of meaning helped to summarize the core idea and meaning of each theme. In other words, this process clearly does not involve thinking about lists of themes or paraphrasing but analyzing to refine the specifics of each theme to generate clear definitions and names for each theme. For instance, as most of the content involves, for example, closeness, privacy, shared information, or disclosure, the theme was named "emotional support as sharing in Thai culture". Alternatively, with most commonly found terms - commiseration, distress, and non-acceptance, the theme was named as "informational and emotional support in dealing with other people's ignorance".

At the final phase, I produced the report by writing all the themes with their detailed description and explanation with particularly vivid examples or extracts which capture the essence of the point demonstrated. However, my write-up did more than just provide data but was embedded within an analytic narrative for my data. In this way, my analytic narrative goes beyond description of the data in relation to my research question with counter-arguments and rebuttals reinforced by other previous studies. Also, these arguments helped to ensure that each theme of social support dimensions are clearly and logically linked with one another.

In terms of translation, I did analyses in Thai and chose to translate into English for some segments that answered the research questions. I also asked two native English speakers to check the translations for grammatical correctness and clarity. In this way, I thought of the English expressions closest in meaning to the Thai expressions so that the participants' feelings and perspectives could be retained.

3.6 Credibility and Validity of the Study

After data collection and during analysis of the research data, it is essential to make sure that data remain authentic. In terms of the research credibility and validity,

authenticity involves genuine experiences, understandings, and truths in terms of trustworthiness (Bridges & McGee, 2011). In this way, the representation of participants' voice should be true to the "life worlds" of those they are describing (Winter, 2002, p. 146). In order to enhance this authenticity, according to Lincoln and Guba (1985), "fairness" that aims to elicit a balanced view of all voices and perspectives is essential; therefore, every participant must be allowed to share their experience, understandings, and knowledge with the researcher in the context being studied (p. 72).

This fairness also involves reflexivity that, as discussed earlier, enables the researcher to engage in both as an inquirer and a respondent for research participants; thus, multiple voices of the researcher and participants can be promoted (Lincoln & Guba, 1985). As for my research, in addition to self-reflexivity during the process of observations and interviews, at the final phase, reflexivity also occurred during other research processes like triangulation ("a judgement of the accuracy of specific data items") and member checking ("a judgement of the overall credibility") (Lincoln & Guba, 1985, pp. 315-316) in order to enhance thick description that helps readers to understand robust detailed information about participants' experiences.

In this research, three kinds of triangulation were used, namely "theoretical, data, and methodological triangulation" (Salazar, Mijares, Crosby, & DiClemente, 2015, p. 224). Theoretical triangulation is concerned with use of multiple theories to explain and analyze findings (Salazar et al., 2015, p. 224). In this, I used social psychological theory of stress and coping, theories of social constructionism, and the theory of communication privacy management to analyze results in my study. Secondly, data triangulation involves using different sources of information regarding "time, space, and person" to increase the validity of a study (Salazar et al., 2015, p.

224). These sources are mainly from different persons (i.e., HIV/AIDS infected participants and the healthcare providers) at different times in terms of weeks and months in which data were collected and in different places (i.e., three different HIV/AIDS organizations). In this way, additional and multiple sources of information gave more insights into a topic with comprehensive similar data. Therefore, this helps to analyze data to draw conclusions and outcomes. As for methodological triangulation, two methods (i.e., observations of support groups and in-depth interviews) were used to gather data with "within methods" triangulation (Salazar et al., 2015, p. 224). This approach involves multiple data collection strategies from the same type of approach; in this way, in order to answer the same research question on social support and disclosure intertwined with Thai culture, observations and interviews were conducted with participants and providers.

In addition to triangulation, member checking includes asking participants to confirm or disconfirm the accuracy of the researcher's observations and interpretations and to solicit their views about the credibility of the findings (Creswell, 1998). Although Lincoln and Guba (1985) have described member checks as a continuous process during data analysis (e.g., by asking participants about hypothetical situations), it has largely been interpreted and used by researchers for verification of the overall results with participants. In this respect, I started to solicit feedback on findings from MSM with HIV/AIDS and the healthcare staff near the end of the project by sharing transcripts, themes, and explanations with them. In order to complete member checking from all the interviewees and support group participants, I spent time doing this checking process for approximately one to two months and a half.

In doing so, I returned to the field and asked MSM participants and the staff of Organization A, Organization B, and Organization C to read my preliminary findings, themes, and explanations with study participants and to offer comments. The participants were asked to review, critique, and suggest revisions where necessary. I shared my interpretation of the data and my statement of tentative assertions – "Do you think my interpretation is correct?....And if not, how would you interpret these findings?". This member checking was not only to prevent misinterpretation of what the participants have said and done but also to identify researchers' biases and misunderstanding of what they have observed or analyzed (Krefting, 1991).

3.7 Ethical Considerations: Confidentiality and Privacy

In order to prevent violation of privacy, I used pseudonyms and altered any potentially individuating personal information except a pseudonym master list that contained participants' pseudonyms and real names. This list allowed me to associate not only each individual participant with their data more precisely but also the multiple observations and interviews with the participants so that I was able to track the development of social support over time in the face-to-face support group meetings. The pseudonym master list was stored on my laptop that could be accessed only with my personal account, including the account user ID and password. All the identifiable data (i.e., the pseudonym master list, field notes of observation and interview scripts) will be destroyed three years after successful defense of the dissertation.

CHAPTER 4

RESULTS

Thai MSM (Men who have Sex with Men) with HIV/AIDS need care and support that vary across periods of infection. Also, healthcare providers have to know how to respond to their problems in a proper, professional manner. Nevertheless, there are some potential difficulties facing both healthcare providers and medical staff.

This chapter mainly discusses the co-construction of social support and the interviewees' understanding of the relevant social support communicated to them. With the observation of support groups and in-depth interviews, types of support can be explored more deeply. From the large volume of past research – both quantitative and qualitative – there are four major forms of social support: emotional, informational, instrumental, and appraisal. The basic dimensions of support that have been established in social science research are unimpeachable and thus a reasonable architecture for organizing an inquiry using a social constructionist approach to yield insights into how these bedrocks of support are enacted in the unique context of infected Thai MSM. Each section, around each major theme, will indicate how Thai culture and the realm of sexuality shape the provision of these common forms of support in this distinct context. The support experiences of infected Thai MSM will be illuminated in 15 major themes, which are subsumed under the four principal types of social support.

Three themes relate to emotional support: (a) Emotional support as sharing in Thai culture; (b) identification and normalization of connection; (c) avoiding emotionally upsetting talk. Another five themes relate to informational support: (a)

Double informative support: Advice on how to manage challenging information from doctors; (b) Informative support on dealing with traditional Thai folk beliefs; (c) Informative support on dealing with the challenges of HIV/AIDS disclosure; (d) The importance of accurate information about HIV/AIDS; (e) Information on preparing for employment after disruption caused by the HIV/AIDS issue. Further, there is one theme involving both informational and emotional support, which is informational and emotional support in dealing with other people's ignorance.

As for the last two kinds of social support, there are three themes associated with instrumental support: (a) Collectivistic network assistance with the necessities of living with infection, (b) Aid to improve interpersonal relationships complicated by infection, (c) Creating and sharing information in and about safe, private spaces. Three themes deal with appraisal support in terms of positive reappraisal: (a) Using familial love and duty to motivate reappraisal of self-care, (b) Reappraising the self to achieve acceptance of homosexuality and HIV/AIDS infection, (c) Using spiritual beliefs to reframe and achieve positive reappraisal.

The following section uses the four major forms of social support to organize the results, but in the development of each theme, it reveals how Thai culture, privacy concerns, and sexuality issues intertwine to shape how these other, possibly universal, dimensions of support are constructed within the context of social support for HIV+ MSM in Thailand.

4.1 Emotional Support

As the most fundamental type of social support, emotional support concerns caring and understanding in order to alleviate or prevent distress. This is associated with emotion-focused coping, which directly deals with seeking and providing emotional support. This emotional support is categorized into three main themes: (a)

Emotional support as sharing in Thai culture; (b) identification and normalization of connection, and (c) avoiding emotionally upsetting talk.

4.1.1 Emotional Support as Sharing in Thai Culture

This theme indicates that emotional support occurs only between those in the relationship or within the circle of some close or intimate support networks. In other words, private information is held privately among one's intimate group, with no sense of any individual ownership, and it is not shared with those outside of one's intimate group. Essentially, this private sphere can help facilitate emotional expressions. This emotional theme is more about communication between care providers or informal networks and MSM living with HIV/AIDS.

Shared privacy occurred when one participant who had been infected for 20 years was forced to reveal both his sexuality and HIV/AIDS status to his mother and his female siblings:

> After five years of my infection, when persistently asked about getting married, I felt a little annoyed and told my mother about my infection. Then, she said that she won the first prize of the lottery. Two double rewards. The first was my homosexuality, while the second was my HIV/AIDS infection. Then, she said, that's fine if I still take care of my own health. After that, I told my mother that only the two of us know this secret, and she said she would not tell this to anyone else. Soon after that, on the same day, my two elder sisters called me, asking how I was and told me to take care of my health. Nevertheless, I didn't say anything much but called my mother back to ask how the information had spread. Despite my HIV/AIDS status being known by my mother and elder sisters, we hugged and loved each other just like before. This is how we support one another, and it is vital for me to continue living. (Aun, gay healthcare provider, infected 20 years)

Within the immediate family, the participant revealed his HIV/AIDS status to his mother who then passed on this information to his sisters. Probably, at first, his mother might have felt disappointed with what her son had told her and sarcastically responded that she had: "…won the first prize of the lottery" or had obtained "two double rewards" in having discovered such in-depth information about her son that

had previously been a secret. Despite the sarcastic statements, the family later expressed empathy for him. in this context, there is a focus on “hen-jai” or seeing into the heart with sympathy and empathy which is expressed by his elder sisters or mother toward him (Kitiyadisai, 2010, p. 24). In other words, they were willing to listen, being flexible and forgiving, and accommodating towards him in times of distress as his mother had later managed to encourage him to overcome this awkwardness. At this point, she was no longer depressed by his disclosure of having HIV/AIDS and discovering that she has a homosexual son, but rather, she changed this negative approach to a far more positive attitude by saying “that’s fine”. In receiving a telephone call from his older sisters who advised him to look after his health, he then telephoned his mother. Nevertheless, the participant himself seemed not to regard this situation as any major trouble but interpreted as shared support, and, in addition, both his mother and sisters were concerned about him rather than full of blame, and all family members expressed affection between one another. This indicates the significance of an interdependent relationship between the in-group members, because the whole family helped this participant to “continue living”. As is evident, Thai family members are directly involved in each other’s individual lives. Because this HIV/AIDS issue can evoke the feeling of embarrassment even among family members, this could be a very confidential matter considered difficult to be revealed. Therefore, this conversation topic is still private for the self and the other(s).

This kind of shared privacy of information on HIV/AIDS set directly between these parties involved corresponds to work undertaken by Ramasoota (2001), who stated that: “the Thai language does not have a word for privacy but refers to it by descriptively translating from English as khwam pen suan tua or khwam pen yu suan tua, meaning ‘the state of being private’” (p. 97). Such privacy belongs to all intimate

members of the same household; therefore, it can be said that there is no individualistic privacy in traditional Thai culture (Ramasoota, 2001). Furthermore, the Buddhist teaching involves this notion of sharing together in times of 'suk-lae-duk' (happiness and sorrow); in other words, the Thai concept of equality can be reflected in the phrase of 'ruam-duk-ruam-suk' (sharing-suffering and happiness) (Kitiyadisai, 2005, p. 19).

The notion behind this is, according to Buddhist beliefs, that "the rights of ownership of land, water, lakes, trees, natural resources and even our own individual bodies are all illusory; however, we accept them as necessary in order to pursue personal development and self- improvement" (Kittiyadisai, 2005, p.19). As such, human- made rules and laws of privacy that shape human avarice and ego must be overcome, and people must see them as non-existent (Kittiyadisai, 2005). In this way, Theravada Buddhism teaches the emptiness of self (*anattã* in Pali); if the self is an illusion, individual privacy has no meaning. Collectivism teaches that the group, particularly one's intimates, is the locus of being, into which the individual must dissolve (Frank, Enkawa, Schvaneveldt, 2015). So, even for an anxious, infected, homosexual Thai, "privacy" entails personal information that is held privately among one's intimate group, with no sense of any individual ownership. Thus, Aun showed no negative reaction to his mother's apparent unilateral decision to disclose his news, but rather accepted the literal and figurative embrace of familial support. Clearly, the Buddhist religion is closely associated with the notion of this shared privacy in Thai collectivistic culture, and again this contrasts with the privacy notion that is upheld within Western cultures, which focuses more on individual privacy that should not be intruded upon by any outsiders (Kitiyadisai, 2005).

In a similar vein, this information shared within family members is also

evident in terms of the emotional support between the participant, Tuee and several family members, specifically, his aunt and his mother. Additionally, the participant's HIV/AIDS status was leaked to his mother after he had confidentially informed his aunt:

> At that time, when I was very weak and ill and looked very thin, I told my aunt that I was infected with HIV because she knew others infected with HIV/AIDS. Because of this, she might be able to understand me as someone living with this disease. I then asked her how I should tell my mother about this. She told me not to worry about this and wanted me to accompany her to the temple. Then, on the next day, at the temple, I saw my mother looking at me with worried eyes. This is because my aunt had already passed on the news that I had a problem with my blood to my mother. At that moment, I tried to avoid eye contact with her. I walked to the back of the toilet door and saw my mother – I burst into tears. Then, she told me that this issue would be discussed at home, not at the temple. While I was crying hard, she comforted me, urging me to forget about this problem and find the proper treatment. (Tuee, infected 9 years)

Due to her concern over the participant's HIV, the aunt passed on the secret to his mother. According to Hofstede (1991), in a collectivistic culture, "people from birth onwards are integrated into strong, cohesive in-groups", which often includes extended families (with uncles, aunts and grandparents) (p. 51). Because of this, the secret of having HIV/AIDS can be shared among the family members, who are very close to each other. Thus, Tuee expressed no frustration that his aunt had shared his information with his mother, and the mother saw no need to justify the aunt having told her son's secret. Rather, when the participant's mother knew about this infection, she and her son did not immediately communicate about this issue but waited until the appropriate time came for a private discussion. Moreover, rather addressing the aunt's having revealed the son's delicate information, son and mother move directly to expression of sorrow and perhaps embarrassment; the moment before they engage in conversation is full of emotion as expressed through the nonverbal communication (i.e., "avoid eye contact" and "burst into tears") between both the participant and his

mother. These different nonverbal means of communication correspond to Ting-Toomey's (1988) description of how a high-context culture values "group value orientation, spiral logic, indirect verbal interaction, and contextual nonverbal style" (p.25). As can be observed, this kind of emotional support is contextual as to how people can decide to solicit and receive support, and is likely to depend heavily on the nature of the relationships they have with their social networks like in a collectivistic culture (Taylor et al., 2004).

In the circumstances, in this regard, both the participant and his mother knew what happened but did not want to explicitly mention HIV/AIDS. This contextual factor also pertains to "kalathesa" in Thai, which is equivalent to time (kala) and space (thesa) (Oupra, 2009. p. 31). In other words, it is important to be mindful of manner, behavior, and expression according to the time, the occasion, and the relationship during social interactions. In this instance, the participant's mother considered this deeply private issue concerning sexual mores to be inappropriate for discussion in a Buddhist temple, as it was a very public and religious place and an open space. After all, it might be said that Tuee employed indirect means of communication based on the concept of "krengjai" in order not to bother his mother.

4.1.2 Identification and Normalization of Connection

Those working in the healthcare field who aim to help those living with HIV/AIDS provide emotional support through identification and normalization of connection. This communicative strategy promotes trust and intimacy between the staff as the formal support networks and their patients.

In the following quote, the healthcare provider promotes rapport with a client through both nonverbal and verbal communication of identification and normalization of connection; in these ways, the care providers give the client emotional support,

making the latter feel less anxious, which in turn might make the client more ready to talk about their experiences. In this example, the healthcare provider refers to interactions around the time of the initial HIV/AIDS diagnosis:

> Mostly I gently pat the back of my patients' shoulders or touch their hands and arms to show that I have no revulsion towards them. In this way, I want to make them feel that they are my friends who have been through this kind of situation like me before. In addition, with a male gay status like them, it is easier for me to nonverbally communicate with them in this way than other female staff. Then, they can become more familiar with me and start to talk to me, asking if they will be able to study or work. Will they die? Or will their parents feel sad about them? Finally, I have to explain, for example, that they haven't done anything wrong. It isn't the end of the world. Like me, I say to them, "I can still live my life normally". (Phod, gay healthcare provider, infected 17 years)

The staff member employed direct tactile of "patting" and "touching", which are examples of nonverbal immediacy, or behaviors that "enhance closeness to and nonverbal interaction with another" (Meharabian, 1969, p. 203). These touches clearly convey empathy for the person who has just received emotionally upsetting news, as well as acceptance, which is threatened by stigmatizing illness. (Of course, the explicit statement, "they haven't done anything wrong", also conveys acceptance.). Shared sexual orientation also promoted identification and relationship, which opened the door to intimate conversation, exploring fears associated with death, family, and work, as intimates. In these ways, the healthcare worker provided emotional support, making the care receiver feel more comfortable before the conversation starts.

Nonverbal expression of emotion and feeling can be more impactful and significant than words. Typically, "low contact cultures", including Thailand, evidence less immediacy behaviors such as touching in general terms, especially between non-intimate others (Andersen, 2008; Andersen, Andersen, & Lustig, 1987). Nevertheless, Thai proxemics as related to contact culture normally involves not so

much intimate interpersonal contact, but this may also depend on levels of intimacy. With respect to this intimacy, the specific bodily touching, such as touching the patients' shoulders, hands and arms, is commonplace among the Thai healthcare staff and infected clients. The use of gentle pats in the current context suggests that such behavior may lead to a sense of acceptance, connection, and closeness and therefore to greater satisfaction with the healthcare providers among these men living with HIV/AIDS. In addition, it can be seen that people of the same sexual orientation can use touch to achieve a sense of connection and closeness in the context of HIV/AIDS social support.

Besides, the care receivers' questions revolving around his life and parents reflect collectivistic values intertwined with interdependent relationships in Thai culture. This kind of value is bound with emotional connections associated with close attachments. In other words, at its core, collectivism embodies a state in which an individual's identity is part of the broader society or group; in addition, collectivism involves a longing to interact with and be recognized by the group as a whole (Hofstede, 2001).

Further, responding to his patients' concern, the healthcare staff was trying to make the patient feel less alone in his health problem; by revealing that he shared the patient's experience, the staff member established identification with the patient. In turn, the patient saw not only that the staff member had previously suffered this kind of unpleasant experience, but that he eventually was able to overcome it; as he said, "It's not the end of the world" and "I can still live my life normally." These two statements reassure that, no matter how hard or adverse the situation is, there is reason to be hopeful of living a normal life.

Although doctors are often more distant and unfamiliar to HIV/AIDS patients than are the staff at centers providing social support, the following quote illustrates that doctors also can provide emotional support by empathizing with and accepting their patients. The doctor used both verbal and nonverbal communication to make her patient feel that they were mostly the same in terms of life in general.

> At the early stage of infection, my doctor told me while wholeheartedly hugging me, “It’s ok. You see. This is me who still remains with you. We are both normal. You are also an individual with a normal condition”. Furthermore, there was one instance when I told her that I liked to go to a famous pub in Bangkok and the doctor said, “I also like to hang out at this pub - it is superb!”. Alternatively, I talked with my doctor about cooking some special Thai dishes, and she said that she also liked to do this kind of cooking activity. (Pui, gay healthcare provider, infected 5 years)

The doctor not only expressed verbal identification with the patient/client (i.e. “we are both normal”, and we like the same things) but also used nonverbal language of hugging to convey emphatic (“wholehearted”) empathy and acceptance. Despite the social (doctor-patient), gender, and infection status differences between them, the doctor was able to use identification and validation to reinforce the idea that they are normal people with a normal, reliable relationship. HIV+ Thai MSM evidently found emotional relief in these in-tact connections. The quote is also interesting for its implications related to power and control. This contrasts somewhat with Hofstede and Hofstede’s (2005) power distance dimension, which is defined as “the extent to which the less powerful members of institutions and organizations within a country expect and accept that power is distributed unequally” (p.46). In other words, this dimension deals with unequal power.

Because patients often regarded their doctors as one of their most important sources of psychological support, a doctor’s empathy could be a powerful mode of support, not only to reduce patients' feelings of isolation, but also to validate their

feelings or thoughts as being totally normal. Thus, it is quite significant that Pui, in the previous quote, perceived the doctor—one normally presumed to hold authority that distances her from patients—experienced a doctor who expressed such clear identification and normalization of connection.

From these two quotes relating to the theme "identification and normalization of connection," it is clear that providing emotional support requires cultural sensitivity, mutual understanding, and rapport; such sensitivity involves awareness and understanding of "a deeper level of emotions that attach to your own culture and the way your culture may be perceived by others" ("Cultural Awareness or Sensitivity", n.d., para 7). Cultural sensitivity is, in other words, a way to build the bridge of identification, empathy, and acceptance across the divide that might otherwise separate care providers and patients. Thus, being culturally sensitive helps these two parties to interact with each other appropriately.

4.1.3 Avoiding Emotionally Upsetting Talk

Apart from the use of communication in active coping strategies, as illustrated above, coping strategies focusing on passive emotion that involve behavioral and cognitive avoidance also play significant roles. In this regard, avoiding emotionally upsetting talk is another way of providing emotional support. This third theme involves attempts to communicate about issues other than infection. This communicative strategy is used not only by members of the HIV+ MSM's social network but also by themselves in order to mitigate the stress caused by their health status.

To avoid conflict and unnecessary arguments, a healthcare provider quoted in the following tried not to mention his patient's coming late for an appointment but, instead, spoke kindly to him to re-arrange the meeting time. The healthcare provider's

tactful and generous conversation is especially important because the patient was likely still in the early stages of coming to terms to diagnosis just six months earlier, and because the support provider had known this patient for only a few weeks:

> When one of my patients could not meet me at his appointed time because he had just woken up, he wanted to postpone the meeting until around 1 pm. Then, I replied to him, "That's fine, please just come to the hospital. *Khun Mae* will wait for you *Nu*. So, let's meet up in the afternoon. *Nu* can have a good meal and come see *Khun mae* later". When he came ten minutes ahead of the set schedule, I said to him, "*Khun Mae* hasn't finished doing his things yet, I'm very sorry. At least, Nu is here now. Better late than never". (Preen, gay healthcare provider, infected 19 years)

This health care staff member was very patient in taking care of his patient. When his patient did not come to see him as appointed, he did not express anger or put pressure on him at all and tried to make his patient feel that this change of appointment time was not his fault. For example, the patient was encouraged and motivated with the statement "better late than never". This is associated with the empathy in patient-care situations that allows providers to understand and discuss a patient's inner experiences and perspective (Hojat, Gonnella, Mangione, Nasca, & Magee, 2003). This empathy is also used with pronouns expressing closeness or intimacy. The staff used the second-person personal reference "Nu," which is similar in meaning to "my little girl" in English, and is used to express kindness to someone younger (Jiapong, 2011). Furthermore, this is one of the pronouns used more often by kathoeys or feminine gays (Saisuwan, 2011). In addition, the first-person pronoun "Khun Mae", which means "mother" in English, was used to refer to a senior gay female staff member. Again, the use of this parental term connotes not only emotional closeness but also kindness. In Thai culture, the terms of address for non-kin are limited to those signifying the kin who are on the mother 's side and older than the person being referred to (Prasithrathsint, 2001). This indicates the importance of

"matrilineality" and "seniority" in Thai society (Prasithrathsint, 2001, p.263). Also, these kinship terms on the maternal side are more preferable because people might feel closer to their mother than their father (Vongvipanond, 1994). This further indicates that, "once kinship terms are adopted, both parties know that the relationship has reached a satisfactory level (Vongvipanond, 1994, para. 12).

In addition to this aspect, in terms of sexuality and language, while straight and masculine men value traditional masculinity but devalue femininity and homosexuality, gay men embrace traditional femininity and accept "their sexuality, expressing gay language, mannerism, and desire" (Price, 2004, p. 325). According to Kulick (2000), language and sexuality are intertwined with one's identity; in other words, identity creates a specific linguistic convention to convey their individual desires. As such, terminologies and semantically grammatical use of feminine forms to refer to other males in certain contexts are not "the same thing as saying there is a gay or lesbian language" (Kulick, 2000, p. 247). These terminologies are gendered pronouns used among openly homosexual men; this is a new manner of substituting female pronouns and titles, such as "she, her, hers, Miss, Mother, and girl" for making reference to one another among homosexual men (Legman, 1941, p.1155). This is also consistent with the use of the pronoun "Khun Mae" (a respectful Thai term meaning "mother" in English).

The significance of personal pronouns has been shown in research such as that by Kashima and Kashima (1998), who noted that the language used by people in collectivist cultures often does not require the use of "I" and "you," whereas the languages used by individualists do. Nevertheless, in many collectivistic societies, the language reflecting the level of interaction among extended family members refer to the meaning of "I" and "you" in the form of maternal versus paternal grandparents,

aunts, uncles, etc. (Trakulkasemsuk, 2012). It also became apparent that this kind of language is used in the weak tie relationships between the gay healthcare staff and the gay individual infected with HIV/AIDS.

Similarly, this language and sexuality play a crucial role in a more friendly, intimate conversation between healthcare providers and their patients to avoid any conflict. Clearly, this aims to promote very close relationships between both sides, the helpers and those who are suffering. This kind of conversation often occurs with those newly infected (those who were initially diagnosed between one week to one month ago), who are not confident about having normal sexual activities with others:

> I would not say "Don't worry" or "That's ok", like what doctors tend to say to make them forget their problem for a while. However, laughing without worry and making jokes with one another are far more important. For example, when my patients and I say we have to be beautiful like angels, we do not need to care about the public or the media. Last night, I said, "I have got ten sticks and what about you? This is the kind of language we use with each other (using high pitch and rising tone). I like to tell them that having wrinkles caused by laughter is much more important than sinking into depression or pretending to be happy with no desire for food or sleep. Then, they totally agree with what I said. (Pui, gay healthcare provider, infected 5 years)

The member of staff tried to make his clients, particularly those with more feminine qualities, think that they are truly beautiful (i.e. "beautiful like angels" and "not care about the public or the media") or succeed in something with fun (i.e., "having got ten sticks", which represents ten male sexual organs). Using this gay language can make the patients feel more relieved and involved in the conversation. Also, as can be noted from this interview excerpt, using high pitch and rising tone is the characteristic of this gay language.

Croteau (1996) claimed that, out of fear of discrimination, LGBT tend to avoid explicit language that discloses their sexual identity when disclosing their status to others. On the other hand, these people in my research may prefer to reveal their

sexual orientation to their own LGBT group members. As Berger and Mallon (2015) indicated, homosexual people share a gay community subculture, which consists of "a distinctive and reinforced set of values, behaviors and language" (p. 156). Therefore, the language commonly understood between the gay healthcare staff and the gay persons living with HIV/AIDS plays a crucial role in this Thai healthcare context. This is consistent with Burgess (1949) who asserted that "the homosexual world has its own language incomprehensible to outsiders" (p. 234), such as the term "sticks". Thus, gay men can share emotional intimacy by using gay language with one another. Furthermore, this kind of conversation between gay staff and their gay patients living with HIV/AIDS is related to the contextual criteria that involves selection of a topic about health, beauty and sex rather than HIV/AIDS. Relatedly, this kind of conversation comfortably made only within the group may, otherwise, not generally accepted by other people in this Thai hetero-patriarchal society which prioritizes the heterosexual norm.

Also, the language focusing on other issues, such as health and beauty, is evident in a support group at Organization B. The moderator and other two support group members as patients avoid the stress-inducing topic of infection as can be noted in the following conversation:

> Preen: OMG! How fancy your face is today! What kind of powder are you using? (lengthening sound with mid-low tone and smiling) (Moderator and gay healthcare provider, infected 19 years)
>
> Pong: Just a few brushes on my face, Khun mae (lengthening sound with mid-low tone). It is very necessary to take care of our health from now on. Otherwise, when I am getting older and older, it might be too late. (Infected 19 years)
>
> Preen: That's why these days whenever I see you, you look more and more beautiful compared to when I saw you for the first time.
>
> Pong: Absolutely, Khun mae (lengthening sound with mid-low tone).

> Preen (turning to Karn): And you. Wow! You've got more muscles after working out. It is perfectly ok. Don't make it bigger than this though. It is excellent now. Your face and body are perfect. Very smart, dude. Why do you look bigger in pictures? Given this, you can be a celebrity
>
> Karn: Thank you very much (while smiling proudly). (Infected 1 year)

The staff support group moderator was casually talking to Pong about his beauty (e.g., "How fancy your face is today!") and Karn about his good-looking body (e.g., "more muscles", "perfectly ok"). Depending on the person addressed (i.e., feminine or masculine gay), he used different wording. This reflects the difference of preferred appearance and personality between these two kinds of homosexual groups in Thai society (Geczy & Karaminas, 2013). This can also be observed from the lengthened vowels that is a phonetic variable ideologically associated with expressiveness and gayness to tease each other in Thai culture in order to show closeness (Saisuwan, 2016).

Of note here, there are two types of gays in Thai culture: the "gay king" (sexually insertive) and the "gay queen" (sexually receptive) as explained in Chapter 2. Relatedly, the term "gay king" denotes a degree of masculinity and an insertive role, while "gay queen" refers to a more feminine gender expression (Ojanen, 2009, p. 8). In this case, these sub-gay identities ("gay king" and "gay queen"), thus, embody different varieties of "phet" in Thai culture.

Thus, communication could proceed as it would in friendly everyday banter focusing on each individual's different gay features without mentioning the words HIV or AIDS. In addition, the use of the phrase "Khun mae" in this support group, as stated earlier, reemphasizes the emotional closeness and kindness a participant, named Pong, could feel toward this support provider.

Besides the healthcare providers, family members can also help avoid the unpleasant feelings surrounding HIV/AIDS. This can be observed in the recollection of a conversation between a mother and her son:

> Rather than my father, I asked only my mother how she felt if one day I was infected with this HIV/AIDS, and she said that those with this disease could be cured nowadays and soon other people would forget this disease. However, whenever I had blisters caused by mosquito bites, by mentioning that this could be related to HIV/AIDS, trying to imply that I might have become infected, she did not want to me to worry about it and said that everybody could have such blisters in this season. To be honest, I felt that my mother might have known that I was infected with HIV/AIDS but did not want to talk about it and did not mention my homosexuality. (Roon, infected 1 year)

The mother of this participant tried to help him avoid talking about suffering from HIV/AIDS or the likelihood of infection even though there were some symptoms (i.e., blisters) of having the disease. The mother in the collectivistic culture, like in the findings of my research, is regarded as the most dependable person who could help relieve them from their stress. In this familial collectivistic context, participants disclosed more to the sister or mother than to other family members or non-family others. This can explain why Roon felt more intimacy with his mother than his father. In addition, this high-context culture is associated with contextual knowledge, meaning that both the mother and the son knew about his HIV/AIDS situation and even his homosexuality, but did not want to state it explicitly. This avoidance of unpleasantness and implicit acceptance and support, which is noticeable in other excerpts about interactions with mothers discussed above, may contribute to the importance of mothers that more generally characterizes Thai collectivist culture (Meecharoen, Northouse, Sirapo-ngam, & Monkong, 2013; Poonnotok, Thampanichawat, Patoomwan, & Sangon, 2016).

Moreover, in the following quote from the interview, a participant intended to see how his close friend would react if he told him about his infection diagnosis. After

answering his initial questions about the infection, his close friend avoided raising this issue:

> I thought that at that moment I had already died. Also, I did not fear or need any help from my friends. After revealing my disease to my family, I then decided to reveal my HIV status to one of my very close gay friends to know whether he would accept this and continue to associate with me. At first, he asked me when I was infected and what had happened. I told him all the information. Then he said that I looked healthy as always and it was good that I took care of my health so well. From then on, he never mentioned my HIV/AIDS at all but only talked about traveling, eating and so on. It was like nothing was happening as to what I had told him about my HIV/AIDS situation (Aun, gay healthcare provider, infected 20 years)

This explicit disclosure to his intimate friend occurred within the context of self-stigma – in Aun's own words: "I thought at that moment I had already died". Having already felt dead, and thus with little to lose, he seems to have been willing to risk finding out whether his close friend would accept him or not. Perhaps unexpectedly, his friend expressed no disgust but rather an appreciation of his sound health and subsequently said nothing more about HIV/AIDS. As from the quote, his friend talked only about other social activities instead of health updates. Thus, this kind of distraction, by moving away from their friend's HIV status, is an important form of emotional support.

Aun's explicit disclosure in the preceding quote is, nevertheless, uncommon in Thai high context culture, in which implicit communication commonly occurs. According to Hall (1976), in high context communication, "most of the information is either in the physical context or internalized in the person while very little is in the coded, explicit, transmitted part of the message" (p. 79). In this context of conflict avoidance, the participant's friend treated him according to the Buddhist principle of "krengjai" (fear of embarrassing the other) and "henjai" (having empathy) (Kitiyadisai, 2010, p. 24). This approach also saved the other's face. As discussed

above, even though privacy in Thai culture means a collectively shared privacy based on the Buddhist notion of sharing together in times of 'suk-lae-duk' (happiness and sorrow), there is also the private affair, like the Western concept of privacy regarding face-saving:

> The combination of privacy as 'private affairs' ('rueng-suan-tua') and the right of 'non-interference' works in support of 'saving face' and hence, interference by outsiders is interpreted as a 'disrespect' that is dangerous insofar as it can lead to 'losing face' (Kitiyadisai, 2005, p. 18).

Thus, this participant's disclosure corresponds to the contextual criteria related to the timing of disclosure in terms of privacy management. The participant waited for the right moment for disclosure to his friend in an explicit rather than implicit or gradual way: when he felt as emotionally low and lost as he possibly could. The friend, having heard this unusually explicit disclosure, provided emotional support for Aun at this very vulnerable moment by following the principles of krengjai and henjai (having empathy) and avoiding any further mention of Aun's illness.

4.2 Informational Support

A second apparently universal type of social support is the provision of information or general advice (House, 1981). In challenging situations, information can aid decisions (Mattson & Hall, 2011). It is thus related to problem-focused coping, which involves attempting to resolve stressors. In the discourse (or data) gathered for this project, informational support was categorized into five themes: (a) Double informative support: Advice on how to manage challenging information from doctors; (b) Informative support on dealing with traditional Thai folk beliefs; (c) Informative support on dealing with the challenges of HIV/AIDS disclosure; (d) The

importance of accurate information about HIV/AIDS; and (e) Information on preparing for employment after disruption caused by the infection.

4.2.1 Double Informative Support: Advice on How to Manage Challenging Information from Doctors

Doctors are the primary source of medical consultation when Thai HIV/AIDS infected individuals have problems with their health and need medicinal treatment. This communication is often difficult because doctors and patients are likely to have different understandings of the use of anti-viral medicine. However, negotiating a mutually acceptable anti-viral prescription is vital.

In the following interaction, during a support group session among MSM with HIV/AIDS at Organization B, this issue of anti-viral prescription was raised and discussed in order to identify the best way of talking with a doctor:

> Noong: Last month I tried to negotiate with an egotistical doctor who at first didn't listen to my request of change of the medicine H 250 or H 30. This kind of medicine could, at its worst, make the face disfigured or cause sunken cheeks. Then, the doctor told me to go to Organization B where people l iving with HIV/AIDS gather to discuss several issues regarding HIV/AIDS medicine. (Infected around 3 years)
>
> Kai: Which kind of insurance are you using? If you have social insurance, you can leave this hospital and go to other ones, instead. Alternatively, you could talk to your doctor again, say your life quality is better except for your mental health. This is because your friends teased you as to how terribly you have changed. So, you are very upset and stressed. This is like the Thai proverb about the use of cold water to pat the other. (Infected 11 years)
>
> Noong: Ok, I'll probably try talking to the doctor again.

In this excerpt**,** one support group member talked about a problem regarding the change of medicine and how his doctor did not understand him. Another group member, Kai, who might have had more experience approaching doctors, in having been infected for 11 years, thought of a communication technique that can be used to talk to the doctor in a polite and respectable way – the healthy and beautiful

appearance of the patient is essential as the stigma of HIV/AIDS is still intense. The gay queen is effeminate, and thus very concerned about looks, as reflected in Noong's worry about a particular antiviral prescription causing facial disfigurement or "sunken cheeks." Again, this reflects the varieties of sub-gay identities in terms of sexual role as discussed earlier in emotional support. While having distinctive erotic interests and objects of sexual fascination, each of the modern Thai identities is a gender more than it is a sexuality.

Noong found the doctor too "egotistical," a concept related face. Related to high power distance, the higher one's position, the more important their personal image in terms of face in Thai culture. Komin (1990) explains, "Thais are very 'ego' oriented, to the extent that it is very difficult for the Thai to dissociate one's idea and opinions from the 'ego' self" (p. 135). This paternalistic communicative style can be explained by the nature of Thai ego orientation, particularly "kiat", which often has a connotation of possessing rank or a position of authority, signified by a title or a prefix to one's name (Persons, 2008, p. 57).

As an idea about how to minimize the doctor's ego and create a more mutual understanding, Kai reminded Noong of a Thai proverb**;** to pat the other with cold water means trying to use persuasive words to make the other party calm down or become compliant. This corresponds to the Thai expression, "jai yen", literally translated as a 'cool heart' or as meaning to become patient (Vongvipanond, 1994, para. 30), which is essentially telling someone to 'chill out' or 'calm down' if they present a somewhat short-tempered response. In Buddhism, calmness is a virtue which is essential in creating peace and harmony, so Thais aim to avoid any type of interpersonal conflict. This is one of the main Buddhist teachings: "Holding on to anger is like grasping a hot coal with the intent of throwing it at someone else; you

are the one who gets burned" (Hassler, 2016, p. 62).

In another instance, however, this calmness seems not to arise as the doctor talked to his patient by scolding and blaming him for his disorganized plan for taking his anti-viral medicine. Recognizing that the doctor and patient might misunderstand one another, the healthcare provider in the following quote recalled an interaction in which he tried to explain to the patient what might have been the doctor's true intention, and thus encourage him to be more receptive to information from the admonishing doctor:

> There are state hospitals or clinics that have many patients. There could be criticism but this is not purely intended to be criticism. This is like the teacher and the student; in this case, there is good intention. Sometimes the doctor needs to warn the patient or complain about something inappropriate for their treatment or lifestyle. (Frowning) when my patient further asked me what he should do, then I said just listen to him and do what the doctor needs you to do. (Phod, gay healthcare provider, infected 17 years)

As the quote suggests, the care provider reconstructed a patient's experience, suggesting that the patient misinterpreted the conversation and the doctor's instructions as condemnation; the staff member suggested that the true intention of the doctor was to remind the patient of the importance of his lifestyle and maintaining his self-care. To accomplish this reconstruction, the staff made an analogy likening the doctor to a teacher and the patient to a student. The student should pay attention to and comply with the teacher's instructions to achieve the student's goal. This corresponds to research conducted by Pettit (2008), which found that the doctor-patient relationship directly reflects the teacher-student relationship. Effective doctors and teachers are knowledgeable, understanding, empathetic, personable, nonjudgmental, and qualified. Similarly, effective patients and students are attentive and responsible for their actions (Pettit, 2008). Spencer (2003) also recognized close analogies between teacher-student and doctor-patient communication, and the

principles for giving clear explanations. A doctor should be able to communicate understandably to help the patient with the medical regimen; this teacher-student relationship plays a crucial role in this situation in coordinating action for effective treatment.

It is interesting to note that a nuance in the informational support reflected in the preceding quote. Phod's reconstruction suggests that, rather than a condescending criticism, the doctor spoke out of compassion. In this context, Phod's suggestion for reconstruction softened what his client experienced as criticism; he provided emotionally soothing advice ("listen to him and do what the doctor needs you to do") designed to help his patient hear the doctor's crucial medical information. However, his frowning at this point may indicate that the misunderstanding between his patient and doctor is a serious issue that should be solved.

4.2.2 Informative Support on Dealing with Traditional Thai Folk Beliefs

Another form of informational support was the exchange of information about healthcare based on Thai folk beliefs. This discourse appeared to be designed to put these traditional beliefs into historical perspective, thus both making sense of past practices that conflict with modern medicine while implicitly validating belief in modern practices. Conventional treatment of HIV infection involves the use of various anti-viral medicines. These practices conflict quite glaringly with traditional beliefs about health and healing. This kind of support is mainly communicated between healthcare providers and MSM with HIV/AIDS

In the following interaction, the participants reminisce about the time before antivirals were available, when traditional practices were seen as important treatment options, but infected Thai MSM and a healthcare provider were negotiating traditional beliefs and emerging modern therapies:

> Tik: After reading from a newspaper or magazine that advertised herbal medicine for those infected with chronic diseases, my friends and I discussed and decided that we might try going to see the doctor called Nain who was famous for making boluses in another Thai northeastern province, Sakon Nakorn. At that time, around 20 years ago, there was no sufficient knowledge on the treatment of HIV/AIDS even from doctors with a PhD degree in Sexual Transmitted Diseases or STD. (Infected 20 years)
>
> Preen: At that time of the early spread of HIV/AIDS, the information was quite hard to find, indeed. (Moderator and gay healthcare provider, infected 19 years)
>
> Mie: Fifteen years ago, I also had to find the information by myself and I learnt from an entertainment magazine that there were some kinds of Thai herbs, some of which looked like tree roots or leaves that could be boiled to heal HIV obtained from a person who had a certificate in traditional Thai medicine. Then, I got a piece of A4 paper with the medicine saying what I shouldn't eat, like some fish's skin or some kinds of vegetables that could make the medicine less effective. Clearly, there were so many restrictions on food that one could choose only a few to eat. Also, I went to see another traditional Thai medicine clinic called "Bang Pakong" where he had to pick up 4-5 Thai herbal pills per week. These pills were called "wee ones" and contained potassium and calcium. Nevertheless, such alternative Thai medicine did not help improve my physical condition at all. Rather, at the Thai Red Cross, the staff would give me more information about the medicine more suitable for HIV/AIDS treatment. (Gay healthcare provider, infected 15 years)

At this support group session, a participant named Tik recalled the time when "there was no sufficient knowledge" about treatment, and he had to depend on traditional medicine in the form of boluses and the healer. Preen appears to confirm Tik's judgment of the inadequacy of traditional beliefs (i.e., that "sufficient knowledge" was scarce) when he agrees that "information was quite hard to find". Mie also agreed with Tik's judgment of traditional medicine. After reviewing his attempts to treat infection with pills called "wee ones" dispensed by a traditional Thai medicine clinic, which "did not improve my physical condition at all", Preen sought "information about the medicine more suitable for HIV/AIDS treatment" from the Thai Red Cross. In these ways, the support group members provide informational support in the form of validating assessments of the relative value of traditional Thai

medicine and modern treatments.

The importance of this sort of information support can be better appreciated with a bit more historical context. According to Fordham (2005), throughout the 1990s, Thai newspapers and magazines widely published information about traditional healing with herbal therapies to lessen HIV/AIDS-related conditions or, as claimed, completely cure this disease. MSM infected with the terrifying and still mysterious disease thus consulted traditional healers like “Nain”, mentioned by Tik in the preceding exchange. The doctor Nain studied an ancient medical textbook referred to as the “Bible of Buddha” translated from Pali into Thai. This manuscript contains not only detailed methods for mixing herbal medicine but also the properties of various kinds of other herbal medicine on offer (กฤตสอร, 2556). Promoters of these treatments commonly legitimated their claims by asserting ancient knowledge, knowledge discovered through the study of mysterious Buddhist formulas, or gifts of arcane knowledge from forest dwelling ascetic monks (Fordham, 2001).

However, at that same time, there were also widespread warnings about the many unqualified doctors who boasted about their herbal medicines (Fordham, 2005). Thus, infected MSM seeking treatment had to negotiate the conflicting claims of traditional healers and proponents of still ineffective modern medicine. While it is clear from the exchange above that the participants have resolve this conflict in favor of modern antiviral treatments, they may have lingering reservations. Indeed, traditional Thai medicine, based on a deeply rooted system of belief, has continued to play a role in Thai culture that it has played for many centuries (Maneenoon et al., 2015). Therefore, sharing judgments of relative efficacy of traditional and modern treatments serves as informational support, validating preference for the latter as a buffer against ancient cultural influences.

The following excerpt from an exchange between a healthcare provider and MSM with HIV/AIDS at a support group at Organization B also illustrates the need to validate assessments of the relative worth of traditional and modern medicine:

> Mikkie: Some of my friends also boiled grilled lizards before eating them, believing they were alternative medicine. As for me, after hearing about HIV/AIDS treatment with the use of toads as miracle drugs from other people, my friends told me that they would find some toads that were at a construction site. I was a little shocked but then agreed to what they said. We ate almost twenty toads, which were beheaded, cleaned, to wash away their poison and finally grilled in order to make a fermented liquor. At that time, we believed in these alternative medicines more than the doctors who were usually opposed to their use. (Infected 20 years)
>
> Bu: I depended on some boluses, and I also sold this kind of medicine at that time and did not want to tell the doctors about this. Otherwise, the HIV/AIDS infected support group participants would not be allowed to take them. This is what I heard from them. However, if we took these boluses for a long time, this could damage the liver. My friends also told me about potted herbal medicine in those days. This kind of medicine, like an appetizer, made me feel hungry very easily, so I had to eat more and more food. Even though I began to look healthier, my HIV/AIDS condition worsened and worsened. (Gay healthcare provider, infected 15 years)
>
> Preen: That potted medicine probably contained steroid, too. If you consume too much, it could affect you in some way. (Moderator and gay healthcare provider, infected 19 years)
>
> Bu: Yeah. I learned that it had this kind of chemical mixed in there.
>
> Tik: This is why I feared this kind of medicine at that time. Instead, after hearing from my friends, I went to see a famous monk as a medium who said that I was doomed to be like this because of my karma. He told me to get a pig's head and put burning joss sticks into this and to pray to some gods. Some of my friends also drank some water believed to have magical power to heal this disease. (Infected 20 years)

As the quotes demonstrate, some kinds of local food, like grilled lizards or toads, were believed through superstition to heal HIV/AIDS, so they were regarded as alternative medicine. More specifically, many believed that the nocturnal Asian lizard, particularly the tongue and internal organs, could be used as treatment (Thornhill, 2011). More recently, some researchers have claimed that there is a

chemical substance in these lizards that inhibits the HIV/AIDS virus (TokayGeckos.org, 2013). These beliefs are also supported by Chinese medicinal textbooks that discuss various traditional treatments for HIV/AIDS (TokayGeckos.org, 2013). For example, boluses are believed to cure HIV/AIDS and several other diseases.

In time, claims about the benefits of lizards as an HIV/AIDS cure were said to be an unfounded hoax (Caillabet, 2013). For example, Bu points out that, after taking traditional medicines, although "I began to look healthier, my HIV/AIDS condition worsened and worsened". Preen then joins the interaction to state that these medicines contain steroids, which can damage antibodies and some internal organs (also see เฉลิม แสนยากร, 2012), which Bu affirms ("Yeah. I learned that it had this kind of chemical mixed in there"). After this, Tik notes his concerns in those earlier times, and his effort to avoid harmful or ineffective medicine by going to a "famous monk" who prescribed yet another traditional treatment. Tik also notes that the monk pronounced him to be doomed according to karma derived from a Sanskrit word that means "act", "action", "deed" (Burns, 2012; Gombrich, n.d., p.1). Thus, present suffering is the result of our own past actions (Sayadaw, 2018).

Although we cannot say with certainty whether he took this treatment to have changed this fate and kept him alive for another 20 years, or as his contribution to the group's recitation of ineffective traditional medicines, what he says next is instructive. It seems reasonable to suppose that he would have said that the monk's treatments saved him if this was indeed his belief; after all, the group participants are clearly reviewing ineffective and dangerous therapies, presumably because they have such strong interest in avoiding these and identifying effective treatment. But instead,

Tik's next sentence adds yet another treatment to the list traditional medicines (drinking "water believed to have magical power to heal this disease"). Because the arc of the conversation has traced ineffective and harmful traditional medicines, and because Tik said nothing to suggest that the monk's prescription was effective, it seems reasonable to infer that he was simply adding two more items to the growing list of ineffectual therapeutic superstitions.

According to Bhavakhunworakit (2012), as Thai society has changed following capitalism and consumerism, some Buddhist practices have come to be regarded as superstitious, and Buddhist temples' money making techniques, which commercialize on the "magic", have come to be seen with suspicion. These magic monks engage more in contemporary issues and less in Tripitaka-based Dhammic teachings (Kitiarsa, 2005). In other words, these monks practice mantra, spiritual "magic", and use amulets more attuned to the "spirit of capitalism" than Dhammic wisdom (Kitiarsa, 2005, p. 2). Nevertheless, the Buddhist monks who promote the herbal medicine and the laypeople who follow the use of alternative medicine, perceive these seemingly miraculous interventions as being beneficial, as means to alleviate mundane suffering. However, it is very clear from the interaction that the participants view these practices with suspicion, preferring instead the modern antiviral therapies. In this way, their interaction in the group provides informational support in the form of validation of these judgments. In a culture where thriving belief in traditional medicines might challenge their embrace of the modern, finding validation of their outlook is an important form of mutual support. While information exchanges with healthcare support networks are necessary to promote care and treatment, informational support on disclosure can help those living with HIV/AIDS to communicate effectively with non-infected others, especially the loved ones, about

their condition.

4.2.3 Informative Support on Dealing with the Challenges of HIV/AIDS Disclosure

Another significant theme in informational support has to do with how to manage disclosure of one's HIV/AIDS status. Contemplating this disclosure arouses concern as this regards the potential for these bonds to be broken entirely. Both support providers and MSM with HIV/AIDS often support one another with information and advice.

Disclosure to parents may be the most difficult and, as a result, simply avoided, since this involves such a sensitive and highly emotionally involved relationship. Upon diagnosis, patients need someone to talk to about their condition. In the following interview excerpt, Noom, a non-infected healthcare provider, explained this situation:

> When my patients are confused and ask me whom they should tell about their HIV/AIDS, mostly I suggest they tell their parents, who might feel sad at first, like for the first few days, but, after a while, gradually come to understand them. This is because they are their sons. The parents should not be annoyed with them; otherwise, these participants will become more depressed. Most parents feel that it is good to know that their sons are willing to openly communicate with them. Then, they can find some ways to help their children living with HIV/AIDS. This works very well with today's parents, but they appear to hesitate to do what I suggest and say they will think about it. (Noom, healthcare provider)

Parents in Thailand have the most significance for people living with HIV/AIDS, and at least some of them appear to display understanding and acceptance of their children under any circumstances. Clearly, the healthcare provider thinks that the closeness between parent and child is the most significant part of collectivistic culture. Thus, the staff does not want his patient to think about feeling embarrassed about providing a self-disclosure to his parents or to worry about being a burden to

the family. In this respect, collectivistic society focuses more on “small group membership” or “relational social identity” focusing on subjective well-being, and this also includes favoritism (Brewer & Yuki, 2007, pp. 310-311). However, this kind of relationship varies within collectivist cultures. In this respect, Pye (2000) explained, “Chinese social identities are primarily based on particularistic relationships radiating from immediate family to extended kin to shared identities based on one’s hometown, whereas Japanese social bonds are more subjective and are mainly based on the personal relationships of indebtedness and obligation” (p. 126). Compared to these two cultures, Thai collectivistic culture is more likely to match Chinese social identities. In any case, the care receivers’ responses show hesitancy, which means that they are not sure if following Noom’s advice will turn out well. This reluctance corresponds to the following explanation of the occurrence of unfamiliarity in the son-to-parent relationship.

Notwithstanding such in-group favoritism, in Thai culture, there are also horizontal interpersonal relations based on a dichotomy between familiarity and unfamiliarity (Uckaradejdumrong, 2016). A familiar relationship is not necessarily characterized by closeness or intimacy; it can be attached to distance. Hence familiarity can exist in either an intimate or a distant relationship (Uckaradejdumrong, 2016). This concept of familiarity is not in line with Noom’s statement about open communication between the mother and the son. This suggests that not every mother and child in Thai culture feel attached to one another.

Disclosure to parents involves not only divulgence of the disease status but simply notifying the parents of an important family matter. However, contextual considerations are important; knowing the parents’ health condition, financial security, and any major illness-related attitudes are very significant. These

considerations are illustrated in the following exchange between MSM with HIV/AIDS and a healthcare provider:

> Mikkie: I think whatever problems we have, the only ones who are still concerned about us and will not leave us behind are our parents. (Infected 20 years)
>
> Pang: But the problem is my parent's health (sighing). I am not sure how much they can take when I have to reveal my HIV/AIDS condition to them. Nevertheless, my healthcare provider told me that I should check if my parents have any chronic diseases that come with old age, like heart disease, diabetes, high blood pressure and so on. If they do not have any such diseases, I could gradually give them the appropriate knowledge about HIV/AIDS. After that, I will know when to find the right moment to reveal my HIV/AIDS status to them. (Infected 9 months)
>
> Kit: As for me, I do not want my parents to know about this because I think that they, with their conservative beliefs surrounding HIV/AIDS, might not be able to accept this. So, I decided to tell my brother instead as he could be the breadwinner for my family after me just in case I have any accident in the future. (Infected 5 years)
>
> Bu: So, it depends on the situation. If disclosure to parents is only to inform, this might not lead to any good result. (Moderator and gay healthcare provider, infected 15 years)

As the quotes suggest, at this support group session at Organization B, the support group members discussed who they could tell about their HIV/AIDS diagnosis. One participant, named Mikkie, commented on disclosure to parents to the others, while Pang referred to checking the parents' health, particularly for any chronic diseases, before he revealed his HIV/AIDS status to them. If their parents are fine, then the fact that this disease is not as terrible as the parents might suppose it to be means it can be shared before the patients disclose their HIV/AIDS status. It can also be noted that Pang, who had been infected with HIV/AIDS for almost a year, did not dare to disclose his HIV/AIDS status immediately after knowing of his infection but waited to do this later. As can be noted from his sighing, he was concerned about

this situation and this deals with fear of burdening social networks or the concept of "kreng jai" in Thai culture.

On the other hand, Kit, infected for 5 years, wanted only his brother, who could become the family breadwinner, to know about his health condition. The "breadwinning" concept emphasizes the Thai hegemonic masculinity as the leader and caretaker of the family (Defillipo, 2017). In addition, Kit's disclosure to his brother means trying to avoid hurting his parents' feelings. This refers to the importance of "katanyu katawethi" firmly ingrained in Thai Buddhist culture, refers to the reciprocation of action that occurs from the sense of gratitude and debt, especially between the parent and child (Phillips, 2000, p. 255). More specifically, the term "katanyu" means "a constant sense of awareness on the part of someone for benefits which another person has bestowed upon him" while "katawethi" means "doing something in return for them" (Phillips, 2000, p. 255). In contrast, "akatanyu" or ingratitude is considered extremely unacceptable in Thai society (Klausner, 1993, p. 275). As a result, children in the Thai collectivistic society owe gratitude to their parents who have raised them since birth, so they must remember this virtue and repay the debt of gratitude to their parents whenever possible (Komin, 1990). Therefore, any deeds, like this disclosure HIV/AIDS, which cause distress to parents should be avoided at all cost.

Therefore, the HIV/AIDS disease as well as the familial expectation of the son's role as breadwinner are intertwined with the whole family's emotional connections and close attachment in this Thai collectivistic context (see previous section on emotional support). As such, the decision to disclose HIV/AIDS is a very sensitive health issue that must be carefully considered. Due to this tension in familial

relationships, another support group member, Bu, suggested that it might not be necessary to make any disclosure to his parents.

Another approach to disclosure, in addition to total withdrawal of disclosure, is delay of disclosure. For example, Pang proposed to use “incremental disclosure” or “testing the water,” in which an individual reveals the minimal amount of information and gauges the reaction of the target before disclosing in more depth and detail (Petronio, 1991; Tardy & Dindia, 2006). Incremental disclosure is also related to the high-context communication style in collectivistic cultures in that it involves indirectness and restraint in self-disclosure (Gudykunst & Nishida, 1986).

Despite these precautions related to disclosure, some family members simply may not accept an infected member. Thus, referring to others who have been through this HIV/AIDS experience and who are still healthy, as information preceding one’s own disclosure, could be helpful. Kai and Tew, MSM with HIV/AIDS, recommends this strategy in the following exchange at Organization A:

> Arm: I still do not dare reveal my HIV status to any family members, especially, my parents. I am not confident doing so. (Infected 7 months)
>
> Thim: As for myself, I am not worried that my parents will know my HIV/AIDS condition as they died long time ago. Now I care about my relatives most since they have very little knowledge about HIV/AIDS. They are very afraid of this disease. There was one relative who died from this disease … I was not sure if I should tell them about my status or not. I have been asking myself about this. They may understand my situation or they may not. No matter how much they care about me, one day they might not want their children to come near me. Therefore, I would prefer to keep this secret to myself till I die. (Gay healthcare provider, infected 8 years)
>
> Kai: You might talk to them first about some of your friends infected with HIV who are still healthy and strong. Then, tell them about the current medical advances that can heal this disease, unlike the past when many people living with this disease died. When they seem to understand this issue, you can then find the most suitable time to reveal your own HIV status. I have given this kind of information to some of my friends. It seems to work with them. (Infected 11 years)

> Tew: Yeah, I totally agree with you. I felt very relieved after honestly telling my mother and sister that I was HIV/AIDS infected. At first, I decided to reveal my gay status to them during the first three months after I knew my positive blood result, which was the first challenge for me. I did this because I thought it was fair to let them know more about myself. They might have suspected my gay sexual orientation for so long but did not speak about it. Around a year later, I then told them about my HIV/AIDS; however, before that I talked about some of my friends infected with HIV/AIDS who were still fine and healthy. Finally, they told me that if so, I can just go consult the doctor and find some treatment like my friends. (Infected over one year)
>
> Mod: What was your parents' reaction when they knew that you were gay, then? (Moderator and gay healthcare provider, infected 18 years)
>
> Tew: They were a little shocked, but seemed to be ok. They might not have been totally willing to accept it. You know, if they knew both these facts – that I am both gay and HIV positive, they might have become very depressed and not been able to get over it.
>
> Thim: (silent) …

In this exchange, both a participant diagnosed only 7 months earlier and another who was diagnosed 8 years earlier did not know whether to reveal their HIV/AIDS to their parents. Two others either with longer (11 years) or shorter (over 1 year) experience of living with HIV/AIDS suggested that their fellow group members could tell their parents gradually. Because of the seriousness of the infection, and because parents lacked knowledge about the disease, these advisers suggested that it was necessary for the participants to give information on the positive aspects of recent treatment innovations. In this case, Kai suggested to tell parents first about healthy and strong friends living with HIV/AIDS followed by telling them of current medical advances. Then, Tew reinforced this idea by citing his successful experience of also gradually disclosing, with the situation being finally accepted by his parents. This indicates that, due to the very high stigma of HIV/AIDS in Thailand, people infected may need to gradually disclose their infection by employing a strategy of giving verbal hints about their HIV/AIDS-positive status. Verbal hints can be made by

starting with a general conversation about HIV (Serovich, Oliver, Smith, & Mason, 2005; Siu, Bakeera-Kitaka, Kennedy, Dhabangi, & Kambygu, 2012). Nevertheless, Thim's silent response could be seen as an ambiguous sign that conveys various meanings; in other words, it could be interpreted either as reluctance or (dis)agreement. This is consistent with the idea suggested by Johannesen (1974) who declared that silence can mean, for example, carefully pondering exactly what to say next, agreement or disagreement, or a state of indecisiveness. Interestingly, even though Thim works as a healthcare provider, he still has difficulty revealing his HIV/AIDS status and does not know how to cope with this barrier. This indicates high internalized stigma.

Another participant named Tew suggested that the gradual disclosure also include homosexuality, which should become known before the HIV/AIDS status is introduced. Even though sexuality seems less serious than HIV/AIDS, since he decided to tell them this before his disease status, it required time and effort during the first three months. In addition to this, the sexuality orientation issue is like a chronic, long-standing problem for him and his parents, as he said, "They might have suspected my gay sexual orientation for so long, but did not speak about it". His concern shows that homosexuality in terms of expected sexual role is still not widely accepted in Thai families like his, and the fact that his parents have avoided raising this issue of sexuality might be due to their preference to avoid arguments with their son. Therefore, his parents might perceive that homosexual identity transgressing family normative roles can discourage disclosure of homosexuality in Thai society (Jackson & Sullivan, 1999). In this way, the social pressure to be in conformity with the expectations of family (i.e., preservation of family units and preserving lineage through marriage) is extremely intense; indeed, these sanctions may have a stronger

effect than religious or legal sanctions (Taywaditep, Coleman, & Dumronggittigule, 2004). Thus, gradual disclosure, which takes time, might require some acceptance by others. This slight acceptance of MSM status in Thailand, thus, contrasts with what Winter (2006) has previously claimed about the total or relatively high acceptance of MSM in Thai society.

Moreover, as the concept of "kalathesa", as explained in emotional support, concerns appropriate time, space, and relationships, this Thai custom involves both the disclosure of HIV/AIDS or their homosexual identity. Thus, knowing when to release all of this information could prevent negative reactions or conflict.

Apart from the information on the gradual disclosure of HIV/AIDS condition or sexuality to parents, information on finding the right moment when everything else in their lives has settled is also essential in order to minimize the negative reactions or feelings of others. At this support group session at Organization A the support group participants, mainly MSM with HIV/AIDS, discuss this kind of information:

> Mod: Do you think that disclosure to others, like your family members, is that necessary? (Moderator and gay healthcare provider, infected 18 years)
>
> Esse: Now my parents don't know about my health condition, and I don't think it is necessary to tell them. (Infected 4 years)
>
> Mikkie: But you know, maybe it is not that serious. There is still a way out of this problem. I think it depends. Even though I do not mind telling others about my AIDS status, since some Thai people always forget things quickly, I would rather disclose my status when everything else in my life has settled like having my own condominium. Until then, I will probably reveal my AIDS status to some of my family members or even the public like an invited guest on the Thai talk show on TV "At Ten". (Infected 20 years)
>
> Mos: I am also determined to tell parents about my HIV status after ten years when I am stronger and settled. My mom, for example, will say that there are no concerns about my health. (Infected 2 years)
>
> Esse: Maybe. It is up to the time, but I am still not sure when it will be the right time for me.

The quotes from this support group session suggest that the parents might feel relieved when they know that their son is fine. Furthermore, this concern over the timing as related to disclosure can also be seen from participants both with long (22 years) and short (2 to 4 years) HIV/AIDS infection periods who were still not sure about obtaining full acceptance by parents and the public in general, which might reflect uncertain feelings and little understanding of HIV/AIDS in Thai society as discussed earlier. Nevertheless, it can be noted that, despite the quite negative perceptions of HIV/AIDS and homosexuality in Thailand, Thai people might not care so much about the issue. As was suggested by Mikkie, Thai people “always forgot things quickly”. This kind of forgetfulness might be rooted in Buddhism, which emphasizes complete forgiveness; the very phrase "mai pen rai" (or "it doesn't matter" in English) is typically used in everyday Thai society (Boonyarit, Chuawanlee, Macaskill, & Supparerkchaisakul, 2012, p. 3). This concept reflects the Buddhist perspective on avoiding conflict and any past deeds of misbehavior. Further, merciful and forgiving vaกlues based on Buddhism can be demonstrated in the Thai people’s character, because “Thais are essentially a self-accepting people … There is a high level of acceptance of events, an ability to move on after problems, rather than analyzing them and trying to work out why they occurred” (Lithgow, 2000, p. 245).

Therefore, the participants’ reluctance seemed to lessen when they thought they were ready to reveal their HIV/AIDS status. This appears to reflect both the contextual criteria and risk and benefit ratios, both of which contribute to the decision to disclose one’s HIV/AIDS status. In this case, Mos had chosen to reveal his HIV/AIDS status at a time when he would feel perfectly fine. The most suitable time is when he becomes healthy like others, and there is more benefit in doing this so that everybody else will no longer regard him as a patient with a chronic, severe disease.

Nevertheless, by the end of the exchange, Esse was not ready to make such a disclosure: “Maybe. It is up to the time, but I am still not sure when is the right time for me”. This may suggest that his self-esteem was still low, and that he was not fully prepared for disclosure yet.

Of course, there might be more unpleasant than pleasant consequences, particularly if this is considered as being against the Buddhist canon or religious position. This actually occurred with a Thai Buddhist monk named Chai who kept his HIV/AIDS a secret just before he entered monkhood:

> At first, I hesitated to disclose my HIV/AIDS status to some others who came to the temple, because during that time, this disease with its highly stigmatized status definitely aroused fear; this disease solely led to death. In fact, I wanted to reveal this to others, but my disciples told me that I had better not tell other people who could spread this news very quickly and later turn against me. Also, what I feared more was my AIDS status becoming known to other monks who could subsequently expel me from my monkhood. (Chai, infected 5 years)

Here the highly stigmatized disease is a great threat to the monk – one of the most revered figures in Thai society. The stigma might cause others to “turn against” him: not only the public but also other monks. According to Kirsch (1977), Thai Buddhist monks are above laymen in the hierarchy of moral achievement and detachment from worldly cares. Monks are thus expected to act with sobriety and restraint. Due to their higher moral attainments, monks are respected and revered by their loved ones (Kirsch, 1977). In this moral universe, monks should not be infected with a disease that is directly associated with sexual behavior. According to Phra Thattajiwo, sexual perverts, whom he identifies with AIDS, are receiving the karmic consequences of sexual misconduct in their past lives, and such people persist in their perverse behavior even in this life, weakening their bodies and making them susceptible to infection from AIDS (Jackson, 1995). In addition, Viddhanaphuti

(1999) posited that HIV/AIDS infection, which is inextricably linked with sexuality and promiscuity, is “considered polluted and sinful”. Monks enjoy a high status in Thai social order; therefore, they are supposed to manifest “purity and sacred (ness)” (p. 6). Indeed, one of the Buddhist canons states that those living with chronic diseases, including HIV/AIDS, are not allowed to enter into monkhood, as they may not be able to fully practice dharma and the Buddhist scriptures, even though it has been claimed that the Buddhist teachings give special attention to the mind’s power to strengthen or weaken the physical well-being of ordained individuals (Ratanakul, 2008). In other words, contending with HIV/AIDS is supposed to be “the combined effort of the mind and the body to overcome a disease” rather than “a fight between medicine and disease” (Ratanakul, 1999, p. 19).

These considerations reflect an analysis of the risks and benefits of disclosure (Petronio, 2002). The monk’s disciples believed that concealing the disease status would protect him from expulsion from the monkhood. The discloser might relieve stress, gain social support or become closer to the disclosee; on the other hand, embarrassment or rejection can also occur.

Information on disclosure to loved ones also involves the concept of “kalathesa”, as discussed in the earlier section on emotional support requiring mindfulness of manner, behavior, and expression according to the time, the occasion, and the relationship during social interactions. Disclosure can help the discloser feel more relieved and facilitate mutual and understandable communication. Nevertheless, based on “kalathesa”, if one discloses something too soon, there are the risks of interpersonal conflict (Psychology CU, 2017). Therefore, basic information should be given before more detailed information so that the discloser can observe the other party’s reaction (Psychology CU, 2017).

While disclosure requires tact and diplomacy, sharing accurate information about HIV/AIDS is even more important to promote mutual understanding and ongoing connectedness in long-term relationships.

4.2.4 The Importance of Accurate Information about HIV/AIDS

Even though there have been several campaigns to promote understanding and knowledge of HIV/AIDS, public understanding is still quite limited. According to Apinundecha, Laohasiriwong, Cameron, and Lim (2007), people in Thailand still lack sufficient knowledge regarding HIV/AIDS, are confused about the two terms of HIV and AIDS, and thus labor under a variety of misconceptions about the disease.

This problematic issue of inaccurate knowledge of HIV/AIDS was discussed and shared among support group members - two healthcare providers and MSM with HIV/AIDS - at Organization A:

> Pui: I wanted to see my friends' reactions towards HIV/AIDS. After I told them about one man who is very handsome and infected with HIV/AIDS but that it is a pity that he has this disease. Then, my friends added, "yeah, very sad. He shouldn't be infected with AIDS". However, I said that he is HIV infected; then, some of my friends said that I just wanted to show off my English knowledge. Even so, I explained to them the difference between AIDS and HIV, that the latter occurs before the former. They were surprised how these two do not have the same characteristics. Finally, I decided not to reveal my HIV/AIDS status to them for fear of what they would feel against me, as well. (Gay healthcare provider, infected 5 years)

> PA: Yeah, recently I found one university student asking if kissing can lead to AIDS. So, we do not even need to ask about the difference of the terms "HIV" and "AIDS" at all. More surprisingly, some of them think that HIV is not even associated with AIDS. (Infected 8 years)

> Thee: This is hopeless and no different than around 10 years ago when people misunderstood that it was only AIDS killing us. At that time, we were exposed to the propaganda of Wat Phra Bat Namphu showing the pictures of the rotten and skinny bodies of people living with AIDS. They had no choice but only died. You see, the temple not only wanted the viewers to feel offended by this disease to refrain from unsafe sex but also make donations to the temple to help these afflicted people. Another thing I want to mention is the term MSM, which not only people in general but also our own group still mistranslate as 'chai rak chai'. In fact, this term MSM means 'men who have sex with men'.

> Suppose some gay individuals who haven't had sex before could be called or categorized as 'MSM', as well. I think that is not fair (Infected 13 years)
>
> Bu: I think that most of us became aware of the positive blood result when we are in critical condition, not good condition. This can make others perceive that there is only AIDS, that which they have also seen through some media. (Healthcare provider, infected 15 years)
>
> Ae: So, this is about the long-term solution at the national level, like Korea promoting tourism through drama. We may associate public awareness through media with HIV/AIDS or a correct understanding of MSM, and the director could make a plot of this in order to increase awareness among the audience. (Infected 8 months)
>
> Mod: (Raising voice and eyebrows) But if the drama series contains only the real, undiluted facts surrounding HIV/AIDS and the lives of the people infected with this disease, the entertainment aspect would fade. On the other hand, if there is no knowledge of HIV/AIDS given to the audience at all, the movies will become too sentimental. If there was a movie company that made a movie containing mainly the academic content of HIV/AIDS, the movie ratings would drop. (Moderator and gay healthcare provider, infected 18 years)
>
> Ae: Ok. it's about ratings, too.
>
> Mod: Yeah. You see that is the marketing thing.

As these quotes have shown, the support group participants together shared their experience of other people's misunderstanding of HIV/AIDS. Two support group members, Pui and PA, wanted to point out that Thai people take it for granted that the terms HIV and AIDS are the same. They think that the former sounds more formal since the latter is heard more often, but that both terms describe the same disease. However, a more accurate description would be that HIV is a virus that slowly weakens the immune system, whereas AIDS usually takes time to develop from HIV, occurring when the body can no longer defend itself and so various diseases may develop (Aidsinfonet, 2016; Avert, 2016). During the first period of AIDS awareness, the Thai media and population characterized it as a foreigners' disease, which mysteriously caused a number of deaths in Thailand (Fordham, 1993).

Also, the media repeatedly presented frightening images of AIDS as a death sentence, repeatedly showing skinny, weak patients. The disease is still associated with promiscuity as a tool in suppressing what is considered people's immoral sexual desire (Chaiyasit & Paiboonrungroj, 2013). At this point, Thai people have probably heard the term "AIDS" so often that they are not familiar with the term "HIV". This visualization of such skinny, weak patients is further reinforced by those who, as Bu said, "are in critical condition, not in the good condition". Also, this is relevant to the case of the widely communicated portrayal of AIDS by the Thai temple Wat Phra Bat Nam Phu mentioned in this support group session. With its frightening images, some audiences undoubtedly felt compassionate and sympathetic toward those patients based on the Buddhist belief that compassion is related to selflessness to alleviate others' suffering (Ratanakul, 1999). This compassion, which leads to merit-making as a Buddhist good deed, can bring good results in the present or next life (Ratanakul, 1999). The frightening images of HIV/AIDS that this temple presented were therefore highly persuasive as it is a temple well known for providing mental and physical care for people living with AIDS since 1992 (WHO, 2016). Consistent with Kotler and Roberto (1989), this temple providing the hospice service is a credible source that could persuasively convey fear-based messages; accordingly, this credible source has greater influence on shaping the thoughts of people who believe this kind of fear-based message. Although this fear appeal might be intended to promote compassion, people living with HIV/AIDS, especially MSM as the highly stigmatized group, might find its pitiable depictions of HIV/AIDS sufferers depressing (Goldsmith, 2004). People afflicted by the disease may need more empathetic messages (Goldsmith, 2004).

In addition, according to another participant, Thee, the common translation of

MSM as “chai rak chai” was not accurate, as it is not fair to say that “some gay individuals who haven’t had sex before could be called or categorized as ‘MSM’”. The literal translation of the term “chai rak chai” is actually “men who love men” in English; therefore, this implies that they do not necessarily have sex with other men (Singhakowinta, 2016, p. 36). Furthermore, the term “chai rak chai” erases the potential ambiguity and negativity that the word “phet” (sex) in Thai may attach to the term; this is unlike the official Thai translated term for homosexuality, “rakruamphet” (lit. love same sex) (Singhakowinta, 2016, p. 36). In this way, apart from sexuality and gender, “phet” carries a negative term which indicates sexual acts in terms of having sex (Jackson, 1997). Because of this, this term “chai rak chai” opens up the idea that a person of the same sex/gender could potentially form romantic relations with no sexual activity (Singhakowinta, 2016). Clearly, this corresponds to what Plummer (1984) said about the unfixed socio-historical construction of sexual meanings and rather constantly negotiation through individuals’ interaction.

In order to ameliorate this situation, another participant, named Ae, talked about movies that have not yet been made. My field notes indicate that the other participant, named Mod, argued about what would be the more appropriate features of movies and showed disagreement by raising his voice and eyebrows. However, after this specific observation of the support group, a TV drama called Hormones (Season III) depicted the confusion among the Thai public surrounding the terms HIV and AIDS. In this drama, a teenage boy named Phala, infected for ten years, cares for his health very well with regular anti-viral medicine consumption (“พละ ฮอร์โมน ตัวละครที่ทำให้หลายคนเข้าใจ ‘มีเชื้อ HIV ไม่ได้แปลว่าเป็นเอดส์’ ", 2015, para. 1). He explains that being HIV positive does not mean having AIDS; that when HIV as a virus enters the body, it will destroy

the white blood cells, which will enable opportunistic diseases to occur with AIDS ("พละ ฮอร์โมน ตัวละครที่ทำให้หลายคนเข้าใจ 'มีเชื้อ HIV ไม่ได้แปลว่าเป็นเอดส์", 2015). In this way, the audience enjoys entertainment but also receives knowledge. This kind of TV drama could also help shift Thai viewers' perceptions away from the ghastly images of HIV/AIDS while also instilling more accurate knowledge about this disease.

The lack of accurate knowledge on HIV/AIDS among family members in the Thai collectivistic culture is also a serious issue, which could undermine PLWHA's living condition. Take for example the case of a patient who had difficulty living with his family members. Because of this, his healthcare provider had to provide meaningful information to enhance the understanding of the condition among the family:

> There was one case of a patient who had been infected for around four years living in a big family (elder brothers and sisters, aunts, uncles, and several others) and I had to help them understand about HIV/AIDS. Basically, because they are a large conservative Islamic family who still stigmatize gays with HIV/AIDS, I decided to show them this and that, for example, hugging, touching, drinking and eating together with the patient. At the same time, I gave knowledge on HIV/AIDS to the family members by citing successful case studies that proved HIV/AIDS could not be spread easily from person to person. This was to ensure that them that it was not easy to become infected among family members. They could still touch him without any concerns. After that, they seemed to better understand what I had explained to them. (Maze, gay healthcare provider, infected 5 years)

According to the interview excerpt, the staff tried to promote this understanding by explaining the correct ways of living with an infected family member, using both verbal and nonverbal messages (e.g., hugging, touching, drinking, eating). These verbal and nonverbal cues can be considered supportive messages, which are "specific lines of communicative behavior enacted by one party with the intent of benefiting or helping another" (Goldsmith, 2004, p. 386). In this context of social support, both verbal and nonverbal behaviors aim "to provide

assistance for those who are in need of aid" (Burleson & MacGeorge, 2002, p. 374). Correspondingly, Sundaram and Webster (2000) stated that the nonverbal language, which accompanies the verbal language can convey the speaker's competence and persuasiveness; in addition, the listeners normally interpret nonverbal cues before verbal language. Therefore, besides verbal statements, the way the staff used the nonverbal means to depict engaging in routine activities together helped to ensure them they could live together and helped the family members better understand how to interact with the infected family member. Even though Thai culture places great emphasis on implicit communication, sometimes not only non-verbal but verbal communication as language of social support can be employed together in friendly and effective ways to foster understanding between in-group members. This corresponds to the main characteristic of Thai culture as "low masculinity culture" that focuses on cooperation and compromise (Hofstede, 2018).

As collectivist family culture emphasizes interdependence among members, relationships with others are more important while personal autonomy and space are considered secondary (Markus & Kitayama, 1991). Although stigma is still widespread in Thai culture, familial conflict over HIV/AIDS must be avoided. The excerpt suggests that the patient infected with this disease for four years still had problems living with his loved ones that suggested their misunderstanding of HIV/AIDS. In addition, the family had stigmatizing attitudes toward homosexuality and the disease.

This lack of accurate knowledge of HIV/AIDS can include the knowledge about sexual intercourse with a non-HIV/AIDS infected sexual partner. Support group members who were MSM with HIV/AIDS at Organization B discussed appropriate ways of having sex with sexual partners:

Kik: Because of my HIV/AIDS, I am not sure if my partner will be suspicious of being told to wear a condom. (Infected 2 months)

Lim: How long have both of you been in the relationship? (Moderator and male healthcare provider, non-infected)

Kik: Up to now it has been two years.

Lim: That means you have just been diagnosed and your boyfriend still does not know this?

Kik: Yeah.

Mos: You could say that you are worried about cleanliness or fear of having hemorrhoids. Alternatively, you might also tell him that, searching for information on having sex without protection from the Internet, you learned that both of you could have the chance of being infected with other sexually infected diseases, such as warts, gonorrhea, syphilis, etc. Alternatively, you might say that sexual intercourse can cause colon cancer or tissue disorder. Thus, sex in other ways may be preferable. (Infected 2 years)

King: I think that way could cause a negative reaction, and he might ignore this issue completely. Why don't you say that you fear that gold (slang for feces in Thai) or something dirty will come out and could become messy? Or you might say that these days you are not comfortable with unprotected sex because of harmful food or gastritis and so on. Because of this, you could say that you would prefer sex without penetration. (Infected 4 years)

Joe: (smiling) I'm not sure if that kind of communication would sound convincing. Inhibiting sexual intercourse could unpleasantly affect the romantic relationship. It might be better to say that you got a few new condoms today that are ultrathin from blah blah, why don't we use it? It can help us to keep ourselves clean to prevent….Luckily, if your partner likes to use the condom, then next time it will not be necessary to have bareback sex. Then, you do not have to worry that you will transmit HIV/AIDS to your partner. This works for me. However, I have only just started dating my boyfriend. Therefore, it is not too hard for me to convince him to use a condom. Probably, this might be harder for you since you have been in the relationship with your boyfriend for a long time. It depends on what sexual role you have. If you are 'rook', you could tell your partner as 'rub' that you do not want to clean…too often since you fear you will get hurt or feel uncomfortable. (Infected 6 years)

Kik: Umm ok …

In this interaction, a recently diagnosed group member was unsure about how to talk with his sero-negative boyfriend about using condoms. Mos, a group member

with a longer experience of infection recommended justifying condom use because of the side-effects of unprotected sex, citing a list of sexually transmitted diseases that might worry his sero-negative partner. Unbeknownst to Kik's partner, using condoms would actually prevent the spread of HIV/AIDS in this particular case. Instead of directly disclosing HIV/AIDS status, people may choose to talk to their significant others about less stigmatized diseases, like TB. Overall, using this deflection involves the obvious distinction between HIV/AIDS and other chronic diseases being that HIV/AIDS is highly and sexually infectious; moreover, HIV/AIDS is still not yet socially accepted as a 'normal' chronic disease but associated with immoral and irresponsible action, thus making infected patients vulnerable, stigmatized and disinclined to disclose their disease (Chemaitelly, Awad, & Abu-Raddad, 2014). In Thai society, once someone has HIV in their body, they are immediately sentenced on charges of personal sins, being immoral or having committed wrongdoings ("Index of Stigma and Discrimination against People Living with HIV/AIDS in Thailand", n.d.). Raising the specter of HIV/AIDS might lead the partner to feel like he is being accused of carrying the deeply stigmatized illness; speaking instead in terms of stopping the spread of less threatening STDs is less threatening to identities and relationships. As can be seen, some illnesses are stigmatized, and others are not; therefore, these distinctions are that diseases "exist for social rather than purely biological reasons" (Conrad & Barker, 2010, p. 69). In other words, it depends on the social interpretations varying from culture to culture.

This approach of deflection, thus, differs from Goffman's (1963) description of people coping with stigma by "passing" as normal (p. 73) or simply hiding their condition. However, using the fear of these STDs to motivate compliance could also

lead to negative consequences; threat appeals can trigger defensive reactions that may interfere with or obstruct protective action (Sutton, 1992).

Perhaps in light of these possibilities, both support group members – King and Joe – discussed another recommendation that might pave the way to the use of condoms without triggering the suspicion of the seronegative partner. In this approach, the benefits of condom use are cast more positively. Nevertheless, Joe's recommendation seemed to be more effective than that of King because his did not have anything to do with any excuses about cleanliness or illnesses (e.g., harmful food or gastritis). These excuses might probably, like Joe thought, became more dubious one day if used too often. Therefore, the focus on condom use is straight to the point in terms of having protected sexual intercourse, and this does not require any insincere, unconvincing explanations of sexual abstinence. Even though this strategy, might be harder for Kik (but not Joe), who had had bareback sex with his partner for so long, Joe hoped that citing the benefits of condoms for cleanliness could somehow change sexual attitude and preference. This advice on condom use is reminiscent of research conducted by Garcia, Yam, and Firestone (2006), who reported that the benefits of hygiene and ease of condom use were closely linked to feelings of security, protection and peace of mind.

Furthermore, taking into account sex role is important for providing information on safe sex or HIV/AIDS prevention through condom use. Regarding the sexual roles mentioned by Joe in this excerpt, two types are referenced, their meanings based on intercourse: "rook" ('to preempt' – direct translation in English) or "sexually active" and 'rub' ('to receive' – direct translation in English) or "sexually passive". Relatedly, these terms "Rook" and "Rub" correspond to "King" or "Top" and "Queen" or "Bottom", respectively (Pongtriang, O'Brien, & Maguire,

2017, p. 2), and, importantly, these refer to gay sub-identities of "phet" as discussed earlier in Chapter 2. Understanding the difference of these sub-identities can help to negotiate sexual intercourse in order to meet their sexual desire in accordance with each individual's sex/gender.

I also observed one participant, Joe, smiled while he seemed to disagree with what another support group had just said. This suggests a desire to avoid interpersonal conflict between parties. Sometimes Thai people hide their feelings to avoid hurting others' feelings: Mulder (2000) observed this non-confrontational character in most Thai people:

> A smile may be a sign of kindness, of forgiveness, of friendly inclinations; a smile may also be merely polite, a way to smooth interaction or a sign that one is willing to listen. A smile may indicate agreement, or self-confidence, but may also be a means to gently express one's opposition or doubt. A person on the defensive may smile, and one may smile when sad, or hurt, or even insulted. It has been said that the Thais have a smile for every emotion and with so many nuances of smiling, the smile often hides more than it reveals. (Mulder, 2000, p. 1)

Of course, Joe's smile might have been interpreted as the expression of opposition and doubt because he did not totally agree with King's proposed communicative strategy about making some excuses of refraining from having sexual intercourse. Apparently, these participants did not want to have a heated argument.

In another example regarding insufficient knowledge surrounding HIV/AIDS, the issue was oral sex and HIV/AIDS infection rather than intercourse. In the following interview excerpt, Bu, a healthcare provider spoke about his patient infected for three to four years and how he instructed the patient on how to have safe oral sex with his partner:

> When my patient infected with HIV/AIDS for around three to four years asked me how his boyfriend could still have oral sex safely with him, I told him the way his boyfriend could use…, and that it should not be too…. Otherwise, oral mucosa could be damaged and infected. Besides, most gay people like to

> swallow... I then asked for more information on this from medical staff. They said that if there are no inner organ wounds, that's fine. The stomach acid can digest the semen. Nevertheless, it is better to avoid consuming that fluid. (Bu, gay healthcare provider, infected 15 years)

Here the staff gave very specific instructions to his patient on how to have safe oral sex (i.e., should not be too…) and supported the claim that his recommendation was safe with medical information. This corresponds to Dixon (2002) who reported that the virus cannot enter the body through the skin unless there is a wound, a rash, or some other cracked area on the skin. Even though this patient had been diagnosed four years earlier, he appeared to know little about the association between infection and oral sex. This might be because such information is rarely shared in Thailand, where the influence of Buddhism on law, culture, moral values and social life treats sex as a taboo topic; talk about this is considered impolite and thus inappropriate for open discussion (Kay, Torabi, & Jeng, 2003). Talking openly about sex is associated with the term "phit kalathesa" or not being aware of the time and place in Thai (Van Esterik, 2000, p. 212). Sutham Thammarongwit labels this "culture of silence" about sexuality in Thailand, attributing it to a predominant distaste for overt expressions of sexuality (Thammarongwit, 2001, p. 125). Based on Buddhist belief, sex is a great sin associated with the negative value of craving or "kilet", passion or "tanha", and lust or "raakha" (Thammarongwit, 2001, p. 125). Nevertheless, the issue of sex in Thai culture may be taken to extremes because the attitude of contemporary Thai Buddhists toward laypersons' sex or sexual behavior is stricter than that reflected in the Pali canon or in traditional or popular Thai accounts of Buddhist ethics by reason of good image of the country (UNDP, 2014).

Furthermore, as the quote suggests, not only the patient but also the healthcare provider seemed to be uncertain about the sexual knowledge as the latter had to ask

about this specific information from the medical staff who might have had more experience or knowledge than him. This indicates lack of appropriate sex education in Thai schools. Finally, Thai sexual education does nothing to promote students' analytic and critical-thinking skills related to sexuality ("Review of Comprehensive Sexuality Education in Thailand", 2016). Thai sex education emphasizes the prevention of teenage pregnancy, sexually transmitted infections and HIV, as well as sexual anatomy and development, while topics related to gender, sexual rights and citizenship, sexual and gender diversity, and safe sex for same-sex couples are less often taught ("Review of Comprehensive Sexuality Education in Thailand", 2016).

This pattern of neglect is also reflected in prejudices in Thai society in economic employment. Information about jobs for those living with HIV/AIDS is thus an important topic of supportive communication.

4.2.5 Information on Preparing for Employment after Disruption Caused by Infection

Although it has been asserted that people living with HIV/AIDS have found it easier to work in Thailand in recent years, they still face difficulties finding a job. A recent survey on 233 HIV-positive Thai people found that 26.18% had been refused jobs because of their infection (Wipatayotin, 2012). This is reflected in talk among support group members consisting of a healthcare provider and MSM with HIV/AIDS about which type of employment is the most available to them. Interaction in a support group session at Organization A illustrates this point:

> Kong: I felt that life is limited. At that time, when I applied for a job, they required a blood examination. I feared that they would know my HIV/AIDS result, which could mean the end of the world. Even though several companies, like Thai Airways and hotels, rejected me after the result, I did not give up on my life. (Infected 18 years)
>
> Maze: You know why they asked for your blood results? (Infected 5 years)

Kong: Probably the service sectors, like Thai Airways, realize that if I have to work and serve customers all night, some kinds of medicine might prevent me from working effectively. So, they decided not to hire me.

Maze: After that what was your life like?

Kong: I did not give up on my life. I sold goods but did not tell any friends about my HIV/AIDS status.

Mod: But you know, from what I have heard from you here, this kind of situation may stigmatize people living with chronic diseases, particularly those with HIV/AIDS. If applicants are found to have chronic diseases, particularly HIV/AIDS, they might be considered the last choice. This kind of situation still exists and we believe it really still. But in my view, this chronic status does not lessen our working potential, but I doubt if they will still give us an opportunity. In fact, as a whole group rather than as each individual we should demonstrate that we really have real working ability. For us, if we believe that we are ill and weak and are not as competent like those with normal blood results, it means this situation is not going to change at all. Then, where should we be in society? What will we do? (Moderator and gay healthcare provider, infected 18 years)

Kit: I later found out that I had been infected with this disease after I had been working at my company. Four years after I knew about my infection, I gave my blood results to the head of the HR department who I am very close to. She was shocked at first and said that she couldn't believe it because I still looked healthy. Finally, she told me that she would tell me beforehand which health programs of the company do not require HIV/AIDS examination. Up to now she has not revealed my secret to anyone. (Infected 5 years)

Mod: So, your company has different options for you to choose from?

Kit: It depends. Sometimes the health programs are highly charged, and in this case, my company does not consider HIV/AIDS examination necessary. This is because the company wants to save as much costs and budget as possible.

Mod: Therefore, doing freelance jobs rather than permanent ones might be a better choice, especially for job applicants since the latter requires a medical certificate. Unfortunately, this certificate applies to many careers, including both state and private organizations.

In this exchange, support group members engaged in conversations about the kinds of job opportunities for the people living with HIV/AIDS and those that do not require medical documents. Kong, opened the conversation by talking about his job applications being rejected by large companies. He believed this was because these

companies are concerned that he would not be able to work fully due to his health. Nevertheless, the group moderator seemed not to be convinced that such large companies were genuinely worried about Kong's working condition being affected by his medicine, as he said: "from what I have heard from you here, this kind of situation may stigmatize people living with chronic diseases, particularly those with HIV/AIDS". Thus, what those companies said could just be an excuse. This discrimination in Thailand, which is still critical, corresponds to Suriyasarn (2015) who explained that, like heterosexuals with HIV/AIDS, gays living with this disease are not entitled to full participation in the labor market, contrary to what is recommended by international law on the subject matter. Furthermore, several of the executives have claimed that they know HIV/AIDS cannot be spread at the workplace but fear that customers will not be able to accept this issue (Thaiplus, 2016).

Meanwhile, those already working may be required to have an annual health check-up, like the participant Kit. While Kit talked about HIV/AIDS as a serious subject that could not be disclosed to anyone in the company except the head of the HR department, this disease was also regarded as unimportant for treatment since the company needed to "save costs and budgets as much as possible". If the employees were found to have HIV/AIDS, they might be fired without being sent for further treatment. Alternatively, the company might also underestimate the prevalence of this disease among its employees. For whatever reason, this indicates the HIV/AIDS issue was deemed of little value for consideration.

In the meantime, the moderator tried to make other support group members realize their potential and empower them by saying "as a whole group rather than as each individual we should demonstrate that we really have real working ability". This reflects Goffman's (1963) discussion of normalcy: the process of differentiating those

who are “normal” from those who are different or “deviant,” namely, the stigmatized (Goffman, 1963). Nevertheless, it appears that this idealized notion is hard to put into practice now as it leads to only rhetorical questions in the dialogue: “Where should we be in society?” and “What will we do?” without any further comment or suggestion on this point of normalcy until the end of the conversation when the moderator concludes by way of relief, that having a freelance job, which does not require a medical certificate, is the ideal option for the HIV/AIDS infected participant.

In addition to freelance jobs, however, some permanent ones may still be open to those living with HIV/AIDS. This was discussed between a healthcare provider and MSM with HIV/AIDS in another support group when a participant who had just finished his university degree was worried about being hired for a hotel job:

> Esse: I am a bit confused now if I can work full time at a hotel. I fear that I will not be accepted by food catering companies or hotel services. I have been looking for hotel jobs at several places since I graduated. (Infected 4 years)
>
> Lim: You know, there are still some of them, like Crowne Plaza hotel, welcoming us. As far as I know, TOPS supermarkets or Centara hotels normally require the medical certificate. You might have to look for the information on these services before the application. (Moderator and male healthcare provider, non-infected)
>
> Noong: I used to work at several hotels. Then, one day I decided to quit my job at a hotel and decided to look for a new one, which required me to show them the HIV/AIDS blood test result. Can you guess whether I was accepted? The answer is “no”. However, I did not give up on searching for this kind of job. Finally, I could work at a small hotel. I think the largest ones are harder for us to gain employment. (Infected 3 years)
>
> Esse: Thank you. It’s very good for me to know which ones will accept me or not. I’ll spend time checking it out.
>
> Arm: It’s the same problem with cooking work, which requires cleanliness and safety. If customers know that I have HIV/AIDS, they may not want to eat my food. Because of this, I cannot be hired as a chef at many restaurants. I think that owning a restaurant and being a chef by myself is much easier. This

> way, I do not need to tell them about my HIV/AIDS infection. (Infected 7 months)

In this support group session at Organization B, a support group member was concerned about career limitations. One support group member said they might still have the opportunity to apply for a job in the area of food and hospitality services, after which another member clarified this further by saying that employment in the field depends on hotel to which they apply. Moreover, because catering and hotel services are so often fearful that their reputation would be tarnished if their customers knew they employed infected people, another group member suggested that it is better to own their own business, like owning a restaurant. Again, rejection of employment and fear of HIV/AIDS infection through food reflects a misunderstanding of HIV/AIDS caused by inaccurate information as explained in an earlier quote. In addition, the importance of this discussion is underlined by the significance of the Thai food and hospitality industries, a robust and growing sector of the economy (Thailand Economic Monitor 2017: Digital Transformation).

4.3 Informational and Emotional Support in Dealing with Other People's Ignorance

Despite many campaigns to promote better understanding of HIV/AIDS in Thailand, persistent, harmful, and hurtful ignorance about HIV/AIDS remains widespread. This misunderstanding is associated with deeply ingrained negative attitudes and indeed revulsion toward HIV/AIDS infected people. To cope with this, support group participants, including patients and gay healthcare providers, commiserate, sharing both informational and emotional help with one another.

Below is a group support session at Organization B, where a distressing aspect of the HIV/AIDS campaign was discussed among a healthcare provider and HIV-infected patients:

> Bu: The gay population is already labeled as the main group living with HIV/AIDS. Even the campaign for HIV/AIDS is highlighting this target gay population. My friends and I feel that we are vulnerable encountering this issue of unsafe sex. It is a double stigma involving gay and HIV/AIDS status. (Moderator and gay healthcare provider, infected 15 years)
>
> Karn: Yeah. I also wonder why this kind of situation is like this, and how we can change this attitude toward our group always being linked with HIV/AIDS. (Infected 1 year)
>
> Chain: I think one reason is that gay MSM do not like to have safe sex, like in gay saunas. That's how I understand that AIDS infection is easily spread among our group. (Infected 20 years)
>
> Bu: So, if we still behave like this, it is very hard to change this stereotypical attitude of the public toward us.

Repeatedly associating the gay population with HIV/AIDS, as in these health campaigns, may do as much harm as good. In this instance, Bu said the risky behavior is associated with attitudes instilled in the public's mind, and Karn validated this actual situation by saying, "Yeah. I also wonder why this kind of situation is like this…". Then, another group member, Chain, further supported this kind of labeling by talking about the unsafe sex of MSM. Finally, Bu, a healthcare provider, agreed with what Chain had said and concluded that it is impossible "to change this stereotypical attitude of the public", indicating the public distrust toward the MSM group. Throughout this commiserating process, the participants shared their understanding of the campaigns putting emphasis on or reminding the audience of the so-called promiscuity of MSM. Clearly, they exchanged their views and hurt feelings with one another, which helped them to be aware of the real causes leading to the negative aspects of the HIV/AIDS campaign.

These HIV/AIDS campaigns, run in just the past few years to reduce the rates of infection among this target population, are in stark contrast to the pervasive silence about homosexuality that preceded this new regime. In other words, before these

HIV/AIDS campaigns, Thai society generally did not acknowledge the existence of the gay population (Lyttleton, 1996). An example of a newer approach is "edutainment", as for example in the "Adam's Love" campaign by the Thai Red Cross AIDS Research Center. This campaign uses high-profile celebrities as ambassadors to break down stigmas and emphasizes building strong online resources and social networks (ifrc.org, 2015). Nevertheless, as indicated in the previous quote, the campaigns can make homosexual people feel that they are being negatively judged. In turn, this might demotivate the seeking of healthcare services like those for HIV/AIDS.

Thus, Thai public campaigns might make society think that their sexual group is careless about unsafe sex. They might fear that the public will associate HIV/AIDS with gay groups, like in the Western world where early media referred to the illness as "a gay disease, gay cancer, or gay plague" (Herek & Capitanio, 1999, p. 1), reflecting an initial assumption that it struck only gay men.

In short, infected MSM fear that there is little acceptance of homosexuals even though Thailand is perceived to be among the more tolerant nations in Southeast Asia with respect to same-sex attraction (Manalastas et al., 2017). Mhode and Nyamhanga (2016) report that gender inequality determines the extent to which sexism will mark the course of the HIV disease; for example, in a highly patriarchal society, like Thailand, the disclosure of HIV positive status is more likely to provoke stigma. Because of this, gay HIV positive people could be discouraged from accessing healthcare services or revealing themselves to other people.

This ignorance about HIV/AIDS is associated with the direct relationship between the external social network and the family as a strong tie network. In this, the former has a strong impact on the latter. The following session in which healthcare

providers and MSM living with HIV/AIDS at Organization A is an example of this impact:

> Pui: I realized that I had learned how some little points could later turn into bigger and bigger problems. The best example of this is how messages stigmatizing HIV/AIDS are conveyed from one person to another, on and on. People who do not understand the facts about this disease inaccurately say that HIV/AIDS is terrifying and should be treated highly cautiously. This kind of gossip is responsible for labeling. Then, one day when they – and this happened to me – are affected by HIV/AIDS, they become aware of this anti-social attitude. This makes us feel even hopeless and more saddened by this incident. (Gay healthcare provider, infected 5 years)
>
> Thee: Some people even fear others who die of HIV/AIDS – their bodies are put into black garbage bags without coffins during cremation. In fact, the dust that is spread in the air is nothing. When they do not accept anything about HIV/AIDS, they will not believe anything but hold onto conservative ideas. It can be difficult to make other people understand the facts. If we leave this situation for society to learn by themselves, it seems even more impossible. This is because they do not know and do not want to learn anything even though information on HIV/AIDS is available everywhere. (Infected 13 years)
>
> Mod: Yeah. Actually, specks of dust are nothing. No HIV or AIDS at all. (Moderator and gay healthcare provider, infected 18 years)
>
> Arm: You see. Because of this, I do not dare to reveal my HIV/AIDS condition to my family (using serious tone of voice). I am not sure if they have been exposed to such incorrect information on HIV/AIDS from some media or their friends. Because of this, I am not sure if they will be able to accept my disease, not to mention my gay status. I wonder if they have sufficient knowledge of this disease. They expect a lot from me, especially to get married. In addition, my younger brother, who respects me and sees me as his role model, may become very disappointed. I feel very ill at ease whenever I think of this (sobbing). (Infected 7 months)
>
> Mod: Umm … This is the current situation that is hard to change. So, our concerns about this are absolutely right.

At this meeting, the support group members were discussing people's misunderstanding of HIV/AIDS. Pui whined about their ill-informed gossip as he said, "how messages stigmatizing HIV/AIDS are conveyed from one person to another on and on … This kind of gossip is responsible for labeling". This gossiping in Thai culture is consistent with the idea that people in high-context cultures grow up

learning to exchange detailed information on a very broad range of topics in order to update themselves within their group (Grove & Hallowell, 1999, para. 15). Moreover, according to Baumeister, Zhang, and Vohs (2004), in some cultures, gossiping is the cause for positive talk, whereas the reverse is true for other cultures (Baumeister et al., 2004). In this regard, gossiping about HIV/AIDS in Thai culture can be more negative as the network verbally attacks the participant in an implicit way. Correspondingly, Gluckman (1963) asserted that gossip can help suppress conflict, providing a forum for "internal struggles within the groups" to be "fought with concealed malice, by subtle innuendo, and by pointed ambiguities" (p. 313). This gossip has again reflected the Thai shame culture which is determined by the Buddhist belief that any immoral conduct has to be restrained. Otherwise, it can be criticized by the society.

Another participant, Thee, then validated this incidence of anti-social attitude by pointing out the lack of proper knowledge of HIV/AIDS, which related to "cremation" and "specks of dust" of the bodies. He also stressed that this negative and inaccurate attitude toward HIV/AIDS is still prevalent and that it seems extremely difficult to change. He talks about Thai people's unwillingness to accept and learn the facts about HIV/AIDS. This causes great uneasiness for infected Thais. These exchanges regarding deplorable and hopeless circumstances made Arm, still living with his family, become more depressed and fearful since both his HIV/AIDS and sexuality status are involved. As the eldest son in Thai society, Arm was acutely aware that he is expected to be the leader and role model in the family.

More specifically, as noted, older siblings may take on the role of an attachment figure or a secure base for younger siblings. While this interdependence of siblings could reflect cooperation in the individualistic culture (Fox, Willfuhr,

Gagnon, Dillon, & Voland, 2016), for collectivistic culture, this is more related to power distance determining the obedience of the younger sibling towards the older one. Personal relationships in Southeast Asia are vertically structured: “father-son, older brother -younger-brother, teacher-student” (Suwannapirom, 2005, p. 35). This also relates to the Confucian value of social harmony and stability. In Confucian teachings, harmony and stability are maintained by unequal relationships (Ferle, 2016). If one does not fulfill the expected role, the well-being of the entire group can be disturbed. These tenets of Confucianism provide the concept of what Hofstede refers to as power distance (Ferle, 2016). Similarly, in the Thai patriarchal culture, the traditional role of brothers as seen from the quote reflects the significance of heteronormativity entwined with Thai cultural and traditional practices. Thai men are expected to be strong and reasonable, a family leader, and responsible for the nation by doing military service (Choomgrant, 2009, p. 23), and they are expected to fulfill social obligations by marrying and fathering a family (Jackson, 1997).

Being able to commiserate and share advice about how to deal with these constant existential threats of cultural heteronormativity and widespread ignorance about and misunderstanding of HIV/AIDS, these group members could both ventilate and experience validation of their stress and give and receive advice. This indicates that these group participants cannot trust the broader culture to support them, strain to cope with its ignorance, and thus rely on informational and emotional support from the group.

It is also clear that concerns about others’ ignorance about and attitudes toward HIV/AIDS extend to interactions with medical staff. The risks and stresses of these interactions are also topics for both commiseration and information (in this case, giving and receiving perspective) about heterosexual care provider ignorance, as

illustrated in the following interaction between a healthcare provider and other HIV-infected MSM at Organization B.

> Bu: Because of the secretiveness and stigma that gay people living with HIV/AIDS have experienced, this group does not want help or feel comfortable to talk with other sexual groups, like female nurses who criticize or satirize their HIV/AIDS and MSM orientation. (Gay healthcare provider, infected 15 years)
>
> Esse: That's true. Female staff seem to understand me, but there is still something that I do not feel comfortable about talking with them such as sexual role or some specific terms that MSM know and like to use….Basically, I can talk with female healthcare providers about general topics, such as CD4, food, health, and exercise but not other personal issues that can make me feel embarrassed and the language we use is more like the informal one for our group. Some of the straight female or male healthcare providers do not have much knowledge of our sexual activity and may express revulsion against us. Once a female staff at the Thai Red Cross did not dare ask me about my sexual role. This is probably because we met just once. She might feel more comfortable asking this kind of direct question from her intimate patient (Infected 4 years)
>
> Mai: Probably, it depends on the individual. In my case, my female healthcare staff is very nice and funny. Moreover, some of us cannot always talk to healthcare staff of the same gay sexual status as us about everything, including sexual activities. (Infected 5 years)
>
> Esse: Yeah. That's true. But I still feel more inclined to talk to healthcare staff of the same gay status as we can become more familiar with each other more quickly.

Even though, as discussed earlier, there is some tolerance of gay people in Thailand, tolerance is often contingent on gay individuals acting appropriately according to social norms (UNDP, 2014). Such multiplicity and contextualization are valued as Thai people are tolerant of private space for homosexuals. As Morris (1994) stated, "virtually any [sexual] act is acceptable if it neither injures another person nor offends others through inappropriate self-disclosure" (p. 32). Therefore, hostile attitudes may be hidden (UNDP, 2014). The participants are apparently sensitive to interactions with straight care providers, perhaps because such providers see "MSM" as people engaging in behaviors that put men at risk of infection (Adam's Love, n.d.).

Esse's major concern in the preceding excerpt, that of knowledge and understanding of MSM and HIV/AIDS, reflects that sex education in Thailand mainly discusses heterosexual sex, and HIV/AIDS knowledge is limited. In addition, Thai sex education is based on traditional values of heterosexuality and patriarchy, while Thai textbooks often assert that LGBT gender identities are caused by broken families ("Sex education strengthens sexual discrimination in Thailand", 2016). Also, because sex is a taboo topic, it is difficult to open discussions among both heterosexuals and homosexuals. This is consistent with Esse's discomfort about talking with straight care providers about gay sex and preference to speak with providers who are also gay. Discussing this in the group is a way to check this outlook for its informational and/or emotional validity. The importance of this check is surely magnified in a culture where even health care providers are seen as potentially hostile to HIV-infected MSM.

It may also be worth noting that the inadequacies of Thai sex education reflect Altman's notion of "global queering" in Asia as relates to the HIV/AIDS epidemic. That is, the epidemic has caused immense panic throughout the region as well as huge pressure on governments to foster sex education campaigns promoting "proper" sexual behaviors and safe sex practices to prevent the spread of the virus (Singhakowinta, 2016). This panic may have reduced taboos about public discussions of sex and sexuality, but it also promotes the perception of homosexual sex as "deviant" or "unnatural" (Singhakowinta, 2016, p. 21). So, as noted in the earlier discussion of information campaigns, efforts to educate the Thai public about the threat of HIV have also inculcated fear and stigmatization of MSM to such an extent that support group members are reluctant to be candid with heterosexual care providers.

The fact that the support group members were working through their beliefs and evaluations of these matters was also evident through another support member, Mai, who argued that his female healthcare staff was not hostile to Mai's homosexuality and infection. Consistent with this, there is some evidence, provided by Lim (2002), that women have less homonegative, more accepting attitudes than men. However, Mai was sensitive to the complexities, aware that one cannot be sure who is safe to talk to, noting that this "depends on the individual." Moreover, Mai asserted that there were times when it might be better for a gay patient to talk with a straight care provider, although Mai did not elaborate. Reflecting the group's ongoing efforts to work out what to believe—and how to feel—about disclosure and open communication with care providers, Esse then reasserted his being more comfortable talking with gay providers. Talking about health with care providers is obviously very important, but it is also evidently stressful, and this stress is an important topic for processing within the group even if it does not result in a clear resolution of members' informational and emotional concerns.

Moreover, since this pessimistic view of HIV/AIDS pervades Thai society at all levels (i.e., the public, family and friends, medical staff), Thai HIV/AIDS infected people are also no exception. In fact, they ought to understand one another better than healthy people. However, they might have been treated in a similarly unfair and disapproving manner, and this fear can become more and more severe until it turns into distrust among the infected:

> Arm: I really want those living with HIV/AIDS to communicate with each other, but they seem to be very embarrassed. For example, I had a friend who went for a blood examination and then told me about his positive HIV/AIDS status. However, one month later, he told me that he had not been infected at all. This made me think that he was trying to conceal something from me. He might not want to have access to medical treatment, or become distant from me. My friend and I were crying together but a week ago I asked him if he had

> taken medicine. He told me that he was normally healthy. This could be due to the fact that he did not want not only me but also his other friends to know about this. (Infected 7 month)
>
> Lim: Yeah. It is quite strange why both with the positive blood result try to keep their distance from each other. Aren't they happy to see each other with the same condition so that they can feel that they are not alone and can further support each other? (Moderator and male healthcare provider, non-infected)
>
> Pui: This is what I don't understand, too. Recently, I met my friend who went for a blood examination for the second and third time and picked up some kind of medicine at an anonymous clinic, which I believe is anti-viral. When I saw him and asked what he was doing here, he seemed to be too embarrassed to tell me about his HIV/AIDS. Finally, he admitted that he just found out that he was infected. (Gay healthcare provider, infected 5 years)
>
> Mai: I've found this before. After I told one of my friends infected with HIV/AIDS that I also had this disease, he intended to announce this news that I had HIV/AIDS by talking to me loudly about what I had told him among other friends in the shopping mall. You see anything could happen even if he and I had the same HIV/AIDS condition. From then on, I did not dare reveal my HIV/AIDS condition to anyone. (Infected 5 years)

As the excerpt above suggests, the participants at Organization B discussed the discomfort of mutual communication among those living with HIV/AIDS. The participant, Arm, felt desperate for this disclosure between them as he said, "they seem to be very embarrassed", even though both the participant and his friend are both HIV/AIDS positive gays. In addition, this shows that the participant's friend felt reluctant to reveal his status, as Arm said, "My friend and I were crying together but a week ago I asked him if he had taken medicine. He told me that he was normally healthy." This kind of similar experience was validated and shared by the other two support group members, Pui and Mai. After Pui described what happened between him and his infected friend, Mai assured both Arm and Pui that they were not the only two who had gone through this painful experience. In fact, he had had a worse experience than theirs, and this might have worsened due to the involuntary disclosure made by another with the same HIV/AIDS condition. The aim behind this

might be to shift one's own shame and guilt to the other as the victim of critical remarks. In this case, the support group member, Mai, provides Arm and Pui with informational support (they are not alone in these experiences) and emotional support (Mai validates the pain that Arm and Pui felt in these experiences). Moreover, given the highly internalized stigma reflected in infected people hiding their status from others similarly infected, the need for validation is probably quite substantial.

This stigma associated with disclosure also corresponds to Brown, Macintyre, and Trujillo (2003), who explain that "felt" or "perceived" or "internal" stigma refers to the particular undesirable attribute, disease (such as HIV), or association with a particular group or behavior (e.g. homosexuality and promiscuity). Such internalized stigma can inhibit participation in most community activities. This stigma could also be linked with the issue of face, that involves "nata" or "face-eyes", which is an umbrella term for human worth (Persons, 2008, p. 57). Concerning the concept of ego, this issue of face means that the person deserves to be accepted and respected. In writing about the importance of face in Thai culture, Vongvipanond (1994) said, "Like in many languages, face comes to mean "reputation, honor, respectability, credibility and integrity", and a Thai can "lose, save, earn or gain and salvage his/her face" (para. 21). In short, Thai face is related to self-esteem. According to Ukosakul (2003), face or "Nâa" in Thai culture involves ego, self-identity, dignity, and pride as "face is the container for honour" (p. 298). Therefore, it involves both the self and the other in gaining face, as well as not making others lose face, and is, thus, intimately linked to honor and shame (Ukosakul, 2009). In this regard, one's face exists in relation to not making others lose face, and in turn saving one's own face. This way is related to "avoidance mechanism" that has been developed to protect ego Thai people have in order to deflect all unnecessary conflicts or confrontations (Kapur-Fic, 1998,

p. 523). Also, in addition to “kiat” as explained earlier in the section of informational support, “saksi” means that the person deserves to be accepted and respected (Persons, 2008, p. 56) and “chuesiang” reflects the recognition of society, including the greatness or goodness of a person, by giving the reinforcement of societal feedback (Persons, 2008).

4.4 Instrumental Support

Another kind of social support is instrumental support, which is direct and tangible aid (e.g. money, goods) or service (e.g. taking care of patients, doing a job) (House, 1981). As such, like informational support, it is most obviously related to problem-focused coping, which aims to resolve the stress by reducing the stressor. However, as a result of problem management, instrumental support can also be emotionally healing. My analyses of the corpus of interview data and notes from field observations yielded three themes in instrumental support: (a) Collectivistic network assistance with the necessities of living with infection, (b) Aid to improve interpersonal relationships complicated by infection; and (c) Creating and sharing information in and about safe, private spaces.

4.4.1 Collectivistic Network Assistance with the Necessities of Living with Infection

Instrumental assistance with the basic necessities of living is important for PLWHA and is surely also important for its emotional meaning for those recently infected with this disease. Money is vital for PLWHA, as it is necessary to obtain medicine and medical care. The following interview excerpt from a HIV/AIDS infected gay patient illustrates this:

> After my mother knew of my AIDS status, she said that my heath condition was not a big trouble for her. Also, she added that if I did not have any money, she, despite being an ordinary fruit vendor, would sell anything, whether

> precious or not, she had. Then, I said to her that I would take some belongings to the pawnshop, and I would work to get the money back (Tuee, infected 9 years)

The participant's mother's wholehearted support is consistent with the reciprocal relationship in terms of "filial piety", which, according to Yeh and Bedford (2004), pertains to children caring for parents emotionally and physically to repay for parents' efforts in raising them. In addition, regarding this moral virtue, older adults are viewed positively and respected (e.g., a source of wisdom and magical power), and offer various types of resources to people in the younger generations, while young people, in return, are attentive to their elders and provide care and support when needed (McCann, Giles, & Ota, 2017). This is reflected in the participant's statement, "I would work to get the money back". The parent, thus, regards security and best wishes as most important for her son. This is another aspect that shows how a Thai parent does not have prejudice and dislike for her son, and this contrasts with misunderstanding of HIV/AIDS related to inaccurate information, as discussed earlier. This reciprocal relationship between parents and children in Thai culture involves filial piety based on Theravada Buddhism which teaches a definite reciprocity and considers karma as the basis of ethics and morals (Xing, 2013). Nevertheless, this is different from filial piety in Confucianism, which seems to focus more on the duty of grown children towards their parents when the parents are old as a one-way duty and disregard of karma (Xing, 2013).

Karma, as explained earlier in the informational support, can be interpreted as a reflection of "mai pen rai" (Knutson, 1994). Related to this, Buddhist belief in karma promotes relationships based on the need to balance past life karma: who owes whom what and paying back (Ince, 2010). Also, as discussed in the earlier section on emotional support, the quote reflects Buddhist teachings in his mother's "metta"

(kindness), “karuna” (compassion), and “hen-jai” (see into the heart or understanding, sympathy and empathy) (Kitiyadisai, 2010, p. 24).

Reciprocal relationships are evident not only in parent-child dyads like the one just considered but also in interactions between healthcare staff and their clients. The following quote of a gay healthcare provider illustrates this:

> Are you free, nu? Can you take khun pii to the doctor? Khun pii will pay for the transportation fees. Then, we will find something to eat together … Later, he said, ‘That’s fine, Khun pii’, but I said, ‘No, you have to take it. Money cannot help Khun pii. This as a little thing can be shared with you. When pii has more, pii will not forget you, as well. Next time, when nu is sick, Khun pii will visit nu. (Preen, gay healthcare provider, infected 19 years)

In this recollection, Preen offered money to his patient to facilitate assistance. Money was paid in return for help, but money was not regarded as the most important material thing by Preen. According to Clark and Mills (1979), being in a communal or close relationship often motivates people to be prosocial, and intimate relationships are expressed by caregiving and helpfulness.

The personal pronouns used in the reported conversation show an interesting contextualization of instrumental support. The pronouns convey connectedness, intimacy, and respect among the people involved. The second-person personal reference “nu” is similar in meaning to “my little girl” in English, and thus shows kindness to someone younger (Jiapong, 2011). This pronoun is used more often by kathoeys or feminine gays (Saisuwan, 2016). Furthermore, the kinship term “pii” refers to ‘elder brother/sister’, while “khun” is a polite and very common word meaning 'you', which is equivalent to the address ‘Mr.’, ‘Mrs’, ‘Ms.’, or ‘Miss’ (Andrews & Siengthai, 2009, p. 75). In this context, ‘khun pii’ represented the elder gay healthcare provider addressing the younger one, his patient, in a polite way. As such, this language might even enhance the intimacy and trust between the two

parties. The speaker's personal pronouns "nu" and "pii," refer not merely to another person but to the relationship between the speaker and hearer as "my little girl" and "elder brother/sister". Similarly, using the polite form "khun" reflects relational concern and connectedness. In these various ways, the use of personal pronouns builds an important context for instrumental support; it is not merely the provision of necessity or an exchange relationship. Rather, the instrumental support is a reflection of bonds of interdependence, closeness, intimacy, and caring.

Prosocial instrumental support is also shown in relation to other basic necessities, such as food and accommodation. In the following, an infected participant also recalled his mother's care:

> When my mother knew that I was infected with HIV, she told me that she was not sure if she was happy or sad. My mother preferred me to do nothing. She said I did not need to farm or cook, but just help my nephew do his homework and play with him. Then I agreed with what she said. (Phod, gay healthcare provider, infected 17 years)

According to the quote, the participant's mother offered to do not only the household chores but also outdoor tasks when she knew about her son's infection. The mother cared about her son's well-being so much that she did not want him to feel stressed by and exhausted from farm work, and this contrasts with more traditional parenting in collectivistic cultures, including the Thai culture, where parents assume that their male children are hardworking (Fongkaew, 2002). However, the mother's help, in this case, might also be considered inconsistent with the concept of the Buddhist filial piety which emphasizes the reciprocal relationship between parents and children.

Assistance in accommodation is also evident in the formal network support. In the following interview excerpt, the healthcare provider discusses a recently infected patient dealing with an allergic reaction to treatment and who feared that his

neighbors disliked and were gossiping about his illness. The patient was staying with his boyfriend in a rented house when Phod, the healthcare provider, offered him a place to stay:

> You could come to stay with me for as long as you can until your condition improves and you feel better. Then, the patient said that he preferred to do so since he was not ready to meet anybody yet. During his stay, when I was out to work, I asked the housekeeper to take food and drink to him. However, when we were together, I did not talk to him about his condition but instead made more general topics of conversation, for example clothes, foods, or even gorgeous men, to make him feel at home. He also joked with me and we later became close to each other. In this way, we treated each other like Pii and nong. I want to make him feel that we can talk about everything with each other. (Phod, gay healthcare provider, infected 17 years)

As can be noted, Phod offered not only instrumental support in the form of a new place to live but he offered emotional support by raising more general topics of conversations instead of HIV/AIDS; Phod wanted his patient to feel at ease as much as possible to release him from the stresses of his physical reaction to the treatment and the stresses caused by hostile neighbors. The latter were prompted by the patient's appearance, caused by the side effects of treatment. These signs of physical illness commonly evoke fear of infection and exclusion by wider society (Chan, Stoové, & Reidpath, 2008). As can be seen, related to the Thai shame culture, this exclusion occurred due to gossiping, which was like pressure put on Phod's patient. As discussed in informational support, this gossiping incident, which is a kind of implicit verbal attack prevalent in the Thai high context culture, drove his patient out of the community. Furthermore, this again reflects the face loss of Phod's patient in this interdependent relationship with other community members in this Thai shame culture. Nevertheless, this reciprocal treatment like "pii" and "nong" - big brother/sister and little brother/sister - here in this interaction between the gay healthcare provider and his patient can create the sense of cooperativeness, trust, and a friendly environment for communication. In this way, it releases any tensions and

concerns of losing face during conversation (Burapharat, 2009, p. 666). Moreover, this aspect of interconnectedness is also important for the interpersonal relationships of those living with HIV/AIDS and their partners.

4.4.2 Aid to Improve Interpersonal Relationships Complicated by Infection

HIV/AIDS can be a very challenging illness; its effects reach every corner of one's individual life as well as every corner of society. In this context, assistance in relational maintenance is a particularly significant form of instrumental support. This kind of communicative work aims to promote goodwill between parties.

Fundamentally, the romantic relationship is also important between serodiscordant Thai MSM couples or mixed status couples. There is a useful system for MSM living with the illness when an HIV positive person would like to help his HIV negative partner keep their relationship going. In this support group, a recently infected partner and his non-infected partner had been given information on the project named "Opposites Attract," held by the Thai Red Cross.

> Pla: I am not sure whether my sero-negative boyfriend and I can stay together. I still fear that my partner will be infected with the disease from me whenever we have sex. Despite using a condom, we are still worried about sexual safety. (Infected 1 month)
>
> Lim: This is another big question in staying together. Do you still often have sexual activity together? (Male healthcare provider, non-infected)
>
> Pla: Much less often these days.
>
> Mie: Actually, there is a project called the "Opposites Attract" project run by HIV/NAT. Often, when the patients come, they need to have their blood tested again to make sure which one is positive or negative. Then, the one with the positive blood status has to take anti-viral medicine and his partner with the negative status could take PreP that can prevent anti-viral germs. In this case, the participants can use their social insurance or gold card insurance or own money to receive medicine. The main purpose of this project is that by taking medicine more quickly the result is lower levels of virus. I am also helping to be a volunteer who is seeking to recruit several HIV/AIDS infected patients with seronegative partners into this program. I can give you my phone number so that you can talk to me about the project later or if you have any questions,

> you can ask me before deciding to participate in this program. If both of you are ready now, I can take you to HIV/NAT as the research center under the supervision of the Thai Red Cross. It is still open now. (Gay healthcare provider, infected 15 years)

In this exchange, a volunteer with a 15-year infection not only shared information about a project that supports the co-habitation of those living with differing infection status but actively sought to facilitate a fellow group member's participation in the program. Interventions like the project of "Opposites Attract" help clients reinterpret and reconstruct the meaning of HIV-related issues, to establish new roles and connections within the partner relationship, to improve ways of communication, and to advocate safe sex with risk-management or risk reduction practices. Thus, in trying to enroll Pla in this project, Mie aimed to protect Pla's relationship with his lover. As can be noted, this serodiscordant relationship entails acceptance and non-judgmental attitudes toward each other's blood status; this positive and empathetic view is, thus, a strong contrast to negative, distorted messages about HIV/AIDS prevailing in Thai society.

Furthermore, medicine for staving off illness despite unprotected sex is recommended. Antiretroviral (ARV) drugs are used to suppress the HIV virus and stop the progression of HIV disease (WHO, 2016), while PrEP ("Pre-Exposure Prophylaxis") is used to prevent HIV negative people from becoming infected (AIDS.gov, 2016). A key element in serodiscordant couples' prevention strategy is the use of antiviral agents as either pre-exposure prophylaxis or in the form of treatment as prevention (Muessig & Cohen, 2014). However, to participate in the program, Mie said, it is necessary to have blood tests at the research center to confirm that a couple actually has discordant infection status. Moreover, because MSM and transgender individuals are the largest number of HIV infections in Thailand,

treatment in this specific population is needed (Amfar, 2015). For this reason, this population does not have to take any risks by waiting for their "level of CD4 to drop to or below 200"; this is a change from past practice, when CD4 cell counts were mainly used to guide decisions on when to start HIV treatment (AIDSINFO, 2016).

In addition, regarding payment for medicine, Mie recommends using the gold card (if Pla is unemployed) or social insurance (if Pla is employed). According to Kirdruang (2010), "the universal healthcare coverage scheme" (UCS) or the gold card policy in Thailand covers people who are self-employed, unemployed, disabled, children, and the elderly (p. 2). This gold card together with 30 baht (approximately US$0.92 or €0.68) has to be presented together with the patient's national identification card every time (s)he accesses health services (Coronini-Cronberg, Laohasiriwong, & Gericke, 2007).

Although several generations of policy makers from the Ministry of Public Health (MoPH) have tried to expand coverage, no government had been willing to foot the bill for major reform. A previous government headed by the Thai Rak Thai (TRT) Party offered a populist program that included low-cost health care; so far this has allowed change and promoted more equality of healthcare welfare for more disadvantaged people in Thailand (Hughes & Leethongdee, 2007). The disadvantaged groups include some of those living with HIV/AIDS. Nevertheless, this thirty-baht healthcare scheme has been underfunded; as such, the benefits of this healthcare system may not yet have been fully realized (Thoresen & Fielding, 2011). This could, to some extent, undermine the equality of healthcare access.

Another way to strengthen interpersonal relationships is the buddy system designed for those of the same infection status. In the following excerpt, Pui, a support group member living with HIV/AIDS for 5 years, wanted to help Kla, a group

member infected for just one week, when it became clear that Kla was extremely depressed and needed a friend for comfort:

> Pui: I could refer you to someone or a friend living with this disease like you from my own group. I believe he is willing to make friends with you because it is very hard to have such a gay friend with HIV/AIDS. You see, there are still many like you. Do you want to get to know him? (Gay healthcare provider, infected 5 years)
>
> Kla: Yeah. Could do. (Infected 1 week)
>
> Pui: But you have to be willing to meet up with him. You cannot feel depressed like this because he may not be ok if he also wants to seek friends like you to cope with this stress. So, are you ready to meet him? I will introduce you to this person first and many others in my own group afterwards.
>
> Kla: (silent, contemplating for around one minute) Yes. It is very interesting. I think I am ready for this because I want to know another person whom I can talk to and feel very comfortable with.

Being so recently diagnosed, Kla was not only in a state of depression and uncertainty, but he had not yet developed a circle of friends living with HIV/AIDS. He needed another person with experience with infection, including more friends living with HIV/AIDS, to build supportive relationships with this community. Similarly, Thai PLWHA may achieve a high level of collectivist social peer support through a buddy system based on Buddhism. This can be explained by one of the main Buddhist notions regarding sharing in times of distress as involving "suk-lae-duk" (happiness and sorrow) and "ruam-duk-ruam-suk" (sharing-suffering), as discussed earlier (Kitiyadisai, 2005, p. 19). This is also reinforced by the belief in karma, which determines the mutual encounter of these individuals destined to be in this same kind of situation. This is karmic relationship or "reunion karma" of people who previously were separated by circumstances beyond their control and later decided to come back again and finish the incomplete life together in another time and space (Edwards, 2011, p. 63). Belief in reunion karma can make buddies relate

with each other, which will, in turn, foster the development of a reciprocal bond. This feature of this reciprocal bond based on reunion karma can also be associated with the Thai kinship system. According to Vongvipanond (1994), the term “yaat” (or ‘relatives’ in English) is a word Thais use to refer to anybody who is, either closely or remotely, related to them by blood, by marriage, or just by association (p. 2). Even visitors could be given “yaat” status if they want to be assimilated into the group. Moreover, “yaat” status emphasizes a more intimate relationship than the friendship status. This is consistent with Gamble and Gamble (2014), who explained that cultures with collectivistic values refer to friends with labels typically reserved for family in individualistic cultures: i.e., brother, sister, or cousin. These labels name long-lasting rather than transient relationships. Also, this reflects the value of horizontal collectivism, which involves equality and cooperativeness (Parks, 2015). Due to this familial significance, an individual can regard the other person as someone more than just a friend after both have established greater intimacy and familiarity with each other.

Pui’s admonition of Kla to avoid a show of depression when meeting a potential new buddy might reflect the self-stigma or internalized stigma that each of them already have. Whatever the motive, the advice was clearly intended to foster the relationship Pui helped to create through his introduction. In other words, Pui was not merely giving informational support; he was actively trying to shape Kla’s behavior to improve the chances that his relationship building will work out well. In addition, the silent moment before Kla’s response indicates that, due to being in the early stages of infection, he was pondering the issue, probably unsure as to whether he was ready to meet another person with whom he was not acquainted. Nevertheless, at last,

he accepted the invitation to join this buddy system, which could minimize his loneliness and increase his will to live.

As can be seen, the loneliness and distress of infected participants could be reduced when they have an opportunity to meet and communicate with one another privately. In addition, it could even be better if they become fully involved in activities within their own private and safe spaces in order to feel free to be themselves.

4.4.3 Creating and Sharing Information in and about Safe, Private Spaces

Thai MSM living with HIV/AIDS also supported one another by sharing information in and about safe spaces. This became evident in the safety of a support group session held by Organization B:

> Preen: Let me ask you which gay sauna is the best one now? (Moderator and gay healthcare provider, infected 19 years)
>
> Som: Ramkamhaeng or Ratchada … R3? After the Fortune shopping mall – you have been there before (lengthening sound with mid-low tone) (Infected 13 years)
>
> Kong: Yeah, right behind the old Yaohan. Now it is Tesco Lotus. (Infected 18 years)
>
> Preen: (jokingly) Be careful of syphi … *na ka* (lengthening sound with mid-low tone)
>
> Pong: Nah. It has to be said that those with big breasts and long hair are forbidden … (Infected 19 years)

To begin, this interaction nicely illustrates the relaxed information sharing on saunas that is possible in the safety of the support group. The participants, who have been long infected with HIV/AIDS, are evidently not depressed; rather, they readily engaged in a causal conversation, joking about “those with big breasts and long hair” being excluded from a sauna, and comically or satirically warning one another to “Be careful of Syhi” (syphilis). In addition, the polite particle “na ka”, is typically used for

females, but was used here by the feminine infected gays in the support group. Again, this casual conversation and information sharing was possible in this very private setting where gay support group members felt comfortable and secure to express themselves freely. Also, communicating with use of vowel duration and gay accent as discussed earlier in emotional support could foster this closeness among them very well. Due to this information given, they would know more about which saunas they should go to for fun and relaxation among their own group without fear or embarrassment.

The sauna can be understood as a gay "ghetto", a term that has been variously defined by sociologists (Levine, 1979, p. 183). Wirth (1928) asserted that a ghetto is an urban neighborhood where people have their own distinctive culture and live separate from the established mainstream society, and whose inhabitants are often characterized as morally deviant (e.g., prostitutes, criminals). However, Levine (1979) offered a definition that nicely illuminates the current context: a "gay ghetto" or gay institution refers to "a conspicuous and locally gay sub-culture that is socially isolated from the larger community, and a residential population that is substantially gay" (p. 185). In other words, these are the places where gay people gather and feel that they belong. As for ghettos in Thailand, the male sex industry is extensive in the main cities, including Bangkok, with a variety of sites for male commercial sex encounters (McCamish, Storer, & Carl, 2000). These include the male go-go bars, the saunas and gyms offering massage services, karaoke bars, male escort services, and clubs that offer a range of services, one of which may be commercial sex encounters (McCamish, Storer, & Carl, 2000).

As can be noticed, the discussion of this topic was fully accepted in the support group setting, whereas discussion of homosexuality and sexuality are

considered inappropriate among the general Thai public. This is often expressed in Thai words characterizing gays as “one-track mind”, “lewd”, “sex-obsessed”, “sex-crazed”, or “nympho” (Taywaditep, Coleman, Dumronggittigule, 2004, p. 1030). In Thai culture, one’s sexuality or gender must not be seen to openly go against the accepted norms and should not bring shame to one’s self and one’s family (although contemporary Thai society appears to be more accepting of homosexuality, UNDP, 2014). In short, the kind of sexual conversation illustrated in the safety of the private support group normalizes gay sociality. In this sense, it is not only implicitly informative but also explicitly instrumental in that it models the sort of freedom and ease that is possible in safe spaces.

Similarly, in another support group session held by Organization A, several support group members shared information on safe, relaxing places and outdoor recreational activities that a particular group of gay people living with HIV/AIDS could participate in:

> PA: There will be a trip to Hua Hin at the weekend, from Saturday 10th till Sunday 11th October. Anyone interested in joining this trip can write down your name. We have limited spaces – only 20 persons. The whole trip costs 1,100 baht, which includes food and accommodation. (Infected 8 years)
>
> Kai: What is this trip about? (Infected 11 years)
>
> PA: It is mainly about free activities for our group, like the sea. This can be an opportunity to relax or have outdoor meetings that allow us to socialize and communicate with one another on topics like our lifestyle and medicine or even other issues. This is a good time for us to make new friends living like us with HIV/AIDS.

As PA suggested, retreats for people living with HIV/AIDS can help them create new bonds and promote intimacy. Also, such excursions could make people whose illness feels life-limiting, to be able to feel more normal and life-embracing. The interaction might also reflect the concept of a gay ghetto, where gays living with

HIV/AIDS gather and interact with each other comfortably within their own group. This kind of isolated, private place away from outsiders' disapproval encourages them to socialize with others like them. There would also be open information sharing about gay lifestyle and medical habits among people living with HIV/AIDS, and fun activities, like ice-breaking activities to foster connections. This high level of social integration implies active engagement in various social relations (social networking) and social activities, and a sense of belonging and identification with one's social roles (Brissette, Cohen, & Seeman, 2000). These PLWHAs can feel a sense of their community as the key feature is that the participants in this kind of activity were only infected homosexuals.

This restriction of gender inclusion is also related to those communities in both collectivistic and individualistic societies of in-group and out-group members regarding different sexual orientations. Triandis (1994) claims that, while in-groups tend to be ascribed (e.g., kin, religion, village, and nation) and defined through tradition in collectivistic cultures, they tend to be achieved (through similar beliefs, attitudes, values, and occupations) in individualistic cultures. Nevertheless, these in-group/ out-group attitudes, beliefs or values associated with sexuality are also prevalent in collectivistic cultures as in the Thai society, where there is a difference in the sense of belonging between homosexual and heterosexual communities. In other words, as discussed earlier in the theme of informational and emotional support in dealing with other people's ignorance, sexual and gender minorities are not completely accepted by the Thai heterosexual population, and this is consistent with what Morris (1994) stated regarding the tolerance of sexuality and gender in Thailand, as was mentioned above. Because of the existing prejudice against homosexuals by heterosexuals in Thailand, gay and lesbian individuals tend to turn

towards the gay community and build alternative spaces that allow them to express themselves despite their difference from the homophobic majority culture. Thus, collectively, they foster a positive sense of being gay because they have established their own separate community (Cass, 1979; Minton & McDonald, 1984). This negative attitude toward Thai homosexuals can be explained in terms of the Buddhist belief that a person is born homosexual because of a karmic consequence for committing adultery in their past lives, thereby violating precepts on sexual misconduct (Pipat, 2007). Also, Thai patriarchal society determines the cultural norm of practice for Thai men as discussed earlier in the theme of informational and emotional support in dealing with other people's ignorance (Choomgrant, 2009). Further, Thai society considers that homosexuality is, as antithetical to Buddhist ideas of self-control, a willful violation of natural heterosexual conduct, arising from a lack of ethical control over sexual impulses (Yip & Smith, 2010).

As can be seen, the gay groups in the support group and in the retreat were trying to protect the information flow within their private sphere and did not allow people of other sex/sexual orientation be involved in their activities. This kind of information flow is also evident in another kind of social gathering for gay people living with HIV/AIDS in the formal network. In the following quote, Aun, a gay healthcare provider, talked about social gathering events:

> Our patients are informed of events called "family days" at Organization A here several HIV/AIDS activities are held in accordance with important events of that time, such as Mother's Day, Thai New Year's Day, etc. For example, on Mother's Day, with the theme of love, patients are told to imagine, 'Supposing they were mothers, would they be able to take care of someone as well as their mothers'? As for Thai New Year's Day, there is a traditional ceremony of paying respect to the director and senior staff of Organization A. It is a good time for the young and senior staff to express good wishes to one another. Moreover, they can play games, share HIV/AIDS experiences; this is a good opportunity for the new or old patients and the healthcare staff to meet and know each other. On this family day, the staff and the patients

> were like siblings ‘pii’ and ‘nong’ in the same family. (Aun, gay healthcare provider, infected 20 years)

At Organization A, family day is normally organized to celebrate and help those living with HIV/AIDS recall important moments. This day, which takes place on the last Saturday of every other month, preserves the knowledge of Thai culture. In addition, the private space of Organization A’s activities allows people who would otherwise have difficulty both being themselves and participating in important cultural events. As such, this gay community is seen as safe and secure for those infected with HIV/AIDS for family day parties.

In terms of culture, Leake and Black (2005) reported that collectivist societies value performing activities that are traditionally sustained over generations, instead of changing the system. Further, there may be a focus on spiritual rather than material advancement. Thus, people living with HIV/AIDS in this collectivistic society organize group activities that focus on social bonding based on the Thai family system throughout the year and hold the event every year. In these activities, new patients meet old patients, all of whom relate to one another like their own family members. Therefore, the previous discussion of the Thai kinship system is also relevant here. Besides horizontal collectivism in Thai culture, vertical collectivism also plays a crucial role, as typically in the Thai familial system, age or seniority determines the choice of kinship term (Vongvipanond, 1994). Also, the feeling of ‘pii’ and ‘nong’ (brotherhood and sisterhood) here is important to create harmonious relationship and make each other feel part of an intimate, collective group (Bhuraphat, 2009, p. 666).

As can be seen from the quote about Organization A’s activities above, the words “pii” and “nong” are used by the staff and patients on the family day. In this

respect, as a genderless language, the former is used to show respect for a person who has greater experience and knowledge and would often be older than the person talking, when referred to as “pii”; the reverse is true for the latter (Burapharat, 2009, p. 666). As discussed earlier, these fraternal pronouns, “pii” and “nong”, demonstrate closeness among the group members who regard and treat one another like siblings to foster open communication. Therefore, these Thai personal pronouns feature supportive familial style in relationships

In addition to emotional, informational, and instrumental support, one last major form of social support is appraisal support, which focuses more on cognitive process, and particularly on positive reappraisal.

4.5 Support for Positive Reappraisal

According to Lazarus and Folkman (1984), events are appraised for any threat or challenge, as well as their controllability. Appraisals can be adaptive or maladaptive depending on their appropriateness to circumstances. Because HIV/AIDS is such a difficult condition both physically and psychologically, negative appraisals are common and not always helpful. For this reason, a very important form of support for those dealing with infection is that which helps them to shift from (maladaptive) negative appraisal to more adaptive positive assessment. Often this takes the form of helping someone to reevaluate the resources at their disposal (Schmidt, Tinti, Levine, & Testa, 2010). According to appraisal theory, unlike the sort of rapid firing of emotional response to a threatening circumstance, reasoning is a slower, more deliberate, and thorough process that involves logical, critical thinking about the stimulus and/or situation (Marsella & Gratch 2009). In this “two-process model” of appraisal theory, associative processing and reasoning both work in

reaction to perceptual stimuli, thus providing a more complex and cognitively based appraisal of the emotional encounter (Smith & Kirby, 2000). My analyses of the corpus of interview data and notes from field observations yielded three themes within this tenet of "support for positive reappraisal": (a) Using familial love and duty to motivate reappraisal of self-care, (b) Reappraising the self to achieve acceptance of homosexuality and HIV/AIDS infection, and (c) Using spiritual beliefs to reframe and achieve positive reappraisal.

4.5.1 Using Familial Love and Duty to Motivate Reappraisal of Self-Care

Many Thais affected by HIV/AIDS consider their parents to be the most significant and influential persons in their lives. This parental issue was raised in the support group session on anti-viral medicine consumption. Even though some claim that current anti-viral medicine is more accessible and easier to take because of a new, simpler medication regimen, there is still discomfort concerning medicinal consumption which was discussed among a gay healthcare provider and other MSM living with HIV/AIDS.

> Esse: I am sick of taking medicine that must be taken on time regularly. Also, I experience drowsiness as the side-effects of the medicine. Admittedly, I sometimes try to avoid taking it. (Infected 4 years)
>
> Thee: But you know, it is much easier to obtain anti-viral medicine nowadays compared to 10 years ago or so when I had to pay for the medicine by myself. That was so expensive. (Infected 13 years)
>
> Tik: As for me, at that time when I was not familiar with taking many antiviral medicine each day ,I felt discouraged. My doctor asked me one question – if I still have a mother? "If so, would you be tolerant in taking the medicine for her?" Then, she asked if I had ever thought of living alone or with my family. After all, what I want to say here is that if you still have a family, don't you want to make yourself stronger and healthier in order to make them become happy? It is also more convenient for you now to take fewer medicines compared to me in the past. (infected 20 years)
>
> Mie: I heard from one of my patients that when he made himself a burden for his parents who would, in turn, also suffer from this irresponsible deed, it

> could be, according to Buddhist belief, a great sin that would send him to hell rather than heaven. As such, he had to take anti-HIV medicine so that he could become healthy as soon as possible. (Gay healthcare provider, infected 15 years)
>
> Esse: I see. I also want to make my parents as happy as I can (speaking with low volume and pitch)

In the preceding interaction at Organization B, Esse complained that side-effects of medicine made them feel unwell. In response, Thee compared today's low-priced medicine to that of the past, which was regarded as being extremely precious. In this way, he wanted Esse to know about the importance of today's medicine and that it is more easily obtained. Then, another participant, Tik, talked about his situation in which previously he had to take a greater amount of medicine with their combined side-effects. He further added that at that time the doctor had mentioned the mother and the family in order to remind him of these close relationships. Similarly, Mie mentioned his patient as having this difficulty taking medicine and refers to being "a burden for his parents". This relates to "baap" or 'sin' in English, while the other extreme is "boon" or 'merit'. Culturally and traditionally, Thai children view parents like Buddhist saints because parents have only pure and unconditional love for their children and do not want anything in return (“สาธุ..พระอรหันต์อยู่ในบ้าน"คำเทศน์สมเด็จโตฯที่ทำเอาร.๔”, 2559). Therefore, children should not offend or sadden their parents but respect and pay them back with gratitude. Viewed in this light, committing misdeeds that might harm parents is like harming the Buddhist saints, which is considered sinful.

Esse's discouragement was gradually lessened as he was questioned this way, particularly regarding not only the medicine consumption but also the parental issue posed by Tik and Mie. Due to this issue being centered on the parents, Earth's final answer was his wish for his mother's happiness, so he had to take the medicine.

Nevertheless, his lowering pitch and volume indicates that he would attempt to do this, even though he was still depressed. This determination can mainly be related to the concept of "katanyu katawethi" and filial piety, as discussed earlier. Clearly, this filial piety involves caring for aging parents and satisfying parents' wishes and dreams even after their deaths (Yeh & Bedford, 2004). Concern for parents' happiness is also consistent with "horizontal collectivism," which focuses on in-group cohesion, empathy, and reciprocity co-occurring with "vertical collectivism" regarding deference to elders (Ter Lakk, Gokhale, & Desai, 2013, p. 424).

Living with HIV/AIDS can be more complicated when comorbidities are present, like thalassemia. This can make a recently infected individual feel discouraged since this disease even weakens his physical condition. Thus, in order to boost the patient's morale, Thim, as a healthcare provider, needed to raise not only the parental issue but also that of his life with HIV/AIDS that he had been living for around 7 years as a role model:

> Around that time when I first worked at the POZ Home Foundation, I received a call from an HIV/AIDS-infected patient's boyfriend who told me that there was something wrong with his lover. When I went there to see the patient, who was living with thalassemia and HIV/AIDS, he said that he wanted to have his normal life back, since he had parents to look after. I then said to him to recall his parents' benevolence and ask himself what he wanted to do for them. As for me, I don't have that opportunity because my parents passed away. Therefore, if he could revive the rest of his life, he could repay his gratitude to his parents. Also, I had been through this difficult time just like him. I did not want him to be afraid, as every problem has its own solution. Furthermore, I told him that I had been taking medicine for many years and now I had recovered. Anyway, it depended on how we take care of our health. He then stared at me for a while and said when his condition became better and better, he also would like to help others who are infected like he is. Finally, I held his hands and told him not to give up on his life, and if there is any chance, I will come back to see him in the future. (Thim, gay healthcare provider, infected 7 years)

The preceding interview excerpt illustrates that another way of encouraging someone infected and suffering to take medicine when they might otherwise not want

to is to characterize self-care as an opportunity to repay gratitude to one's parents; to underscore this idea, Thim reminded him to consider "his parents' benevolence". Thim also heightened the urgency of showing this gratitude or katanyu katawethi by noting that the patient, unlike Thim, still had a mother to take care of.

Also, sharing the experience further motivated the patient to keep on living and take care of himself until he became healthy like his healthcare provider. Besides, with higher morale, the patient considered being able to further help others in a similar situation in order to minimize their depression and boost their morale – just like what he was experiencing at that moment. This indicates that the actual situation is not as hopeless as the patient might have imagined. Further, both nonverbal and verbal communication are used to assure the patient that he would not be left alone; rather, the healthcare provider would always be his friend and look after him from then on. This is when the staff said, "I held his hands and told him not to give up on his life, and if there is any chance, I will come back to see him in the future".

The following interview excerpt interweaves the sense of debt to parents with the desire to take care of one's family as motivators for positive reappraisal. Again, self-care becomes much more important for discouraged patients when reminded of this familial responsibility, so this is thus an important form of appraisal support. This was suggested by a gay healthcare provider:

> I will ask patients with very low morale if they are ready to keep on fighting or giving up. For example, I told a patient infected for one year that, as the breadwinner of the family, to keep on living. I asked, "You know why your parents try very hard to educationally support you so that you would have not only a good career but also decent income". So that he could take care of his own family, I had to keep telling him about this. He then replied to me that he would try his best to keep living by paying attention to his work. (Aoo, gay healthcare provider, infected 10 years)

The healthcare staff's emphasis on "the breadwinner", as discussed earlier in

informational support, is particularly important for infected MSM because of the crucial role of men in Thai society. The traditional belief that men are the dominant class in society is strongly persistent. The male worker is stereotypically regarded in their workplace as tougher and stronger compared to the female worker (Herrick, 1999). This is also consistent with Hofstede's (2001) analysis of the masculinity dimension of culture, which advocates male assertiveness, toughness, and material success. This notion of being the breadwinner in Thai society relates to a well-known Thai proverb: "Elephant front legs-hind legs". According to this proverb, elephants walk by first moving their front legs, which are thought to represent men as the leaders, while the hind legs, representing women, then follow (Jermsittiparsert, 2016, p. 20). Although Thai women are playing ever more crucial roles in most types of economic activity in modern Thai society (Kongsompong, 2008; Praparpun, 2009), the traditional notion of the male breadwinner is still a trope that Thim called on to support his patient's positive reappraisal of self-care. Also, from the quote, the participant's parents may or may not know of their son's homosexuality. However, they still expect him to fulfill the masculine breadwinning role. This is suggested by the patient seeming to agree with what the healthcare provider had said about the normative Thai gender role.

In addition, the staff reminding his patient of the parents relates to parent-child relationship. For this moral virtue, older adults are viewed positively and respected (e.g., a source of wisdom and magical power), and offer various types of resources to people in the younger generations, while young people, in return, are attentive to their elders and provide care and support when needed (McCann, Giles, & Ota, 2017). As can be noted from the quote, the staff said to his client, "your parents try very hard to educationally support you. So that you would have not only a good career but also

decent income". In addition, the staff reminded him that in order to repay his parents, it is necessary for him not to give up on his work. After all, this again involves filial piety associated with reciprocity between parents and children based on Theravada Buddhism.

Duty or responsibility to one's family, and particularly one's parents is also mobilized in the most dire cases of negative appraisal: when supporting a suicidal client. When clients lose hope, reminding them of their parents can be a powerful motivator to counter the hopelessness and shift the appraisal of self-care enough to stave off suicide. In the following interview excerpt, a healthcare provider used this trope to support a recently infected suicidal client:

> Regarding the monk's suicidal attempts, I asked him, "if you do not want to live in this world any more or lose your life, who do you think will be the first person to be sad?" Then, he replied that he did not want to sadden his parents. In this way, I will select more positive terms or the euphemism "sia chee wit" rather than the word "tai". For example, I said, "Most people end their life with opportunistic diseases, not AIDS". Then, I further asked, "Have you ever had these opportunistic diseases? And did you recover from them? (If yes, there is nothing to worry about. All along this process, I selected more positive terms or "sia chee wit" rather than "tai" in order not to make him feel offended. (Chain, gay healthcare provider, infected 20 years)

In this particular instance, a monk preoccupied with committing suicide was reminded of his loved ones. What makes this particularly interesting is that Buddhist monks are supposed to let go of depression and worldly matters, but this monk was attached to a vicious cycle, just like a layperson. To help the monk see an alternative to whatever frame of reference was leading him to suicidal thinking, the staff raised questions about the effects of suicidal attempts on the suffering of loved ones. This reminded the monk of his interdependent relationships, which ought to be evident to someone steeped in the Buddhist principle of karma. However, perhaps because he was raising such a challenging frame in the context of a life-or-death crisis, the

speaker was careful to avoid creating more distress or adding insult to injury, and so thinks that the "euphemism" of death, that is "sia chee wit", was preferable to the word "tai", both of which mean die in English. In addition, before he asked about the opportunistic diseases his care receiver had experienced, he asserted the fact that dying is a result of opportunistic diseases rather than HIV/AIDS itself by using rhetorical questions to help his care receiver realize the fact of HIV/AIDS disease (e.g., "Have you ever had these opportunistic diseases? And did you recover from them?). According to Holder (2008), euphemism is a polite term used to replace an inappropriate or rude expression. In a similar vein, Hornby (2005) defines euphemisms as words or expressions that refer indirectly to some unsuitable or unpleasant issue in order to make it seem more acceptable. In this way, the term "sia chee wit, literally translates as 'lose one's life', sounds more formal and less direct than "tai", which means 'to die'. Evidently, the support provider used euphemism to avoid further inflaming an already distraught client as he undertook the delicate task of nudging the client to a more positive appraisal of self-care.

Similarly, reminiscence of family members is also illustrated in the following interview excerpt. A care provider gently worked through these challenges by first suggesting self-love and then shifting to familial love when the first attempt at positive reframing appears to fail:

> I would offer some alternatives that, for example, are listed, ranging from number one to number five. In this way, I would not suggest only the number one. Otherwise, it would seem that I was guiding them in some way. Thus, it is better for them to have more choices before making final decisions. For example, when one of my clients was thinking about suicide, I asked who he loved most, he said his parents followed by his siblings and his boyfriend. I further questioned, "What about the last one?". He was thinking for a while. Then, I asked him, "What about yourself? Don't you love yourself?" After hearing my question, he replied to me that if he had loved himself, he might not have thought about committing suicide. Finally, I said, "It isn't about loving yourself or not but you just said that you loved those people and you

> were going to hurt yourself. How about them?" Then, he began to realize the consequences of committing suicide. (Aun, gay healthcare provider, infected 20 years)

As the quote above shows, the care receiver has the freedom to prioritize their life alternatives rather than being pressured to have "only the number one" choice. Different interpersonal relationships are raised and compared with one another; importantly, this again emphasizes the interconnectedness in the Thai collectivistic society. In this respect, the patient was prompted to consider the suicidal thoughts or attempt, which could affect those surrounding him, particularly family members. Therefore, the individual self is the most important factor that has greatest impact on familial support networks as the healthcare staff said, "it isn't about loving yourself or not but you just said that you loved those people and you were going to hurt yourself. How about them?"

Moreover, in terms of self-acceptance, this pertains to the hopelessness and depression caused by low self-esteem. Similarly, this low self-esteem can become more complicated with participants who seemed to be concerned not only about his HIV/AIDS but also their homosexuality. Therefore, this complication of the two negative aspects makes these participants feel uncomfortable with the double stigma compared to heterosexuals.

4.5.2 Reappraising the Self to Achieve Acceptance of Homosexuality and HIV/AIDS Infection

Given the extent of prejudice, ignorance, and stigma associated with homosexuality and HIV/AIDS in Thai culture, another very important form of social support is helping infected MSM to construct more positive reappraisals of their sexuality and illness. Of course, the pervasiveness of these prejudices, their tendency to be introjected as self-hate in these men, makes such efforts quite challenging.

Infected participants can be overwhelmed by intense concerns about both their HIV/AIDS status and gay identity. In the following excerpt, a care provider talks with patients at Organization A who are feeling depressed about their infection and their sexuality, hoping to encourage a positive reappraisal, thereby also supporting them emotionally with his soft, gentle tone of voice:

> Not all MSM or gay people are infected with HIV/AIDS. However, society attributes the cause of the spread of HIV/AIDS to MSM's promiscuous behavior, but is my patient really promiscuous? No. Media encourages the association of gays with HIV/AIDS, and that every gay man must always have HIV/AIDS caused by carelessness and must absolutely be sentenced to death because of their promiscuity. Is that carelessness also true for my patient? No. And how do we know when HIV/AIDS will come to him. Also, it is not wrong for us to be MSM or to be part of this sexual group. In fact, human nature is to have sexual relationships, but this is different from us who are not heterosexual males or females. We are born to have sexual pleasure in order to fulfill our sexual identity and cannot choose our sexuality. One may have sex with the same man who others also used to have sex with. It is easy to find one after the other without strings attached. Therefore, in the happy moments, we cannot restrain ourselves from enjoying sex and we thus have to accept whatever will come to us. As such, this is not our mistake at all. Finally, my patient nodded and seemed to understand what I told them, and a day later, I called to ask about their condition. Most of them said that they felt much better than the previous day and thanked me. (Mod, gay healthcare provider, infected 18 years)

In this instance, the staff wants to say that HIV/AIDS is not always caused by gay sexual promiscuity and followed by death. All of these misconceptions come from the media, and his patient as an individual gay person is not necessarily like that. It appears that the patient's partner or boyfriend might have transmitted this disease to him instead of his sexual promiscuity. Moreover, both heterosexuality and homosexuality are both normalized in terms of sexual pleasure and restraint. Even though the public negatively views MSM as promiscuous in general, his patient does not need to care about them as the true nature of MSM differs from that of heterosexual people. It seems that the staff tries to explain that we as MSM should understand ourselves better than any others of other sexual orientations. At this point,

the staff wants to explain that there is a biological reason for sexual carelessness by referring to having “sexual pleasure in order to fulfill our sexual identity”. Therefore, the MSM community is not disgusting, and being part of the MSM community or being associated with other MSM should not be regarded as ignoble or unacceptable. The staff tried to help the patient better understand what MSM are typically like, thereby lessening confusion over being part of MSM peer networks.

In the preceding excerpt, Mod used rhetorical questions in several cases, aiming to elicit self-affirming responses, and using this soft, gentle voice can show not only concern and comfort but also relieve any fears or concerns for the patients (Cooper & Gosnell, 2014). It may be quite surprising that such encouragement of positive self-reappraisal is necessary in contemporary Thailand, but stigmatization of both homosexuality and HIV/AIDS has been occurring since the late 1980s, when a number of writers drew on Buddhist teachings to construct arguments against homosexuality, thus fostering widespread fear and angst in public discussions of the illness (Jackson, 2003). Also, as discussed earlier, this understanding of homosexuality is antithetical to Buddhist ideas of self-control over sexual desire. These stigmatized views of homosexuals correspond to Gagnon’s (2005) view, that homosexual behavior is characterized by higher rates of problems as regards sexually transmitted disease, depression and suicidality, high numbers of sex partners over the course of life, and short-term sexual unions. In a similar vein, Holland (2004) stated that many male homosexuals persist with promiscuity and other risky sexual practices in spite of good knowledge of the risks, suggesting that “intense sexual desires bordering on obsession-compulsion characterize a disproportionate number of male homosexuals, making many of them more-or-less oblivious to the risks” (p. 254).

Of course, encounters with other homosexual men cruising for sex in big cities can increase the incidence of HIV/AIDS and other STDs, particularly without condom usage because there are no concerns about pregnancy. On the other hand, the sexual opportunities of male heterosexuals are limited not necessarily by greater sexual self-responsibility but also by the availability of women who prioritize men with high status, power, and resources over physical attractiveness (Holland, 2004; Kenrick, 2010). However, this distorts the reality of gay men. Apart from their outward physical appearance, in terms of personality like that of heterosexual others, gay men also pay attention to the traits of their partners. In other words, this suggests that homosexual men also care about their partners' personality and socio-economic status.

Furthermore, stigmatization of sexuality and infection may not necessarily be perceived at the same time, as the former can occur before the latter. In other words, men may have been aware of their homosexuality and able to accept it before their HIV/AIDS infection. Becoming infected, with all the stigma attached to the illness, while still in the process of countering anti-homosexual prejudices in the struggle to form a positive self-image, or infection shortly thereafter, creates its own emotionally challenging dynamics. The following interview excerpt illustrates one healthcare provider's efforts to offer support in such circumstances:

> I have met patients who could accept their MSM status except for their HIV/AIDS condition. They realize that they are gay but it is difficult when they have just found out that they are infected. Most of them claim that they have not been having a lot of different sexual partners or sexual relationships. Probably, they were not sexually promiscuous, and their partners spread these HIV viruses to them. I remind them that what we fear now is being labeled. I give some examples of many other heterosexual men and women who also engage in sexual promiscuity. In this way, I just want them to think that, no matter what sex we are, we are not different. Moreover, I further draw an analogy between a prisoner and an HIV/AIDS infected individual to show that not everyone who goes to jail is devious. Similarly, not all of us infected with

> HIV/AIDS are sexually promiscuous. It is important that the issue of homosexuality be separated from that of being infected with HIV/AIDS. (Phod, gay healthcare provider, infected 17 years)

As the quote suggests, it is important that the issue of homosexuality be separated from that of being infected with HIV/AIDS. Related to the literature review in Chapter 2, early sex/gender socialization involves learning during childhood from friends or families that homosexuality deviates from the heterosexual norm. Later socialization into sex norms occurs through formal education, which, as we have already noted, has been historically prejudicial in Thailand. As Merton (1949) explained, part of the maintenance of societal norms involves identifying certain kinds of behaviors as deviant from the social norm. Over time, this process of socialization achieves a smooth and gradual conformity to and internalization of social values and expectation. Thus, this sexual socialization occurs long before HIV/AIDS infection. Because both homosexuality and HIV infection are stigmatized, individuals are susceptible to infection, and its stigma, while they are still in the process of forming positive appraisals of their counter-normative sexuality. To support self-acceptance of being gay, care provider Phod reminds his care receivers that homosexuals and heterosexuals have similar sex drives. One other interesting rhetorical move in Phod's support is the comparison between gay individuals living with HIV/AIDS and prisoners. Here, too, we see an effort to protect the patient's self-appraisal. Not all of those who have made a mistake (committed a crime, had unprotected sex resulting in infection) are maleficent.

Even if a person has managed to form a positive sense of self as a homosexual, the stigma of HIV can be challenging. In the following interview excerpt, the healthcare provider used something like the Socratic method to challenge the negative appraisals of a recently infected monk:

> When a monk was very worried about his HIV status, I used an open-ended question like, “How will anyone know you are infected with this disease if you don’t tell them?” Then, the monk added he had blisters on the skin, so I asked him if anyone could have these blisters. The monk told me that he feared that when he dies his condition would fully manifest itself and his relatives would know he had been infected with this disease and so he would finally be expelled from the monkhood. I responded that it was hard to say depending on how well he took care of his health, and I asked how the monk took care of his health. He said that so far he had not taken alcohol or junk food or smoked. Finally, I wrapped up by saying, “What you have done is right. You should turn this crisis into good opportunity for caring about your health. This is how I encouraged the monk to form his analytical thinking to move from the abstract and vague kind of thinking to concrete thinking”. (Chain, gay healthcare provider, infected 20 years)

As the quote illustrates, the monk feared his loved ones learning of his infection, offering one anxiety after another as he challenged Chain’s support. To counter negative appraisals based on such concerns, Chain persisted in his use of questions and clarifying statements designed to encourage the monk to reflect and to confirm a more hopeful outlook. Finally, Chain attempted to solidify his efforts with the comment, “What you have done is right”. In these ways, he attempted to counter the monk’s fear that others would learn that he had contracted this stigmatizing disease.

The monk’s fears and the importance of the support that might help him achieve more positive appraisals are more understandable in light of Buddhist precepts. Monastic rules forbid HIV/AIDS infection. As discussed earlier, the Theravada Buddhist canon states that those living with chronic diseases, including HIV/AIDS, are not allowed to be ordained, as they may not be able to fully practice the dharma and the Buddhist scriptures (Ratanakul, 2008). Even more basically, the Buddhist canon forbids sexual misconduct by the pious laity as well as by monks and nuns (Jackson, 1993). Moreover, most contemporary Thai Buddhist writers follow early Buddhist attitudes and describe sex as extremely distasteful, even for the laity.

One Thai writer on Theravada Buddhism, Isaramuni, “equates sexuality with raving or desire (“tanha” in Sanskrit or “khwam-yak” in Thai) and sexual lust (“raga” in Sanskrit or “kamnat” in Thai), which are antitheses of the Buddhist ideal of dispassionate equanimity” (Isaramuni, 1989, p. 4). This concept of “tanha” is one of the four Buddhist Noble Truths, the cause of suffering, which must be overcome conscientiously (Samovar, Porter, McDaniel, & Roy, 2013, p. 142). For these reasons, the infected monk would be associated with sexual misconduct. Having submitted to “tanha”, the monk flaunted the Noble Truths that should guide all monks. Countering these anxieties and the strongly negative appraisals they support was thus a difficult challenge for the would-be support-provider.

Chain, who aimed to help the monk to a more positive appraisal of his circumstances, also had to counter the monk’s worries about the stigmatization of homosexuality, not just his infection. Again, this is related to bad karma of homosexuality accumulated in past lives, so homosexuals are not considered for ordination. Moreover, the Buddha's ban on the ordination of “pandaka*”* (effeminate gays) reflects concern about the disruptive effect of effeminate transvestite homosexuals in an order of celibate, predominantly heterosexual monks (Jackson, 1993, para. 4). Nevertheless, this prohibition of homosexual people’s ordination could be inconsistent with the Buddhist cannon as anattā or non-self, the unique doctrine at the heart of Buddhism, denies an identity or lasting entity at the center of any being, including sexuality (Sirimanne, 2016). In addition, Dewaraja (1994) talks about this idea of inferior karma which has been used in patriarchal societies, including Thailand:

> However, it does not necessarily follow that social practice conforms to theory. The egalitarian ideals of Buddhism appear to have been impotent against the universal ideology of masculine superiority. The doctrine of

> Karma and Rebirth, one of the fundamental tenets of Buddhism, has been interpreted to prove the inherent superiority of the male. According to the law of Karma, one's actions in the past will determine one's position of wealth, power, talent and even sex in future births. (para. 17)

In the face of these reasons to feel bad about his gendered sexuality and worry about his ability to remain a monk, Chain, a gay healthcare provider, worked toward a more positive appraisal in this area by continuing to use queries and clarifying statements, turning the monk's behavior into an asset rather than a liability:

> I explained to him, "As I said, who would know you have HIV/AIDS if you do not allow others to know about this? In the same way, if you conduct yourself properly and do not display any inappropriate behavior, who would know?" Then, I further asked him to tell me what the Buddhist canons are. He then told me numbers one, two, three, four, five: the practice of dharma, modest behavior, meditation, and conscientiousness, respectively. He then told me that everything depends on his mind, and I said that was right. Finally, I asked, "If you act out femininely, will people lose faith in you?" He replied to me that he had never done that before. Finally, I said to him, "You see, you have behaved very well." In this way, his attitude toward his gay identity that was, at first, extremely negative, turned into something more positive. (Chain, gay healthcare provider, infected 20 years)

In response to the monk's anxieties about the stigma of homosexuality, Chain tried to make him think about himself reflectively with a series of questions, for example, related to the Buddhist cannons about behavior. At last, Chain suggests, the monk appeared to understand and knew he could return to his normal conduct in the monkhood.

One other very important aspect of Chain's efforts to change the monk's appraisal of his situation is rooted in the idea that monks are supposed to be "sam ruam", meaning moderate in expressions and conduct, based on the Buddhist precepts of equanimity ("uppekha") and appreciative gladness ("mudita") (Kittiyadisai, 2010, p. 25). According to these teachings, a person should not express excessive emotion, whether elation, grief, or anger, in order to avoid causing discomfort or embarrassment to others. In increasing the monk's positive self-appraisal, the support

was also designed to move the monk from fear and despair to a more moderate emotional outlook.

4.5.3 Using Spiritual Beliefs to Reframe and Achieve Positive Reappraisal

Providers of support for MSM living with HIV/AIDS often use religious or spiritual teachings to suggest cognitive reappraisals. It is believed that the fundamental function of religion is to help individuals to seek meaning and purpose in life. Clark, for instance, believed that "religion more than any other human function satisfies the need for meaning" (Clark, 1958, p. 419; also see Pargament, 1997). Therefore, this function of religion can thus be applied to readjust negative views or attitudes and turn them into more positive ones, as illustrated in the following quote from a person who lived alone with infection for nine years due to coming from a broken home:

> Once I was very worried about my HIV/AIDS condition, I decided to tell my godfather, who I also respect as a teacher, about the disease I was suffering from. He told me how to live harmoniously with nature and focus on the present, and I then asked him how I could do that. He said, according to Taoism, the past is unredeemable and should be ignored, whereas the future is uncertain. Therefore, we should do our best in the present and let the present consequences guide us to the future consequences. I was confounded by what he taught and asked him for clarification. He said that this was similar to rice growing, in that after putting the fertilizer into the soil, we wait for the produce. He also referenced Hinduism and Buddhism, that we shouldn't commit any acts of bad karma that make others suffer, and that good karma that helps people can make me feel a valuable part of society. This helped me stop brooding over the past, of my being infected with HIV/AIDS, which cannot be corrected. (Tom, infected 4 months)

As the quote implies, this recently diagnosed participant was able to recover from distress through religious lessons. He was taught about the uncertainty of life, especially that relating to the past and the future, and encouraged to live in the present.

Several religions view the present as most significant. Both Taoism and Theravada Buddhism value consciousness of the present moment over past and future possibilities (Hanrahan & Anderson, 2010). Hinduism also puts more emphasis on the present moment with rewards of faith and belief than the past or the future (Burns, 2012). As such, Buddhism and Hinduism share the concept of karma. Tom's godfather clarified this through an analogy between the prospect of "rice growing" and of present action. Thus, rice cultivation and harvest reflect life itself, and many Thai concepts or expressions mention rice (London, 2008). Analogies of giving birth are more generally useful in explaining the connection of present and future.

Using religion to reappraise and cope with a contemporary health problem is thus an illustration of the more general practice of adopting and adapting religion to the present time. This reflects Barnlund's (1989) observation that religions "did not homogenize the societies they enveloped. It was usually the other way around: societies insisted on adapting the religions to their own cultural traditions" (p. 192).

Buddhism is also suggested as a means of coping with depression from stigmatization in the following excerpt from MSM living with HIV/AIDS:

> Kik: Sometimes I feel very depressed. I am not sure if I will be able to deal with this. Will I die of this disease? Sometimes, I want to leave this world as soon as I can. (Infected 2 years)
>
> Aoo: (smiling and looking worried) You know committing suicide is a great sin. Also, your parents have educated you in the hope that they will rely on you. What about the others behind you? Also, will your whole family feel more heartbroken and embarrassed if other relatives and neighbors know that you have died because of this. (Gay healthcare provider, infected 10 years)
>
> Kai: As for me, right after knowing that I was infected with HIV/AIDS, I was thinking about committing suicide on Rama IV road. At that time, I was about to unconsciously jump into the road full of vehicles. Suddenly, it seemed to me that my parents were calling my name even though they had passed away. I then stopped thinking about hurting myself. (Infected 11 years)

> Mikkie: Kik, why don't you turn to Buddhist dharma, then? I began to study Buddhism regarding karma after knowing about my infection for nine months in order to help myself understand the situation regarding my being gay and having HIV. This helped me realize that the former life determines the present life; therefore, I shouldn't be depressed but accept the present. Furthermore, making merit or setting a bird/fish free can help me to have a better life in the next life. This can also make me happy. As the doctor said, it is a kind of antibody. Also, praying before bedtime is good for me. Do you think it is ok for you? To be honest, once I decided to kill myself as well by hanging myself, but my parents found out and told me if I hanged myself, I had to keep killing myself like this in the next life and forever. Then, they took me to the temple to pay respect to the Buddha image and listen to a dharma talk. (Infected 20 years)
>
> Pong: Me too. My family told me to stay patient and use the Buddhist dharma in terms of karma and encouraged me to make donations and meditate to calm and relax myself. I hope this method can work for you. (Infected 19 years)

In this meeting of Organization B a participant infected for two years was so overwhelmed by the illness that he was suicidal. Reflecting the previously discussed strategy of using familial love and devotion to support reappraisal, Aoo explained the consequences of attempting suicide for his family members. Not only is suicide sinful according to Theravada Buddhist beliefs, as it violates the first precept of Buddhism, to abstain from taking life, but it is sinful precisely because of its harmful effects on the family. Therefore, suicide costs one the opportunity to perform ethical deeds. In addition, the way he smiled reflected again the non-confrontational character in most Thai people to conceal sadness or pain as discussed by Mulder (2000) in the preceding analysis of informational support. Also, this can be explained by the worried eyes that came with smiling.

Another support group member, Mikkie, referenced karma in way that seemed well suited to directly contradicting the widespread stigmatizing belief that Thai PLWHA have become infected because of their own "karma" (Viddhanaphuti, 1999). According to Buddhist beliefs, everything one does, either good or bad, is one's karma; in other words, both good and bad karma determine the states and situations in

one's life. One's good deeds are rewarded while one is also punished for one's bad deeds. The reason why a person is reborn in the agonizing cycle of birth-death-rebirth is that one still has karma; the cycle continues until one's karma is all gone (Saisuwan, 2016). Bad or undesirable states or situations in the current life are believed to be the result of one's bad deeds in previous lives and a cause of lower incarnations in future lives (Saisuwan, 2016). Buddhists consider homosexuality to be predetermined by heterosexual misconduct in previous lives (e.g., adultery, prostitution, sexual activity with children, sexual irresponsibility) (Methangkun, 1986). However, homosexual activities in the current life do not accumulate future karma; homosexuality is not seen as sinful but only a way to pay for one's heterosexual misconduct considered as sin in previous lives (Saisuwan, 2016). The very important associated concept of merit making is the notion that doing good helps to maintain the positive balance of karma for oneself (Caffrey, 1992; Sasat, 1998). Nevertheless, this notion of karma associated with homosexuality is still under debate as discussed earlier in terms of inferior karma which has been used in Thai patriarchal society.

Nevertheless, this current research shows that belief in the Buddhist karmic cycle of birth-death-rebirth not only helped infected MSM achieve positive reappraisals but also restrained them from physical self-destruction and cultivated belief in merit-making to help them reach a better next life. This also illustrates the Buddhist principle of self-reliance or responsibility for one's own religious attainments rather than placing this responsibility on the clergy or God (Samovar, Porter, McDaniel, & Roy 2013). Furthermore, as can be observed from the quote, Mikkie's parents, probably devout Theravada Buddhists, seemed not to be upset or annoyed by his homosexuality and HIV/AIDS as they did not criticize him but

encouraged him to become calmer and find some Buddhist ways for relief. Clearly, in this case, his parental empathy and concern overpower other negative feelings (e.g., distress, contempt, etc.) against him.

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CHAPTER 5

DISCUSSION

5.1 Summary of the Findings and Discussion

There is a saying that "communication can be considered the concrete and objective expression of the permanent process of reconstruction of the different 'contexts of reality' we build and cultivate in everyday life" (Vizer, 2009, p. 17). This qualitative study advances research on social support for HIV/AIDS infected MSM in Thailand beyond works that typically employ the quantitative framework.

The objective of the study is to increase researcher and the society understanding of helpful and ineffective social support by HIV-infected MSM, their family members, and those working in the healthcare field. Also, this understanding of forms of social support can contribute to more healthful and safe livelihood of MSM whose HIV status can be prevented from progressing to full-blown AIDS.

Forty-six people participated in the study. These included MSM over 18 years old with a wide range of infection periods, as well as their social workers and nurses. These participants came from Bangkok and its vicinity. Observations and interviewee recruitment took place at three organizations (renamed Organization A, Organization B, and Organization C to protect confidentiality). During the four months of data gathering, two main research tools used were in-depth interviews and observations of support groups running from 50 minutes to one hour.

The feature of communication is reflected by the fifteen main themes under the four main dimensions of social support: Emotional support, informational support, instrumental support, and appraisal support in terms of positive reappraisal. All of these have shed light on new perspectives of sexuality, culture and privacy

management related to social support for Thai HIV/AIDS infected MSM. In analyzing these themes, I have found answers to the three questions about (1) how sexuality and culture intertwine with social support in ways that create challenges and in the ways that support providers try to overcome these challenges, about (2) what patterns and processes of communication Thai support networks have employed to socially support MSM living with HIV/AIDS, and about (3) how successful communication strategies are used for social support.

The final chapter summarizes the results of the study and discusses the findings derived from the themes of each social support dimension. Moreover, the research limitations, future research, theoretical and practical implications in social support for Thai MSM living with HIV/AIDS are presented.

5.1.1 Emotional Support

Three emotional support themes were observed in this study: (a) Emotional support as sharing in Thai culture, (b) identification and normalization of connection, and (c) avoiding emotionally upsetting talk. All are related to Thai culture regarding Buddhism as one of the three pillars of Thailand's national values (Harvey, 2000), and collectivism in Thai interdependent relationships.

Reflective of the country's Buddhist and collectivist culture, empathy and sympathy or the concept of "henjai" are essential for the emotional support process. This is evident in emotional support through identification and normalization of connection, for example, when a healthcare provider said, "I want to make them feel that they are my friends... Finally, I have to explain, for example, that they haven't done anything wrong. It isn't the end of the world. Like me, I say to them, "I can still live my life normally". In this context, identification and normalization of connection was an emotional lifeline. This finding clearly corresponds to previous research

conducted by Lee et al. (2010) and Yoshioka and Schustack (2001) on homosexuality and promiscuity associated with Thai PLWHA. In another instance, the doctor reminded his patient that he had, in fact, a normal health condition: “It’s ok. You see. This is me who still remains with you. We are both normal.” It can be seen that, in this case, a doctor’s empathy could be a powerful mode of support, not only to reduce patients' feelings of isolation, but also to validate their feelings or thoughts as being totally normal. This rapport building between doctors and patients is also consistent with the research conducted by Kaplan, Greenfield and Ware (1989) who illustrated that, to ensure compliance with medical information, physicians must form a reciprocal relationship with patients; such efforts foster closeness, familiarity, and thus improved interpretation of messages (both verbal and nonverbal). This is in contrast to Parinyavuttichai (2002) who explained, in Thai hierarchical society, social status is based on both ascribed criteria (age, birth, and family background) and achieved criteria (education, position in work, wealth, and power). Power and authority can thus be forbidding. Therefore, in the context of the doctor-patient relationship, the hierarchical distance between Southeast Asian doctors and patients, in a culture where very subtle, polite and mostly nonverbal communication is valued, appears to be a barrier to the type of communication promoted by Western guidelines, which presume an open exchange of ideas and equal contribution to the entire communication (Claramita, Nugraheni, van Dalen, & van der Vleuten, 2013). This is also important because, as Baile et al. (2000) have shown, patients often regarded their doctors as one of their most important sources of psychological support.

Thai culture was also reflected in the avoidance of emotionally distressing talk. Avoiding such talk provided emotional support by creating a space for hope and by conveying tacit acceptance. For example, one participant said, “I...decided to

reveal my HIV status to one of my very close gay friends... Then he said that I looked healthy as always and it was good that I took care of my health so well. From then on, he never mentioned my HIV/AIDS but only about traveling, eating and so on". Alternatively, in a support group, a healthcare staff appreciated his patients rather than remind them of their unpleasant HIV/AIDS condition: "That's why these days whenever I see you, you look more and more beautiful compared to when I saw you for the first time". Corresponding to Yoshioka and Schustack (2001), based on Thai cultural values, this avoidance of rather uncomfortable topics is preferred, and this is in contrast to the research asserting that healthcare staff often judge and associate those with the HIV infection with immoral behaviors, with fears based on prejudice related to any potential contagion (Hossain & Kippax, 2010). Indirect expressions of acceptance also likely enhanced emotional support by sharing dangerous secrets with the family and identification and normalization of relationships. This finding of indirect expressions is also consistent with the research on implicit social support discussed by Taylor, Welch, Kim, and Sherman (2007) in Chapter 2.

Influenced by Buddhist precepts, "loving-kindness (metta)" and "compassion (karuna)", the support networks can rely on empathetic and sympathetic communication (Thera, 1994, para. 1). This indicates that Buddhism and socialization help to internalize beliefs through generations. Therefore, Buddhism as generally practiced in Thailand can be understood in terms of the collectivistic value, although the literature on the Thai world view emphasizes Buddhism as opposed to collectivism (Yablo & Field, 2007). Tiranasar (2004) further stated:

> Buddhism has supplied cognitive and evaluative elements that have been incorporated into Thai culture and built into the Thai social structure. Consequently, Buddhism is deemed as the instrument of the Thai people's identity and cultural continuity. Buddhism is consistently woven into all

> thoughts and actions of the Thais whose cultural life has been their great attachment to the doctrines and rites of the Buddhist order (para.13).

This Thai collectivism and its Buddhist empathy and sympathy are also evident in the research on cross-cultural perspectives on social work in Thailand and the United States conducted by Black (2013). After noticing differences of Thai and US therapeutic relationship, a participant as an intern of the Social Work International field placement program could understand that there was the connection between Theravada Buddhism and the concept of karma to Thai parents' unconditional acceptance of their children with disabilities or diseases, like HIV/AIDS (Black, 2013).

In another vein, privacy in Thai culture indicates a distrust of outsiders and protection of the privacy boundary around personal matters. In this regard, the exterior privacy boundary establishes privacy rules that regulate dissemination or protection of this information to nonfamily members or non-intimate individuals (Petronio, 2010). Related to the concept of "ruam duk ruam suk", this kind of shared privacy is limited only to the people they know or those in their small limited network (i.e., healthcare providers, immediate or extended female family members or gay friends) who seemed to understand them. Even though participants were often hesitant to disclose their sexuality and illness due to the powerful associated stigmas, they expressed no distress when, after disclosing their secrets to a family member, that person in turn shared this information with other family members without consulting the study participant. On the contrary, participants appeared to find vital emotional support in the embrace of their family after their information was known to all. Individualistic privacy is not only contrary to Thai culture focusing on privacy shared among extended family members but would constitute a barrier to emotional

support as sharing of distressing information that is so important in Thailand. Also, this information sharing between extended family members in the collectivistic culture indicates “boundaries around subsystems of mother and father, sibling relationships, grandparents, and father and daughter” (Petronio, Ellemers, Giles, & Gallois, 1998, p. 576). This flow of information is based on “the interface” which provides common ground for members to exchange their views (Petronio et al., 1998, p. 576). Evidently, “collectivism” and “social connections” still exist in Thai society even though the Western consumerist culture, making lives more competitive and less socialized, has influenced the modern-day lifestyle of every corner of Thai society.

5.1.2 Informational Support

In terms of informational support, corresponding to the previous research discussed in Chapter 2, given culture and privacy, information seeking on HIV/AIDS related-issues is mainly from the group of infected gay people rather than non-infected others with different sexual orientations. However, informational support is concerned with more than just health issues; it also includes other social aspects reflected by all five themes of informational support: (a) Double informative support: Advice on how to manage challenging information from doctors, (b) informative support on dealing with traditional Thai folk beliefs, (c) informative support on dealing with the challenges of HIV/AIDS disclosure, (d) the importance of accurate information about HIV/AIDS, and (e) information on preparing for employment after disruption caused by infection. This involves reliance of information from these infected MSM. The HIV/AIDS infected participants chose to communicate their information within their own group, and this information sharing among in-group members is related to common ground involving mutual understanding (Wu & Keysar, 2007). This common ground can also be explained by “experiential

knowledge" of some group members, and this makes members of self-help or support groups "experientialists" and the groups "experiential learning communities" (Borkman, 1990, p. 5). In this respect, Thai participants believe that their support groups were reliable and knowledgeable about the subjects of concern and used these support groups as a platform for discussion and consultation for the future actions that can help them to fit into the society. For example, in a support group session, one group participant suggested to another that he should renegotiate with an egotistical doctor calmly and gently as he referred to a Thai proverb - "the use of cold water to pat the other". In other instances, support group members at Organization B discussed ways to reveal private information to parents or seronegative partners with indirect communication, and this reinforces the idea that Thai society is based on the high context feature with the aim to maintain harmonious relationship. It can be seen that narratives in these support groups, as discussed in Chapter 2, help to affirm decisions about medicine and daily life practices.

Another noteworthy function of support groups is that they provide venues for exchanging ideas that are not discussed openly in the society, where people generally do not have sufficient knowledge to discuss these subjects. For example, the support group members talked about misconceptions of the terms HIV/AIDS and MSM or about sharing experiences (e.g., jobs and disclosure). Consistent with Lyttleton's (2004) Thai support groups discussed in Chapter 2, this discussion of these topics that might be deemed inappropriate by the society can take place only in the support groups involving the importance of "kalathesa" (awareness of time and space) and "kreng jai" regarded as Thai social order to avoid interpersonal conflict. As for the latter, Komin (1991) strongly disagrees with Mulder (1979) for connecting the idea of fear to krengjai, as well as his connecting krengjai to both Buddhism and Weerayudh

(1973)'s affliative society. In this case, Komin stressed that as part of the process of social smoothing, "krengjai" underlies a significant part of everyday interpersonal behavioral patterns of the Thai (p. 161). Nevertheless, as most Thai people subscribe to Buddhism and live in the stratified hierarchical society, the cultural value "krengjai" can be influenced by these two important factors (Klausner, 1993; Mekthawornwathana, 2012). Also, since this Thai Buddhist society, as discussed in Chapter 2, regards disease with its physical symptom as disturbed harmony, fear of bothering others is involved here and, therefore, reflects the importance of interrelationship in Thai society. This avoidance of conflict is highly and socially contextual in the Thai culture. This in-group support also involves in-group orientation which can be related to Petronio's (2002) "exterior low/interior high permeability rule orientation" (p. 164). Exterior low/interior high permeability means that linking the private information with outsiders is not acceptable; on the other hand, the in-group members loosely hold and exchange information with one another (Petronio, 2002). This complements well the observations made by Liamputtong (2012), who reported that, in most situations, PLWHA will not disclose their HIV/AIDS status in order to prevent social rejection and avoid being isolated from participating in the socio-cultural events that still do not openly accept their infection status.

All of these observations show that these HIV/AIDS infected participants prefer and feel more comfortable to discuss their stresses within their own group because they distrust other people in the Thai society who still lack genuine understanding of their lives not only in terms of disease but also diversity and fluidity of Thai sexuality/gender status. This intertwined and mutually constituted sexuality and gender in the Thai culture is, therefore, in contrast to the Western theory of social

construction of gender and sexuality like what Rubin (1992) argued about the separation of gender and sexuality as discussed in Chapter 2. Moreover, this kind of disclosure of private information within support groups is consistent with the idea of a selective process of disclosure involving the cognitive appraisal of reactions from loved ones (Shushtari, Sajjadi, Forouzan, Saliman, & Dejman, 2014).

Soliciting information from support groups or healthcare providers also indicates division of HIV/AIDS infected in-group members and other healthy out-group members in terms of the notion of essentialism and dominant images of homogeneity in Thailand. This essentialism can further be explained by Hofstede's concept of high uncertainty avoidance in the sense that Thai society does not readily accept change and is very risk adverse, as change has to be seen for the greater good of the in-group (Hofstede, 2018). Therefore, the participants needed to consult with one another for reassurance that everything would be fine before they could talk about their HIV/AIDS status to other healthy people (i.e., their family members, boyfriends or doctors). In addition to this, "long-term orientation", according to Hofstede (2018), also makes Thai culture more normative than pragmatic. In other words, Thai people focus on great respect for traditions. With such high uncertainty avoidance and long-term orientation, participants, with both short and long infection, feared to disclose and later refrained from seeking information from other people who might not understand their particular ways of living. This difference of health and sexual/ gender status is also associated with the notion of difference in Thai-ness explained by Yoko (2006):

> "Thai-ness" and homogeneity are "incessantly stressed in official and other discourse while repressing differences… Those who do not fit into the narrowly defined 'Thai-ness' have therefore been deemed 'others' and outsiders, threats to the unity of the homogeneously conceived nation (p. 283).

This aspect of Thai-ness is then exercised by those wielding power and used as a means of retaining power and creating a sense of prestige, even though Thai-ness (literally translated as "*khwam pen Thai*") is associated with freedom, independence and adaptability (Kinney, 2011).

5.1.3 Informational and Emotional Support in Dealing with Other People's Ignorance

This notion of essentialism is also associated with another theme involving both informational and emotional support, which is informational and emotional support in dealing with other people's ignorance. As further refinement of the separate functions of emotional and informational support as explained in Chapter 1, these two kinds of support can be integrated into commiseration as another means of providing social support for infected MSM discriminated against and stigmatized by Thai society.

Cutrona and Suhr (1994) stated that nurturant support includes not only expression of caring or empathy but also commiseration, and social network support. Kelley and Kelley (2013) explain that commiseration typically involves reflecting on a mutual response to a common experience shared by the caregiver or sufferer, whereas pity, sympathy, or compassion arise from a unilateral response of the sufferer or the caregiver. However, Radley and Figley (2007) explained that compassion encompasses "feelings of condolence, pity, sympathy, empathy, and commiseration, all of which are synonymous with one another and are connected to altruism" (p. 207). Correspondingly, this compassionate altruism is inextricably intertwined with empathy and sympathy in the Buddhist context. As Makransky (2012) stated:

> ...compassion is a form of empathy. We sense others' suffering as like our own and naturally wish them deep freedom from it. Thus, compassion is informed by the wisdom that understands our basic situation: the inner causes of our suffering and our potential for freedom and goodness. From a Buddhist

> perspective, compassion with wisdom is the foundation of emotional healing (p.1)

Correspondingly, according to Sirikanchana (n.d.), the altruistic characteristics of Theravada Buddhism are composed of "loving kindness (mettā), compassion (karunā), wisdom (paññā), loving interest (chanda) and self-knowledge (attaññutā)". Based on this Theravada Buddhist ethic, Thai social group members develop altruistic behavior with the emphasis on mutual empathy and sympathy without prejudice in order to help end the suffering of others (Inada, 2016; Ratanakul, 1998). Again, mutually shared communication corresponds to the emptiness of self (*anattã* in Pali) that stresses no ego. Also, this mutuality again can be related to "ruam duk ruam suk" that makes infected support group members feel that they belong to the group. However, this mutuality is different from other religions (e.g., Judaism, Christianity, and Islam) because these religions are monotheistic, and each successive religion believes that its God is the same as its predecessor(s) (Neusner & Chilton, 2005).

Clearly, the findings have shown that with this altruism, the participants altogether were emotionally and compassionately involved in the discussion of HIV/AIDS and social issues in the support groups as their safe venue. Throughout all the quotes, the participants mutually validated one another's feelings and thoughts. For instance, Mai assured both Arm and Pui that they were not the only two who had gone through this painful experience, as he said, "I've found this before... You see anything could happen even if he and I had the same HIV/AIDS condition". Because of this Buddhist altruism, there is a sense of deep bond among these Thai HIV/AIDS participants who might think that they cannot seek this genuine commiseration from other groups. Also, corresponding to Sharf and Vanderford (2003)'s narratives, wounded storytellers can reshape their identities and identify their critical life-

changing incidents through other support group members' multiple perspectives for adaptation to illness.

In addition, from the findings, support group's conversations mainly revolved around commiseration of sharing experiences rather than proposed solutions to the HIV/AIDS issue. This can be observed, for example, when support group members had exchanges about a controversial issue of HIV/AIDS status disclosure to the gay male healthcare staff with the same disease status or the female nurse. In another instance, the group participants wondered why even those with the same infection status did not want to talk openly about one another's infection. Since there were no solutions agreed upon by the support group members, this indicates that ways to ameliorate HIV/AIDS-related stressors in Thailand are still controversial due to the widespread prejudice and non-acceptance of infected gay Thais. Related to negative attitudes toward homosexuality in Thai culture, Thai-ness emphasizes "positive representations that are purified from embarrassing sexual margins: a Thai-ness which is free from transvestites, gay boys and prostitutes" (Haritavorn, 2007). Also, this ideology of Thai-ness is used to manipulate the concepts of morality, purity, and other socially subjective qualities based on Theravada Buddhism to suppress people infected with HIV/AIDS (Kata, 2017). These mainstream thoughts on Thai-ness obviously contrast with the Thai innate tolerance to keep Thai society harmonious and united, thereby stressing sexual division and rejection. Consequently, lack of sexual knowledge is the main problem causing prejudice and discrimination. This can be explained by research in Thailand that demonstrated that sex education programs do not provide the knowledge adolescents need to make healthy decisions related to sexual preference (Kay, Jones, & Jantaraweragul, 2010). In addition, Lyttleton (1996) found that education programs in Thailand were being controlled by central

authorities from a top-down perspective. Unfortunately, according to Maxwell and Kamnuansilpa (2016), this problematic top-down approach persists, and Thailand's current leaders appear to be moving toward even greater hierarchy by placing education within a more strictly controlled centralized system. This approach emphasizes Thai ultra-nationalism, conditioning students to obey while doing little to improve classroom instruction and student achievement, so top-down, centralized management structures hinder learners' development both nationally and locally (Maxwell & Kamnuansilpa, 2016). As a consequence, Thai sex education information lacks essential details, focusing instead on the negative consequences of sex, and omitting information on the positive aspects.

5.1.4 Instrumental Support

As for instrumental support, assistance from in-group members between infected people and their support networks, particularly those experiencing the same HIV/AIDS status, are in accordance with the previous research discussed in Chapter 2, as can be seen from the three themes: (a) Collectivistic network assistance with the necessities of living with infection, (b) aid to improve interpersonal relationships complicated by disease status, and (c) creating and sharing information in and about safe, private spaces.

Most participants living with HIV/AIDS shared their private information with healthcare providers or those with the same illness status in order to gain assistance. Also, as most of them were assisted by these HIV/AIDS in-group members, this is related to collectivism regarding sense of belonging and intimacy in the interpersonal relationship. For example, retreats can promote warmth and intimacy among PLWHA. Such a private and safe sphere is consistent with the research conducted by Chenard (2006), regarding self-care and social support to "maintain a sense of

normalcy in their lives"; these men seek individual people, groups, social settings, or environments where they can feel safe and supported enough to make themselves feel normal; they tend to avoid persons, environments or contexts where they felt threatened by social stigma (p. 91). Group participants regularly attend the annual weekend retreat for PLWHAs because it gives them a sense of their community and complete freedom from having to hide: a temporary reprieve from the stigma threats that otherwise pervade their lives (Chenard, 2006).

Apart from preference of ingroup members, which generally deals with a sense of belonging related to the same sexual/disease status, the current research has also found that the Thai sibling system using "yaat" that includes "pii" and "nong" plays its essential role in favor of one group over others. In other words, infected homosexuals who want to get involved in the relationship or group were welcomed. For example, when a healthcare staff who had recently met a patient used the pronoun to show closeness, like "Are you free, nu? Can you take khun pii to the doctor?". Alternatively, this brotherhood is also evident in social activities specifically organized for infected gay people. For example, as one healthcare provider said, "On this family day, the staff and the patients were like siblings 'pii' and 'nong' in the same family". In addition, through the buddy system, Thai PLWHA may achieve a high level of collectivist social peer support based on the Buddhist concept of "ruam duk ruam suk" (sharing suffering and happiness). This corresponds to Cohen, Wu, and Miller (2016), who stated that religion is the determinant of the collectivist outlook in some ethnic groups, like African American men; "collectivistic Western religionists" have a communal sense of belonging. (p. 1238). Moreover, Cohen, Hall, Koenig and Meador (2005) also theorized that, in the United States, American Jews and Catholics as well as other groups are likely to have collectivistic values based on

religion, while American Protestants and some other groups were particularly likely to subscribe to individualistic forms of religion. However, there might be greater empathy and collective sense of belonging among Thai participants than those of other collectivistic religious groups, like African Americans.

Altogether, this notion of Thai Theravada Buddhism can reinforce the importance of *anattã* regarding "egoless mutuality or non-egocentric relationality" of human beings to promote mutual co-dependence (Shin, 2017, p.72). Thai interdependent society that willingly welcomes and accepts those infected with HIV/AIDS into the group is unlike Confucius societies, where social members can only tolerate others as long as the latter do not cause trouble to them (Neville, 2016). On the other hand, this kind of relationship in individualistic cultures involves more trust between individuals; as Brewer and Yuki (2007) stated, in these cultures, inclusion of others is mainly based on "category-based social relationship" or case by case decision (i.e., choosing to associate with individual others based on preference or trust) (pp. 313-314).

This expression of intimacy and acceptance of others like close family members in Thai culture can help to foster empathy and genuine, open communication with one another in order to boost self-esteem. Also, this kind of interdependent relationship inextricably intertwined with the sense of brotherhood can also be related to horizontal collectivism in Thai culture, regardless of hierarchy. In other words, with this flexible nature of Thai hierarchy, principles, rules and policies are likely to be less important for Thai people, and it is quite common for them to change their decisions and behaviors according to the situation to smooth interpersonal relationships (Dokkularb & Lord, 2013).

This can also be related to Petronio's (2002) "exterior low/interior high permeability rule orientation" (p. 164). Exterior low/interior high permeability means that linking the private information with outsiders is not acceptable; on the other hand, the in-group members loosely hold and exchange information with one another (Petronio, 2002).

5.1.5 Support for Positive Reappraisal

Consistent with previous research, it has been found that HIV/AIDS made Thai gay care receivers feel hopeless at living their lives as can be noted from the three themes: (a) Using familial love and duty to motivate reappraisal of self-care, (b) reappraising the self to achieve acceptance of homosexuality and HIV/AIDS infection, and (c) using spiritual beliefs to reframe and achieve positive reappraisal. The findings of positive reappraisal have shown that mainly spiritual care through use of Buddhism in relation to parental and karmic issues can help to positively change the negative attitude toward HIV/AIDS for those homosexual patients. In this way, research participants greatly depended on Buddhism for psychological readjustment despite the claim that Buddhism is nowadays disregarded as the value of individualism makes more and more Thai people focus on self-interests (Visalo, 2012). Rather, Thai Buddhist culture has influenced spiritual and holistic care for the HIV/AIDS infected participants who could later develop their own "individual subjective experiences" to live their life by using these religious teachings as discussed in Chapter 2. For example, a participant recounted to other support group members about taking medicine to make himself stronger and healthy so that his mother would become happy. Similarly, in another instance, a healthcare provider encouraged his critically ill care receivers to continue living: "I then said to him...As for me, I don't have that opportunity because my parents passed away. If he could

revive the rest of his life, he could repay his gratitude to his parents." Altogether, the concept of "katanyu katawethi" (i.e., the reciprocation of action from the sense of gratitude especially between the parent and child) based on the teachings of Buddhism is, therefore, so impactful that they can change the stigmatized perspectives long instilled in their mind. This Thai cultural value has been fostered in order to "sustain intergenerational bargains in a time of rapid change and social fragmentation" (Upton, 2010, p. 58). This value is used to maintain order in Thai society that prioritizes respect toward those who bestow "bunkun" or "favor that incurs a sense of gratitude and debt on the beneficiary" (Knoedel, Ofstedal, & Hermalin, 2002, p. 40). Clearly, the concept of "katanyu katawethi" and "bunkun" are firmly ingrained in Thai Buddhist culture as the strong normative basis for the prevailing pattern of familial support. Therefore, family is still a crucial influencer and members in the family, even though, as discussed earlier in emotional support, there has been change of Thai culture in terms of family ties. This shift toward independence and individualism corresponds to the research undertaken by Prystay (2004), who explained that in the past, family ties were in a strong position because elders were primarily the influencers of ideas and opinions for younger generations; however, the decline of that influence is caused by globalization and Western influences. This increase in self-esteem supported by family is also consistent with Cohen (2004), who states that social relationships may directly or indirectly encourage healthy behaviors and being part of a social network provides self-esteem and purpose to life. Furthermore, it was also found that the Brazilian collectivistic family positively influences the self-esteem, self-confidence and self-image of the infected person. Also, it can bring benefits in relation to the treatment given with

moral support to enhance the feeling that life is worth living (Da Silva & Tavares, 2015).

Another crucial role of Buddhism in terms of reappraisal is karma, which helps to make the infected MSM feel less anxious and worried about their current conditions. For example, one participant suggested to another one more recently infected: “I began to study Buddhism regarding karma after knowing about my infection for nine months in order to help myself understand the situation regarding my being gay and having HIV”. In this way, the concept of karma, which is related to self-acceptance, involves non-self or impermanence (*anattã* in Pali) (Reinhard, 2017). Thus, this again emphasizes the importance of letting go and of insights into how to live a more peaceful life.

Furthermore, this positive reappraisal also involves holistic treatment with health of the body and of the soul through Socrates’ logos arguments (Tsouna, 2015). Socratic questioning is often used to stimulate the recall of prior knowledge, promote comprehension, and build critical-thinking skills, like teachers asking questions to help students uncover what has been learned, to comprehensively explore the subject matter (Neenan, 2009; Tofade, Elsner, & Haines, 2013). For example, by using a directive and active therapeutic style, a healthcare provider advised HIV/AIDS infected a gay patient who was thinking about a suicide attempt: “I asked who he loved most...I further questioned, ‘What about the last one?’... ‘What about yourself? Don’t you love yourself?’”. Alternatively, these rhetorical questions can help to solve another extremely serious life issue associated with HIV/AIDS and homosexuality. For example, the healthcare providers assist their patients in gaining self-acceptance and insights into the true nature of their disease and homosexuality: “As I said, who

would know you have HIV/AIDS if you do not allow others to know about this?... Finally, I asked, “If you act out femininely, will people lose faith in you?’”.

Of note here, the main complicated issues are labelling and the limitations that the participants impose on themselves in terms of illness and sexuality. In this respect, Thai cultural norms dictate appropriate behavior (i.e., kalathesa) of Thai male homosexuals, indicating the importance of Thai gendered sexuality (i.e., the role of gender in an individual's life is informed by and impacts others' perceptions of their sexuality) and sexual morality determined by Buddhist-based Thai-ness. Thus, under this cognitive approach, Socratic questioning which focuses on self-reflection or “relationship with internal experience” is intertwined with the practice of mindfulness (Hayward, Ellett, & Strauss, 2015, p. 157). In light of this, mindfulness has its crucial role in finding solutions to critical life events.

Obviously in this Thai health context, the concept of mindfulness is rooted in the Thai Buddhist belief that “sati” or right mindfulness is a way to end suffering rather than mindfulness influenced by cognitive therapy as suggested in the Western literature (Christopher, Christopher, & Charoensuk, 2009, p. 305). With “sati”, one is able to let go of clinging to memories of the past and fears of the future. Furthermore, thoughts are regarded as mere thoughts rather than reality, and “in letting go of the obscuration of thoughts, one is therefore able to perceive and respond freshly to present-moment experience” (Garland, Gaylord, & Park, 2009, p. 5). As can be seen, holism based on Thai Theravada Buddhism mainly seeks exploration of ultimate truths and experiential understanding or “enlightened experiencing” of the interdependence of phenomena (Case, 2013; Ho, 1995, p. 123). This contrasts with the general concept of integration and connection of Confucius or Taoist holism - the former focuses on “relational self” with the society, while the latter involves countless

"manifestations of self" (Ho, 1995, p. 120 & p. 131). Therefore, this critical self-reflection based on Buddhism enables the participants in this research to carefully think about true causes of their suffering, eventually becoming enlightened, discovering some solutions.

5.2 Limitations and Future Research

Due to time constraints and inconvenience, many research participants, including HIV+MSM and moderators, could not attend several support group sessions and join in-depth interviews as planned. In addition, compared to other forms of social support, there were very few exchanges of emotional support and positive reappraisal in support groups; on the other hand, in-depth interviews were the main tool. Because of unfamiliarity between some participants and me as the researcher, they probably felt too embarrassed to express their feelings and emotions in the live support groups. Also, sometimes, some support group moderators, particularly at the Organization B, did not have moderating skill, as they did not know what questions should have been raised during group discussions or how to manage turn-taking during interactions. Rather, some support group members took this leading role in asking questions and moderating the groups.

Regarding in-depth interviews, some questions pertaining to stigma or HIV/AIDS issues were not raised because of time constraints. In addition, some of the interviewees spoke so fast that I could not write down all the keywords or probe and follow up the questions at that moment. In these cases, I had to ask about the points related to the previous questions much later. Moreover, diaries as planned during the pre-research process, could not be obtained as the participants of the three HIV/AIDS organizations felt that it was not convenient for them.

There are also some limitations on research participants who self-identified themselves as MSM from Bangkok and its vicinity. They were recruited from only three HIV/AIDS organizations based in Bangkok (i.e., Organization A, Organization B, and Organization C). Therefore, the data might differ in other MSM groups or other sexual groups living in other provinces.

Despite the four-year lapse of my research between 2014 and 2018, discrimination and some positive and negative attitudes toward HIV/AIDS still remain true in Thai society. As a result, it is very useful for the study to be further developed in order to track the progress of this HIV/AIDS situation of Thai MSM. To improve the way support groups were conducted, more extended time periods and more group sessions on different days might also be implemented so that the research participants would have time to attend meetings. In this way, the researcher could also build more rapport with the participants, and they would become more comfortable talking and sharing feelings and ideas on various HIV/AIDS issues with one another in support groups despite the presence of the researcher. Alternatively, focus group discussions would also help the moderator to probe issues in depth, discuss new issues as they arise, and ask participants to elaborate on their responses (Palomba & Banta, 1999). As for the in-depth interviews, qualitative longitudinal research is needed for the researcher to return to interviewees to explore changes occurring over time (Thomson & Holland, 2010). Finally, in order to encourage participants to write diaries, they may be asked to e-mail their diary entries directly to the researcher, either at the end of the day or as they happen. In this way, various forms of technology (e.g., smartphones or tablet devices) may also be used to record feelings and experiences at a time most convenient to them.

5.3 Theoretical Implications

Some other theories could be employed to investigate other aspects of those living with HIV/AIDS in addition to social psychological theory of stress and coping, social constructionism in terms of health and sexuality, and privacy management theory. For instance, communication accommodation theory could be used to study convergence or divergence of the messages; alternatively, the study of conflict management can also be employed to explore different styles of communication exchanges in terms of interpersonal conflict that occur between parties (Thomas & Kilmann, 2010). In addition, the Cass's (1979) identity model, which laid out six stages of coming out – "identity confusion, identity comparison, identity tolerance, identity acceptance, identity pride, and identity synthesis" - can be used to analyze socialization and the process of disclosure. Further, some theories related to identity, like Common Ingroup Identity Model proposed by Gaertner and Dovidio (2012) could be used to explore ingroup favoritism and intergroup bias. Finally, other methodological approaches (e.g., grounded theory and content analysis) could also be employed in future research in order to construct new theory through the analysis of data or to analyze some arguments embedded in the text, respectively.

5.4 Practical Implications

These research findings can make Thai government aware of the importance of HIV/AIDS and sexuality issues. Then, it can develop and implement some policies or laws to protect or benefit those MSM living with HIV/AIDS. In this respect, physical/psychological harm or discrimination against those with homosexuality or HIV/AIDS might be made unlawful. On the other hand, medicine and medical services can be made more accessible for HIV-infected MSM.

As for HIV/AIDS organizations, with more knowledge of communication strategies, care and support programs of different kinds (i.e., support groups or other

recreational activities) can be designed to meet gay patients living with HIV/AIDS' need with more caution. In addition, health agencies will be able to launch more health campaigns that promote appropriate knowledge of HIV/AIDS associated with sexuality.

The findings can also be useful for educational sectors (e.g., Ministry of Education, schools, universities), in that right understanding and knowledge of health, disease and sexuality will be included in curriculum which places more emphasis on the third gender and useful information on socially stigmatized diseases. This can promote a bottom-up approach and decentralized system of education that leads to true knowledge for more peaceful and less divisive society.

Finally, with knowledge from research findings, not only healthcare providers but also the family or society in general will be able to employ more careful communication styles and techniques suitably adjusted to foster patients' physical and psychological wellbeing in accordance with different kinds of social support. Furthermore, the providers will be able to have more awareness of the importance of withholding any prejudice or bias in order to communicate with fairness.

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APPENDICES

BANGKOK UNIVERSITY
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Appendix A

Institutional Review Board (IRB) Approval

OHIO UNIVERSITY
Office of the Vice President for Research

13F047

Office of Research Compliance
RTEC 117
Athens, OH 45701-2979

T: 740.593.0664
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The following research study has been approved by the Institutional Review Board at Ohio University for the period listed below.

Project Title: Communicating Social Support for HIV+ Thai Men who Have Sex with Men (MSM)

Primary Investigator: Wuttichai Phaovanich
Co-Investigator(s):

Faculty Advisor: Austin Babrow
(if applicable)

Department: Communication Studies

[redacted]

Rebecca Cale, AAB, CIP
Office of Research Compliance

2/7/14
Approval Date

1/21/15
Expiration Date

This approval is valid until expiration date listed above. If you wish to continue beyond expiration date, you must submit a periodic review application and obtain approval prior to continuation.

The approval remains in effect provided the study is conducted exactly as described in your application for review. Any additions or modifications to the project must be approved by the IRB (as an amendment) prior to implementation.

Adverse events must be reported to the IRB promptly, within 5 working days of the occurrence.

S

Appendix B

Consent Form for HIV+ Thai Men who Have Sex with Men (English Version)

Ohio University Consent Form

Title of Research: Communicating Social Support for HIV+ Thai Men who have Sex with Men (MSM)

Researchers: Wuttichai Phaovanich and Prof. Austin S. Babrow

You are being asked to participate in research. For you to be able to decide whether you want to participate in this project, you should understand what the project is about, as well as the possible risks and benefits, in order to make an informed decision. This process is known as informed consent. This form describes the purpose, procedures, possible benefits, and risks. It also explains how your personal information will be used and protected. Once you have read this form and your questions about the study are answered, you will be asked to sign it. This will allow your participation in this study. You should receive a copy of this document to take with you.

Explanation of Study

This study investigates social support related to HIV+Thai men who have sex with men (MSM). Although formal and informal support networks can help HIV+ MSM alleviate their stress and cope more effectively with their illness, Thai culture can make it difficult for MSM to seek and obtain support. Concern over loss of face or fear of open communication with healthcare providers and other authorities might also obstruct social support seeking. For these reasons, the project will examine participants thoughts, feelings, and communication behavior in the realm of social support in an effort to better understand characteristics of successful and unsuccessful supportive communication in an important segment of the Thai population living with HIV/AIDS.

Research Procedures

If you choose to participate in this study, you will be asked to do three things. First, Wuttichai Phaovanich, the main researcher, will observe between 3-6 formal support groups meetings organized by the POZ Home Center or Thai Red Cross's Wednesday Friends Club or the HIV Foundation based in Bangkok. If you are a participant in those group meetings, the researcher will be observing you, along with other participants who consent to participate in the study. Second, Mr. Phaovanich will conduct private one-on-one interviews that will take between 30-60 minutes. Third, you may be asked to keep a diary for between 1 and 2 months, in which you record and reflect on social support experiences. Mr. Phaovanich will ask to receive journal entries every 15 days and may ask brief questions to clarify his understanding of journal writing.

Duration of the Study

If you participate in all observed social support group meetings, your participation in the study will last approximately 8 months: a maximum of 6 months during which during which Mr. Phaovanich observes social support group meetings, plus one-on-one interviews with anyone wishing to be interviewed but not having been interviewed before the end of support group observations. Social support group meeting time will be determined by the sponsoring organization (POZ Home Center or The Thai Red Cross's Wednesday Friends Club or the HIV Foundation), but generally last 60-90 minutes. The single face-to-face interviews will take between 30-60 minutes. Journal entry length will be determined by the participant, but generally should be a minimum of one paragraph, written daily, for 1-2 months.

Risks and Discomforts

Risks or discomforts of participation include the likelihood of being observed during discussions of sensitive topics, and discomfort or upset from hearing, recalling, or revealing sensitive information. Similarly, during one-on-one interviews, participants may be asked to discuss sensitive and potentially emotionally upsetting topics. Participants who find it difficult to cope with participation for any reason, and at any time, will be encouraged to contact counselors at the POZ Home Foundations, the Thai Red Cross's Wednesday Friends Club, the HIV Foundation. You can also find counseling services in the Bangkok area by (going to website and/or calling hotline). Participation is completely voluntary, and you will be free to (a) refuse participation in any aspect of the study and (b) end your participation in the study at any time.

Benefits

Individually, you may benefit from this study by having the opportunity to talk about challenges of your situation. This may be helpful for your mood and possibly for self-insight about these challenges and how to better manage them.

This study is also important because it will help researchers and Thai society understand better what makes social support helpful and what inhibits effective social support. Because of this, improving social support among HIV+ MSM, particularly in Bangkok where the incidence of HIV/AIDS among MSM is very high, is likely to help members of this community live more healthfully and safely.

Confidentiality and Records

Your study information will be kept strictly confidential. Records of observations, such as tape recordings and notes, will be kept in a locked file cabinet in Mr. Phaovanich's home and will be used solely for academic purposes. Participants will be asked to use no identifying information (e.g. their real names) throughout the research process. Mr. Phaovanich will erase any personally identifying information from transcripts or other materials, except for an ID number assigned to participants and used exclusively for organizing data. All recorded data will be destroyed within two years of the completion of my research in 2016.

Additionally, while every effort will be made to keep your study-related information confidential, there may be circumstances where this information must be shared with:

* Federal agencies, for example the Office of Human Research Protections, whose responsibility is to protect human subjects in research
* Representatives of Ohio University (OU), including the Institutional Review Board, a committee that oversees the research at OU.

Compensation

Free English courses will be offered to HIV+ MSM for 10 months so that they will be able to use it for their career life. Furthermore, the names of diary writers will be entered into a lottery/drawing for a gift voucher (e.g. 300 baht (approximately US$10) food or book coupons).

Contact Information

If you have any questions regarding this study, please contact Mr. Phaovanich at wutti1825@msn.com or 085-1920483

If you have any questions regarding your rights as a research participant, please contact Jo Ellen Sherow, Director of Research Compliance, Ohio University, (740)593-0664 or (email address).

By signing below, you are agreeing that:

- you have read this consent form (or it has been read to you) and have been given the opportunity to ask questions and have them answered
- you have been informed of potential risks and they have been explained to your satisfaction.
- you understand Ohio University has no funds set aside for any injuries you might receive as a result of participating in this study
- you are 18 years of age or older
- your participation in this research is completely voluntary
- you may leave the study at any time. If you decide to stop participating in the study, there will be no penalty to you and you will not lose any benefits to which you are otherwise entitled.

Signature Date

Printed Name

Version Date: [insert mm/dd/yy]

Appendix C

Consent Form for Consent Form for HIV+ Thai Men who Have Sex with Men

(Thai Version)

หนังสือเจตนายินยอมเข้าร่วมการวิจัย

หัวข้อในการศึกษาวิจัย : การสื่อสารเพื่อให้การสนับสนุนทางสังคมแก่ชายรักชายไทยผู้ติดเชื้อ เอช ไอ วี

ผู้ทำการศึกษาวิจัย : นาย วุฒิชัย เผ่าวนิช และ ศาสตราจารย์ ดร. Austin S. Babrow

ท่านกำลังได้รับเชิญให้เข้าร่วมในการวิจัยนี้ เพื่อที่จะสามารถตัดสินใจว่าต้องการที่จะเข้าร่วมในการวิจัย หรือไม่ ท่านควรเข้าใจเกี่ยวกับรายละเอียดของการวิจัย ความเสี่ยงและประโยชน์ที่อาจจะเกิดขึ้นเพื่อประกอบการตัดสินใจในครั้งนี้ ซึ่งกระบวนการนี้เรียกว่าการยินยอมเข้าร่วมการวิจัย เอกสารฉบับนี้จะแสดงรายละเอียดเกี่ยวกับวัตถุประสงค์ในการศึกษาวิจัย ขั้นตอนในการศึกษาวิจัย รวมถึงความเสี่ยงและประโยชน์ที่อาจจะเกิดขึ้นระหว่างทำการศึกษาวิจัย และ อธิบายว่าข้อมูลส่วนตัวของท่านจะถูกนำไปใช้และเก็บรักษาเป็นความลับอย่างไร เมื่อท่านได้อ่านเอกสารฉบับนี้แล้ว และเมื่อคำถามของท่านได้ถูกตอบเรียบร้อยแล้ว ท่านจะถูกขอให้ลงชื่อในเอกสารฉบับนี้เพื่อที่จะเข้าร่วมในงานศึกษาวิจัย ท่านควรจะเก็บสำเนาข้อมูลฉบับนี้ไว้กับท่านด้วย

อธิบายโครงการวิจัย

การวิจัยนี้มีวัตถุประสงค์เพื่อสำรวจการสนับสนุนทางสังคมที่มีต่อชายรักชายไทยผู้ติดเชื้อ เอช ไอ วี แม้ว่าจะมีเครือข่ายการสนับสนุนในรูปแบบที่เป็นทางการและไม่เป็นทางการอยู่มากที่สามารถช่วยบรรเทาความเครียดและอาการเจ็บป่วยของผู้ติดเชื้อ แต่วัฒนธรรมไทยทำให้การมองหาหรือการรับการช่วยเหลือของผู้ติดเชื้อเป็นเรื่องยาก นอกจากนี้ ความอับอายและ การไม่กล้าที่จะสื่อสารอย่างเปิดเผยกับเจ้าหน้าที่หรือบุคลากรที่มีความชำนาญด้านสุขภาพอาจจะเป็นอุปสรรคต่อการมองหาความช่วยเหลือด้วยเช่นกัน ด้วยเหตุนี้ การวิจัยนี้จึงมุ่งศึกษา ความคิด ความรู้สึก และพฤติกรรมการสื่อสาร ซึ่งเกี่ยวกับการสนับสนุนทางสังคมของผู้เข้าร่วมวิจัยเพื่อที่จะเข้าใจลักษณะของการสื่อสารที่ประสบความสำเร็จ หรือล้มเหลว ในกลุ่มชายรักชายไทยผู้ติดเชื้อ เอชไอวี/ เอดส์

ขั้นตอนในการศึกษาวิจัย

เมื่อในกรณีที่ท่านมีความสมัครใจในการเข้าร่วมการวิจัยครั้งนี้ ท่านจะได้รับการเสนอให้มีส่วนร่วมใน 3 ขั้นตอน โดยขั้นตอนแรก นายวุฒิชัย เผ่าวนิช หรือผู้ทำการศึกษาวิจัย จะเข้าร่วมสังเกตการพูดคุยในกลุ่มสนับสนุน (support group) 3-6 ครั้ง ซึ่งจัดขึ้นที่ ศูนย์ พอส โฮมเซ็นเตอร์ กรุงเทพ หรือ ที่ ชมรมเพื่อนวันพุธ สภากาชาดไทย กรุงเทพ หรือ ที่มูลนิธิ เอช ไอ วี ต่อจากนั้น ผู้วิจัยจะสัมภาษณ์รายบุคคล โดยจะใช้เวลาประมาณ 30 ถึง 60 นาที ต่อจากนั้น ผู้วิจัยอาจจะขอให้ท่านเขียนบันทึกประจำวัน เป็นเวลา 1 ถึง 2 เดือน โดย เขียนเล่า และ คิดทบทวนถึงประสบการณ์

ซึ่งเกี่ยวกับการช่วยเหลือทางสังคมในแต่ละวัน ซึ่งทุกๆ 15 วัน ผู้วิจัยจะขออนุญาตเก็บบันทึกประสบการณ์ที่เขียนไว้ในแต่ละวัน และถามคำถามสั้นๆเพื่อที่จะทำความเข้าใจให้ตรงกับสิ่งที่เขียนไว้

ระยะเวลาการวิจัย

ถ้าท่านเข้าร่วมพูดคุยในกลุ่มสนับสนุน การมีส่วนร่วมในการวิจัยนี้จะใช้เวลานานสุดประมาณ 8 เดือน โดยการพูดคุยในกลุ่มและการสัมภาษณ์รายบุคคล จะใช้เวลารวมประมาณ 6 เดือน ช่วงเวลาการจัดกลุ่มจะกำหนดโดยองค์กรที่สนับสนุนกิจกรรมดังกล่าว (พอส โฮม เซนเตอร์ หรือ ชมรมเพื่อนวันพุทธ หรือ มูลนิธิเอชไอ วี) แต่โดยทั่วไปใช้ระยะเวลา 60-90 นาที ส่วนการสัมภาษณ์ใช้ระยะเวลา 30-60 นาที นอกจากนี้ ความยาวของบันทึกประจำวันจะถูกกำหนดโดยผู้เข้าร่วมวิจัย แต่โดยทั่วไปแล้วควรจะมีความยาวโดยประมาณอย่างน้อย 1 ย่อหน้า ซึ่งเขียนเป็นประจำทุกวัน ใช้ระยะเวลา 1-2 เดือน

ความเสี่ยงและความอึดอัดใจ

ความเสี่ยงหรือความอึดอัดใจ อาจจะเกิดขึ้นได้ในช่วงระหว่างการสัมภาษณ์ ผู้เข้าร่วมวิจัยอาจจะมีการพูดคุยหัวข้อที่มีความละเอียดอ่อน และมีความเป็นไปได้ที่จะส่งผลกระทบต่อสภาพจิตใจและความรู้สึก การเขียนบันทึกประจำวันก็เช่นกัน อาจจะทำให้นึกถึงเหตุการณ์ที่สะเทือนใจและเกิดความเศร้าขึ้นได้ อย่างไรก็ดีผู้เข้าร่วมงานวิจัยมีสิทธิ์ที่จะกำหนดขอบเขตเนื้อหาที่จะพูดและ เปิดเผยต่อผู้วิจัย ถ้าผู้เข้าร่วมวิจัยท่านใดก็ตามไม่สะดวกเข้าร่วมการวิจัย สามารถติดต่อเจ้าหน้าที่ขององค์กรของท่าน หรือ สามารถติดต่อศูนย์บริการให้คำปรึกษาในกรุงเทพมหานครโดยไปที่ เวปไซต์ http://www.adamslove.org/d.php?id=39 และ/หรือ โทรสายด่วนเบอร์ 02 252-2568-9 หรือ 1663.การเข้าร่วมวิจัยในครั้งนี้เป็นการสมัครใจของท่าน โดยท่านมีสิทธิที่จะปฏิเสธ หรือ ไม่เข้าร่วมหากท่านไม่ประสงค์หรือไม่พึงพอใจต่อการศึกษาวิจัยครั้งนี้เมื่อใดก็ได้

ประโยชน์ที่จะได้รับจากการวิจัย

ท่านจะได้ประโยชน์จากงานศึกษานี้ โดยได้มีโอกาสพูดคุยเกี่ยวกับปัญหาที่เกิดขึ้นกับตัวท่านเอง และ สิ่งนี้อาจจะช่วยในเรื่องของการจัดการทางอารมณ์ ความรู้สึก และการเข้าใจปัญหาที่ดีขึ้น

งานศึกษาชิ้นนี้มีความสำคัญ เนื่องจากจะช่วยให้ผู้วิจัย และสังคมไทย เข้าใจว่ามีปัจจัยอะไรบ้างที่ทำให้เกิดการช่วยเหลือทางสังคม และ เป็นอุปสรรคต่อการช่วยเหลือ ดังนั้นการพัฒนาการช่วยเหลือทางสังคมจะช่วยให้กลุ่มชายรักชายผู้ติดเชื้อเอช ไอ วี โดยเฉพาะอย่างยิ่งในเขตกรุงเทพมหานคร ซึ่งมีอัตราการติดเชื้อสูงขึ้น สามารถอยู่ในสังคมด้วยสุขภาพที่ดี และมีความปลอดภัย

ความลับและการบันทึกข้อมูล

ข้อมูลการศึกษาของท่านจะถูกเก็บไว้เป็นความลับอย่างถึงที่สุด การบันทึกข้อมูลสำหรับศึกษาวิจัยจะถูกจัดเก็บในรูปแบบของ เทปบันทึกเสียงและ บันทึกส่วนตัวประจำวัน และอุปกรณ์เหล่านี้จะถูกเก็บรักษาในที่เก็บเอกสารสำคัญในที่พักอาศัยของผู้วิจัย และจะใช้เพื่อวัตถุประสงค์ทางวิชาการเท่านั้น ท่านจะถูกขอให้ใช้ข้อมูลที่ไม่ระบุตัวตน เช่น ชื่อจริง เป็นต้น ตลอดกระบวนการวิจัย ผู้วิจัยจะลบข้อมูลส่วนตัวที่สามารถระบุตัวตนทั้งหมดของผู้เข้าร่วมวิจัยจากบทถอดเทปสัมภาษณ์หรือเอกสารอื่นๆ ยกเว้นเลขประจำตัวที่ให้กับผู้เข้าร่วมวิจัย ซึ่งจะใช้สำหรับจัดเก็บข้อมูลเท่านั้น ข้อมูลบันทึกทั้งหมดจะถูกลบทำลายภายใน 2ปีหลังจากการวิจัยนี้เสร็จสมบูรณ์ในปี 2559

นอกจากนี้ ในขณะที่ทำการวิจัยข้อมูลต่างๆจะถูกเก็บไว้อย่างเป็นความลับสูงสุด แต่ในบางกรณีผู้ทำวิจัยอาจจะต้องรายงานข้อมูลเหล่านี้แก่หน่วยงานตรวจสอบวิจัยที่เกี่ยวข้อง ดังนี้

*หน่วยงานของรัฐบาลกลาง เช่น หน่วยงานพิทักษ์สิทธิมนุษยชนเพื่องานวิจัย ซึ่งกำกับดูแลในเรื่องของ สิทธิและเสรีภาพแก่ผู้ถูกวิจัย

*ตัวแทนของมหาวิทยาลัยโอไฮโอ รวมถึง คณะกรรมการตัดสินผลงานวิจัยที่กำกับดูแลการจัดทำงานวิจัยของผู้ศึกษา ที่มหาวิทยาลัยโอไฮโอ

การชดเชย

ท่านจะได้เรียนวิชาภาษาอังกฤษฟรีเป็นเวลาสิบเดือน เพื่อที่จะได้พัฒนาความคล่องในการใช้ภาษาสำหรับชีวิตประจำวัน และ การทำงาน และชื่อของผู้เขียนบันทึกประจำวันจะถูกลุ้นชิงโชคบัตรกำนัล เช่น คูปองแลกอาหารและหนังสือมูลค่า 300 บาท

เงื่อนไขและรายละเอียด

ในกรณีที่ท่านมีข้อสงสัยหรือ คำถามเกี่ยวกับการศึกษาวิจัยครั้งนี้ กรุณาติดต่อ คุณวุฒิชัย เผ่าวนิช ที่ อีเมล์ wphaovanich@gmail.com หรือ โทรศัพท์ 084-1691650 หรือ ศาสตราจารย์ ดร. Austin S. Babrow ที่ อีเมล์ babrow@ohio.edu

ในกรณีที่ท่านมีข้อสงสัยในสิทธิ เกี่ยวกับผู้เข้าร่วมวิจัย ในการศึกษาวิจัยครั้งนี้ กรุณาติดต่อ คุณ Jo Ellen Sherow ผู้อำนวยการฝ่ายวิจัย มหาวิทยาลัยโอไฮโอ ที่เบอร์โทรศัพท์ (740)593-0664 หรือ อีเมล์ sherow@ohio.edu

เมื่อท่านลงชื่อในหนังสือเจตนายินยอมนี้ ถือว่าท่านได้ยอมรับตามข้อตกลง ดังนี้

- ท่านได้อ่านรายละเอียดในเอกสารนี้โดยละเอียด (หรือผู้ทำวิจัยได้แจ้งรายละเอียดของเอกสารนี้แก่ท่าน) ด้วยตนเองและท่านได้รับโอกาสที่สอบถามข้อสงสัยต่างๆจนเป็นที่พอใจแล้ว

- ท่านได้รับทราบถึงความเสี่ยงที่อาจเกิดขึ้นระหว่างการวิจัยและได้รับคำอธิบายจากผู้วิจัยจนเป็นที่พอใจแล้ว
- ทางมหาวิทยาลัย โอไฮโอ ไม่มีส่วนรับผิดชอบในค่าความเสียหายที่อาจจะเกิดขึ้นระหว่างการทำการวิจัยครั้งนี้
- ท่านมีอายุ 18ปี ขึ้นไป
- ท่านมีความประสงค์อย่างยิ่ง ที่จะมีส่วนร่วมในการศึกษาวิจัยครั้งนี้
- ท่านมีสิทธิที่จะปฏิเสธหรือ ไม่เข้าร่วมหากท่านไม่ประสงค์หรือไม่พึงพอใจต่อการศึกษาวิจัยครั้งนี้เมื่อใดก็ได้ โดยท่านจะไม่ได้รับผลกระทบ หรือเสียสิทธิประโยชน์ใดๆที่ท่านควรจะได้รับ

ลงชื่อ .....

วันที่…….

ชื่อ (ตัวบรรจง) ..... วันที่: (วว/ดด/ปป) …/…/…/.

Appendix D

Consent Form for the Staff of Three HIV/AIDS Organizations

(English Version)

Ohio University Consent Form

Title of Research: Communicating Social Support for HIV+ Thai Men who have Sex with Men (MSM)

Researchers: Wuttichai Phaovanich and Prof. Dr. Austin S. Babrow

You are being asked to participate in research. For you to be able to decide whether you want to participate in this project, you should understand what the project is about, as well as the possible risks and benefits, in order to make an informed decision. This process is known as informed consent. This form describes the purpose, procedures, possible benefits, and risks. It also explains how your personal information will be used and protected. Once you have read this form and your questions about the study are answered, you will be asked to sign it. This will allow your participation in this study. You should receive a copy of this document to take with you.

Explanation of Study

This study investigates social support related to HIV+ Thai Men who have Sex with Men (MSM). Although formal and informal support networks can help HIV+ MSM alleviate their stress and cope more effectively with their illness, Thai culture can make it difficult for MSM to seek and obtain support. Concern over loss of face or fear of open communication with healthcare providers and other authorities might also obstruct social support seeking. For these reasons, the project will examine your thoughts, feelings, and communication behavior in the realm of social support in an effort to better understand characteristics of successful and unsuccessful supportive communication in an important segment of the Thai HIV+ population.

Research Procedures

You are being asked to consent to observation as a group moderator in regularly scheduled support group meetings at the POZ Home Center Foundation or The Thai Red Cross's Wednesday Friends Club or the HIV Foundation you have been involving in. Also, you are being asked to be interviewed if you wish. The single interview will take between 30-60 minutes with you as the staff who take care of HIV+ Thai MSM.

Duration of the Study

If you participate in all observed social support group meetings, your participation in the study will last approximately 8 months: a maximum of 6 months during which Mr. Phaovanich observes social support group meetings, plus a month or two following those meetings during which Mr. Phaovanich will be finishing one-

on-one interviews with any of you wishing to be interviewed but not having been interviewed before the end of support group observations. Social support group meeting time will be determined by the sponsoring organization (The POZ Home Center Foundation or The Thai Red Cross's Wednesday Friends Club or the HIV Foundation), but generally last 60-90 minutes. The single face-to-face interviews will take between 30-60 minutes.

Risks and Discomforts

Risks or discomforts of participation include upset from hearing, recalling, or revealing sensitive information. Similarly, during one-on-one interviews, you may be asked to discuss sensitive and potentially emotionally upsetting topics. You will be free at all times to determine the extent to which you wish to speak and the content you wish to reveal. Participation is completely voluntary, and you will be free to (a) refuse participation in any aspect of the study and (b) end your participation in the study at any time.

Benefits

Individually, having the opportunity to talk about challenges of providing social support may be helpful possibly for self-insight about these challenges and how to help HIV+Thai MSM better manage them.

This study is also important because it will help researchers and Thai society understand better what makes social support helpful and what inhibits effective social support. Because of this, improving social support among HIV+ MSM, particularly in Bangkok where the incidence of HIV/AIDS among MSM is very high, is likely to help members of this community live more healthfully and safely.

Confidentiality and Records

Your study information will be kept strictly confidential. Records of observations, such as tape recordings and notes, will be kept in a locked file cabinet in Mr. Phaovanich's study room at his home, and only the researcher will have the key to open the cabinet. The information will be used solely for this research of communicating social support for HIV+ Thai men who have sex with men (MSM). You will be asked to use no identifying information (e.g. real names) throughout the research process except that the researcher will use the master pseudonym list containing your real names and pseudonyms that will be kept by only the researcher to track the progress of social support over time. This master list will be kept in a separate locked filing cabinet from the audio tapes and written interviews. Mr. Phaovanich will erase any personally identifying information from transcripts, the master pseudonym list or other materials, except for an ID number assigned to you and used exclusively for organizing data. All recorded data will be destroyed within two years of the completion of my research in December 2016.

Additionally, while every effort will be made to keep your study-related information confidential, there may be circumstances where this information must be shared with:

* Federal agencies, for example the Office of Human Research Protections of the United States government, whose responsibility is to protect human subjects in research
* Representatives of Ohio University (OU), including the Institutional Review Board, a committee that oversees the research at OU.

Compensation

As compensation for your time/effort, you as the staff will be provided with free English lessons for 10 months. These lessons will help you to improve communication in English. Also, Mr. Phaovanich will be willing to help you with social support activities for HIV+ Thai MSM as far as he can.

Contact Information

If you have any questions regarding this study, please contact me Mr. Phaovanich as a researcher at wutti1825@msn.com or 085-1920483 or Prof. Dr. Austin S. Babrow at babrow@ohio.edu

If you have any questions regarding your rights as a research participant, please contact Jo Ellen Sherow, Director of Research Compliance, Ohio University, (740)593-0664 or sherow@ohio.edu

By signing below, you are agreeing that:

- you have read this consent form (or it has been read to you) and have been given the opportunity to ask questions and have them answered
- you have been informed of potential risks and they have been explained to your satisfaction.
- you understand Ohio University has no funds set aside for any injuries you might receive as a result of participating in this study
- you are 18 years of age or older
- your participation in this research is completely voluntary
- you may leave the study at any time. If you decide to stop participating in the study, there will be no penalty to you and you will not lose any benefits to which you are otherwise entitled.

Signature Date

Printed Name

Version Date: [insert mm/dd/yy]

Appendix E

Consent Form for the Staff of Three HIV/AIDS Organizations

(Thai Version)

หนังสือเจตนายินยอมเข้าร่วมการวิจัย

หัวข้อในการศึกษาวิจัย : การสื่อสารเพื่อให้การสนับสนุนทางสังคมแก่ชายรักชายไทยผู้ติดเชื้อ เอช ไอ วี

ผู้ทำการศึกษาวิจัย : นาย วุฒิชัย เผ่าวนิช และ ศาสตราจารย์ ดร. Austin S. Babrow

ท่านกำลังได้รับเชิญให้เข้าร่วมในการวิจัยนี้ เพื่อที่จะสามารถตัดสินใจว่าต้องการที่จะเข้าร่วมในการวิจัย หรือไม่ ท่านควรเข้าใจเกี่ยวกับรายละเอียดของการวิจัย ความเสี่ยงและประโยชน์ที่อาจจะเกิดขึ้นเพื่อประกอบการตัดสินใจในครั้งนี้ ซึ่งกระบวนการนี้เรียกว่าการยินยอมเข้าร่วมการวิจัย เอกสารฉบับนี้จะแสดงรายละเอียดเกี่ยวกับวัตถุประสงค์ในการศึกษาวิจัย ขั้นตอนในการศึกษาวิจัย รวมถึงความเสี่ยงและประโยชน์ที่อาจจะเกิดขึ้นระหว่างทำการศึกษาวิจัย และ อธิบายว่าข้อมูลส่วนตัวของท่านจะถูกนำไปใช้และเก็บรักษาเป็นความลับอย่างไร เมื่อท่านได้อ่านเอกสารฉบับนี้แล้ว และเมื่อคำถามของท่านได้ถูกตอบเรียบร้อยแล้ว ท่านจะถูกขอให้ลงชื่อในเอกสารฉบับนี้เพื่อที่จะเข้าร่วมในงานศึกษาวิจัย ท่านควรจะเก็บสำเนาข้อมูลฉบับนี้ไว้กับท่านด้วย

อธิบายโครงการวิจัย

การวิจัยนี้มีวัตถุประสงค์เพื่อสำรวจการสนับสนุนทางสังคมที่มีต่อชายรักชายไทยผู้ติดเชื้อ เอช ไอ วี แม้ว่าจะมีเครือข่ายการสนับสนุนในรูปแบบที่เป็นทางการและไม่เป็นทางการอยู่มากที่สามารถช่วยบรรเทาความเครียดและอาการเจ็บป่วยของผู้ติดเชื้อ แต่วัฒนธรรมไทยทำให้การมองหาหรือการรับการช่วยเหลือของผู้ติดเชื้อเป็นเรื่องยาก นอกจากนี้ ความอับอายและ การไม่กล้าที่จะสื่อสารอย่างเปิดเผยกับเจ้าหน้าที่หรือบุคลากรที่มีความชำนาญด้านสุขภาพอาจจะเป็นอุปสรรคต่อการมองหาความช่วยเหลือด้วยเช่นกัน ด้วยเหตุนี้ การวิจัยนี้จึงมุ่งศึกษา ความคิด ความรู้สึก และพฤติกรรมการสื่อสาร ซึ่งเกี่ยวกับการสนับสนุนทางสังคมของผู้เข้าร่วมวิจัยเพื่อที่จะเข้าใจลักษณะของการสื่อสารที่ประสบความสำเร็จ หรือล้มเหลว ในกลุ่มชายรักชายไทยผู้ติดเชื้อ เอชไอวี/ เอดส์

ขั้นตอนในการศึกษาวิจัย

ท่านกำลังถูกขอเพื่อแสดงความยินยอมในการเป็นผู้ดำเนินการอภิปรายในกลุ่มสนับสนุน ซึ่งจัดเป็นปกติตามตารางที่มีการนัดหมายที่ มูลนิธิ พอส โฮม เซนเตอร์ หรือ ชมรมเพื่อนวันพุธ สภากาชาดไทย หรือ มูลนิธิ เอช ไอ วี และท่านซึ่งเป็นเจ้าหน้าที่ดูแลกลุ่มชายรักชายผู้ติดเชื้อ เอช ไอ วี กำลังถูกขอให้เข้าร่วมสัมภาษณ์ การสัมภาษณ์เดี่ยวใช้เวลาประมาณ 30-60 นาที

ระยะเวลาการวิจัย

ถ้าท่านเข้าร่วมในกลุ่มสนับสนุน การมีส่วนร่วมในการวิจัยนี้จะใช้เวลานานสุดประมาณ 8 เดือน โดยการพูดคุยในกลุ่มและการสัมภาษณ์รายบุคคล จะใช้เวลารวมประมาณ 6 เดือน ช่วงเวลาการจัดกลุ่มจะกำหนดโดยองค์กรที่สนับสนุนกิจกรรมดังกล่าว (พอส โฮม เซนเตอร์ หรือ ชมรมเพื่อนวันพุทธ หรือ มูลนิธิเอชไอ วี) แต่โดยทั่วไปใช้ระยะเวลา 60-90 นาที ส่วนการสัมภาษณ์ใช้ระยะเวลา 30-60 นาที นอกจากนี้ ความยาวของบันทึกประจำวันจะถูกกำหนดโดยผู้เข้าร่วมวิจัย แต่โดยทั่วไปแล้วควรจะมีความยาวโดยประมาณอย่างน้อย 1 ย่อหน้า ซึ่งเขียนเป็นประจำทุกวัน ใช้ระยะเวลา 1-2 เดือน

ความเสี่ยงและความอึดอัดใจ

ความเสี่ยงหรือความอึดอัดใจ อาจจะเกิดขึ้นได้ในช่วงระหว่างการสัมภาษณ์ ผู้เข้าร่วมวิจัยอาจจะมีการพูดคุยหัวข้อที่มีความละเอียดอ่อน และมีความเป็นไปได้ที่จะส่งผลกระทบต่อสภาพจิตใจและความรู้สึก การเขียนบันทึกประจำวันก็เช่นกัน อาจจะทำให้นึกถึงเหตุการณ์ที่สะเทือนใจและเกิดความเศร้าขึ้นได้ อย่างไรก็ดีผู้เข้าร่วมงานวิจัยมีสิทธิ์ที่จะกำหนดขอบเขตเนื้อหาที่จะพูดและ เปิดเผยต่อผู้วิจัย การเข้าร่วมวิจัยในครั้งนี้เป็นการสมัครใจของท่าน โดยท่านมีสิทธิที่จะปฏิเสธหรือ ไม่เข้าร่วมหากท่านไม่ประสงค์หรือไม่พึงพอใจต่อการศึกษาวิจัยครั้งนี้เมื่อใดก็ได้

ประโยชน์ที่จะได้รับจากการวิจัย

ท่านจะได้ประโยชน์จากงานศึกษานี้ โดยได้มีโอกาสพูดคุยเกี่ยวกับปัญหาที่เกิดขึ้นกับตัวท่านเอง และ สิ่งนี้อาจจะช่วยในเรื่องของการจัดการทางอารมณ์ ความรู้สึก และการเข้าใจปัญหาที่ดีขึ้น

งานศึกษาชิ้นนี้มีความสำคัญ เนื่องจากจะช่วยให้ผู้วิจัย และสังคมไทย เข้าใจว่ามีปัจจัยอะไรบ้างที่ทำให้เกิดการช่วยเหลือทางสังคม และ เป็นอุปสรรคต่อการช่วยเหลือ ดังนั้นการพัฒนาการช่วยเหลือทางสังคมจะช่วยให้กลุ่มชายรักชายผู้ติดเชื้อเอช ไอ วี โดยเฉพาะอย่างยิ่ง ในเขตกรุงเทพมหานคร ซึ่งมีอัตราการติดเชื้อสูงขึ้น สามารถอยู่ในสังคมด้วยสุขภาพที่ดี และมีความปลอดภัย

ความลับและการบันทึกข้อมูล

ข้อมูลการศึกษาของท่านจะถูกเก็บไว้เป็นความลับอย่างถึงที่สุด การบันทึกข้อมูลสำหรับศึกษาวิจัยจะถูกจัดเก็บในรูปแบบของ เทปบันทึกเสียงและ บันทึกส่วนตัวประจำวัน และอุปกรณ์เหล่านี้จะถูกเก็บรักษาในที่เก็บเอกสารสำคัญในที่พักอาศัยของผู้วิจัย และจะใช้เพื่อวัตถุประสงค์ทางวิชาการเท่านั้น ท่านจะถูกขอให้ใช้ข้อมูลที่ไม่ระบุตัวตน เช่น ชื่อจริง เป็นต้น ตลอดกระบวนการวิจัย ผู้วิจัยจะลบข้อมูลส่วนตัวที่สามารถระบุตัวตนทั้งหมดของผู้เข้าร่วมวิจัยจากบทถอดเทปสัมภาษณ์หรือเอกสารอื่นๆ ยกเว้นเลขประจำตัวที่ให้กับผู้เข้าร่วมวิจัย ซึ่งจะใช้สำหรับ

จัดเก็บข้อมูลเท่านั้น ข้อมูลบันทึกทั้งหมดจะถูกลบทำลายภายใน 2ปีหลังจากการวิจัยนี้เสร็จสมบูรณ์ในปี 2559

นอกจากนี้ ในขณะที่ทำการวิจัยข้อมูลต่างๆจะถูกเก็บไว้อย่างเป็นความลับสูงสุด แต่ในบางกรณีผู้ทำวิจัยอาจจะต้องรายงานข้อมูลเหล่านี้แก่หน่วยงานตรวจสอบวิจัยที่เกี่ยวข้อง ดังนี้

* หน่วยงานของรัฐบาลกลาง เช่น หน่วยงานพิทักษ์สิทธิมนุษยชนเพื่องานวิจัย ซึ่งกำกับดูแลในเรื่องของ สิทธิและเสรีภาพแก่ผู้ถูกวิจัย
* ตัวแทนของมหาวิทยาลัยโอไฮโอ รวมถึง คณะกรรมการตัดสินผลงานวิจัยที่กำกับดูแลการจัดทำงานวิจัยของผู้ศึกษา ที่มหาวิทยาลัยโอไฮโอ

การชดเชย

การชดเชยสำหรับเวลา/การช่วยในงานวิจัยครั้งนี้ ท่านซึ่งเป็นเจ้าหน้าที่ดูแลผู้ติดเชื้อจะได้เรียนภาษาอังกฤษฟรีเป็นเวลาสิบเดือน เพื่อที่จะช่วยพัฒนาการสื่อสารภาษาอังกฤษ และ ผู้วิจัยยินดีที่จะช่วยเหลือในกิจกรรมสนับสนุนทางสังคมสำหรับกลุ่มชายรักชายผู้ติดเชื้อเอชไอวี ตามความสามารถที่พอจะช่วยได้

เงื่อนไขและรายละเอียด

ในกรณีที่ท่านมีข้อสงสัยหรือ คำถามเกี่ยวกับการศึกษาวิจัยครั้งนี้ กรุณาติดต่อ คุณวุฒิชัย เผ่าวนิช ที่ อีเมล์ wphaovanich@gmail.com หรือ โทรศัพท์ 084-1691650 หรือ ศาสตราจารย์ ดร. Austin S. Babrow ที่ อีเมล์ babrow@ohio.edu

ในกรณีที่ท่านมีข้อสงสัยในสิทธิ เกี่ยวกับผู้เข้าร่วมวิจัย ในการศึกษาวิจัยครั้งนี้ กรุณาติดต่อ คุณ Jo Ellen Sherow, ผู้อำนวยการฝ่ายวิจัย มหาวิทยาลัยโอไฮโอ ที่เบอร์โทรศัพท์ (740)593-0664 หรืออีเมล์ sherow@ohio.edu

เมื่อท่านลงชื่อในหนังสือเจตนายินยอมนี้ ถือว่าท่านได้ยอมรับตามข้อตกลง ดังนี้

- ท่านได้อ่านรายละเอียดในเอกสารนี้โดยละเอียด (หรือผู้ทำวิจัยได้แจ้งรายละเอียดของเอกสารนี้แก่ท่าน) ด้วยตนเองและท่านได้รับโอกาสที่สอบถามข้อสงสัยต่างๆจนเป็นที่พอใจแล้ว
- ท่านได้รับทราบถึงความเสี่ยงที่อาจเกิดขึ้นระหว่างการวิจัยและได้รับคำอธิบายจากผู้วิจัยจนเป็นที่พอใจแล้ว
- ทางมหาวิทยาลัย โอไฮโอ ไม่มีส่วนรับผิดชอบในค่าความเสียหายที่อาจจะเกิดขึ้นระหว่างการทำการวิจัยครั้งนี้
- ท่านมีอายุ 18ปี ขึ้นไป

- ท่านมีความประสงค์อย่างยิ่ง ที่จะมีส่วนร่วมในการศึกษาวิจัยครั้งนี้
- ท่านมีสิทธิที่จะปฏิเสธหรือ ไม่เข้าร่วมหากท่านไม่ประสงค์หรือไม่พึงพอใจต่อการศึกษาวิจัยครั้งนี้เมื่อใดก็ได้ โดยท่านจะไม่ได้รับผลกระทบ หรือเสียสิทธิประโยชน์ใดๆ ที่ท่านควรจะได้รับ

ลงชื่อ .....

วันที่…….

ชื่อ (ตัวบรรจง) ..... วันที่: (วว/ดด/ปป) …/…/…/.

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FOUNDED 1962

Appendix F

Participants' Information

Organization A

Participant	Age	Periods of Infection	Position	Province
1. Ae	44	8 months	Patient	Bangkok
2. Arm	24	9 months	Patient	Bangkok
3. Esse	26	4 years	Patient	Bangkok
4. Kai	41	11 years	Patient	Bangkok
5. Kit	42	5 years	Patient	Bangkok
6. Kla	22	One week	Patient	Bangkok
7. PA	38	8 years	Patient	Bangkok
8. Watt	44	11 years	Patient	Bangkok
9. Tew	33	Over 1 year	Patient	Bangkok
10. Thee	56	13 years	Patient	Bangkok
11. Aun	49	20 years	Gay healthcare provider	Bangkok
12. Maze	30	5 years	Gay healthcare provider	Bangkok
13. Mod	48	18 years	Gay healthcare provider	Samut Sakhon
14. Pui	25	5 years	Gay healthcare provider	Bangkok
15. Thak	46	14 years	Gay healthcare provider	Bangkok
16. Thim	45	8 years	Gay healthcare provider	Bangkok

Organization B

Participant	Age	Periods of Infection	Position	Province
1. Joe	37	6 years	Patient	Pathumthani
2. Karn	32	1 year	Patient	Bangkok
3. Kik	24	2 years	Patient	Nonthaburi
4. King	26	4 years	Patient	Bangkok
5. Kong	38	18 years	Patient	Bangkok
6. Mai	36	5 years	Patient	Bangkok
7. Mikkie	45	20 years	Patient	Nonthaburi
8. Mos	25	2 years	Patient	Bangkok
9. Noong	28	3 years	Patient	Bangkok
10. Pang	27	9 months	Patient	Bangkok
11. Pla	28	1 year	Patient	Bangkok
12. Pong	42	19 years	Patient	Pathum Thani
13. Som	46	13 years	Patient	Bangkok
14. Tik	51	20 years	Patient	Bangkok
15. Aoo	35	10 years	Gay healthcare provider	Bangkok
16. Bu	52	15 years	Gay healthcare provider	Bangkok
17. Chain	51	20 years	Gay healthcare provider	Bangkok
18. Lim	55	Non-infected	Male healthcare provider	Bangkok
19. Mie	47	15 years	Gay healthcare provider	Bangkok
20. Preen	49	19 years	Gay healthcare provider	Bangkok

Organization C

Participant	Age	Periods of Infection	Position	Province
1. Black	22	1 year	Patient	Bangkok
2. Chai	24	5 years	Patient	Bangkok
3. Keng	23	1 year	Patient	Bangkok
4. Roon	29	1 year	Patient	Bangkok
5. Tom	26	4 months	Patient	Bangkok
6. Tuee	41	9 years	Patient	Samut Sakhon
7. Bie	24	4 years	Gay healthcare provider	Bangkok
8. Noom	41	Non-infected	Male healthcare provider	Bangkok
9. Phod	43	17 years	Gay healthcare provider	Bangkok
10. Toon	23	Non-infected	Female healthcare provider	Bangkok

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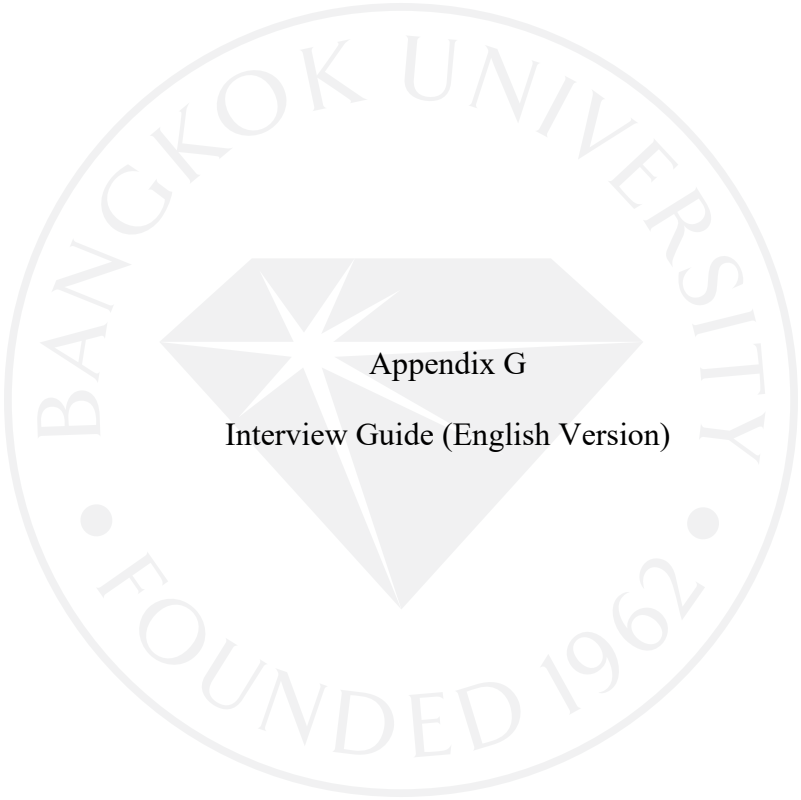


Appendix G

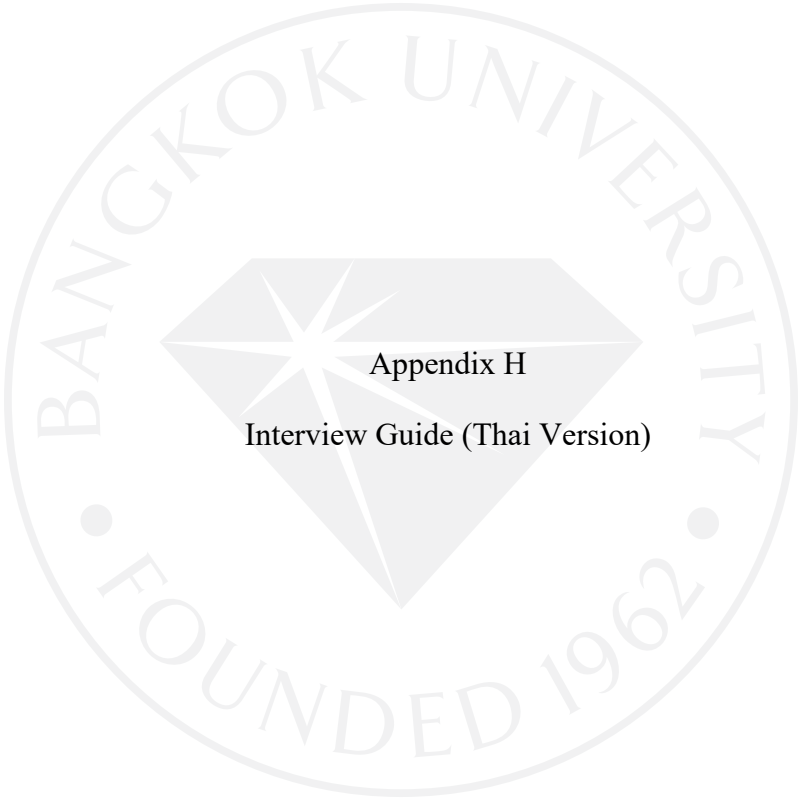
Interview Guide (English Version)

Questions for HIV+ Thai MSM

- When you find yourself wanting to talk about HIV/AIDS with someone else, what are you looking for, what do you want to accomplish?
- Tell me what you think a supportive message does or is.
- Can you recall a time when you received very positively supportive message? Please tell me about it.
- Can you recall a time when you received an unhelpful or hurtful message from someone who probably thought they were being supportive? Please tell me about it
- Can you recall a time when you wanted or did not want to communicate your private information with people in your community (family, friends, or monks), people in the healthcare setting (doctors or heathcare staff) or even other MSM with HIV/AIDS? Please tell me about it.
- What encouraged you most and least to talk to those support networks?

Questions for the Staff

- Tell me about a time when you think you were especially successful at providing social support (to people in target population). How did you communicate with them? Could you tell in any way that your message was supportive, and if so, how?
- Tell me about a time when you tried to communicate but think you failed to make your MSM understand your real intent of providing support with positively support message.
- When experiencing such communicative difficulty of support, how did you solve this problem?



Appendix H

Interview Guide (Thai Version)

คำถามสำหรับกลุ่มชายรักชายไทยผู้ติดเชื้อ เอชไอวี

- เมื่อคุณพบว่าตัวคุณเองอยากจะพูดคุยเรื่อง เอช ไอ วี/เอดส์กับคนอื่น อะไรคือสิ่งที่คุณกำลังมองหา อะไรคือสิ่งที่คุณต้องการทำให้สำเร็จ
- กรุณาเล่าถึงข้อความ/คำพูด เชิงบวกหรือเชิงสนับสนุนที่คุณได้รับมา
- คุณสามารถนึกถึงช่วงเวลาที่คุณได้รับข้อความ/คำพูดในเชิงบวกหรือเชิงสนับสนุนได้หรือไม่
- คุณสามารถนึกถึงช่วงเวลาที่คุณได้รับข้อความ หรือ คำพูดที่ทำให้คุณรู้สึกเสร้าเจ็บปวดจากบุคคลที่คุณคิดว่าคุณจะได้รับคำพูดเชิงบวกหรือเชิงสนับสนุนได้หรือไม่ โปรดเล่าให้ฟังเกี่ยวกับประสบการณ์นี้
- คุณสามารถนึกถึงช่วงเวลาที่คุณอยากหรือไม่อยากจะสื่อสารข้อมูลส่วนตัวกับผู้อื่นในสังคม (ครอบครัว, เพื่อน, หรือพระ) บุคลากรในสถานพยาบาล หรือ ศูนย์ดูแลสุขภาพ (หมอ บุคลากรทางการแพทย์ หรือ เจ้าหน้าที่ดูแลด้านสุขภาพ) หรือแม้แต่ กับกลุ่มชายรักชายที่ติดเชื้อเอช ไอ วี/ เอดส์คนอื่นๆ ได้หรือไม่ โปรดเล่าให้ฟังเกี่ยวกับประสบการณ์ที่เกิดขึ้น
- อะไรที่ทำให้คุณมีกำลังใจมากที่สุดหรือน้อยที่สุดที่จะพูดคุยกับบุคคลในเครือข่ายสนับสนุน

คำถามสำหรับเจ้าหน้าที่

- เล่าให้ผมฟังเกี่ยวกับช่วงเวลาที่คุณคิดว่าคุณประสบความสำเร็จในการจัดหาการให้การสนับสนุนทางสังคม (สำหรับคนในกลุ่มประชากรเป้าหมาย) คุณสื่อสารกับพวกเขาอย่างไร กรุณาเล่าถึงข้อความในเชิงบวกหรือเชิงสนับสนุนของคุณในทางใดก็ตาม
- เล่าให้ผมฟังเกี่ยวกับช่วงเวลาที่คุณพยายามที่จะสื่อสารกับพวกเขา แต่กลับล้มเหลวที่จะทำให้กลุ่มชายรักชายเข้าใจถึงเจตนาที่แท้จริงของคุณในการให้การสนับสนุนพวกเขากับข้อความเชิงบวก
- เมื่อคุณพบว่ามีความยากลำบากในการสื่อสารเชิงบวกหรือเชิงสนับสนุนกับพวกเขา คุณแก้ไขปัญหานั้นอย่างไร

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