The lived experience of posttraumatic growth in gay men after an HIV diagnosis: An Interpretative Phenomenological Analysis

Written by

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Abstract

As a result of advances in highly active antiretroviral therapy, human immunodeficiency virus (HIV) has been reconceptualised as a long-term chronic health condition instead of a death sentence. Nonetheless, receiving a positive diagnosis can still be an extremely traumatic experience. Whilst there are many people living with HIV who struggle with their diagnosis, some can also manage to find meaning from it and so experience positive change within their lives. This research seeks to explore the lived experience of eight HIV-positive gay men between the ages of 35 and 50 who have experienced posttraumatic growth (PTG) since their diagnosis. Interpretative phenomenological analysis (IPA) was used to analyse interview data. Four super-ordinate themes were identified: the first highlights the struggle as the men grapple with their diagnosis. The second theme explores how the men have developed more positive and meaningful relationships with themselves and other people, as well as embarking on a new relationship with their HIV. The third captures the men's positive growth as they begin to find meaning, whilst creating a more positive mindset, and instigating experiences that would enable them to experience flow and positive emotions. The final super-ordinate theme captures the ways in which the men wrestle with their identities whilst living as HIV-positive gay men. I then discuss these in light of the literature and draw implications for counselling psychology.

Keywords

Human immunodeficiency virus (HIV), posttraumatic growth (PTG), positive psychology, IPA, LGBTQ psychology, gay men.

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Chapter 1: Introduction

Many individuals will experience defining moments which have a huge impact on them, and which have the potential to change the course of their future. One of these moments might be a positive diagnosis of human immunodeficiency virus (HIV). This can bring about a chain of life-altering, traumatic experiences that can affect the overall quality of life for the individual who has been diagnosed (Martin & Kagee, 2011; Theunink, Lake, & Gibson, 2010). Such a diagnosis can be highly stressful (Nightingale, Sher, & Hansen, 2010), and for many, this may be so traumatising that they meet the diagnostic criteria for posttraumatic stress disorder (PTSD) (Anderson et al., 2010; Martin & Kagee, 2011). As well as loss of physical health, the virus can also bring a number of mental health concerns, with 48% of those living with HIV struggling with conditions such as depression and substance abuse (Whetten et al., 2008).

Whilst there are many who struggle with their diagnosis, there are others who are diagnosed with HIV and manage to find some meaning from it (Nightingale et al., 2010). These people can sometimes experience positive change, which brings them to a level of functioning higher than before they were diagnosed (Murphy & Hevey, 2013). This is known as posttraumatic growth (PTG), and can be defined as perceptions of positive change, resulting from a struggle with taxing life events and their consequences (Tedeschi & Calhoun, 1996). These positive changes can be experienced in a number of different ways (Littlewood et al., 2008).

As HIV/AIDS continues to impact the global community (Gayle & Hill, 2001), it is gay men who comprise the vast majority of people living with HIV in the cultural and geographic West, which includes the United States, United Kingdom and Australia (Beyrer et al., 2012; McGregor et al., 2015). It is also gay men who remain the group most at risk of becoming HIV-positive in the UK, comprising 53% of those diagnosed in 2017 (Health Protection Agency, 2017). In addition, HIV-positive gay men are known to experience higher rates of depression and anxiety disorders than the general population (Lyons, Pitts, & Grierson, 2012; Miners et al., 2014). A third of these HIV-positive gay men are reported to have posttraumatic stress disorder (Carter, 2010), and there is a growing body of evidence that suggests there is significant sexual ill health and social isolation for those living with HIV in England (Bourne et al., 2012). These factors, combined with facets of living with the disease, leave HIV-positive gay men vulnerable to high levels of distress (Ciesla & Roberts; Lyons, Pitts, & Grierson, 2012; Miners et al., 2014).

These statistics demonstrate that the experiences of gay men living with HIV are worthy of further research attention, in particular, research which aims to make sense of an individual's experience of PTG after an HIV diagnosis could offer greater understanding for those impacted by the disease. Since PTG focuses on internal strengths and recourses that improve resilience (Westefeld et al., 2004), this study contributes to the fields of counselling psychology and positive psychology and may help build bridges of understanding between the two disciplines (Joseph & Murphy, 2013).

This study has further significance and relevance for the field of counselling psychology. A brief overview which demonstrates the nature of and values within this field will follow, and will demonstrate this additional relevance. The essence of counselling psychology, which makes it distinct from other psychological professions, is its particular set of values and ethics (Walsh & Frankland, 2009; Woolfe, 1996). Counselling psychology is not only grounded in a set of values, but is in essence the application of those values (Koehn, 1994) and so is considered ethics-in-action. One of these primary values is the interest in the individual, which justifies IPA, which is idiographic and fits the epistemology of counselling psychology. The practise guidelines of the Counselling Psychology divisions of the British Psychological Society (BPS; 2005, p.7) state that the profession considers its responsibility to the "wider world" whilst also challenging "the views of people who pathologise on the basis of such aspects as sexual orientation".

An element of counselling psychology's responsibility to the wider world is research and applied work in several broad domains, including health (Gelso & Fretz, 2001) and sexuality (BPS, 2005). The discipline also has an influential role in service delivery, meaning there is a need to participate in, endorse and reward interdisciplinary research and application which has the potential to lead to the development of policy that benefits individuals with chronic health conditions.

There is also a need for a wide range of expertise at all levels of therapeutic activity to promote the health and well-being of individuals with HIV (Werth et al., 2008). Furthermore, LGBTQ psychology shares a common aim with counselling psychology, which is that of representing underrepresented groups, and therefore a commitment to social justice (Goodman et al., 2004; Motulsky, Gere, Saleem, & Trantham, 2014), with an aim of challenging the social marginalisation of individuals (BPS, 2013) who suffer discrimination. Since this study strives for knowledge about PTG in gay men living with HIV, this makes it relevant to counselling psychology, LGBTQ psychology and positive psychology, due to it being the umberella term for PTG.

1.1. Overview of study

This research contributes to the fields of counselling, positive and LGBTQ psychology by exploring the PTG experiences of gay men living with HIV. This chapter has given an overview of the present study and offered a rationale for the significance of this participant group. It introduced the concept of HIV, followed by the notion of PTG, and finally the participant group: gay men living with HIV and PTG. Finally, a summary of its relevance to counselling psychology and LGBTQ psychology was presented.

The study commences with a review of the existing literature in the area, detailing viewpoints from both qualitative and quantitative research, as well as handbooks and narrative material, followed by an outline of the ways in which this present study can contribute to the field of counselling psychology. It then moves on to a detailed engagement with methodology. This engagement is crucial to the study considering the methodological choice of interpretative phenomenological analysis (IPA) and its commitment to both careful phenomenology and interpretation. After the practical details of how the research was carried out in the methodology section, the findings chapter will follow. The detailed account of the results is key in a piece of IPA, as this allows the reader the opportunity to have a real sense of the material. This also enables a clear description of the journey from participant statements to themes, discussion and conclusion. This is followed by the discussion chapter, which looks at the findings in light of the literature review as well as any additional literature that has been deemed suitable. The discussion then leads into the clinical implications and methodological considerations, and finally the conclusion.

Chapter 2: Literature Review

In this chapter I discuss the existing literature that is relevant to the topic of gay men who are living with both HIV and PTG. I embark on this by first looking at the field of positive psychology, and so investigating the roots of PTG. This is followed by an overview of PTG, PTG theory and past research in PTG, in particular with response to illness and HIV. I then introduce other literature on the participant group (gay men) in relation to the topics of HIV and PTG. I conclude the chapter by discussing the work that has led to the current research issue as well as why this issue is important and relevant to counselling psychology.

The literature was sourced through a systematic search for research on PTG in individuals who are HIV-positive. The following computerised databases were used for the selection of studies of psychological and medical literature: *Google Scholar*, PsychArticles and PsychInfo. The key words that were used to search for articles in these databases were: posttraumatic growth, HIV and PTG, illness and PTG, positive psychology, HIV and positive psychology, finding meaning after trauma, gay men, HIV and PTG, gay men and HIV, qualitative research on gay men and HIV. Initially the focus was specifically on PTG, HIV and gay men. However, further searches focused on PTG and illness as well as gay men and HIV. This proved successful and yielded an abundance of research exploring a wealth of experiences attached to having an HIV diagnosis and which included beneficial findings.

2.1. Positive Psychology

This section gives an overview of positive psychology. This allows a full understanding of the field's position, and show how it has influence in a number of different areas, including counselling psychology. This is followed by a discussion of its history, followed by past research and theory.

Positive psychology is defined as the scientific study of ordinary strengths and virtues, and encourages a more open and appreciative perspective regarding human potentials, motives and capacities (Sheldon & King, 2001). It is the study of the conditions and processes that contribute to the flourishing or optimal functioning of people, groups and institutions (Gable & Haidt, 2005). Despite being a relatively young discipline, positive psychology has accrued many notable achievements, including recognition for its scholarly output and being well represented in a range of academic publications (Linley & Joseph, 2004; Lopez & Snyder, 2004; Peterson & Seligman, 2004; Snyder & Lopez, 2002). In addition, an influx of positive psychology books have been published (Bannink, 2011; Fredrickson, 2009; Seligman, 2011; Snyder & Lopez, 2005). Positive psychology focuses on achievement and empowerment (Miller, 2008) through the development of the social and emotional aspects of learning. It argues that both behaviour and attitude will be improved if people learn to manage their emotions, feel optimistic about themselves and their ability to learn, and reflect on longer-term goals (Banda Pilot site, 2007).

A focus on developmental strengths, resilience, positive adaption and optimal human functioning are not new concepts (Frazier, Lee & Steger, 2006). Instead, these concepts have a history in counselling psychology (Mollen, Ethington, & Ridley, 2006) as a result of its origins in the humanistic movement. Indeed, counselling and positive psychology share a number of similarities (Gelso & Woodhouse, 2003). These similarities are evident in the common central values that focus on strengths and optimal human functioning (Gelso, Nutt Williams, & Fretz, 2014; Walsh, 2003). It is therefore important to recognise that the roots of both counselling and positive psychology are embodied within the humanistic approach, most notably through the work of Carl Rogers (1951) (Vossler, Steffen, & Joseph, 2015).

Positive psychology is now recognised as a profession within counselling psychology (Vossler et al., 2015), with one of its successes being the ability to raise public awareness around happiness and well-being (Wallis, 2005). This success is what has set it apart, as it does not merely look to diagnose and remedy psychopathology but also aims to identify positive aspects of the human experience and so overcome challenges that arise (Georges & Tomlinson-Clarke, 2015). This shows the similar aim of identifying human strengths in both counselling psychology and positive psychology.

History of positive psychology

Positive psychology emerged in the late 1990s and has links with counselling psychology research and practice. Like counselling psychology, it has roots in the humanistic psychology of the 20th century, which focused on happiness and fulfilment (Mollen, Ethington, & Ridley, 2006). This new wave of positive psychology can be traced back to Martin Seligman's (1998) presidential address to the American Psychological Association, in which he initiated a shift in psychology's focus towards a more positive direction (Seligman, 1999). Seligman realised that psychology had deserted the latter two of its three pre-Second World War missions, which were: curing mental illness; helping all people lead more productive and fulfilling lives; and identifying and nurturing high talent (Linley et al., 2006), therefore he decided to give attention to interventions that focused on identifying strengths and improving well being.

Positive psychologists do not claim to hold the key to having a good life, but they attempt to unite theory and research about what makes life worthwhile (Peterson & Park, 2003). Research within positive psychology is not intended to replace what is known about human suffering, but rather to supplement it. The objective is to give a more balanced scientific perspective of the human condition with its peaks, valleys and everything in between; to understand both suffering and happiness (Seligman et al., 2005). It aims to unite scattered and disparate lines of theory and research about what makes life worth living (Seligman et al., 2005). This is what motivated Seligman (1999) to crystallise a theory that could underpin what is important when trying to help people lead more productive and fulfilling lives.

According to Seligman (1999), positive psychology is concerned with three levels: the subjective, individual and group levels. The *subjective* level is about feeling good within the self (pleasure), rather than doing good or being a good person. It is concerned with feeling contentment and satisfaction (in the past); hope and optimism (for the future); and flow and happiness (in the present). The *individual* level is about positive individual traits and being a good person. This includes having the capacity for love and vocation, courage, interpersonal skills, perseverance, forgiveness, future mindedness, spirituality, high talent and wisdom. The *group/community* level is about the civic virtues and the institutions that move individuals toward better citizenship, which include responsibility, nurturance, altruism, civility, moderation, tolerance, work ethic and other factors that contribute to the development of citizens and communities (Seligman & Csikszentmihalyi, 2000). The latter two levels have been criticised by academics such as McDonald & O'Callaghan (2008), who suggest that positive psychology is only interested in neo-liberal values that create individualism. This is discussed further at a later point in this chapter.

Past research and theory of positive psychology

It is important to identify broader positive psychological theory, as this can be useful when exploring how individuals can change their behaviour in order to reach towards a greater sense of well-being. Martin Seligman is considered the father of the positive psychology movement. Seligman et al. (2005) conducted a controlled internet study and found that psychological interventions increased individual happiness. They tested five concepts and reported that three of them were successful for increasing happiness and decreasing depressive symptoms. These were pleasure, flow and meaning. *Pleasure* is subjective and includes a variety of the things that one does in everyday life, such as having a morning coffee, shopping, listening to music, having a chat with a friend and so on. However, pleasure alone does not lead to true happiness; it is more about the self seeking pleasurable experiences.

Flow is defined as the experience that enables the feeling of being on top form (Csikszentmihalyi, 1990). It means to have full engagement with an activity and results in feelings of freedom, enjoyment, fulfilment, skill and being present. It is within this state that somatic concerns such as food and the passing of time are ignored (Csikszentmihalyi, 2007). Flow is subjective to the individual. Examples of activities that may create flow include creative arts, sports, spiritual practice and many more. Seligman (2011) suggests that one ought to know one's personal strengths and then re-craft life so that it incorporates them, leading to an 'engaged' way of living.

The third concept is about creating a sense of *meaning* or purpose to one's life. This consists of knowing what one's highest strengths are and using them in the service of something that is believed in, something that is bigger than oneself. A sense of meaning is subjective to the individual and can be found through religion and spiritual beliefs. Meaning can also be created through other forms of behaviour, such as employment or having a family.

Seligman (1999) further suggests that all three of these factors are needed to lead towards optimum life satisfaction, with ‘true happiness’ being found more in flow and meaning than in pleasure alone (Seligman & Csikszentmihalyi, 2000).

Seligman (2011) went on to publish an updated version of his theory with two new core elements. He named this the well-being theory, and stated that it utilises the mnemonic PERMA: Positive emotion, Engagement, Relationships, Meaning and Accomplishments. *Positive emotion* is subjective to the individual and can be achieved in the same way as pleasure. It is important to distinguish between pleasure and enjoyment, however, with pleasure being connected to bodily needs, such as thirst, hunger and sleep. Enjoyment comes from intellectual stimulation and creativity. *Engagement*, similar to flow, suggests that enjoyment is subjective. It is important for each individual to discover what activities they can engage in, so that they can become entirely absorbed in the present moment. *Relationships* and social connections are incredibly important, and building strong emotional connections with other human beings are crucial for love, intimacy, physical interaction, and support in difficult times. *Meaning* is explained above in Seligman’s (1999) earlier theory. *Accomplishments* are about having goals and ambitions, which direct one towards achievement, and therefore a sense of pride and fulfilment, once they have been accomplished. This pushes a person to thrive and flourish.

Summary

The above sections introduce positive psychology and demonstrate its value within counselling psychology, as well as its relevance in this present study. An overview of previous research and the theory of positive psychology was also demonstrated, most notably the work of Seligman (2011). This supports the argument that positive psychology is not just about thinking positive, it is about finding an overall sense of well-being that includes pleasure, meaning, purpose, connection, relationships and achievement. The next section focuses on PTG, with particular reference to illness and HIV. Literature will also be presented on HIV and gay men within the context of PTG. Finally, to give a more balanced perspective, a critique of positive psychology and PTG is given.

2.2. Posttraumatic Growth (PTG)

There are four primary areas in which positive psychology research is taking hold and receiving attention within counselling psychology (Vossler et al., 2015). The first of these is *gratitude* research, which can be conceptualised in different ways, from a momentary feeling of appreciation and recognition of benefits to a long-term disposition (Bono, Emmons, & McCullough, 2004). The second is the *'build what's strong'* approach, which is a supplement to the 'fix what's wrong' approach, which is diagnosing in order to prescribe (Nelson, 2009), and so points to the importance of giving equal attention to both problems and strengths (Gassman & Grawe, 2006). Thirdly, positive psychology is involved with the *promotion and* *cultivation of resilience* by increasing emotions, such as humour, serenity, trust and compassion (Fredrickson, 2005) which are suggested as factors which may help people cope with adversity and enhance emotional well-being. Finally, positive psychology has contributed the concept of *PTG*, which refers to a positive change in an individual, as a result of an attempt to cope in the aftermath of a traumatic life event (Tedeschi, Park, & Calhoun, 2004; Joseph, 2011; Linley & Joseph, 2004). It is this final element which is the focus of this study.

While it has long been understood that trauma can have many negative consequences, such as poor quality of life, psychological distress and severe maladjustment (Magruder et al., 2004), research has now shown that trauma can also have positive consequences (Tedeschi & Calhoun, 1996). This phenomenon can be referred to as stress-related growth or PTG (Park & Helgeson, 2006), and it has led to psychologists becoming increasingly interested in the positive life changes that occur after a stressful event (Cadell, 2007). This has resulted in a number of researchers exploring the phenomenon of PTG (Tedeschi & Calhoun, 1996), stress-related growth (Park, Cohen, & Murch, 1996; Luszczynska et al., 2012) and benefit finding (Tennen & Affleck, 2002).

It is important to recognise that this notion of positive change due to a traumatic experience is not a new idea. PTG goes back to teachings from various religions and spiritual belief systems such as Islam, Hinduism and Buddhism, which contain the idea that it is through pain that transformation can take place (Tedeschi, Park, & Calhoun, 2004). PTG also has roots in the period following World War II, when there was a drive to study the effects of stress. At this time, logotherapist Viktor Frankl published ‘Man’s Search for Meaning’ (Frankl, 1946), in which he described surviving and finding meaning whilst in a concentration camp. Later, Maddi (2002), Kobasa (1979), and others used existential philosophy to describe stress as a challenge which can result in thriving rather than just ill-health.

Theory and past research of posttraumatic growth

The concept of PTG creates an interesting challenge for researchers and theorists in the trauma field (Pat-Horenczyk & Brom, 2007), as it suggests that after an individual experiences a distressing event, despite being debilitated, at some unspecified time later, that individual can grow from the trauma (Frazier et al., 2009). This is why several researchers have tried to refine the various effects of PTG by pioneering different theories, all deriving from historical positive outcomes after a trauma. What has been found to be central to these theories is *meaning* (Tedeschi, Park, & Calhoun, 2004). If the person who has experienced the trauma finds meaning in it, then this has the potential to bring them relief, and may change core assumptions they once held (Tedeschi & Calhoun, 1996).

The term PTG was first used by Tedeschi and Calloun (1996) and has been employed and integrated into counselling psychology practice through a variety of interventions, which include Eye Movement Desentization and Reprocessing (EMDR), Compassion Focussed Therapy (CFT) and Cognitive Behavioural Therapy (CBT) (Nelson, 2011). This has led to research being carried out on the dominant negative, and pathological narratives, which highlights the focus on the negative effects of trauma, including labels such as ‘victims’ and ‘damaged’ (Hutchinson & Lema, 2009). It has been discovered that the use of a positive framework in work with trauma clients enabled psychotherapists to focus on strength and competencies that facilitated a more meaningful alternative story (Vossler et al., 2015). Other clinical work includes grief therapy approaches exploring PTG processes, such as spiritual and religious meaning making following sense-of-presence experiences in bereavement (Steffen & Coyle, 2010; 2011; 2012).

The PTG theory from Tedeschi and Calhoun (1996) suggests five instruments of change, which are: relating to others, new possibilities, personal strengths, spiritual change and appreciation for life. These can be simplified into three broader categories: changes in self, changes in interpersonal relationships, and changes in philosophy. *Changes in self* refers to the ways in which people can change how they perceive themselves, such as growing emotionally, becoming a better person, or feeling stronger and more self-assured (Tedeschi & Calhoun, 1996). Trauma may bring about an awareness of vulnerability, but it also has the potential bring about growth through the recognition that individuals are strong enough to handle the challenge that they have faced (Calhoun, Park, & Tedeschi, 1998).

Changes within interpersonal relationships include recognising the importance of particular relationships and deepening them, and observing a greater appreciation of loved ones (Tedeschi & Calhoun, 1996). This change also emphasises the ability to have greater compassion for others, as well as a greater capacity to express emotion and reach out for help, whilst increasing supportive relationships that have not been previously utilised (Tedeschi & Calhoun, 1996; Tedeschi, Park, & Calhoun, 1998).

Changes in philosophy refers to an increased appreciation of existing beliefs as well as having a new perspective and a shift in priorities which enhance life (Tedeschi & Calhoun, 1996). Other changes may include new spiritual belief systems, or new strengthened existing beliefs (Calhoun, Park, & Tedeschi, 1998), such as those which may be questioned when facing death following a diagnosis of HIV.

There has been a great deal more research since Tedeschi and Calhoun (1996) first used the term PTG. This includes research from Woodward and Joseph (2003), who performed a thematic analysis on the growth processes of people who had experienced early childhood emotional, physical or sexual abuse. They found three super-ordinate themes related to positive change processes which encompassed 10 emergent themes. These were: *Inner drive toward growth* (will to live); *Vehicles of change* (awakening or responsibility, validation and acceptance, love and nurturing, liberation and freedom, mastery and control, belonging and connection); and *Psychological change* (changes in self-perception, gaining new perspectives on life, changes in relationships) (Woodward & Joseph, 2003).

Further research identified a theory known as the 'thriver model' (Mangelsdorf & Eid, 2015). This is a process model which describes how growth occurs after a major life event. One of these possibilities can be disruption to the core belief (Cann et al., 2010), where an individual's assumptions of the world are questioned as the new experience is integrated into existing mental structures. There are three key components to the thriver model: meaning making, supportive relationships and positive emotions. *Meaning making* is the key process which enables mental reorganisation for both positive and negative life events. In order for growth to occur, it is more likely that individuals have *supportive relationships* and *positive emotions*. This contributes to growth by creating an emotional and social environment that constitutes a positive change process (Mangelsdorf & Eid, 2015).

Prior to Tedeschi and Calhoun (1996) developing their theory on PTG, research on facing trauma was on resilience, which has since received attention in its own right within counselling psychology (Vossler et al., 2015). Research from O'Leary and Ickovics (1995) aimed to focus on strengths and ability for resilience in the face of adversity. They suggest that resilience and thriving are a dynamic process of adaptation, influenced by numerous individual and social factors. These emerge and change over the life course and are identified in behavioural, cognitive or affective domains. O'Leary & Ickovics's (1995) theory suggests three possible outcomes after a traumatic event: *Survival* (those who never regain their previous level of functioning); *Recovery* (those who return to their previous level of functioning); and *Thrive* (those who move beyond their previous level of functioning and flourish, experiencing growth as a result). This suggests that PTG is not just about learning to live with the effects or bounce back from trauma but can also act as a springboard to further development and personal growth (Tedeschi, Park, & Calhoun, 1998).

Posttraumatic growth and illness

There have been numerous studies examining the relationship between benefit finding and disease adjustment (Stanton, Bower, & Low, 2006; Tomich & Helgeson 2004), many of which have described a positive relationship between PTG and illness (Rini et al., 2004; Barskova & Oesterreich, 2009; Bellizzi, 2004; Cordova et al., 2001). Hefferon, Grealy and Mutrie (2009) reviewed 57 published articles on PTG and life-threatening physical illness, and found four key themes emerging from their meta-analysis: reappraisal of life and priorities; trauma equals development of self (rebirth, new way of being); existential revaluation; and awareness of the body (physical health). These findings suggest that illness-based PTG has unique elements compared to other forms of PTG (Bohlmeijer & Bannink, 2013), particularly in cases such as cancer and HIV, since such illnesses force people to confront their mortality.

Research shows there has been a significant rise in cancer patients experiencing PTG (Weiss, 2008). Cancer survivors, unlike other trauma survivors, must learn to live with the very real threat of disease recurrence. Despite this, PTG is a common experience (Carboon et al., 2005). However, PTG depends on a number of factors in cancer patients, such as a person's demographics (age, sex, personality, coping style and so on) and factors relating to the event (such as its type, severity, temporal proximity) or the environment (for example, social facilitation, culture) (Bellizzi, 2004; Cordova et al., 2001; Heiland, 2004; Ho, Chan, & Ho, 2004; Lechner & Antoni, 2004; Manne et al., 2004; Oh et al., 2004; Sears, Stanton, & Danoff-Burg, 2003; Thornton & Perez, 2006; Weiss, 2004). This complexity of factors means it is difficult to predict when PTG will occur for people living with cancer.

Other studies on PTG and cancer include qualitative research, such as a study that explored the experiences of 40 women who experienced breast cancer

(Weiss, 2008). After being asked a series of questions relating to the changes since their diagnosis, 98% of these women reported key positive changes with the way they perceived life (Weiss, 2008). A further phenomenological study with 12 women living with breast cancer found that a relationship between PTG and psychosocial adjustment was beneficial for the most ‘hopeful’ women (Stanton, Danoff-Burg, & Huggins, 2002). This suggests that a positive frame of mind (Rini et al., 2004) is important for PTG to occur.

Longitudinal quantitative studies allow for the measurement of PGT growth. This has led to a greater clarity around which factors result in positive change (Schroevers et al., 2010). Schroevers et al. (2010) carried out research on long-term cancer survivors (n = 206) who reported experiencing greater positive consequences of their illness eight years after diagnosis. Change occurred as a result of social support from friends and family, and was characterised by reassurance, comforting and problem-solving in the period following diagnosis. Further research by Stanton, Bower and Low (2006) found between 53% and 83% of breast cancer patients (n = 60) had reported some benefits since their diagnosis, such as richer life experiences or feeling more present and aware in their day-to-day lives. Finally, Dunigan, Carr and Steel (2007) discovered that liver cancer patients (n = 41) experienced positive change through a shift towards a more positive frame of mind, and lived longer, compared to those who had low positive change since their diagnosis, further implying that psychological factors are important for PTG to occur.

Psychological factors for those who have been diagnosed with a life-threatening illness have a much greater impact on health than previously thought (Affleck et al., 1988). Adjusting to an illness-related threat represents a major challenge for patients' cognitive systems (Luszczynska et al., 2012). This has led to a growing interest in cognitions relating to mental and physical health among survivors of life-threatening illnesses (Sawyer, Ayers, & Field, 2010). Some findings suggest that it is common for patients to adopt coping mechanisms which enable them to avoid thinking about their cancer (Carboon, 2005; Barskova & Oesterreich, 2009), although this finding has been criticised in other studies as it has been suggested that this strategy inhibits growth (Watson, Clark, & Tellegen, 1988; Bellizzi, 2004).

This body of research has led to theories which suggest there are stages that must be worked through before PGT can be reached following a disease diagnosis.

Acceptance

There have been various theories developed around working towards an 'acceptance' of a life-threatening illness. Morse (1997) defined five distinct stages of responding to such an illness, which are suggested to be experienced in a linear way. The first stage is *uncertainty or vigilance*, during which the individual attempts to maintain emotional control whilst trying to understand their condition and its severity. Then comes the *disruption* stage, when the individual realises that the serious disease affects them, and that there is a risk to life. At this stage there are high levels of stress, and the individual is most likely to experience trauma (Morse & Johnson, 1991) and face existential issues posed by the diagnosis (Doka, 2008). The third stage is to *strive for recovery*, as an individual tries to gain control over their illness, resulting in the use of resources from their personal world and environment. This stage can often be confused with PTG. The fourth stage is *striving to restore oneself*, whilst trying to make sense of an altered reality, in light of grief for what has been lost. The final stage is to build up trust and *learn to live* with the altered self and body. This is where the individual attains a new equilibrium, as a result of getting to know and accept the illness, and its consequences.

In contrast, Charmaz (1995) suggests that avoiding thinking about an illness can result in the inhibition of growth. Charmaz (1995) identified the biographical disruption one can experience through a life-threatening diagnosis, and suggested two ways in which individuals can respond which influence the possibility of PTG. The first of these is *ignoring and minimising*, whereby the significance of the disease is rejected, and potential identity transformations may be averted. The second is *adaption*, in which the altered body and illness identity are integrated into the self, and the individual surrenders to the experiences and consequences of illness. The role of *adapting* to a chronic illness implies an involvement of identity for possible change as the individual comes to terms with their illness.

Adapting to a diagnosis can be an integral part of the process of PTG and can determine the psychological outcome of someone who is going through this experience, whereas avoidance can negatively impact an individual and prevent PTG.

In summary, Morse (1997) and Charmaz (1995) offer theories that suggest a linear way of going through a process of acceptance, however in reality, the human experience is not linear and people do not progress through these stages in an ordely fashion (Cheng & Cheung, 2005; Sears et al., 2003). The human experience can be chaotic and paradoxical, especially after being diagnosed with a disease such as HIV (Landstra et al., 2013; Chuang et al., 1989; Namir et al., 1987; Nelson, 2011).

Time

When an individual is diagnosed with a life-threatening illness, they become distinctly aware of the temporality of life. Carstensen, Isaacowitz and Charles (1999) suggested socio-emotional selectivity theory, which claims that the perception of time plays a fundamental role in the selection and pursuit of social goals. They suggest that social motives fall into two categories: *the acquisition of knowledge* and *the regulation of emotion*. When time is taken for granted and presumed to be open-ended, knowledge-related goals are prioritised. However, when time is perceived as limited, emotional goals assume primacy. This suggests that when time is potentially limited through a life-threatening illness, short-term emotional goals such as desire to spend time with friends and family take priority. Since being diagnosed with HIV is a traumatic life event, people who survive this may be better able to regulate emotion, which is linked to PTG. In addition, since HIV is no longer considered a terminal illness, knowledge-related goals may still have importance alongside emotional goals, providing a new impetus to achieve life-long ambitions and experience new things.

Posttraumatic growth and HIV

This section investigates PTG in those who are living with HIV, which has been reclassified from a fatal disease to a chronic, long-term, manageable infection (Green & Smith, 2004; Pakenham, Dadds, & Terry, 1996). People living with HIV have an increased likelihood of leading a fuller, longer life (Rosenfeld, Bartlam, & Smith, 2012; Simon, Ho, & Karim, 2006). However, people who have been diagnosed with HIV can often experience symptoms such as depression, anxiety, fear, helplessness and guilt (Hays et al., 1990; Lawless, Kippax, & Crawford, 1996; Metcalfe et al., 1998; Richardson et al., 2001), implying that life can still be a struggle for those affected. This is supported by research which further highlights the on-going distress associated with receiving a positive diagnosis (Anderson et al., 2010; Hult, Maurer, & Moskowitz, 2009), and demonstrates that people living with HIV report levels of anxiety and depression much higher than the general population (Chaudhury, Bakhla, & Saini, 2016). These factors can lead to chronic stress, which is related to harmful coping skills and a weakened immune system, further reducing the quality of physical and mental health for those with HIV (Segerstrom & Miller, 2004). These harmful coping skills and high levels of stress can exist side by side with experiences of PTG, which is discussed within this chapter.

Stigma, disclosure and support

Research by Kamen et al. (2016) on PTG and HIV was carried out using a cross-sectional design and analysis of data from a baseline, self-report questionnaire with people living with HIV (n = 334). Factors such as HIV-related stigma, disclosure of HIV status and emotional support were measured. Kamen et al. found that HIV-related stigma, disclosure to sexual partners, and emotional support were significant predictors of PTG. Stigma was associated with lower PTG, while disclosure and emotional support were associated with higher PTG. These authors (Kamen et al., 2016) highlight the need for interventions that are designed to help people living with HIV to disclose their status to loved ones, with the goal of increasing social support.

Similar findings were discovered by Zeligman, Barden and Hagedorn (2016), who investigated the influence of HIV-related stigma and social support on PTG.

Zeligman et al. (2016) carried out research in adults living with HIV (n = 126). They used a descriptive, correlational design to examine PTG, social support and stigma for those diagnosed with HIV, as well as the predictive nature of stigma and social support on PTG. They used three instruments in the study: the Posttraumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996); the Multidimensional Scale of Perceived Social Support (MSPSS; Zimet et al., 1988); and the Berger HIV Stigma Scale (Berger, Ferrans, & Lashley, 2001). Zeligman, Barden and Hagedorn (2016) presented a number of findings and provided insight into how counselling psychologists can provide services, such as strength-based techniques (recognising resilience / identifying and building strengths) for clients living with HIV. Their findings indicated the ways in which social support contributed towards PTG. However, stigma had the opposite effect, and was found to inhibit PTG. One possible explanation for this is that HIV stigma has such a negative presence for individuals living with the illness that it holds them back from moving in a positive direction following their diagnosis.

Internal stigma

Stigma related to HIV can be defined as, “prejudice, discounting, discrediting, and discrimination directed at people perceived to have AIDS or HIV” (Herek et al., 1998, p. 36). Both actual and perceived HIV stigma can create substantial internalised stress, which can in turn impact the ability to adjust to and work through a diagnosis (Herek et al., 1998). Internalised stigma occurs when an individual believes that stigmatised beliefs held against them are valid, which can influence how they view themselves in light of their diagnosis (Zeligman, Barden, & Hagedorn, 2016). Lee, Kochman and Sikkema (2002) suggest that people living with HIV can begin to internalise their experiences of stigma and so have the potential to become more vulnerable to feelings of rejection and stigma, resulting in deliberation over whether or not to disclose their HIV status. Stigma was also found to decrease social support for people living with HIV, and to negatively influence potential PTG arising from social systems (Zeligman, Barden, & Hagedorn, 2016).

There is a vast amount of research on internalised stigma arising from HIV status and homophobia. Internalised homophobia also needs to be considered for this study, since the UK is primarily a heteronormative society, and growing up in such a society could have a huge influence on the development of gay men (Mayfield, 2001). Growing up in such a culture as a gay man often results in experiences of negative societal attitudes towards homosexuality, as well as internalised stigma, which can manifest as shame around same-sex attraction and relationships (Shidlo, 1994). This negative view that a person can have towards their own sexuality is known as homonegativity (Weinberg, 1973), and is more common in older gay men (David & Knight, 2008).

Cognitive style and demographics

Milam (2006) carried out research using correlational analysis with 412 participants randomly selected from public HIV clinics. Participants' demographics, optimism, pessimism and PTG scores at baseline were used to predict viral load levels and CD4 counts at follow-up (a mean of 19 months later), after statistically controlling for disease status at baseline. Optimism, pessimism and ethnicity were examined as potential moderators of the relationships between PTG and disease status. Depressive symptoms and health behaviours, including antiretroviral adherence, diet and exercise as well as illicit drug, cigarette and alcohol use were examined as potential mediators. It was suggested PTG is a positive psychological strength that may buffer against physical illness, and that optimistic cognitive styles are important for PTG to occur. Milam (2006) found that certain sub-groups had significant associations for PTG, such as with Hispanic people versus non-Hispanic people or those with low levels of optimism versus those with high levels. PTG was inversely associated with viral load among those who were low in pessimism, and was inversely associated with depressive symptoms, alcohol and illicit drug use.

Past trauma

An individual may experience PTG as a consequence of a past traumatic event that occurred in childhood (Bannink, 2014). A study by Chin et al. (2013) found that HIV-positive women who had been sexually abused when they were children were able to adjust to their diagnosis as a result of their past traumatic events. These women showed a greater overall reduction in symptoms such as depression, posttraumatic stress and anxiety compared to those who did not experience abuse. This was especially present in the cases of those who suffered the most severe sexual abuse as children. These participants showed an even greater reduction of stress and depression. Critically, this suggests that past trauma enables an individual to be more resilient when facing trauma later in life.

Trauma of receiving a diagnosis of HIV

This section outlines how an HIV-positive diagnosis can lead to an individual experiencing trauma. Research has historically focused on the negative outcomes of trauma (Cadell, 2007), especially with the addition of post-traumatic stress disorder (PTSD) in the DSM-III (Spitzer & Williams, 1980). There has now been a wealth of research on the ways in which experiencing a traumatic event can impact an individual, such as alteration of core beliefs or the questioning of themselves, their world and their place in that world. This questioning can itself be uncomfortable and sometimes traumatic for the individual (Walter & Bates, 2012).

Trauma can be used to describe several different concepts. It may denote an extreme event, the process of coping with adversity, or the resulting outcome of coping with trauma and disaster (Pat-Horenczyk & Brom, 2007). Human beings experience trauma in a number of ways, with common examples including bereavement, natural disasters, military combat, terrorist attacks, sexual assault and illness (Hobfoll, 1998). Trauma can also occur after an existential crisis of some sort, such as growing older (Bannink, 2014). The impact of the trauma can create neuro-physical changes to behaviours, cognitions and emotions. Multiple or on-going trauma can be caused from existing in a place of constant threat, such as living in a war zone or being a refugee (O'Leary & Ickovics, 1995). This is an important consideration, as one may ask whether the experience of living with HIV is a 'one-off' trauma or an ongoing one (Luszczynska et al., 2012). These different experiences may influence how an individual deals with their diagnosis.

The trauma of receiving an HIV-positive diagnosis can trigger symptoms of PTSD, which are similar to those caused by exposure to other traumatic events such as serious injury, sexual violence and the threat of death (APA, 2013). An HIV diagnosis can impact a person's ability to cope (Basavaraj, Navya, & Rashmi, 2010). Reactions in the weeks following a diagnosis of HIV include intrusive thoughts, clinical levels of anxiety and avoidant responses (Ironson et al., 1990). Other experiences can occur some time after the diagnosis (Anderson et al., 2010). These include denial, anxiety, depression and suicidal ideation (Coates, Moore, & McKusick, 1987; Ostrow et al., 1989). Increased amounts of stress may also be experienced at many points throughout the illness trajectory (Sherr et al., 2011). Therefore, HIV can bring a series of mental health concerns to those living with the condition (Nightingale et al., 2010), with estimations of around 48% of those living with HIV suffering from depression (Whetten et al., 2008).

This section has shown support for the presence of trauma after an HIV diagnosis. The following section presents some of the experiential research on gay men who are living with a positive diagnosis of HIV.

Experiential research on HIV positive gay men

A number of studies have reported the various ways in which HIV is spread within the gay community, such as risky behaviour through multiple sexual partners, unprotected sex, and chemsex (combining sex and illicit drugs) (Bourne et al., 2015, Diaz, 1998; Adam et al., 2017; Ahmed et al., 2016; Zhang et al., 2017; Rogers et al., 2003; Amirkhanian et al., 2003; Smith, 1988). Other studies have shown higher rates of depression in gay men compared to straight men, as well as the psychological impact of related issues, such as stigma, aging, sexual dysfunction, social isolation, poverty and loss of family and friendship networks. However, it has been robustly reported that gay men are more likely to seek help and accept treatment than straight men (Abelson et al., 2006; Judd et al., 2000; Tate et al., 2003; Ciesla & Roberts, 2001; Komiti et al., 2003; Dawson et al., 2002; Newman et al., 2008, Anderson et al., 2010; Catalan, Meadows, Douzenis., 2000; Chesney & Smith, 1999; Flowers, Duncan, Knussen, 2003; Flowers, Knussen, & Church, 2003; Flowers et al., 2006; Green & Smith, 2004; Hult, Maurer, & Moskowitz, 2009; Ironson et al., 1990; Kelly, Langdon, & Serpell, 2009; Ostrow et al., 1989; Perry et al., 1990; Reid, Flowers, & Larkin, 2005; Stutterheim et al., 2009; Chuang et al., 1989; Morin et al., 1984; Namir et al., 1987; Schwartzberg, 1992).

There are also studies that identify personal benefits following an HIV diagnosis, such as identity reconstruction to a more favourable self, finding meaning, making healthier life choices and deepening relationships (Carricaburu & Pierret, 1995; Schwartzberg & Janoff-Bulman, 1991; Brashers et al., 1999; Stoelb, 2006; Viney & Bousfield, 1991; Kessler et al., 1988, Viney et al., 1989; Amos, 2015; Bower et al., 1998; Flowers & Davis, 2012; Flowers et al., 2011; Flowers, Duncan, & Knussen, 2003; Flowers & Langdridge, 2012; Hernansaiz & Tapia, 2017; Hult, Maurer, & Moskowitz, 2009; Jenkins, 1995; Weis et al., 2016; Kelly, Langdon, & Serpell, 2009; Littlewood et al., 2008; Luszczynska et al., 2012; Lyons, Heywood, & Rozbroj, 2016; Lyons, Pitts, & Grierson, 2012; Miners et al., 2014; Murphy & Hevey, 2013; Namir et al., 1987; Sawyer, Ayers, & Field, 2010; Schwartzberg, 1993; Schwartzberg, 1994; Werth et al., 2008).

As shown above, there has been a wealth of research carried out on the experience of HIV-positive gay men, however, there is a relative lack of research that directly links HIV positive gay men and PTG. This present study has identified this gap in the research and is linking broad positive psychology theory directly with the experience of HIV-positive gay men. For the purpose of this literature review, only a few of these studies will be explored at greater depth. Studies were selected due to their relevance to the topic of PTG, HIV and gay men.

Flowers et al. (2011) carried out an IPA study (n = 14) with HIV-positive gay men and assessed the psychological impact of an HIV diagnosis in post-antiretroviral accounts. Participants were recruited through advertising in the gay press and were aged between 22-54. All had been diagnosed after the introduction of antiretroviral drugs, with an average time of four years since diagnosis. Findings focused on the participants' struggle with adjusting to their positive HIV diagnosis, and there were a number of themes identified, such as *crisis, loss and challenges*, which suggested that there was a change in identity since diagnosis. This was found to be especially evident in older participants who had received mixed messages over HIV, which was initially perceived as a death sentence but since the development of antiretroviral drugs has been seen as a life-long disease. The theme *integrating HIV* described a sense of damaged identity, demonstrating how participants struggled with their relationship with HIV, which affected them both psychologically and physically. This was found especially in older participants whose appearances had changed due to lipodystrophy (a side effect from the medication associated with the first wave of antiretroviral medication). Disclosure of status was also a major concern. Finally, *adjustment and assimilation* suggested that acceptance of HIV was relational and depended on perceptions of acceptance from others.

Overall, this study suggested that HIV diagnosis was deeply shocking and unexpected for participants, and that stigma and fear dominated their accounts. HIV was understood to be a shameful, fatal and life-changing condition (Flowers et al., 2011). In addition, starting medication and dealing with its further psychological challenges, such as the impact of lipodystrophy (Blanch et al., 2002; Collins, Wagner & Walmsley, 2000; Kelly, Langdon, & Serpell, 2009) and the possible psychiatric side effects of antiretroviral therapies (Arendt et al., 2007) was seen as a challenge.

Along with all of the negative aspects of becoming HIV-positive, it was identified that participants discovered some benefits from their diagnosis. These consisted of: a *birth of a new self*, as the potential loss of future helped the men make positive changes in the present; *new optimism to fulfil dreams; changes in lifestyle;* a *driving impetus* which they hadn't had before; *positive improvements* to their attitudes, self and life; *a new sense of optimism* about the future; *healthier lifestyle*; and *feelings of wholeness*, honesty and peace, which had followed years of uncertainty and confusion (Flowers et al., 2011). This research supports the notion of PTG and demonstrates some of the different ways it can be experienced by gay men after an HIV diagnosis.

Gay men remain the group most at risk of becoming HIV-positive in the UK (Health Protection Agency, 2014). The impact of HIV can leave these men feeling isolated and afraid of others finding out about their status, as they can feel shame in disclosing their condition (Cao et al., 2006; Maguire et al., 2008). Further complications are caused by the presence of stigma, decisions about disclosing to loved ones, and a higher prevalence of prior trauma/sexual abuse (Bornovaova et al., 2008; Rintamaki et al., 2006).

Skinta et al. (2014) carried out an IPA study with gay and bisexual men (n = 8) who were recruited following participation in a psychotherapy group for HIV-related shame. Participants were between the ages of 39 and 58 and were between two and 23 years post-diagnosis. These authors (2014) identified that gay men continue to struggle with disclosure and stigma associated with HIV, and the sense that there is something toxic about being HIV-positive. The following three themes were identified: *stigma in response to serosorting*; *disclosing serostatus to others*; and *attempting to negotiate a spoiled identity*. It was suggested that the distress associated with HIV was often related to relationships within the gay community, as it can isolate people while they search for a new place to belong socially (Skinta et al., 2014). Skinta et al. (2014) concluded that despite more supportive communities for HIV-positive individuals and medical advances, HIV stigma continues to pose difficulties and challenges to the integrity of gay men. This contributes to a change of self-identity, behaviour and relationships.

HIV as ‘other’

Further research by Flowers and Langdridge (2012) explores the story of a gay man’s relationship with his HIV. The empirically grounded research explored how the participant had come to find a way to accommodate his HIV through forming a relationship with it, in the way one may experience an animal as an ‘other’. Flowers and Langdridge (2012) explored the interplay between the human and non-human animal, which in this case was the HIV virus. It was discovered that the participant was able to develop a relationship with his HIV through their shared commonality of needing the body to survive, which took centre stage instead of the HIV. The research suggested that the participant and virus had to find a way to co-exist and become more companionate (Flowers & Langdridge, 2012). This suggests a unique story of human-animal relating, coming together, and forming a relationship to resolve their differences (Flowers & Langdridge, 2012).

HIV and Aging

The number of HIV-positive people aged 50 and older has increased (Cahill & Valadez, 2013) due to the illness no longer being a death sentence. Older gay men living with HIV particularly struggle with their diagnosis, since they face stigma from multiple sources, which intensifies as they age, having a negative impact on health and well-being (Peate, 2013). Older HIV-positive gay men are more likely to be diagnosed with depression compared to the general population and this risk has been shown to increase with age (Gebo, 2006). This may be because older HIV-positive gay men have to deal with more stigma about their illness as well as other ageism-related issues. In addition, these men are faced with public misconceptions about HIV and anti-gay prejudice, all of which have been found to affect mental and emotional well-being (Peate, 2013). As HIV research tends to be focused on younger gay men (Peate, 2013; Gebo, 2006), it is critical that research with those who are ageing with the disease is carried out, as more HIV-positive gay men are reaching old age and finding that their mental health is affected. The following section further discusses research on PTG which is specific to gay men who are living with a positive HIV diagnosis.

Quantitative research on PTG and HIV-positive gay men

Bower et al. (1998) discovered that PTG was experienced after the loss of a loved one to AIDS. The participants (n = 40) completed a questionnaire which categorised them into optimistic and pessimistic groups. HIV-positive men who lost a loved one to AIDS were more aware of their mortality, which helped them create a more optimistic attitude regarding their outlook and approach towards life. This also benefitted their physical health, through a stronger immune system, leading them to lower rates of AIDS-related mortality over time (Bower et al., 1998).

Further research discovered that some men living with HIV experience a reinvigoration for life, whilst at the same time experiencing the significant stress that is associated with a chronic illness diagnosis (Kessler et al., 1988; Viney et al., 1989). This suggests a paradoxical experience in which many feelings are felt at the same time. An individual may experience PTG, yet still struggle with uncomfortable feelings. This led to a cross-sectional study from Schwartzberg (1993), who investigated the ways in which AIDS affected the lives of HIV-positive gay men in the existential realm of functioning. His findings showed how gay men were able to experience personal growth through a new appreciation of life and creating more meaningful relationships with others as well as a more positive relationship with the self. The men in this study also discussed the ways in which they were able to prioritise their own needs and values and partake in more enjoyable activities, which offered new experiences (Schwartzberg, 1993). Participants were able to develop a sense of belonging through new communities, whilst also experiencing isolation. The men felt a loss of possibility and hope, in light of their disease, whilst feeling that their diagnosis was a punishment for being too hedonistic. The men felt their future was stigmatised, and they were contaminated, and they therefore used various strategies to receive attention love, recognition or validation. Participants developed spiritual growth through religion, which was a way of helping them cope with their sense of powerlessness over HIV.

These findings are important to consider in the context of the current research, as Schwartzberg carried out this study in 1993, at a time when the likelihood of death after a diagnosis was extremely high. In the present day, with the development of medication, those with HIV can live longer lives. It will be interesting to see if some of these themes still exist, or if they have altered following HIV's changing status.

Group and community

Schwartzberg's (1993) findings were reflected in findings from more recent studies, such as that of Lyons, Fletcher and Bariola (2016), who investigated collective resilience as a protective factor for the mental health and well-being of HIV-positive gay men. They carried out a survey of people who were living with HIV. Some 89% of survey participants (n = 402) identified as gay men and therefore became the focus of the research. Findings reported that those who belonged to a social group were less likely to experience symptoms of mental health disorders, such as depression and anxiety, and more likely to experience positive mental health, individual resilience and life satisfaction as well as higher overall health. This was in comparison to those who were more isolated, who were less likely to report high collective resilience, and therefore were more dissatisfied with life (Lyons, Heywood, & Rozbroj, 2016).

Belonging to a resilient group or community appears to be a protective factor for the mental health of HIV-positive gay men. This offers new insights into understanding and identifying ways of supporting and improving the lives of this population (Lyons et al., 2016; Poortinga, 2012). HIV-positive gay men often feel marginalised or unsupported in the general community; therefore, being part of a supportive group who have a sense of shared identity helps limit low self-worth and internalised stigma (ASHM, NCHSR, 2012). This highlights the role that could be played by community programs, social groups and organisations in supporting the mental health and well-being of this vulnerable population (Lyons, Heywood, & Rozbroj, 2016).

Critique of positive psychology and PTG

Positive psychology has flourished in the short time that it has existed. However, it has not fallen short of criticism (Friedman, 2008; Friedman & Robbins, 2012). Some have argued that positive psychology has failed to acknowledge humanistic psychology's philosophical background, and that it should not dictate what is or is not first-rate science, or whose standards must be adopted by others (Taylor, 2001). Others have suggested that positive psychology has become a persecutor in the United States as it tyrannises those who don't follow suit (Held, 2002, 2004, 2005).

McDonald and O'Callaghan (2008) suggest that positive psychology has resulted in a series of contradictions, positing that Seligman and his movement have become constrained by a dogmatic set of rules and regulations. They also argue that positive psychology has followed a pathway which means it has unwittingly fallen into supporting current neo-liberal values that have created a social world characterised by exclusion, alienation and meaninglessness. They further suggest that positive psychology would be better suited for workplace managers, as they are primarily interested in neo-liberal values that create individualism, competitiveness, independence, entrepreneurship, dynamism, productivity and flexibility (Birch & Paul, 2003; Bourdieu, 1998; Casey, 1999, 2002; Deery & Walsh, 1999; Hughes, 2005; Rose, 1996; Schor, 1991; Sennett, 1998). Such critics suggest that positive psychology appears to give shortcuts to insight and understanding, which lead to false promises of happiness. They believe that it tells people how to live by following a specific formula, rather than teaching people to think about living and cultivating a life that works for them (Van Deurzen, 2009).

Despite valid criticism, such as positive psychology interventions only offering shortcuts to therapy, and further questions of it being used only in particular circumstances (Lambert & Erekson, 2008; Van Deurzen, 2009), it still has something to offer. One aspect of positive psychology is a shift in the way one frames the world, offering a new perspective and thinking in a more positive way, especially when dealing with chronic illness. This could be interpreted as pressure on people with chronic illness to engage with positive thinking, which add to an already overloaded psychological burden (Petticrew, Bell, & Hunter, 2002), however there is a vast amount of research on the benefits from a positive outlook in terms of quality and length of life after having chronic illness (Greer, Morris, & Pettingale, 1979; Ruini & Vescoveli, 2013; Cordova et al., 2001).

Further research on PTG by Zoellner and Maercker (2006) identified a two-component theory called the Janus-Face model, which suggested two coping styles related to PTG. The first of these is functional. This is self-transcending, constructive, characterised by re-appraisal and mastery, and elicits positive adaptation. The second is illusory, which involves cognitive avoidance, characterised by self-deception and distraction. This suggests that PTG can be an illusion, is dysfunctional and palliative, and therefore is a perceived positive change rather than an actual positive change, which leads to poorer cognitive functioning in the long term (Blix et al., 2016; Engelhard, Lommen, & Sijbrandij, 2015). With this theory in mind, it can be suggested that there is potential difficulty in identifying whether or not the PTG in this study is ‘actual’ positive change or ‘perceived’ positive change. Perhaps a way of helping with this process could be to explore how grounded the men are within the reality of the struggle of their HIV.

Summary

The previous sections introduced PTG theory and showed past research in regard to illness, whilst offering an overview of various acceptance theories. PTG was then explored in terms of HIV, whilst investigating the challenges involved for those diagnosed, such as stigma, disclosure and the trauma of receiving the diagnosis. Various ways of coping were then explored, such as cognitive styles and resilience from past trauma. The section then described experiential and quantitative research on gay men and HIV, followed by a critique of PTG and positive psychology.

2.3. Relevance to Counselling Psychology

The present study utilises a sample of eight HIV-positive gay men living in the UK. The research aims to offer a number of contributions to the field of counselling psychology. Firstly, the study can highlight the importance of ongoing HIV research against the backdrop of the alarming increase of HIV worldwide, especially within the gay community. It is also important to give a rich and nuanced account of the men's stories, to gain a first person understanding of the phenomena around living with HIV. Secondly, the study contributes towards the understanding of the unique phenomenon of experiencing PTG after an HIV-positive diagnosis and how this can impact a person. This not only offers relevance to both counselling and positive psychology, but also demonstrates that there is a future for those living with an HIV diagnosis. Therefore, the study could make a difference for those who are living with HIV. Thirdly, the research could offer practitioners further insight into the implications of working with this particular group, thus offering theoretical transferability (Smith, Flowers, & Larkin, 2009). Practitioners should consider their clients' overall lived experience, which could include a range of biopsychosocial factors such as lifestyle, behaviour, culture and so on, which are particularly important to this participant group. Interventions from practitioners would need to take into account the way gay men make sense of their illness, in the context of their past experience and present concerns. This is important as it contributes to strength-based propositions for practitioners and policy makers when dealing with those who are HIV-positive.

Ethos of counselling psychology

Researchers have struggled to a develop single, coherent definition for counselling psychology, which aims for a marriage between counselling and psychology (Moore & Rae, 2009). Psychology is a broad term that covers diverse sub-specialities, which can differ dramatically in terms of their ethos, philosophical grounding and approach to research. It is traditionally seen to be rooted in experimental behavioural sciences (Woolfe et al, 2003), which are based on empiricism and treating humans as ‘subjects’ (Van Deurzen-Smith, 1993). However, counselling psychology comes from a background that is embedded in humanistic and phenomenological-existential ideas based on empathy, acceptance and congruence. Its aim is to not merely outline a set of values but rather to offer an application for those values (Cooper, 2009), aimed at promoting an individual’s subjective well-being, as opposed to dealing with psychopathology (Woolfe et al., 2003; Spinelli, 2001). In relation to further defining counselling psychology, consideration must be taken with its relation to other allied disciplines, such as clinical psychology, psychotherapy and counselling.

The role and identity of the counselling psychologist is full of paradoxes and challenges as they draw assumptions and influences from both scientist-practitioner and reflective-practitioner models of psychotherapy and psychology (Woolfe et al., 2010), with an emphasis that these can work hand-in-hand. This role has been described by the Division of Counselling Psychology as “marry(ing) the scientific demand for rigorous empirical enquiry with a firm value base grounded in the primacy of the counselling or psychotherapeutic relationship” (2005, p. 1). This means the counselling psychologist must adhere to two different philosophies: those of the empirical-scientist and the subjective-reflective-practitioner, which requires a significant level of intellectual and emotional confidence (Orlans & Van Scoyoc, 2008). This can be difficult at times and can create an uncomfortable tension between *being with* a client (being in relationship and focusing on the individual in the here-and-now) and *doing something to* the client (application of theory and technical expertise) (Woolfe et al., 2003).

Moore and Rae (2009) carried out a discourse analysis with eight London-based chartered counselling psychologists who defined themselves as ‘outsiders’. They found that counselling psychology was seen as an ‘unorthodox’, ‘maverick’ and at times a ‘threat[ening]’ approach that is not always acceptable to mainstream views. These findings align with counselling psychology’s postmodern philosophical position of avoiding schoolism and deconstructing established ways of thinking and practicing (Clarkson, 1998), which is further reflected in postmodern research methods such IPA. It is within this postmodern, relativistic position that the question of needing a unified identity for counselling psychology is raised (Moore & Rae, 2009; Spinelli, 2001). Therefore, counselling psychology can be seen to have multiple identities and to incorporate a multitude of viewpoints and practices, which are broadly subjective, humanistic and phenomenological in nature.

This thesis can be seen to embody the ethos of counselling psychology, due to its ‘maverick’ work that is aimed at exploring traditional psychology and its understanding of LGBTQ and positive psychology while at the same time prioritising the idiographic experience. The thesis is committed to making a contribution to empirical enquiry, whilst holding onto values such as prioritising participants’ unique, subjective experience whilst attempting to adopt a critical, reflexive and flexible approach to theory (Vossler et al., 2015). At the same time, the research aims to explore all paradoxes, divergences and different perspectives that are encountered (Kasket, 2012). This research employs an IPA methodology, with an idiographic approach, which reflects the values of counselling psychology. Its aim is to represent the subjective and multifaceted experience of the participants, and to provide practitioners with knowledge of some of the issues facing HIV-positive gay men who experience PTG. This knowledge will contribute to therapeutic interventions, which can then be adapted and integrated into service provisions to meet the needs of HIV-positive gay men. This is discussed more fully in the final chapter, where I consider the research’s contributions to counselling psychology.

Status of positive psychology within counselling psychology

Both positive psychology and the concept of PTG have been employed and integrated into counselling psychology practice (Hutchinson & Lema, 2009;

Nelson, 2009), such as clinical work inspired by PTG (Vossler et al., 2015). The positive psychology framework has also been drawn upon to enable psychologists to focus on strength and competencies, and to develop rich, meaningful alternative stories with their clients (Hutchinson & Lema, 2009). Other work inspired by PTG has explored posttraumatic growth processes with regard to religious and spiritual meaning making. This was following experiences of a sense-of-presence after bereavement, which has been clinically orientated towards grief therapy approaches (Steffen & Coyle, 2010, 2011, 2012). This research reflects the ethos of counselling psychology, since PTG is grounded in positive psychology theory. Positive psychology and counselling psychology share a philosophical underpinning rooted in human strengths and optimal functioning. It is through this commonality that they can stimulate one another to further develop their fields (Gerstein, 2006).

The philosophical orientation of counselling psychology facilitates personal adjustment and interpersonal functioning across the developmental lifespan (APA, 2015; Gelso & Fretz, 2001). One of the primary features and unifying themes in the work of counselling psychology is a focus on client strengths, assets and potentialities regardless of psychopathology (APA, 1999; Gelso, Nutt Williams, & Fretz, 2014; Savickas, 2003). Lopez et al. (2006) carried out an analysis into counselling psychology scholarship. They explored how much of the research in the area was devoted to human strengths, positive processes and positive outcomes over the previous 50 years. They discovered that 29% of the research analysed (Magyar-Moe et al., 2015) was positively focused. Further analysis found that counselling psychology's philosophical commitment to studying people's strengths had resulted in a large scholarly base which has been fairly consistent throughout the decades (Lopez et al., 2006).

Lopez et al. (2006) conducted a follow-up analysis from mid-2004 through to mid-2014 which had some surprising results. Only 13% of the random sample of counselling psychology research had a positive focus, which was less than half the amount found in 2006 (Magyar-Moe et al., 2015). This suggests that positive psychology has lost representation in major counselling psychology journals, despite the creation of an American Psychological Association (APA) Positive Psychology division in 2004, and the International Positive Psychology Association in 2007. This is also despite positive psychology's growing body of literature in journals such as *the Journal of Positive Psychology* (2006) and *Journal of Happiness Studies* (2000), textbooks (Lopez, Teramoto Pedrotti, & Snyder, 2015; Peterson, 2006) and large compilations (Lopez, 2009; Lopez & Snyder, 2011; Parks & Schueller, 2014). This raises the question of why positive psychology has lost representation in counselling psychology.

Counselling psychology's ambivalence about positive psychology

There are challenges within the relationship between positive psychology and counselling psychology. Positive psychology was seen as a newcomer in the 1990s. However, it already had history in counselling psychology research and practice (Mollen et al., 2006). Positive psychology has been noted for not adequately acknowledging counselling psychology's role in embracing strength-based perspectives (Mollen, Ethington, & Ridley, 2006) as its focus is on positive adaption and optimal functioning (Frazier, Lee, & Steger, 2006).

At the same time, counselling psychology does not always embrace and credit positive psychology as clearly as it professes to (Robitschek & Spering, 2013). Counselling psychology has always had a positive focus but needs to affirm its identity (Mollen et al., 2006; Robitschek & Woodson, 2006), which has been watered down by an increased focus on deficits and allegiance to the medical model (Tyler, 1992). Its close links with the medical model have brought greater prestige (Tyler, 1992), and employment opportunities (Meara & Myers, 1999). However, this has also had implications for the identity of the profession, and has led to a focus on distress and neglect, which is opposed to traditional growth orientation (Vossler et al., 2015).

The neo-liberal argument

This section has been included to provide an argument against the criticism that positive psychology takes a neo-liberal position. There are many reasons why professional self-absorption and low innovation as well as a disinterest in client agency and cultural contexts exist in the counselling psychology literature (Vermes, 2017). One such reason is firmly embedded in the culture of Western individualism and its intention to pursue and maximise individual interests over those of society (Vermes, 2017), an argument which has been staked against positive psychology. An essay by John Locke (1693) on human understanding suggests that people are born with ‘blank slate’ minds, and that opinions and ideas come from experiences, which are essentially individually-based and self-concerned. This viewpoint may be important when exploring PTG for people living with HIV, as it raises the question of whether PTG only benefits the individual experiencing it, or also benefits the wider community. Locke (1693) suggests that people are entitled to their views, independent of others, and that truth is established through personal trial and examination (Woolhouse, 1995). The pursuit of individual happiness has been defended as a socio-political right and moral good. It remains a right and orientation to the good life in contemporary neo-liberal states, although this position has now been given a distinctively entrepreneurial twist (Sugarman, 2015). Binkley (2013) suggests that happiness is being recast by neo-liberalism as an entrepreneurial project. To put it simply, he suggests the road to fulfilment is similar to the road for business success, that is, becoming more independent, self-sufficient, enterprising, competitive, flexible, adaptable and risk-seeking, while becoming less reliant on government support, and pursuing self-interest. Exploiting happiness leads to the cultivation of attributes, assets, potentials and purpose for the sake of personal success. Therefore happiness becomes both a goal and a means (Sugarman, 2015), leading to a particular type of individualism.

A distinction has been made between two types of individualism: utilitarian individualism and expressive individualism (Bellah et al., 1996). This distinction may help identify how individualism is being made use of in today's counselling psychology. *Utilitarian individualism* is about individual self-improvement and initiative to make the most of available opportunities. This may be used in counselling psychology as a form of problem management or an opportunity development therapy that focus on goals, tasks and methods for clients to achieve desired change (Bellah et al., 1996). This type of individualism may be more attuned to strength-based techniques, which can be used in positive psychology. In contrast, *expressive individualism* is about existential freedom to celebrate oneself, and to express feelings as one chooses regardless of social convention. This is evident in today's person-centred and existential therapies, and in the use of reflexive methods.

Critically, individualism has been argued to drive a need for wealth, power and status, while aggregated individualism drives social inequality, national imperialism and war (Joseph, 2011). This raises the question as to whether mainstream therapy models ultimately serve the public well. If counselling psychology methods were to move away from therapist-centric models, theories and practice, and towards a focus on mental health from a socio-cultural perspective, then ideologies would need to evolve into more of a culturally-informed, collectivist approach (Vermes, 2017). However, it has been shown that a good relationship between client and therapist is reparative and that human functioning is relational rather than individual (Cooper, 2009).

These methods are used in counselling psychology and positive psychology as they focus on the individual's potential for happiness, combining self-improvement with being able to express oneself, whilst also finding meaning and purpose. This is what is referred to as authentic happiness (Seligman, 2011). This results from recognising and activating unique potentials that come with individual virtues and character strengths, and so build positive self-regard. This is perhaps when happiness has a positive impact on the wider community, as the wider community may be able to benefit from an individual's improved well-being. This therefore suggests that positive psychology and counselling psychology do have similar values to individualism, but not exclusively. If a person is unable to be well for themselves, how can they be well for anybody else? This implies that working on the individual will in turn impact the wider community and this counteracts the neoliberal argument.

LGBTQ Psychology

This research extends the existing understanding of LGBTQ psychology as it sits at the intersection of counselling psychology and LGBTQ psychology. LGBTQ psychology is concerned with the lives and experiences of LGBTQ people and is affirmative in its approach (Clarke & Peel, 2007; Coyle & Kitzinger, 2002). Its core components consist of contributing to social change, understanding the lives and experiences of non-heterosexual and non-cisgender individuals, and challenging heternormativity and heterosexism, as well as homophobia, within the discipline of psychology and the wider society (Peel, 2014).

LGBTQ psychology brings with it a pursuit of social justice, which constitutes rights to fairness and equity (Bell, 1997) through the promotion of well-being for communities, which is particularly important for oppressed groups (Sloan, 2000). Since social justice aligns with the goals of counselling psychology, this results in a need for counselling psychologists to identify and challenge the oppression of marginalised individuals (Goodman et al., 2004). However, social justice methods are limited in counselling psychology training (Speight & Vera, 2008). Therefore, it is important to recognise not just the desire to understand the lives of LGBTQ people, but that social justice is a commitment of this research, due to its exploration of the complexity of the lives of HIV-positive gay men, who experience discrimination as a result of being gay, HIV-positive or both.

This research promotes social justice, and makes links between LGBTQ psychology and positive social change in a number of ways, as suggested by Clarke et al. (2010). Such research can function as a political act, as demonstrated by early researchers who risked their careers and reputations by carrying out affirmative research on LGBT and HIV. This research can give HIV-positive gay men a voice, demonstrated by these participants being able to tell the story of their HIV journey. Awareness can be raised around issues facing those living with an HIV-positive diagnosis, as well as those facing gay men, which can challenge faulty and prejudice assumptions, especially around the reasons why and how gay men become diagnosed. This research could give further insight into the experiences of people who live outside social norms, and therefore allow for an understanding of how those norms operate. This research in particular could explore the efficacy of the intervention of positive psychology, with regard to HIV-positive gay men, as well as how this could bring about growth.

Overall, the number of benefits for carrying out LGBTQ research are considerable and can be useful to practitioners, HIV-positive people, gay men and others who are associated with these identities. This knowledge can offer a better understanding of the experience of HIV-positive gay men and further inform HIV services which support people living with HIV and gay men. These factors give further purpose, meaning and rationale to this present study, since the research offers an opportunity for a minority group's voice to be heard and documented, which can be extremely empowering to those who are involved (Clarke et al., 2010).

Summary

This chapter has provided an introduction to the present study, including an overview of theoretical constructs and past research as well as a history of positive psychology and PTG, along with research on gay men, HIV and PTG. The chapter also aimed to show further rationale as to why the topic was chosen as a focus of research. This is in light of the perception of HIV continually changing and evolving, being perceived as a life sentence rather than a death sentence (Flowers, Knussen, & Duncan, 2001).

Research is starting to consider strength-based approaches (recognising resilience and identifying strengths) for people who are living their life with HIV (Milam, 2004; 2006). This is especially true in the growing literature on PTG, which is contributing towards various mental health approaches. The way people who are diagnosed HIV-positive are counselled has changed from a crisis, awaiting death's approach, to interventions that incorporate quality of life topics such as relationships, careers and so on (Dahlbeck & Lease, 2010). Research has shown that people who do experience PTG also experience gains in overall mental health, as well as physical gains, such as increased medication adherence and decreased viral load (Manne et al., 2004; Murphy & Hevey, 2013, Sawyer et al., 2010). This further reinforces the need to develop approaches that provide more effective mental health for HIV-positive people, such as PTG and strength-based interventions within counselling psychology and psychotherapy.

In order to further support counselling psychology to encourage PTG, further developments are needed which pay more attention to working with HIV-positive clients. This is relevant to the field of counselling psychology as these developments increase awareness of potential PTG by adopting a focus on growth or positive aspects of functioning. This could help psychologists enhance their clients' ability to facilitate change and foster growth in their lives, which may be considered a different type of intervention compared to those designed to alleviate distress (Amos, 2015). The following chapter further investigates the relevance of this study in terms of counselling psychology.

This chapter has given an overview and rationale of how the study can contribute to counselling psychology. It demonstrates its contribution to the fields of social justice in terms of LGBTQ psychology, as well as exploring criticism that positive psychology has received regarding its potentially neo-liberal position. The following chapter discusses the method used for this study (IPA), and give a thorough overview of the whole research process.

Chapter 3: Methodology

The chapter begins by introducing the research question and aims of this study. This is followed by a presentation of the philosophical and theoretical underpinnings of IPA, the chosen methodology. It will also offer a rationale as to why this methodology was chosen, followed by a description of the study's recruitment process, ethical considerations, data collection and analysis.

The research question is: ***What is the lived experience of gay men who experience PTG after an HIV-positive diagnosis?***

The aims of this research are:

- To explore the experience of gay men living with an HIV-positive diagnosis.
- To investigate PTG in gay men.
- To explore the overall experience of PTG in HIV-positive gay men.

3.1. The Qualitative Approach

A qualitative approach has been chosen as a research method, since the goal of this thesis is to provide a rich and descriptive account of a particular phenomenon by accessing meaning, interpretations and perspectives while remaining sensitive to the voices and concerns of individuals (Lyons & Coyle, 2016; Willig, 2013). This is opposed to the aims of quantitative research, which require the reduction of phenomena to numerical values for analysis (Smith, 2008) and are based on gathering observable, measurable data as well as using statistical analysis to generate empirical evidence.

A qualitative research epistemology is more appropriate for this study, as such an approach is diverse, complex and nuanced (Holloway & Todres, 2003). Qualitative explorations provide rich descriptions of the phenomena under investigation. These tend to be obtained via small samples (Smith & Dunworth, 2003) and through the exploration, description and interpretation of the experiences of the participants, both socially and personally (Smith, 2008). Using a qualitative method for this research gave access to participants' subjective worlds by allowing an intensive engagement with each participant (Coyle, 2000). Since this study focuses on gay men experiencing PTG after a HIV diagnosis, this approach was a good fit, as it generated rich data and detailed accounts from each participant (Braun & Clarke, 2013). Also, since the research is concerned with the health of gay men, who form part of the wider LGBTQ community, a qualitative approach seemed appropriate, as such methods have a long history of LGBTQ research and have become more popular within LGBTQ psychology, particularly in Europe and Australasia (Clarke et al., 2010). Finally, the use and value of qualitative methodologies has been widely demonstrated in the field of HIV and AIDS (Jarman, Walsh, & De Lacey, 2005).

Epistemological considerations

This study is underpinned by critical realism (Bhasker, 1975), which suggests that there is a real world that sits ‘behind’ the subjective and socially located knowledge that a researcher can access (Madill, Jordan, & Shirley, 2000). This means that knowledge can only be viewed as emerging from contexts and as reflecting the researcher’s position, which is partially accessed through the reality constructed by individual meaning, rather than suggesting an absolute truth or single reality. This fits with IPA’s phenomenological and hermeneutic foundations (Finlay & Ballinger, 2006). These two foundations of IPA were employed to demonstrate that the research attempted to “truthfully represent the participant’s subjective world” (Willig, 2012, p. 5). This is a view Willig believes to be appropriate for qualitative approaches, and also supports counselling psychology’s values of privileging the other’s subjective experience over an expert stance (Cooper, 2009).

The aim of this study is to explore how gay men make sense of their experience of living with HIV and PTG rather than how they construct an account of their experiences. Critical realism suggests that phenomena are perceived and experienced in a fluid and subjective way, depending on an individual’s beliefs and expectations (Finlay, 2006). This allows for the subjectivity inherent in the research question while also acknowledging the reality of the experience (Willig, 2013). Phenomenology allows for the possibility of there being more than one reality, which is appropriate for this research question. While all participants experienced being gay, living with HIV and undergoing PTG, the reality of each aspect was different for each man (Willig, 2012). Although participant experience was affected by social constructs, my research did take a critical stance towards the values which influenced participants' construction of meaning. I remained aware of theories and other external influences on the research by adopting a questioning approach to how data may be interpreted through different lenses (Willig, 2013).

The extreme realist approach was dismissed as an approach for this study because is it argued that while actions and events occur in reality, they cannot be accurately described, since individuals can only draw from their own subjective experiences. I also found it impossible to produce accurate knowledge about a participant's account without imposing my own experiential perspectives on the data. The extreme relativist position was also rejected as an individual's account provides the researcher with access to their experience of an actual reality, not one purely constructed by language, despite participants' accounts being mediated through culture, language and politics (Pilgrim & Rogers, 1997).

Interpretative phenomenological analysis

IPA is a qualitative research approach that aims to explore in detail how participants make sense of their personal lived experience (Smith, Flowers, & Larkin, 2009). IPA, with its phenomenological focus, gives subjective experience primacy (Holloway & Todres, 2003) and is concerned with understanding a person's lived experience, perception and views (Reid, Flowers, & Larkin, 2005) of a particular event or process. Through the process of data collection, the researcher commits to understanding people's everyday experience of reality in great detail, to try to gain a full understanding of the phenomenon in question (McLeod & Balamoutsou, 2001). Researchers attempt to achieve this by exploring, describing, interpreting and situating the ways in which the participant makes sense of their experiences (Smith & Dunworth, 2003). Therefore, this is an appropriate methodology to apply to the study of the lived experiences of HIV-positive, gay men who have experienced PTG since their diagnosis.

IPA is also an established methodology in clinical, health and social psychology, provides a stance and protocol for the analysis of experiential qualitative data (Reid, Flowers & Larkin, 2005; Smith & Osborne, 2004; Smith et al., 2009) and has been used several times to explore sensitive and under-explored topics, such as sexual health (Flowers, Duncan, & Knussen, 2003; Flowers et al., 2006) and other issues in HIV research (Dibbs & Kamlesh, 2012; Flowers et al., 2006; Jarman, Walsh, & DeLacey, 2005). As this present study is on HIV and LGBTQ participants, this reinforces the choice of IPA as the methodology for this research.

IPA is influenced by particular areas of philosophy of knowledge (Smith & Osborn, 2004; Smith, Flowers, & Larkin, 2009). Since the primary goal of the IPA researcher is to investigate how an individual makes sense of their experience, they draw on the fundamental principles of phenomenology, hermeneutics and idiography (Smith, Flowers, & Larkin, 2009). Phenomenology is the first major underpinning to IPA. It is the exploration of what a particular experience is like for an individual. It implies that people are intentional and are creatively involved in constructing their sense of meaning (Smith, Flowers, & Larkin, 2009). Phenomenology is concerned with pure description from an individual, with the aim to enter their world, and a commitment to try to understand their perception or account of an event, as opposed to an attempt to produce an objective statement of the event itself (Smith & Osborne, 2004). This is in order to gain a rich source of ideas about how to examine and comprehend lived experiences (Smith, Flowers, & Larkin, 2009).

It is important to show that there were tensions in the research design due the study's blend of phenomenology and positive psychology. Positive psychology informed the research question and the interpretation of data following the participant-centred descriptive analysis. During analysis, I was looking for the men's overall lived experience of HIV and PTG. Whilst I was aware of positive psychology theory, I tried to keep an open mind, so that I would not miss other experiences of PTG that were not included in existing theory. I did this in practice by using a positive psychology lens to complete the literature review, however during interviewing and analysis I tried to be as open and phenomenological as possible by attempting to bracket, to allow the data to emerge from the participants. I then made sense of this through the lens of positive psychology theory.

The second underpinning of IPA is hermeneutics, which is the theory of interpretation (Smith, Flowers, & Larkin, 2009). IPA acknowledges that access to participants' experience is dependent on what those participants tell us about that experience, and that the researcher then has to interpret that account. IPA therefore involves a double hermeneutic, as the researcher tries to make sense of the participant's attempt to make sense of their world (Smith, Flowers, & Larkin, 2009). The researcher will balance description with insightful interpretation, which anchors these interpretations within the participant's account. A degree of reflexivity is employed since the researcher carries with them their previous experiences, preconceptions and assumptions. It is accepted that these will have an influence on their interpretation of participants' experiences.

Idiography involves the detailed investigation of phenomena for a specific, small sample size in order to focus on the detail of individual accounts. This keeps a close focus on meaning rather than causal relationships, with a degree of transparency and a clear account of process (Hefferon & Gil-Rodriquez, 2011). Idiography is concerned with reflecting detail about the perceptions and understandings of a small group, rather than making premature generalisations about larger populations (Smith, Flowers, & Larkin, 2009). The idiographic slant of the study gives a voice to HIV-positive gay men who have experienced PTG since their diagnosis. This therefore offers the reader the opportunity to appreciate the phenomena of HIV and PTG at the level of the individual, as well as the wider group of participants (Flowers et al., 2006).

IPA has been selected as an appropriate and suitable methodology for analysis due to its existential philosophical foundations, which is inline with my main therapeutic orientation, having completed training at an existentially focused school. Its theoretical underpinnings stem from phenomenology – which originated with Husserl's (1927) attempt to construct a philosophical science of consciousness – with hermeneutics, and with symbolic-interactionism (Biggerstaff & Thompson, 2008). Husserl's phenomenological enquiry focuses on the consciousness of the individual (1927). He suggests that phenomenology involves stepping outside of everyday experience, in order to examine that everyday experience, whilst adopting a reflexive gaze that is directed inwards, towards perception (Shinebourne, 2011). He used the term 'intentionality' to describe the relationship between the process in consciousness and the object of attention. Whilst attempting to identify key structures and features of the human experience, Husserl went on to develop a phenomenological method called 'bracketing' (or epoche), which involves putting assumptions to one side to focus on perceptions of the world through engagement in a series of reductions. Husserl's notion of bracketing is an important part of the research process of IPA, as it attempts to focus on the process of reflection, whilst seeking to capture a particular experience, by a particular group of people. However, this is never fully possible, and therefore IPA allows the possibility of subjective influence of the researcher (Flowers, Smith, & Larkin, 2009).

The role of the researcher in IPA is important as they bring their own history, values assumptions and perspectives into the research. Heidegger (1962) questions the possibility of the existence of knowledge outside of the interpretative stance and used the term ‘person in context’. This was in response to his concern with the ontological question of existence itself (Pietkiewicz & Smith, 2012), as we are situated in a meaningful world, observing, thinking, feeling and engaging in order to make meaning from that world (Smith, Flowers, & Larkin, 2009). Heidegger also suggested that relatedness to the world is a fundamental part of our constitution (Larkin, Watts, & Clifton, 2006), and that intersubjectivity aims to describe and make sense of this relatedness. The key idea for IPA researchers is that human beings are ‘thrown into’ a world of objects, relationships and language. Secondly, by being-in-the-world, being is always perspectival, temporal and always ‘in-relation-to’ something (Heidegger, 1962/1927). This implies that the interpretation of people’s meaning making is a key component to phenomenological inquiry (Smith, Flowers, & Larkin, 2009).

This study involves HIV, which is an embodied experience. Merleau-Ponty developed the idea of the embodied nature of our relationship to the world, and suggested that the body is essentially the vehicle/means of communicating with the world (Merleau-Ponty, 1962). He also proposed that we see ourselves as different from anything else in the world, due to being human. Merleau-Ponty's view is that the body shapes the way in which we know the world. He suggests practical activities and relations, with the physical and perceptual (body-in-the-world) elements being more meaningful than abstract or logical ones (Anderson, 2003). This suggests that the body is central in experience; however, the lived experience of being a body-in-the-world (Smith, Flowers, & Larkin, 2009) cannot be entirely captured. I attempted to capture the embodied experience of what it is like to live with HIV, as much as possible, through being aware of how questions were worded, and by participating in reflective exercises during analysis. However, this experience was difficult to capture fully, and this was a limitation of which I was mindful when developing the project.

Sartre (1948) says that existence precedes essence, and the self is not pre-existing. He goes on to state that we are always in a process of becoming ourselves, a process which is influenced by one's historical, biological and social climate. Sartre stresses that the individual has freedom to choose and is responsible for their actions within the context of their life (Smith, Flowers, & Larkin, 2009). With regard to IPA, Sartre extends Heidegger's ideas and develops the importance of personal and social relationships, in that it is better to conceive of our experiences as dependent on the presence and absence of our relationships to other people (Smith, Flowers, & Larkin, 2009). Since counselling psychology values are based on prioritising and understanding an individual's unique subjective and intersubjective experience, in relation to themselves, others and the world (Orlans & Van Scoyoc, 2008), these philosophers and IPA are seen to be a good epistemological fit for this study.

Rigour in qualitative research

Demonstrating the validity of a qualitative study is important, but arguably more difficult than for a quantitative study, due to criteria resting on different epistemological assumptions (Lewis & Ritchie, 2003). There are, however, a variety of guidelines for assessing the validity and quality of qualitative research. Yardley's (2000) guidelines are recommended when using IPA (Smith, Flowers, & Larkin, 2009). Yardley (2000) suggests that qualitative research is specifically concerned with an individual's experience, and that the researcher should allow patterns and meanings to emerge that have not been specified in advance. Yardley's (2000) guidelines are: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance.

Sensitivity to context was achieved from the early stages of this research process (Smith, Flowers, & Larkin, 2009) by exploring the relevant theoretical and empirical literature and theory (Yardley, 2000), as discussed in the literature review. Another important aspect here was my reflexive role; when interacting with participants, I showed empathy and tried to put them at ease. Each interview had open-ended questions, as I wanted to encourage participants to respond with what was important to them, rather than be inhibited by concerns about what I was looking for (Wilkinson, Joffe, & Yardley, 2004).

Yardley (2000) emphasises commitment and rigour thorough data collection and in-depth engagement with the topic as a route to validity. I achieved this by carrying out an analysis that had both breadth and depth. IPA assumes attentiveness to participants during data collection as well as to the analysis (Smith, Flowers, & Larkin, 2009). Methodological competence was required to achieve unique insights through empathic understanding of participants' perspectives. I immersed myself in one participant's verbatim account at a time, then left a gap before starting another. It was through a skilful analysis of the dialogue that the rich interpretations were derived (Smith, 2008).

It was important that the research was carried out in a way that was robust and could be clearly followed. This depended on my research question, my theoretical approach, methods employed, and interpretation of the data (Smith & Osborn, 2008). I was careful when describing findings not to use language which reported general statements as concrete evidence. Transparency is another important feature that demonstrates the rigour of qualitative research, and can be achieved when the research stages are written up (Smith, Flowers, & Larkin, 2009). A fully transparent analysis was presented with all tables, themes and quotations, so that it was clear where interpretations had come from.

Reflexivity, which is a way of assessing and taking into account the ways in which the researcher may have affected the research, is another important part of the process (Parker, 1992). I have gone into more detail about this in the section below.

The final principle for this research is its aim to make a contribution and a difference in the wider community through its application from other practitioners and policy makers through dissemination. Overall, these aspects of validity were imperative so that the research could have an impact, something I was aware of throughout the process. I have, therefore, included a chapter on the relevance of the research to counselling psychology, and explored this within the conclusion.

3.2. Reflexivity

This section of the methodology chapter focuses on reflexivity, and is written in italics so that it is clearly identifiable. There are more sections within this chapter that follow the same format to make the reflexivity clearly identifiable. IPA suggests that part of the qualitative process is an acknowledgment and presentation of the researcher's understanding and preconceptions about the research (Finlay & Gough, 2003). In this section, therefore, I explore how my values, ideas, personal interests and experiences have shaped the research process. My aim is to provide the reader with insight into my perspective and the effects it might have on the interpretation of the data, and so allow the research *process to be scrutinised throughout.*

My interest in HIV and AIDS was first triggered when I was a small child, after seeing advertisements on television. I found the messages of impending doom and death from AIDS so traumatising that the emotions created by those adverts remain with me to this day.

I moved to London in my 20s, and had my first taste of the gay scene after meeting a group of gay friends. I was first exposed to someone living with HIV after a friend was diagnosed, and I then realised that the illness was no longer the death sentence it had been decades earlier. After seeing my friend’s struggle with his diagnosis and how he managed to find personal meaning with it, I became fascinated with the idea of PTG.

I became interested in positive psychology during my undergraduate degree, where I wrote my dissertation on human motivation and growth. This led me to the theories of Carl Rogers (1951) and Martin Seligman (1999), as well as to Abraham Maslow’s (1943) hierarchy of needs. These ideas resonated with my own personal philosophy of life, and have helped motivate me throughout life, as I try to be mindful of what is in my best interest and healthy for me.

During my training as a counselling psychologist, and as part of my placement, I started volunteering as a trainee psychologist with an HIV charity, working with women and gay men. My experience in this capacity helped me understand what it might be like to be HIV-positive. While some of my clients managed to find meaning in their diagnosis, others didn't and appeared to be in a permanent state of despair. I became fascinated with the idea of what made an individual find meaning from such a traumatic experience, and so be able to move on with their life.

Within the process of my training as a counselling psychologist, I have been exposed to many theoretical perspectives, which have both reinforced and challenged my initial assumptions and beliefs. My beliefs that knowledge and meaning are subjective products of real experience have been reinforced, hence my epistemological stance. My clinical practice has raised my awareness of how my own assumptions, values and beliefs can affect meaning making for both the client and myself, from the experience and narrative clients bring to therapy. This has also made me aware of my influence on this research, which has been essential in the process of my learning, in both the research and my clinical practice.

Throughout the process of this research, I reflected in a research journal to enhance my awareness of myself and of the issues that arose throughout. I *realised that this process could not be rushed and that it was important I revisited each part of the process to consolidate the learning. It was important that I was proud of what I was trying to achieve, which was to gain knowledge about the topic of gay men and HIV, and how this could provide insight into the ways in which health professionals might be able to assist this particular client group in the UK.*

3.3. Participants

Table 1, below, shows demographic information about the research participants. Each has been allocated a pseudonym to comply with confidentiality.

Table 1. Participant information

Name	**Age**	**Years Diagnosed**	**Ethnicity**	**Dual diagnosis (Hepatitis C)**	**Trained counsellor**	**Residence**
Marley	50	5 years	White British	No	No	London
Gavin	50	5 years	White British	No	No	London
Kristof	38	3 years	White British	No	No	London

Tron	35	2 years	White Australian	No	No	London
Matteo	43	5 years	White British	Yes	No	London
William	48	4 years	Black Caribbean	No	Yes	London
Sid	36	3 years	White British	No	Yes	London
James	44	5 years	White British	No	Yes	London

Since IPA uses small, purposively selected samples (Smith, Flowers, & Larkin, 2009), eight participants were recruited for this study. There are many advantages of between six to eight participants, a number which is recommended for studies in clinical doctoral programmes (Smith, Jarmen, & Osborn, 1999) so that the data is not overwhelming yet allows an opportunity to examine both similarities and differences between individuals, due to depth not breadth (Turpin et al., 1997). My aim was to intimately familiarise myself with the data and to focus on the similarities and differences that emerged, and this would not have been possible with a larger sample.

Participants were recruited through an HIV charity in London and an advertisement was put out on Facebook. Leaflets were put in the waiting area of the primary counselling service at a different branch to the one in which I worked, in order to prevent the possibility of recruiting any of my own clients. Participants identified as gay men, aged between 35 and 50, were HIV-positive, identified their experience of being diagnosed HIV-positive as traumatic, and felt they had experienced PTG since their diagnosis.

The men's age range was carefully selected so they were old enough to have seen the 'don't die of ignorance' tombstone advert in the 1980/1990s. The maximum age of 50 years was chosen to capture a close age range within a particular generation. In addition, HIV-positive gay men over 50 years old are from a different generation who are more likely to experience certain issues such as an increase in depression (Peate, 2013; Gebo, 2006), and therefore could be investigated in a different study. The men had all been diagnosed for at least two years, but no longer than five years. The inclusion criteria of a two-year gap post-diagnosis is of importance, as I wanted to minimise any trauma that could be caused, since participants would be reminiscing about a potentially extremely painful experience. These two years may have also given participants time to recover from the shock of the diagnosis, and work through it, so that they had had time to make sense of it for themselves. This range was also selected to try to capture the early experience of growth, as I wanted them to have a clear memory of being diagnosed, yet also to give them enough time to come to terms with their diagnosis for ethical reasons. The fact that three of the participants are experienced counsellors might have had an impact on their interviews, as they would have perhaps have worked through their HIV and been more able to articulate their feelings, giving more of a detailed account of their experience.

I decided to disclose that I was gay to the participants as research has suggested that LGBTQ psychologists who are identified possess an ‘insider advantage’ when it comes to accessing and recruiting participants (LaSala, 2003). Being part of the LGBTQ community is thought to impart credibility and specialist knowledge that enables the researcher to gain access to and secure the trust of potential participants (Clarke et al., 2010). After the initial telephone call, an information sheet was sent out to the participants (Appendix 1), which briefly outlined the purpose of the study and what taking part would entail, as well as a consent form (Appendix 2). One potential participant who came through the online advertisement was interested in taking part, but failed to meet the two to five year diagnosis criteria, since he had been diagnosed a little over a year. I had a long conversation with the man in question, and it became clear that he wanted to tell his story, so I decided to refer him to the HIV charity organisation for therapy, which he proceeded to do.

Response to the recruitment strategy was slow. There were several potential participants who were keen to take part, yet failed to meet the age requirement or *post-diagnosis time criteria. These difficulties made me a little frustrated and impatient, as I was eager to get started. It is noteworthy that almost half the participants were trained counsellors. I feel that this research may have been appealing to this group as they would have had the personal tools to work through their diagnosis, which may have possibly been a way for them to crystallise and share their story. This could have affected the research, meaning participants were able to offer deeper insight when articulating their interpretation of their experience.*

3.4. The Interview

Each participant was interviewed on a one-to-one basis, without interruption, in a private room in a counselling service. The schedule followed an exploratory path (Dibbs & Kamalesh, 2012). Semi-structured interviews were carried out to explore both the worldview of the participants and their experiences since they had been diagnosed with HIV. This process can be viewed as a collaborative experience that emphasises the participant as the expert in their field (Alexander & Clare, 2004). The semi-structured approach allowed me to cover issues of primary concern and interest, the interviews were not rigid in sequence (Knight, Wykes, & Hayward, 2003).

The main aim of the interview was to try to enter the participant's psychological world as much as possible and go in the direction indicated by each participant. They were free to share experiences, so that they were given the best opportunity possible to tell me their story (Smith, 2008) and what they deemed important. This approach was adopted to allow data that was rich in detail and to help identify key conceptual issues (Green & Sobo, 2000). I offered minimal prompting unless I felt the participant was straying too far away from what we were discussing, when I would focus on their account of the impact of the diagnosis. I often required more detailed information and so would question participants' assumptions by using open, phenomenological questions to gain insight into how they perceived HIV in their everyday lives (Flowers et al., 2006). There were times I would have liked to explore something further; however, there was a time restriction, and so the conversations were limited.

The following is the list of questions that were asked in the semi-structured interview, although these were not necessarily asked in this order.

- What was your experience of being diagnosed with HIV?
- What effect did the diagnosis have on your life – if any?
- Have you found any meaning or purpose since your diagnosis?
- Has the diagnosis changed you in anyway?
    - Negative – Lifestyle/choices/struggles to find meaning.

    - Positive – Lifestyle/choices/found any meaning.

- How do you perceive the future?
    - Health, relationship, career etc.

The men all shared highly emotive and personal material during the interviews, and there were times when this made me anxious. This resulted from my attempts to manage my new role of interviewer, which is different to being a psychotherapist. It became apparent to me that these men wanted to talk about experiences and emotions which were meaningful to them. All participants knew that I was a trainee psychologist and had experience working within the gay community as well as with people living with HIV. I was mindful of my own experiences of being a gay man living in London, and had to also be aware not to let my own preconceptions interfere with the process of the interview as much as possible. I attempted to do this through regular discussions with my research supervisor, as well as writing in a reflexive journal.

3.5. Analysis

The term IPA recognises the dual nature (or double hermeneutic) of the analytical approach and acknowledges that while IPA is committed to exploring a participant's world, the researcher achieves this through a process of interpretative activity (Jarman, Walsh, & De Lacy, 2005). In line with the idiographic stance of IPA, each transcript was repeatedly read to get a general sense of the participant's account, and then sequentially analysed in-depth (Smith, Flowers, & Larkin, 2009). I found that every time a transcript was read, more insight was gained into the participant's world. I created two margins on either side of the verbatim transcript and used the right-hand side to make notes relating to aspects that had stood out to me, such as key phrases, interesting points, summaries of content, connections between different aspects of the transcripts and initial interpretations (Smith, 2008). After re-reading each transcript, I used the margin on the left-hand side to note emergent themes, which were drawn from the transcript. My approach to transcription notation was that I edited the text to reduce it, as the quotes were initially too long. I did this by not including repeated words and pauses, unless I felt they were interesting and added something to the analysis. If I did include a silence then an elipse was used. If the participant did something non-verbal that was interesting, then I would record this in my note taking along with the sentence, which was uttered by the participant and the time it occurred, so it was easy to locate during analysis.

During the analysis, I had to try to maintain an awareness of my own beliefs and assumptions. This was in order to remain true to the participant, and while this was difficult to achieve, I did it to the best of my ability. This is where I also attempted to set aside the positive psychology lense that had been used for the literature review. I wanted to avoid the possibility of being led by an agenda and *finding something in particular, rather than being open to what each participant brought. Again, I found keeping a reflective journal helpful here. Van Deurzen (2014) suggests that each of us is embedded in the world, which provides a unique particular perspective. She suggests a beneficial research technique which I used throughout the process of my research, based on the mnemonic SOAR: State of mind, Orientation, Attitude, Reaction. I observed my state of mind and took account of both the participant's and my own point of view of the world as much as I could. I tried to be as aware of the current emotional state and mood of both the participant and myself. This technique was a useful, mindful exercise which I used to 'check in' with myself before each interview and session of analysis. By thinking about the participant's approach as well as my own, I was able to orient myself. This also gave a good indication of the participant's worldview, beliefs, cultural bias, and theoretical belief system. I made note of what the participant's attitude had been towards the research question, which I based on their tone, mannerisms and body language. If something stood out, then I would make a note of it.*

3.6. Emergent Themes

Emergent themes were listed in the left-hand margin, and psychological summaries of the comments I had made in the right-hand margin. At this stage, the transcript was still treated as data, and sections were dealt with equally, without special attention to any particular passage. This is known as horizontalisation of data, meaning treating all information equally, which is a key aspect of phenomenology . Consideration was taken so that data was not derived as a result of expectations shaped by my awareness of relevant literature, or by the previous transcript. On completion of individual analysis, I created a super-ordinate list of themes from each interview and compared them to accumulate emergent-themes within higher-order categories, called ‘super-ordinate themes’ (Knight, Wykes, & Hayward, 2003). To help with this process, I printed and cut out the themes, which helped put them into clusters. It was only after the themes had emerged from the data that theoretical concepts from the literature were acknowledged as enhancing my psychological understanding of the themes, which suggests an analysis informed by theory but not driven by it (Riggs & Coyle, 2002).

I found this stage quite overwhelming at times and had to have regular breaks between reading each transcript. This was so that I could have ‘fresh eyes’ when looking for themes in the verbatim account of the next participant. This stage was also both exhilarating and frustrating as I began to make stronger connections between the themes. Further frustration came when I realised I had missed some fantastic opportunities to explore some potentially rich additional data during the interviews.

3.7. Ethical Considerations and Confidentiality

All names and any identifying details were changed. I recorded the interviews on a digital recorder and transferred the files to an encrypted USB stick for storage, deleting the files from the recorder at this point. All of the information, such as demographic and interview data, that was provided to me was given a code, and that is how it was identified in a locked filing cabinet. The information will be kept for at least six months after the completion of my course and will be treated as confidential. If this research is ever published, I will make sure that neither names nor other identifying details are used. The data is stored according to the Data Protection Act and the Freedom of Information Act.

To comply with ethical considerations, I sent an email to participants detailing the project aims, confidentiality procedures, time commitment expected, method of data collection, and the right to refuse information or withdraw from the study. In accordance with the BPS ethical guidelines (2010), my primary concern was to protect participants from harm, and preserve their autonomy and dignity, since the topic of this research is personal and may bring up painful memories.

I digitally recorded the interviews and stored them in a file on my personal computer, which is password protected. I transcribed the interviews myself and changed any information about the participants that might have identified them, or any other people they identified during the interview. It is only when this thesis has been marked that all recordings and transcripts will be deleted to maximise anonymity and confidentiality.

I did not engage in psychotherapy with the participants within the interviews. This was established by firmly setting the boundaries at the beginning of the interview. This is important, as I did not want to open anything up for the participant that could not be contained within the interview time, as this was not an on-going relationship, and therefore it would not have been safe or ethical to do so. I recognised that these exchanges were interviews by staying focused on the research question and interview schedule, asking open questions, and not interpreting responses. The interviews were carried out in a counselling room, which had a receptionist and a system in place in case of an emergency. Another person was always aware of my location at all times, thus ensuring my safety.

3.8. Debriefing

The aim of the debriefing was to ensure that participants left the interview in the same frame of mind, they had when entering the interview as much as possible. This was something I was aware of when exploring with the participant, as I did not want to open a topic that could not be contained when they had left. Before the interview, I provided an explanation of the research aims and objectives and went through the information sheet (Appendix 1), so that the participant was clear about what was happening. This offered an opportunity for questions regarding the research and procedure of the interview, though most of the participants did not ask any questions. All participants signed a consent form (Appendix 2). I thanked the participants post-interview, and then gave them the opportunity to describe and reflect on how they found the experience.

I contacted participants via email two weeks after the interviews to check in with how they were feeling, and all responded with appreciation. I also discussed a contract between the participant and myself regarding how to behave in the event of meeting unexpectedly. The participants were divided regarding this. Most felt comfortable being acknowledged; however, one of the participants did not want to be acknowledged. Each participant was also given details of my supervisor and of the NSPC and told they could make contact if they wanted more information or were concerned about the study in any way (Appendix 3).

Summary

The aim of this chapter was to give an overview of the methodology used within this study. I have introduced and outlined the rationale for IPA, and detailed the strategies employed during the recruitment process. I have also described the approach to data collection and analysis, as well as shown reflexivity throughout the process. In the following chapter, I attempt to create an account of the participants' experiences.

Chapter 4: Findings

4.1. Overview

The interpretative phenomenological analysis (IPA) of the semi-structured interviews with eight HIV-positive gay men is presented in this chapter. The analysis led to the emergence of four super-ordinate themes.

- The struggle
- Change in relationships
- Positive growth
- Identity

The themes have been uncovered through the researcher engaging in a double hermeneutic process (Smith, Flowers, & Larkin 2009), meaning this is a subjective interpretation. This section may have looked different if they had been analysed by another researcher. However, findings have been laid out and evidenced enough so that it is possible to follow my interpretation and rationale.

This chapter explores the super-ordinate themes, as well as the relevant emergent themes, which are highlighted by verbatim extracts from the transcripts. While the super-ordinate themes were common across the accounts, areas of difference and divergence are also discussed, in keeping with IPA.

4.2. Super-ordinate Themes and Related Emergent Themes

Table 2. Table of super-ordinate themes and emergent themes.

Super-ordinate theme	**Emergent theme**
1. The struggle	1.1: Coping 1.2: Emotional release 1.3: Medication
2. Change in relationships	2.1: Relationship with self 2.2: Relationship with others 2.3: Relationship with HIV
3. Positive growth	3.1: Finding meaning 3.2: Positive thinking 3.3: Flow
4. Identity	4.1: The past 4.2: Being a gay man 4.3: Living with HIV

4.3. Introduction to the Themes

The four super-ordinate themes provide an overview of the accounts of HIV-positive gay men who feel they have experienced PTG since their diagnosis. The first theme, *the Struggle*, highlights participants' account of their struggle in coping with their HIV diagnosis and taking their HIV medication.

The second theme, *Change in relationships*, explores the men's experience of the changes in relationships with the self and with others. It also highlights the way the men began to relate to their HIV. It considers the process of changing their perception of who they are, in light of their diagnosis, and the way they perceive other people.

The third theme is *Positive growth.* This theme explores the different ways the men started to engage with their world, developing coping strategies while they navigate through their diagnosis. The final theme, *Identity*, highlights that despite experiencing PTG, the men still face challenges whilst living with HIV, in light of their struggles from the past, and with their identities as gay men.

4.4. Super-ordinate Theme 1: The Struggle

This super-ordinate theme aims to capture the men's struggle as they come to terms with their diagnosis. Participants labelled the events that led to them contracting HIV in a variety of ways – from a 'one off' one night stand without protection (William, James, Sid, Kristof, Tron) to some ‘risky behaviour’ with numerous partners (Marley), or a ‘numbers game’, which is a way of saying that it was a high probability that they would have eventually contracted HIV (Gavin, Matteo). The following emergent themes follow the men as they struggled to cope with their diagnosis, experiencing shock, defeat, hopelessness and disappointment. It was also difficult for the majority of the men to accept that the medication would give them an opportunity to survive, as they perceived that medication as a burden, a life-long commitment, and a daily reminder that they were carrying a potentially deadly disease. Overall, this super-ordinate theme shows what it was like for these gay men to experience an HIV-positive diagnosis.

Emergent Theme 1.1: Coping

The men remembered vividly and felt the need to tell the story of their struggle to cope when receiving their HIV-positive diagnosis. There was a sense that some of the men expected their diagnosis and some of them did not; nevertheless, it was still a shock as they tried to cope with their news. What is interesting in the following extracts is the ways in which the men go into autopilot and show the importance of being able to *‘get on’* with their lives and get through their day:

Kristof: “*I was in denial. I went to the gym and then burst out crying. I had to keep going. I just didn’t expect it to be honest.”*

Marley: *“I was in shock and couldn’t get my head around it. I just had to get on with it, I suppose. There have been a couple of times when I’ve been on my* *hands and knees thinking 'why the fuck has this happened to me?' but it has."*

Matteo: "*I was like 'oh fuck' and I just felt a disappointment in myself but I had to get on with it."*

The men were filled with fear and anxiety as they confronted their new reality. They felt shock and despair on hearing their diagnosis, illustrated in Marley's quote when describing being on his '*hands and knees'*. At the end of his quote, Marley answered his own question; resigned in his powerlessness and hopelessness in the reality of his situation, there is no *'why'*. Some of the men felt resigned to their news, yet instantly show an element of resilience and the need to '*keep going'.*

Some of the men's first concern was other people knowing about their status, although this became a worry for all participants at some point in the process. The following extracts show this:

Gavin: "*I didn't take any time off work at all. I sort of dealt with it in a way, as no one could know. I had to get on with it and deal with it."*

Sid: "*I thought to myself – how can anyone know about this. I can't remember being upset at the time. I just felt a bit spacey."*

William: *"Surprise that wasn't a surprise, in a way, as I knew when I put myself at risk. It was a one-off. I thought, my life is over – no one can ever find out* *about this. I'm going to kill myself. So I created a fantasy in my mind of how I'd do it."*

The men were concerned about disclosing their HIV status and worried that others would now perceive them as different. This is what motivated Gavin to deal with it himself – so no one else would know – whilst Sid describes being *'spacey',* demonstrating his shock. William fantasised about suicide, which suggests he was in such despair that he felt the easier option for him was to end his life, as he thought that living with HIV meant his life was already over.

The following quote demonstrates Tron's experience of receiving his diagnosis:
Tron: *"I just needed to put autopilot on, keep moving and get on with it. I went to work the following day, I had no sleep, I finished the job, and then I went on the Internet, and went home, and started to look for a place to live. My head couldn't have been any further away from my body."*

Tron states he: *'just needed to put autopilot on'*, demonstrating his resilience and determination to survive, as he closed off from his feelings, as a coping strategy to function and get through the day. This is further reinforced at the end of his statement, where he describes his head and body as separate, suggesting a psychological and emotional disconnection as a way of coping with the news.

In summary, this emergent theme shows how these men went into autopilot, as a way of coping with their news, whilst trying to get on with their lives. There is sense of powerlessness through a lack of personal control, as they fight their emotional reactions towards their deeply shocking news yet show high levels of resilience in their will to survive. Despite the diagnosis they still found it highly important to get through the day as ‘normally’ as possible. This way of coping can be interpreted as denial, as the men split from strong emotions in order to get on with things, until they are ready to engage with them at a later time.

Emergent Theme 1.2: Emotional Release

This emergent theme shows the men’s emotional release, as the news of their HIV-diagnosis began to sink in and they faced their new reality. The following extracts show Tron and William’s emotional reaction, which was filled with despair, hopelessness and sadness, yet offered relief at being able to express themselves and surrender some control.

Tron: “*Something just came over me and I didn’t know what was going on. My body just took over my mind. It took three days before I cried and that was a really big emotional step for me because at that point, I hadn’t cried. I was so frozen – I really felt like I was having an out of body experience. I’ve never had that before.”*

William: “*I think it was a good few days before I started crying. I would cry before and after bed. The strong capable persona would slip and I’d get into*

> *hysterical tears. I can't remember ever crying at that level of energy before, so I knew how I was very afraid and scared."*

Both men had taken time to emotionally engage with the news of their diagnosis. Once the shock dissipated they lost a sense of control, as they were overcome with emotion. They both described a shift within themselves before releasing and expressing their emotion, with William saying his: '*strong capable persona would slip'*, implying that to express emotion and cry is an inability to be strong. Tron described that his: '*body just took over [his] mind*,' suggesting his feelings had taken over and he could no longer control his emotions. This appeared to be a powerful experience for Tron, demonstrated through his description: *'out of body experience'*. This ties in with his previous quote in emergent theme 1.1, where he suggested his head and body being separate, implying a feeling of disconnection.

In summary, this emergent theme shows that this was a confusing time for two of the men, as they simultaneously tried to engage with their feelings and thoughts and so make sense of their new reality. This level of emotion shows how both men felt despair, yet there is a sense of relief and freedom from trying to be in control, as they were able to emotionally express themselves.

Emergent Theme 1.3: Medication

This emergent theme attempts to show how the men have engaged with the idea of taking HIV medication. What is interesting here is the various ways the men struggled with the medication, despite the fact that it allows people to live long, full lives. The following extracts show the struggles these men had in accepting treatment as something positive.

Gavin: "*The medication that you take has lots of other side effects. I get incredibly tired, and some of the medication doesn't allow you to disperse fat, so I lose weight slower."*

James: *"I became depressed from the medication and thought it was due to stress within my life and it got quite serious, and I had suicidal thoughts. The trouble with depression is it's hard to take responsibility."*

Marley*: "I remember getting three months' worth and I remember getting these tablets to take one-per-day. I thought it's another milestone in this diagnosis. I thought I'm going to have to do this for the rest of my life."*

Matteo: *"Treatment caused me depression, which I'd never really suffered from before in my life. I didn't want to do anything."*

William: *"Treatment was another terrible experience, as I thought 'oh my god' – now I'm going to have to take drugs every day for the rest of my life. I was also aware of the potential side effects."*

Although the medication enables people with HIV to live long lives, these men are pre-occupied with its side effects. This knowledge is confusing as it feels paradoxical; they want to live long lives, yet feel that the medication can be harmful to their health. This is a burden as they must not only live with their HIV, but also with the potential of developing other conditions associated with their medication. James and Matteo found that the medication had made them feel depressed. Gavin, James and Matteo all experienced health issues linked to the medication's side effects, which contributed to them living in fear of other possible long-term effects.

William and Tron decided to create a positive experience to introduce the medication into their lives. This was a way of building up the self and creating a feeling of control over their situation:

Tron: *"I started taking some vitamin C tablets, pretending to take the medication three weeks before I started treatment, as once I started I wouldn't be able to stop. All of those little things started building up my confidence. Thinking I can do this – I can overcome this. This is good for me, and will help me live."*

William: "*My friends came to stay and we did a little ceremony with the drug. My friend said 'this drug is going to make you stronger than you are today, and is a benefit to your body – so take it in a positive way.' It was lovely. These people are still in my life, and I'll never forget what they did for me."*

This was a valuable experience for William as it cemented his relationship with some of the friends he had made since the diagnosis. He made a choice, with the support of friends, to actively create an empowering, positive experience connected to the medication. Through this experience, William found himself belonging within a new community, along with other HIV-positive gay men. This ceremony focused William on the benefits of the medication, which gave him a sense of choice, by taking it in a positive way, as opposed to the focus on the potential side-effects in his previous quote.

Tron chose to be proactive and use vitamins, which are usually used to optimise health, as a way of introducing the medication. This focused him on the health benefits of the medication and reinforced the idea that the medication is an anchor for health and vitality, which was important to Tron. In this way, he was able to build up and offer positive reinforcement to the self, in preparation for taking the medication. This was an empowering experience for Tron, as he installed a more positive relationship with his medication, giving him a feeling of control.

In summary, this emergent theme shows the men's struggle to accept HIV medication, as they grapple with the knowledge that it would keep them alive, yet make them feel unwell, both physically and psychologically. Taking the medication would also be a daily reminder of their illness. Participants acknowledged the potential future side effects of their medication, with some already experiencing symptoms. A few of the men developed a good relationship with their medication by engaging in a positive experience, helping them prepare and build up the self in preparation to take it for the first time. This created a shift in terms of how they perceived their medication, by placing more emphasis on the benefits, as opposed to the disadvantages of taking it. This showed the men had paradoxical feelings around their medication, yet had coping strategies in place to defend against their anxieties around their HIV diagnosis, as they struggled with their feelings towards their new reality.

Summary of super-ordinate theme

This super-ordinate theme captures the men's experience of an HIV-positive diagnosis. They recognised that their lives would not be the same again, as they struggled to come to terms and cope with the diagnosis. Although medication is available, some men struggled with introducing and accepting the commitment and dependency of having to take it every day for the rest of their lives. This was something the men battled with, whilst also perceiving it as another milestone in the process of getting an HIV diagnosis. It is interesting to see how important it was for the men to tell their story and relive the moment they received the shocking news of their diagnosis – this is the starting point from which they had to learn how to cope and to develop PTG. This super-ordinate theme gives an overview of the struggle to cope when receiving an HIV-positive diagnosis and offers insight into what it is like for gay men to go through this experience.

The next section will attempt to demonstrate the ways in which the men have developed PTG through a change in their relationships since their diagnosis. These include relationships with self; relationships with others; and relationships with HIV.

4.5. Super-ordinate Theme 2: Change in Relationships

This super-ordinate theme shows how the men needed to draw on their own personal resources, both internally and externally, to help them cope through the process of their HIV diagnosis. It was within this process that the men begin to experience PTG, as they made changes to their relationships, which allowed them to enrich their sense of self, as well as giving deeper meaning to their relationships with other people. The men also began to relate to their HIV.

Emergent Theme 2.1: Relationship with Self

This emergent theme shows the ways in which the men made healthy changes to their relationships with themselves. These extracts demonstrate PTG for the men as they begin to communicate with the self in a more supportive and positive way, whilst acknowledging a more favourable self:

Kristof: *"I've realised I've got to forgive myself. I know that I have emotionally developed and am a much better man than I was before."*

Matteo: *"I won't punish myself and live with regret – I don't think it's healthy for me. I realised it has made me who I am today, and I have grown as a person. I'm a sum of all those experiences and I've become a better person from it."*

William: *"I've decided to step into who I am – into my identity as a black, gay man. I was trying to be as acceptable as I could with my gayness, and I hadn't recognised that I was restricting myself from being me. The* *diagnosis started me on a road to look at things differently, and be a better person, in a way that was kinder to myself."*

These extracts show that the men had developed more positive relationships with themselves through self-care and support, which shows evidence of their PTG, with statements such as: '*I'm thinking more of what's good for me'*, '*Let go of expectations of myself*', '*I've got to forgive myself*', '*not good for me and my well-being*', '*kinder to myself*'. The men had started to put their own needs first and stopped being so hard on themselves. William felt more authentic, and had begun to accept his identity, referring to his ethnicity and sexuality. This had previously been restricted to fit with his perception of other people's expectations of him. Matteo described awareness of a healthier way of communicating with the self and stated that his experience contributed to the better person he is today. We can therefore see that the diagnosis helped the men connect to a more favourable sense of their identity.

Similar to William, Gavin became more authentic with others and freed himself of other people's expectations:

Gavin: *"It's made me realise that I don't have to take crap off people and I WON'T, whereas before I was a very easy going and placid person. I'm thinking more of what is good for me."*

Gavin suggests he: '*doesn't have to take crap off people*', which was followed by: '*I WON'T'*, as if making an active choice and reaffirming his new-found boundaries in terms of putting himself first, whereas before the diagnosis he was more passive and willing to put up with more for the sake of others.

Authenticity for others meant to be able to show vulnerability. This is shown in the following extract:

James: *"I have grown by allowing myself to be vulnerable and knowing that it's not going to destroy me. I have also released the pressure of not always being seen as the 'well one', which was an important shift. I let go of expectations of myself, and stopped trying to be perfect. It is that what makes me human, and I think before the HIV, I was trying to be perfect."*

Like William and Gavin, James freed himself of other people's expectations, and showed that he could allow himself to trust others and be vulnerable. The diagnosis gave him no choice but to remove the pressure he put on himself to be seen by others as '*the well one'*, since HIV is not perceived as being well. HIV helped him reject the idea of perfection and accept his imperfections, as he perhaps feels it is now impossible to be perfect whilst living with HIV.

Some of the men are conflicted with how they are feeling, as demonstrated by the following extract:

Sid: *"I might as well move on, and once I'd come to the realisation that this is life now, and this is how it's going to be, there is no point in sitting there and feeling sorry for myself. It's simply not good for me and my well-being."*

Sid's comments: '*I might as well*', '*no point…feeling sorry*', show a sense of acceptance in his attitude, as he came to terms with his HIV. He does not want to be a victim of his new reality, and knows that to survive, he must stay motivated for life instead of *'sitting there'.* Sid has an awareness about which attitude to life is healthier for him, and he shows resilience in trying to move himself forward.

In summary, this emergent theme shows how the men engaged with their PTG and felt empowered as they acknowledged the personal growth and emotional development they encountered since their HIV diagnosis. They have a heightened sense of awareness of what is in their best interest, whilst grappling with a more nurturing and compassionate relationship with the self. They utilised internal resources to communicate self-support, which resulted in an awakening of greater self-care and understanding, whilst accepting particular aspects of themselves they may had previously rejected. This has enabled a sense of independence for the men as they built themselves up in light of their diagnosis.

Emergent Theme 2.2: Relationship with Others

In this emergent theme, the men discuss the ways in which they have developed deeper and more meaningful relationships with other people, which shows evidence of PTG for the men. The following extracts demonstrate changes in the way they related to other people, through showing greater appreciation to people in their lives:

Marley: "*I learnt to nurture relationships. It's given me life-long friendships that are real friendships: real, deep and meaningful. I couldn't have had those relationships before."*

Kristof: *"My sisters and friends – I think that's what happiness is – when you're valuing the relationships you have now. I've got much more of an appreciation of the people in my life."*

Sid: *"I have gained friends. I didn't know anyone who was HIV-positive before. This made me feel accepted, because I see others in a similar position, and how they are getting on with their life."*

Tron: *"It was a huge shock to me to realise that there are some amazing people out there. There are people out there who don't mind things like this and accept whoever."*

The men described a new appreciation for the people within their life which, for some, was something they were unable to feel prior to the diagnosis. James, Kristof and Marley all described ongoing relationships which had been enriched through a new-found appreciation, while Tron, Sid and William found value in new relationships. Sid was inspired by others with HIV *'getting on with their life'*, whilst Tron developed faith in the wider community. The men felt accepted, which allowed them to feel more emotionally connected with others who are both similar and different. The following is another example of this:

William: *"My relationships changed – I ended the ones that I had for the wrong reasons. I did a group at an HIV support network for black, gay men. So that turned my life into a new direction. I had never had an interaction like that with friends prior to my diagnosis."*

William sought out those with whom he could identify (HIV positive, gay, black men), as a way to get a better understanding of himself. Through this new community, he was able to relate in a deeper, more authentic way, and end relationships he had for the wrong reasons. The men took comfort from the acceptance they received from others after their diagnosis, with comments such as: '*made me feel accepted'*, '*accept whoever'*, '*there was total acceptance'*. This offered a feeling of belonging and membership to a new community and a greater sense of inclusion, which helped them to come to terms with their own diagnosis. The following extract from James is another example of this:

James: *"I couldn't, or I wasn't going to deal with this on my own. I recognised that*

> *trying to deal with everything on my own had not worked out very well for me. I thought 'what are friends for?' 'Am I trusting them enough to support me?' This is that wakeup call. I have to love and trust them enough to support me."*

James made an active choice not to deal with his diagnosis alone, replacing '*couldn't*' with '*wasn't*'. He recognised that, despite trying to be too independent prior to the diagnosis, that was not how he wanted to proceed, as that kept him emotionally isolated from others. He was able to allow himself to be vulnerable and reach out for support, which was a relief, and led to a new awakening in his connections with other people. This ability to show his vulnerability suggests he developed a level of trust in others to be there for him since his diagnosis.

In summary, this emergent theme shows that the men developed a deeper appreciation of the people in their lives and were able to change the nature of their relationships and seek support from others. This gave the men a level of self-acceptance through the acceptance of others, as they were able to find a sense of belonging to new or existing communities. They conceptualised HIV in relation to the positive influence of love and support from other people, through friends, family and support groups, which allowed them sense of belonging. The men have now developed a deeper connection and a sense of belonging with specific groups of friends and family. Others (William and Sid) felt a sense of invigoration as new members of a community, such as HIV/gay support groups. Finally, Tron felt a universal sense of belonging to an extended community beyond family, friends, gay and HIV, and a deeper sense of kinship with humanity. This sense of deeper belonging to a group with a shared identity, whether gay, HIV-positive, family, or just human, appeared to offer a protective factor, with new insights into understanding and supporting ways of improving the lives of these men as they tried to find benefits in the face of their diagnosis

Emergent Theme 2.3: Relationship with HIV

This emergent theme demonstrates the men's relationships with their HIV. This was a minority theme that only four men spoke about. However, it is included due to the unique way one of the men developed his relationship with his HIV. The following are extracts from James' account:

James: *"It's another organism living in my blood that is trying to thrive to survive and live like the rest of us are. We all try to survive and live. It doesn't have the consciousness to kill you. It doesn't target you. It's like an avalanche – It doesn't point you out. It's not a villain. Not a premeditated consciousness. It has no value system or consciousness as to whether it likes me or not. It just is. Me and this organism share the same space."*

James: *"It's the relationship to it that causes the problem, pain is inevitable, and suffering isn't. HIV teaches me to be in relationship with something that could potentially kill me, but what could really kill me is a toxic relationship with it."*

James identified with his HIV, and recognised their shared goal for survival, saying: '*me and this organism share the same space*' and '*thrive to survive'*. The nature of the relationship with his HIV is important for him, as he felt that a negative relationship could be detrimental to his health: '*what could really kill me is a toxic relationship with it*'. He worked hard to create a neutral relationship with his HIV and made an active choice to find a positive way of relating to it, saying: '*pain is inevitable, and suffering isn't*', implying he has come to terms with his diagnosis and taken responsibility, whereas if he didn't, he would perceive HIV as conflicting, and therefore, toxic.

James's ability to move towards a more companionate relationship with HIV, whilst removing any anger and regret for the disease, has created a sense of respect and recognition for it as a living thing. Through creating a neutral relationship, and removing the enemy, as well as detaching any sense of being a victim, has helped dissipate the feeling of powerlessness, and therefore his fight with it. He has created a way of coping and identified that his HIV's needs are the same as his. His comments, such as: '*another organism living in my blood', 'live like the rest of us are'*, imply that he has created a sense of 'otherness' for the HIV, creating a divide and a distance between himself and it. Unexpectedly, this also led to a sense of togetherness, bringing him closer to the virus through his acceptance of it as a living other. This shows the paradoxical nature of James' relationship with his HIV, as he tries to create a positive relationship with it as the other.

James appeared to diffuse any anger he has towards his HIV by taking away the feeling of victimisation, saying: '*It doesn't have the consciousness to kill you'*, '*It doesn't target you', 'It doesn't point you out', 'It's not a villain', 'not a premeditated consciousness', 'It has no value system or consciousness as to whether it likes me or not'*. He made all of these statements in quick succession, reinforcing that he has not being targeted by his HIV, and that he does not want to become angry, take it personally or punish himself. By seeing HIV as a living thing that isn't the enemy, James is able to stop personalising or victimising himself. HIV does not *'point you out'* and *'target you',* it just is something that is, something he has to live alongside. James's use of the word '*we'* identified a sense of sameness with his HIV, which helps him relate to it in a more harmonious way. The statement: '*HIV teaches me to be in relationship with something that could potentially kill me*,' means that finding peace with HIV, instead of a battling it, helps him live alongside it.

In contrast to James, some of the men identified the HIV as part of their identity:

Gavin: *"I just accept that it's part of who I am now."*

Kristof: *"It's part of me to be honest and it's part of my transformation in life, and part of my path. It's come to a point now where I don't need to tell people because it's not really an issue for me. I don't find it's an issue for them, so I don't need to find acceptance from others."*

Sid: *"It's something that I can't change and it's a part of you. In a way it felt like way back in the past when I was just coming out as gay. It was like just having a second coming out, and I survived that, and look at what I'm doing, and where I am now."*

Although the men still struggled with their diagnosis, some had accepted their HIV as part of their identity. Kristof accepted that HIV is a *'part of him'* and acknowledged it as a trigger for a transformation within his life, giving it meaning for him. He also stated that becoming HIV-positive was *'part of my path',* which perhaps implies it was inevitable and part of his destiny to become HIV positive.

Sid uses the pronoun '*you*' instead of 'me', creating distance between himself and his HIV. Kristof and Sid both describe disclosing their HIV to others as not an issue any longer. Kristof said it has: '*come to a point where I don't need to tell people*', suggesting he was previously concerned with disclosing his status to others, but no longer needs their validation; he has now come to terms with the HIV and is able to validate himself. Sid's quote *'it felt like I was coming out again'*, suggested the difficulty of disclosing his status to others, as he compared it to coming out as a gay man, which he *'survived*'. This suggests that having told others is a marker of achievement for him, and offers him a feeling of liberation.

In summary, this emergent theme presents the men's paradoxical feelings about their HIV. Some of the men have developed a more positive relationship with their

HIV and incorporate it into their sense of identity, whilst helping to dissipate internal stigma.

Summary of super-ordinate theme

This super-ordinate theme aimed to capture the changes in the men's relationships since their diagnosis, which is part of their experience of PTG. All the men developed more understanding in their relationships with the self, such as more self-acceptance, self-forgiveness and greater self-care, resulting in a more favourable sense of self. The men were also able to draw upon support and develop more meaningful relationships with other people which had more authenticity, care and a deeper connection. There was a sense that the men struggled with their relationships with their HIV. However, various coping strategies were developed. Some incorporated their HIV into their identity, and found a more positive way of relating to it. This appeared to help the men come to terms with their HIV, so they were able to live their lives as 'normally' as possible. Overall, this super-ordinate theme shows how these gay men struggle with their HIV diagnosis, yet can still go on to experience PTG, by creating a more meaningful relationship with the self, and with other people.

The following super-ordinate theme demonstrates further PTG experiences, as the men discuss positive growth and develop coping strategies since their HIV diagnosis.

4.6. Super-ordinate Theme 3: Positive Growth

This super-ordinate theme attempts to capture the ways in which the men continued to experience PTG, as they began to engage in their worlds differently. A range of experiences are shown, including: finding new meaning and purpose; being able to incorporate a more positive way of thinking; and finding activities that help the men experience positive emotions and flow. These experiences gave participants a sense of resilience and motivation to survive, as they were able to find benefits from their illness.

Emergent Theme 3.1: Finding Meaning

This emergent theme shows how the men began to engage more deeply in their lives as they face their new reality. The men identified and acknowledged meaning within their lives, which supports the notion of PTG, while dealing with existential concerns:

Matteo: *"I've reached a point in my life where I'm more stable and I know myself a bit better. I've gone through these things and I've come out the other end. I've started to realise a bit more about what really matters and what has meaning in my life."*

Marley: *"Any life-changing event makes you stop and take stock of life. It makes you aware of your own limitation and gives you a different outlook on life."*

Tron: *"I have realised how much control I have over my life, and my time, and how many choices I can make for a better life for myself and others. It's all*

> *about interpreting how I see things and how I see people. You can find meaning in everything you do, especially the little things."*

The men demonstrated an increased awareness of their mortality through comments such as: '*take stock'*, '*aware of own limitations'*, *'what really matter'*, suggesting they have begun to find more meaning in their lives. This enabled the men to find a deeper, more meaningful way of engaging within their worlds as they recognised they have worked through their diagnosis and '*come out the other end'* to feel more '*stable*'. The men are able to see life in a different way; Tron spoke of '*choices*,' which implies he feels in control and is actively making his life better through a changed perception. Marley spoke of a different outlook triggered by his awareness of his mortality. Matteo discussed stability and a better understanding of himself.

The following extract represents the men's search for more meaning whilst facing the reality of their morality:

Gavin: *"The biggest thing it's made me realise is that you are mortal and we will die – we all will die. So I just really want the best I suppose, live my best, the best I can."*

Gavin's states: '*you are mortal'*, whilst using *'you'* instead of 'I', which is perhaps a way of distancing himself from the reality that he will eventually die. He followed this with '*we will die'*, as if to correct himself, followed by '*we all will die'*, emphasising the '*all'.* Using the word '*all'* created a sense of inclusion with all others, and a reminder that we all eventually die, with or without HIV. Gavin repeated the word *'best'*, demonstrating his desire to make the most of the experiences in his life.

Like Gavin, other men become increasingly aware of their mortality, and stated that they no longer took time or life for granted and now had an impetus to fulfil goals:

William: *"I found meaning in this awful experience. I made the decision with myself to do something positive. I love the idea that I am continuing to grow as an individual – this allows me to validate my own existence. My purpose was to make this process better for others."*

James: *"Living with HIV is a big reminder of your own mortality – you have to get on and do shit and live your life. It's not a Disneyesque thing but it's about making your life meaningful, even if it's uncomfortable and difficult. I don't believe in fluffy notions of happiness but I believe in meaning in context."*

William found purpose by improving the process for others going through an HIV diagnosis. This active choice to do something positive allowed him to '*validate*' his life and find purpose, which gave his HIV meaning. James appeared to develop a greater sense of what happiness meant to him; one that appeared grounded in the reality of life's struggles. His use of the phrase '*meaning in context'* suggested an awareness that meaning is subjective, can be found in various ways and is not universal.

In summary, this emergent theme shows how the men have increased focus on existential matters to explore what was important in their lives. They offered critical reflection and rumination of important issues, which gave them a heightened sense of appreciation and meaning in their lives. This disruption to the men's core beliefs as they mentally reorganise was anxiety provoking, yet somewhat exhilarating, as they searched for deeper meaning. Their new reprioritised values helped them take stock and gave them a sense of purpose and validation. There is an urgency of wanting to fulfil personal ambitions without further procrastination, as the men became aware of their mortality. These ambitions include making the process better for other men who are going through the process of an HIV diagnosis, which is empowering.

Emergent Theme 3.2: Positive Thinking

This emergent theme attempts to capture changes in the way the men began to think since their diagnosis. The following extracts show how the men endeavoured to apply a more positive way of thinking, to help them cope with their diagnosis, which offered them optimism and hope for the future:

James: *"I'm optimistic about the future. I believe in conditionality as things come* *together – it's what you make of that."*

Kristof: *"I have much more of a positive view of life and I see a better future. A positive future."*

Sid: "*It does give you a different take on life and you do think you have to be more positive about the future, because in the beginning you don't. I've grown as a person, put myself first and learnt to deal with something and adapted well to it."*

The men acknowledged the possibility of more positivity ahead with comments such as: *'optimistic about the future', 'see a better future', 'positive about the future'.* These extracts demonstrate how, despite living with a lifelong disease, participants were able to see a future. Sid's quote showed this has not always been the case; he has had to develop this way of thinking, suggesting he has come to terms with his diagnosis. The men showed resilience and focus, as they try to cope the best they can, as in Matteo's quote below:

Matteo: *"I like to see the positive in life. You've just got to pick yourself up and deal with it the best way you can. I have a destination in mind, plot a course, and head to it. Things will always hit you along the way. Then just think about enjoying the journey and not losing sight of that – it's not just about the destination anymore."*

Tron*: "Life isn't about taking shelter from the storm – it's about learning to dance in the rain. There are always going to be things that are upsetting but it's how you choose to view and act on it. You can make it positive, and that* *pretty much sums up everything about the last few years. It's what I have learnt and how it's put things into perspective."*

Matteo and Tron showed determination to work through their diagnosis and get on with their lives. Both described enjoying the process of life more, through comments such as: *'see the positive', 'enjoying the journey', 'learning to dance in the rain', 'make it positive'*. The men demonstrated an active change in the way they thought about life, as they negotiated a more positive way of thinking, which encouraged determination, hope and optimism, whilst enhancing enjoyment and satisfaction. The men recognised their resilience, and felt able to take on the challenges of life, which is due to them been able to work through their HIV diagnosis.

The following extracts further show evidence of a more positive way of thinking:

Gavin: *"Just try and be a little bit more forward and positive thinking, in terms of I want to do lots of things, such as fulfil my bucket list. You never know what's going to happen."*

Marley: *"Everything you encounter is experience and you can turn what you interpret as a negative into a positive. I always think you should make the most of every situation and try and be happy, and kind, and thoughtful and tell people what you think of them. I mean no one likes a misery."*

The men are motivated to have a more positive mind-set for different reasons. Marley was more aware of being positive for the sake of others, saying '*kind, and thoughtful and tell people what you think of them*', while at the same time being concerned with how he is perceived *('no one likes a misery')*, which raises questions around whether he is actually feeling this way, or putting on a brave face for the purpose of others. In contrast, Gavin described more of an awareness of himself and what he wants to achieve, with an impetus to fulfil personal ambitions, saying *'I want to do lots of things', 'fulfil my bucket list',* whist also discussing a feeling of uncertainty around what the future holds.

In summary, this emergent theme showed the men's resilience, and how they have adapted positive coping strategies to defend against their HIV-positive status. The men were determined to get through and deal with their diagnosis, which appeared to have given them more of an impetus to work towards and achieve their goals. They perceived that choosing a positive attitude, in light of their diagnosis, was an achievement, which supports the notion of PTG for the men. They recognised that they are strong enough to face the challenge of being HIV-positive and have a positive mind-set, giving them hope and optimism for the future, despite the diagnosis being a constant challenge for them.

Emergent Theme 3.3: Flow

This emergent theme attempts to show the experiences of the men as they prioritise activities that allow them to feel present and in flow, which shows evidence of PTG. This theme is striking as it shows how the men engaged in various activities that help them connect and feel present, yet at the same time, escape from their day-to-day reality:

Kristof: *"I like to do things that take me away and help me forget about my everyday troubles, like drawing and painting."*

Matteo: *"I take the time to do the things that make me happy. I like doing things that are able to absorb me and take me away from my everyday concerns. Things like cooking."*

Tron: *"It's more about doing what makes me happy and what makes me feel like I'm relaxed. I've always loved music and cooking nice food and that's more of a focus for me right now – things that do actually make me happy and where I can lose myself in time."*

William: *"I'm doing volunteer work and dedicating myself to something to give my time to other people – this helps me forget about all of my own concerns and get enmeshed into other people's."*

The men started to engage in activities that make them feel happy yet offer them relief by temporarily allowing them to forget about their everyday concerns. Tron stated that his focus is doing things that make him happy, showing that he is prioritising his needs and evoking feelings of happiness, whilst at the same time finding escapism. William found flow through his volunteer work, which has given purpose to his life, whilst allowing him escapism through stepping into other people's worlds.

The following quotes further show evidence of the men finding flow:

Marley: *"I do more things that I want to do now. Things like painting really help me feel more connected in a strange sort of way."*

Sid: "*I give a little push to try new things now. I did improvised theatre last year and that was something I could immerse myself in."*

The men have found a way of coping with the burden of their diagnosis by offering themselves moments of escapism, which helped them forget their concerns and allowed them to experience moments of flow. This seemed to be a new experience for some of the men, evidenced by Marley saying: '*help me feel more connected in a strange sort of way*', which suggests there has been a shift in the way he connects with himself compared to before his diagnosis. It was also difficult for some of the men to stay motivated to experience new things, illustrated by Sid, who suggested he needs to: *'give a little push to try new things*'.

In summary, this emergent theme showed the paradoxical experience of the men as they engage in activities that distract and allow them to escape reality, whilst at the same time seeking enjoyment, pleasure and flow. These moments offer relief, as the men experience total absorption into whatever it is they enjoy doing, without HIV being on their minds.

Summary of super-ordinate theme

This super-ordinate theme captures the change in the men, as they continued to experience PTG and developed different ways of engaging in their lives that offered comfort, as they coped with their new reality. There were many personal struggles for the men, and there was a sharp awareness of their mortality, which motivated them to engage with their lives more deeply. The men made a conscious decision to find meaning in their diagnosis, think more positively about their lives, and engage in things that enabled them to feel positive emotions. Some of the men found meaning through financial contribution and volunteer work, whilst others found meaning in new experiences. Overall, this super-ordinate theme suggested that the men are actively choosing a way to not just survive, but to thrive, whilst showing resilience in the face of their disease. It shows how these gay men are able to go on and experience PTG, despite living with a deadly disease.

Previous super-ordinate themes have shown the men's struggle as they attempted to cope with their HIV-positive diagnosis, followed by the men experiencing PTG, through their relationships both with the self, and other people, whilst also finding more meaningful ways of engaging in life, thinking more positively and engaging in activities that helped them experience positive emotions. The final super-ordinate theme will show that despite the PTG experiences of these men, they still struggle with the reality of their lives.

4.7. Super-ordinate Theme 4: Identity

This super-ordinate theme demonstrates that despite the men experiencing PTG since receiving a HIV diagnosis, they continued to grapple with their new reality and life challenges. This does not imply that PTG has not occurred, as the struggle of life and PTG are not mutually exclusive. The men experienced an identity crisis as they tried to make sense of their new identity, whilst considering their past and living in the present as HIV-positive gay men.

Emergent Theme 4.1: The past

This emergent theme aims to show how the men have struggled in their past; struggles which had a lasting effect, and which were crucial points in the men's lives that informed part of their identity. The men acknowledged a greater sense of resilience due to these experiences, which they claimed helped them deal with their diagnosis:

Gavin: *"I have come through so much worse than this and survived other things."*

Kristof: *"I managed stuff from the past okay and got on with my life – I lost my Mom and Dad when I was young."*

Matteo: *"The feeling of being an outsider at school, so all I did was study hard. I was bullied for being different. I didn't know at the time but it was because I was gay, and this created a lot of strength within me later in life."*

The men acknowledged that past experiences had helped them develop coping strategies and create a greater strength in later life, and that overcoming these struggles helped them cope with their HIV diagnosis. These struggles also enabled the men to develop in other ways. Matteo dealt with the bullying by focusing on his academic studies, whilst James became fiercely independent:

James: *"I've always had to rely on myself from a very young age. My dad was in jail and my older brother was very violent to my mother and me. I remember hurting myself and I would go in the house and just sit on the stairs and cry and not go up to anyone. There's always that sense of being on your own even when around other people. I was taught not to be a problem because I was reliant on other people to look after me."*

James built his independence from childhood, which created loneliness and an emotional disconnection and isolation from others in his suffering. He learnt not to show vulnerability to others, with the concern that he may be a burden, and would therefore be rejected. This may have resulted in James feeling unable to reach out for support.

The following extracts show further evidence of the ways in which the men have become more resilient following their past struggles:

Marley: *"I've always been quite independent from being a lad when my parents divorced, and I had to look after my Mom, little brother, and myself, so I think I should have been able to deal with this myself."*

Sid: *"What doesn't destroy you only makes you stronger. I've had traumatic things happen to me in the past. I think it does prepare you and make you stronger…and it makes you look at things like steel and move on. It's not the end of the world – you have to move on, and you don't really have a choice."*

Marley stated that he '*should*' have been able to deal with his diagnosis alone because he had dealt with challenging circumstances in his childhood. Sid used the word '*steel'*, suggesting his past experience had hardened him, and so he is more resilient when facing his HIV. He also repeated the words *'move on',* perhaps offering self-encouragement to move on, since he feels he has no other choice.

In summary, this emergent theme showed how the past gave the men more resilience when dealing with their HIV, which allowed them to get on with their lives the best they can. The acknowledgement of their strength awakened a sense of responsibility for some (such as Marley looking after his mother and younger brother after parents' divorce; James taking responsibility for himself through his neglect; Kristof's parents dying), while others developed mastery and control (Matteo became studious at school, as a way of avoiding the bullies). These earlier, emotionally challenging experiences are used as points of reference to show how far participants have come. The memory of being able to come through these earlier experiences helped participants to feel stronger in the face of their

HIV. The men felt a sense of validation and pride as their past informs part of their identity.

Emergent Theme 4.2: Being a Gay Man

This emergent theme demonstrates participants' challenges with their identity as gay men in light of their HIV. The following extracts show how the men have had to re-evaluate their values since becoming HIV-positive, and how these values fit with living as a gay man. It is interesting to see how the men have particular perceptions of who and what they need to be in order to feel a part of the gay community:

Gavin: *"With HIV, as you get older, your testosterone drops, which for a gay man is not a particularly good thing, as your libido goes. So how can you live like a proper gay man?'*

Matteo: *"I hadn't realised how I looked for excitement and looked to not miss out, because I felt excluded at school, and I've carried that with me for a long time. That pressure of keeping up appearances never goes on the gay scene, so it's easy to keep going out, doing risky behaviour, and that's why I have this. I just can't keep up anymore."*

Kristof: "*It's really my idea of the whole gay scene that's changed – unprotected sex with random people on drugs. So that's changed my philosophy because if you take drugs it has an effect on your HIV."*

Tron: *"My biggest concern is about being gay and not about being positive. My*

> *future still looks pretty sketchy because I don't know if I'm going to find someone and have the happiness that you want when you grow old. The gay world is so unpredictable and there are values and morals in that society that I don't follow."*

The men described a shift in their perception of what it means to be gay, which left them feeling uncertain and perhaps isolated. They made a lot of assumptions and generalisations about other gay men, which suggests stereotyping. Gavin made a link between sex and being gay, and presumed that having a high sex drive is being a *'proper'* gay man, which implies he felt a low sex drive is a sign of not being '*proper'*, and is therefore a sign of inadequacy. The men recognised the pressure of trying to belong, and acknowledged this as harmful, with some suggesting that it was the gay lifestyle of drugs and sex that had led them to becoming HIV-positive, such when Matteo says: *'it's easy to keep going out, doing risky behaviour, and that's why I have this'.*

The men showed an increased awareness of self-care, as they became more aware of what is healthier for them, both physically and psychologically. This led to a reappraisal of life priorities, as the men described a change of philosophy and re-evaluated their moral and value systems, whilst trying to reorganise their priorities, which appear to be different to the ones they had before diagnosis. They grappled with their identity and struggled to understand where they belong. They once perceived living as a gay man within a particular type of gay community as normality, but since their diagnosis there had been a shift, which created unsettling feelings. This is difficult, as feelings of isolation remind them of past experiences of not belonging, shown in Matteo's quote about feeling like an outsider at school.

Some of the men had given up trying to be accepted, and had diminished hope in trying to keep up with the construct of living as a gay man. James shows this in the following extract:

James: ***"****How we go around to look for little scraps of love everywhere, and that's how I became HIV in the first place. I don't think I'm alone in that. How we go around and fit in with society of trying to be a good gay, or fit in with heterosexual norms, or heading down the gym to train in the hope that someone might like me on the gay scene."*

James used the word '*we'*, which suggests that he feels part of a new community of HIV-positive gay men with similar emotional experiences and a shared compassion over how they contracted HIV, whilst seeking acceptance. He identified with this new community through commonalities with other HIV-positive gay men. This gave him more of an informed sense of identity and offered exclusivity from other non HIV-positive gay men.

Overall, this emergent theme shows how the men had developed a greater awareness of their mental and physical health, and were choosing more healthy options, as they adopted a different way of life, focusing on the long term as opposed to the short term. This created an identity crisis as the men began to question how they had been living their life, creating a feeling of difference and separateness from other gay men. There is a sense of irreparable loss of the gay culture, due to participants moving away from some of the things they had once enjoyed. This change in behaviour subsequently removed the men from some of the pressures they perceived within the gay community, whilst at the same time leading to a feeling of isolation away from a community they once felt so included by.

Emergent Theme 4.3: Living with HIV

Although the men were able to identify positive changes in their lives, they still grappled with their HIV status, as part of their identity. This emergent theme aims to capture the essence of these struggles, demonstrating that being diagnosed is an on-going journey, as the men live with the consequences of the disease and with knowledge that there is no cure and therefore no destination to strive for:

Gavin: *"The tablets are very strong chemicals. They age your body, you're more prone to cancers, heart attacks, strokes, and they raise cholesterol. It's a big worry and you're always concerned that you're going to become ill. I'm* *still very heavily laid down with the stigma of HIV and still haven't told my family."*

Matteo: *"It eventfully fucks up your liver. It's hard to know it's always there. Well it's a new level of stigma and it's a lot to deal with, and that's a lot of burden to have."*

Sid: **"***I want to go travelling but there are still countries that ban HIV and others are funny about taking medication. I couldn't go for a year because how am I going to carry a year's worth of medication? And obviously future partners – I have to think about that because not everyone is okay about HIV."*

James: *"One of the things that I don't like about being positive is I would really like to live abroad but it makes things much more complicated. I don't want to be – but it symbolises a part of my life and to an extent it weighs down moving forward."*

William: *"I would say that whilst everything seems wonderful – I haven't told my family. I wouldn't want to burden them as they will think that I'm going to drop dead. So if, and when I do tell them – the more years that go by the better."*

Despite finding coping strategies, the men felt that their HIV loomed over, burdened, and limited them in some way. For example, James and Sid felt that their HIV limited their freedom to follow up on personal ambitions to move abroad, and many of the men described the constant worry for their health, acknowledging the potential damage the medication may do to their bodies. There was also concern about disclosing to other people through fear of how they will be perceived. William and Gavin haven't told their families, which is something that plays on their minds, whilst Sid was concerned about telling future partners. Gavin did not use the personal pronoun 'I' but instead uses *'you*,' in the context of becoming ill, which is possibly his way of creating distance from such an anxiety inducing reality.

The following extracts show how the men live with the concerns and stigma that are still associated with living with HIV:

Kristof: *"It's about the stigma that people attach to HIV. It's the little things like someone sharing your food from the same fork, and they would think that they are going to get HIV from that. At first I thought to myself I was a walking plague, because of the disease in your body."*

Tron: *"I've started to develop anxiety from bizarre things like a small cough. I don't want my brothers and sisters to see me dying. It's my biggest fear. It brings you back to reality – I actually have a condition that has killed over 35 million people and there are still people in the world dying from it."*

Tron described heightened stress and anxiety for health and well-being, catastrophising small ailments, such as a cough and his biggest fear was close family watching him die, which suggests a worry for others, over himself. The men are living under the constant threat that they may develop a serious illness associated with their HIV at any time. Kristof demonstrated an awareness of stigma, and used *'your'* instead of 'my' when describing having the disease in his body, which is perhaps a way of creating distance with and therefore managing the HIV.

The men struggled with anxiety, as they were reminded of their diagnosis by taking the medication, which also reminded them of possible side effects, resulting in a heightened awareness of their health. They were concerned with the stigma that surrounds HIV and how others would perceive them once they find out about their status, as well as trepidation for the well-being of loved ones in terms of how they would receive the news, if told.

In summary, this emergent theme showed how the men still struggled greatly with a wealth of unsettling feelings, such as fear, anxiety and despair, as they faced the reality of living with HIV. Their whole world has changed, along with their identity, as they try to find a new position in the world. This created uncertainty and insecurity for the men, as they navigated their way through their lives, whilst dealing with the daily reminder and limitations of their HIV status.

Summary of super-ordinate theme

This super-ordinate theme has explored the participants' past struggles, as well as the ongoing challenges of living as gay men and living with an HIV diagnosis. This process was immersed in anxiety as they struggled with their identity, and where they belong in the world. Present concerns about finding their way and concerns for their future also played heavily on the men’s minds. In most cases, their HIV diagnosis created a change in the way they viewed the gay community, meaning they now feel a sense of isolation from it, compared with having once felt that that community was where they belonged. One can see that these feelings were daunting for the men as they tried to navigate a new identity, whilst at the same time trying to find a community that fits with their new set of values and needs. In summary, the men are experiencing PTG yet still struggle with their HIV, as these two experiences are not mutually exclusive and are experienced at the same time. PTG offers the men a different way of living, which allows them to cope with their new reality. This does not imply the men do not worry about their future and are always thinking positive. This theme shows the men are not in denial about their diagnosis and are in touch with their reality, yet can still grow, show strength, and be optimistic, which is admirable in the face of the challenges they face.

4.8. Overview of super-ordinate themes

The overall story of these super-ordinate themes captures the HIV journey of these participants, as they attempted to reconstruct their identities with a new philosophical framework in light of their disease. This shows a re-evaluation and change in attitude and behaviour in relation to the former self, whilst trying to accept life as an HIV-positive gay man. This was one of the many challenges the men in this study had to face, as they tried to maintain physical health, keep up with the pressures of appearance, isolation, uncertainty, stigma, loss, internal struggles, identity and life as a gay man. Despite the many challenges, these men were brave enough to make changes and adopt positive coping strategies as they experienced a change to inner strength, found meaning, thought more positively, and engaged in activities that evoked positive emotion, all whilst grappling with existential concerns as they faced their mortality. They developed more favourable habits and ways of being that were in their best interests and would fundamentally contribute towards a different future identity, with a greater purpose and longer-term fulfilment, whilst deepening their relationships with self and others. The men showed resilience, with their ultimate desire to live long, full, healthy lives, without being limited by their HIV-positive status. Despite the men experiencing a range of benefits, they still had to live with the reality of their diagnosis. This suggests that their HIV journey is an on-going struggle, and PTG is not a destination, showing that coping strategies and the struggle of HIV can exist side by side.

Chapter 5: Discussion

This study aimed to explore the lived experience of PTG in HIV-positive gay men. This chapter discusses the results in light of existing literature and psychological theory. In line with IPA, extra literature was added to the discussion where the findings indicated areas which had not already been included (Smith, Flowers, & Larkin, 2009). The findings showed four super-ordinate themes, which provided an overall account of what it is like for HIV-positive gay men to experience PTG. These four are: the Struggle; Change in relationships; Positive growth; and Identity.

The following discussion is in three sections, to ensure that each of the three research aims are achieved: Gay men and HIV; Gay men and PTG; The experience of PTG in HIV-positive gay men. The first of these sections explores gay men's experience of living with an HIV-positive diagnosis, demonstrating participants' struggle with their diagnosis, as they try to make sense of their new identity, in light of their HIV. The second investigates PTG for gay men, showing the men's experience of PTG through a change in the way they relate to the self, and to other people. This also demonstrates the ways in which the men started to engage in their world differently, by finding meaning and adopting a way of thinking and engaging in activities that allow them to feel positive emotions. The third section describes the study's contribution to the field of LGBTQ, positive and counselling psychologies. This final section shows the holistic picture of the previous two sections and offer contribution to knowledge within LGBTQ, positive and counselling psychology, whilst also suggesting practice implications and limitations of the work.

5.1. Gay Men and HIV

This section shows how the first research aim was met in this study. The study's findings are discussed in light of existing literature on gay men's experience of living with an HIV-positive diagnosis. Receiving an HIV diagnosis had an extremely detrimental impact on the psychological and emotional well-being of these men, who described feelings of anxiety, fear and helplessness, similar to findings in a number of other studies (e.g. Hays et al., 1990; Metcalfe et al., 1998, Flowers, 2011). The diagnosis created significant 'biographical disruptions' in terms of continuity between the former and future self, which was first described in the context of chronic illness by Bury (1982) and Corbin and Strauss (1987). Perceptions of these biographical disruptions had become a threat to participants' familiar sense of self, as they wrestled with the deeply shocking and often unexpected HIV diagnosis (Flowers et al., 2011; Hernansaiz & Tapia; Sherr et al., 2011).

Learning to live with HIV proved challenging for the participants in this study, as they tried to paradoxically both adjust and adapt to their HIV diagnosis through integrating it into the self, whilst at the same time rejecting it. The findings of this study conflict with various theories about response to a life-threatening diagnosis. The first of these is *ignoring and minimising versus adaption* (Charmaz, 1995). Charmaz suggests that *adaption*, which is required before achieving PTG, refers to acceptance of a disease. This is in contrast to *ignoring*, which can inhibit growth. It can be seen that the men in this study were able to incorporate their HIV into their identity through stating it was part of their identity, whilst at the same time rejecting it, implying that an HIV diagnosis is paradoxical in nature, with many different feelings felt at once. Therefore, adaption is not a static destination and feelings associated with HIV are constantly interchangeable and fluid, which means the men can '*ignore and minimise*' and '*adapt*' to their HIV at the same time.

Morse (1997) similarly, suggests that an individual needs to accept their illness before they can experience any growth. The men in this study experienced a full range of emotions which included uncertainty, anxiety and fear as they struggled with existential concerns, while also trying to maintain a sense of emotional composure. These findings fit with the first two stages of Morse's (1997) five-stage response theory; that is, '*uncertainty*' and '*disruption*' (stage one / two). Participants claimed to have found benefits since their diagnosis, whilst '*utilising resources'* within their personal world and environment (stage three) – as they strive to gain control over their illness. The latter two stages (stage four / five) describe making sense of '*one's altered reality*', and '*learning to live'* with the altered self, attaining a new equilibrium, leading to full acceptance of an illness and its consequences. The men in this study have moments where they fit with all five stages simultaneously, and experience many opposing feelings at once. Therefore, these current findings are in agreement with Weiss (2008), who states that when considering positive coping with a chronic illness, theories such as those of Morse (1997) and Charmaz (1995) are too prescriptive, and that there is no linear way of accepting an HIV-positive diagnosis, since living with HIV is dynamic and fluid and results in many paradoxical feelings being experienced at the same time.

As the men adjusted to their illness, some described HIV as being part of them, as they began to incorporate the disease into their identity. This process has been described in other studies (Flowers et al., 2011; Flowers & Davis, 2012). However, it was James's way of relating to his HIV that was unique in the current findings. James did not incorporate his HIV as part of him, like some of the other men. He developed a relationship with his HIV by living alongside it, as a companion, with the hope of creating a healthy relationship with it. This is reminiscent of findings from Flowers and Langdridge (2012), who described the experiences of a man who had been living with his HIV for 20 years, and who had developed a way of relating to it as the 'animal-other'. James's narrative offers a unique perspective and provides an alternative understanding of how one might learn to live with a disease ('other') differently, through understanding and compassion for it as a living organism, creating less toxicity and dissipating negative feelings. The findings in this study are different to Flowers and Langdridge (2012), as James put emphasis on cultivating a healthy relationship with his HIV, whilst seeing it as very much the ‘other’, whilst the man in Flowers and Langdridge’s (2012) study interchanged his relationship with his HIV as the ‘other’ but also incorporated it as part of his identity.

Living alongside an illness such as HIV can create an antagonistic relationship based on a battle for survival due to the life or death nature of the disease. However, James chose to not battle with the virus but to coexist with it as another species through a mutual thrive to survive, which dissipated its power. This impacted him as he developed a more caring relationship with the self, due to his bound up, embodied relation with HIV as the ‘other’. Haraway (2003, 2008) suggests that through co-evolution, humans and companion animals have become involved in a process that ‘opens up’ the world for each other. This symbiotic relationship is then extended outwards to consider the relationship between human and animal-other, therefore challenging the beliefs of human exceptionalism. Therefore, this process has allowed James to see that others are equal to him, and that he shouldn’t need to take the position of trying to be exceptional through being perceived as the ‘*well one*’, but can instead be vulnerable.

It is clear that the psychological impact of their HIV status was a constant struggle for these men and others in the literature (Anderson et al., 2010, Hult, Maurer, &

Moskowitz, 2009), highlighting the on-going distress associated with a positive diagnosis. Participants found that daily reminders of their HIV became trigger points of stress as they moved through the process of their diagnosis (Sherr et al., 2011). For some, taking the medication, which is argued to be a constant reminder of their HIV status (Flowers et al., 2006, Spiers et al., 2016), became one of these stressors, despite the knowledge that the medication greatly reduced the possibility of their becoming sick, and gave them a sense of control over their disease.

Similar to findings from Flowers and Davis (2012), the men all described their HIV as central to their sense of self. This resulted in them being heavily laden with the stigma that surrounded being HIV-positive, both inside and outside the gay community, as they attempted to move forward in their lives. As in other studies (Skinta et al., 2014), HIV-related stigma continued to pose difficulties for the men, suggesting that managing disclosure was central to these men's coping strategies; the men often had to make the decision of whether or not to disclose their status. Disclosure and acceptance by others had helped my participants come to terms with their HIV, meaning disclosing their HIV status was a healthy behaviour that went hand in hand with higher PTG (Flowers & Davis, 2012; Kamen et al., 2016). Some of my participants chose to disclose their HIV status to family, which empowered them (Flowers et al. 2011), while others did not, despite family being highlighted as a delicate yet key area for support (Stutterheim et al., 2009). This could lead to isolation from those not disclosed to (Cao et al., 2006; Maguire et al., 2008; Wenzlaff & Wegner, 2000; Terrence Higgins Trust, 2001), and a sense of remaining guarded in the presence of those not told, with an attempt to prevent feelings of shame and stigmatising thoughts (Lee, Kochman, & Sikkema, 2002).

In order to cope and move forward in their lives, the men referenced early childhood trauma to remind themselves that they were strong enough to navigate through their HIV. This concurs with findings from Woodward and Joseph (2003), who discovered three themes in their study of the effects of early childhood trauma on growth in later life, which were inner drive, vehicles of change and psychological change. The men in the present study used these early experiences as vehicles of change, as they thrived to survive in the past, and had now started to do this with their HIV diagnosis also, reminding themselves of how far they have come. The memory of coming through these earlier experiences highlighted their resilience, and gave them a sense of achievement, whilst creating strength and hope for the future.

In summary, these findings support previous research on HIV-positive gay men, and demonstrate the struggle involved in living with this life-long disease. The next section addresses the second aim of this study by discussing the experience of PTG for these men.

5.2. Gay Men and PTG

In order to answer the second research aim this section investigates the men's experience of PTG, and illustrate findings in light of existing positive psychology theory. The aim of this section is to highlight that growth is possible for those living with an HIV-positive diagnosis and that existing theory is evident in these men's experiences. In order to structure the findings in this section, Seligman's (2011) PERMA theory is used to map out the five elements of well-being, which are interwoven with existing literature on PTG and theories from Mangelsdorf and Eid (2015) as well as Tedeschi and Calhoun (1996). This study, along with other research on chronic illness (Rini et al., 2004; Weiss, 2008), revealed that participants expressed new insights in terms of illness benefits, which lead to a new and more favourable future identity. Participants in this study suggest that their diagnosis was a wakeup call that has allowed them to grow in a number of ways (Schwartzberg, 1993, 1994).

Seligman (1999) suggests there are three different levels in positive psychology: the *subjective level* (feeling good with oneself); the *individual level* (being a good person to others); and the *group/community level* (altruism/being a good citizen).

The men in this study demonstrated a deeper understanding of and compassion for the self through more kindness and self-forgiveness, linking with Seligman's (1999) *subjective level*. These findings are consistent with those of other studies,

which outlined the birth of a new self following a chronic illness diagnosis (Hefferon et al., 2009; Flowers et al., 2011; Milam, 2006; Luszczynska, 2012; Zeligman et al., 2016). The men also demonstrate Seligman's latter two levels of 'individual' and 'group/community' (1999), by showing the capacity for love and forgiveness towards others, whilst also taking responsibility for, nurturing and being part of a community, such as volunteering, or being involved in making the process of an HIV diagnosis better for others in the same position.
Seligman's (2011) theory of well-being (PERMA) will now be investigated in light of the findings of this study, to see whether the men had a greater awareness of their well-being: *positive emotion*, *engagement, relationships*, *meaning* and *achievement*.

'*Positive emotion',* the first component in Seligman's (2011) theory, is also supported by Mangelsdorf and Eid's theory (2015). The men in this study sought more pleasurable experiences in order to create positive emotion, which contributed to their growth by creating a more positive emotional environment while helping to constitute their positive change process. This offered moments of pleasure in hobbies, as well as motivation to try new experiences through a range of activities. This suggested that the men were more aligned with the self and were able to prioritise their needs helpfully.

The men's behaviour changed as they began to engage in new activities that would enable them to relax and experience being in the moment, which unites with the third element in Seligman's (2011) theory, that of '*engagement'*. The men talked about doing activities that enabled escapism and created psychological flexibility by reducing moments of intense stress. These activities improved the men's well-being (Landstra et al., 2013). Therefore, they appeared to be an important exercise, as participants were building in moments of peace away from the strain of thinking about their HIV.

However, this sense of escapism can create a paradox for the men as they try to find a way to achieve flow (Csikszentmihalyi, 2007), whilst at the same time avoiding the reality of their HIV. Critically, this raises questions around whether or not the men are feeling present and in flow, if they are trying to avoid their reality, or whether they are feeling several emotions all at once. Do the men have to be thinking about their disease to experience growth? Watson et al. (1988) suggest that avoidance of thinking about one's illness inhibits growth, which is further supported by Zoellner and Maercker (2006), who state that a potential coping style for PTG is the illusory coping style. This is defined as cognitive avoidance, characterised by self-deception and distraction. This implies that PTG could be dysfunctional for the men in this study, and that they may only be experiencing 'perceived' and not 'actual' positive change, which leads to worse cognitive functioning in the future, as found in other studies by Blix et al. (2016) and Engelhard et al. (2015). The difference between the men in this present study and some of the studies mentioned above, is that these men are not deluded or avoiding their struggle. They firmly acknowledge the ongoing challenges within their lives that will not go away, whilst also identifying the growth they have experienced. It is important to recognise that growth is not a destination and is a constant work in progress for these men, and due to their recognition of both the struggle and the growth, they are more aware and in touch with their reality. This suggests that their growth is built on ‘actual’ and not ‘perceived’ positive change.

Seligman (2011), Tedeschi and Calhoun (1996) and Mangelsdorf and Eid (2015) are all in agreement when they suggest *‘relationships’* as one of the core elements of well-being, raising the importance of strong emotional connections with other humans through love and intimacy. The men in this study were able to access supportive relationships by creating a social environment which, through stability and care, enabled a positive growth process. Participants developed increased appreciation for existing relationships and found new relationships, while becoming more aware of the importance of nurturing these bonds. This links to the socio-emotional theory of Carstensen, Isaacowitz and Charles (1999), which suggests that when the perception of time has been limited, emotional goals assume primacy over knowledge-related goals. This implies that there is further need for emotional regulation, which is dependent on other people. This newfound sense of connection gave support through a sense of community with others and offered participants collective resilience and well-being (Lyons et al., 2016; Schwartzberg, 1993).

These findings imply that the men had a greater understanding of the self, as they recognised their need for support in their vulnerability, which increased supportive relationships that were previously not utilised. This also resonates with other studies which suggest that emotional support is a key factor for PTG (Kamen et al., 2016; Woodward & Joseph, 2003; Lyons et al., 2016; Zeligman, Barden, & Hagedorn, 2016), demonstrating that social support is important which helps to frame psychological well-being whilst protecting participants against distress from limiting low self-worth and internalised stigma.

Seligman (2011) suggests that '*meaning'* is one of the fundamental ingredients to his well-being theory, which is also supported by Mangelsdorf and Eid (2015) and Tedeschi and Calhoun (1996). The men in this study have a greater sense of awareness and are able to experience more significant moments as they seek meaning. Whilst some were empowered and found meaning as active experts in their own HIV experience, so that the HIV no longer had a master status (Goffman, 1963), others found meaning in a new behaviours that would give them a greater sense of purpose (Weiss, 2008; Flowers et al., 2011). Overall, they were able to appreciate their existence, along with little things they had once taken for granted in their everyday lives. Therefore, engaging in meaning-making appeared to be a coping strategy that lowered the men's stress (Sowell et al., 2000) and contributed to the controllability and positive reframing of their illness (Frankl, 1959; Jenkins, 1995).

It was important for the men to recognise that they were able to deal with their HIV diagnosis, as this manifested into a sense of '*accomplishment'.* The accomplishment element of Seligman's theory is about goals and ambitions, suggesting a destination to reach. In the case of these men living with HIV, there is no destination of a cure, as HIV is a life-long disease, and has no end point. Therefore, trying to maintain a direction towards achievement may add pressure and impact negatively, while conflicting with coping strategies, as has been found in other studies on chronic illness (Petticrew et al., 2002; Tod et al., 2011; Arman et al., 2002). Perhaps the accomplishment for the men in this present study is learning to survive one day at a time and remaining hopeful whilst living with their HIV.

Tedeschi and Calhoun (1996) suggests *'changes in self'* as part of their PTG theory. This relates to the current findings; as the men experienced positive changes in and deeper understandings of the self, they were able to prioritise their own needs. They recognised their personal strengths through self-perception, evolving emotionally and becoming better people. Participants grew through the recognition that they were strong enough to handle the challenges they faced. This demonstrates a more positive relationship with the self, as the men were able to offer greater self-care through positive self-communication and self-support, which was developed through a change in their thinking.

As in other studies (Hefferon, Grealy and Mutrie, 2009; Aspring, 2001; Flowers et al., 2011; Kessler et al., 1988; Viney et al., 1989), these participants expressed a different way of thinking which was reinforced by a more positive frame of mind. While positive thinking became a coping strategy in order to defend against their HIV-positive status, such a strategy can be difficult, especially in the face of a chronic illness, and may in fact add to the psychological burden, as found in other studies (Tod et al., 2011; Petticrew et al., 2002). Positive thinking also has the potential to restrict authentic feelings as those living with HIV feel conflict with their true thoughts and feeling about their illness, which may increase their stress (Arman et al., 2002; O'Baugh et al., 2003). However, the men in this study found comfort in their new positive way of thinking, which appeared to be an effective coping strategy that gave them greater optimism (Biggar et al., 1999) and allowed for better psychological adaption (Simoni et al., 2006) as they adjusted to their HIV.

In summary, this section united the findings of the men in this study with existing positive psychology theory. This showed how the men's experiences are in line with the values of positive psychology and therefore supports the idea that they are reaching towards experiences that offer them a greater sense of wellness, which strengthens their well-being. As in Nightingale et al. (2010), most of these men came to terms with their new identity as they navigated their way through their disease. Through resilience and positive adaption, the men aimed to achieve their desires and future identities, despite struggling with their HIV.

5.3. Contribution to LGBTQ, Positive and Counselling Psychology

The findings of this study demonstrate the complex ways in which HIV-positive gay men experience and manage to live with a life-long disease. This study echoed the findings of previous research on gay men, HIV and PTG, such as finding meaning, deepening relationships, positive thinking and instigating new experiences that enable positive emotion (Flowers et al., 2001; 2003; 2006; 2012; 2011; Skinta et al., 2014; Bower et al., 1998; Schwartzberg, 1993; Lyons et al., 2016; Kessler et al., 1988). It also reinforced existing positive psychology theories of well-being and PTG (Flowers & Davis, 2012; Flowers et al., 2003; 2012; Bourne et al., 2012; Schwartzberg, 1993; Mangelsdorf & Eid, 2015).

The findings showed that becoming HIV-positive had allowed the men to see life in a different way, which not only enriched their lives but also improved their health through making healthier choices. However, while participants were able to experience PTG and find ways of coping, they had not necessarily ‘overcome’ or ‘accepted’ their HIV. Although not entirely negative about their experiences, participants were not fully positive either, as aspects of positive growth, hope and optimism existed side-by-side with despair, hopelessness and anxiety. This shows that their experiences were paradoxical in nature and needed on-going juggling, as the men struggled with positive psychology strategies and existential concerns.

Furthermore, this study expanded existing understandings by providing additional information on how gay men manage their experience of living with HIV. For instance, it expanded on findings from Flowers and Langdridge (2012), by adding to knowledge of how HIV can be related to in a potentially healthier way. One of the participants in this study developed a way of relating to his HIV as the ‘other’ species, and managed to develop a companionate relationship with the virus, which gave him more control over his feelings and allowed him to live in a more harmonious manner.

IPA identified four overarching themes that highlight how understanding and managing an HIV diagnosis can impact an individual’s life. The current findings offer insight into the existential struggle and positive coping techniques adopted by the participants, as they live with the knowledge that they carry a life-long disease, controlled by a dependency on medication, whilst at the same time engaging in a more enriched, meaningful and healthy life.

The aim of both counselling psychology and LGBTQ psychology is to represent minority populations to broaden psychological understanding (Pugh & Coyle, 2000; Clarke & Peel, 2007). Therefore, an essential underpinning of this research was to challenge psychological understandings (Monteflores & Schultz, 1978) of LGBTQ issues and expose heternormative assumptions (Glassgold, 2007), whilst exploring gay men’s experiences, in light of HIV and PTG.

The focus of my research was PTG in HIV-positive gay men, with the hope of uniting positive psychology theory with the findings in this study. As a gay man, I could identify with particular aspects of the lives of these men. However, I am not HIV-positive, so could not fully know what that experience is like. This does not take away the impact HIV has had on me, through seeing the suffering of the people I know, both professionally and personally, living with the disease. Therefore, the findings of this study show how positive psychology interventions (Seligman, 2011; Seligman et al., 2005; Tedeschi & Calhoun, 1995 ;1996; 2004; Tennen & Affleck, 2002) can support people struggling with HIV, as it does not need to be the end but, as in the case of these participants, can be seen as an awakening and a new way of living. My central aim was to give these men a voice to tell their stories; that while facing the reality of living with a life-long disease, they were still able to have enriched, fulfilling lives with a heightened sense of awareness, making healthy choices that contributed to their well-being. This highlights that pain and growth can occur simultaneously following an HIV diagnosis, and that even with the ongoing presence of trauma, PTG is possible.

Clinical implications

This study provides a contribution to understanding aspects of the phenomenon of being gay, HIV-positive, and experiencing PTG since a diagnosis. Due to the small participant group of eight gay men living in the UK, this study was idiographic in nature; therefore only theoretical transferability should be considered, rather than empirical generalisability (Smith, Flowers, & Larkin, 2009).

The hope of this study was to gain insight into the lives of HIV positive men who have experienced PTG, with the aim of disseminating this knowledge to professional counsellors. This is to help them recognise that reaching a place of growth following a difficult event is possible for clients living with HIV, regardless of how impactful the event has been on their emotional and psychological well-being. In addition, clients who have had a painful and traumatic experience with their diagnosis may find comfort in the fact that they can still a reach a place of growth, achieve personal benefits, and fulfil their ambitions.

The men presented narratives of difficulties from their past, and it was evident that a range of other biopsychosocial factors as well as their HIV status had impacted on and contributed to their overall lived experience: coming out as gay, living in the gay community, and childhood trauma. Practitioners need to be aware of not oversimplifying the unique challenges of the emotional and mental health issues of this group (Vostanis, 2014). Interventions should take into account the context of the way this client group make sense of their illness, against the backdrop of living within the gay community, against which discrimination and HIV stigma can be rife. Therefore, an LGBTQ affirmative approach is essential for working with this client group, and it is critical that the therapist makes this stance clear to clients. The goal of the therapy should be feeling good with one's identity, consistent with more recent approaches to gay affirmative psychotherapy (Johnson, 2012). Assumptions that one must be ‘out’ with their sexuality or HIV status should not be made (Rieger & Savin-Williams, 2012), despite research showing that these factors have a positive impact (Kamen et al., 2016).

Counselling psychology places great importance on the subjective experience of clients in a collaborative relationship with the health professional, while seeking to understand their inner worlds and constructions of reality (Strawbridge & Woolfe, 2010). Therefore, coping strategies employed by the participants in this study can provide insight for health professionals when developing interventions, taking into account the way HIV can impact an individual’s sense of identity. This could help clients come to terms with their illness and create a new sense of identity as they navigate life with the continuous challenge of HIV. Therapeutic interventions need to pay closer attention to relational aspects between people and their illnesses; such interventions would enable those living with HIV or other life-long diseases to find more relational ways of communicating (Kleinman, 1988), to find meaning and to accept a diagnosis. This has the potential to reduce stress, and therefore lead a more tolerable and harmonious life, as opposed to one filled with conflict.

An intervention for counselling psychologists could include a narrative process which helps HIV-positive clients make sense of their subjective experiences through the integration of their past, present and future (Inder et al., 2011). All of these aspects were shown in the present study to be prevalent when contributing to the men’s sense of identity. This supports PTG by reframing identity in terms of an individual’s timeline. A combination of taking stock and recognising resilience from the past while building hopes for the future creates a story for the individual. In addition, since findings from the current study show the importance of support from others in facilitating PTG, this intervention could be developed for groups, which will offer support from shared experiences and give a sense of community and belonging (Dodds et al., 2004).

As shown in this study, the struggle with HIV is on-going, which means interventions need to consider the ways in which medical treatment is perceived and experienced, both physiologically and emotionally. It is challenging to digest the idea that in order to stay alive and well, one must take medication every day for the rest of one’s life. Therefore, on-going attention must be paid throughout the journey of HIV management, as it is a life-long disease. This means that short-term interventions may not be the most beneficial for this client group, and there should be on-going psychological treatment due to the fluid and paradoxical nature of this disease.

As well as working therapeutically with those who have been affected by HIV, the counselling psychologist could also help prevent further transmission through psycho-education, and by supporting informed decision-making around sexual risk behaviour (Bor, Evans, & Levitt, 2007; Bangsberg, 2008; Flowers, 2001). Psycho-education about HIV is also important for the family and friends of those who have been diagnosed, as it enables them to understand not only the diagnosed person's needs, but also their own needs in supporting their loved one (Vanable et al., 2006). This could dissipate the stigma of how HIV is perceived, and therefore encourage disclosure, which has been shown to support PTG (Skinta et al., 2014). This could also offer an opportunity to explore personal meaning for friends and family, in light of the diagnosis, as well as support meaning for the HIV-positive client.

In summary, these suggestions are intended to improve counselling for this specific client group of LGBTQ people. Interventions which encourage strength-based techniques (such as identifying and building strengths; recognising resilience; planning with hope for the future) while at the same time understanding the social context of HIV-positive gay men could lead to health benefits such as decreased levels of depression, less substance use, fewer hospitalisations, increased medication adherence, and stronger immune systems (Milam, 2004; Murphy & Hevey, 2013; Sawyer et al., 2010; Cadell, 2007). These recommendations are intended to supplement the broad LGBTQ therapeutic guidelines which are already established (e.g. APA, 2011; BPS, 2012).

This research has developed my own clinical practice, in which I raise awareness of issues which may come up when working with gay men and HIV within my team. I offer various positive psychology interventions (mindful-based PERMA exercises) through the workshops and team meetings in which I participate. I also run a group for HIV-positive gay men, where I encourage participants to share not just their HIV story, but the story of their whole life. This is to allow the space for the men to make sense of their new identity, in light of their past, present and future. It is through this group work that the men are able to recognise their strengths and resilience from the past, as they create a new sense of belonging and connection to others who are in a similar position.

Implications for counselling psychologists in training

Counselling psychologists in training should be made aware that trauma clients have the potential to reach a place of growth following their traumatic event. The Council for Accreditation of Counselling and Related Educational Programs (CACREP, 2009) has reported the need for counsellors to be more knowledgeable of the impact trauma can have on clients (Webber & Mascari, 2009). HIV continues to be potentially traumatising, and can impact the overall mental health of clients, regardless of its changing status from a death sentence to a life sentence (Flowers et al., 2001). It is therefore relevant for counselling psychologists in training to focus on both the negative and positive outcomes following a traumatic event like an HIV diagnosis. Counselling psychologists should also be made aware of the potential nature of growth in this context, such as enriched relationships, being able to recognise personal strengths, increased gratitude for life and so on. It is also important to have professionally trained counsellors available on demand at local Genitourinary Medicine (GUM) clinics to support clients who have just been diagnosed (British HIV Association, 2011).

Theories of PTG have a place in counselling psychology courses and research, such as this present study, since they affirm the growth of clients who are experiencing benefits after an HIV-positive diagnosis. Therefore this supports the relevance of positive psychology in the realm of counselling psychology and raises the argument of the topic being taught on counselling psychology courses. It is part of the role of a counselling psychologist not only to help people cope with the challenges of life, but also to help them thrive and reach their potential. Therefore knowledge of positive psychology theories would be beneficial when dealing with the many issues that people face, especially chronic illness.

Research implications

The present study explored the lived experience of eight participants and contributed to the pool of studies that have explored the lived experience of HIV-positive gay men. The study was unique, as it is focused on HIV-positive gay men who had experienced PTG since their diagnosis.

Future studies in this area might explore ways to enable PTG in aging HIV-positive gay men, since there is now a maturing population living with HIV (Lawrence & Cross, 2013). There is general concern for the ageing population with regard to work, leisure and quality of life as the lifespan increases (Carney, 2016), and for those living with HIV, these areas are even more challenging. Therefore, it is more important than ever for health professions to consider policy-orientated research into happiness and well-being, especially for those with chronic illness who face greater challenges in their day-to-day lives as they age. This would help with the process of ageing whilst living with the disease, as it is older HIV-positive gay men who are more likely to struggle with their mental health and become diagnosed with depression (Gebo, 2006). Exploring different ways of enabling PTG after diagnosis would help HIV-positive gay men in their present, as well as, in later life. If positive psychology interventions were already in place, men living with HIV would be able to develop tools and find more meaning from their lives in light of their disease, throughout the lifespan. This would therefore impact service provisions by reducing demand for mental health services for the older generation of gay men who are living with HIV.

This study focused only on gay men who had been diagnosed between two and five years ago. Due to this lack of diversity, future research should include gay men who have been diagnosed for five years or more. This enables longer-term understanding of PTG and its sustainability over a long period of time. Additionally, since all participants of this research lived in London, despite this not being a criteria, future research could benefit from recruiting from broader sources, and thereby gaining a more diverse sample. This could be achieved through expanding geographically and exploring experiences in other parts of the UK, especially smaller towns and suburbs. This is important as HIV may be perceived as more ‘normal’ in London, with almost 40% of new UK diagnosis in 2017 occurring in the capital (Health Protection Agency, 2017), whilst in areas with fewer cases of HIV, gay men living with HIV may have very different experiences.

Research on PTG and HIV is increasing. Such research is necessary as the face of HIV is constantly changing, and therefore our knowledge will need to be updated. The current study contributes towards existing literature by adding to research surrounding PTG for gay men living with HIV. Although the reality of HIV has continued to change in that it is now viewed as chronic, rather than terminal, the present study suggests a great deal of trauma is still found in the diagnosis.

Finally, taking into account that this research is on PTG, gay men and HIV, it is important to recognise the contribution of positive psychology, and how this plays a pivotal role in the process of working with a client who is struggling with trauma. Research has shown that people who have a greater sense of their well-being and are able to enjoy their lives are at a lower risk of developing problems with activities of daily living and show less decline in physical function. Enjoyment of life is relevant to future disability and mobility; therefore efforts to enhance well-being at older ages may have benefits to society and health care systems (Steptoe et al., 2014). This is especially for those who are living with a life-long disease. This supports the need for longitudinal studies on positive psychology and those who are living with a chronic illness.

Critique of Research

As with all studies, this research contains several limitations. Firstly, it is important to state that a single qualitative study lacks the ability to provide empirical explanations. The study can, however, provide a basis for broader enquiry with a larger group (Giorgi, 2008), and lead to useful insights which have wider implications (Pringle et al., 2011). With this in mind, it is important to address the limitations of this present study in order to assess the validity of results and conclusions.

The study involved individual interviews with gay participants, which were carried out by myself, a gay interviewer. There were benefits of having an ‘insider advantage’, as this allowed the participants to feel more comfortable with sharing details of their lifestyle, which may have been shocking for someone who is not gay. These experiences were shared with an understanding that participants would not be judged as I already had ‘insider’ knowledge of what goes on in the gay community. There was also a sense from some of the participants that their lifestyle was common practice for other gay men, and therefore an assumption that I led a similar lifestyle. However, there may also be disadvantages. I may have falsely assumed some aspects of participants' meanings and, due to that same 'insider' status, failed to note what was unique and interesting. This subsequently could have limited the ability to interpret data and so led to social desirability bias or the fear of 'loss of face' (Clarke et al., 2010).

Nearly all of the participants in this study were recruited through HIV support services. Therefore, these participants may have been encouraged towards the same ideas of personal growth, while those not accessing support services may have a different experience (Walch, Roetzer, & Minnett, 2006). This type of recruitment has a tendency to generate samples of white, educated, professional, middle-class people (Clarke et al., 2010). Six of the participants fell into this bracket, meaning that it might have been beneficial to use recruitment strategies to target a more varied group of participants from different backgrounds.

Finally, participants had to have experienced PTG as a pre-requisite for the study, which may have led the participants to describe their experience of HIV in an overly positive manner, leaving out more difficult elements of their journey so far.

Chapter 6: Conclusion

The purpose of this study was to gain an in-depth understanding of the lived experience of gay men who had experienced PTG since having an HIV-positive diagnosis. This research explored the experiences of eight gay men who spoke of a wide variety of feelings, emotions, thoughts and actions. The findings are consistent with existing literature on the lived experience of HIV, other chronic illnesses, and the theory of PTG.

Even when elements of these men's experiences were perceived as positive, the struggle was still on-going, as the men constructed a sense of identity in the face of living with their chronic illness. As Charmaz (1995) suggests, identity re-construction takes place when individuals can perceive themselves in new roles that have meaning and find renewed strength due to, or in spite of, chronic illness. Therefore, this new sense of being for the men suggested that what is no longer a threat to their lives makes them stronger, while at the same time they may be stronger because they live with a constant threat that will never leave them. This demonstrates that the men were in touch with their struggles and had confronted their mortality, whilst at the same time they had chosen to live their lives in the best way they could, giving them a feeling of empowerment. This proposes that their relationship with HIV is a work in progress and not static, as they navigated their path through life and reconstructed new meaning and identify in a fluid way. This means that PTG and the struggle of HIV exist, side by side.

This study contributes to the fields of counselling, positive and LGBTQ psychology by demonstrating the meaningful, negative impact a HIV diagnosis can have on an individual. However, it also recognises the positive impact of PTG, and shows that such growth can be reached, bringing beneficial outcomes for those diagnosed. The benefits identified in this study support existing positive psychology theory (Seligman, 2011; Mangelsdorf & Eid, 2015; Tedeschi & Calhoun, 1996), and were shown by the changes in the behaviour and thinking processes of the participants. These consisted of engaging in activities that allowed positive emotion, deepening relationships with the self and others, finding meaning and purpose. Participants also engaged in positive thinking, which has been criticised by numerous studies (Held, 2002; McDonald & O'Callaghan, 2008; Tod et al., 2011; Petticrew et al., 2002; Arman et al., 2002; O'Baugh et al., 2003). Despite these criticisms, positive thinking was a good way of coping and helped participants manage their day-to-day thinking while giving them hope and optimism for the future.

One of the most important offerings of this study is its implications for clinical practice, as it highlights that pain and growth can occur simultaneously for a client following an HIV diagnosis, and that even with the event being traumatising, PTG is a possibility. This shows the importance of positive psychology interventions for clinicians working with this client group, since there is great strength when a client is able to find meaning after facing trauma. Finally, this study offers hope to people who are living with this life-long disease. It demonstrates that people do not need to be defined by their HIV-positive status and can go on to live a fulfilling life, as they continue to grow, whilst reaching towards their dreams and ambitions.

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Appendices

Appendix 1. Participant information sheet

Growth after trauma: An interpretative phenomenological exploration into the lived experience of gay men diagnosed with HIV.

By: Lee Valls as a requirement for DCPsych from NSPC and Middlesex University

NSPC Ltd
61-63 Fortune Green Rd
London
NW6 1DR

Middlesex University
The Burroughs
London NW4 4BT

Date: …………………………..

You are being invited to take part in a research study. Before you decide to participate, it is important for you to understand why the research is being done and what it will involve. Please take your time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take your time to decide whether or not you wish to take part.

<u>What is the purpose of the research?</u>

This study is being carried out as part of my studies at NSPC Ltd and Middlesex

University. Many people suffer after having a traumatic experience and there a wealth of research that focuses on the stress caused by this. However, there are people who experience some element of growth after their traumatic experience. The experiences of these people will be the focus of my research. My study is designed to explore the lived experience of gay men who have been diagnosed HIV-positive and the ways in which they have found meaning in their diagnosis. You are being asked to participate because you have replied to my advertisement asking for gay men who have an age limit within the range of 35–50 years and were diagnosed with HIV between two and five years ago.

What will happen to me if I take part?

I would like to interview you on one occasion. Interviews will take around one hour, and will be conducted in a therapist room in King's Cross, London. I will be using a qualitative research methodology called interpretative phenomenological analysis (IPA) to uncover the main themes arising from what you and other participants tell me about your experience of growth and finding meaning.

What will you do with the information that I provide?

I will be recording the interview on a digital recorder and will transfer the files to an encrypted USB stick for storage, deleting the files from the recorder. All the information you provide me will be identified only with a project code and stored either on the encrypted USB stick, or in a locked filing cabinet. I will keep the key that links your details with the project code in a locked filing cabinet. The information will be kept for at least until six months after I graduate and will be treated as confidential. If my research is published, I will make sure that neither your name nor other identifying details are used.

Data will be stored according to the [insert here the name of the appropriate authority: in the UK the Data Protection Act and the Freedom of Information Act]

What are the possible disadvantages of taking part?

In the interview, I shall be asking you about your experience of being diagnosed with HIV and what that was like. Talking about these personal experiences may be distressing. If this happens, please let me know, and if you wish, I will stop the interview. Although this is very unlikely, should you tell me something that I am required by law to pass on to a third person, I will have to do so. Otherwise whatever you tell me will be confidential.

What are the possible benefits of taking part?

Being interviewed about your experience has no direct benefit, although some people may find it an opportunity to reflect, and could find this beneficial.

How will I give my consent?

You will be given a copy of this information sheet for your personal records, and if you agree to take part, you will be asked to sign the attached consent form before the study begins.

Participation in this research is entirely voluntary. You do not have to take part if you do not want to. If you decide to take part, you may withdraw at any time without giving a reason. See specific guidelines for consent in a separate document [“consent – psychology guidelines”].

Who is organising and funding the research?

This study is fully self-funded. Since there is no funding, no expenses can be claimed.

Who has reviewed the study?

All proposals for research using human participants are reviewed by an ethics committee before they can proceed. The NSPC research ethics sub-committee have approved this study

Thank you for reading this information sheet.

If you have any further questions, you can contact me at: lee.valls@hotmail.co.uk

If you have any concerns about the conduct of the study, you may contact my supervisor:

Patricia Bonnici– pbonnici@gmail.com

Or

The Principal

NSPC Ltd. 61-63 Fortune Green Road, London NW6 1DR Admin@nspc.org.uk 0044 (0) 207 435 8067

Appendix 2. Informed consent

Growth after trauma: An interpretative phenomenological exploration into the lived experience of gay men diagnosed with HIV.

By: Lee Valls as a requirement for DCPsych from NSPC and Middlesex University

Written Informed Consent

Title of study and academic year: Growth after trauma: An interpretative phenomenological exploration into the lived experience of gay men with HIV

Researcher: Lee Valls

Supervisor *(only for students):* Patricia Bonnici

Please circle

I have understood the details of the research as explained to me by the researcher and confirm that I have consented to act as a participant. Y/N

I have been given contact details for the researcher in the information sheet. Y/N

I understand that my participation is entirely voluntary, the data collected during the research will not be identifiable, and I have the right to withdraw Y/N from the project at any time without any obligation to explain my reasons for doing so.

I further understand that the data I provide may be used for analysis and subsequent publication and provide my consent that this might occur. Y/N

___________________________ ____________________________

Print name Sign Name

Date: __________________________

To the participants: Data may be inspected by the Chair of the Psychology Ethics panel and the Chair of the School of Social Sciences Ethics committee of Middlesex University, if required by institutional audits about the correctness of procedures. Although this would happen in strict confidentiality, please tick here if you do not wish your data to be included in audits: ___________

Appendix 3. Debriefing

Growth after trauma: An interpretative phenomenological exploration into the lived experience of gay men diagnosed with HIV.

By: Lee Valls as a requirement for DCPsych from NSPC and Middlesex University

Thank you very much for your valuable contribution to this study. During the interview you will have had the opportunity to discuss anything that has come up for you during our exploration.

Two weeks post interview you will also be contacted (unless you say otherwise) by the researcher to ensure that nothing further in the light of our meeting has caused you any concern.

Should you feel the need and if you wish, there is an opportunity for you to engage in personal therapy. A list of local therapists is provided and you can choose either to refer yourself or be referred directly by myself, as the researcher. The following are links to sites where you will find a directory of therapists:

BACP: http://www.itsgoodtotalk.org.uk/therapists

BPS: http://www.bps.org.uk/bpslegacy/dcp

Counselling Directory: http://www.counselling-directory.org.uk

Following the interview, if you feel concerned by what you have shared, please don't hesitate to contact me by telephone on (0207 435 8067) or via email at (lee.valls@hotmail.co.uk). You can also contact my supervisor: Patricia Bonnici – pbonnici@gmail.com

Thank you once again for helping with this research.

Contact Details:

Lee Valls

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Appendix 4. Extract from Analysis

Having a positive attitude is important Positive self-image Feels he is good to others Despair Acceptance	P: I mean I've always had a really positive attitude to life anyway and make the most of every day and try and be happy and be kind and thoughtful and be happy and tell people what you think of them – so I've always been glass half full instead of half empty. There have been a couple of times when I've been on my hands and knees thinking 'why the fuck has this happened to me' of all people why… but it did. It didn't get me down really just a few times.	• Aware of his own positive frame of mind. 'I'm really positive and make the most of everyday' and kind and thoughtful. Relation with the other. • 'Being on my hands and knees' feeling despair. • Feeling like it is not fair. Why him. • 'Of all people' interesting term – seems like he feels he didn't deserve it.

		• Putting unrealistic pressure on self ‘try and be happy everyday’ (for whom?) • Repeated ‘happy’ • Honesty

Appendix 5. Journal entry

I am aware of how overwhelmed I feel with information, as I try to step inside each of the participants' world. Therefore, I have decided to build in a little more time, between reading the transcripts, so that the men do not keep merging into one, resulting in me being more confused with who has said what. I have found this stage of the process extremely demanding, as it requires me to keep my utmost attention whilst being absorbed in each of the men's worlds. This is very challenging for me, as I have a short attention span.

I can become side-tracked by attending to a desire of theorising the discussion from the participants, instead of staying with their experience. This is particularly the case with my tendency to seek positive psychology theory. I am mindful that this sometimes interferes with what I perceive to be less positive aspects of the men's experience. I am aware that this may interfere by preventing me from truly capturing the men's experience. I hadn't realised just how uncomfortable it was for me to not find a positive solution from both my own experience, or other peoples'. I will continue to work on this in my personal therapy, as I learn to sit with the less positive experiences of others, as this will also help me as a practitioner.

Appendix 6. Email to participants

Dear (participant),

Hope you are well. I am sending you this email to briefly outline some details of the process ahead.

The aim of this research is to explore the experience of post traumatic growth for gay men who are HIV-positive. I would kindly ask for up to three hours of your time for the interview, which will take place at (location of interview changed depending on where I could get a therapy room). The interview is recorded and it is only I who has access to the audio file. These will then be stored under a pseudonym and treated with the strictest confidence. The method of data analysis will be Interpretative Phenomenological Analysis (IPA). At any time throughout the process, you have the right to refuse information or withdraw from the study.

I greatly appreciate your participation in this research and if you have any further questions then please do not hesitate to ask.

Best wishes,

Lee Valls

Appendix 7. Recruitment Material

Are you a gay man, aged between 35 and 50, diagnosed HIV-positive between two and five years, identified your experience of being diagnosed as traumatic, yet felt you have experienced positive changes since your diagnosis. If so, I would love to hear from you and learn more about your experience. Please email me on lee.valls@hotmail.co.uk to find out more information.