EXPLORING A POSSIBLE RELATIONSHIP BETWEEN CHEMSEX AND INTERNALISED HOMOPHOBIA AMONG GAY MEN IN SOUTH AFRICA

by

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Declaration

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Topic

Exploring a possible relationship between chemsex and internalised homophobia among gay men in South Africa

I declare that the above dissertation is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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Signature

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Dedication

I would like to dedicate this dissertation to my mom, Mariam Cassim. Thank you for your unconditional love and encouragement. You have always stood by and supported me. I fondly remember the time you accompanied me to Unisa and waited for two hours outside while I completed my exam. Even though you are no longer with me I know that your spirit continues to guide me. May Allah (God) grant you the highest level in heaven. Allah has you in his arms and I have you in my heart.

In loving memory

Your son

Naeem

Abstract

The purpose of the study was to explore the complex ways in which chemsex and internalised homophobia may be linked. The study sought to: Elucidate the concept of internalised homophobia; determine the challenges experienced by gay men and how psychoactive drugs influence their sexual relationships with other men; and also explore a possible relationship between chemsex and internalised homophobia. The study hopes to contribute to a better understanding of the challenges that are faced by gay people and the reasons why some gay men participate in chemsex. A total of eleven participants were identified from an LGBTIQ+ friendly drug rehabilitation centre and a gay bath house in Cape Town. A qualitative approach was used to conduct the study by conducting semi structured interviews with each participant. The theoretical framework used to elucidate the concept of internalised homophobia among the LGBTIQ+ community was underpinned by the minority stress model. This model was used to explain the concepts of homophobia and internalised homophobia. The methodological framework used was qualitative research, which focuses on the stories of individuals and is concerned with the social construction of the individual's life, and specifically Thematic Analysis which assisted in identifying patterns or themes in people's accounts. The findings were that even though there is a relationship between internalise homophobia and chemsex, there are many other factors and influences that play a role, such as the individuals' backgrounds, their experiences in coming out as gay, and other life circumstances. In conclusion, the study suggests that there is much more that can be done to break down the stigma and prejudice facing the LGBTIQ+ community, which is a first step towards addressing the chemsex phenomenon and related psychological consequences.

Keywords: *chemsex, internalised homophobia, gay, psychoactive drugs, LGBTIQ+, drug rehabilitation, drug use, drug addiction*

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CHAPTER 1

ORIENTATION TO THE STUDY

1.1 Introduction

In 1973 the term "homosexuality" was removed from the second edition of the American Psychiatric Association (APA), Diagnostic and Statistical Manual (DSM) as a mental disorder (Drescher, 2015) and overnight millions of people were no longer considered to suffer from a severe mental illness. Similar changes gradually took place in the international mental health community, and in 1990 the World Health Organisation (WHO) removed homosexuality from the International Classification of Diseases (ICD-10) (Cochran et al., 2014). As a result of these changes, homosexually moved away from medical and psychiatric scrutiny and gradually became contested within other institutions such as government, religion, media and educational institutions. Although there are notable changes in the way homosexuality is now viewed, it is important to state that throughout the world discrimination towards homosexuals remains prevalent. In fact, many societies still have negative sentiments, stigma and prejudice towards homosexuals and these are some of the reasons why homosexuals choose not to disclosure their sexuality or are uncomfortable with their sexual orientation.

Gay men who are in conflict with their sexual orientation are more likely internalise society's views on homosexuality. This concept is referred to as internalised homophobia. Internalised homophobia is defined in different ways by scholars. A widely published and cited definition is the one by Meyer and Dean (1998) who say "when homosexuals accept the negative attitude towards themselves, they experience a sense of devaluation, self-loathing and poor self-regard" (p. 163). Herek (2004) broadly defines internalised homophobia as "negative

feelings about one's homosexuality" (p. 19). The concept of internalised homophobia is the focal point of this study and will be discussed in more detail in the literature review.

Individuals experiencing internalised homophobia deal with their feelings of poor self-esteem and a sense of devaluation in many different ways. Research indicates that some gay men use drugs and alcohol to help them deal with the stresses of stigma and shame about their sexuality (Weber, 2008). The feelings of exclusion that are experienced by gay men tend to limit the types of social outlets available to the gay community, which generally leads to the formation of subcultures and venues exclusive to the lesbian, gay and bisexual (LGB) community. The development of a gay culture provides gay men the opportunity to identify with a group of other gay men and experience a feeling of inclusivity. Berube (2010) explains that gay bars, saunas and Party and Play (PnP) venues are places frequently visited by some gay men and have over the years provided a sense of identity, created a sense of community and pride in their sexuality, to enjoy "safety zones" where gay men could be sexual and affectionate with each other with minimal threat. Such venues are the primary place where many gay men initially start forming their gay identity. However, substance use is commonly associated with the clubbing culture or other similar gay venues such as the popular gay saunas and PnP venues. Research shows that such arenas serve not only as social centres "to build community and cultural identity" (Ghaziani & Cook, 2005, p. 32) but also as key settings for drug use (Fazio et al., 2011). Because sexuality is so intricately intertwined with learned behaviour, drug use often becomes the common way of socialising even outside the gay venues such as online internet-based dating or geo networking hook up apps available on smartphones (Swardt, n.d.). The use of drugs to enhance sexual behaviour is a growing trend in South Africa and the world over. This phenomenon is known as chemsex and it is the focus of this study.

Concerning drug use, Abdulrahim et al. (2016) state that the prevalence of substance use and abuse and their complications among gay men are generally higher when compared to

those found in the general population. This drug use is frequently associated with risky sexual activity such as unprotected sex, leading to the risk of acquiring sexually transmitted diseases (David & Stall, 2008). With regard to chemsex, Stuart (2016) explains that "chemsex is a word that was invented by gay men and adopted by the gay men's health sector to describe a unique sex and drug trend" (para 3). He further explains that chemsex is a 'syndemic' of behaviours and circumstances uniquely connected to the gay culture. Kwan and Ernst (2011) define a syndemic as "the convergence of two or more diseases that act synergistically to magnify the burden of disease" (p. 351). I will discuss the syndemic as defined above in relation to the chemsex phenomenon in the literature review chapter.

McHall et al. (2015) define the term chemsex as the voluntary intake of psychoactive and non-psychoactive drugs in the context of recreational settings to facilitate and enhance sexual intercourse, mostly among gay men (p. 762) as cited in (Giorgetti & Raffaele, 2017). Even though the chemsex phenomenon is not confined to the gay community (sexualised drug use is a common occurrence in almost every society throughout the world), this dissertation focuses specifically on gay men. The chemsex trend has recently also taken root in South Africa among members of the gay community, which has elicited my interest in the subject, with a focus on the possible relationship between internalised homophobia and chemsex.

1.2 Aims and objectives of the study

This study aims to explore the complex ways in which chemsex and internalised homophobia may be linked. The study is carried out to:

1. Elucidate the concept of internalised homophobia.
2. Determine the challenges experienced by gay men and how psychoactive drugs influence their sexual relationships with other men.
3. Explore a possible relationship between chemsex and internalised homophobia.

It is hoped that this study will contribute to a better understanding of the challenges that are faced by gay people and the reasons why some gay men participate in chemsex.

1.3 Significance of the study

The subject of internalised homophobia and substance use within the Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ+) community has been widely researched internationally, but not much work has been done in Africa and South Africa specifically. Many international researchers posit that there is a positive relationship between internalised homophobia and substance abuse but not much research has been done between internalised homophobia and chemsex, hence the motivation for this study. According to the Centre for Substance Abuse Treatment (CSAT) (2001), LGBTIQ+ persons are:

> (a) more likely to use alcohol and drugs than the general population, (b) more likely to have higher rates of substance abuse, (c) less likely to abstain from use, and (d) more likely to continue heavy drinking into later adulthood (p. 13).

The article further states that "20–25% of gay men and lesbians are heavy alcohol users, compared to 3–10% of the heterosexual population" (p. 13). Cabaj (2000) explains that although alcohol and drug use and abuse provide comfort at times, LGBTIQ+ individuals may experience increased use, abuse, and possible dependency. The situation is worsened by the presence of negative feelings towards oneself which is defined as internalised homophobia.

Internalised homophobia is a concept that is generally poorly understood by so many LGBTIQ+ individuals and yet it has the potential to cause much harm and possibly to lead to mental health issues, substance use disorders and even health related issues such as acquiring sexually transmitted diseases. Internalised homophobia induces anxiety, depression, low self-esteem and other intrapsychic problems that lead to using alcohol and drugs to ameliorate these

effects. However, the link between internalised homophobia and chemsex is typically stated in general and abstract terms. In this study I aim to explore how the two phenomena are linked and also to show the challenges that are faced by gay men that lead to drug use and them chemsex. The lived experience of gay men will be used.

1.4 Research questions

The research questions were designed with the intention of gaining a better understanding of the subject and addressing the needs of the research hypothesis (Burgess 2001). In my dissertation, the following questions were posed with the aim of elucidating the possible relationship between chemsex and internalised homophobia.

- How do participants define homophobia?
- How do participants define internalised homophobia?
- To what extent are participants aware of internalised homophobia?
- What are the participants' experiences of internalised homophobia?
- What are the coming out experiences of participants?
- How has internalised homophobia affected the participants' lives?
- What challenges do participants face on a daily basis?
- What kinds of drugs do participants use?
- Which drugs do participants use to boost sexual experience (chemsex)?
- How has drug use affected the lives of participants?
- How do participants describe positive and negative aspects of their chemsex experiences?
- How does chemsex fit into the rest of participants' lives?

- Do participants see a link between internalised homophobia and chemsex, and if so how do they describe the link?
- How and to what extent does chemsex appear to be related to internalised homophobia in the lives of participants?

The above list of research questions was designed by first reading existing literature on the subject of internalised homophobia and chemsex and identifying areas of further exploration on the subject.

1.5 Personal motivation

As a young boy growing up in an Indian, Muslim community, I remember many lessons taught at Madrassah reinforcing the sin and disgrace relating to being gay. The very same message was further reinforced at home when my mother and siblings spoke ill about a gayman who lived in our community. Words like “moffie” and statements such as “kyk hoe lyk hy!” and “wat sal mense dink?” resound in my mind until now. At age 16, I felt confused about my sexuality; I felt that something about me was different. I felt like a “moffie” and more frightening, I was concerned about what people would think of me. For a long time I struggled to understand what was happening, and the only thing I remember feeling was an overwhelming need to express myself and to be heard. For the greater part of my adolescent years I denied the feelings and physiological response of my body when an attractive boy crossed my path. I believed that my friends and family would not understand what I was going through or that they would judge me for the way I felt. Subsequently I began accepting their views that being gay was wrong and sinful. I prayed and kept hoping that I would someday change. I started dating girls hoping that I would eventually be able to suppress my homo-erotic feelings and be able to live a ‘normal’ heteronormative life.

I remember spending hours alone in my room trying to make sense of what was going on and at the same time desperately trying to escape from my own head. The feelings and emotions became so overwhelming and with no one to talk to about what I was experiencing. I remember taking one of mom's blades and cutting myself until I saw blood streaming down my arms. This was by no means an attempt to commit suicide, but more a need to feel something real. The blood oozing from my arms created a sense of relief and made me feel much better. For a brief moment I felt good - there was no pain or feeling of emptiness.

People who self-injure commonly report that they feel empty inside, over or under stimulated, unable to express their feelings, lonely, not understood by others and fearful. Self-injury is their way to cope with or relieve painful or hard-to-express feelings. This made sense to me when I eventually read an article about self-mutilation in *People* magazine. I was in denial for various reasons: I was afraid of being called a moffie or being rejected by my friends and family. I was afraid that I would be punished by God and that my Islamic school (Madrassah) teachers would shun me or ask me to leave madrassah.

After matric, I came out to myself but stayed in the closet. I began reading on the subject of homosexuality and started talking to other men using various social media platforms such as mamba online. I learnt about the concept of homophobia and internalised homophobia and the theory resonated with me. At this point, I chose to make a difference in my life and years later, I left home and moved to Cape Town. I found others like myself and began meeting men at bars, saunas and on geo-networking apps such as Gay Romeo and Manhunt. Through my journey of self-discovery, I met other gay men who shared similar stories to mine and notably each of them chose a different path depending on their own unique challengers and circumstances.

I began recognising how some have internalised the views of others such as family and friends for various reasons, including religion, fear of being rejected and the shame relating to

their sexual attraction for men while at the same time growing up in a community were homosexuality is rejected. As I began navigating through life within the gay community of Cape Town, I observed many other challenges over and above homophobia and internalised homophobia, most notably gay men struggling with issues relating to their physical appearance, need for intimacy and love. Drug and alcohol use were central at gay clubs and saunas and struck me as a way for some men to get the attention and acceptance they so desperately needed. This culture of drugs within the gay community invoked in me a desire to understand why some gay men turn to drugs, while others do not.

Within my social circles I have met a few men who were comfortable enough to share some of their personal life experiences with me. One of my dear friends was core inspiration of the study. He frequently used drugs for recreational purposes and even though I never approved of his behaviour, we remain good friends. I wanted to understand his motivation for using drugs and more specifically why he only had sex while on drugs. During my conversations with him he began sharing personal stories about how lonely he felt growing up and in his need for affection, sought the company of other men, some much older men who took advantage of his youth and innocence. Over time he found comfort in the feeling that came with taking drugs as it allowed him to escape some of the trauma he had experienced as a child. Using drugs while having sex was the only way he could connect with other men. From my observation, some men take drugs to cope with their sexuality while others use drugs to gain a sense of belonging or both. These encounters prompted me to research deeply into the relationship between internalised homophobia and chemsex with the hope of better understanding the phenomenon of chemsex sex and its relation to internalised homophobia.

1.6 Brief outline of the dissertation

The dissertation begins with a brief outline of the study, followed by a personal motivation for why the topic was chosen. Chapter 1 presents the rationale and objectives of the study. Chapter 2 presents a review of the literature on homophobia, internalised homophobia and chemsex. Chapter 3 outlines the research design, focusing on the methods that were used to collect and analyse data. Chapter 4 presents the findings and discussions followed by a conclusion in Chapter 5.

CHAPTER 2

THEORETICAL FRAMEWORK AND LITERATURE REVIEW

2.1 Introduction

In this chapter I will review existing literature and various theoretical frameworks that are central to the subject of internalised homophobia and chemsex. I will begin by providing a brief overview of homosexuality and other related constructs such as homophobia, internalised homophobia, minority stress and the coming out process. Then I will focus on the causes and effects of internalised homophobia and on sexualised substance use, "chemsex" as either a possible cause or effect of internalised homophobia. Lastly, I will explore existing literature on the possible relationship between sexualised drug use and internalised homophobia.

2.2 A brief overview of homosexuality

Gay male homosexuality forms part of a spectrum of non-conforming sexualities that include Lesbian, Bisexual, Transgender, Intersex and Queer, together with other non-conforming sexualities, commonly abbreviated as LGBTIQ+. For the purposes of this study, the term homosexuality will be used to refer to gay men.

Virtually every civilisation has had some record of the presence of homosexuality, from Ancient Greece to Rome to Victorian England, right up to the present day (Zive, n.d.). Homosexuality was at first accepted in many ancient civilisations (such as ancient Greece), but became less accepted as Christian and Islamic religious and cultural practices began to dominate the world. Today attitudes towards homosexuality are slowly becoming more accepting in many societies, but vestiges of anti-homosexuality remain everywhere and, in some contexts, this is still the predominant sentiment.

Across the world religious beliefs have and continue to strongly shape the attitudes towards homosexuality. More than any other religion, Christianity played and continues to play a role in the way homosexuality is perceived. Ritter and Terndrup (2002) state that sexual prejudice began to rise as the state of Rome was falling, and through the Middle ages, the dominance of the Christian church led to homosexuality being viewed as unnatural. In line with the story of God burning Sodom and Gomorrah as a result of the prevalence of homosexuality and the verse in Leviticus 18:22 ("You shall not lie with a male as one lies with a female; it is an abomination"), homosexuality gained the status of 'sodomy', which is a sin. This is also true of Islamic contexts that view homosexuality as sexual deviance that is punishable by law - even by death in some Muslim countries.

The view that homosexuality is a sin was spread to many other nations during the colonial era, when the bible was used as a tool of domination, and these views continue to pervade many societies post colonialism. Yip (2005) stated that most religions tend to categorise behaviours associated with homosexuality as ''unnatural", ''ungodly", and ''impure" as cited in Adamczyk and Pitt (2009, p. 19). Active involvement in religious practices, exposure to religious literature (such as the Quraan and Bible) and frequent interaction with religious family and friends are some of the factors that are likely to encourage homophobia (Adamczyk, 2009). Similarly, the teaching that homosexuality is a sin and all homosexuals will be punished according to religious doctrines may lead to religious people encouraging others to become anti- homosexual.

This situation was worsened by the classification of homosexuality as a mental illness in 1952 with its inclusion in the DSM drawn up by the APA (1952), which classified it as a sociopathic personality disturbance (Drescher, 2015). In the 2nd edition of the DSM, homosexuality was listed as one of the sexual deviations APA (1968). Only in 1973 did the APA remove "homosexuality" as a diagnosis from the second edition of the DSM.

Across the world there have been many struggles for homosexual rights. On 27 June 1969 a homosexual bar in Greenwich Village New York was raided by police (a common occurrence at the time). On this particular day, the patrons at the bar fought back instead of passively enduring humiliating treatment (Armstrong 2006). The stonewall riots (as the incident came to be known) was not the first record of a riot where the gay community fought back against authorities; However, it came to be considered to be the start of the gay liberation movement and a turning point in the history of gay life in the United States. In South Africa gay rights struggles made little headway during the apartheid era, but after liberation, on 1 December 2006 it became the only country in Africa to have legalised same-sex marriage, and the fifth country to have done so worldwide (Progressive prudes, 2016). The legalisation of homosexuality paved a way for reforms in the way gay people are viewed and treated, though it has to be mentioned that homophobia is still alive in the country. In a recent survey of 3000 South Africans' attitudes towards homosexuality and gender nonconformity (Progressive prudes, 2016) the following findings were made:

1) More than 2 in 4 of all South Africans indicated that they will 'accept' a gay family member.
2) More than half, 51% of all South Africans believe that gay people should have the same human rights as all other citizens, even though 72% feel that same sex sexual activity is morally wrong
3) Of the participants, 1 out of every 2 people believed that gay and lesbian people should be included in 'my culture and tradition.
4) Most participants, 8 out of 10 said they have not – nor would they ever consider – verbally or physically abusing someone who was gender non-conforming.
5) Many people, 450 000 South Africans have physically harmed women "who dress and behave like men in public in the prior 12 months".

6) Many, 7 out of 10 South Africans feel strongly that homosexual sex and breaking gender dressing norms is simply wrong and disgusting (p. 3).

From the above it is clear that even though South Africans have made great strides towards a change in attitude towards homosexuality and gender non-conformity, they for the most part remain (as the title of the report suggests) "progressive prudes" who hold on to conservative views on homosexuality while accepting the new political and social order with regard to homosexuality.

2.3 Homophobia

There are many historical accounts of lesbian and gay people being treated inhumanely and unfairly as a result of their sexual orientation, and today homosexuality is still illegal in 73 countries across the world, while same sex marriage is legal in only 26 countries (Hutt 2018). According to an annual report by the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA) (2017) there are eight countries in which homosexuality can result in the death penalty, and dozens more in which homosexual acts can result in a prison sentence.

Berg, Kaas and Ross (2016) explain that legal restrictions on same sex relationships, hate crimes against gays and lesbians, bullying of gay teens and societal rejection of homosexuals are examples of heterosexism that denigrate and devalue non-heterosexual forms of identities, behaviours, relationships and communities. The abuse, ill-treatment and denigration of gay people as a result of fear, ignorance, prejudice and bigotry is what is referred to as homophobia.

The term homophobia was first introduced by Weinberg (1972) and traditionally describes a negative affective response to LGBTIQ+ individuals, that includes feelings of fear, anxiety, discomfort and any associated behaviours (Lottes & Grollman, 2010). Banks (2003) concurs with this definition and describes homophobia as the irrational fear of, or aversion to

homosexuals and homosexuality. Modisane (2014) explains that homophobia is also commonly understood as hostility towards LGBTIQ+ individuals including negative feelings or attitudes towards non-heterosexual behaviour, identity and relationships which can be attributed to the root of discrimination experienced by many LGBTIQ+ individuals.

In an article by Todd (2016) titled "Gay men are battling a demon more powerful than HIV – and it's hidden" as cited by Jones, (2016) the writer puts the blame not on homosexual people but on society that is limited in its view. Todd writes:

> It is a shame with which we were saddled as children, to which we continue to be culturally subjected. The problem gay people have is not their sexuality, but rather society's attitude to it. It is our experience of growing up in a society that still does not fully accept that people can be anything other than heterosexual and cisgender (para 6).

Homophobia can manifest in different forms, for example homophobic jokes, assault, hate crimes, discrimination in the workplace and negative media representations (Modisane, 2014). There are many different ways in which LGBTIQ+ people experience homophobia, including malicious gossip, being bullied at school, discrimination at work, being rejected by family and friends, sexual assault, or even, in some countries, being jailed or sentenced to death. Unfortunately, the history of homophobia and the oppression of gay people by the state, communities and families is long and traumatic the world over.

Pew (2013) conducted a survey to determine various countries' response in respect of the acceptance or rejection of homosexuality. The findings of the study show that there is a broader acceptance of homosexuality in North America, the European Union, and much of Latin America, but equally widespread rejection in predominantly Muslim nations and in Africa, as well as in parts of Asia and in Russia. Opinion about the acceptability of

homosexuality is divided in Israel, Poland and Bolivia. Attitudes about homosexuality have been fairly stable in recent years, except in South Korea, the United States and Canada, where the percentage saying homosexuality should be accepted by society has grown by at least ten percentage points since 2007. These are among the key findings of a new survey by the Pew Research Centre conducted in 39 countries among 37 653 respondents in 2013 (Pew, 2013).

The legacy of past discrimination continues to leave many homosexuals excluded from general society. Stigmatisation and discrimination affects the LGBTIQ+ community in a number of ways. It creates psychological difficulties related to rejection, which can manifest as depression, and these difficulties often lead to harmful behaviour such as excessive alcohol and drug use. Stigma may also be internalised where issues of self-esteem and self-worth are negatively impacted (Hahm, 2012).

Dlamini (n.d.) wrote an article published on the Anova health website, titled *Dealing with prejudice*. In his article he shares accounts of African men in townships who suffered homophobic attacks within their communities. He gives an example of Simphiwe (24) from Duduza township in Ekurhuleni who says that he tried to commit suicide because of being discriminated against by his family. In his own words Simphiwe says:

> It is never easy growing up as a young gay man in the township. In 2013 my family wanted me to go to the initiation school because they believed that it was going to change me into a 'real man'. I felt so hurt and lonely and I thought that the only thing to do was to end my life. I decided to drink rat poison and became unconscious; my grandmother was the one who found me lying on the floor and called an ambulance (para 2).

Teboho (30), is another openly gay man from Bluegum View section in Duduza who recounted his experiences of homophobia as follows:

> I was once raped by three guys. It was at night and I was from a local tavern. I have never reported the matter to the police station because we are always ridiculed, and our cases are not taken seriously (para 3).

From the above discussion and experiences that were shared by the victims of homophobia, it is clear that homophobia is real and its effects are far and wide reaching. The coming out process is also greatly influenced by the level of homophobia experienced and subsequently resulting in LGBTIQ+ individuals internalising the homophobic views of others. In the next section, I will explore the coming out process within the LGBTIQ+ community.

2.4 Coming out: A gay identity

Generally, coming out is a process of disclosing one's sexual identity to family and friends. However, the Urban dictionary (2016) defines coming out as "telling certain people in your life that you are lesbian, gay, bisexual, pansexual, etc. this definition is more specific. Coming out is a never-ending process, because every time you move, change jobs, or make new friends you have to decide whether to share your sexual orientation or not. It's not always a good idea, because there is still prejudice and discrimination in workplaces" (n.p.). Davies and Niel (2000) state that Beckett (2000) describes coming out in her work with a young Muslim man as the process of 'inviting in' rather than coming out, where significant people are selectively invited into knowing more about the person's life and sexuality. The authors argue that coming out signifies more than seeking acceptance from others whereas the word "inviting in" translates to someone who has accepted their sexuality and in so doing decides who to disclose their sexuality to without fear of being rejected or victimised.

The coming out process involves the identification and acceptance of a label other than straight (Dziengel, 2015). Coming out is not as simple as making an announcement about one's sexuality and then feeling liberated, it is an ongoing complex and recurrent process.

There is the real fear of being rejected, victimised or even abused. The constant decision about when to come out, and to whom at each social or professional situation (work, friends, family, neighbours, and so on) is a very stressful and anxiety provoking for many individuals particularly where the level of internalised and externalised oppression is high (Carroll 2010).

Coming out carries the risk of rejection by parents, family and friends (Nell & Shapiro, 2011). The coming out process generally starts with recognising one's sexual orientation, as shown in the Cass (1979) six-stage theory of identity formation, then disclosing to a same-age peer, then to a sibling and finally to parents (D'Augelli & Hershberger, 1993). This process is usually riddled with challenges and fear because it threatens one's identity and sense of belonging. D'Augelli (1995) describes this psychological dilemma as on the one hand feeling isolated by non-disclosure and on the other hand, fearing victimisation if they come out. Cabaj (2000) states that:

> The coming out process may very difficult to negotiate depending on the intensity of internalised homophobia. The gay person may believe, depending on familial, religious, cultural, and local societal influences, that homosexuality is a sin, an illness, unnatural, evil, or will only lead to sadness, loneliness, and isolation (p. 9).

Hillier and Harrison (2004) studied the coming out process of Australian LGBTIQ+ youth and found that young people were worried that disclosing their sexual preference would bring shame upon their families and they feared being rejected by their families and friends. This was more prevalent in religious families and in families from ethnic minority backgrounds. However, concealing one's sexual orientation can lead to adverse psychological and physical health outcomes (Meyer, 2003) which makes coming out a better option despite the associated challenges.

A case study by Nell and Shapiro (2011) shows that in South Africa where as many as 900 000 South Africans under the age of 20 are gay or lesbian, coming out is still a major challenge mostly because of culture, religion and divergent generational views. One of the participants in their study captured this problem:

> Most parents were themselves brought up in a world where homosexuality was considered not only morally wrong but was also illegal by law. Strong religious views exacerbated this but so did something as simple shame – 'what will I tell my friends?' (p. 13).

From this statement, it is clear that coming out challenges what parents consider morally and legally right, because they grew up at a time when homosexuality was considered a crime. Additionally, accepting societal views leads feelings of shame and these taints the coming out process. Concerning religion, one of the participants said:

> We are unacceptable to the Charismatics and the Catholics and we were told that the Muslim Council had declared that being gay was an abomination (p. 23).

Another participant narrated this interaction with his aunt:

> I remember one day at this family function [my aunt] said to me, 'You know, Allah hates faggots; you need to stop behaving like one.' I think that was one of the worst things that was ever said to me (p. 23).

This statement brings home the level of antagonism that homosexual people have to face on a daily basis where they are rejected by the family, at school, by the church and community. With regard to coming out, the participants in Nell and Shapiro's study narrated the following experiences:

> "When I came out to my mother, she chucked me out."

"When you tell your parents you were raped, they just say you deserved it."

"When I told my dad, he just got in his car and drove away. He is more accepting now."

"My mother went ballistic when someone suggested she had a gay child. How can I tell her?"

"It was only when I came out to my parents that the crap started" (p. 14).

From these comments, it seems legislative changes have not fully changed the minds of people with regard to homosexuality. Many people still view homosexuality negatively.

Savin-Williams (1994) lists the following as some of the negative outcomes that have been found immediately following self-disclosure in adolescents: verbal and physical abuse, substance abuse, criminal activity, declining school performance, and suicide attempts. Savin-Williams and Dubé (1998) add that it is not uncommon for parents to react to their son or daughter's self-disclosure with shock, anger, or denial, which can undoubtedly be difficult for the individual who has just come out. Gay people who face rejection, prejudice and discrimination after coming out often develop mental health problems.

Garnets, Herek and Levy (1990) found that following victimisation, LGBTIQ+ individuals can often develop sleep disturbances, headaches, restlessness, bowel difficulties, and deterioration in their personal relationships. In addition, being a victim of a hate crime or experiencing victimisation can change the way an individual views the world. The individual may no longer feel the world is safe and predictable and may find it difficult to trust others. He or she may begin to view him or herself as weak and vulnerable, reinforcing a negative self-view (Al-Mateen, Lewis & Singh, 1998).

Research shows that sometimes gay men from religious backgrounds react by rejecting their religious identity (Dahl & Galliher, 2009; Singer & Deschamps, 1994) whereas others

reject their sexual identity (Piazza, 1994). There are however cases where homosexuals are able to integrate both religion and sexuality without having to compromise either. In other words, religions such as Christianity and Islam that denigrate homosexuality influence gay people to reject their sexual orientation. Rejecting one's sexual identity because of religious beliefs typically defines internalised homophobia whereby the individual internalises religious doctrines and views on homosexuality and as a result rejects the part of themselves that identifies as gay. Gay men have also reported isolating and compartmentalising their multiple constructions of the self (Baumeister, Shapiro, & Tice, 1985; Coyle & Rafalin, 2000; Dahl & Galliher, 2009; Schnoor, 2003). Many gay men nevertheless attempt to create a true version of themselves while maintaining a close connection with their religion and spirituality. Living a spiritual or religious life while maintaining a positive sense of existential well-being (that is, a sense of life purpose and satisfaction) are significant predictors of sexual minorities' self-esteem, self-acceptance of sexual orientation, and feelings of inclusion (Tan, 2005). Identifying with a minority group can cause gay men to be hesitant to come out and identify within the LGBTIQ+ community. Failure to accept one's sexual identity can impact negatively on intimate relationships. Meyer (2003) points out that LGBTIQ+ individuals who conceal their sexual orientation are not only at risk from increased psychological distress, but also are much less likely to access support from the LGBTIQ+ community or to receive the benefit of affiliation with other stigmatised individuals.

Gay people fare better if their coming out is met with openness and acceptance, especially by the family. The study by Nell and Shapiro (2011) shows that gay people need the support of their families and communities. That being the case, communities need to be conscientised about the importance of accepting and loving their children despite their sexual orientation. Schools also need to assume a critical stance in educating students about

acceptance of and tolerance for those who are different from the majority, including gay and lesbian individuals (Morrow, 1993).

Research also shows that there are many advantages to coming out despite the challenges that gay people face. Nell and Shapiro (2011) found that for most LGBTIQ+ people with whom they spoke, the experience of coming out was positive – not because there are no negative reactions but because it is a process of self-acceptance that is powerful and liberating. Feelings such as freedom and liberation are commonly described from people who have come out, as well as pride in acknowledging one's true self (Fitzpatrick, 1983, as cited in Savin-Williams, 1998). In simpler words, coming out concretises one's identity and takes away the guilt feelings and shame.

Feelings of guilt and shame are closely linked to the concept of internalised homophobia which is a result of minority stress. The two concepts are explored in the next section.

2.5 Internalised homophobia and minority stress

Internalised homophobia is a common experience within the LGBTIQ+ community both in South Africa and across the world. While there exists a substantial amount of academic literature on the subject of internalised homophobia, the concept is not easily translated and understood by the very same individuals who live through the experience. According to Meyer (1995) internalised homonegativity (IH) refers to the process whereby lesbian, gay and bisexual persons internalise societal messages regarding gender and sex, often unconsciously, as part of their self-image. Internalised homophobia therefore represents "the gay person's direction of negative social attitudes toward the self" (Meyer & Dean, 1998, p. 161) and in its extreme forms, it can lead to the rejection of one's sexual orientation. Internalised homophobia is further

characterised by an intrapsychic conflict between experiences of same-sex affection or desire and feeling a need to be heterosexual (Herek, 2004).

Homosexuals are in most cases raised by heterosexual parents in heteronormative households which frequently promote anti-homosexual beliefs which are further reinforced by religious and societies views on homosexuals. LGBTIQ+ individuals are exposed to many years of homosexual discrimination and negative sentiments, thus, until they come out, most homosexuals lack the affirmation, support or mentorship required in order to help them develop a healthy sociosexual identity (Hetrick & Martin, 1984). When homosexuals (more specifically during their adolescent phase) are faced with societal and familial expectations of who and what they are meant to become as they grow up, they are far more likely to internalise society's views on homosexuality. Furthermore, there are many negative consequences for the mental health of an individual when considering the intrapsychic conflict between homophobia, internalised homophobia and their sexual identity formation.

A framework that is commonly used to elucidate the concept of internalised homophobia among the LGBTIQ+ community is the minority stress model. This model will be used in this study to explain the concepts of homophobia and internalised homophobia. The theory of minority stress posits that LGBTIQ+ individuals living in a heterosexist society are sexual minorities; consequently, they are prone to chronic stress resulting from stigmatisation, prejudice and discrimination (Meyer, 1995, 2003). Cornish (2012) explains that being a member of a minority group brings about additional stressors that lead to increased risk of psychological distress. The concept of minority stress has been applied widely to the study of mental health outcomes such as substance abuse (Lehavot & Simoni, 2011; Hatzenbuehler, Nolen-Hoeksema & Erickson, 2008), suicide (Lewis et al., 2003), and affective disorders such as depression, post-traumatic stress disorder (Hatzenbuehler, 2009), and internalised homophobia (Frost & Meyer, 2009).

According to Meyer (2013) there are two types of minority stress processes, namely: distal stressors and proximal stressors. Distal stressors refer to events and experiences outside the person, and proximal stressors refer to stressors that are transmuted through socialisation and experienced by the person through internalising cognitive processes. Distal stressful experiences are life events, chronic strains, everyday discrimination and even non-events (these are anticipated life course events) that bring about an increased level of anxiety and stress (McFarlane et al., 2011). Proximal stressors include internalised negative social attitudes, such as internalised homophobia, discrimination, stigma, and the concealment of sexual and gender identity. The minority stress model states that these stressors can lead to adverse health outcomes such as depression, anxiety, substance use disorders, suicide, and various other physical health outcomes that are responsive to stress (Barkan et al., 2012; King et al., 2008; Marshal et al., 2008).

As a minority stressor, internalised homophobia has also been linked to several negative outcomes such as low level of confidence, increased anxiety, feelings of shame and even depression (Frost & Meyer, 2009). The feelings of anxiety, shame, and devaluation of LGBTIQ+ people are inherent to internalised homophobia and are likely to be more overtly manifested in interpersonal relationships with other individuals (Coleman, Rosser, & Strapko, 1992). To alleviate these feelings, individuals may avoid meeting potential partners and forming lasting relationships. Their fear of being rejected and issues of low confidence prevent them from developing lasting and deep relationships with other people. ln a bid to escape from their current realities, some may end up seeking negative outlets such as abusing alcohol and drugs or using substances as an enabler for engaging in sexual relations while avoiding intimacy and interpersonal closeness.

Meyer and Dean (1998) argue that gay men with higher levels of internalised homophobia are less likely to be in intimate relationships, and when they are in relationships,

they are more likely to report problems with their partners when compared to gay men with lower levels of internalised homophobia. Similarly, Ross and Rosser (1996) demonstrate that among gay and bisexual men, internalised homophobia is negatively associated with relationship quality and the length of individuals' longest relationships.

With regard to non-romantic relationships, internalised homophobia can affect the quality of LGBTIQ+ individuals' friendships, familial relationships, and other social relationships (Frost & Meyer, 2009). For example, a higher level of internalised homophobia has been linked to loneliness (Szymanski & Chung, 2001), less social support in general, and less support specifically from other LGBTIQ+ people (as a proportion of all support received; Shidlo, 1994). In line with minority theory, there are many scholars who have explored the causes and effects of internalised homophobia and below are some of their views.

2.6 Research on causes and effects of internalised homophobia

From the above discussion, we understand that internalised homophobia is defined as "the experience that LGBTIQ+ individuals are subjected to society's negative perceptions, intolerance and stigmas towards them, and as a result, turn those ideas inward and then believing that they are true" ("Rivot & Riot", n.d.). Internalised homophobia can have many effects on the life of gay men and in this section l examine some of the causes and effects of internalised homophobia.

For many gay men, growing up gay or straight was never a topic of debate around a dinner table. The subject of homosexuality and gender non-conforming behaviour was simply never a topic for debate. Boys are expected to be "boys" in the stereotypical fashion and in most cases raised in conservative households with either religious on societal influences in respect of gender and sexuality expectations. When considering Cass's (1979) six stage identify formation theory which explains the process of self-discovery and acceptance, stage

one refers to identity confusion. At this stage the gay individual becomes consciously aware of his homosexual thoughts and feelings and behaviour (Cox & Gallios, 1996). Cass (1979) states that this stage is masked by inner turmoil and confusion. It is at this stage where the individual begins to question his identity in relation to all influences imposed on him as a child. During this stage, individuals can either accept their differences and begin to embrace the changes, thereby become further committed to accept their homosexual self; or they may realise that they are homosexual and therefore different, but reject the change for various reasons, thereby changing their perception of their behaviour and thoughts as being homosexual and convince themselves that they are not gay (Degges-White, Myers & Rice 2000). The negative thoughts and feelings such as anxiety, shame, and devaluation of self are inherent to internalised homophobia and are likely to be most overtly manifested in interpersonal relationships with other LGBTIQ+ individuals (Coleman, Rosser, & Strapko, 1992). Cass (1979) further states that in stage two of his theory on Identity formation that when the LGBTIQ+ individual attempts to change their perception of themselves and deny their sexuality and discontinue any behaviours that are considered homosexual they are at increased risk of self-harm. Cass's theory is congruent with much other academic research which posit that internalised homophobia can lead to the higher levels of stress, risk of acquiring sexually transmitted diseases and mental health issues. Other studies, however, have linked lesbian, gay, bisexual and transgender community connectedness to risk behaviours such as exchanging money or drugs for sex, unprotected anal intercourse and substance use (Amirkhanian et al., 2006; Carpiano et al., 2011) as cited in (Cabaj, 2000).

In the next section, I aim to explore existing literature on the possible relationship between internalised homophobia and chemsex. The next section further elucidates the chemsex phenomenon within the gay community.

2.7 Chemsex: A gay syndemic

Milstein (2002) defines a syndemic as "two or more afflictions, interacting synergistically, contributing to excess burden of disease in a population" (p. 1). The conceptual framework was introduced in the 1990s by medical anthropologist Merrill Singer and at the time, the notion of a syndemic was used to describe the interactions among substance abuse, violence and AIDS that had become a full-blown health crisis in Hartford in the USA. Singer and Romero-Daza (1994) as cited in Milstein (2002) stated that:

> We have introduced the term 'syndemic' to refer to the set of synergistic or intertwined and mutually enhancing health and social problems facing the urban poor. Violence, substance abuse and AIDS, in this sense, are not concurrent in that they are not completely separable phenomena (p. 2).

While investigating HIV prevention in drug users, researchers took notice of the constellation of elements that impinged on risk, structural factors, such as lack of housing and poverty, and social aspects such as stigma and lack of support systems as precursor for violence in communities and reinforcing the disease burden between substance use and AIDS (Sharma, 2017).

Based on the definition of syndemic by Singer (1994), many other syndemic studies have emerged and published within the academic context; one such example is an article published by O'Leary (2014) which postulates that "the spread of HIV and other STDs among gay men has been labelled a syndemic because in this population a number of different and interrelated health problems have come together and interact with one another" (p. 12).

Taking into account the definition of a syndemic, one can hypothesise that a possible relationship between chemsex and internalised homophobia is a syndemic within the homosexual community. That being the case, this dissertation focuses on the synergistic

relation between internalised homophobia and chemsex. As depicted above, is has been identified that individuals with high levels of internalised homophobia are more prone to suffering from depression, mental health issues and substance use or abuse. This chapter therefore, explores the biopsychosocial effects of substance use and abuse among gay men, and describes the development of these problems as a syndemic process of interaction with other daily life stressors such as dealing with issues of coming out, homophobia and internalised homophobia from the onset of early adolescent which progresses throughout their adulthood. This chapter adds to that explanation, the possibility that the lifelong effects of experiencing homophobia, internalised homophobia and the coming out process at a very early age is a centrally-important force in syndemic production among gay men who participate in sexualised drug use behaviour.

2.8 Sexualised substance use and abuse: chemsex

Substance use is no new phenomenon and has been around since prehistoric times. Throughout history, psychoactive substances have been used by priests in religious ceremonies, healers for medicinal purposes or the general population in a socially approved way (Croc, 2007). However, the abuse of substances leading to addictions and other health problems is a fairly recent phenomena that has given rise to public and health concerns. In this dissertation, I focus on the use and abuse of drugs within the homosexual community with focus on drugs as a precursor for sex.

Over the last few decades, drug use within the homosexual community has gained much focus in the media, public scrutiny and academic studies. Flentje and Sorensen (2015) explain that since the late 1970s, when substance abuse research first began to include lesbian, gay, and bisexual (LGB) subjects in study findings, scientists have reported significantly higher overall rates of substance use and substance use disorders among sexual minorities as compared

to their heterosexual counterparts. Clubs and bars are common places and central to the use of various drugs within the gay community. Drugs often serve a very deliberate purpose in helping individuals to relax, to socialise, to mitigate social unease and to gain confidence in seeking sexual partners (Bourne, 2012).

According to a National Institution of Drug Abuse (NIDA, 2017) survey, LGBTIQ+ individuals are more than twice as likely as heterosexual adults to have used any illicit drug in the past year. However, the availability of credible data on the prevalence of drug use within the gay community varies from country to country and gathering information can also be challenging as researchers may recruit a sample of men who are found in places where drugs are commonly used and such samples may not be completely representative of the general population of gay men, but instead, subpopulations of drug using gay men. The inconsistency of different recruitment methods of collecting data and the different types of drugs used in various countries across the world may also be another limitation towards the finding on the drug use within the gay community.

Sexualised drug use within the homosexual community has become a topic of increasing public concern, and the term chemsex was introduced to describe the phenomenon which seems to plague particularly the gay community. ‘chemsex’ is a colloquial term, first used in the UK and then adopted in countries across the world, which describes sex under the influence of psychoactive substances, typically crystal methamphetamine, mephedrone and gamma-hydroxybutyric acid (GHB) or gamma-butyrolactone (GBL) (McCall, 2015). The combination of drugs used during chemsex varies from country to country, but a common drug which is almost synonymous with chemsex is crystal methamphetamine. It is important to state that chemsex is a rising phenomenon within the gay community, but there is limited quantitative research which shows the variations of drugs used in different countries, and in

cases where there has been research conducted on the topic, most of the academic literature focuses on the qualitative analysis of chemsex.

Throughout the 1990s and early 2000s the most common illicit drugs used by gay men were marijuana (dagga), amphetamine (speed), methylene-dioxy-meth-amphetamine (MDMA, or ecstasy) and cocaine (Bourne et al, 2016). There is extensive academic literature and media coverage on chemsex drugs in many European countries as mephedrone, crystal meth and GHB (Bourne et al, 2016). However, very little data exists on the extent of chemsex in South Africa (Collison, 2017) and much of what has been published draws reference from international studies. Most articles featuring chemsex are published by online newspapers such as the Mail and Guardian and Times Live or dating websites such as MambaOnline.

Chemsex drugs enhance the feeling of confidence, allowing one to ignore possible negative consequences, increases openness towards sexually adventurous activities beyond the normal boundaries, stimulate a heightened sense of pleasure and stamina that can increase the sexual endurance for extended hours and even days. Chemsex could be considered a syndemic within the gay community because of the adverse effects it can have on mental and physical health, namely depression, substance use disorder and even increased risk of HIV and other sexually transmitted infections. As stated above, a syndemic suggests the presence of two or more diseases which adversely interact with each other, negatively affecting the mutual course of each disease trajectory, enhancing vulnerability, and these are made more harmful by experienced inequities such as internalised homophobia, homophobia and minority stress (Sharma, 2017). While extensive literature exists on the negative effects of chemsex drugs, it is also important to consider that not all chemsex experiences are negative and have disastrous consequences and more research should provide focus on the pleasures experienced and how it also exhibits some benefits to gay men. In the next section, I will explore existing literature on the various types of drugs closely associated with chemsex.

2.9 Types of drugs commonly associated with chemsex

Recreational drug use within the LGBTIQ+ community remains an important health concern in many countries and is an ongoing epidemic within the gay community. The progressive use of recreational drug and other more illicit psychoactive substances increase individuals' chance of engaging in unsafe sexual encounters such as condomless sex and acquiring sexually transmitted diseases. For many gay men, substance use has become an integral part of their sex lives, locking them into continued use, thus, giving rise to the chemsex phenomenon and associated risks such as addiction.

Not all drugs are associated with chemsex. Stimulants, namely crystal methamphetamine (hereafter referred to as 'crystal meth' or tik), GHB/GBL, mephedrone and, to a lesser extent, cocaine and ketamine are commonly associated with chemsex (Bourne et al., 2014). Stimulant drugs typically increase heart rate and blood pressure and trigger feelings of euphoria, but crystal meth, GHB/GBL and mephedrone are not the only drugs which creates feelings of euphoria and feelings of sexual arousal (Gafos, 2017). These drugs are often taken in combination with other drugs which further facilitates longer sexual sessions, reduced inhibitions and sexual risk-taking behaviours.

In the United Kingdom specifically, the combination of drugs used during chemsex are mephedrone, GHB, GBL, in combination with crystallised meth (Steward, 2016). The combinations differ slightly in various other countries in the world. In South Africa, the common drugs used to facilitate chemsex sessions are crystal meth and GHB, a slight variation to the chemsex drugs used in Europe which includes mephedrone. Mephedrone is a powerful stimulant and is part of a group of drugs that are closely related to the amphetamines.

Table 2.1 depicts the commonly used chemsex drugs in South Africa and most other international countries

Table 2.1 Chemsex drugs

Common name (Street names)	Means of delivery	Typical effects	Typical duration
GHB/GBL, street names: G, Gina, liquid ecstasy	Swallowed in small liquid doses	Sedation and anaesthetisation: euphoria, disinhibition; drowsiness	Up to 7 hours
Mephedrone, street names: bath salts, drone, M-CAT, White Magic and meow meow.	It comes in the form of tablets or a powder, which users can swallow, snort or inject.	Stimulation, sexual arousal, euphoria, empathy feelings	2 to 4 hours
Crystal methamphetamine, street names: Christine, Tina, T, crystal, ice, Tik	Snorted as powder, smoked in glass pipe, or injected	Stimulation: exhilaration, alertness, disinhibition; agitation, paranoia, confusion, aggression	4 to 12 hours

* Synthesised from the Nation Institution of Drug Abuse (2016)

By definition, chemsex differs from generic illicit recreational drug use such as ecstasy (Bourne et al., 2014); as it is thought to be associated with higher-risk sexual activity and linked to an increase in transmission of STIs (Bonell et al., 2016; Stuart & Weymann, 2015). Most studies suggest that chemsex involves two or more drugs used. The combination of drugs is broadly defined as polydrug use, and by definition is the use and combination of more than one drug to either increase the effects of some drugs or to counter the effect of certain other drugs with the intention of creating the desired outcome. Polydrug use is not only limited to illicit drugs, and the most common form of polydrug use is alcohol and marijuana, which are both considered legal in some countries but still constitute drugs and in combination can be referred to as polydrug use.

In the definition of chemsex, crystal meth and GHB are most commonly used together and in the next section I will elucidate the effects of both crystal meth and GHB with the aim of understanding the combination of these drugs and how it affects the chemsex user.

2.9.1 Gamma-Hydroxybutyrate or GHB

GHB is a central nervous system depressant similar to other central nervous depressants such as alcohol and benzodiazepines (Galloway et al., 1997; Kam & Yoong, 1998). It was first synthesized in 1960 and used for various clinical reasons, namely: the treatment of narcolepsy, used as an anaesthetic and for the treatment of alcohol dependence (Anderson, 2018; Labroit, 1964). Its street names include "G" or "Liquid E". GHB is usually presented in a colourless odourless liquid form and taken in small doses. Based on the fact that GHB is acquired illegally, it varies in concentration. Guessing the correct dosage may be extremely difficult and so users are cautioned to start with low dosages and increase use until an appropriate dosage it obtained. Agro (2017) wrote in an online article titled "Alright, let's talk about GHB: A user's guide" and he says:

> Everyone's threshold is different, and an effective dose for each person is different. Around 1.5-2 mL is an average starting dose to feel effects, somewhere between 2 and 4 ml is the sweet spot for most people. Body size matters for dosing G; some bigger/taller people with naturally higher tolerances have to take up to 5 mL for a good high. For others, 4 ml is enough to make them puke. A too-high dose has the universal effect of making you pass out into an unarousable sleep for a few hours. (n.p.)

Liquid GHB in small amounts produces mild euphoria, eases anxiety, enhances sociability and heightens sex drive (Brown, Alfonso & Dunn 2011; Sumnal et al., 2008 as cited in Rebekah & Van Hout, 2014). Following the recreational high, GHB also has severe side effects. The most commonly reported side effects are sweating, loss of consciousness, nausea, confusion and exhaustion (Anderson, 2018). In larger doses, it induces a coma-like sleep commonly referred to as a G sleep. GHB usually takes effect within 15 minutes, with the peak occurring between 25 and 45 minutes after taking it (Bernasconi et al., 1999). It has been

postulated that GHB acutely facilitates slow-wave sleep, during which growth hormone release takes place (Galloway et al., 1997), and as a result it is also used as a weight loss aid and muscle enhancer.

In recent years, GHB has become popular in recreational use and most commonly used in combination with Crystal methamphetamine (Bourne et al., 2014) which is discussed below.

2.9.2 Crystal methamphetamine

According to the NIDA (2018), methamphetamine is a stimulant drug usually in the form of a white, bitter-tasting powder or glass like fragment. Stimulants are a class of psychoactive drug that increase activity in the brain. These drugs can temporarily elevate alertness, mood and awareness. Commonly known stimulants are caffeine, nicotine, prescription drugs such as Ritalin and as mentioned above, methamphetamine (Cherry, 2018). Crystal meth can be smoked, snorted, swallowed and mixed with water or 'slammed' NIDA, (2018), which is the term used when injecting drugs (crystal meth) into your blood using a syringe. Liam McClelland shared his story as part of Gay Star News Chemsex Series (2017) and narrated his slamming experience as follows: "The powerful euphoria created from injecting drugs, made him 'just want to be fucked'."

Slamming allows the drug to reach the brain mush faster than any other form of ingestion and intensifies the feelings experienced. Crystal meth produces an intense feeling of euphoria, disinhibition and sexual confidence, far greater than any other form of stimulant. It also makes participation in high-risk behaviours such as group sex, sex with multiple partners, or aggressive sexual practices easier (Lea et al., 2016). According to NIDA (2017), some of the long-term effects of crystal metha include: extreme weight loss, severe dental problems, feelings of anxiety, paranoia, hallucinations among others.

In the next section, I endeavour to explore literature on the psychological experiences of how drugs affect the brain's reward pathway in comparison to understanding how the brain's natural reward pathway system functions in relation to GHB and crystal meth.

2.10 The neurochemistry of drugs

In this section I will discuss the neurochemistry of GHB and crystal meth in order to elucidate the possible motivations for why it is used recreationally by some gay men. GHB (Xyrem) is described by the National Institute on Drug Abuse (2017) as:

> A central nervous system (CNS) depressant. In low doses, the drug serves to relax the body and the mind. Users feel intoxicated. They have extra energy, are happy and very talkative. There are other side effects of GHB, including: Loss of inhibition, Increased sensuality, Increased sexual appetite (NIDA, 2017).

According to WHO (2012) Expert Committee on Drug Dependence, "GHB has four sexual enhancing effects: disinhibition (e.g. relaxation), heightened sense of touch, enhancement of male erectile capacity and increased power of orgasm" (p. 27). The report further cites that GHB is creates anti-anxiety effects.

In contrast, crystal methamphetamines are extremely addictive stimulants and when ingested; they increase the body's natural brain chemical called dopamine. Dopamine is involved in body movement, motivation, and reinforcement of rewarding behaviours (NIDA, 2017), and when dopamine is released in large quantities, it creates a feeling of euphoria, disinhibition and sexual confidence. However, extensive literature on the subject of chemsex, refers to the poly use of crystal meth and GHB.

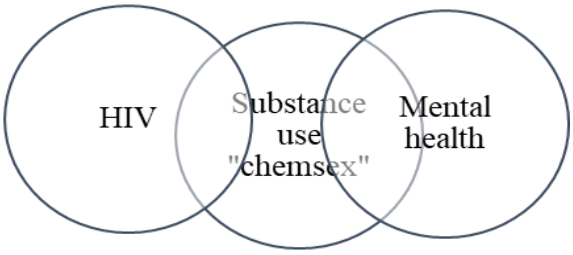
Bourne (2014) explains that most men report that mephedrone and GHB/GBL makes them feel aroused, "with this effect even more pronounced among men who used crystal meth

and/or injected drugs" (p. 47). However no clear studies exist elucidating the neuropharmacological effects of using both crystal meth and GHB simultaneously.

2.11 Comorbidity: Substance use disorders, mental health and HIV

The National Institute of drug abuse (2018) defines comorbidity as two or more disorders or illnesses occurring in the same person. They can occur at the same time or one after the other. Comorbidity also implies interactions between the illnesses that can worsen the course of both. In this section, I explore the comorbidity between substance use "chemsex", mental health and HIV within the gay community as shown in Figure 2.1.

Figure 2.1 Chemsex as seen from the perspective of comorbidity



The use of chemsex drugs is accompanied by higher-risk sexual activity, which is much the same for the use of any other drug. The most significant articles on the issue have appeared in the field of infectious diseases (Fernández-Dávila, 2016), indicating an increase in primary HIV infection among men who have sex with men (MSM). The disinhibiting effects of chemsex drugs makes it more likely for men to have sex without using condoms. Researchers from Public Health England, Imperial College London and University College London (UCL) (2017) reported that men who practiced chemsex were also more likely to have anal sex without a condom, including anal sex without a condom with someone with an unknown HIV status.

They were more likely to have a bacterial STI , hepatitis C and had more sexual partners in the previous year.

Gay and bisexual men also have a much higher propensity to abuse methamphetamine than heterosexual men (Ferrusi et al., 2014; Ross et al., 2004). The elevated use of methamphetamine is particularly troubling, as it has been linked to increased risk of HIV transmission, especially among gay and bisexual men (Ferrusi et al., 2014).

Many people who abuse drugs are not only at risk of developing a substance use disorder or acquiring a sexually transmitted disease, but studies indicate that persons who use and abuse drugs are also at risk of developing other mental illnesses (Ross & Peselow, 2012). HIV and mental health issues such as depression and other mental health problems can be most devastating to individuals and are some of the major public health concerns.

2.12 Intervention measures and harm reduction

From the above review, it is evident that LGBTIQ+ communities have been and are currently subjected to many challenges. Theories of internalised homophobia, minority stress as well as homophobic prejudice have been widely researched and continue to be the subject of academic interest. Researchers have spent many decades studying the above-mentioned theories and concepts with the aim of understanding their related consequences such mental health issues, substance use disorders, social issues relating to family and religious dysfunctions and more importantly issues relating to physical health such HIV/AIDS.

Treating LGBTIQ+ individuals requires careful consideration and skill especially when dealing with stressors that are associated with the gay LGBTIQ+ community. Some of the many issues that exist among the LGBTIQ+ community are: Internal and external discrimination and homophobia, relationship concerns, sexual identity/gender confusion, trauma/abuse, body dysmorphia, societal and personal stigma, issues relating to physical and

mental health and substance abuse including sexualised substance use. Although seeking therapy and speaking to someone who has extensive knowledge and experience with issues specific to the LGBTIQ+ community can be helpful, it is important that the therapist should understand the biological, psychological and social challenges facing the homosexual community and tailor the therapy to individual unique circumstances.

When homosexuals decide to disclose their sexuality, there is an inherit fear of how society, family friends and even colleagues at work will receive the news and further fears of being discriminated or victimised. Counselling can be most beneficial to individuals who are dealing with issue of homophobia, internalised homophobia and other related issues such as depression, anxiety, substance use disorders and physical health issues such as HIV/AIDS

However, private counselling can be expensive and unattainable for many individuals and some LGBTIQ+ individuals may experience shame and discomfort speaking about their problems. There are many LGBTIQ+ non-government organisations available to gay men in South Africa, including Men's Health, ANOVA Health and OUT.

Government agencies and NGOs also offer services relating to safe sex and drug use practices. While many organisations promote safe sex practises and abstinence from drugs, some gay men continue to engage in unsafe sex and drug use. In this context a "harm reduction" approach, which entails accepting that drug use will continue but working to mitigate the associated harms, is often the most sensible. Despite substantial international evidence demonstrating the effectiveness of harm reduction strategies in working with drug users (Klingemann, 1996, as cited by de Swart et al., n.d.; Purchase et al, 2006), drug policy in South Africa has generally adopted a punitive stance.

In South Africa, services for LGBTIQ+ individuals who use or abuse substances have primarily been abstinence based. By contrast, Stuart and Weymann (2015) developed a

downloadable Care Plan document which may be used by patients or guide clinicians through some simple behavioural-change steps. The article advises small achievable goals which, when successfully completed, gives the patient a sense of confidence and achievement which encourages greater goals, as opposed to a repetition of failed goals (e.g. abstinence forever) which may then demotivate people.

While treatment centres for any person who suffers from a substance use disorder are available in almost every country in the world, what makes it difficult for gay men, is the stigma that surrounds homosexuality displayed within our community, family and religions experienced by gay men. This leads to the fear of being completely honest and fully disclosing their situation or need for help by health professionals, friends or families. Fear of discrimination and internalised stigma result in delayed health seeking behaviour, or in increased risk-taking behaviours. This often leads to self-medicating, avoiding prevention tests and screening, and approaching health services as a last resort and therefore very late.

Limited research exists on the treatment of substance use for gay men who use drugs specifically with the intention of engaging in sexual encounters and who have developed a substance use disorder through the continuous use of drugs as a precursor to sex. ln an online magazine column titled "*What is chemsex"*, Stuart (2015) states that "the larger majority of gay men seeking chemsex support are not seeking support with a drug problem or an "addiction" issue; mostly they are seeking resolution to the sexual health consequences of their drug use" (para 7). While some men become addicted to drugs, there are also many who never develop an addiction and continue using drugs as a precursor for sex.

According to Anova Health (n.d.) recreational substance use has repeatedly been linked to sexual risk-taking in samples of gay men across South Africa. Driven by the need to implement a more client-centred care for substance-using gay men. Health4Men, a project of the Anova Health Institute, implemented the first pilot harm reduction programme for gay men

in South Africa in 2012, in partnership with Mainline, a Dutch organisation focused on drug use and care for users. The initial programme design was based on Health4Men's experiences of providing clinical and mental health services to gay men, including both injecting and non-injecting drug users in Cape Town.

Harm reduction is a set of principles that guides the treatment of drug-related problems, as well as the development of public policy, that is pragmatic, non-judgemental and client-centred (Hobden & Cunningham 2006). The South African National AIDs Council (SANAC) (2017) implemented the National LGBTI HIV framework (2017- 20122) in collaboration with various other non-governmental organisation (NGOs) to implement HIV and STI prevention, care, and treatment for all members of the LGBTIQ+ community in South Africa. The Plan outlines five interlinked service packages, namely:

> Health, empowerment, psychosocial support, human rights, and evaluation. The Plan also endorses the provision of PrEP for HIV negative gay and bisexual men and Universal Test and Treat (UTT) for all LGBTIQ+ persons (p. 2).

Health programmes such as the above are designed for the general population and adopted for the LGBTIQ+ community and these may inadequately cater for the additional needs of LGBTIQ+ populations. The South African government provides few specialised health and social services focusing on LGBTIQ+ community (Rispel & Metcalf, 2009). An inclusive approach is required that aims to address the determinants contributing to drug use and to provide services that reduce drug related harms.

2.12 The relationship between internalised homophobia and chemsex

Internalised homophobia is a concept that is much more nuanced than its simple definition would suggest. The hateful behaviour of family, church, community and peers has the most profound effect on gay people. When LGBTIQ+ individuals are told by the very

persons whom they trust and look to for guidance that being gay is wrong and sinful, for most part of their life they believe the message as true until they become aware of their sexuality and the concept of homophobia within society. Furthermore, the stigma that surrounds homosexuality displayed within our community, family and religious makes the experience an extremely negative one, which leads to shame and secrecy. This shame and secrecy findings in a strong sense of differentness and of peculiarity which pervades the consciousness of many gay people (Plumer, 1996).

In a qualitative study by Bourne et al., (2016) on chemsex among gay men in South London, recruited 30 gay men for qualitative semi-structured interview were subjected to a thematic analysis and the findings established two major motivational factors for combining sex and drugs:

> The first major group of motivations for combining drugs with sex was that drugs provide the means by which men can have the sex they desire by increasing libido, confidence, disinhibition and stamina. The second major group of motivations for chemsex was that drugs enhance the qualities of the sex that men value. Drugs made other men seem more attractive, increased physical sensations, intensified perceptions of intimacy and facilitated a sense of sexual adventure (p. 1).

Bourne et al.'s, (2016) study points to the importance of acknowledging and understanding the (real or perceived) positive aspects of sexualised drug use that motivate some gay men to engage in it. In a somewhat similar vein, William Fairman and Max Gogarty in a documentary on chemsex presented the culture of drug-fuelled sex parties on London's gay scene (Glyde, 2015) and in it several men who were interviewed presented detailed accounts of wild and blissful sexual highs. However, the participants described their motivations for engaging in chemsex in somewhat less positive terms than those in the Bourne et al., study. They identified internalised homophobia, shame and stigma as some of the motivations for

engaging in chemsex. They stated that using mind altering psychoactive drugs helped them deal with the shame and stigma they experienced growing up as gay men in London.

Stuart (2005), a writer, researcher and gay rights campaigner, narrated his experiences as a gay man growing up, stating that he was subjected to homophobic prejudice and discrimination as an HIV positive gay man. In an interview Stuart (2015) said:

> There is no textbook on how to be a gay man, growing up learning to hide your sexuality is a normality for many people from sexual and gender minorities. Hypervigilance starts early and can become second nature. Until you get on top of those feelings, sex and drugs can be ways to make them go away (n.p.).

This statement shows that, at least in the perception of some gay men, there is a link between internalised homophobia, drug use and chemsex. However, there are conflicting findings on the subject of internalised homophobia and substance use. Some findings suggest that there indeed exists a relationship between internalised homophobia (Dudley et al., 2004; Weber, 2008) and drug use, while other research found no relation between internalised homophobia and drug use (Erikson, 2014; Hequembourg Dearing, 2013 as cited in Puckett et al., 2017).

There are many possible reasons that can account for the mixed findings, including the use of outdated measures of internalised homophobia, use of internalised homophobia scales that are not well validated, and varied measurement of alcohol and drug use (Puckett et al., 2017). As important as these methodological issues are, variations in what different studies choose to emphasise could affect the results and finding of studies with the same or similar research objective. Some place the primary emphasis on the immediate beneficial pay-offs for chemsex participants (increased libido and more intense sexual pleasure), others on possible psychological inadequacies (such as low self-esteem or internalised homophobia) that

subconsciously propel people towards chemsex, and yet others on the possible harms (such as HIV infection and addiction) that might result from chemsex. It seems self-evident that all of the above do provide needed insight into chemsex, but the details of how these different factors play out in the lives of individual chemsex participants still need to be more fully elucidated.

CHAPTER 3

RESEARCH METHOD

3.1 Research design

The study used a qualitative approach involving face to face interviews with the aim of gathering in-depth personal accounts from each participant. The objective of conducting face to face interviews was to find answers to questions in a socially constructed way and to create an opportunity for further interpretation and understanding of the feedback provided during the interview through a probe and response method. Qualitative research focuses on how people make sense of their lives, experiences and the structures of the world and to gain a deeper understanding of the phenomena being studied (DeFranzo, 2011; Meriam, 1998). In achieving this, the research process becomes inductive in that the researcher builds abstractions, concepts and theories from details provided during the interviews (Creswell, 1994).

I focused on the stories of individuals and the social construction of the individual's life, making use of Thematic Analysis to identify patterns or themes within the qualitative data (Braun & Clarke 2006; Taylor-Powell & Renner, 2003). My purpose was to explore the research participants' lived experience in relation to the subject of internalised homophobia and its possible relationship to chemsex.

My focus was on individuals' personal accounts and on describing the stories of each individual, including how they interpret the world from their own personal perspective (Terre Blanche, Durrheim, & Painter, 2006).

3.2 Research area and sample

I identified two avenues for recruiting participants to be part of the study. First, a sample was drawn from the population in a registered LGBTIQ+ friendly addiction treatment centre that is based in a small Karoo town in the Northern Cape. The centre is a long-term treatment facility that caters for individuals who are referred by an addiction treatment facility in Cape Town. In cases where patients require additional care, they are then referred to treatment centre based in the Northern Cape for specialised treatment. The Northern Cape treatment centre is unique in that it has a specific focus and care plan for LGBTIQ+ individuals who have been diagnosed with a substance use disorder. According to their website, they offer anonymous and confidential counselling to LGBTIQ+ people, their friends and family. Counselling is provided to assist people in dealing with issues of: accepting one's sexuality, sexual orientation or gender; or dealing with religious and spiritual issues. To maintain client confidentiality, the practice manager referred suitable patients to me after discussing the detail of my research proposal with them and by first obtaining their expressed consent to participate in an in-depth semi structured interview. The sample from treatment centre are patients who have developed an addiction to one or more substances and are currently undergoing rehabilitation therapy.

The second group of participants was identified from a popular gay bath house (The Hothouse) that is situated in Greenpoint which is in the heart of Cape Town's LGBTIQ+ community. The Hothouse is frequented by straight, gay and bisexual men for various reasons, namely: socialising, enjoying a night out or engaging in sexual activities while maintaining a certain level of anonymity. The Hothouse was selected because it seemed likely that some of its patrons would regularly engage in sexualised drug use but would not currently be under treatment for alcohol or substance related problems. I felt that recruiting this second group of participants would help me to avoid presenting a one-sided account based only on the lives of people who are struggling with addiction. I obtained written permission from the owner of the

Hothouse to place a leaflet inviting participation in the study. I placed my leaflet close to the reception desk where patrons who enter or leave would see it.

My inclusion criteria were simply that participants should be gay men who have participated in chemsex. Biographical details of the sample are presented in the findings chapter.

3.2.1 Brief description of each participant

Below I present a brief description of the context in which I met each participant:

I received a call from the manager at Northern Cape treatment centre who informed me that there are two patients who were interested in being interviewed after reading my research proposal. Based on the travelling distance I decided to stay over at the Tuishuis in town and the next morning met with **Rob** (note that I have changed participants' names to protect their identities) and interviewed him in the family room at the rehabilitation centre. The family room was considered a safe space for the patients. Rob had the opportunity to read my research proposal and was quite open to sharing his experiences with me.

Marcus was another participant referred from the treatment centre in the Northern Cape; however, we only met a month later when he returned home to Cape Town. I received a message from him informing me that he had returned home and was keen to talk to me about his experiences. We agreed to meet at a little quint coffee shop in Blouberg overlooking Table Mountain.

Anthony was the third participant from the Northern Cape treatment centre. I also met with him soon after he returned to Cape Town. Anthony decided to move back in with his family from Mossel Bay, a coastal town situated in the Southern Cape, approximately 400 km away from my home. During a brief visit to Cape Town, Anthony contacted me and agreed to

meet. We sat down in at a quiet little coffee shop in the city centre and proceeded with the interview.

The remaining participants all contacted me after seeing the invitation I left at the Hothouse. **John** and I were previously acquainted, and upon seeing my name on the request to participate form, he sent a message indicating that he was willing to participate. John and I met at his place as he usually works from home and proceeded to conduct the interview at his home office.

During the interview phase of my dissertation, I would drop participation request leaflets at the Hothouse once a week, ensuring that there were always forms available for patrons who pass through the reception area. During one of my visits to the hothouse I came across **Leon** who observed me placing the leaflets at the reception desk. Leon walked over to the table and started reading one of the forms. A few minutes later he asked me if I would be interested in hearing his story. I immediately accepted his invitation and agreed to meet the next day.

Zak contacted me via email in which he jokingly remarked that he loves talking about himself and would be keen to chat to me. We agreed to meet at a mall close to both our homes. We ordered some coffee and began chatting about his experiences. Zak and I met quite late in the evening and the quietness of the shopping centre at the time allowed us the opportunity to have a meaningful conversation without too many disturbances. I really enjoyed speaking to him - he was funny and very open about his experiences and made me feel at ease.

Wayne was another Hothouse patron with whom I had a slight previous acquaintance via mutual friends, so he responded to my request via WhatsApp. Wayne considered himself a regular visitor to the Hothouse and expressed an interest in being interviewed. He jokingly describes himself as young and free to meet men without the hassle of taking them home to

mom and dad. In the gay culture, this term is referred to as NSA (No Strings Attached). We briefly spoke about my dissertation and met over the weekend for the interview at my place.

Beachboy contacted me by email saying that he had been a recovering addict for the last eight years and would gladly speak to me if I thought that it would help. We later agreed to meet at the club house of his complex with a beautiful view of the Atlantic Ocean and began the interview.

Rentboy also responded to my request for participation from the Hothouse via email and, much like Zak, jokingly remarked that he loves talking about himself. I agreed to meet him in Cape Town at which point we would find a comfortable place to talk. When I arrived at his place I waited to meet him outside his apartment building. After a few minutes I saw a young good-looking boy with a very pretty face and well-dressed walking towards me. When we met in public, he seemed very shy and almost paranoid, as if he was being watched. He would take a few steps ahead of me and never made any eye contact during this time. Upon noticing his uneasiness, I eventually suggested that we go up to his apartment and continue with the interview. When we arrived at his place, I observed an immediate change within him - he become more relaxed and eventually made eye contact with me. At this point it felt a lot more at ease and comfortable to talk. He apartment had the most amazing unobstructed view of the entire Table Mountain.

Don is a 47-year single gay guy from the Southern Suburbs of Cape Town who contacted me after reading the Hothouse leaflet. A successful guy who comes from a very conservative family. I met Don at his house in Cape Town and as I walked in the lounge I immediately became aware of the vintage art hanging on the hall and the beautiful antique furniture. Don's persona and character gave me the impression that he comes from a wealthy and well-established family.

I met **Elly** at the hothouse while dropping off a batch of request for participation leaflets at the reception desk. Elly was about to pay before leaving but casually picked up and read one of the leaflets. He told me he would be happy to be interviewed and we agreed to meet later that day at a friend's place in Cape Town. When I arrived at his friend's place that night, I was introduced to two other men, but conducted the interview with them in another part of the house. They returned after the conclusion of the interview, and moments before I left the three guys began snorting cocaine.

3.2 Data collection methods

As shown above, data for the study came from interviews with individuals in a private setting with no distractions and at a time and day most convenient to them. The total number of participants was eleven (11). At the Northern Cape treatment centre, the interviews were conducted in a private meeting room. For participants recruited via the Hothouse, interviews were conducted at a venue convenient to both myself and the participants.

Data were collected using semi-structured interviews. Semi-structured interviews are conducted with an open framework, which allows for focused, conversational and two-way communication. They can be used both to give and receive information. The advantages of semi structured interviews are that they allow the researchers the opportunity to prepare the questions ahead of time and the participants the freedom to express their views in their own terms. Semi-structured interviews can provide reliable, comparable qualitative data and encourage two-way communication (Cohen, 2006). However, conducting semi-structured interviews can be time consuming and the researcher must take care not to design prescriptive or leading questions.

3.3 The interview questions

When designing an interview schedule, it is imperative to ask questions that are likely to yield as much information about the study phenomenon as possible and also be able to address the aims and objectives of the research. In a qualitative interview, a good interview questionnaire requires "a respect for and curiosity about what people say, and a systematic effort to really hear and understand what people tell you" (Rubin & Rubin, 1995, p. 17). It is usually best to start with questions that participants can answer easily and then proceed to more difficult or sensitive topics (Keegan & Ward, 2003). This can help put respondents at ease, build up confidence and rapport and often generate rich data that subsequently develops the interview further.

Through repeatedly revisiting the transcripts, I realised that some themes could have been included and discussed in the findings chapter, but these were excluded. The reasoning for the exclusions was that the topic focused the study on internalised homophobia and its possible relationship to chemsex. Further attention could for example be given to how gay men who participated in a study on chemsex depicted their friends' and families' reaction to their coming out as gay. However, the focus would then have been diverted away from the core purpose of my dissertation.

During the interview process it was important that the researcher remained vigilant about unintentional bias that may influence the research outcome and participants response in relation to the questions asked. Issues of reflectivity, discussed in more detail below may have also limited the outcome and validity of the study.

Structured questions lead to a better management of the interview experience and allowed a sense of control over the approximate time spent with each participant; however, a semi structured interview allows for the participant to share additional information that they

may feel is important to share or that could contribute to the study. A semi- structured interview allows the researcher the opportunity to ask additional questions with the intention of gaining a better understanding or seeking clarity on some of the structured questions which formed part of the set interview questions. The additional questions are referred to as "throw away questions". Throw away questions serve a variety of purposes, used as an aid to build rapport with the participant, on occasion, these questions can be used to relax the subject whenever the interviewee indicates that sensitive areas have been breached (Berg, 1998).

I compiled a list of questions to ask in the interviews, but these were not addressed in strict sequence, thus allowing for some deviation so that participants would feel free to provide additional information depending on the tone and nature of the conversation. The flexibility of this approach, particularly compared to structured interviews, allows for the discovery or elaboration of information that is important to participants but that may not have previously been thought of as pertinent by the researcher (Chadwick et al., 2008).

I tried to address the following questions at some point in each interview, as far as possible first asking about participants' lived experiences before moving on to their opinions about drug use and sexuality. Follow-up questions (given in brackets below) depended on how the participant responded:

- Tell me about your experience of coming out or not coming out as a gay man. (Why do you think is it that you did/have not come out? What challenges have you encountered in your life as a result of hiding your sexual orientation/of coming out? How has coming out/not coming out affected your relationships?)
- Tell me about your experiences with drugs. (Do you take recreational drugs/prescribed medication drugs/drink alcohol/smoke marijuana? How did you first start using drugs? How often do you use drugs? What kinds of drugs do you use? How long have you engaged

in drug use? Have you ever used a combination of drugs at the same time? What was your motivation for taking drugs?)

- Please share your chemsex experiences, whatever comes to mind. (How often have you engaged in chemsex and when do you usually do it? Please describe some of the positive and less positive aspects of your chemsex experiences. How do your chemsex experiences fit into the rest of your life?)
- How do you understand the concept of internalised homophobia? (Do you consider yourself as having experienced internalised homophobia, and if so how do you see it affecting your personal and social life? Do you feel that there is a link between your chemsex experiences and internalised homophobia, and if so how would you describe the link?)

The length of the interviews varied between an hour and ninety minutes depending on the individual interviewed. Some participants were more open to sharing their experiences while others were more selective about what they shared. Building rapport prior to the interview also assisted some of the participants to feel more relaxed and comfortable sharing their experiences, which contributed to the overall time spent conducting the interview.

With participants' consent, I made a voice recording of each interview and transcribed it verbatim, as far as possible noting extra-verbal elements such as sighs, gestures and strong emphasis in square brackets.

3.5 Analysis

Qualitative data analysis tends to be an ongoing and interactive process which implies that data collection, processing, analysis and reporting are intertwined (Creswell et al., 2010). I thus in a sense started the analysis as soon as the first interview got underway and refined my understanding throughout the interviewing process; however, the main analytic labour occurred only after all the interviews had been completed and transcribed.

In approaching the analysis, I drew on two sets of guidelines - a five-step process suggested by Taylor-Powell and Renner (2003) and a six-step process suggested by Braun and Clarke (2006). For the sake of brevity, I shall refer to these two sets of authors as TPR and BC below.

Step One- Both sets of authors recommend starting by becoming familiar with one's data by repeatedly revisiting it. I did this in two ways: first, by carefully re-listening to the interviews in the course of transcribing them, and second by repeatedly re-reading each transcript until I felt that I had a good idea of the key things that were said in each interview. While doing this, I, as recommended by both TPR and BC, made notes of impressions and reflexive thoughts that came to mind, such as patterns that I started to see emerging and my impressions regarding how I could conduct subsequent interviews more effectively.

Step Two- TPR calls this step "Focus the analysis", which involves identifying the key questions that one wants to analyse and answer. This entails reviewing the purpose of the study, specifically in relation to the data obtained, and focussing on what each transcript contributed to providing answers to the research questions. To implement this step, I gave some careful thought to how each transcript helped to illuminate the possible relationship between internalised homophobia and chemsex, as well as the various sub-questions relating to this central focus. BC's second step is called "Generate initial codes" and, although not identical to TPR's step two, it is similar. They suggest breaking up the text into smaller, more manageable units that are coded in terms of different aspects of the research question. BC's and TPR's conception of this step is similar in that it involves relating the text to the research questions in a preliminary way, as a precursor to developing broader themes, but differ in that the BC approach is more comprehensive and systematic. In my case I leaned more towards TPR's conception of this step, but, did do some informal coding and highlighting of sections of text as a means of starting to give structure to my analysis.

Step Three- This step is termed “Categorize information” by TPR and “Search for themes” by BC. The idea is essentially to categorise the information into identifiable themes and subthemes. In order to achieve this, I, as is recommended by both sets of authors, read and re-read the transcripts in order to draw the meanings out of what was said in the interviews and to find potential themes. As can be seen in the next chapter, the themes that suggested themselves to me were mainly a combination of conceptual categories flowing from the research questions and themes relating to various life stages that most of my participants appeared to go through.

Step Four- TPR’s fourth step -“Identify patterns and connections within and between categories” roughly corresponds with BC’s steps fourth step- “Review themes” and fifth step - “Define themes”. The idea is to refine what each theme is about by reviewing what elements are subsumed under it and by considering how it relates to other themes. To implement this theme, I looked carefully at the sections of transcripts that I had identified as somehow belonging to or illustrating a theme and tried to make sense of the similarities and differences in people’s responses within each theme. I noticed, for example, that although a clear theme of progression from less to more hardcore drugs seemed to be present in most transcripts, there were some notable differences with regard to exactly how this played out, which required that I had to be more specific about how I defined the theme.

Step Five is called “Interpretation” by TPR, which corresponds with BC’s step 5 - “Writing-up”. This step entails using the identified themes to explain the findings. The key here is to focus on communicating the analysis to third parties (e.g., the readers of a thesis) in a way that is compelling (it can include visual displays and tables) and believable. Ideally this should be much more than simply summarising the data; a good thematic analysis interprets and makes sense of the data. My efforts in this regard can be seen in the following chapter.

3.4 Ethical considerations

Ethical issues were especially important in my study as it involved both a sensitive topic (unconventional sexual behaviour and possibly illegal drug use) and, arguably, a vulnerable group (people who have experienced homophobia and who may be experiencing psychological struggles regarding their drug use and sexual identity). I structured my approach to the ethics of the study using a useful set of five recommendations provided by Smith (2003):

First, discuss intellectual property frankly. For my dissertation research this is not much of an issue, since I am the only author, but I do understand that my supervisor may be interested in being the second author of an article flowing from the dissertation.

Second, be conscious of multiple roles. Multiple roles are not per definition unethical, but, require extra caution to ensure that there is no abuse of power or intimacy. For example, if academics invite students to participate in a study they should make it clear that nonparticipation will not affect their course grades. In my case the issue of multiple roles was quite important. In several cases participants knew me in more than one role: as researcher and MA Psychology student, as some kind of professional connected to the management at the Northern Cape treatment centre, and as an acquaintance from Cape Town's gay social scene. I tried my best throughout to convey to participants that I was engaging with them purely as a researcher and that our interaction would not have any spill-over into other realms. I informed all participants at the outset that I could refer them to professional counselling should they feel the need for that. In practice, none took me up on the offer. However, several did engage with me in a manner that was suggestive of seeking advice from a psychological professional. In such cases I tried to give honest and kind responses regarding my opinions, but, made sure to point out to them that I am not a qualified psychologist. There were also a few participants who seemed inclined to involve

me in more informal social interaction, but I politely declined explaining that this would jeopardise the 'objectivity' of the research. Overall, my aim was to ensure that the interviews were conducted without any undue influence and that the participants felt comfortable being interviewed. My point is that there were no major lapses in this regard.

Third, follow informed-consent rules. Informed consent is the best-known ethics issue, and I made sure that I followed the APA (2000) Ethics Code in this regard to the letter, informing participants in detail about the purpose of the research, the expected duration of the interview and procedures such as signing an informed consent form *prior* to starting the interview. I also informed participants about: their rights to decline to participate or to withdraw at any time; the sensitive nature of the interview; potential risks; who I would share the interview transcripts with (only my supervisor); how I would archive the voice recording (kept on a secure password protected device, to be deleted five years after completing the dissertation); who participants could contact with questions or to report any unethical behaviour; and how the material would be published in a way that would not reveal their identities. I provided each participant with a detailed written explanation (see Appendix A: Participant information sheet/ volunteer request) of the study and the above issues, which I then again discussed with them prior to the interview. Each participant also signed a written consent form - see appendix B.

Fourth, respect confidentiality and privacy. Management at Inner Peace knew which of their clients agreed to be interview by me, but other than that I did not reveal participants' identities to anybody. I kept voice recordings of all interviews on a password-protected device and transcribed the interviews myself. The transcription files were also each individually password protected. I used pseudonyms throughout the transcriptions and changed some biographical details in cases where I thought they might compromise a participant's right to confidentiality.

Fifth, tap into ethics resources. In my case, this involved studying APA ethics guidelines and applying them, as best I could, to my study, but also to draw on the resources available at my University, including formal guidelines provided by the Department of Psychology at Unisa, advice from my supervisor, and guidance from the Ethics Committee at the Department of Psychology, from whom I obtained formal clearance for the study (see Appendix C) from the department of Psychology at the University of South Africa. My ethics clearance reference number is: PERC- 17033.

3.5 Reflexivity

In all research, but especially qualitative research, the researcher should be mindful of his or her personal strengths and biases. Denzin and Lincoln (2000) argue that "behind the theory, method, analysis, ontology, epistemology and methodology of qualitative research, stands the personal biography of the researcher who speaks from a particular class, gender, racial, cultural, and ethnic community perspective" (p. 18). Just as the artist is the primary instrument in painting, the researcher is the primary research instrument in qualitative investigation (McCaslin & Scott, 2003). Therefore, it is important for the reader to have a level of understanding of the relationship the researcher has with the research question and with the participants.

I tried to attain a level of reflexive awareness by writing down my own experiences and feelings with regard to homosexuality, drugs and sex - part of which is reproduced in Chapter one. This helped me to understand some of my own strengths (for example, as a gay man who comes from a conservative religious background I have intimate personal familiarity with issues of homophobia and internalised homophobia), but also my own potential biases (for example, I do not use alcohol or drugs and so tend towards something of an outsider's perspective on these matters).

I also did some “member checking” by speaking to participants and others about my emerging interpretations and by keeping a reflexive journal. As Hibbert, Coupland and MacIntosh (2010) put it:

> The process of reflection suggests a mirror image which affords the opportunity to engage in an observation or examination of our ways of doing, or observing our own practice, whereas reflexivity is more complex, involving thinking about our experiences and questioning our ways of doing (p.1).

In line with this statement, I tried my best own up to my own biases and assume a neutral stance free of biases so as to reach credible and unbiased conclusions

CHAPTER 4

PRESENTATION AND ANAYSIS OF FINDINGS

4.1 Introduction

In this chapter I endeavour to elucidate the psychosocial dynamics of sexualised drug use (‘chemsex’) by gay men in relation to coming out and internalised homophobia. I further endeavour to explore if a relationship exists between internalised homophobia and chemsex in the lives of gay South African men, and if so what the nature of the relationship is.

Homophobia is one of the major forces that gay people must deal with in our society, and it in some instances gives birth to internalised homophobia a phenomenon within an individual that is incorporated by societal norms and external pressure as expressed by societal

forces directly (Katz-Wise, Rosario & Tsappis, 2016). In simpler terms. internalised homophobia is the acceptance and projection of negatives societal view about gay people on the self. Homophobia and internalised homophobia, as stated will also be discussed in relation to chemsex. Sexualised drug use, often called 'chemsex' or 'party and play', is the practice of intentionally using drugs before or during sex to increase both sexual pleasure and arousal, and is practised mainly by gay, bisexual and other men who have sex with men (MSM) (Kirby T &, Thornber-Dunwell M, 2013).

In the chapter, pseudonyms will be used to identify the participants so that their identity is not compromised. I will begin by presenting biographical information about the participants, providing a pen-sketch of each participant, and then continue to explore themes that arose from the interviews using the analytic approach described in the previous study.

4.2 Getting to know the person behind the story

Eleven men between the ages of 24 and 50, who were living in Cape Town at the time of research and had a history of substance use or abuse, and who identify as gay were interviewed. Biographical information about the individuals is presented in Table 4.1, which includes the individuals' pseudonyms, age, relationship status, employment history and residential area.

Table 4.1. Biographical details of the participants

Pseudonym	Age	Relationship status	Employment	Residential area
Elly	43	Single	Employed	Moved back to Montague but previously stayed in Cape Town
Rob	43	Single	Former sex worker and currently unemployed	Maitland

Anthony	28	Single	Call centre manager	Mossel Bay
John	30	Single	Accountant	Bellville
Leon	48	Single	Unemployed	Parow
Marcus	40	In a relationship	Medical doctor and currently unemployed	Milnerton
Wayne	41	Single	H R Officer	Paarl
Zak	47	Single	Self employed	Milnerton
Beach boy	38	Single	Web developer	Sea Point
Rent boy	26	In a relationship	Male escort	Cape Town, CBD
Don	50	Single	Advertising producer	Plumstead

Elly is a 43-year-old, who has experienced many hardships in life and this was evident in his lack of personal hygiene, self-care and stressed physical appearance. Elly had a condition referred to as “meth mouth” (severe tooth decay) that is thought to be caused by a combination of the side effects of drugs, a common occurrence when someone has uses excessive amounts of crystal meth over an extended period of time. Although Elly no longer considered himself a drug addict, he admitted to using drugs on rare occasions when visiting friends in Cape Town or the odd visit to the Hothouse.

Rob is a 43-year-old who, since leaving home at the age of 20, has never found a place that he could call home and his only means of survival was by becoming a sex worker. Coming to Inner Peace was the first time he experienced some kind of peace within himself and a place that felt like a home to him. Rob spent three months at Inner Peace and remains committed to maintaining sobriety and finding a healthy life path that no longer includes drugs and escorting. Prior to conducting the interview, I noticed that Rob was wary of me and it took him a while before he felt comfortable enough to open up and start talking to me about his experiences.

Anthony is a 28-year-old who was well-groomed, and came across as a confident and attractive guy. Anthony spoke candidly about his experiences and I sensed that he felt comfortable speaking to me. He started the conversation by mentioning that he lost his job due to his drug abuse and that he has taken the matter to the Council for Conciliation, Mediation and Arbitration (CCMA). He also suffers from depression and is currently being treated with antidepressant medication. I was most impressed with how Anthony remained positive about his outlook on life and by how determined he was to overcome his setbacks in life.

John is a 30-year-old whom I had previously met socially at the Hothouse in Greenpoint, Cape Town about 5 years ago. Subsequent to our first meeting we connected on Facebook, but never maintained a close friendship. John represents the typical well-built, attractive looking confident guy you would find in the gym, overtly obsessing about his body and looks. However, during our interview I learnt that John was actually quite shy and insecure. He explained that he had great difficulty with his weight and was bullied as a child for being the fat kid at school. John saw my call for participants at the hothouse and made contact with me and even though we had a prior acquaintance, I agreed to interview him, but remained mindful of maintaining professional boundaries and strict adherence to the ethics requirements from the university's ethics committee. John continues using drugs but has a desire to stop and approached his local church for support.

Leon is a 48-year-old who lacked physical care and personal hygiene. It was evident that he had suffered a great deal of hardship in the past and that circumstances in life resulted in him returning back to his family home. There were moments during our interview where I felt a sense of discomfort, more especially when he asked me personal questions and enquired if I had ever engaged in drug use or if I would consider doing it once off. During my interview I learnt that he would entice younger men or boys by offering them drugs with the intention of

disinhibiting them so that they would become more amenable to chemsex experiences. Leon continues using drugs specifically for chemsex experiences.

Marcus is a 40 year old gay male who was in a relationship at the time of the interview and who was employed as a medical doctor. Marcus rarely maintained eye contact with me whenever he spoke about something relating to his drug use and chemsex experiences. He also became quite anxious and I noticed how he fidgeted with his hands while gazing at the floor as he continued speaking. Marcus mentioned that he had been diagnosed with major depressive disorder and general anxiety disorder, which may be a result of his excessive drug use. Marcus is currently a recovering addict and said that he would like to maintain sobriety.

Wayne is a 41-year-old, well-groomed man who was quite friendly during our interaction. I sensed that at times Wayne became slightly withdrawn and nervous during the interview; however, he remained engaged, answered all my questions and was very honest about his personal challenges, including his HIV diagnosis. Wayne mentioned that he has never considered himself addicted to drugs and that he prefers using drugs to enhance his sexual experiences.

Zak is a 47-year-old who looked much younger than his age. He had a laid-back character and a great sense of humour. Zak previously lived and worked in the United States and shared quite a bit of detail about his life spent overseas, including his experiences with chemsex. During the 2010 soccer world cup, he returned home and made the decision to stay in South Africa. Zak currently lives at home with his father and is trying out new business ventures.

Beach boy is a 38-year-old. He was eager to participate in the interview but made sure that he checked the authenticity of my research before agreeing to meet with me. We sat down to conduct the interview at his apartment in Sea Point, which is situated on the main road

overlooking the Atlantic Ocean. Beach boy's physical appearance resembled the typical pretty boy that one would expect to find on the scenic Cape Town beaches. During our interview, he mentioned that he has been in recovery for the last eight years and found the motivation to be drug and alcohol free by maintaining a close relationship with his family, keeping his body fit and maintaining a positive outlook on life.

Rent boy is a 26 year old male escort who, surprisingly, came across as extremely shy and self-conscious when we met at the coffee shop across the road from his apartment. I noticed that he was extremely conscious of people watching him. As soon as this behaviour became apparent to me I immediately suggested that we go someplace private. We moved to his department, and Rent boy appeared to feel more relaxed and comfortable in his personal space and began speaking to me with more confidence. During our interview he started smoking some substance which I think may have been Mandrax. As the conversation progressed I sensed that he was actually very lonely and that he appreciated the company. I also learnt a great deal about the gay male escorting industry.

Don is a 50-year-old who came across as someone who was very set in his ways. During the interview, I gathered that he was clear about his preferences in life. As a single man he enjoys the freedom of doing whatever he wants, which includes using drugs to enhance his sexual experiences. Don was not very open to sharing parts of his sexual experiences and his feedback seemed rather evasive at times. I at one point felt like ending the interview as I felt that he was not really forthcoming in response to my questions but decided to continue and complete the interview as agreed.

As is usual in qualitative research, the participants are not meant to form a representative sample of the larger population of chemsex practitioners. But still, I was pleased to be able to gain access to such a diverse group of men, with a variety of different life histories and currently finding themselves at different points in their engagement with sex, sexual

identity and drugs. Among other factors, the differences in age among the participants ensured that there was considerable variety in the nature of their encounters with (internalised) homophobia and drug use. For example, Don grew up in an era when homosexual acts were firmly taboo (and illegal), whereas Rent boy was still a toddler when homosexuality was legalised.

Despite this diversity, there were some commonalities in the sample. Most were single, which probably made it easier for them to engage in chemsex. All were users or former users of drugs and all had in the past engaged, or still continued to engage in chemsex. Although some of the participants were unemployed, most were people who held reputable jobs such as medical doctor, web developer, accountant, advertising producer, call centre manager and so on. This shows that drug use is not selective and does not discriminate against socioeconomic status, race or age. Some of the participants had, however, lost their jobs due to drug use, as will be shown later in the chapter.

An interesting observation is that more than a half of the sample interviewed were in their forties and when I reflect on the possible reasons for why this may have occurred, my automatic response is to consider the generation in which they were raised. Anyone within their forties was raised during the late 1970s. I asked myself what life was like during the 1970s in South Africa and across the world and if this had any bearing on why most of the respondents were in the said age group. This is a point for further research, exploring how different eras affected gay people and to what extent colonialism or apartheid promoted homophobia and internalised homophobia in gay men. The apartheid era can also be compared to the post-apartheid era where there is better acceptance of homosexuality.

4.3 Defining the term homophobia and internalised homophobia

Homophobia and internalised homophobia are two concepts that are not exclusive of each other. Throughout life there appears to be a continuous play between homophobia and internalised homophobia as shared by the individuals whom I have had the privilege to interview.

During the interviews, I began by asking the participants to tell me about their lives and experiences as gay men who are using or used drugs in the past. My intention was for each participant to start by engaging with the lived realities of their life histories rather than to jump directly to abstract, theorising about issues such as internalised homophobia. This means, the discussions about internalised homophobia and its possible link to chemsex came towards the end of each interview. However, in terms of presenting findings from the interviews here, I switched the sequence around and started by describing participants' responses when asked directly about internalised homophobia. This is in order to facilitate reading participants' accounts in the context of their explicitly formulated understandings of internalised homophobia.

I asked each participant if he was familiar with the term internalised homophobia and if he had experienced internalised homophobia in his life. Most of the participants were not familiar with the term but had experienced or observed homophobia. John said: "I know what homophobia is but I don't know what internalised homophobia is." Don expressed the same sentiments by saying "I read about it in your proposal but only know more about homophobia." Leon confused homophobia and internalised homophobia by saying:

> Is it like when people don't accept you're gay and would think badly of you. These people in the complex… I think they know I'm gay and when they see me with a guy coming into the complex it's like they're judging me, especially if it's a non-

white…. There was once a situation where these men were breaking into people's houses and cars and everyone thought I was involved because they see me with a different guy and sometimes with a non-white. I don't understand them.

What Leon is describing is a homophobic experience whereby he is suspected of crimes he did not commit simply because he is gay. Rob also confused the two terms: "I think it's what we actually tell ourselves or what we don't like about the next person's choices we create a kind of a barrier and we discriminate based on that." Table 4.2 summarises the level of understanding of the concept of internalised homophobia among the participants.

Table 4.2. Participants' definitions of internalised homophobia

Name	**Definition**
Elly	You have to conform to other people's views and their norms… That is what I understand by it.
Wayne	Internalised homophobia is probably when you realise you're gay but you haven't come to terms with the fact that you are gay and that you're not quite openly gay or you are gay but you don't want the world to know that you're gay or you have certain qualms about being gay.
Zak	Uhm self-loathing gays? There is a lot of guilt associated when you linked to religion and stuff.
Beachboy	Yes, I read the information sheet you sent me.
Rentboy	Explain it to me…Oh okay it is almost like my ex-boyfriend, the way he dealt with life.

Don	I read about it in your proposal but only know more about homophobia.
Anthony	Yes much like what I explained earlier about what my parents said about being gay and the force I felt to get a girlfriend.

Elly, Wayne and Zak seemed to have a better understanding of what internalised homophobia is, though Elly and Zak did not fully understand the concept. The majority (8) of the eleven participants either did not know or confused the term with homophobia. Marcus was the only participant who was able to provide a compelling definition of the concept:

> So it's uhm, where I have taken the external homophobia that is around me that people in society display and that is evident in the world around me and I accepted it as something that is part of me. I take it into myself that I feel badly about myself because other people have been negative towards who I am or me being homosexual.

Elly and Zak had read some literature on internalised homophobia hence their limited ability to explain what the term means. Given these findings, it is safe to assume that only one participant knew about internalised homophobia before coming into contact with the research leaflet.

Based on the feedback received from the participants interviewed, it can be hypothesised that the concept of internalised homophobia is somewhat poorly understood within the LGBTIQ+ community. Although some of the individuals have a partial understanding of the concept of internalised homophobia, it was clearly not something that they commonly thought or spoke about. I am of the view that gay people need to be conscientised about internalised homophobia because understanding the concept of internalised homophobia can present many benefits to people who may be subject to such

experiences by helping them place the feelings of self-hatred in the context of the larger struggle for the acceptance of gay identities.

4.4 Lived experiences of homophobia and internalised homophobia

After explaining and discussing the meaning of internalised homophobia with participants, several shared accounts of how they internalised the homophobic views of others, which caused a great deal of confusion, as well as feelings of shame and despair. They experienced internalised homophobia, without knowing what they were going through and how wide-spread the phenomenon is among gay people.

Like many gay men, the participants in this study faced challenges unique to being gay and experienced various taunts, stigma, prejudice and even threats based simply on their sexual preferences. Some of the participants were subjected to rejection and even abuse by family members. Of the eleven participants, eight left home at an early age and two ended up on the streets at some stage in their life. It is of course impossible to tell with certainty, but it seems possible that for some of the participants' experimentation with drugs and sex was an outlet for the inner pain and rage resulting from being rejected by family or judged by society. It is also possible that drug use facilitated (gay) socialising for the few who were accepted by their families.

It is highly likely that most of the participants in this study who are aged forty or above were subjected to a greater degree of anti-homosexual discrimination during their adolescence and young adulthood than the younger ones because, pre-liberation, social norms and the legal frameworks were much less accommodating of homosexuality. Anti-homosexuality sentiments that were prevalent during the apartheid era may have contributed to their turning to drugs as an outlet and means of socialisation in the face of a condemning society.

Rob, who is 43 years old, was one of the participants whose early socialisation occurred at a time when homosexuality was still very much taboo. He was raised in a religious family and growing up he was subjected to many cultural and religious beliefs that were not supportive of homosexuality. He believed in God and Jesus and based on the version of the Christian faith that he was taught, he understood homosexuality to be a sin. As soon as Rob started having feelings for other men he felt that his thoughts and feelings were against God's teaching and that he was committing a sin. Rob turned to religion and asked Jesus to help him to make his feelings for men go away. He said" I prayed to Jesus and whatever but it didn't go away, so I just made a pact with Jesus to try get me out of this", by which he meant his current living situation. Rob eventually left home, without the security of having a place to stay or money to buy food. He was determined to get away from his adopted family who at the time were not accepting of his sexuality. Rob took a leap of faith and decided to find accommodation in Cape Town, where he later met new friends and started having sex for money.

From this account, it is clear that Rob experienced a degree of internalised homophobia in that he internalised anti-gay religious doctrine and family traditions and culture and consequently believed that his feelings for men were sinful and wrong. He also tried to 'fix' his unacceptable homosexuality with the help of Jesus. For years he believed he could pray away the situation and this was born of his desire to be a 'normal man' who has feelings for women. Eventually, he did come to some form of self-acceptance in the sense of accepting his homosexuality as an immutable reality (even though an unwelcome one) which could only be managed by removing himself from the hostile family environment.

The pain of internalised homophobia in a religious family environment is also evident in Wayne's story:

> You know growing up as Christian and having these biblical beliefs that you know a man should not be laying with another man all of these things that is how I was taught in church. I knew that what I was doing is wrong so I had mixed feelings afterwards.

From the statement above, it seems Wayne was conflicted by his feelings for other men as they contradicted what was taught by his faith. The Christian beliefs taught to him as a child about homosexuality made it difficult for him to reconcile his feelings for men with the teachings of his faith. Wayne's feelings are common in gay people who come from strong religious backgrounds and the conflict usually results in internalised homophobia and slows down the process of coming out.

When I spoke to Wayne, he mentioned that he would still very much like to maintain a relationship with his faith and become more steadfast in church. He says that having sex is amazing and feels good but the relationship with God and his spirituality is equally as important. However, stated that taking drugs helps him to forget about the constant battle in his mind and, for a few moments, he feels liberated and free to have great sex with men without any nagging thoughts that he is committing any acts of sin; however, soon after the drugs wear off he feels dirty and impure again. Wayne also mentions that in order to gain a closer connection with God, he must refrain from having sex and drugs (taking into account that his drugs is a precursor for sex). It seems fairly clear that Wayne's account is indicative of someone who has internalised the negative views of his faith regarding homosexuality. The conflict inside him has bred a dependency on drugs that promote his participation in chemsex. Wayne's story shows that there is a direct link between internalised homophobia, drug use and to his participation in chemsex.

Another participant who seemed to have internalised homophobia as a result of religion is Beachboy who recounts:

> I was 14 the same time I had sex with a guy who was actually from my church. We were the same age and good friends and I think three weeks after we were in church and the dominee preached about something like no man shall lie with another man. I remember we still looked at each other and were like "We are so fucked!"

Despite the fact that Beach boy had been engaging in same sex relations since the age of fourteen years old he only came out to his parents at the age of twenty-one, for fear that he may be rejected by his parents whom he describes as very religious and conservative. Beachboy internalised the dominee's preaching and felt that he was acting in sin and will be punished, and only seven years later did he have the courage to come out to his family. The statement, "like we are so fucked" nevertheless has clear humorous overtones and is suggestive of the secret camaraderie in the face of adult censure that is a staple of youth-oriented novels and movies. It would therefore be a mistake to view somebody like Beachboy's internalised homophobia simplistically as a matter of swallowing negative judgements of one's sexually 'whole'. There is resistance in the form of he and his friend's humorous, sarcastic (and above all secret) commentary on the dominee's pronouncements, and, as was the case for Rob, eventually there is a measure of self-acceptance – at least to the extent of accepting that his sexuality would not change and would have to be declared to his family.

Prior to coming out, Beach boy suffered through a great deal of shame and confusion brought on by his family and their religious views of homosexuality. He mentioned that "it took me a long time to process and to deal with, I was struggling to come to terms with you know… I am gay and you know it is just how it is".

Several of the participants had difficulty coming out to their parents based on religious doctrines and for fear of being rejected by family who were described as religious and

conservative. When Rob, Wayne and Beachboy internalised the biblical views of homosexuality (or at least conservative interpretations of the Bible), they in doing so rejected their true sexual identity which was further reinforced by the fear of being rejected by family and friends.

Apart from religion, many communities irrespective of race have negatives perceptions of gay people, and as such, gay people struggle to open up about their sexual orientation for fear of judgement. Participants internalised society's views of homosexuality in various ways. Reflecting on the accounts it is evident that each individual's experience was unique; however, there are common themes which can be derived from internalising the homophobic beliefs of others. Much like the internalised views of religion, some of the prominent themes included fear of being abandoned, pressures to conform to a heteronormative lifestyle, and feelings of shame.

Marcus started having feelings for boys at the age of fourteen, and even though he realised that he was gay, he kept his secret from his parents until the age of nineteen. At this point, he again developed feelings for a boy and, as the story unfolds, his parents got to know about his sexuality:

> She started crying and then my dad like pushed us all off into a room so that the rest of the family wouldn't hear the conversation. It was quite intense. I ended up crying while they were talking, but they didn't understand and they just kept asking me stupid questions like why? And have I tried going out with girls and uhm, like how could I do this... . I was trying to explain that I didn't have any choice in the matter and that if I … like if I were … if I had any choice do they really think I would have chosen to be gay. I was getting so frustrated. I actually ended up rolling on the floor in pain and then they just … they didn't … my mom

> wouldn't talk to me about it anymore … like after that my mom would talk to me about very trivial things. She basically wasn't speaking to me… just like cordially and politely. It was like this for about 4 years. I felt very rejected, very isolated and I felt shame. I felt like there was something wrong with me.

One could hardly wish for a clearer statement of internalised homophobia: "I felt there was something wrong with me." Marcus's story captures the journey that is commonly travelled by gay people when they discover that they are gay. Most boys realise their attraction to other boys during their teenage years. Graziano (2005) explains this about this stage:

> In the awareness phase of individual sexual identity, individuals are aware of feeling different from the heterosexual norm; however, same-sex thoughts and feelings do not imply self-labelling. The affective state of the individual is likely to include confusion, fear, and/or bewilderment.

Marcus felt guilt and shame because his sexual feelings did not fit in with the expectations of his family and community. His situation was worsened by the taunting and bullying that he experienced at school for being different. Research suggests that gay and lesbian students are victimised at a far higher rate than others on college and university campuses with rates four times higher than the rate of victimisation reported for the general student population (Comstock, 1991). The victimisation can include being chased or followed; having objects thrown at them; being punched, hit, kicked or beaten; being victims of vandalism or arson; being spat at; and, in some cases, being assaulted with weapons (Comstock, 1991). This means Marcus was carrying a lot of emotional and physical pain from being rejected and bullied by his peers. This is a huge burden for a teenage boy who is already confused by his feelings. In addition to his confusion, he lived in fear of being discovered and rejected by his parents. Marcus's story captures what being different is like in a rigid society.

Marcus' coming out moment is nothing but traumatic and it also reveals family bigotry. When Marcus' family discovers that he is gay at the age of nineteen, instead of accepting him, his family tries to force him back into being 'normal' according to their standards. They ask him why he chose to be gay as if it is a fashion he chose to align himself with. The pain of internalised homophobia is captured in the statement, "I ended up crying while they were talking but they didn't understand". Marcus' family reacted from a point of ignorance and intolerance. Instead of hearing his story, they judged him in line with their beliefs of what a man is and the kind of relationships he should have.

Marcus also expresses the pain of finding out he is different and has no power to change the situation which shows he had not fully accepted his identity as a gay man. His family compounded the situation by being insensitive, leading to much physical and emotional pain. The moment of "rolling on the floor in pain" is a culmination of all the internalised pain and torture he went through in the past, combined with the pain of his family rejecting him**.** Berg, Munthe-Kass and Rose (2016) explain that legal restrictions on same-sex relationships, hate crimes against gays and lesbians, bullying of gay teens, and familial and social rejection of homosexuals are examples of heterosexism that denigrate and devalue non-heterosexual forms of identities, behaviours, relationships, and communities. Such behaviours promote internalised homophobia, which can still happen after coming out. The person will be out but still at some level loathe themselves for being gay.

After coming out or being discovered, Marcus' fears of rejection are realised. His mother pretends the conversation did not happen but is cordial as if talking to a stranger, which is a form rejection. His family's reaction borders on mental abuse and it reinforces his self-hatred and sense of shame. The external prejudice, stigma and even abusive attacks by his family and school friends had a direct impact on his mental health and social interactions with

other people with whom he met during his adult life. All these experiences could have driven him to drugs and chemsex.

Anthony also suffered because his family had opposing views to this homosexual identity. In his account, he recalled the moment of telling his mother about his sexuality as follows:

> Her response was: "What did you say?" I replied "What if I'm gay?"… and she continued to say "but you can't be gay .. gay people get AIDS and stuff like that"…. But I said … "I'm gay!" My mother then said to my dad "why don't you just hit him or talk some sense into him?"

Anthony's mother was afraid for her son, fearful that he may become involved in unsafe sexual practices and end up with HIV. Anthony eventually rejected his family's views on his sexuality and left home, soon after which he met a loving guy and enjoyed a loving stable relationship for the next four years before they broke up. The stability of his relationship gave Anthony a sense of 'normality' which fit with his parents' view of what a relationship should be like. Anthony described his relationship as the kind of relationship that would make any parent proud which shows that he mirrored and judged his relationship in terms of heteronormative relations. His fiancé was a non-drinker or smoker, with a great job and came from a respectable wealthy family. Anthony's parents were also quite prominent in their community and with the similarities between the families, they began to accept the fact that their son was living with another man. After four years, the relationship ended and break- up with his fiancé represented an end of a life that mirrored his mom and dad's relationship, which is a sign of internalised homophobia. Anthony once again felt lost and a sense of emptiness, together with many of the feelings experienced by internalising others' views of homosexuality.

What can be said about the accounts that are presented above is that family acceptance is an important factor in the coming out experiences of gay people. The participants who come from strict and religious backgrounds suffer mostly because they face antagonism from the church, community and worse off from the family. Societal, religious and family bigotry provide a fertile ground for internalised homophobia to flourish and internalised homophobia breeds a lot of negativity including fear, shame, low self-esteem and loneliness.

As narrated in the personal accounts of the individuals interviewed, five participants appear to have internalised their families' homophobic views, which affected their coming out and as a result the course of their entire life, while some participants internalised religious and societal views but were nevertheless accepted by their families. A few participants were accepted by their parents and loved just the same irrespective of their sexuality when they came out.

From the presentation above, it is clear that the concept of internalised homophobia, is a subjective experience that can reveal itself in various ways over a period of time, as illustrated in Marcus and Anthony's stories. It is not as simple as taking on another's view of homosexuality and then deciding not to come out as LGBTIQ+. Some of the individuals interviewed were never rejected by their families or friends, notably John and Don. From what participants told me, my impression is that internalised homophobia can be much more subtle than the standard academic definitions make it appear. I personally have issues with internalised homophobia, despite the fact that I live a perfectly open gay life with my fiancé, in that I limit my association with other gay men who I consider to be feminine or flamboyant. I have somehow internalised the view that a man should act like a man and it will require deeper reflection and time to change my views. All eleven participants, in my view, experienced some form of internalised homophobia in that by simply denying their sexually for whatever reason,

they have internalised negative views of homosexuality. However, this manifested differently in each case and seldom seemed to resemble a 'textbook case'.

4.5 Coming out and its challenges

The term 'coming out' is commonly used to refer to an individual's self-disclosure about their sexual identity or sexual orientation. Coming out is not always a once-off process, and for some LGBTIQ+ individuals coming out is never an option. Internalised homophobia, external homophobia, and minority stress are some of the reasons why people choose not to fully disclose their sexual orientation. Family members react differently to the news, with some accepting and embracing the individual's coming out while others go into denial or reject the person and at times abuse the person in a bid to normalise them. A prominent theme that emerged from the interviews was that of leaving home soon after coming out, based on the fact that families were not accepting of the sexual disclosure.

Elly had this to say:

> When I was 17 years old my family were in denial, I certainly weren't and uhm most of my immediate family like my siblings and them didn't accept it and so I thought I wasn't going to make myself unhappy in order to please other people. So what I did was, I left home. I ran away from home. My parents never knew where I was for like two years and that also resulted in some major other challenges in my life because what I should have been doing is studying and doing things and all that - instead I ran away from home because I was unhappy.

Elly's insistence that he was not in denial, together with his decision to please himself rather than his family, are strongly suggestive of resistance to being pushed into a position of internalised homophobia – unlike his family, he refused to deny the fact of his homosexuality. However, as with several of the other participants, the solution – to 'run away from home' –

came at a price. He lost an opportunity to further his studies that could have changed his socio-economic status. Rob reacted in a similar way to his family's lack of acceptance:

> I decided to leave because that they weren't going to accept my decision or my sexuality… so ya…but actually I decided to leave because the house is too strict for me I wanted to party because I was young at the time and wanted to do all my shit that I wanted to but I could not do it in the house…you know I could not even do it in that area where we lived…. I probably could… but I mean not to the …at the liberty that I actually wanted too. You know town? I love town.

Both Elly and Rob had no place to go, but they felt that they needed to liberate themselves from their prevailing situations. They were at peace with their sexuality (at least to the extent that they accepted it as an incontrovertible fact) and felt restricted by their prevailing environment. They made a brave decision to leave home despite not knowing where their next meal would come from. During the interviews, they shared many stories of the challenges they faced and decisions they made that were not always in their own best interest. Similarly to Rob and Elly, Anthony also decided to take an 'escape route', but in his case he planned his escape for two years subsequent to coming out:

> They never accepted it, so for two years I faked my life. I did what they wanted me to do and said what they wanted me to say. I went to church, I took part in youth activities just to cover it up but I still couldn't go to the library on my own. The only person they would let me go to was the girlfriend. But at the back of my mind I planned my escape of how I am going to run away after I get my matric certificate. The day I got my matric certificate my bags were packed already and I packed my bags and at that time I was working part time at Mug & Bean.… I saved so much… now imagine an 18-year-old with R18000 and I had

> to come to Cape Town and do something with that… That was December. I took my things and I moved to Cape Town.

Anthony's parents planned to send him to university and would have cared for him until he graduated from university, but he felt untrue to himself and the feeling of being trapped motivated him to leave home without thinking of consequences of what may happen thereafter.

Elly, Rob and Anthony left home because they were rejected for being true to themselves. According to Erik Erikson's theory of Psychosocial Development cited by ("Psychology Notes HQ" 2017):

> We all encounter a certain crisis that contributes to our psychosocial growth, and whenever we experience such crisis, we are left with no choice but to face it and think of ways to resolve it. Failure to overcome such a crisis may lead to significant impact on our psychosocial development.

Erickson refers to Fidelity and Identity versus Role Confusion as important life tasks for adolescents between the ages of 12 and 18 years. Questioning of the self is normal at this life stage: "Who am I? How do I fit in? Where am I going in life?" The adolescent is exploring and searching for their own unique identity. Erikson believes that if parents allow the child to explore, they will discover their own identity. If, however, parents continually push him or her to conform to their views, the teen will face identity confusion. In the case of Elly, Rob and Anthony they were never accepted so they opted to leave home and find a community where they could fit into. Later in the chapter I will revisit the choices made by these individuals and the resultant effects later in their lives.

In the study, another theme that was prominent was of concealing one's identity after discovery and for some, for many years in a bid to fit in. However, concealing one's identity can interfere with forming and maintaining close relationships, psychological and physical ill-

health (Ryan et al., 2015). At the time of concealment, most participants were not in fulfilling relationships and the exercise of concealing their identity impacted negatively on their emotional and psychological well-being. Internalised homophobia, concealment and low self-acceptance provided fertile ground for emotional problems and drug use as shall be shown later in the study. This is evident, perhaps, in the fact that Marcus is on antidepressants and is also being treated for general anxiety disorder and insomnia. He had this to say about his personal life:

> I kept to myself aside and don't give too much away. I judge and assess people. I am quite good at that despite what some people think… I'm quite perceptive with respect to people's personalities. So I always do an assessment first before I decide to give any information. So I am not very trusting.
>
> **Naeem:** So you have a base level of mistrust?
>
> **Marcus:** I think so, yes.

Through the interviews, I observed that the fear of coming out was a reality for many gay people as they are afraid of being stigmatised and rejected. I also observed that negative reactions to disclosure seemed to be associated with higher depression and lower self-esteem. Like many gay people who are not accepted by their loved ones, gay men perpetuate the lie that they are straight so that they can be accepted by their family. Lying in order to fit in meant that they are in denial and withheld an important part of their identity and this led to the feeling of shame and insecurities. Zak had this to say:

> I came out to my family at about 26, but, thank God I didn't wait until I was 26 before having sex! I was still in denial through my first relationship I was supposed to be, 'Bi now pay later'. You know it was just a matter of… my biggest issue was not accepting myself proudly when I was younger.

Zak lived a life as a bi-sexual man in a bid to fit in with society. His relationship with a woman was for show in front of society and the relationship he had with another men was a secret. Zak blames this on lack of self-acceptance. Denial therefore seems to a prevalent factor among gay people especially soon after finding out they are gay. Beachboy was aware of his sexuality from the age of fourteen but only came out to his family at the age of twenty one for fear of how they may react. He also had not come to a point of self-acceptance in front of the world. He said, "when I was 21 I came out to my family and to my friends I was probably 19." Beachboy went on to say that "It took me a longer time to process and to deal with, I was struggling to come to terms with you know… I am gay".

Beachboy, like several of the other participants, postponed coming out because he was afraid of his family's reaction and therefore lived a lie for years, concealing his identity as a gay man because of fear of rejection.

In a nutshell, concealment and denial are common features when gay people find out they are gay. It takes time, at times years before most of them come out and through this process conflict, fear, shame are common companions.

Although most participants encountered challenges when they came out, not all family members rejected their children who came out and those who were accepted by their families seemed to have a better view of life and society. Rentboy denied his sexuality for a while, but when he came out, the results were encouraging and positive. His story is as follows:

> I went to a party with my friends and my sisters decided that they were going to have a get together with mummy. So the plan was I tell her and run away to the party and then she would be with my sister and then they would soften the blow. It was necessary because it did affect her in a way, because mothers know, they always know. So I told her and all she said was yes she knew that there was

something different about me and that I was always the soft one. She said that the only problem she will have is if I was to go out there and make a fool of myself, which is quite funny because now I'm an escort and a well-known escort.

John said the following about his coming out:

> Most of my immediate family knows that I am gay… but other family don't know. Some of my high school friends don't know… some of them who saw me in gay bars they knew or know. At 19 I decided to come out to my mother and I wrote her a letter. I think it was 6 pages long and it was planned quite well I had like a spider diagram planned on what I needed to mention in the letter and all that… so I wrote it and then sent her a message and told her there is something on my bed for her and she must let me know what the answer or what she thinks of it .. so I messaged her and didn't hear anything from her and I was a bit stressed because I went to a gay bar .. so I went out and didn't hear anything from her at 3 o'clock in the morning already .. so I messaged her and asked for an answer on the letter so I know if it's okay to come home. So I messaged her and she said it's fine and everything and the next morning we spoke about the letter and started crying and things were fine afterwards.

John, who had mentioned that he has always been shy and lacked confidence as a child growing up, chose to write a letter as he feared confronting his parents directly. Many gay children prefer coming out to their parents by letter as it is much safer option for them to articulate their thoughts and compose their emotions with the uncertainty of how their parents may react.

Although parenting literature often focuses on the mother-child relationship (Davies, 2004), the heterosexual-father and gay-son relationship considered herein has not been a focus of as much research (a notable exception being a doctoral thesis by Livingston, 2014) and

further research would be required to deepen our understanding of the process and the impact of coming out to one's father. This study shows that fathers too play an important role in parenting their children, adolescents, and emerging adults (Wong and Hong, 2014). According to Livingston (2014):

> Fathers are important to their children's development... and parents of sexual minority youth are no exception. For example, active fathering promotes a stronger father– son relationship, including increased communication of affection between father and son... Additionally, a parental focus on sexuality-specific support and acceptance of their children promotes better outcomes for sexual minority youth, such as lower internalised homophobia" (p. 3). Marcus narrated his coming out story to his father as follows:

> He read about it and said that he had a different impression of what it was and what it meant and so on… uhm and so I felt that he was more understanding. So he came around quite quickly.

Marcus's story shows that when parents who are ignorant about homosexuality keep an open mind and make an effort to learn, the results can be encouraging and positive for all involved. The stories that are presented above show that gay people go through much pain when they realise they are attracted to people of the same sex. It is not a choice, but who they are. Coming out to a world that is rigid in terms of what is normal is painful and challenging for them. What they need is acceptance and love from their family and friends and not judgment and rejection. Katz-Wise, Rosario and Tsappis (2016) mentioned that the continued importance of parents in the lives of youth is indisputable: beginning at birth, extending through adolescence and even into emerging adulthood, affecting all relationships beyond

those with the parents. Being accepted and loved by our parents is a fundamental step towards dealing with the challenges of coming out.

What this study centralises is that the journey of self-discovery, coming out and self-acceptance is not a lineal one. All participants travelled unique journeys some more challenging than others. With regard to homophobia, ten of the individuals shared personal accounts of homophobia which they had experienced growing up. Their accounts prove that homophobia is still prevalent in South Africa and at times it comes from those closest to us. A few trends that were identified from their stories were:

- They felt the need to hide their identity from family or friends during the early stages of their lives when they became aware of their true self and identity.
- All the individuals interviewed eventually came out to family (specifically to their mothers) and then to the rest of the family such as their siblings and also to their friends.
- Post coming out, each family reacted differently to hearing about their child who recently confessed his sexuality to his parents, ranging from supportive to completely against it. Some participants face humiliation, insults, rejection and being totally ignored by family members. Six of the eleven individuals' parents were completely unsupportive and five of the eleven individuals' parents were supportive of the children coming out as gay. For some, acceptance came at a later stage. Additional research is required in order to understand the impact of coming out as a gay child in a heterosexual family.

On a personal level, I withheld my sexuality from many friends and co-workers for many years subsequent to coming out to my immediate family. I felt that I would be judged by my Muslim friends and colleagues for being a gay Muslim and one of my biggest fears was that I may be limiting my personal career growth with my company. I feared that senior leaders

in my organisation would not deem me fit for a promotion based on my sexual-orientation and I had convinced myself that their perception of gays is that they are not capable of managing or taking on a senior role. As a result, I have denied my true self in pursuit of career growth. It has taken me a decade to change my views and admit my true sexuality to others and to challenge their views even at the risk of not attaining further career advancements. As a young professional, I still hope to attain further success in my career, but more importantly I aim to do so as my true self and not as a fabrication of what someone else wants me be to be.

4.6 The progressive use of drugs from early adolescence to adulthood

In the study, all eleven participants used or continued to use drugs for recreational purposes and chemsex. Their reasons for starting drugs and their continued use were investigated and the findings are presented in this section.

Table 4.3 depicts the participants' progressive drug use from the initiation drugs taken during adolescent years and the progression throughout their adult years. The table indicates that even though there are some commonalities between the eleven participants interviewed, not all individuals followed the same path. Drugs were also used based on availability and popularity at the time or specific to their environment. Ecstasy was most popular during their clubbing and partying days and over time all eleven participants eventually progressed to the use of crystal meth (sometimes in combination with GHB) which is a sexual boosting drug.

Table 4.3 Progressive drug use

Name	Participant's response	Entry drugs	Progressive drug
Elly	Like I first started with cannabis, but cannabis has always sort of been hand in hand with most of the other drugs like back in the day we would do like Ecstasy with	Cannabis, Dagga, Weed or Marijuana	Crystal meth

	little bit of acid…a candy flip….		
Marcus	Ecstasy was my drug of choice. I did do some weed a couple of times but if I really wanted to have a good time I would take ecstasy.	Ecstasy	Crystal meth
John	It started with Kat and coke, then okay - I've never done heroin or acid but basically everything other than that. I used Crystal meth, Kat , GHB, weed and stuff.	Kat and Coke, Ketamine and Cocaine	GHB predominately and Crystal meth
Don	I started with cocaine, and ecstasy and some weed.	Cocaine and Ecstasy	Crystal meth
Anthony	We went to a trance party and then one of my colleagues I got her there as well and she was like do you trust me, do you trust me and she was like open your mouth, open your mouth and then she said open your month and she put something on my tongue I think it was something called a scooby. That was what we did those psychedelic drugs and things … a scooby is almost like an ecstasy. I liked the feeling of it as well…. All this drug I only did it once or twice, until he really introduced meth to us	Ecstasy	Crystal meth

	and I saw him smoke it and I thought fuck it let me try this as well and then I liked it.		
Wayne	I started using alcohol at the age… of… I think I was also in standard 7. I also started experimenting with dagga and also then the first time I explored with chemical drugs, it was ecstasy also when I was in matric. So that was the first time I started experimenting with chemical drugs. I think it carried on like that for 3 years with the ecstasy.	Dagga and Ecstasy	Crystal meth
Rentboy	When I was I think 19 years old, but that time it was just ecstasy, weed and alcohol".	Ecstasy, weed and alcohol	Crystal meth
Zak	All my friends smoked weed, these are functional affluent people and then growing up threw the rave party scene. I think these where all barriers to entry. Crystal was my last barrier.	Marijuana	Crystal meth

Rob	I initially started with cannabis but then I graduated to ecstasy and from ecstasy onto cocaine and cat and tried crystal and GHB and ketamine (laughs) and what else(pause) and of cause acid. That sorts of rounds it up.	Cannibals, Weed, Dagga	GHB
Beachboy	So, like the gateway is alcohol… I think if you speak to people in recovery programmes or go to AA meetings they will tell you.	Alcohol	Crystal meth

The table above shows that there was a historical progression from relatively mild substances such as dagga and ecstasy to more powerful and addictive substances such as crystal meth and GHB. A similar progression can also often be seen in the histories of individual drug users. All eleven participants were users of drugs, with some starting in their teens, and others in their twenties. For most of them it was also possible to discern a progression from 'softer' to 'harder' drugs. Below, the participants reflect on their entry into a life of drugs and how their drugs use progressed over time. Elly had this to say about his drug use:

> Actually, the funny thing is because of my upbringing I was in the beginning very, very anti-drugs. I used to go to gay bars and would never understand how these people would be dancing the whole night, they would just be bouncing around the whole night until a friend of mine gave me an E (ecstasy) one night and it changed my

> life completely. I discovered a part of me that I never knew before existed. Previously I used to be a wallflower and never interacted much, socially and all of a sudden, I felt beautiful and people started noticing me. I became a different person; a person I started liking better. I first started using drugs at the age of 26 or 27 there around…well actually, I speak under correction it wasn't ecstasy, I always smoked the odd joint but I never considered it a drug more like a herb. I started at about 18 or 19ish. It was never really a habit more like on weekend or a recreational type of thing.

Elly received very little support from the people who he expected to love and support him. He mentions that his family continued to live in denial about his sexuality and as such he had very little support and no one to talk to about his experiences. Even though Elly accepted his sexuality, he was faced with a great deal of unhappiness caused by the estranged relationship with his family which made him feel insecure about himself and as a result he would avoid social interactions with others for fear of being further rejected.

Elly describes himself as a "wall flower", someone with an introverted personality who would attend parties and social gatherings but would usually distance himself from the crowd and actively avoid being in the limelight. Listening to the Elly describes himself as a wallflower, seems like an accurate description based on the internalised emotional turmoil he endured post coming out to his family and after leaving home. Everything changed for him after one night when a friend gave him an ecstasy while out clubbing; soon after taking the drug, Elly describes a complete transition into an entirely different person. The single magical drug made Elly feel beautiful, confident and that people were starting to notice him which in reality was a simple change of self-perception. After his first drug experience Elly continued using ecstasy in order to sustain the incredible positive feeling and over time progressed to other more illicit substances in order to sustain his new-found confidence:

> You call it a candy flip because you do the ecstasy and acid together. I don't really like acid because it makes you like hallucinate and you know it wasn't really my kinda thing …oh… but then there is crystal and g that works pretty well together. The other … let me just think… ketamine, that's pretty okay on its own. You know that's like a horse tranquiliser. Powerful stuff! I've done some pretty serious stuff and had really good fun, I've enjoyed it all and the combination and all.

As a teen Elly started off by using ecstasy and then later in life began experimenting with other more illicit types of drugs such as acid, crystal meth and GHB. Elly explains the different reactions of drugs by saying that ecstasy made him feel confident and more sociable while the effects of crystal meth and GHB were described as follows:

> It takes you to a different level and also sexually and it sort of heightens all of your senses and experiences and makes it better than what you would when you just have normal sex. It makes you lose your inhibition. Uhm. You know you would do things you wouldn't normally do but it maybe being like a little fantasy in the back of your mind, it actually sort of enables you to act on it.

Elly highly valued the effect of the drugs and their ability to enhance self-confidence and inhibit self-consciousness. His past insecurities had a detrimental impact on his ability to be socialise and to interact with other men. He describes how crystal meth enhanced his sexual confidence by moderating the fear of rejection and so that he could act out his desires, made him feel good about himself and increased his libido. Later in life when he started meeting men and forging relationships, the crystal meth helped him overcome the barriers preventing him from engaging in conversation or sexual contact because the perceived probability of rejection was high. Crystal meth served both to remove this cognitive barrier and increase his feeling of euphoria while having sex with men.

Marcus described his journey with drugs as follows:

> Tammy and I went out to clubs and I would sneak a drink or two here and there. That was my first time with alcohol. It wasn't excessive and it didn't become a problem at all. It was just an experiment and then the next drug was ecstasy and that was when I was in Bloemfontein and I started smoking cigarettes. In Kimberly I felt very socially isolated – I had no friends there. The ecstasy helped me with that. … Yes, it also made you feel cosy and chilled… so you like don't have to go partying you can also chill – it puts you in such a good mood.

In his early twenties, Marcus would enjoy a drink or two while out clubbing as most teenagers do; however, things changed when he left home and was sent to Bloemfontein to complete his medical community service. When Marcus arrived in Kimberly, he was already dealing with an inordinate amount of emotional issues which were a result of being bullied at school, the rejection he felt by his family soon after he disclosed his sexuality and then the feeling of shame he felt as a result of all the events that took place throughout the course of his life. While in Kimberly, Marcus felt quite insecure about himself and had difficulty making friends and as a result he felt very alone. At this point he was introduced to ecstasy, which elevated his mood, gave him a sense of confidence and allowed him to connect with people. Whatever internalised emotions that were holding him back from expressing himself seemed to dissipate as soon as he took the ecstasy. Both Elly and Marcus described quite eloquently how ecstasy allowed them to overcome the shame, low level of confidence and low self-esteem they had previously felt. Crystal meth therefore transformed them into sexually confident men who were brave enough to pursue and act on all their sexual fantasies with no inhibition.

Wayne also started off smoking marijuana over weekends during the adolescent phase of his life. He had the following to say:

I started using alcohol at the age… of… I think I was also in standard 7. I was probably 13 years old… a lot of things happened at the age of 13. I started using alcohol but it was only at parties…then I also started experimenting with dagga and also then the first time I explored with chemical drugs was ecstasy also when I was in matric I think that was the age of 19 and then we would go to parties and clubs me and as a group of friends sort of experimenting, that was very nice feeling, because it was like the feeling of sharing certain things like we would tell each other I love you, because it makes you feel warm and fuzzy inside and you enjoy the music and boys would tell boys I love you and girls would tell girls I love you and boys would tell girls I love you. It was just an amazing feeling we would go clubbing every weekend and then after clubbing we would go to someone's house and chat and fall asleep and then go home and like the same evening we would hook up again and go clubbing and Monday go to work and the following week we would do it again. So that was the first time I started experimenting with chemical drugs. I think it carried on like that for 3 years with the ecstasy and then I think I started. When I moved to Johannesburg, that was at the age of I think 25 years, I started experimenting with kat and this one guy introduced me to kat and we would have the most amazing sex on kat and uhm the only time that I would use kat was with this one particular guy and then I would go visit him or he would call me and say he's got kat for us and I would go visit him and we would have marathon sex and we would have sex throughout the night.

Wayne was later introduced to ecstasy and describes the feeling as 'warm and fuzzy' a feeling that he really enjoyed which allowed him to connect with other people. His comment about feeling 'warm and fuzzy' has a much deeper nuance to it: Wayne mentioned that as child growing up, he had no friends and felt lonely. He would spend hours playing by himself and had no one to share his experiences with. His mom and dad where always working and there

were no other adults to care for him and as such Wayne ended up taking care of himself. He also continued to explain the effects of ecstasy on his friends, some of whom were straight: they would embrace their true feeling and acknowledge how they felt and expressed love for one another. This kind of admission of feeling would not normally be verbalised by a straight teenage guy, more especially not to other gay men which further illustrates that ecstasy does create a level of closeness across all sexuality and gender boundaries. Drugs helped Wayne sustain the elevated feelings and it motivated him to continue using ecstasy for the next three years.

When Wayne moved to Johannesburg, his association with drugs continued. He made new friends while out visiting gay baths and clubs where his newly acquainted friends introduced other types of drugs such as Kat, and crystal meth. Wayne did not hesitate trying different drugs based on his pleasant experiences on ecstasy and when his socialising eventually moved away from the club scene to a more intimate setting, the drug use changed from ecstasy to crystal meth and kat which gave him a taste of chemsex. He was involved in marathon sexual encounters with a stranger. Wayne describes his experience on crystal meth by saying:

> Uhm, Yoh! It made me very horny, it made me wanna have sex all the time, it made me wanna… sort of like have sex with… it gives you, you want to sort of give into your fantasy. You wouldn't mind having more cocks at once, basically when I am on chems. I just want to be bottom, like a powerful bottom and take big cocks.

Wayne describes an intense sexual and euphoric feeling while on drugs, his total loss of inhibitions and his desire to push beyond boundaries by trying out extreme sexual activities. Crystal meth transcended him into someone powerful and bold enough to be sexually subdued by dominant well-endowed men, yet also a bottom, someone who assumes an exclusively passive role during anal intercourse, and who feels free to enact his deepest sexual fantasies.

From the data presented above, it seems there is truth in the anti-drug propaganda that is aimed at school children that warns against dabbling in 'soft' drugs as they may lead down a 'slippery slope' to more dangerous hard drugs. It is easy to dismiss such warnings as simplistic and overly deterministic, but based on the interviews I conducted with participants, it seems that entry drugs usually do lead to the use of hard drugs: Invariably alcohol, nicotine and marijuana were substances used in combination with ecstasy during their adolescent years, and then later in life they progressed to other more illicit drugs such as cocaine, Kat, crystal meth and GHB. The participants explicitly mentioned that alcohol, weed and ecstasy were all used in combination to create a heightened sense of pleasure and to enhance their social interaction with friends while out clubbing and partying. The progression of drug use to other more illicit drugs such as crystal meth and GHB was a result of the euphoria and confidence they felt. The participants continued using drugs based on the motivation to connect with other men for sexual pleasure and to increase their libido, further boost their confidence, and help them to explore sexual boundaries.

The stories shared by Elly, Marcus and Wayne are in line with existing literature on the subject of chemsex. According to Page and Nelson (2016) many of the chemsex drugs are known to trigger feelings of euphoria and sexual arousal and can facilitate long sexual sessions over an extended period of time. Participants' stories suggest that the effect of using drugs went beyond euphoria, arousal, disinhibition and stamina, but also tended to induce a feeling of instant rapport with sexual partners and helped to manage negative feelings, such as a lack of confidence and self-esteem. However, using drugs a 'social lubricant' appears to have been a temporary phase in participants' drug histories. All the participants interviewed stated that they no longer use drugs as a social medium, that is before going out to clubs or to elevate their moods in order to become more social. Those who still used drugs at the time of research, did so exclusively to get high, horny and motivated to engage in long sessions of chemsex. The

drugs help them build up confidence to meet other men, it helps them to lower their inhibitions so that they become less selective about who they are having sex with, and also help then become more sexually explorative so that they can build up the courage to perform sexual activities that they would not ordinarily do.

Of the eleven individuals interviewed, three felt that they had progressed too far and that their continued drug use was no longer benefiting their lives. They experienced serious consequences in life such as losing their jobs, becoming sick and infected with HIV and other sexually transmitted diseases. In Cape Town the predominant drug of choice for chemsex is crystal methamphetamine and this is the drug that all of the participants eventually ended up using; however, more research needs to be done in order to fully understand the psychological association of drugs and sex.

During the interviews, I observed a great deal of personal and psychological trauma experienced by the individuals who are using drugs and participating in chemsex, but also heard compelling accounts of how drugs enhanced people's social and sexual pleasure. I grew up with the belief that drugs are all bad and that as a Muslim I would be condemned to the fires of hell if I indulge in any kind of drug. However, having listened to the views shared by the participants I have a greater understanding and appreciation for what motivated them to use drugs and now find myself less judgmental of drug users. I have learnt to appreciate each persons' life stories and circumstances. I find the stories told by the individuals who eloquently describe the pleasure and euphoria experienced while on drugs rather intoxicating and, to be honest, it makes me somewhat envious of their experiences. In the next section I aim to explore more fully how participants went in pursuit of pleasure by means of chemsex.

4.7 A chemsex experience: In pursuit of pleasure

In this section, I explore the more visceral role that chemsex had in the lives of some of the interviewed participants. During the interviews, I asked each participant to share their chemsex experience, whatever comes to mind, but I found that only a few participants were open to sharing intimate details of their experiences. While some of the participants interviewed were quite open about sharing the details of their chemsex experiences, others were more selective about what they shared. Most commonly, each person shared details of how drugs made them feel, but, did not elaborate on what they did while taking drugs. Perhaps they felt that it was important to maintain a certain level of respectability while at the same time endeavouring to answer my questions as honestly as possible. If the roles were reversed, I image that I would not be entirely comfortable telling someone whom I have just met salacious details of my drug fuelled sexual experiences either! Sharing such intimate details with someone may bring about feelings of discomfort, shame and fear of being judged. I considered the fact that some of my participants may have cautioned against feeling shame, discomfort and being judged, and as a result could have withheld some intimate details of what actually transpired during their chemsex episodes and focused more on how they felt while having sex on drugs.

Beachboy had this to say:

> So GHB makes you feel a little bit drunkish, so you have a bit of euphoria. So, you just like feel really kinda happy and floating… like floating. I think it is… I don't know the chemical composition or testosterone levels, it's almost like an animal type and like the kat or crystal really gives you the energy and you stay awake, you have a line of kat and shot of G. So basically, you have to base the GHB consumption according to your weight. So, someone who is a bit bigger would need a bit more. So,

you have like this combination of energy awake and extreme horniness and it like from a physical performance point of view you can like just really just go on for hours and also sometimes makes you extremely horny.

Beachboy's story confirms what the other participants said about crystal meth as a sexual drug. According to Beachboy it promotes wakefulness and longevity which the participants required for their chemsex marathons. Elly shared this chemsex experience as such:

> My first chemsex experience let me try and think of one that will be interesting at least…. probably my first introduction was cocaine. This boy used to get me to play with other boys and the two of us and lots of drugs and it went on for hours and hours and hours obviously we used the Viagra and then we tried crystal and GHB and coke. The problem with coke it gives you limp dick and even with the help of Viagra somewhere along the lines you just loose it… it kinda becomes pointless. Then oh ya I forget to tell you that (laughing) I was a crack whore at some point (laughing) the problem with that shit is that it doesn't really heighten your sexual arousal it's like one of those pointless kinda drug. You know there has got to be some sort of incentive you know what I mean. Like crystal and GHB is pure sex nothing else. It just a much more heightened sexual awareness and things, it's not just about losing your inhibitions you become aware of your sexual desire. You know we sort of started exploring things we never would have. I don't really want to go into all that much detail, in all the nitty gritty. You get up to shit you never in your wildest dream thought you would do and the drugs is just the catalyst. It's kinda very difficult to explain to you to someone who have never done it. You discover things about yourself that you never knew about.

I remember the embarrassed look on Elly's face as he tried talking about his chemsex experiences. I could sense that he was aware of my presence and in his mind he had already formulated his own perception of me. I cannot assume what he was thinking, but I am sure that it had some influence on the interview and the information he shared. Elly desisted from sharing intimate details of his chemsex experiences but was kind enough to talk about the way drugs made him feel. He briefly spoke about an encounter with another guy with focus on how the drugs facilitated sexual longevity.

Elly explained that he used cocaine and heroin in the past, but these had seemingly fallen out of fashion with the rise of crystal meth and GHB, which he describes as, 'pure sex'. Pure is defined as not mixed or adulterated with any other substance, so I would define 'pure sex' as the simple pleasure of making love with someone for the sake of physical expression of animalistic desires. This means Elly participated in sexually activities for the sake of physical enjoyment, nothing more.

It is evident from Elly's narrative that the anticipated incentive or reward from using crystal meth and GHB was the intense feeling of pleasure he experienced while having sex, the total loss of his inhibitions, and the courage to explore sexual boundaries. said he captures this inhibition in the statement, "you get up to shit you never in your wildest dream thought you would do and the drugs is just the catalyst". But judging from the statement and the smile on his face that will forever be imprinted in my mind, I imagine that these must have been most salacious and hedonistic experiences.

Rent boy was considerably more open to sharing intimate accounts of his chemsex experiences and had this to say:

> I literally have a client a day that I use chems with. The first time I was slammed and fucked, and this is amazing because number one I don't have to go

> through the concentration of slamming myself (that brain that I explained to you earlier that burst into colours) but while you're slamming you have to put so much effort into keeping yourself in control but when you get slammed, like so someone was slamming me and number two there is already another different guy fucking me. The slammer and the fucker. Now I'm so horny and into this guy fucking me now, so turned on, I wasn't aware of the slammer and when he slammed me that high made me go blank. I couldn't think of anything but of that feeling of that guy fucking me, nothing existed, it was like going into space. Picture a penis amazingly fucking you but like as an image, like a switch of light that was the only thing I could concentrate on and everything else was blank. The next thing I remember is I open my eyes the guy who slammed me was so fucken turned on and the guy fucking me is like…. they so turned on by what I was feeling it is intense. It was like I was in this mode of complete bliss for like ten minutes but for me it felt like forever, it just there was no structure to life itself.

Rentboy, Anthony and Marcus spoke candidly about slamming. The thought of injecting (or slamming) was reviled and feared by most of the participants in the study. These participants often conceived of injecting as 'crossing a line' from sex and drugs for recreation into addictive behaviour. Rentboy who made his living as an escort describes his first slamming experience as absolute bliss and pure unadulterated pleasure. Reading his passage, while taking into account my limited experience in chemsex, I probably would not be able to do justice to interpreting the chemistry and pleasure felt by Rentboy. The passage resembles similar experiences described by other participants such as feeling disinhibited, euphoric, increased stamina, and the courage to explore sexual boundaries. Rentboy narrated that the ten minutes of sex felt like it went on for hours, an aspect of time being suspended, and in that moment, he

was transcended into a different reality where everything was magical and no unpleasantness existed.

Rentboy continuously smoked what I think, in retrospect, may have been mandrax during our interview, and eventually as the conversation progressed he slowed down and stopped smoking. After an hour, towards the end of our interview, I could tell that Rentboy was becoming increasing anxious and as I looked at him, I saw a young sad and lonely boy, lost. After the interview, Rentboy shared some more information about himself. I learnt that he was living in a client's apartment for a few days and expected to leave soon, that he had no other place to go, and that the uncertainty worried him. The need to be continuously high was his way of suspending time so that the harsh realities of his life would no longer exist within the suspended realm.

Another participant who shared his chemsex experiences is Rob who described his experience as follows:

> All my experiences were chemsex experiences. I think the orgy … I think that was actually …. How do I explain it… it was just like the whole sexual thing become just like some kind of a religious thing…like a religious worship thing…that was one of the weirdest experiences. There was like weird …different weird things… normally you kind of worship the guy with the most money, the most drugs. Sexual experience was very distorted from what people think it should really be… but personally for me I think it was more for the money and to take the shame away.. so the orgies that I had … once 8 people in a room at somebody's house everyone naked… the thing is when you're drug induced you couldn't care … you actually just want to be naked… like the less you got on the better and you didn't basically care what you were doing.. whether you had someone's dick in your mouth or your dick in someone's arse… it didn't matter… because there is this feeling of enjoyment that and it becomes so

intense that sometimes you don't even know what happens afterwards… but ya what you do know…. you had a fucken good time… The actual sexual feeling you know. The euphoria everything about it… but I must also tell you, your thought processes go haywire now that I'm thinking about it. Dildos, bottles and stuff like that… I just wanted stuff inside of me and …. the more intense it got the more I lost my inhibitions and the weirder it became.

Rob introduces his description of a chemsex orgy with the idea of worship, and the rest of his account is also strongly suggestive of some kind of almost religious event. Like the participants in a Gregorian chant, those involved in the kind of chemsex orgy Rob describes give themselves over to a collective transcendence that seems to soar above them and to have a beauty and an energy of its own. Individual participants find themselves in an intensely sensual, but nevertheless dream-like state, surprised to observe their own role in the proceedings as if from the outside. From Rob's narration, it is clear that the use of sex boosting drugs opens the participants to new and heightened experiences that are not possible when sober.

Marcus who participated in chemsex also explained the experiences as follows:

No, I think the chems brought out the desire. I didn't know I think it was a side of me that was hiding and only came out when I was on drugs. It must have been some inhibited side of me that came out. After a while, I was just using it on my own. I had like hallucinations and imaginary partners. I would share a story but my memory of that time is very vague. I told you what I remember about being tied up and the pegs attached to my nipples. The doctor friend had a jacuzzi and you know he took photos of me naked…. I can't remember what else happened. I also used to place a notice up on the conversation board on manhunt saying that I am looking for a master who wants a slave. The one time I remember walking into this guy's house and he instructed me

> to take my cock out and walk into the house, he kept giving me orders. I had to crawl into the passage on my hands and knees and into the bedroom on my knees, he was walking behind me watching me crawl into the room naked on my hands and knees… it was something I enjoyed. I was submissive to him and naked, being observed.

The continued use of drugs affected Marcus negatively by causing hallucinations and forgetfulness, but still, from the snippets he narrated, the use of sex drugs led to different but intense sexual encounters with strangers. Marcus advertised for hook-ups and met with strangers purely for sex.

According to Cabai (2008), substance use serves as an easy relief, can provide acceptance, and more importantly, mirrors the "comforting" dissociation developed in childhood. Alcohol and other drugs cause dissociation from feelings and anxiety, mimicking the emotional state many gay people had to develop in childhood to survive. These "symptom-relieving" aspects help fight the effects of homophobia; it can allow "forbidden" behaviour, allow social comfort in bars or other unfamiliar social settings, and provide comfort through the dissociative state itself. From my conversations with chemsex participants, l can attest to that there is some truth in what Cabai's (2008) says that substance abuse can be used as a psychological crutch or an escape hatch from feelings of inadequacy. However, it is also clear to me that the chemsex experience is more than that – in and of itself, it also provides intense pleasure and an opportunity for participating in some kind of collective transcendental experience. My sense is that to properly understand why and how people participate in chemsex, it is necessary to acknowledge both the psychological pathology that no doubt plays a role in driving people to these extremes, and the fact that people seek out chemsex for reasons of transcendental pleasure that go beyond dysfunctional attempts at self-medication.

It is also worth bearing in mind that the association between sex and drugs is in part simply that – an association that becomes ingrained through repetition. Many men have their

early homosexual sexual experiences while drunk or high. This association is a very powerful behavioural link – the ‘‘pleasure’’ and release of substance and the pleasure and release of sex. This association is very difficult to change or ‘‘unlink’’ later in life. For gay men especially, sex and intimacy are often split off or dissociated from one another. Again, substance use may allow acting on feelings long suppressed or denied, but also mirrors the dissociative experience and makes it harder to integrate intimacy and love. Drescher and Guss (2000) explain that sex and/or substances provide an instantly gratifying relief or satisfaction of longings and needs, decreasing the more complex challenges of love and intimacy. For many men, this linking of substance use and sexuality persists and may become part of the coming-out process and the formation of a social and personal identity.

Many gay people continue to feel self-hatred and the use of mood-altering substances temporarily relieves this pain, but then reinforces this self-loathing in the drug withdrawal period thus, creation cyclical behaviours. Alcohol and many other drugs can cause depression, leading to a further worsening of self-esteem. Because of the childhood experience of not being acknowledged or accepted for who he or she is, gay men and lesbians are especially sensitive to rejection, and may expect it or even seek it out unconsciously. Substance use helps many to brace themselves from rejection by others and may make ‘‘living in the closet’’ with its built in need for denial and dissociation, easier or even possible. Substance use seems to serve as an easy relief from negative feelings, can provide a degree of social acceptance, and, more importantly, reinforces what has come to be a comforting dissociation developed in childhood. The symptom-relieving aspects of substance use can serve to disinhibit what are experienced as forbidden behaviours, provide comfort through the familiar experiences of numbness, dissociation, and isolation of feelings”.

4.8 The highs of chemsex as presented by the participants

In the previous section, I observed that the chemsex drugs were used for a wide variety of reasons and met various needs for each of the individuals interviewed. They had a diverse, complex and sometimes conflicting effect on the sex lives of the men I interviewed and were used for a wide range of reasons, meeting varied needs at different times in their lives. While for some the use of drugs provided powerful and positive effects, facilitating a range of desired behaviours or feelings, for others they resulted in a range of negative consequences and also negatively affected their sexual encounters. In this section I endeavour to explore the various positive and less positive consequences of chemsex drugs and the effect they had on the lives of the interviewed participants.

4.8.1 Increase sexual desire, stamina and libido

Almost all of the men interviewed reported that the drugs used increased their libido which by definition is an increased sexual desire. Elly had this to say:

> All the drugs, like crystal, GHB , acid and ecstasy… it's all uppers. It takes you to a different level and also sexually and it sort of heightens all of your senses and experiences and makes it better than what you would when you just have normal sex.

The term 'uppers' is a street name for amphetamine-based psychostimulant drugs that produce increased wakefulness and focus in association with decreased fatigue. Crystal meth is commonly referred to as an upper and as described by Elly, the chemical effects of crystal, acid and ecstasy heightened his senses, which is congruent with the known effects of these drugs. In the passage, Elly mentions that the pleasure he felt motivated him to use drugs during sex and over time he stopped having sex without drugs. Rob mentioned that, "it makes you horny so your sex drive increases tremendously and your endurance too... ou can go on for

hours and hours". Rob's statements concurs with Elly's that the drug increases sexual drive and endurance.

Zak had similar experiences:

> I think the crystal that I have I enjoy for several reason, I enjoy the delayed cum… it prolongs that period and you know once you come it's over and it's also the being awake I have always had a problem with going to sleep and meth is the perfect facilitator

And Wayne goes on to say:

> So like, I think the reason you do drugs is because it gives you different pleasures, like you can act out without any inhibitions and have sex for long without coming. When you're in a relationship, when I was in a relationship, you make love, sometimes you do fuck… but it is more like you want to explore someone because you kiss someone you're sensual and you want to believe that you want to make love by the touching and the feeling you have without chemicals. Sex without chemicals you have a different feeling, like I said you want to make love and the feeling that you have is supposed to be the feeling of love and sometimes you get a bit erotic and just fuck but it's still love at the end of the day. But when I have sex with chems there is no love it's just pleasure, there is no feeling of love, I could never say that I have been in love with someone being on chemsex, it was just pure fucking without making love and uhm and living off fantasies etc, etc so that would be the difference.

Rob, Wayne and Zak, among other participants, enjoyed long chemsex sessions for the purposes of fun and pleasure. The crystal meth facilitated sexual stamina and they reported being able to have sex for long periods of time without ejaculating and could sometimes go on for hours or even over an entire weekend. Most of the participants interviewed described their

chemsex experiences with numerous men, and by taking drugs throughout this period they could maintain high levels of both energy and desire. The drugs facilitated the increased desire to connect and the chemical stimulation gave them the confidence they needed to meet other men and engage in sex. The drugs appear to be symptomatic relievers and could be enhancers for the low level of confidence that many of the participant may have been dealing with throughout their lives.

Wayne makes a clear distinction between chemsex and sex without drugs. He defines sex without drugs as a more intimate experience between two people who share a connection and mutual love for each other, in comparison to chemsex defining a polar opposite feeling. During chemsex the pleasure of sex is mainly focused on the self. In Wayne's words: "when I have sex with chems there is no love it is just pleasure, there is no feeling of love, I could never say that I have been in love with someone being on chemsex, it was just pure fucking without making love and uhm and living off fantasies etc." He defines both sexual experiences (with and without drugs) as pleasurable; however, chemsex focuses on pleasuring the self while without drugs the focus is on pleasing the other. Chemsex therefore is self-centred whilst sex without drugs is 'other' centred.

Marcus expressed a similar sentiment by saying:

> So the difference is when you're in love. When I had a boyfriend I really liked. The sex would be all about pleasing the other person, It was very synergistic. Like you give you receive and you enjoy each other and the difference with a chemsex experience is uhm.., you're much more selfish and more concerned about your own pleasure.

Other participants however had different experiences, whereby, it is not always about the self. From Rentboy's account quoted previously, "the next thing I remember is I open my

eyes the guy who slammed me was so fucken turned on and the guy fucking me is like…. they so turned on by what I was feeling it is intense", it is clear that the two other participants are turned on by what they imagine Rentboy to be experiencing as much as he is turned on by the feeling of someone else experiencing pleasure from his moment of transport. Rentboy, who spent a few years working as a call centre agent, took pride in giving great service to others, including his sexual clients at the time. Rentboy explained how satisfied his client where when they were slamming and having sex with him simultaneously, he further mentioned that this act was one that made him more competitive in his escorting industry. He felt that the combination of slamming and sex at the same time was like going the extra mile for a client and as someone who previously worked in a client service call centre, he felt proud of the act of as it symbolised great service to his clients. There is a kind of brutal, primordial quality to the moment of shared pleasure that occurred between Rentboy, the slammer and the fucker - a world removed from the gentle caresses exchanged between two long-term lovers - but it would nevertheless be a mistake to imagine the moment as purely self-centred and as entirely lacking in empathic connection between the participants.

All the participants interviewed commented that drugs could significantly enhance sexual desires, intensify physical stimulation, heighten arousal and result in orgasms that they never experienced when compared to having sex without any psychoactive substances. The combination of drugs and sex was highly valued and explains in part, why they were motivated to use drugs for most of their sexual experiences.

4.8.2 Facilitating sexual pleasure, euphoria and reducing inhibitions

Euphoria is described as a feeling or state of intense excitement and happiness, while sexual pleasure is the good and pleasant feelings that can be associated with sexual experiences, and inhibition is defined as a feeling that makes one self-conscious and unable to act in a

relaxed and natural way. Reduced inhibition therefore involves breaking down the barriers of self-consciousness, making one act in a relaxed and at times beyond natural manner. These are some of the experiences that were frequently mentioned during the interviews. Rob had this to say about his chemsex experiences:

> There are some people that just does crazy shit for the sense of wanting to have a good time. It's not you but it takes a lot of the inhibition away so.

And Marcus said:

> It's difficult to explain, it was a complete loss of inhibitions, extreme horniness and so euphoric. It was amazing.

Both Rob and Marcus where unable to act or feel relaxed in the company of other men and so felt the need to alter their state of mind by taking psychoactive drugs in order to meet and engage in sexual activities with men. Feeling nervous or self-conscious are common emotions when going on a first date or moments before any sexual encounter, but for Rob and Marcus the feeling of self-consciousness and being unable to relax were both chronic feelings. Marcus suffered from general anxiety disorder and major depression and Rob battled with his confidence for many years while growing up in a very religious household; he was never able to fully express his true self. Both Rob and Marcus found value in using drugs to mask the feeling of self-consciousness, and the added benefit of drugs allowed them to experience an intense feeling of euphoria and sexual pleasure.

4.8.3 Intimacy, sexual confidence and enabling sexual adventures

There was a great deal of value placed on the feeling of being intimate with the person with whom they engaged in sexual relations with, and the drugs enabled the connection they felt. Several participants described the intense feelings of sexual intimacy and mentioned

that the use of drugs gave them the confidence and courage to try new and potentially more extreme sexual activities. Some of the extreme boundaries where relatively safe while in other cases they presented potential risk which I will explore further on in this section. Rob had this to say:

> It took a lot of the shame away and it made me feel that there is a huge amount of self-confidence uhm and it just the fact it made you feel good and it made feel good and sexy …That was my motivation. It took a lot of the shame away, it numbed my feelings because you know to have sex with multiple partners it's…. I won't say it's not lekker but there is some kind of feeling that you got that you didn't know … but you know … that this is what you do … so it, it gives you that oomph and the euphoria about it, it takes you to places that you won't go when you're sober.

Rob experienced many hardships as a child. He was sexually molested as a child and raised by his uncle who was a pastor at the community church after his mom passed away. Rob had no one to talk to about the way he felt and was neglected by his adopted family. He spent his entire childhood listening to the views of his family, further reinforced by his church, about how sinful it is to be gay. His drug use took away much of the shame he felt as a result of the torment and shame he internalised while growing up. His drug use helped him to overcome the shame he felt about having sex with multiple partners. This kind of shame was instilled in him by his religious family. Rob described how drugs enhance sexual confidence by moderating his feeling of shame and possible rejection and ameliorating its effects by mentioning the fact that the drug use gave him confidence and made him feel beautiful.

In line with the findings of this study, Weatherburn et al. (2016) mention that men who normally lack self-confidence or self-esteem frequently worry about whether others would be sexually or romantically interested in them. This acts as a barrier to engage in conversation or

sexual contact because the perceived probability of rejection is high. Drugs serve to remove this cognitive barrier to lessen the pain if rejection did occur.

Anthony also experienced a positive change when he took drugs, they gave him courage to socialise and try out new things. He explained:

> When I first took the GHB that is where everything started… Along with the drugs can fantasy that you always wanted to experience things that you won't normally do. It's more like now you have the courage to act on what you thought and for some reason it makes you think of the nastiest things you could possibly think of like the meth and GHB they make you do the things you won't act on like as in pig related …ya man it was just weird.

Marcus described his experiences on meth:

> Meth wasn't as sensual or touchy as ecstasy… it was more a wild horniness and sexiness. Like you just want to be a big slut. Just have sex with anyone… want to be used in a way.

Both Anthony and Marcus describe their sexual adventures while on drugs. They felt like they were much more likely to try out and enact their deepest sexual fantasies while under the influence of drugs, specifically crystal meth which promotes primal urges. Marcus enjoyed the feeling of giving up control and to participated in more extreme sexual acts by completely letting go and becoming more submissive.

Taken together, these various "highs" of chemsex (facilitating sexual desire, increasing libido, encouraging sexual adventures, among others) are not of course the only factors that motivated participants to engage in chemsex, but they certainly appear to have been among the important considerations. Whilst, using these drugs had positive effects on their confidence

and ability to explore new things, long term, the drugs had negative effects on most of the participants as demonstrated in the next section.

4.9 The lows of chemsex as presented by the participants

In this section, I present the common and recurring harms associated with chemsex and also focus on the broader impact on the physical, social or mental well-being of the interviewed participants. The harms associated with chemsex that participants described were in some cases acute while for others were more long term and pervasive.

4.9.1 Harms relating to physical and mental health

Physical harms mentioned in the interviews included immediate adverse effects such as accidents caused while being under the influence of drugs, fatigue and exposure to sexually transmitted disease. Medium to long term effects included the development of depression, paranoia and other related mental disorders.

John reported the following:

> GHB mos make you pass out… I like passed out behind the steering wheel. I once woke up between Stellenbosch and Franschoek on a road I didn't even know. My phone was dead and my car was running out of gas. I was so stressed I was like what if my car dies and there was no lights in the surrounding area. There was luckily some street lights and I just followed the lights and luckily got onto the N1 highway in Cape Town.

He continued by saying:

> There was times I would go for days without sleeping and then like just crashed for days afterwards but like even though you're crashing – I still take it… The bad thing

is like when you fall asleep or pass out. You fall asleep but you don't also notice it. Like once I was falling asleep at a hook-up.

John used various drugs throughout his life time but later on settled for GHB and crystal meth. These drugs helped John overcome his low confidence and shyness which he spoke about at the onset of our interview. Growing up as an obese child made John feel extremely self-conscious and the GHB helped boost his confidence level and in combination with meth, increased his sexual desire, reduced his inhibitions and gave him the courage to meet other men.

John explained how GHB/GBL has a relatively short effect, which meant that the need to re-dose or reuse was part of the process of using GHB. However, these doses need to be carefully timed and measured, which becomes more difficult to control - as the effect of the drug accumulates. Over time there is risk that the user may experience drowsiness and fall asleep or possibly become comatose. In John's case, his continued use made him relaxed about the carefully controlled dosage required for his body weight and at times he would become complacent in his usage without considering the consequences. On three different occasions John fell asleep while driving and eventually found himself on the side of the road after some time. He also reports falling asleep during a hook-up, which could have had far reaching negative consequences such as being date raped, mugged or even physically harmed while in the comatose state. At this point in his life, John admits to being addicted to GHB and confesses using it every day, together with a muscle building stimulant for gym. During the interview John expressed a desire to stop using drugs but was unable to admit himself to any rehabilitation centre due to financial constraints. He began speaking to a counsellor at his local church and hopes that they will somehow be able to assist him.

Marcus described similar negative consequences of drug use:

> It was just a horrible time and so I started taking more and more and I would get fuzzy at work and people noticed and there was complaints and so that was the first time I discovered that I have a drug problem or I think at that stage they just thought it was depression with secondary self-medicating.

The many years of shame, rejection and feeling of isolation felt by his family after he decided to disclose his sexual orientation to them where further reinforced throughout university and when he eventually left home, he struggled with making friends for fear of being rejected by others. Marcus also went through an extended period of feeling that there was something wrong with him and that being gay was not normal, based on the views of his family and friends from school. When he eventually graduated as a medical doctor, he was sent away to complete his community service at various hospitals and clinics in and around the Western Cape. The long hours and extensive driving caused a great deal of strain on his life and as a result he started treating himself with Benzodiazepines which is used as a hypnotic sedative to help him sleep and cope with the daily stresses.

Marcus eventually became dependent on benzodiazepine and later on his habitual drug use was noticed by his supervisor. Marcus was at this stage treated for depression and suffered his first serious consequence at work. Over time, Marcus continued using drugs as an enabler to make friends and engage in sexual relations. He lacked the confidence to do so without being disinhibited by drugs. A few years later he developed severe depression and anxiety. His psychiatrist diagnosed him with a major depressive disorder stemming from his drug abuse. Marcus is currently being treated for a substance use disorder, general anxiety disorder and major depressive disorder. Marcus' narrative shows that whilst drugs can aid socialisation, continued use has potential to lead to addiction whose consequences can be far-reaching.

Wayne mentioned another adverse effect of drug use:

> Yeah, there was the paranoia. I don't know, but I was always paranoid. Sometimes you would hook up with a stranger when you're on drugs and sometimes you do it…with …with… sometimes you would use drugs with strangers and sometimes you would do it when you're with someone you know, but I have always felt this paranoia, like I'm not in this safe place. Like I don't know what's going to happen. But the feeling of horniness supersedes the feeling of paranoia and in the back of your mind you feel paranoid and make sure that your car is okay or that your stuff is safe and that people don't take advantage of you wanting to sort of steal your phones or something. I don't know… that always went on at the back of my mind, so I would say I was very horny but there was this major feeling of paranoia.

Paranoia is another medium to long term effect that is commonly reported by most of the participants. As described by Wayne, he became increasingly paranoid while using drugs and this even continued after a year of stopping all kinds of drugs. Wayne maintains that he still feels unsafe as if someone is watching him or has access to his phone.

Rentboy shared a similar experience, involving hearing voices:

> People tend to do this, I kept my tolerance for the amount of crystal that I use for two years and people used to say how you get high from slamming after so long with the amount you use. You can't get higher with crystal even if you use more and more. The only way you can get higher than the norm is if you don't sleep. The crystal gets so strong that you go into a state of delirium, your body is exhausted and your brain can't think anymore and you go into a state of sleep deprivation and you start hearing things, people talking, but it's all in your head.

Rentboy's description shows that drugs eventually take over and change the brain pathways resulting in the user needing more drugs to maintain a high. Using more drugs

generally leads to addiction and in the case of crystal meth sleep deprivation and hearing voices. In the study, two participants were diagnosed with an induced psychotic disorder and are currently undergoing treatment. One of the participants interview suffered a near death experience and ended up in hospital for a few months, while three participants found themselves in serious compromising positions which resulted in physical harm. This study therefore shows that whilst chemsex brings unimaginable highs, continued use of drugs has negative effects that include addiction, sleep deprivation, paranoia, depression, hallucination and hearing voices. The use of drugs to enhance sexual pleasure also increased the risk of sexually transmitted diseases. The next section discusses this.

4.9.2 The risk of sexually transmitted diseases

As mentioned throughout the chapter, the disinhibiting effects of chemsex result in men becoming more sexually adventurous and as a consequence they may end up having unprotected sex. Considering that some chemsex experiences involved sex with strangers, sex with groups of strangers and multiple partners, it is safe to assume that exposure to sexually transmitted diseases was high. Two of the individuals who were interviewed reported having acquired HIV from unprotected sex while on drugs. Wayne and Elly both acquired HIV while having unprotected sex with other men while on drugs.

I was cautious about asking further question due to the sensitivity about the subject and my limited experience in counselling. Wayne and Elly maintained that he felt fine mentioning his HIV status and appreciated that I was able to provide them with access to a counsellor should the need arise during the interview. What can be said about this link between chemsex and sexually transmitted diseases is that the rise of chemsex in South Africa and throughout the world presents many challenges for gay men, and one of the risks is acquiring a sexually transmitted disease.

Marcus confesses to participating in unsafe sex practices:

> I felt so disinhibited that I actually had unsafe sex… I just wanted to try everything. So that next time I tried… I did a slam… it was also really good and amazing and yoh, it was really good.

While Marcus never acquired HIV from his unsafe sexual, encounter he does mention that he has been treated for syphilis on one occasion. Outside of sexually transmitted diseases, some participants suffered financial difficulties and ruin as a result of their drug use and over indulgence in chemsex

4.9.3 Financial ruin

Table 4.4 indicates that while some participants managed to balance their drug using habits without much impact on their day to day life and work, five out of the eleven participants lost their jobs as an apparent consequence of drug use and abuse.

Table 4.4 Employment history

Name	**Former Employment**	**Current employment at the time of the interview**
Elly	Employed	Currently employed
Rob	Former sex worker	Currently unemployed and in rehabilitation
Anthony	Call centre manager	Currently unemployed
John	Accountant	No formal employment but works in a bar
Leon	Unemployed	Unemployed
Marcus	Medical doctor	Unemployed
Wayne	Human Resource Officer	Human Resource Officer
Zak	Self employed	Currently unemployed

Beach Boy	Web developer	Web developer
Rent boy	Male escort	Male escort
Don	Advertising producer	Advertising producer

The participants who lost their jobs lost their sources of income leading to financial ruin. Drug use and abuse therefore has far-reaching consequences on the users.

4.9.4 Harm to self and others

Several participants related incidents when they ended up in compromising situations as a result of their drug use and participation in chemsex. Zak recalled an incident when he inadvertently associated with a crystal meth dealer:

He narrated:

I met this guy and we ended up over at another guy's house. I didn't know the third guy Chris, and at the time I didn't know that he was the biggest crystal meth dealer. Here is my ignorance, he had like a full bag of crystal meth almost like one and a half kilograms of meth. I later heard he was busted by the cops before and here me and my friends are heading off to his apartment. The next morning at about 8 o'clock there is a very loud knock on the door and they don't stop knocking and it turned out that it was the cops, and because of his previous bust he gives up certain rights to search and seize. There was 6 of us who had partied the night before one guy passed out of G naked, there was actually 5 of us, they searched the place and took 3 guys away. Zak's encounter with a meth dealer and the cops could have landed him in jail for drug distribution or some other crime related to drugs. This could have seen him jailed which would have been detrimental to his journey in life. Beachboy also had experiences of putting himself in harm's way while high:

> Like in the moment or just thinking about it I like don't really feel like putting myself in the situation like going to a strange person's house. I don't know what they might do or what they might not do, but when you on drugs you like fuck it let's just do it.

Beachboy and Zak show that decision making while high on drugs became compromised. Both made some poor decisions while on drugs which could have resulted in far greater physical harm. As shown above, one of the participants slept behind a steering wheel and some would wake up in strangers' houses which put their lives in danger.

4.9.5 Other harms – addiction to sex

Chemsex allowed them to do certain things that they would not have considered while sober and the high of being free is what kept them using drugs for sex. Rentboy explained:

> The sex is good, also you can tolerate some things like I can fuck someone (a client) who isn't nice looking. It just enhances the sex so much and you don't have any inhibitions and chems also connects people. So like if both people are slamming they tripping together.

Rob also said:

> Sometimes when I watch porn movies I think to myself that I wouldn't be able to do that without drugs and that is how now that I am thinking about it, I once I had a thing with someone who had muscular dystrophy and he liked toys … you know your body becomes different … You do things that you seriously wouldn't do under normal circumstances. Even though I was induced I could still… had this, wouldn't say a sorry kind of feeling but I had a weird kind of feeling towards this person… you know if I were sober I probably wouldn't have gone and did it with this person… He .. we actually did it with all kinds of weird objects and stuff.

Chemsex allows men to become less rigid, less selective and more open to engaging in sexual activities with sexual partners whom they ordinarily would not have associated with. The act of sex itself is addictive and leaves them wanting more and more, hence the addiction to the chemsex lifestyle.

4.9.6 Loss of time

Time lost is something that can never be captured again. Beachboy stated that drug use and chemsex results in lost time:

> Yes, you can, ya but like I'm definitely not going to fuck for five hours…(Laughing) I'm not even sure what I did back then for five hours.

The participants often spoke about having long lasting chemsex sessions, which ranged from a few hours to a few days. While it could be considered time well spent and enjoyable, Rob felt like he had wasted valuable time that could have been spend more productively. Although the other participants did not express this in words, from their discussions, it can be gathered that a lot of time was lost engaging in sex for the sake of it. This led to addiction and mental problems for others which also required considerable time to recover and heal. Some participants expressed a sense of regret for all the time lost while having sex and drugs.

4.10 The relationship between internalised homophobia and chemsex

In trying to understand the possible role of internalised homophobia in chemsex from participants' life stories, I specifically asked them if they thought there is a relationship between internalised homophobia and chemsex. Ten of the eleven individuals confirmed that there could indeed be a relationship between drug use and internalised homophobia and they gave personal accounts of how they experienced homophobia and how they internalised the beliefs of their family and friends. Elly said:

> I think there is a direct link, it's a kind of escapism, for that moment you live in that moment. There is a direct link. It's probably one of the most satisfying things for you at that time. I think on a mental a level and an emotional level I think it goes beyond a physical level. Just for that moment and that time you can be entirely who you are.

The drugs allowed him to escape his current reality, the hurt and pain brought on by his family and others within his community. He mentioned that he always felt a lack of confidence, and as a result didn't feel beautiful or attractive to others and that was his continued motivation for taking drugs. The drugs transformed him into someone confident, beautiful and attractive to others. Elly struggled with the negativity and homophobic views of others for most of his life and his one certain means of escape was drugs. Elly explained it as follows, "just for that moment and that time you can be entirely who you are". While on drugs he was able to reveal his true self - someone who has not been subjected to harsh criticism by his family and friends for being gay, someone who was raised to be proud and to exude confidence.

Rob also agreed that there is a relationship between internalised homophobia and chemsex:

> Yes… I think so …uhm. Not everybody but the majority of people that I met or came across… I think the shame of what we doing and because of the internal turmoil, they want to do it but don't want to do it because society says say it's wrong and they have to cope with this internal feeling and a lot of them use drugs as a coping mechanism.

Rob had an understanding of the concept of both homophobia and internalised homophobia and clearly stated that drugs helped him to overcome the tumultuous feelings he

experienced. Rob, further mentioned that not everyone who uses drugs does so as a coping mechanism for the homophobia or internalised homophobia experienced in their lives. Some LGBTIQ+ individuals experiment with drugs for various other reasons and their eventual dependence or continued recreational use may be a factor among many other reasons.

Leon though there is a link between internalised homophobia and chemsex as revealed in his narration:

> Yes, you know even though growing up I never had a problem with my family and they never spoke about it or cared much. I felt alone and isolated. When I met my partner, I moved to Johannesburg and was working for myself. I never really came out to other people and would only hang out with other gay guys at clubs or at the rec room. When he died, I looked for that company in other people … a feeling of acceptance, intimacy and the drugs helped me with this. I would take some meth and have chemsex.

Leon was raised feeling alone and isolated from his family who never cared enough to talk to him about his sexuality and in a time when there was limited information and support for members of the LGBTIQ+ community. He withdrew from most forms of socialising in fear of being rejected. Eventually Leon met someone and they built a life together until his partner passed away. The death of his partner evoked the feelings of loneliness once again but at this point after having experienced a sense of closeness Leon sought the company of other men and in doing so, ended up participating in recreational drug use which eventually led to drugs in combination with sex, which helped remove the barriers and suppress the feelings if he were to have been rejected by anyone. Marcus had a similar story:

> Yes, I felt really empty and so my mistrust became a part of me and I withdrew from everyone and the drugs allowed me to be more open.

Marcus's family rejected him after he came out to them about his sexuality, and this led to a great deal of mistrust and a feeling of isolation which affected his confidence levels. Marcus later in life met someone whom he engaged in a co-dependent relationship with for six years and during this time he began abusing drugs in an attempt to mask a lot of the pain and depression he felt.

Zak also held the view that there is a link between internalised homophobia and chemsex. He said:

> Absolutely, but I think I need to get high and totally unpack with someone. My lack of self-acceptance is the biggest regret I have. Had I been more accepting of myself I might have been able to not go through a lot of the experiences I did which were kinda keeping the behaviour and drug use very secret and living the dual life so ya maybe unknowingly I was experiencing it.

Zak blames his lack of acceptancy for the challenges he went through in life with regards to drug use and its effects. He is of the view that had he been more accepting of his sexuality, then his reality would have been different. Lack of acceptance is a sign of internalised homophobia whereby individuals themselves against what is considered 'normal' and they find that they are lacking. The feelings of inadequacy are the ones that pushed Zak to taking drugs in order to connect with other men.

Rentboy did not comment directly on the link between internalised homophobia and chemsex but alluded to chemsex being used by drug users as an escape from the realities of life. He said:

> Chemsex is unfortunately an easy way to run away from any problems. If I have a lot of issues and stress, I'll take my phone and go on Grindr and be like I want to get high now and fuck someone. A lot of times with my ex when we were talking

about serious times, he is like no man I don't want to talk about this now and then they run away to that. Every drug user understands that when they use drugs or chems nothing becomes more important than sex so it is easy for us to forget the issue, it makes us so in love with each other and everything is fixed.

The concept of chemsex as an escape from reality is an important one, irrespective of its connection to internalised homophobia. His statement shows that sex is at times used as a past time or stress reliever by chemsex participants which in itself can lead to sex addiction. This assertion proves that the link between internalised homophobia and chemsex is not lineal but complicated. Beachboy also had a more complex take on how chemsex and internalised homophobia might be related:

I think there could be uhm, I think the following will just mess with your theory a bit. Like my friend, let's call him my friend, he has I think let me put into the Muslim category. The difference between the Cape Town and Muslim communities. Cape Town seems to be extremely conservative. I know of his friends who are married and live a straight life and have gay sex but they don't use any drugs. I don't know how they get to that point in their life. There is this one guy who wants to meet me for lunch and just wants to shag (laughing) I would at least like to have a conversation with a guy. So, I think in that case there may not be a relationship between the two or a need for drugs. I think the guy is so afraid of the community and being rejected and I also think in some cases the wife knows they just go with it because they don't want to be divorced or I don't want to be alone, or for their children, or he is wealthy or whatever. I would almost say if I relate it to myself in the Afrikaans conservative community I would definitely say there is more guys who use drugs and have sex with men who are either married or think they straight. In the Muslim culture for example you're not supposed to drink or smoke but in the Afrikaans and even in the English culture there

> are less boundaries, but I'm not sure if you can justify it like that… there must be a relationship behind it… but I don't think it's that clear-cut.

Beachboy's narration shows that gay relationships are not clear-cut. Some men have internalised homophobic views to a point that they marry women but continue to partake in chemically induced or non-chemically induced sex. In this regard, internalised homophobia leads to the perpetuation of a lie – that the man is straight- but does not always lead to use of drugs or chemsex. It can therefore be argued that whist there is a direct link between internalised homophobia and chemsex, the two are not always mutually aligned.

Anthony understood internalised homophobia and chemsex in terms of a failed attempt at living a 'normal' life:

> Yes …. I think it does in a sense because I lived this normal life with my ex…I didn't want to be like other gay couples doing threesomes etc. Like a normal heterosexual life style like my parents had, but I had thoughts of doing all these things like threesomes and stuff but I had a prejudice towards all that because I associated it with the promiscuous lifestyle… I think all those thoughts were views enforced by my family and when we broke up I ended up doing drugs to feel different and break free.

Listening to Anthony's stories was like holding up a mirror to my own life. I was raised in a Muslim home and much of what I was taught as a child still resides within me. As I navigated through life as a gay man I chose not to participate in much of the gay culture and, like Anthony, I also rejected many of the subcultural practices of homosexuality. I prefer not to conform to certain practices common within the gay culture, such as attend gay prides and parties. I choose to settle down and get married to one person and spend the rest of my life in the ambit of a marriage, much like the traditional views of family which have been instilled upon me through my religious beliefs. In this regard Anthony and I have both internalised the

views of our parents and religion, in the sense that being married and living a traditional life is right and to be single and enjoying a healthy sex life is sinful and promiscuous. Reflecting on Anthony's stories, I am so much more aware of my own life and if some unforeseen circumstances would change my current reality, in that moment I hope to be reminded that drugs will not solve my problem even if it may help alleviate the pain for a short while. The negative consequences far outweigh the short-term pleasures.

In a nutshell, from participants' accounts of their lives, it seems there is a link between their feelings of shame and inadequacy about being homosexual and their sexualised drug use, but it would be an oversimplification to claim that internalised homophobia is the direct cause of their chemsex habits. This research shows that gay men are unique individuals who deal with problems differently and this applies to the realities of internalised homophobia, drug use and chemsex. Whilst the participants admit that internalised homophobia and the feelings of loneliness, inadequacy and shame it induced promoted their drug use and chemsex experiences, it does not always follow that gay men who encounter internalised homophobia will end up taking drugs or participating in chemsex. Some gay men enter into stable relationships and do not take drugs and other live in denial and marry women. In instances where drugs were used to enhance sex, the consequences were dire for some, as addiction took place, with some participants developing physical and psychological challenges. The next chapter presents a summary, conclusions and recommendations of the study.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This study aimed to elucidate the concept of internalised homophobia and how challenges and negative experiences of homophobia, "coming out" and internalised homophobia relate to the use and abuse of chemsex drugs. The study further aimed to determine how chemsex drugs influence the sexual relationships and personal lives of gay men. My findings were that there is a relationship between internalised homophobia and chemsex, but that this varies depending on individuals' backgrounds, their experiences in coming out as gay, and their prevailing circumstances. In the study, it was found that it does not always follow that if one experiences internalised homophobia, they will turn to drugs and chemsex, though it was true of this research group. It is also important to recognise that there are other factors involved

in individuals' participating in chemsex, including simple pleasure-seeking and a lifestyle that includes (non-sexual) drug use.

In the study, I found that the concept of internalised homophobia is poorly understood and explained as external homophobia. My findings suggest that conservative family values and religious influences foster homophobia that gay men experience which predominantly gets internalised from an early age. The finding is congruent with Nicley (2001) who argues that "this internalisation can happen long before the individual recognises their own homosexuality" (p. 23) as cited by (Cornish, 2012). Men who recognise their homosexuality at an early age experience a level of internal conflict between religious and cultural influences towards homosexuality and their homoerotic desires. Generally, men with higher levels of internal conflict are more likely to internalise societal views which affects their developmental process.

I also found out that gay men in South Africa are widely subjected to direct and indirect homosexual prejudice and stigma. Religion, feelings of shame and the fear of being rejected are major deterrents to the coming out process. In other words, gay men who begin to recognise their attraction towards other men from an early age generally chose to delay their coming out to their family and friends because of family, religious and societal attitudes towards homosexuality. Not all participants in my study were rejected by family and friends during their coming out process; however, all were subjected to experiences of homophobia and those who were rejected by family and friends during their coming out process experienced a higher level of internalised homophobia and substance use.

I found that men who use and abuse chemsex drugs have had experiences of homophobia which they internalised in some form throughout their lives. The feelings of loneliness, inadequacy and shame made it easy for them to take drugs as a social crutch, which then led to chemsex. I found that the most common chemsex drugs in South Africa are crystal

meth and GHB, in contrast to similar studies conducted in the UK where is has been identified that the most common chemsex drugs used where crystal meth, GHB/GBL and mephedrone. Further research is required to better understand the variations of the type of drug used in different countries across the world. Understanding the drugs used can help with the development of treatment programmes.

It was also found that chemsex drugs enable gay men to overcome feelings of shame, guilt and low levels of confidence resulting from internalised homophobia. These drugs have the effects of reducing inhibitions, increasing libido, inducing euphoria, and enhancing sexual confidence and motivate gay men to pursue sexually adventurous and hedonistic chemsex experiences.

The study also showed that drugs were used at first within a recreational setting and over time the continued use of drugs progressed to other more illicit types of drugs such as crystal meth and GHB. Drugs were often used to elevate self-esteem and facilitate more intimate connections including sexual intimacy. Crystal meth and GHB were used in pursuit of chemsex pleasure with little awareness or understanding of the negative consequences such as mental and physical health issues, financial ruin, harm to self and others and loss of time.

With regard to drug use, the finding can be summarised under two themes: The highs of chemsex and the lows of chemsex. The highs can be summarised as follows – increased sexual desire, stamina and libido, sexual pleasure, euphoria, reduced inhibition, intimacy, sexual confidence and enabling sexual adventures. The lows of chemsex can be summarised as follows – issues relating to physical and mental health, high risk of sexually transmitted diseases, loss of time, financial ruin and substance use disorder. The findings of this study are similar to findings of qualitative studies conducted in the UK, USA, Spain and Australia;

however, no similar study exists within South Africa on the relationship between chemsex and internalised homophobia.

5.2 Limitations

Some of the limitations of the study are noted below:

The population and sample were limited to persons at one rehabilitation centre and to patrons who frequent the Hothouse. Additionally, the age and cultural or ethnic groups of the sample population are not representative of the diverse population of South Africa.

More than half of the participants interviewed were between the ages of 41 and 50. A quarter of the participants were between the ages of 20 and 30 and only one participant was between the age of 31 and 40. Of the eleven participants who were interviewed, three were from the Northern Cape treatment centre and the remaining eight were contacted via the Hothouse. Identifying participants from Inner Peace was slightly more challenging as the participants were undergoing rehabilitation treatment and not very forthcoming. Only three gay men who were admitted at Northern Cape treatment centre volunteered to participate. The study was also limited to a specific time period. Further research could be conducted at one or more rehabilitation centres and a national study may be beneficial to show how gay men are affected by internalised homophobia and how this relates to their drug use and chemsex.

It is important to state that l experienced difficulty in making contact with a broader sample of suitable participants and had to rely on volunteers due to the increased difficulty of finding LGBTIQ+ patients at other treatment centres and the sensitive nature of the research topic. There was a greater response from the Hothouse (eight participants), but a further limitation presented itself in that only Coloured and White individuals responded to the invitation to participate in the study. This means this study is not representative of other races in South Africa and thus the findings cannot be generalised.

The limitations relating to the sample pointed out above are not meant to suggest that in a qualitative study a 'representative sample' is required, but are highlighted as a caution that the accounts of growing up as gay and of participating in chemsex were sourced from a fairly specific section of the South African population.

A further limitation, but also a strength of the study is my personal positioning as a gay man who has personal experience of homophobia and internalised homophobia and has several acquaintances who have participated in chemsex. This enabled me to bring a knowledgeable insider's view to the study, but, may also have biased my perspective to some extent. Other possible biases relate to my role as an outsider with regard to drug use (I do not use drugs) and casual sexual encounters (I am in a monogamous relationship and engaged to be married). While I tried throughout not to be blinded by my personal positioning (for instance by becoming judgemental about sexual practices), it is nevertheless important to note.

A final limitation concerns the fact that I interviewed only individuals who actually engaged in chemsex. While my intention was obviously not to conduct an experimental study (which might have included a control group of non-chemsex participants) even in a qualitative study such as this it would have been useful to include a group of individuals who do not engage in chemsex in order to compare and contrast their experiences of internalised homophobia with that of those who do.

5.3 Further research

Further research is recommended on the subject of internalised homophobia and chemsex with specific focus on the South African LGBTIQ+ community. Although there are no doubt many similarities with regard to internalised homophobia and chemsex in South Africa and the rest of the world, my limited research suggests that the gay community in South Africa has its own unique challenges attributable to our diverse culture, societal and racial

segregation which are all unique contributing factors to the experience of homophobia, internalised homophobia and chemsex.

A similar comparison study could be conducted with a sample of non-drug users to further understand the impact internalised homophobia within the LGBTIQ+ community in South Africa.

Finally, there are no reliable statistics regarding the actual prevalence of chemsex in South Africa, and epidemiological research in this regard would be very useful.

5.4 Recommendations

When considering the concepts of homophobia and internalised homophobia in relation to how it is understood within society I am reminded of an age old saying: “It is better to deal with the devil you know, than the devil you don't know.” Gay men and as well as all other members of the LGBTIQ+ community are generally fairly familiar with the concept of homophobia. Homophobia (“the devil we know”), is a term that is generally understood, extensively researched and has gained notoriety through years of media attention. However, as my findings suggest, much less is understood about the concept of internalised homophobia (“the devil we don't know”) and that it could be potentially more damaging. Internalised homophobia is far more challenging to deal with as it requires some introspection on the part of the individual who has internalised the negative and stereotypical views imposed by others. The biggest challenge is that gay men must first recognise their sexual orientation which they may have suppressed or denied due to homophobia. A lack of knowledge, recognition and understanding of internalised homophobia worsens the situation pointing to a need to conscientise gay people of what internalised homophobia is and its effects. Understanding what internalised homophobia is before embarking on a self-fulfilling journey of acceptance can help curtail some of the stumbling blocks they may find of their journey.

It is therefore recommended that LGBTIQ+ organisations focus additional efforts on publicising and explaining the concept of internalised homophobia to their constituencies. Non-LGBTIQ+ organisations such as government education departments should also consider including material not only on homophobia but also on internalised homophobia on the various platforms used to create awareness.

The minority stress framework that was used to elucidate the concept of internalised homophobia, including the findings of my study, suggests that gay men living in a heterosexist society are prone to chronic stress resulting from stigmatisation, prejudice and discrimination (Meyer, 1995, 2003). Based on the minority stress theory, gay men are more likely to suffer from chronic stress, depression, anxiety, substance use disorder and acquiring sexually transmitted diseases. Therefore, it is recommended that clinicians, healthcare providers, government, and LGBTIQ+ support centres, should focus on dealing with the underlying causes of clients' internalisation of homophobia and less on symptomatic relief of the results.

We have all heard the phrase "don't do drugs" or "drugs are bad for you" - used by overprotective parents and teachers in an attempt to warn us that drugs are bad. We are all raised to believe that drugs are bad for us and this belief is further reinforced by religion, government and many other anti-drug organisations. These organisations continuously advocate a 'no drug' policy and promote abstinence in a bid to prevent people from using drugs, and also to convince those who are using drugs to stop. The South African drug trafficking act No.140 of 1992 aimed at addressing the use, abuse and drug trafficking states:

> To provide for the prohibition of the use or possession of, or the dealing in, drugs and of certain acts relating to the manufacture or supply of certain substances or the acquisition or conversion of the proceeds of certain crimes; for the obligation to report certain information to the police; for the exercise of the powers of entry, search,

seizure and detention in specified circumstances; for the recovery of the proceeds of drug trafficking; and for matters connected therewith.

Abstinence from drugs continues to be the core message in fighting the drug epidemic in South Africa, except for the use of cannabis which has been declared as legal for personal use.

The findings of my study suggest that not all gay men experience extreme negative outcomes as a result of chemsex and some favour using drugs as a precure for sex. When considering existing policies on drug use and a few of the more recently debated solutions such as decriminalisation of drug use and harm reduction initiatives, I propose that Government, LGBTIQ+ organisations and others dealing with concerns relating to drug use and abuse should consider:

- Alternatives solutions other than abstinence and/or persecution.
- Initiatives and strategies focused on finding solutions that are tailored towards the underlying reason for the why gay men are motivated to use drugs as a precursor for sex.
- Providing non-judgmental, non-discriminatory care and assistance to gay men who are currently using drugs.
- Providing knowledge and working to increase awareness of safer drug use (harm reduction).

Further research can be conducted to evaluate the effectiveness of abstinence versus harm reduction and how the two approaches compare in response to the many challenges facing both the LGBTIQ+ community and the general population.

Conclusion

Throughout the writing of this dissertation, I have gained significant insight about myself and the challenges facing the gay community as well as a deeper appreciation for the community at large. One of the many insights that I have gained is that even though I thought I suffered no obvious ramifications of internalised homophobia and despite my knowledge of the subject, I was wrong. For a long time, I have internalised the views of others who so typically condemn gay men for their association with drugs, AIDS and promiscuity. Such prejudice prevented me from disclosing my sexuality, more especially to people at work for risk of limiting my career progression and partly because over time I had begun to internalise the very same views expressed by others and began rejecting the gay community. I refused to be falsely labelled as someone who does drugs, or have people question whether or not I have a disease, or to be seen as promiscuous. I felt bitter and resentful towards everyone in both gay and straight worlds. I despised being judged by my community, family and co-workers and more than that I despised some members of the gay community for the imagery of gayness that I have built up in my mind, reinforced by the media and online social platforms. At the time, my only defence against any such labelling was to ensure that I become someone respected and considered successful with my community.

Speaking to the participants who were brave enough to share intimate and personal information about their lives with me, allowed me to appreciate their challengers and the many hardships they have endured in life in order to attain a same or similar kind of happiness and contentment as I strive to achieve in my personal life. Furthermore, conversing with the participants of my study, I began to break down my own personal bias and prejudice held in respect of drugs and the many negative perceptions about the gay community guided by my own ignorance and misguided belief. As I conclude this chapter and dissertation, I end with a quote by Stephen Covey (1989) who wrote:

Seek first to understand, before you can be understood. (n.p.)

Gay or straight, we should all first try to understand other people before imposing our views on someone else. Using drugs to enhance gay sex is highly contentious and frowned upon, but yet let us first understand why it is being done before we judge or try to correct the behaviour.

References

Abdulrahim, D., Whiteley, C., Moncrieff, M., & Bowden-Jones, O. (2016). Club drug use among lesbian, gay, bisexual and trans (LGBT) people. Novel Psychoactive Treatment UK Network retrieved from http://neptuneclinicalguidance.co.uk/wpcontent/uploads/2016/02/neptune-club-drug-use-among-lgbt-people.pdf

Adamczyk, A., & Pitt, C. (2009). Shaping attitudes about homosexuality: The role of religion and cultural context. *Social Science Research, 38*(2), 338–351. doi:10.1016/j.ssresearch.2009.01.002

American Psychiatric Association. (1968). *Diagnostic and Statistical Manual of Mental Disorders*, 2nd ed. American Psychiatric Press: Washington, DC, USA.

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, 57(12), 1060-1073. https://www.apa.org/ethics/code/ethics-code-2017.pdf.

Argo, H. (2017). Alright, let's talk about GHB: A user's guide. Retrieved from https://hilaryagro.wordpress.com/2017/04/12/alright-lets-talk-about-ghb-a-users-guide/

Armstrong, E. A., & Suzanna, M. C. (2006). Movements and memory: The making of the Stonewall myth. *American Sociological Review, 71*(5), 724-751 doi: 10.1177/000312240607100502

Bahramnezhad, F., Cheraghi, M. A., Formani, F. K., & Shogi, M. (2014). Ethical challenges of researchers in qualitative studies: the necessity to develop a specific guideline. *Journal of Medical Ethics and History of Medicine* ,*7*(14),**page.** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4263394/pdf/jmehm-7-14.pdf

B. Berg. (2009). Qualitative Research Methods for the Social Sciences. Boston: Allyn & Bacon, pp. 101-157. Retrieved from http://www.sfu.ca/~palys/Berg-2009-DramaturgicalViewOfInterviewing.pdf

Bernasconi, R., Mathivet, P., Bischoff, S., & Marescaux, C. (1999). Gamma-hydroxybutyric acid: An endogenous neuromodulator with abuse potential? Trends in Pharmacological Science, 20, 135-141.

Berube, A. (2010). The history of gay bathhouses. *Journal of homosexuality*,*44*(3), 33 -53. http://dx.doi.org/10.1300/J082v44n03_03.

Burgess, F.T. (2001). *A general introduction to the design of questionnaires for Survey research: Guide to the design of questionnaires* (1st ed.). Leeds, UK: University of Leeds

Bourne, A., Reid, D., Hickson, F., Torres Rueda, S., & Weatherburn, P. (2014). The chemsex study: drug use in sexual settings among gay and bisexual men in Lambeth, Southwark and Lewisham. Retrieved from http://www.sigmaresearch.org.uk/chemsex.

Busardo, F. P., Schifano, F., Tagliabracci, A., Giorgetti, R., Marinelli, E., & Zaami. Simona. (2016). When "chems" meet sex: A rising phenomenon called " chemsex". *Current Neuropharmacology 15*(5), 762- 770. doi: 10.2174/1570159X15666161117151148

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. http://eprints.uwe.ac.uk/11735/2/thematic_analysis_revised_-_final.pdf

Drescher, J. (2015). Out of DSM: Depathologizing homosexuality. *Behavioural Science, 5*(4), 565-575. doi:10.3390/bs5040565

Cabaj, R. P. (2000). Substance abuse, internalised homophobia, and gay men and lesbians: Psychodynamic issues and clinical implications. *Journal of Gay and Lesbian Psychotherapy*, *3*(3-4), 5-24. https://doi.org/10.1300/J236v03n03_02

Carroll, L. (2010). Sexual and gender minority couples. In *counselling sexual and gender minorities*. (Chapter 7). Retrieved from https://counsellingfoundation.org/wp-content/uploads/2017/10/Carroll-L.-2010-Sexual-and-Gender-Minority-Couples-Ch-7-Counselling-Sexual-and-Gender-Minorities-Merrill-Colombus-Ohio.pdf

Cherry, K. (2018). An overview of stimulants and how they're used. Retrieved from https://www.verywellmind.com/what-are-stimulants-2795573.

Clarke, V., & Braun, V. (2013). Teaching thematic analysis: Overcoming challenges and developing strategies for effective learning. *The Psychologist, 26*(2). 120-123. http://eprints.uwe.ac.uk/21155

Cochra, S. D., Drescher, J., Kismodi, E., Giami, A., Garcia- Mareno, C., Atalla, E.,… Reed, G. M. (2014). Proposed declassification of disease categories related to sexual orientation in the International Statistical Classification of Diseases and Related Health Problems (ICD-11). *Bulletin of the World Health Organisation,92*(2), 672–679. doi: http://dx.doi.org/10.2471/BLT.14.135541

Coming out. (2016). In Urban Dictionary online. Retrieved from https://www.urbandictionary.com/define.php?term=coming%20out.

Comstock, G. D. (1991). Between men—between women: Lesbian and gay studies. Violence against lesbians and gay men. New York, NY, US: Columbia University Press.

Creswell, J.W. (2003). Research design: Qualitative, quantitative, and mixed method. Retrieved from https://pdfs.semanticscholar.org/73b7/18e508fa943dfb22a9cb5fb17f888239ad0e.pdF

Degges-White, S., Rice, B., & Myers, J. E. (2000). Revisiting Cass' theory of sexual identity formation: A study of lesbian development. *Journal of Mental Health Counselling, 22*(4), 318 - 333.

De Franzo, S. E. (2011 September 16). What's the difference between qualitative and quantitative research? [Web log] Retrieved from https://www.snapsurveys.com/blog/qualitative-vs-quantitative-research/

Dlamini, E. (n.d). Dealing with prejudice. *Anova health*. Retrieved from https://www.wethebrave.co.za/dealing-with-prejudice/

Drescher, J. (2015). Out of DSM: Depathologising homosexuality. *Behavioural Science 5*(4) 565-575. http://doi:10.3390/bs5040565

Drescher, J. R., & Guss, J. R. (2000). Addictions in the Gay and Lesbian community. New York, London, Oxford, The Haworth Medical Press

Dumay, J., & Qu, S.Q. (2013). The qualitative research interview. *Qualitative Research in Accounting & Management, 8* (3), 238-264. doi 10.1108/11766091111162070

Epprecht, M. (2007). The 'unsaying' of indigenous homosexualities in Zimbabwe: mapping a blindspot in an African masculinity. *Journal of Southern African Studies, 24*(4), 631-65. https://doi.org/10.1080/03057079808708594

Fazio, A., Hunt, G., & Moloney. M. (2011). "It's One of the better drugs to use": Perceptions of cocaine use among gay and bisexual Asian American men. *Qualitative Health Research, 21*(5),625-41. doi: 10.1177/1049732310385825.

Feminism. (n.d.). In Encyclopedia Britannica online. Retrieved from https://www.britannica.com/EBchecked/topic/724633/feminism.

Galloway, G., Frederick, S., Staggers, F., Gonzales, M., Stalcup, S., & Smith, D. (1997). Gamma-hydroxybutyrate: An emerging drug of abuse that causes physical dependency. *Addiction, 92*(1) 89-96. https://www.ncbi.nlm.nih.gov/pubmed/9060200.

Gevisser, M. (1995). A different fight for freedom. Defiant Desire. New York, NY: Routledge, 14-89.

Ghaziani A., Cook, T.D. (2005). Reducing HIV infections at circuit parties: From description to explanation and principles of intervention design. *Journal of the International Association of Physicians in AIDS Care (JIAPAC, 4*(2),32–46. doi: 10.1177/1545109705277978.

Graziano, K. J. (2005) Reflections from University Students in a South African Gay and Lesbian Society. *International Journal for the Advancement of Counselling, 27*(2) 302. doi:10.1007/s10447-005-3188-0.

Gumbo, F. Z., & Stray-Pedersen B. (2013). The interaction of tuberculosis and HIV in Africa. *Journal of AIDS Clinical Research, 4* (228). doi:10.4172/2155-6113.1000228

Hallam, A. (2014). Duality in consumer theory [PDF document]. Retrieved from Lecture Notes Online Website: https://www.econ.iastate.edu/classes/econ501/Hallam/index.html

Herek, G. M. (2004). Beyond "Homophobia": Thinking about sexual prejudice and stigma in the twenty-first century. *Sexuality Research & Social Policy,*1(2),6-24. https://doi.org/10.1525/srsp.2004.1

Hetrick, E. S., & Martin, D.A. (1984). Ego-dystonic homosexuality: A development view. Innovations in psychology. Washington DC, American Psychiatric Association Press

Hibbert, P., Coupland, C., & MacIntosh, R. (2010). Reflexivity: recursion and relationality in organizational research processes. *Qualitative Research in Organizations and Management: An International Journal, 5* (1),47 - 62. http://eprints.gla.ac.uk/44661/1/44661.pdf

Homosexuality. (2018). Encyclopaedia Britannica online. Retrieved from: https://www.britannica.com/topic/homosexuality

Hutt, R. (2018). This is the state of LGBTI rights around the world in 2018. Retrieved from https://www.weforum.org/agenda/2018/06/lgbti-rights-around-the-world-in-2018/

Jones, O. (2016, October, 20). Gay men are battling a demon more powerful than HIV – and it's hidden. The Guardian. Retrieved from https://www.theguardian.com/commentisfree/2016/oct/20/gay-men-hiv-homophobia-lgbt-drink-drugs.

Katz-Wise, S. L., Rosario, M., & Tsappis, M. (2016). LGBT Youth and family acceptance. *Pediatr Clin North Am,63*(6). doi:10.1016/j.pcl.2016.07.005.

Kirby. T., & Thornber-Dunwell. M. (2013), High-risk drug practices tighten grip on London gay scene. *Lancet, 381,*(9861),101-102. https://doi.org/10.1016/S0140-6736(13)60882-X

Kwan, C. K., & Ernst, J. D. (2011). HIV and tuberculosis: a deadly human syndemic. *Clin Microbiol Rev, 24,* 351-376. https://www.ncbi.nlm.nih.gov/pubmed/21482729

Laborit, H. (1964). Sodium 4-hydroxybutyrate. *International Journal of Neuropharmacology 3*(433–52).

Anderson, l. (2018). GHB or Gamma-Hydroxybutyrate. Retrieved from https://www.drugs.com/illicit/ghb.html

Lapadat, C. J. (2010). Encyclopedia of Case Study Research.Thematic Analysis. Twin Oakes. SAGE Publications, Inc.

Lapadat, C. J. (2010). Thematic Analysis. Retrieved from http://dx.doi.org/10.4135/9781412957397.n342

Lea, T., Mao, L., Hopwood, M., Prestage, G., Zablotska, I., de Wit, J., & Holt, M. (2016). Methamphetamine use among gay and bisexual men in Australia: Trends in recent and regular use from the gay community periodic surveys. *International Journal of Drug Policy.* doi:10.1016/j.drugpo.2016.01.003.

Leedy, P. D. (1997). Practical research: Planning and design (6th Edition). New Jersey: Prentice-Hall.

Livingston, J. H. (2014). *The experiences and meaning that shape heterosexual fathers' relationship with their gay sons*. (Doctoral Thesis) Retrieved from http://uir.unisa.ac.za/handle/10500/13606.

Merriam, S. (2009). Qualitative research: A guide to design and implementation. San Francisco, CA: Jossey-Bass.

Meyer, H., & Dean, L. (1998). Internalised homophobia, intimacy, and sexual behaviour among gay and bisexual men. doi: 10.4135/9781452243818.n8.

McCall, H., Adams, N., Mason, D., & Willis, J. (2015). What is chemsex and why does it matter? *BMJ, 351*. Retrieved from http://dx.doi.org/ 10.1136/bmj.h5790.

Nell. M., & Shapiro, J. (2011). Out of the box: Queer youth in South Africa today. Retrieved from https://www.atlanticphilanthropies.org/wpcontent/uploads/2015/09/Out_of_the_box_queer_youth_in_South_Africa_Today_0.pdf

NIDA. (2017). Substance use and SUDs in LGBT populations. Retrieved from https://www.drugabuse.gov/related-topics/substance-use-suds-in-lgbt-populations

NIDA. (2018). Methamphetamine. Retrieved from https://www.drugabuse.gov/publications/drugfacts/methamphetamine

O' Leary, D. (2014). The syndemic of AIDS and STDS among MSM.[Abstract] *National Institutes of Health,81*(1),12-37. doi: 10.1179/2050854913Y.0000000015

Psychology Notes HQ. (2017). Erik Erikson's theory of psychosocial development. Retrieved from URL. https://www.psychologynoteshq.com/erikerikson/

Rebekah, B. A., & Van Hout, M-C. (2014) Gamma-Hydroxybutyrate (GHB): A Scoping review of pharmacology, toxicology, motives for use, and user groups. *Journal of Psychoactive Drugs, 46*(3), 243-251. DOI: 10.1080/02791072.2014.921746

Ritter, K. Y., & Terndrup, A. I. (2002). *Handbook of affirmative psychotherapy with lesbians and gay men*. New York: Guilford Press.

Rubin, H. J., & Rubin, I. S. (1995), Qualitative Interviewing: The Art of Hearing Thousand Oaks, CA: Sage.

Saunders, M., Lewis, P., & Thornhill, A. (2003). Research methods for business students. Harlow, Prentice Hall Financial Times.

Singer, M. (1994). AIDS and the health crisis of the US urban poor: The perspective of critical medical anthropology. *Social Science and Medicine, 39*(7), 931-948.

Singer M. (1996). A dose of drugs, a touch of violence, a case of AIDS: Conceptualizing the SAVA syndemic. *Free Inquiry in Creative Sociology, 24*(2), 99-110.

Slam. (2011). In urban dictionary online. Retrieved from https://www.urbandictionary.com/define.php?term=Slam

Sutherland, C. (2016). Progressive prudes a survey of attitudes towards homosexuality & gender non-conformity in South Africa. Retrieved from https://theotherfoundation.org/wp-content/uploads/2016/09/ProgPrudes_Report_d5.pdf

Taylor-Powell, E., & Renner, M. (2003). Analysing qualitative data. Retrieved from http://learningstore.uwex.edu/assets/pdfs/g3658-12.pdf.

Weatherburn, P., Hickson. F., Reid D., Torres-Rueda, S., & Bourne. A. (2016) Motivations and values associated with combining sex and illicit drugs ('chemsex') among gay men in South London: Findings from a qualitative study. Retrieved from http://researchonline.lshtm.ac.uk/2760425/1/Chemsex%20motivations%20re-SUBMISSION%20v.3.docx.

Weber, G. (2008). Using to numb the pain: Substance use and abuse among lesbian, gay, and bisexual individuals. *Journal of Mental Health Counselling, 30*(1), 31-48. https://doi.org/10.17744/mehc.30.1.2585916185422570

World health organisation (WHO). (2012). Gamma-hydroxybutyric acid (GHB) critical review report. Retrieved from https://www.who.int/medicines/areas/quality_safety/4.1GHBcritical_review.pdf?ua=1

Zive, G. (n.d). A brief history of Western homosexuality. Retrieved from https://www.csustan.edu/sites/default/files/honors/documents/journals/sexinstone/Zive.pdf

APPENDICES

Appendix A: Participant information sheet/ Volunteer request (Northern Cape rehabilitation centre)

PARTICIPANT INFORMATION SHEET / VOLUNTEER REQUEST

Ethics clearance reference number: PERC- 17033

February 2018

Dear

My name is Naeem Cassim and I am doing research under the supervision of Professor Martin Terre Blanche, a professor in the Department of Psychology towards a masters in psychology at the University of South Africa. You are invited to participate in a study entitled "The highs of chemsex and the lows of internalised homophobia". Exploring a possible relationship between chemsex and internalised homophobia among gay men in South Africa.

WHAT IS THE PURPOSE OF THE STUDY?

I am conducting this research to explore the complex ways in which chemsex and internalised homophobia may be linked. The study is carried out to (1) determine the psychosocial challenges experienced by homosexuals and 2. How psychoactive drugs influences the lives of homosexual men. The researcher is undertaken to observer if such a relationship exists within the gay community. The study also seeks to explore the complex and interesting ways in which chemsex and internalised homophobia may be linked in people's lives and possibly poorly

understood by the same individuals going through the experience. The research is premised on the assumption that more knowledge on these two variables may lead to a better self-acceptance by homosexuals who may be denying aspects of who they are and hopefully to better understanding of the attractions and less positive aspects of chemsex.

The information that will be collected in this research will be used for academic purposes only.

WHY AM I BEING INVITED TO PARTICIPATE?

The research focuses on men who have sex with men while using psychoactive drugs. The Inner peace addiction centre was selected because it caters for members of the LGBTI community. The research is focused on gay and bisexual men who have developed a substance use disorder and used drugs while engaging in sexual relations with other men. You are invited to participate in this study that seeks to document the challenges faced by homosexuals and the possible relationship to sexualised drug use (chemsex). This research is carried out for academic purposes and your right to anonymity will be respected. Information will be collected from participants through interviews, as such your voluntary consent is sought to participate in this study.

A letter requesting permission to interview patients was sent to the manager of inner peace. The manager at Inner peace will select potential participants and requested individuals who have given explicit permission will be contacted by myself. In line with POPI (*Protection of Personal Information Act, nr 4 of 2013),* which necessitates the disclosure of how the contact details of prospective participants were obtained. I did not have access to any patient's personal information prior to obtaining your consent, but if you volunteer for the study I will be meeting you personally. My research is based on a qualitative design and approximately twelve

participates will be required for the dissertation. You are therefore invited to participate in this academic research.

WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY?

The study involves one or more semi-structured interviews which will be recorded using a password protected audio recorder. The following questions and sub questions (arranged roughly from general to specific and from lived experience to abstract opinions) will be explored in relation to understanding the relationship between chemsex and internalised homophobia. The interview will begin by requesting basic demographic information. Your name will not be requested to ensure your privacy is protected and that you remain anonymous throughout the study.

How old are you?	Where do you stay?	Are you employed?	How often do you visit the hothouse?
What is your sexual orientation?	What is your Relationship status?		

Questions that are related to the study will include

- Have you come out as a gay man?
- If, no why not?
- If no, what challenges have you encountered in your life as a result of hiding your sexual orientation (physical, psychological, social)
- What social challenges have you encountered in your life as a result of hiding your sexual orientation?

- Has this affected your relationships?
- If yes, when did you come out?
- What challenges have you encountered as a result of coming out?
- Do you take drugs/prescribed medication drugs or alcohol?
- When did you first start using drugs
- How often do you use drugs?
- What kind of drugs do you use?
- How long have you engaged in drug use?
- Have you ever used a combination of drugs at the same time?
- What were the effects of the combination of drugs used.
- What was your motivation for taking drugs?

- Please share your chemsex experiences, whatever comes to mind
- How often have you engaged in chemsex and was it mostly on weekdays or weekends?
- Please describe some of your positive and less positive aspects of your chemsex experiences?
- How does your chemsex experiences fit into the rest of your life?
- Do you understand the concept of internalised homophobia?
- Do you consider yourself as having experienced internalised homophobia, and if so how do you see it affecting your personal and social life?
- Do you feel that there is a link between your chemsex experiences and internalised homophobia, and if so how do you describe the link?

THE INTERVIEW ENVIRONMENT

The interview will be conducted at a public or private venue most convenient to you and may take up to an hour to be completed.

CAN I WITHDRAW FROM THIS STUDY EVEN AFTER HAVING AGREED TO PARTICIPATE?

Participation in this study is voluntary and you are under no obligation to consent to participation. If you do decide to take part, you will be given this information sheet to keep and asked to sign a written consent form. You are free to withdraw at any time and without giving a reason. Your personal identity will remain anonymous during the interview, at the write-up stage and after the completion of this study.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

The information that will be produced in the study may be beneficial to you in understanding the challenges other gay people encounter and also in understanding the possible relationship between internalised homophobia and chemsex. It is hoped that the recommendations made in this study may positively influence gay men and lead to better self-awareness and acceptance. These benefits are indirect and will be as a result of reading the outcomes of the study. Besides the stated outcomes of the study, there are no direct benefits monetary or otherwise that you will receive as a result of participating in this study.

HAS THE STUDY RECEIVED ETHICS APPROVAL?

This study has received written approval from the Research Ethics Review Committee of the Department of Psychology at the University of South Africa. A copy of the approval letter can be obtained from me if you so wish.

ARE THERE ANY NEGATIVE CONSEQUENCES FOR ME IF I PARTICIPATE IN THE RESEARCH PROJECT?

I understand that sharing your personal stories with me may bring about some discomfort and could be traumatic. It is important to know that you have the right to withdraw from the interview at any point without prejudice. The information that will have been recorded up to the point whereby you have decided to withdraw will be deleted from the audio recorder.

Should the interview process become stressful and traumatic, I will be obliged to cancel the session and you have the option of continuing when you feel more comfortable. Should you also require some counselling post the interview, I will arrange for counselling sessions for your benefit.

WILL THE INFORMATION THAT I CONVEY TO THE RESEARCHER AND MY IDENTITY BE PROTECTED?

Yes. This study is for academic purposes only. You will not be asked to state your name or surname. A pseudonym will be used to identify you and strong measures will be taken to ensure that no one can link you to the information you revealed. In the write up of this study, your name will not be used and if the results of this study are published, your identity will remain private. Every measure will be taken to ensure that your personal details remain confidential and that your privacy is respected.

Your story may be reviewed by my supervisor and members of the universities research ethics committee with the intention of ensuring that I have correctly transcribed your information. My supervisor will be invited to sign a confidentiality agreement and only your pseudonym will be disclosed. A copy of the transcript will be made available to you before final submission for to determine that I have correctly represented your story.

HOW WILL THE RESEARCHER(S) PROTECT THE SECURITY OF DATA?

Hard copies of your answers will be stored by the researcher for a minimum period of five years in a locked password protected safe at my house for future research or academic purposes; the audio recordings and electronic information will be stored on my laptop which is password protected. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable. After the required period, the saved recording of our interview will be deleted from my laptop and cleared from the recycle bin.

WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?

No. You will not receive any direct monetary or tangible incentives as a result of participating in this study. As a participant, you will not incur any costs or expenses as a result of participating in this research.

HOW WILL I BE INFORMED OF THE FINDINGS OF THE RESEARCH?

If you would like to be informed of the final research findings, please contact Naeem Cassim on 076 287 4497 or email at naeemcassim2@gmail.com. Should you require any further information or want to contact me about any aspect of this study, please feel free to contact me on the number provided above.

Should you have concerns about the way in which the research has been conducted, you may contact my supervisor Professor Martin Terre Blanche contact via email at Terremj@unisa.ac.za or you may contact the Research Ethics Chairperson of the Department of Psychology, Professor Kruger on krugerp@unisa.ac.za if you have any ethical concerns.

HOW DO I GET INVOLVED IN THE STUDY?

Should you wish to volunteer in the research study please contact me directly on the details provided below:

Email: naeemcassim2@gmail.com Cell: 076 287 4497 (Available on WhatsApp)

Thank you for taking time to read this information sheet and for your consideration to participate in this study.

Thank you.

Naeem Cassim

076 287 4497

Appendix B: Participant information sheet/ Volunteer request (Hothouse)

PARTICIPANT INFORMATION SHEET / VOLUNTEER REQUEST (HOTHOUSE)

My name is Naeem Cassim and I am doing research towards a master in psychology at UNISA. You are invited to participate in a study entitled**: *"The highs of chemsex and the lows of internalised homophobia".***

The study seeks to explore the complex and interesting ways in which chemsex and internalised homophobia may be linked in people's lives. The study is carried out to (1) determine the psychosocial challenges experienced by homosexuals and (2). How psychoactive drugs influences the lives of homosexual men. Most adults have had some experience with chemsex, in the sense that they may have had sex in the context of having drunk alcohol or smoked a joint. Some are (or have been) more deeply entrenched in the chemsex scene in that they use more hardcore drugs specifically to enhance sexual pleasure. I am interested in talking to people who have had some limited chemsex experience as well as to those who have been more intensely involved.

If you would like to participate in this effort to increase awareness and understanding by sharing your personal experience experiences with me, please contact me on:

Cell: Naeem Cassim 076 287 4497

January 2018

Dear Prospective Participant

My name is Naeem Cassim and I am doing research under the supervision of Professor Martin Terre Blanche, a professor in the Department of Psychology towards a masters in psychology at the University of South Africa. You are invited to participate in a study entitled “The highs of chemsex and the lows of internalised homophobia”. Exploring a possible relationship between chemsex and internalised homophobia among gay men in South Africa.

WHAT IS THE PURPOSE OF THE STUDY?

I am conducting this research to explore the complex ways in which chemsex and internalised homophobia may be linked. The study is carried out to (1) determine the psychosocial challenges experienced by homosexuals and (2). How psychoactive drugs influences the lives of homosexual men. The researcher is undertaken to observe if such a relationship exists within the gay community. The study also seeks to explore the complex and interesting ways in which chemsex and internalised homophobia may be linked in people’s lives and possibly poorly understood by the same individuals going through the experience.

Most adults have had some experience with chemsex, in the sense that they may have had sex in the context of having drunk alcohol or smoked a joint. Some are (or have been) more deeply entrenched in the chemsex scene in that they use more hardcore drugs

specifically to enhance sexual pleasure. I am interested in talking to people who have had some limited chemsex experience as well as to those who have been more intensely involved

The research is premised on the assumption that more knowledge on these two variables may lead to a better self-acceptance by homosexuals who may be denying aspects of who they are and hopefully to better understanding of the attractions and less positive aspects of chemsex.

The information that will be collected in this research will be used for academic purposes only.

WHY AM I BEING INVITED TO PARTICIPATE?

Men who have had sex with men while on drugs currently or in the past are invited to participate in my research study This letter is sent out to all members whose name is on the mailing list of the hothouse situated in Greenpoint Cape Town. The selected hot house is a popular gay venue frequented by straight, gay and bisexual men for assorted reasons, namely: socialising, enjoying a night out or engaging in sexual activities while maintaining a certain level of anonymity. The hothouse was selected because it may include participants who engage in sexualised (chemsex) drug use, but who are not necessarily currently being treated for any alcohol or substance related problems. You are invited to participate in this study that seeks to document the challenges faced by homosexuals and the possible relationship to sexualised drug use (chemsex). This research is carried out for academic purposes and your right to anonymity will be respected. Information will be collected from participants through interviews, as such your voluntary consent is sought to participate in this study

Appendix C: Consent to participate in this study

CONSENT TO PARTICIPATE IN THIS STUDY

I, _____ (participant name), confirm that the person asking for my consent to take part in this research has told me about the nature, procedure, potential benefits and anticipated inconveniences of participating in this study.

I have read (or had the details explained to me) and understood the requirements and expectations of the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without prejudice.

I am aware that the findings of this study will be processed into a dissertation but that my participation will be kept confidential.

I agree to the recording of the interview using a password protected audio recording device.

I have received a signed copy (in writing or by email) of the informed consent agreement.

Participant Name & Surname…… (PRINT NAME)

Participant Signature……..Date……

Researcher's Name & Surname……(PRINT NAME)

Researcher's signature……..Date……

Appendix D: Interview Script

throughout the study.

How old are you?	Where do you stay?	Are you employed?	How often do you visit the hothouse?
What is yoursexual orientation?	What is your Relationship status?		

Questions that are related to the study will include

- Have you come out as a gay man?
- If, no why not?
- If no, what challenges have you encountered in your life as a result of hiding your sexual orientation (physical, psychological, social)
- What social challenges have you encountered in your life as a result of hiding your sexual orientation?
- Has this affected your relationships?
- If yes, when did you come out?
- What challenges have you encountered as a result of coming out?
- Do you take drugs/prescribed medication drugs or alcohol?
- When did you first start using drugs
- How often do you use drugs?
- What kind of drugs do you use?

    - How long have you engaged in drug use?
    - Have you ever used a combination of drugs at the same time?
    - What were the effects of the combination of drugs used.
    - What was your motivation for taking drugs?
- Please share your chemsex experiences, whatever comes to mind
- How often have you engaged in chemsex and was it mostly on weekdays or weekends?
- Please describe some of your positive and less positive aspects of your chemsex experiences?
- How does your chemsex experiences fit into the rest of your life?
- Do you understand the concept of internalised homophobia?
- Do you consider yourself as having experienced internalised homophobia, and if so how do you see it affecting your personal and social life?
- Do you feel that there is a link between your chemsex experiences and internalised homophobia, and if so how do you describe the link?

Appendix E: Ethics Clearance