

“So that’s where I’ve probably formed those perceptions from”:

**A focus group study of lesbian, gay, bisexual, pansexual,
transgender and queer individuals’ perspectives on chronic
illnesses**

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This study investigated how lesbian, gay, bisexual, pansexual, transgender and/or queer people (LGBPTQ) perceive HIV/AIDS and rheumatoid arthritis as examples of chronic illnesses. HIV/AIDS continues to be the focus of most LGBPTQ-specific health psychology research. Little research has compared LGBPTQ people’s perspectives of HIV/AIDS with other chronic illnesses. Thirteen focus groups were conducted with 50 LGBPTQ individuals in Aotearoa/New Zealand. Inductive thematic analysis led to development of three themes: stereotyping of chronic illnesses by LGBPTQ individuals; ways of differentiating HIV/AIDS from other chronic illnesses; and inadequacies of sexual health education for LGBPTQ people. These findings contribute diverse perspectives to the health psychology literature on chronic illnesses and have implications for sexual health education in Aotearoa/New Zealand that currently lacks inclusivity for LGBPTQ individuals.

Keywords: Chronic Illness; Sexual Health; LGBTQ Psychology; Focus Groups; Thematic Analysis

Introduction

Research has indicated that lesbian, gay, bisexual, pansexual, transgender and/or queer (LGBPTQ) individuals have a higher prevalence several different chronic illnesses compared to their cisgender heterosexual counterparts (i.e., people who are not transgender and identify as straight), but little is known about the psychology of how those illness are perceived by LGBPTQ people. HIV/AIDS is the most salient example of a chronic illness which is associated with the LGBPTQ community and is stigmatised for both LGBPTQ and cisgender heterosexual individuals alike (Aspin, Penehira, Green & Smith, 2014; Boehmer, 2002; Henrickson & Fisher, 2016; Mundt & Briggs, 2016; Persson & Newman, 2008; Seacat, Hirschman & Mickelson, 2007; Treharne & Adams, 2017). This stigma is centred on the perception of HIV/AIDS as a preventable illness associated with unsafe sexual behaviour (Boehmer, 2002; Persson & Newman, 2008; Seacat et al., 2007). On the other hand, rheumatoid arthritis (RA) is an autoimmune disease which does not have the same association with the LGBPTQ community (McGavock & Treharne, 2011). While the risk of RA may also be minimised by certain behaviours, past research from Aotearoa/New Zealand suggest that whilst RA is stigmatised in terms of its perceived association to old age and disability, it is not stigmatised to the same extent as HIV/AIDS, which is perceived to be associated with being gay, using intravenous drugs or being promiscuous (McGavock & Treharne, 2011). Investigating LGBPTQ people’s perceptions of these two chronic illnesses as pertinent examples is an important expansion to the

existing psychological literature on HIV/AIDS among cisgender heterosexual individuals in Aotearoa/New Zealand (Henrickson & Fisher, 2016; McGavock & Treharne, 2011).

People who identify as LGBPTQ have been marginalised in the majority of health research. For example, Boehmer (2002) analysed 20 years of public health research, revealing that just 0.1% of all articles listed in the Medline database focussed on LGBPTQ people. The available research tends to focus on sexually transmitted infections, with 52% of the articles on LGBPTQ people’s health being specific to HIV/AIDS (Boehmer, 2002). Of this research, 80% of these articles only included gay men, indicating a lack of inclusivity of people with other diverse sexualities and gender identities. Furthermore, the US Institute of Medicine (2011) reported that the existing literature has tended to either categorise all LGBPTQ people as ‘non-heterosexual’, or disproportionately focus on certain subsets of LGBPTQ people (e.g., gay cisgender men) or subsets of healthcare (e.g., HIV/AIDS, cancer).

The existing health research with members of LGBPTQ communities is primarily centred on HIV/AIDS as a sexual health issue and a moral issue, particularly as stigmatising beliefs about sexuality impact on the perceptions of HIV/AIDS (Seacat et al., 2007). There are some notable exceptions to this predominant focus on HIV/AIDS, including research on a range of chronic illnesses other than HIV/AIDS among LGB individuals by Jowett and Peel (2009) and among gay men by Lipton (2004) as well as research on gay men’s perspectives on

attaining health by Adams, McCreanor and Braun (2013). The selective focus of past research is generally at the expense of investigating LGBPTQ individual's perspectives on other specific chronic illnesses, such as the autoimmune health condition rheumatoid arthritis (RA). RA does not have the same recognisability as HIV/AIDS among the general population (McGavock & Treharne, 2011), despite affecting an estimated 1% of the population worldwide (Gibofsky, 2014). Research by McGavock and Treharne (2011) with illness-free heterosexual individuals has found that HIV/AIDS is perceived as more 'serious' than RA. Furthermore, participants perceived there to be more behavioural responsibility if a person was diagnosed with HIV, relative to being diagnosed with RA even when participants were provided with evidence about smoking and high coffee consumption as behavioural risk factors for onset of RA.

HIV/AIDS affects an estimated 3,500 of the population living in Aotearoa/New Zealand and affects more men who have sex with men, although subpopulation prevalence estimates are hard to determine (New Zealand AIDS Foundation, 2017). Aspin et al. (2014) reported that the number of infections of HIV in the Māori population is relatively small. However, research has indicated that Māori women have a higher rate of HIV infections than non-Māori women (Shea et al., 2011). Furthermore, Pākehā men have been found to have better health outcomes if diagnosed with HIV due to a shorter average delay between infection and testing (Dickson, McAllister, Sharples & Paul, 2011). In contrast to the low prevalence of HIV/AIDS in Aotearoa/New Zealand, RA affects an estimated 89,000 people in Aotearoa/New Zealand. RA is more common in women than men, and to a greater extent among Māori women than non-Māori women (Ministry of Health, 2016).

There is some evidence of a higher prevalence of several chronic illnesses among members of LGBPTQ communities compared to cisgender heterosexual individuals, namely HIV/AIDS, cardiovascular disease and chronic fatigue (Cochran & Mays, 2007; Fredriksen-Goldsen, Kim, Barkan, Muraco & Hoy-Ellis, 2013) but no published evidence of differences in the prevalence of RA. Research has also demonstrated that people with diverse sexual identities generally rate their own overall health as worse on average compared to cisgender heterosexual individuals (Lick, Durso & Johnson, 2013; Fredriksen-Goldsen, Kim & Barkan, 2012). These health inequalities are sometimes inappropriately interpreted as indications of inherent pathology or 'risky' behaviours (Fredriksen-Goldsen et al., 2013), which may contribute to stigmatising beliefs about certain illnesses. More recent explanations focus on the stress for LGBPTQ individuals that is inherent in living in heteronormative and cisnormative societies (Riggs & Treharne, 2017).

HIV/AIDS is the most salient example of a chronic illness with health inequalities for LGBPTQ communities. However, perceptions of risk for HIV among subsets of the LGBPTQ populations are not reflective of this. Despite the higher prevalence of HIV/AIDS among gay and bisexual men and other men who have sex with men in Aotearoa/New Zealand (New Zealand AIDS Foundation, 2017) and other locations,

research has demonstrated that up to 89% of gay men rate their risk of contracting HIV as less than other gay men (Gold & Aucote, 2003). This effect was sustained even among gay men who had engaged in unprotected sex in the past six months. This suggests an 'unrealistic optimism' effect, wherein people have the tendency to predict that their own futures will be better than others who are in a similar position (Gold & Aucote, 2003). The original research on unrealistic optimism has indicated that the less experience an individual has of a 'hazard' (such as contracting an illness), the less likely they are to believe it will occur in their future (Weinstein, 1987). Furthermore, unrealistic optimism tends to increase as people perceive the preventative measures of a hazard to have improved (Weinstein, 1987).

The geography of HIV/AIDS raises important questions about the unrealistic optimism effect in locations with lower prevalence of HIV/AIDS like Aotearoa/New Zealand. The introduction of antiretroviral treatment for HIV/AIDS is directly attributable to the lower mortality and morbidity rates in both industrialised and developing countries (Palella et al., 1998). The success of these medications in industrialised countries has led to HIV becoming conceptualised, with some trepidation, as a manageable chronic illness (Russell et al., 2007). However, the prevalence rates of HIV/AIDS are higher in developing countries (with a gross national income categorised as 'low-income' or 'lower middle income'; United Nations, 2014). The World Health Organization (2015) estimates indicate that almost 70% of all people with HIV/AIDS live in the sub-Saharan region of Africa. This is the only area where mortality rates due to communicable disease (particularly HIV/AIDS and malaria) are estimated to be greater than mortality rates due to non-communicable chronic illness (de-Graft Aikens et al., 2010).

The emphasis on the prevalence of HIV/AIDS among gay men may have diminished the focus on other chronic illnesses within LGBPTQ communities (Lipton, 2004). In research by Axtell (1999), lesbian and bisexual women described navigating different identities as their gender, sexual orientation and/or social class conflicted with their identity as it related to their health/ability. A further qualitative study by Jowett and Peel (2009) sought to identify the relevance of sexual identities to people's experiences of chronic illnesses other than HIV/AIDS. Some participants felt more accepted by the LGBPTQ community, whilst others reported greater feelings of isolation, or that they did not fit the stereotype of their sexual identities. Comparing HIV/AIDS with RA may provide insight into how members of the LGBPTQ community frame chronic illnesses in relation to their sexual identity.

As well as expanding the focus of LGBPTQ health research beyond HIV/AIDS, it is also important to acknowledge and explore stigmatisation of HIV/AIDS in relation to sexuality and geography. Recent research has addressed how specific factors might interact to perpetuate stereotypes of HIV/AIDS, with the findings suggesting New Zealanders hold stereotypical beliefs of HIV/AIDS relating to ethnicity and geography (Henrickson & Fisher, 2016). However, past literature has not identified whether LGBPTQ New Zealanders hold

similar stereotypical perceptions of HIV/AIDS. Henrickson and Fisher (2016) examined the encounters black African migrants living in Aotearoa/New Zealand have had with the healthcare system. Participants reported negative experiences with health professionals who do not specialise in HIV/AIDS. These health professionals often made stigmatising assumptions that black African people's ethnicity was a proxy for risk of HIV/AIDS rather than enquiring about sexual history. Many participants reported a variety of poor practices by healthcare professionals, including: unnecessary precautions being taken with HIV-positive patients; breeches in doctor-patient confidentiality; lack of explanations and empathy; and incorrect information being provided. Henrickson and Fisher (2016) concluded that the stigmatisation of HIV/AIDS in Aotearoa/New Zealand has allowed for little progress within healthcare.

Past literature has not addressed how LGBPTQ New Zealanders compare HIV/AIDS to another chronic illness. While there are fundamental differences between HIV/AIDS and RA, they share commonalities in that both are stigmatised, and the media portrayal has shaped the beliefs held among both non-LGBPTQ individuals (Henrickson & Fisher, 2016; McGavock & Treharne, 2011) and LGBPTQ individuals (Gold & Aucote, 2003; Graham, Treharne, Ruzibiza & Nicolson, 2017; Seacat et al., 2013). The present study explored the following research questions using HIV/AIDS and RA as specific examples of chronic illnesses:

1. How do LGBPTQ individuals perceive chronic illnesses such as HIV/AIDS and RA?
2. To what extent do the perceptions of HIV/AIDS and RA reflect stereotypes about population groups based on identities and geography?

METHODS

Participants

In total, 50 participants took part in the study across 13 focus groups; 29 participants identified as cisgender women, 18 as cisgender men, two as gender-fluid, and one as transgender and female. Of these participants, 11 identified as lesbian, 16 as gay, 16 as bisexual, five as pansexual and two identified their sexual orientation as queer. Of the 13 focus groups, the initial eight were single gender groups (i.e., all female participants or all male participants), predominantly to allow LGBPTQ women to have space to discuss issues specific to them without the discussions being dominated by men. The latter five groups were mixed gender (i.e., including some female, male, gender-fluid and/or transgender participants). The participants' age ranged from 18-71 years, with a median of 22. Most participants were younger than 30 but two 71-year-old women participated in one focus group with rich information about social change that was very relevant to this analysis. The majority of participants (88%) identified as New Zealand European/Pākehā, two of whom also identified as Māori. One other participant identified as Māori only, one as African, one as Asian, one as Chinese and one as European.

Procedure

The recruitment process included posters advertising the study, which were placed around the local university

campus, and shared to relevant organisations, email lists and groups on social media. Snowball sampling was also utilised by having participants recommending the study to others who may have been interested. Participants who expressed an interest in the study were emailed information sheet outlining the aims of the study. They were also emailed a list of topics which had been compiled by the researchers in the initial phase of planning the study. The focus groups were conducted in a relatively quiet and private research office on the university campus. Upon arrival, participants were asked to complete a consent form and a demographic questionnaire. As compensation for any expenses related to participating in the study, each participant was given a \$15 supermarket voucher prior to the focus group beginning. The focus groups were facilitated by four researchers (three gay cisgender men and one gay cisgender woman). Each focus group had between two and four researchers present as part of an educational process in addition to providing practical support for the lead facilitator of the group in question.

The researcher leading the focus group reiterated the purpose of the study and the guidelines for the focus group during an introduction. Participants were informed that the focus group would last approximately an hour and a half, but that they could leave early if they wished. They were assured that their statements could be withdrawn or clarified after the focus group, although none chose to do so. Additionally, researchers reminded the participants that they were under no obligation to answer any specific questions. Prior to starting the questions, the researchers introduced themselves by outlining their sexualities and gender identities, with participants asked to do the same afterwards. The focus groups were audio-recorded with permission from the participants and subsequently transcribed.

Ethical approval was granted by the Department of Psychology at the University of Otago and endorsed by the University's Human Ethics Committee.

Data Analysis

The audio recordings were transcribed by a professional transcriber and then checked for accuracy by at least three of the researchers. The anonymity of the participants was protected by removing names and specific places. At this point, participants were contacted and told they could check the transcripts if they desired, though none took up this offer.

The data were analysed inductively at a semantic level (Braun & Clarke, 2006). The aim of the analysis was to provide a detailed account of participants' perceptions of HIV/AIDS and RA, and how these perceptions are formed and perpetuated. The six steps to thematic analysis outlined by Braun and Clarke (2006) were used as a framework for the analysis, which was led by the first author under the supervision of the second author as part of a wider project (Graham et al., 2017). The first author had not attended any of the focus groups and the second author led the facilitation of 10 of the 13 focus groups. This provided a level of distance from the data for the first author and this was reflected on throughout the analysis and writing process following the processes for ensuring quality of qualitative research described by Treharne and

Riggs (2015). The second author supported the analysis and writing by attempting to clarify any details that were unclear from the transcripts and commenting on each step of analysis and writing as an insider to the data collection and the community in question. Step one of the analysis involved multiple readings of each transcript whilst simultaneously listening to the corresponding audio recording to become familiar with the data. Pertinent features of each transcript were noted and used as the starting point for coding in step two. The coding process was completed by listening to the audio recording and reading the associated transcript once again. When data related to the study aims arose, they were written down along with a summary of how the discussion had arisen. These notes and associated quotes were subsequently organised under code headings, which were refined by working through the entire dataset systematically. Step three involved the combining of codes with common characteristics into candidate themes, which were discussed among the authors. In step four, the quotes relating to candidate themes were arranged in a way which presented the theme most coherently. The transcripts were re-read, and the organisation of themes readjusted so as to form the most coherent depiction of the whole dataset in relation to the research questions for the present analysis. In step five, core elements of the reviewed themes were identified and used to name themes and subthemes before further discussion among the authors. In step six, the themes and subthemes were critically examined in developing the final description of the results with final discussion among the authors to refine the overall narrative of the findings in relation to the research questions. Within the quotes that demonstrate the resulting themes, ellipses (...) are used to indicate short pauses, nonverbal features such as laughter are noted in round brackets, and clarifications or masked information are noted in square brackets.

ANALYSIS

Three themes were formulated from the analysis: 1) Stereotyping of chronic illness by LGBPTQ individuals, 2) Ways of differentiating HIV/AIDS from other chronic illnesses, and 3) Inadequacies of sexual health education for LGBPTQ people.

Theme 1: Stereotyping of chronic illness by LGBPTQ individuals

The first theme addresses the ways participants drew on social stereotypes of chronic illnesses. This is highlighted through two subthemes describing stereotypes about who is most likely to have HIV/AIDS or RA that also drew on some comparisons to other illnesses.

Subtheme 1.1: Stereotypes of who gets HIV/AIDS

Participants were forthcoming with their own perceptions of HIV/AIDS. Predominantly, individuals tended to automatically associate the disease with people living in Africa. Furthermore, there was never an identification of a specific country within the African region:

"Also everyone knows someone who's had cancer. Multiple people have had cancer usually and I have

never to my knowledge met anyone with HIV/AIDS." (P2, Group 6)

"Yeah, me neither." (P3, Group 6)

"You just don't, I mean honestly when I think of HIV/AIDS, I think of people in Africa." (P2, Group 6)

This generalised view was not exclusive to location; it carried over to perceptions of which groups of people were most at risk of HIV/AIDS. When encouraged to discuss who might be most at risk of contracting the health condition, several participants drew on stereotypes held by wider society:

"First off probably injecting, drug users." (P3, Group 7)

"Yeah." (P1, Group 7)

"Yeah I would agree." (P4, Group 7)

"Drug users, gay men." (P2, Group 7)

"... someone with HIV, it might be assumed that they caught it... by being promiscuous." (P3, Group 2)

On the other hand, several participants brought up various older news stories that had been covered by the media in Aotearoa/New Zealand, wherein prominent cases of people with HIV/AIDS had challenged the beliefs of who could be affected by the health condition. One example mentioned was the case of Eve (Hunt, 2013). Participants recalled that she was a child who had been refused entry to preschool due to being HIV-positive:

"... it had always been widely perceived as a gay disease and sort of this young girl was like blue eyes and blonde hair and sort of completely sort of shifted sort of, the sort of ideas of what HIV really was." (P1, Group 2)

Subtheme 1.2: Understanding of RA is limited

A common thread in much of the discussion regarding RA was participants' acknowledgement of their lack of prior knowledge of the condition and the way its symptoms may progress. Despite this, a recurring stereotype centred on the idea that elderly women were the primary sufferers of RA:

"And when I think of arthritis, I don't think of like young women... I tend to think of older women." (P2, Group 7).

In addition to this age and gendered stereotype, participants were sometimes dismissive of the symptoms of RA or minimised its debilitating nature. This served to demonstrate the way in which understanding of RA was more speculative compared to the participants' knowledge of HIV/AIDS:

"... I'm feeling like a hot bath would take care of a lot of it [the symptoms of RA]." (P2, Group 10).

Theme 2: Ways of differentiating HIV/AIDS from other chronic illnesses

The second theme addresses the way participants perceived chronic illnesses and differentiated the two illnesses that were the focus of the study. This came about through two subthemes describing the sensationalism and dehumanisation of HIV/AIDS compared to RA.

Subtheme 2.1: HIV/AIDS is sensationalised

When talk of the differences between HIV/AIDS and RA ensued, participants often identified that media stories of HIV/AIDS received far greater coverage than stories of RA:

"... my perception of them is that HIV/AIDS is a lot more serious but I guess that's just because of what, like the media, there's a lot more about HIV/AIDS than there is about arthritis I think so that's where I've probably formed those perceptions from." (P2, Group 7).

Across almost all the groups, participants were quick to explain that not only was HIV/AIDS covered more extensively by the media, but also that it is sensationalised. Participants' comments on this topic revealed the contrast between the perceptions of stories of HIV/AIDS and RA:

"... as you said, it's [HIV/AIDS] sensational." (P1, Group 1)

"All the stories in it so or like just going back to what we were talking about, like you know stories in the news, they always seem to be quite depressing, like they always put a very negative spin on it and it is an illness but you know, they just, yeah and I think people like see it, like I feel like the reason celebrities wouldn't want to say 'Actually I'm HIV-positive' because people just see it as a dirty disease sometimes, like I got it through sex, 'Oh you're a slut' so whereas if you had like asthma or a cancer or something, everyone's like 'Oh poor you, that sucks' even though they're probably still having sex." (P2, Group 1)

"It's [RA] not a very interesting disease that would be in the media..." (P3, Group 7)

This contrast was further strengthened by questions which encouraged the participants if they could name a celebrity who had been diagnosed with either illness as a way of determining familiarity of the illnesses. Several participants could name or describe a person who had been diagnosed as HIV-positive. This trend, however, did not continue when asked to name a person diagnosed with RA:

"Ah isn't there like some basketball player or something, what's his, do you know his name?" (P2, Group 5)

"Magic Johnson?" (R2, Group 5)

"Yeah there you go." (P2, Group 5)

"... can you think of anyone famous with rheumatoid arthritis, anyone in the news?" (R1: Group 7)

"No." (P1, Group 7)

"No." (P4, Group 7)

Subtheme 2.2: Having HIV/AIDS dehumanises individuals more than RA

When asked to compare the differences between living with HIV/AIDS and RA, participants tended to bypass the symptomatic aspects of each health condition, and instead acknowledged the underlying societal stigma of HIV/AIDS to be the biggest differentiating factor from RA:

"So umm comparing rheumatoid arthritis to HIV, what do you think the differences would be like living with them, if that makes sense, like." (R1, Group 7)

"There's no stigma with RA." (P3, Group 7)

"Yeah?" (R1, Group 7)

"Mmm." (P1, Group 7)

"There isn't that stigma towards rheumatoid arthritis..." (P1, Group 6).

"Yeah there isn't a stigma." (P3, Group 6)

Participants were generally in agreement over which types of stigma were associated with HIV/AIDS. These ranged from negative connotations of HIV/AIDS stereotypes, the possibility of being contagious if suffering from HIV/AIDS, or even it being part of a wider stigma associated with all sexually transmitted diseases:

"... Although common knowledge about how people get HIV people do think drug users and gay sex pretty much and both of those things a lot of people are anti so you would get that stigma as well." (P1, Group 6).

Some participants postulated that people may hold certain prejudices against individuals with HIV/AIDS, but not individuals with other chronic illnesses, due to a perceived lack of preventative measures taken by the person with HIV/AIDS. Furthermore, participants hypothesised that people with HIV/AIDS were judged to a greater degree than individuals suffering from other illnesses which could also have been prevented:

"... it's a... different level of sort of judging someone on their life choices... I think there is a sort of dehumanisation which is going on with HIV/AIDS." (P1, Group 12).

While participants acknowledged that societal stigma about HIV/AIDS existed, some participants also actively rejected these perceptions. This also held true when potential stigmatisation of RA was debated:

"... in some people it's still a thing like that like it [HIV/AIDS] only comes from like certain sexual things which is a bit stupid really." (P1, Group 8)

"... maybe they [people with RA] get stigmatised by people thinking that they're being more of a wuss like 'Oh he can't be that sore', that would be dumb..." (P4, Group 12).

Theme 3: Inadequacies of sexual health education for LGBPTQ people

The final theme addresses how LGBPTQ-specific information is crucial for sexual health education in schools, explained through discussions of HIV/AIDS perceptions. The inadequacies of current sexual health education programmes for LGBPTQ people were highlighted through two subthemes describing how sexual health education is heteronormative and unrealistic optimism about HIV/AIDS risk that appears to arise from inadequate sexual health education.

Subtheme 3.1: Sexual health education is heteronormative

When discussing participants' perceptions of HIV/AIDS, the conversation often shifted to the sexual health education programmes within Aotearoa/New

Zealand schools that most participants had experienced a few years prior. The general consensus was that sexual health education programmes were inadequate when participants were in school, regardless of an individual's gender and sexual identity. One participant went so far as to say that *"There's no proper sex ed."* (P1, Group 8). Further discussion revealed that the sexual health education was presented with the assumption that students are heterosexual. It was also noted that there was a passive acceptance of this exclusionary assumption:

"... I was never taught at any kind of sexual education ever that two females could have sex... I kind of turned a blind eye at the time to the fact that it wasn't being mentioned but for the longest time" (P2, Group 13)
"Exactly, exactly the same." (P3, Group 13)
"My first encounter within high school [...] I'm talking about sex education, dental dams were mentioned on a sheet and I actually asked the teacher what were they and she was just as puzzled as the rest of us" (P1, Group 13)

In most focus groups, participants pinpointed a lack of adequate sexual education aimed specifically at LGBTQ people. Moreover, this required participants to seek additional information that was of greater relevance to their sexual identity:

"... sex ed was very heteronormative... I looked up like actual useful sites on how it all works... But like I had to do all the research myself coz they just don't tell you anything." (P4, Group 11).

Subtheme 3.2: Unrealistic optimism about HIV/AIDS risk

The lack of information provided to people with diverse sexual and gender identities in school highlighted discrepancies in knowledge of LGBTQ-associated aspects of sexual health, especially regarding HIV/AIDS prevalence in Aotearoa/New Zealand. Many participants shared the sentiment that they were less at risk of contracting the health condition *because* they lived in Aotearoa/New Zealand:

"... I don't think me or anyone here is really like that in – risk of getting AIDS or HIV like it's probably a bit of a naïve view but like this is [city name], you know New Zealand (laughter), shit doesn't go down here" (P1, Group 5).

The AIDS Epidemiology Group (2013) reported 170 new cases of HIV/AIDS in Aotearoa/New Zealand in 2012. When participants were asked what they know about how many people contract the HIV each year, answers tended to be underestimations by an order of magnitude. One such example arose later in the same discussion as the above quote:

"I hope it'd be pretty low, maybe I dunno, 20 [in all of Aotearoa/New Zealand] you know, hopefully less than that but it's just a guess" (P2, Group 5).

These extracts demonstrate that participants viewed HIV/AIDS as something they were removed from and unlikely to encounter in Aotearoa/New Zealand. Participants' framing of HIV/AIDS reflected an unrealistic effect about their risk of contracting the illness.

Despite the frequency with which the participants drew upon stereotypes of sexuality related to HIV/AIDS, they tended to exclude themselves from these generalisations.

DISCUSSION

The first aim of the present study was to explore how members of the LGBTQ community perceive HIV/AIDS and RA, while the second aim was to examine the extent to which the perceptions of HIV/AIDS and RA reflected stereotypes of population groups based on identities and geography. We found that participants held pervasive stereotypical beliefs about both HIV/AIDS and RA and participants identified the enduring stigma associated with HIV/AIDS as its major difference from RA. One of the reasons participants held stereotypical beliefs about both HIV/AIDS and RA was due to lack of knowledge about either condition. With regards to HIV/AIDS, this highlighted the need for adequate sexual health education that is inclusive of LGBTQ people.

Past research has found that heterosexual New Zealanders explained their perceptions of HIV/AIDS and RA through a number of commonly-held assumptions (McGavock & Treharne, 2011). In particular, HIV/AIDS was found to be deemed far more related to risky behaviours, while RA was perceived to be less 'serious' (McGavock & Treharne, 2011). These assumptions are mirrored in the present study, particularly with regards to the theme 1; it was apparent that LGBTQ individuals held perceptions of HIV/AIDS and RA which were embedded within stereotypes of each illness. Participants in the present study tended to frame HIV/AIDS synonymous with Africa, and when considering communities within Aotearoa/New Zealand, participants labelled certain groups of people as being more susceptible to HIV/AIDS, specifically: gay men, drug users, and sexually promiscuous people. With regards to RA, participants did not relate it to one region or regional group over another. Instead, LGBTQ individuals perceived RA almost exclusively as a condition which affected elderly women. Similarly, participants in both studies described that whilst the media perpetuated much of the stereotypes participants held, it could also challenge these beliefs if expectations were contradicted. Future research could explore what happens when these perceptions are deliberately challenged, and assess whether beliefs about chronic illnesses can change after exposure to sources that diverge from the dominant sensationalised discourses that appear to persist in popular media (for an example related to HIV/AIDS, see Persson & Newman, 2008).

Additionally, theme 2 highlighted that LGBTQ people drew upon negative stereotypes of HIV/AIDS when explaining their perceptions of the health condition. It also indicated that the participants were, to some extent, aware of the effects that such assumptions had; namely, that individuals with HIV/AIDS are dehumanised far more than individuals with RA. When participants contrasted their perceptions of HIV/AIDS against their understanding of RA, the lack of knowledge about the health condition in conjunction with the stereotype of elderly women was reflected by participants minimising both its debilitating nature, and their own risk of being diagnosed. Furthermore, participants recognised that the media portrayal of HIV/AIDS is sensationalised, especially when compared to RA. This is likely to have influenced the development of the stereotypes outlined by LGBTQ individuals.

The second aim of the study was addressed by the discussion pertaining to theme 3. Experiencing sexual health education with the underlying assumption of

heterosexuality led to a lack of understanding of illnesses associated with the LGBTQ community. Participants' underestimated both the number of people in their city with HIV/AIDS, and the overall prevalence rate in Aotearoa/New Zealand. Compounding this, participants drew upon stereotypes of HIV/AIDS by frequent mentions about Africa specifically and yet vaguely. This distinction of location also served to minimise their individual risk of contracting the illness, thereby perpetuating the unrealistic optimism demonstrated by participants in relation to HIV/AIDS.

Participants in the present study noted that they did not have detailed knowledge of HIV/AIDS, and most participants were unfamiliar with RA. The stereotypical perceptions about HIV/AIDS reproduced by participants in our study were similar to those held by some health professionals in previous research. For example, Henrickson and Fisher (2016) found that health care professionals with little experience or specialised training of HIV/AIDS engaged in stigmatising and judgmental behaviour with black African migrants living in Aotearoa/New Zealand while health professionals with more experience and knowledge of HIV/AIDS did not. In our study, participants were united in their belief that the illness affects people from Africa. This was further reinforced by discussions theme 3, wherein a lack of specialised knowledge created perceptions firmly embedded in this stereotype of the health condition. This has implications that increasing people's knowledge about HIV/AIDS may assist in reducing stigmatising beliefs and stereotypes in Aotearoa/New Zealand. Similarly, the majority of participants had limited understanding of RA and its debilitating nature. When describing their perceptions of the health condition participants tended to be dismissive of the symptoms and stigmatise individuals diagnosed with RA. On the other hand, the few participants who had first-hand knowledge of RA were able to describe the condition in detail without relying on broad stereotypes of the illness.

There are four core limitations to the present study. Firstly, using focus groups as the method of data collection has both advantages and disadvantages. Hearing social discussions about perceptions of chronic illness brings an extra depth to the data that individual interviews would not provide; however, group discussions can bring tensions or could have masked differences of opinion. The groups involved a mixture of friendship groups and people who did not know each other, which could have made it hard for some individuals to contribute but also provides a useful reflection of the range of 'natural' conversations about a topic. Secondly, this article describes a secondary analysis of one aspect of a wider focus group project and the first author did not contribute to the running of focus group. There were points in the focus groups where follow-up questions pertaining to the aims of the current study would have been useful; however, the focus group data were suitably rich and relevant to address the specific aims of this article. The analysis was led by the first author who had not attended the focus groups with support from the second author who had lead the facilitating of 10 of the 13 focus groups. Both authors collaboratively reflected on what they brought to the research as insiders or outsiders to the data collection process and the communities in question in the research, which that enriched the analysis. These reflective processes involved discussions in meetings and regular journaling, as described by Treharne and Riggs (2015) in their summary of ways to ensure quality in qualitative research. Thirdly, the sample was predominantly comprised

of younger LGBTQ individuals who were open about their sexuality and active within the LGBTQ community. Therefore, findings may not transfer to the wider LGBTQ community of Aotearoa/New Zealand or other countries. However, the sample did include several people who were not 'out' about their sexuality in all areas of their lives. Lastly, only three participants in the present study identified as Māori. Given the disparity in health outcomes between Māori and non-Māori for both HIV/AIDS and RA (Dickson et al., 2011; Ministry of Health, 2016; Shea et al., 2011), future kaupapa Māori research could explore implications of the present research with focus groups of people who are of Māori descent. This would provide a more comprehensive understanding of the different factors that feed into perceptions of both HIV/AIDS and RA in Aotearoa/New Zealand.

An important implication of the present study is that the sexual health education programme presented within Aotearoa/New Zealand secondary schools seems to exclude the needs of LGBTQ people. Our findings support the argument that sexual health education programme should be expanded to be inclusive of people with diverse sexual and gender identities. However, it must be recognised that school curricula, particularly in relation to LGBTQ education, are reflections of wider social norms (Elia & Eliason, 2010). Assigning blame at the level of schools fails to address the concomitant and prevailing societal hegemonic views of LGBTQ inclusivity (see e.g. Amnesty International, 2018; Riggs & Treharne, 2017). Therefore, adaptations to sexual health education programmes must also include the resources, training, and follow-up required to explore whether such programmes meet their intended aims.

The findings about unrealistic optimism in the present study expand upon those demonstrated by Gold and Aucote (2003) as the sample in the present study incorporated diverse sexual and gender identities, rather than focussing exclusively on gay cisgender men. It should be acknowledged that different subgroups of the LGBTQ community may have disparate concerns pertaining to HIV/AIDS; in particular, the experiences of levels of stigma and risk for gay men is likely to be very different to women who identify as lesbian (Gold & Aucote, 2003). Similarly, the risk of women being diagnosed with RA is much higher than men (Ministry of Health, 2016). Future research should further explore the intersectionality of risk perception within LGBTQ communities. For example, when considering HIV/AIDS or other sexually transmitted infections, examining the interplay between sexuality, sexual practices, perceived risk and statistical prevalence could help develop a greater understanding of the various factors that may influence the unrealistic optimism effect. Another avenue of future research is examining the perceptions of chronic illnesses in other countries, to provide a comparative sample for the findings of the present study. For example, in South Africa the causal link between HIV and AIDS was denied until the turn of the century (AVERT, 2016). Subsequent government funding and resources has seen the antiretroviral treatment programme in South Africa become the largest in the world (AVERT, 2016); it would be fascinating to examine how people in South Africa perceive HIV/AIDS in the wake of such a dramatic change.

The present study demonstrates that the LGBTQ community hold pervasive stereotypes of both HIV/AIDS and RA; these reflect a lack of understanding of both health conditions, and particularly an underestimation of the risk of HIV/AIDS. There is a place for future research which

examines whether these stereotypes can be changed through presenting instances of popular media which may defy expectations. Further to this, future research should explore risk perception of health conditions within LGBPTQ communities outside Aotearoa/New Zealand, as well as comparing other health conditions outside of HIV/AIDS and RA. The findings of the present study indicate a need for improved sexual health education in nations like Aotearoa/New Zealand; at present, the discussions in the

focus groups indicated that such education is presented through a heteronormative lens, and does not adequately present information which may counteract widely-held stereotypes of conditions such as HIV/AIDS. This aspect of education is particularly relevant for people with diverse sexual and gender identities, and future queer expansion to sexual health education has the potential to assist in decreasing the marginalisation of the LGBPTQ community.

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