Communicating Social Support for HIV-Infected Thai Men who have Sex with Men: Emotional Support in the Thai Cultural Context*

การสื่อสารเพื่อให้เกิดการสนับสนุนทางสังคมสำหรับกลุ่มชายรักชายไทยผู้ติดเชื้อเอชไอวี: การสนับสนุนทางอารมณ์ในบริบทวัฒนธรรมไทย

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Abstract

The main objective of this study was to help researchers and Thai society understand better what sorts of emotional support promote health and safety among HIV+ Thai men who have sex with men (MSM). Forty-six key informants (gay patients and healthcare staff infected with HIV and straight healthcare staff without HIV infection) were selected for the study. All of them were over 18 years of age and living in Bangkok and its vicinity. Using interpretive analysis of observations of support group meetings and in-depth interviews, the study observed three distinctive themes that characterized the emotional support among the key informants: (a) Emotional support as sharing in Thai culture, (b) identification and normalization of connection, and (c) avoiding emotionally upsetting talk. The themes appear to reflect both Buddhist and collectivist characteristics of Thai culture. A clear understanding of these cultural nuances will also benefit those who would provide emotional assistance themselves or teach others to speak in emotionally healing ways (e.g., care providers, especially those from other cultures).

Keywords: Thai Cultural Context, Social Support, Emotional Support, HIV/AIDS, Sexuality, Men who have Sex with Men (MSM)

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บทคัดย่อ

วัตถุประสงค์หลักของงานวิจัยนี้ มุ่งที่จะช่วยให้ผู้วิจัยและสังคมไทยเข้าใจว่า การสนับสนุนทางอารมณ์ลักษณะใดที่ส่งเสริมให้เกิดสุขภาพที่ดีและความปลอดภัยในการดำเนินชีวิตต่อกลุ่มชายรักชายไทยผู้ติดเชื้อเอชไอวี ผู้ให้ข้อมูลหลักทั้งหมด 46 คน ได้แก่ ผู้ป่วย และเจ้าหน้าที่ดูแลด้านสุขภาพซึ่งมีสถานะเป็นเกย์และติดเชื้อเอชไอวี และ เจ้าหน้าที่ดูแลด้านสุขภาพซึ่งไม่ได้มีสถานะเป็นเกย์และไม่ได้ติดเชื้อ ได้รับการคัดเลือกให้เข้าร่วมงานวิจัยในครั้งนี้ ผู้เข้าร่วมวิจัยเหล่านี้มีอายุมากกว่า 18 ปี อาศัยในกรุงเทพมหานครและปริมณฑล ด้วยวิธีวิเคราะห์เชิงตีความจากการสังเกตการพูดคุยกันในกลุ่มสนับสนุนช่วยเหลือ และการสัมภาษณ์เชิงลึก ผลการวิจัยพบประเด็นหลักที่สำคัญทั้งหมดสามประเด็นซึ่งสามารถอธิบายถึงลักษณะของการสนับสนุนทางอารมณ์ในกลุ่มผู้ให้ข้อมูลหลัก ได้แก่ (ก) การสนับสนุนทางอารมณ์จากการที่ได้แบ่งปันข้อมูลข่าวสารระหว่างกันในวัฒนธรรมไทย (ข) การเชื่อมโยงความเหมือนและสภาวะปกติที่มีระหว่างกัน และ (ค) การหลีกเลี่ยงการพูดคุยที่ทำให้เกิดภาวะเศร้าทางอารมณ์ ประเด็นเหล่านี้ได้สะท้อนให้เห็นถึงลักษณะของวัฒนธรรมไทยที่ให้ความสำคัญกับพุทธศาสนาและสังคมแบบกลุ่มนิยม ความเข้าใจในความต่างทางวัฒนธรรมนี้จะเป็นประโยชน์ต่อผู้ที่จะให้ความช่วยเหลือหรือผู้ที่จะให้ความรู้กับผู้อื่นด้วย เช่น ผู้ให้บริการด้านสุขภาพ โดยเฉพาะอย่างยิ่งที่มาจากต่างวัฒนธรรม เกี่ยวกับวิธีการพูดคุยเพื่อที่จะเยียวยาจิตใจและอารมณ์ได้

คำสำคัญ: บริบทวัฒนธรรมไทย การสนับสนุนทางสังคม การสนับสนุนทางอารมณ์ เอชไอวี/เอดส์ เพศวิถีชายรักชาย

Introduction

Recent statistics on the global HIV/AIDS pandemic are staggering. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), “36.7 million [30.8 million-49.2 million] people globally were living with HIV infection in 2016,” with approximately 1 million people dying and 1.8 million newly infected in the year (UNAIDS, 2018). Figures for Thailand are also distressing. In 2016, approximately 450,000 people were living with infection (hereafter, HIV+), 6,400 people were newly infected, and there were “16,000 AIDS-related deaths” (Avert, n.d.).

Fortunately, there have been great advances in the efficacy and availability of therapy. Globally, UNAIDS (2018) estimates that “20.9 million people were accessing antiretroviral therapy in June 2017.” In Thailand, 68% of adults and 86% of children infected with the disease were receiving antiretroviral treatment in 2016 (Avert, n.d.). Despite these successes, the disease and associated stigma are exceptionally stressful challenges (Logie et al., 2016; Sapsirisavat et al., 2016). On the latter point, from the earliest stages of the pandemic, infection has been strongly linked with homosexuality (Shilts, 1987/2007). In Thailand, the majority of new infections have been occurring among gay men and men who have sex with men (MSM) (FHI360, 2008). There have been efforts to educate Thais about the disease, and sexual mores are evolving in Thai culture, but ignorance and prejudice persist (Pranee Liamputtong, Niphattra Haritavorn, and Niyada

Kiatying-Angsulee, 2009). Thus, many infected Thais must cope with the double stigma of infection and counter-normative sexuality. Social support can be a lifeline for the afflicted (Cunningham and Barbee, 2000).

The communication of social support is a multidimensional phenomenon. As such, it can be parsed in many potentially meaningful ways, but several forms of support are very widely observed. For example, a Google Scholar search in February 2018 returned over 5,600 citations for "emotional social support," 4,000 for "instrumental social support," over 860 for "informational social support," and 745 for "appraisal social support." Moreover, these dimensions of support recur in the context of a great variety of stressors and in many countries and cultures.

Studies of social support in Thailand are no exception (for a review, see Author, 2018). However, these studies, just like many others, are not always attentive to the possibility that, although the aforementioned dimensions of support have been observed in many contexts, they are likely to have different meanings in different cultures. Accordingly, this paper presents results drawn from a study of social support among Thai HIV-infected men who have sex with men (MSM); because the full range of study results cannot be conveyed adequately in a single paper, this work focuses on emotional support.

Cunningham and Barbee (2000) averred that emotional support is vital for both psychological and physical well-being for people coping with illness. Providing emotional support to a distressed person requires "listening to, empathizing with, legitimizing, and actively exploring their feelings" (Burleson, 2003:2; also see Albrecht, Burleson, and Goldsmith, 1994). In other words, social support is not a linear but an interactional process in which participants struggle with troublesome constructions of their stressor and situation, such as uncertainty about highly valued desires and dreads, ambivalence, diverging expectations and desires, and unpleasant certainties and impossibilities (Babrow, 1992; Dennis, Kunkel, and Keyton, 2008). In such circumstances, "even well-intentioned support efforts can produce negative outcomes" (Dennis, Kunkel, and Keyton, 2008: 416). For example, a study of 42 adults with HIV/AIDS examined their perceptions of interactions in which others thought they were being supportive and found that these ostensible support receivers rated only 55% of the others' actions as supportive (Barbee et al., 1998; also see Goldsmith, 2004).[†]

Therefore, emotional and other forms of supportive communication are not accomplished simply by transmission of a well-intentioned message to a passive receiver. Rather support is worked out interactively, co-operatively, collaboratively (Ford, Babrow, and Stohl, 1996;

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

Mattson and Hall, 2011; Rashid, Rahman, and Rahman, 2016), or "co-constructed" (Jacoby and Ochs, 1995).

Social support in these challenging situations inevitably takes on the character of individual, relational, and cultural resources, as communication creates and reproduces (Giddens, 1984) not only conceptions of the stressor but also participants' identities, relationships, group and organizational memberships, and encompassing culture (Babrow, 1992, 2016; Shi and Babrow, 2007). While there has been some research on emotional support among Thai people living with HIV/AIDS (e.g., Li et al., 2009; Rotheram-Borus et al., 2010), most research in Thailand has focused on sexual behaviors (Tareerat Chemnasiri et al., 2010; Li et al., 2009), treatment, care, and prevention (Logie et al., 2016; Li et al., 2014; Tam, Ho, and Sohn, 2014; Arunrat Tangmunkongvorakul et al., 2013), or disclosure and discrimination (Obermeyer, Baijal, and Pegurri, 2011; Wilson and Yoshikawa, 2004).

In short, there has been little systematic study of experiences with the communication of emotional support among infected Thai MSM. This is unfortunate because, as noted above, even something as apparently universal as emotional support is likely to play out differently depending on cultural context. For example, Korner (2007) found that many Thai people believe that HIV/AIDS is fatal, whereas it is coming to be seen as a chronic illness in the West (Deeks, Lewin, and Havlir, 2013) and strongly associate infection with homosexuality and promiscuity, which, in combination with "gossip culture", makes Thai PLWHA rather more uncomfortable talking about their illness than their Western counterparts (Lee et al., 2010; Yoshioka and Schustack, 2001). Moreover, there is evidence that HIV-related stigma and discrimination, as well as AIDS phobia, may be more severe in Thailand than in the West (Wei et al., 2012; also see Genberg et al., 2009). In addition to these differences in beliefs and attitudes toward infection and sexuality, Asian countries, particularly Thai society, are more rigidly stratified than in Western countries, and face or politeness concerns are much more significant (Oberdorfer et al., 2006; also see Mesquita, 2001). In addition, implicit social support or emotional forms of support, which do not require disclosure or explicit acceptance of one's problem, might be used more frequently than explicit social support in Asian cultures (Taylor et al., 2007). Hence, the following study was undertaken to answer the question, how do culture and sexuality intertwine in emotional support of HIV+ Thai MSM? This research question was also aimed to achieve the following research objective.

Research Objective

To help researchers and society understand better what types of emotional support promote health and safety among HIV+ Thai men who have sex with men (MSM).

Research Methodology

Data Collection

All data collection was conducted, recorded, and analyzed in Thai by the first author, a native of Thailand. After approval from the researchers' university Institutional Review Board, the first author (who collected all data) recruited people living with HIV/AIDS who were using services offered by three Thai organizations (names have been changed to protect confidentiality), as well as their social workers and nurses: (a) Organization A, formed by a support group in 1990, is affiliated with major Thai healthcare providers for PLWHA and offers weekly exams at an immunization clinic and one-on-one consultation and monthly peer support meetings for its infected patients. These meetings are typically moderated by senior healthcare counselors and lasting for one hour. (b) Organization B offers a variety of services, such as home visits, personal and close supervision with assistance, and phone consultations as well as group social support every month in meetings moderated by the recreational activity leader and lasting for one hour. (c) Organization C, an independent non-profit, provides one-on-one care so that individual problems related to HIV are tracked closely and patients supported appropriately.

To gain entry, the researcher contacted the organizational directors. These gatekeepers not only facilitated recruitment of infected MSM patients but also staff care providers. After explanation of the study, 46 people eventually returned signed consent forms (see below). All were over 18 years old and living in the Bangkok Metropolitan Region. Recruiting, interviewing and observation of support groups took place over four months, from June, 2014 to September, 2014. The participants included gay 43 patients and healthcare staff who had AIDS or were HIV+ but had not progressed to the full syndrome. In addition, three non-infected care providers (two straight men and one straight woman) participated.

Observations of support group interactions were supplemented by semi-structured interviews. Such interviewing is non-standardized, as it is not intended to test a specific hypothesis (David and Sutton, 2004). The semi-structured interview used a set of prepared open-ended questions to guide the process, but the interviewer was free to pursue unanticipated responses and themes (Gordon, n.d.), and used prepared and spontaneous probes and follow-up questions to elicit more details in responses that lacked clarity and depth (Rubin and Rubin, 2012). This methodology was chosen for two reasons. First, semi-structured and open-ended questions enabled the researcher to explore the meaning of emotional support for these participants (rather

than constraining meanings by a rigidly predetermined questionnaire or protocol). Second, such interviews are closer to natural conversations than are standardized interviews, and hence are likely to be more comfortable for the interviewees and foster rapport with the researcher.

Data Analysis

Data were analyzed by using a widely cited interpretive method: thematic analysis as described by Braun and Clarke (2006)[††]. The researcher began by familiarizing himself with the data by reviewing field notes, listening to tapes of interviews and support group interactions, and creating verbatim transcripts of all tapes (step 1). Initial codes were generated by combing through the data and underlining words and phrases that appeared to be potentially relevant to communication of emotional support (step 2). The researcher then identified potential themes by color-coding clusters of similarly coded words and phrases (step 3). Emerging themes were then reviewed (step 4), and names and definitions were developed (step 5). A preliminary report with themes within the data was then created (step 6). Results reported below are translations to English after the analyses were completed in Thai.

To enhance research rigor and validity, data and method were triangulated, as suggested by Salazar et al. (2015). This involved the data from HIV/AIDS infected participants and their healthcare providers, collected at different times and in three different HIV/AIDS organizations. These data were gathered through three methods: observations of support group interactions, in-depth interviews, and field notes. Besides, with member checking, near the end of the research project, the researcher shared transcripts, themes, and explanations with study participants. The participants were asked to review, critique, and suggest revisions where necessary.

Research Results

Emotional support entails caring about and understanding a person's distress in order reduce or alleviate upset. In the data collected in this study, three distinctive themes characterized the emotional support among these HIV+ Thai MSM: (a) Emotional support as sharing in Thai culture, (b) identification and normalization of connection, and (c) avoiding emotionally upsetting talk.

a. Emotional Support as Sharing in Thai Culture

Much of the emotional support conveyed and discussed in the groups and interviews reflected the importance of collectivist and Buddhist beliefs having to do with sharing in hardship. Perhaps the most interesting illustrations of this have to do with distinctive ways of sharing what

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

Westerners would call “private” information. Pirongrong Ramasoota (2001:97) notes that “the Thai language does not have a word for privacy but refers to it by descriptively translating from English as *khwam pen suan tua* or *khwam pen yu suan tua*, meaning ‘the state of being private’”. Such “privacy” belongs to all intimate members of the same household; there is no individualistic sense of privacy in traditional Thai culture (Pirongrong Ramasoota, 2001). This is nicely illustrated when Aun, a gay healthcare provider infected for 20 years, was compelled to reveal both his sexuality and HIV/AIDS status to his mother and his female siblings:

“After 5 years of my infection, when persistently asked about getting married, I felt a little annoyed and told my mother about my infection. Then, she said that she won the first prize of the lottery. Two double rewards. The first is my homosexuality, while the second is my HIV/AIDS infection. Then, she said, that’s fine if I still take care of my own health…Soon after that, on the same day, my two elder sisters called me… Despite my HIV/AIDS status being known by my mother and elder sisters, we hugged and loved each other like before. This is how we support one another, and it was vital for me to continue living.” (Aun, gay healthcare provider, infected 20 years)

Not disclosing both his infection and sexuality from his family for many years suggests that Aun was quite uncomfortable about revealing this information. And, indeed, when he disclosed to his mother, her first reaction appeared to be sarcasm (“she said she won the first prize of the lottery”) and suggested that she was upset by both features of the disclosure (“Two double rewards”). However, she quickly rebounded, expressed acceptance, and “Soon after that, on the same day,” revealed the news to his sisters. His sisters responded with loving acceptance, which Aun interpreted as shared support.

A Westerner reading this passage is likely to understand Aun’s hesitance to disclose his sexuality and illness, but is also likely to notice and wonder that Aun seemed to have no reaction to his mother so quickly, and apparently without consultation, sharing the disclosure with his sisters. However, both Buddhism and collectivist culture are incompatible with the idea of individual privacy. Theravada Buddhism teaches the emptiness of self (*anattā* in Pali); if the self is an illusion, individual privacy has no meaning. Collectivism teaches that the group, particularly one’s intimates, is the locus of being, into which the individual must dissolve (Frank, Enkawa, and Schvaneveldt, 2015). So, even for an anxious, infected, homosexual Thai, “privacy” entails personal information that is held privately among one’s intimate group, with no sense of any individual ownership. Thus, Aun showed no negative reaction to his mother’s apparent unilateral decision to disclose his news, but rather accepted the literal and figurative embrace of familial support.

Buddhism also teaches sharing together in times of 'suk-lae-duk' (happiness and sorrow). In other words, the Thai concept of equality is reflected in the phrase of 'ruam-duk-ruam-suk' (sharing-suffering) (Krisana Kitiyadisai, 2005:19). Thus, Aun's mother and sisters were concerned about him rather than blaming, and all family members expressed shared affection. As Aun said, "this is how we support one another," which he said is "vital for me to continue living."

The theme of emotional support as sharing even the most threatening information amongst one's intimate group is also nicely illustrated in the following excerpt:

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

Tuee's disclosure to his aunt reflects their embeddedness in the strong, cohesive extended family that characterizes collectivist culture (Triandis, 1995). The private self has little meaning in the intimacy of one's family, so Tuee expressed no frustration that his aunt had shared his information with his mother, and the mother saw no need to justify the aunt having shared his secret. Rather, mother and son moved directly to nonverbal exchanges of emotion that express sorrow and perhaps embarrassment: His mother's eyes were "worried," Tuee "tried to avoid eye contact with her," and he "burst into tears." As they moved closer to shared emotion on the heels of shared deeply distressing information, Tuee's mother reminded him of the strict boundary around the family (the disclosure would be discussed at home, not at the temple). Finally, having moved fully into the newly altered intimacy of the family, and having drawn a boundary to separate it from the outside world, Tuee's mother offered verbal emotional comfort to her crying son.

b. Identification and Normalization of Connection

As noted above, Thailand's Buddhist culture posits the emptiness of the self; its collectivism also deemphasizes the individual and views connectedness to the group as fundamental (Neff, Pisitsungkagarn, and Hsieh, 2008; Yablo and Field, 2007). In light of the latter, persistent double stigmatization of HIV+ Thai MSM constitutes the grave threat of alienation. Goffman's (1963:3) analysis of stigma suggests that "spoiled identity", based on two "deeply discrediting" attributes, reduces the HIV+ MSM "from a whole and usual person to a tainted,

discounted one". Stigmatization thus threatens and severs secure connection to the group. In light of this, identification with others and normalization of relationships constitute vital emotional support.

Both of the excerpts discussed in the preceding section would also serve to demonstrate reaffirmations of the group bond, but identification with and normalization of relationships outside the family were also important in the observed discourse. For example, healthcare providers often engaged in this form of emotional support. In the following, Phod, a gay healthcare provider infected for 17 years, reported using both nonverbal and verbal behavior to promote closeness, identification, and normalization of relationships with patients:

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

Although touching is generally less evident in "low contact cultures" such as Thailand (Anderson, Anderson, and Lustig, 1987), Thai care providers commonly reported touching patients in this context. Phod reported using touch to provide reassurance as an entrée to intimacy and identification ("I want to make them feel that they are my friends who have been through this kind of situation, like me before"). Shared sexual orientation also promoted identification and relationship, which opened the door to intimate conversation, exploring fears associated with death, family, and work, as intimates. Finally, having established a normal sort of intimacy, Phod provided the validation of a friend, and used identification to assure his worried intimates/friend/patients that they could live a normal life just like him.

Although identification and normalizing relationships with someone who shares one's stigmatizing condition is valuable, it is also emotionally helpful to experience identification and relationship with non-stigmatized others. In the following excerpt, Pui, himself a healthcare provider infected for 5 years, described the efforts of an uninfected doctor who provided emotional support through identification, validation, and relational reassurance:

"At the early stage of infection, my doctor told me while wholeheartedly hugging me, "It's ok. You see. This is me who still remains with you. We are both normal. You are also an individual with a normal condition". Furthermore, there was one instance when I told her that I

liked to go to a famous pub in Bangkok and the doctor said, "I also like to hang out at this pub - it is superb!". Alternatively, I talked with my doctor about cooking some special Thai dishes, and she said that she also liked to do this kind of cooking activity."

Pui's doctor thus verbally reassured him of their relationship ("This is me who still remains with you") and used a powerful nonverbal behavior (hugging) to underline that their relationship was affectionate. Further reinforcing the connection, she also expressed identification and validation ("We are both normal). This connection through identification was clearly meaningful to the doctor, as she continued to identify with Pui on two additional occasions, and meaningful enough to Pui to be memorable. In these ways, despite the social (doctor-patient), gender, and infection status differences between them, the doctor was able to use identification and validation to reinforce the idea that they are normal people with a normal, reliable relationship. HIV+ Thai MSM evidently found emotional relief in these in-tact connections.

c. Avoiding Emotionally Upsetting Talk

In addition to the active emotional support discussed above, communicators were emotionally supportive by avoiding talk that would be emotionally upsetting. For example, family members provided a sort of passive emotional support by avoiding the unpleasant topic of infection. For instance, Roon (infected 1 year) recalled conversations with his mother:

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

Thus, Roon's mother avoided emotional distress by not talking about the likelihood of his infection and suffering from HIV/AIDS even though he was showing symptoms of the disease (blisters). In Western cultures such as the United States, where explicit, direct expression of thoughts and feelings is the norm (i.e., "low-context culture," according to Hall, 1976), avoidance like this is interpretable as straightforward suppression of thought and talk, perhaps to cope with stress-induced emotional upset (Lazarus and Folkman, 1984). However, in a "high-context" culture like Thailand, where meanings are implicit in verbal and nonverbal messages, and context provides much of their meaning, the import of such avoidance is more nuanced. For example, by avoiding talk about infection, dismissing it because "this disease could be cured nowadays and soon other people would forget this disease," and avoiding talk about the possibility that her son

was infected and homosexual, Roon's mother conveyed tacit acceptance of his sexuality and hopefulness about his illness. This avoidance of unpleasantness and implicit acceptance and support, which is noticeable in other excerpts about interactions with mothers discussed above, may contribute to the importance of mothers that more generally characterizes Thai collectivist culture (Warunee Meecharoen et al., 2013; Pichamon Poonnotok et al., 2016).

Friends also provide emotional support by minimizing talk about infection. In the following quote, Aun, gay healthcare provider infected for 20 years, intended to see how a close friend would react to his disclosure of infection:

"I…decided to reveal my HIV status to one of my very close gay friends to know whether he would accept this and continue to associate with me. At first, he asked me when I was infected and what happened. I told him all the information. Then he said that I looked healthy as always and it was good that I took care of my health so well. From then on, he never mentioned my HIV/AIDS but only about traveling, eating and so on. It is like nothing happened after what I told him about HIV/AIDS at all."

Thus, after hearing the story of Aun's infection, his close friend affirmed him (complimented his healthy appearance and behavior), and "from then on, he never mentioned" the illness. Instead, the two discussed mundane topics, seeming to carry on like nothing had changed ("nothing happened") between them. The avoidance of potentially upsetting conversation thus provided direct emotional support. It also reflected emotional support in following the Buddhist principle of "krengjai" (fear of embarrassing the other) and "henjai" (having empathy) (Krisana Kitiyadisai, 2010:20). Moreover, in carrying on like nothing had changed and in empathizing and avoiding embarrassment, Aun's friend provided emotional support by normalizing and securing their relationship (see above).

Finally, healthcare providers also support their patients by avoiding upsetting talk. For example, in the following excerpt, Preen, a gay healthcare provider infected for 19 years, avoided upset in responding to a recently (6 months prior) infected patient who missed an appointment:

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

Thus, rather than immediately confronting or reprimanding the patient for having slept through an appointment, Preen's immediate response was accepting ("That's fine") and explicitly reaffirmed the relational bond ("*Khun Mae* will wait for *Nu*"). Reinforcing both relational commitment and avoidance of conflict and tension, Preen subsequently apologized for being occupied and unable to begin the meeting when the patient arrived early ("*Khun Mae* hasn't finished doing his things yet. I'm very sorry"). In the context of the patient arriving hours after missing the earlier appointment and Preen having to ask the patient to wait because the patient arrived early for the rescheduled appointment, Preen's final comment is delightfully ambiguous: "At least, Nu is here now. Better late than never". It might be a gentle rebuke or further expression of commitment to the relationship, or perhaps both.

Given the freshness of the patient's infection, it is important to note another way that the infected care provider worked to avoid tension and promote a normal and intimate relationship. Preen used the second-person personal reference "nu," which is similar in meaning to "my little girl" in English, and is used to express kindness to someone younger (Jiapong, 2011). It is also often used by kathoeys, or feminine gays (Pavadee Saisuwan, 2011). In addition, the first-person pronoun "Khun mae", which means "mother" in English, is often used to refer to a senior gay female. In short, the use of these parental terms common in the gay community connote the care provider's identification, caring, and emotional closeness, both of which are bound to be especially important for someone in the early phase of coping with the emotionally burdensome tensions of double stigma and social alienation.

Discussion and Conclusion

Given the ubiquity of emotional support in past studies in wide-ranging cultures and other contexts, it was not surprising to observe that this sort of communication is common in support experiences of HIV+ Thai MSM. However, meanings are contextual, so this study was undertaken to identify and illuminate emotional support in the experiences of these doubly stigmatized Thais. Three distinctive forms of emotional support were observed: (a) Emotional support as sharing in Thai culture, (b) identification and normalization of connection, and (c) avoiding emotionally upsetting talk. These forms were seen as reflections of Buddhism, one of the three pillars of Thailand's national values (Harvey, 2000), and the collectivism that is also characteristic of the culture.

Participants were often hesitant to disclose their sexuality and illness due to the powerful associated stigmas. However, they expressed no distress when, after disclosing their secrets to a family member, that person in turn shared this information with other family members without consulting the study participant. On the contrary, participants appeared to find

vital emotional support in the embrace of their family after their information was known to all. Individualistic privacy is not only contrary to Thai culture but would constitute a barrier to emotional support as sharing of distressing information that is so important in Thailand.

Also reflective of the country's Buddhist and collectivist culture, participants gave and received significant emotional support through identification and normalization of connection. With the double stigma of non-normative sexuality and HIV infection, participants faced the grave threat of alienation from the group. In this context, identification and normalization of connection were emotional lifelines. This finding clearly corresponds to previous research conducted by Lee et al. (2010) and Yoshioka and Schustack (2001) on homosexuality and promiscuity associated with Thai PLWHA.

Thai culture was also reflected in the avoidance of emotionally distressing talk. Avoiding such talk provided emotional support by creating a space for hope and by conveying tacit acceptance. Indirect expressions of acceptance also likely enhanced emotional support by sharing dangerous secrets with the family and identification and normalization of relationships. This finding is consistent with the above discussed research on implicit social support by Taylor, Welch, Kim, and Sherman (2007).

Results of this study must be interpreted with caution because, as in all interpretive research relying on observations of naturalistic behavior and in-depth interviewing, the sample of participants is limited (e.g., to residents of Bangkok and its vicinity) and the interviews and analysis of data were guided by hermeneutic rather than post-positivist sensibilities. The aim here was to explore nuances of emotional support as it is communicated in a very particular context. Moreover, even though the methods allowed for more sensitive analysis than would be possible with highly structured interviews, closed-ended questions, and statistical analyses, even richer data would be obtained by following participants over time. A powerful way to do such research would be to both interview participants at multiple points in time (Thomson and Holland, 2010) and ask them to keep journals during the study period (Zimmerman and Wieder, 1977).

In conclusion, as noted in the study rationale, intended social support is not necessarily experienced as supportive. For example, emotional support may be universal, but its meaningfulness surely takes on the shades of cultural context. Therefore, it is likely that competent social support requires knowledge of and adaptation to the cultural values that shape the meaning of support attempts. Studies such as this one are likely to be useful to those who would provide emotional assistance themselves or teach others to speak in emotionally healing ways (e.g., care providers, especially those from other cultures).

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