Stigma and Sexual Health Risk in HIV-Positive African American Young Men Who Have Sex with Men

Jerilynn Radcliffe, Ph.D.,¹ Nathan Doty, Ph.D.,¹ Linda A. Hawkins, Ed.D.,¹ Clare S. Gaskins, M.A.,²
Rinad Beidas, M.A.,³ and Bret J. Rudy, M.D.⁴

Abstract

Understanding the multiple forms of stigma experienced by young HIV-positive African American men who have sex with men and how they relate to sexual risk behaviors is essential to design effective HIV prevention programs. This study of 40 African American young MSM found that 90% of those surveyed experienced sexual minority stigma, 88% experienced HIV stigma, and 78% experienced dual stigma. Sexual minority stigma was characterized by experiences of social avoidance, and HIV stigma, by shame. Individuals with high HIV stigma were significantly more likely to engage in unprotected sex while high or intoxicated. Associations between stigma and sexual practices were examined; youth endorsing higher levels of sexual minority stigma engaged in less insertive anal intercourse. Individuals endorsing more HIV stigma reported more receptive anal intercourse. These findings support the development of stigma-informed secondary prevention interventions for African American HIV-positive young MSM.

Introduction

INFECTION WITH HIV continues to pose significant public health problems in the United States, particularly in ethnic and sexual minority groups, who are disproportionately affected by the epidemic. Recent estimates suggest that half of the approximately 56,000 annual new HIV infections in the United States occur among men who have sex with men (MSM), with African American MSM among the most at risk.¹⁻³ From 1994 to 1998, Centers for Disease Control and Prevention (CDC) surveys found that 14% of adolescent and young adult African American MSM participants ($n = 4000$) were infected with HIV.⁴ More recent CDC findings raise further concern, suggesting a 93% increase in the number of HIV/AIDS cases among African American MSM aged 13–24 years between 2001 and 2006.⁵ These alarming statistics highlight the urgent need for HIV/AIDS prevention efforts targeting young African American MSM.

Secondary prevention for HIV-positive individuals, defined as the enhancement of behaviors that prevent the spread of HIV by already infected persons, is particularly important within disproportionately affected groups. Despite the urgent need for prevention among young African American MSM, the CDC has noted that there are significant gaps in programs

targeting this population.⁶ To inform effective secondary prevention programs, researchers and practitioners must identify factors that contribute to HIV risk in ethnic minority MSM. Risky sexual behavior represents the most well-known risk factor for acquiring HIV.^{5,8} However, data suggest that, as a whole, young African American MSM may have less risky behaviors than other groups,⁷ making it essential to look beyond standard sexual risks to understand contextual factors that may influence transmission. Recent discourse highlights the need for greater understanding of psychosocial factors that contribute to the spread of HIV within this disproportionately affected group of young men.^{9,10} The current study focuses on stigma, which is one factor thought to be particularly salient to African American MSM infected with HIV.⁹⁻¹¹

Emerging research suggests that young MSM infected with HIV may experience multiple forms of stigma related to both their sexuality and seropositive status.^{12,13} HIV stigma may be particularly salient for young MSM who are African American, since research suggests that HIV-positive African Americans experience higher levels of HIV stigma than both Latinos and whites.^{14,15} African American young MSM may be further marginalized by cultural norms that emphasize masculinity and traditional views of family.¹⁶ This co-occurrence of multiple stigmatizing attributes is sometimes

¹The Children's Hospital of Philadelphia, Philadelphia, Pennsylvania.

²Department of Psychology, University of Delaware, Newark, Delaware.

³Department of Psychology, Temple University, Philadelphia, Pennsylvania.

⁴Department of Pediatrics, New York University School of Medicine, New York, New York.

referred to as “double stigma”¹⁷ or “layers of stigma.”¹⁸ Theories of layered stigma suggest that when multiple forms of stigma are present, there will be additive, cumulative effects on individuals’ well-being.

Recently, Dowshen and colleagues¹¹ were among the first to examine HIV stigma and psychosocial correlates in an ethnically diverse sample of 42 HIV-positive young MSM. Participants reported experiencing multiple forms of HIV stigma, including personalized prejudice or discrimination, negative self-image, concerns about public attitudes toward HIV, and fears regarding disclosure of their HIV status. Higher levels of stigma were associated with negative outcomes, including depression, poor self-esteem, lack of social support, and romantic loneliness. Studies of sexuality related stigma among HIV-positive young MSM are sparse. However, experiences of sexual minority stigma have been well documented among nonheterosexual individuals, and are associated with a host of psychological and behavioral health problems, including depression, anxiety, suicidality, and substance use.^{19,20}

Emerging evidence also suggests important links between stigma and sexual risk behaviors. Although studies have yet to specifically examine links between stigma and sexual risk among African American HIV-positive young MSM, HIV stigma has been linked to unprotected sexual intercourse in adult MSM living with HIV.²³ Further, sexual minority stigma has been found to relate to high-risk sexual behaviors among gay and bisexual youth not infected with HIV.^{21,22} It is noteworthy that existing studies of stigma and sexual risk have typically focused on global indicators of sexual risk, such as the frequency of unprotected sexual encounters. However, recent findings suggest the need for greater specificity in the measurement of sexual practices within this population. For example, use of substances prior to or during sexual intercourse represents an important risk factor, given its effects on inhibition and decision-making.²⁵ Additionally, recent work suggests that specific types of MSM anal intercourse (i.e., insertive versus receptive practices) may be differentially related to sexual risk behaviors, including unprotected sexual encounters.²⁴ An improved understanding of specific sexual practices among African American MSM infected with HIV may have important implications for positive prevention strategies.^{24–26}

Researchers and practitioners are increasingly recognizing the need for secondary prevention with HIV-positive youth, including the need for intervention programs that address the multiple forms of stigma experienced by African American young MSM already living with HIV.⁹ The combination of HIV stigma and sexual minority stigma may present significant barriers to individuals’ engagement in HIV health care, interfere with their ability to maintain favorable sexual health practices, and ultimately increase transmission of HIV. Nonetheless, because investigations have yet to examine HIV related and sexuality related forms of stigma in concert, little is known about how individuals’ perceptions of these may be similar or different.²⁷ Furthermore, studies have yet to examine how these two forms of stigma relate to sexual behavior in this population, including both high-risk sexual practices as well as insertive and receptive role-taking during anal intercourse. Better understanding of the multiple forms of stigma faced by young African American MSM infected with HIV is essential to the development of fine-tuned

secondary prevention efforts for this at-risk population of young people.

This investigation extends the current literature on HIV prevention by examining both HIV related and sexuality related stigma in a sample of 40 self-identified African American young MSM living with HIV. The first goal of the current study was to examine the interplay between these two forms of stigma by comparing participants’ perceptions of HIV stigma with their perceptions of sexual minority stigma. With regard to study hypotheses, participants were expected to endorse stigma across both HIV related and sexuality related domains. The second primary aim of the study was to investigate how overall levels of HIV stigma and sexuality stigma relate to youth’s sexual risk behaviors. Consistent with theory regarding the layering effects of stigma, both HIV stigma and sexual minority stigma were expected to relate to more risky sexual behavior during the past 30 days, as measured by frequencies of (1) unprotected sex and (2) unprotected sex while using alcohol or illicit substances. Exploratory analyses also examined links between stigma and anal intercourse practices. In addition to these primary goals, the current study also examined key demographic and contextual variables within the sample, such as age, income, time since HIV diagnosis, use of antiretroviral medications, and biologic markers of disease progression (i.e., CD4 count, viral load).

Method

Participants

Study participants included a convenience sample of 40 young men ages 16–24 years ($M = 20.40$, $SD = 1.99$), who had previously identified themselves as African American MSM. Participants were recruited from an outpatient HIV clinic serving 125 adolescents, 70% ($n = 88$) of whom are MSM and 90% ($n = 112$) of whom are African American. The clinic is based in a northeastern U.S. academic pediatric hospital. Of the first 40 youth approached for this study, all agreed to participate. This sample represents 45% of all the sexual minority men served by this clinic. All youth self-identified as male, and 39 (97.5%) as African American, with one youth identifying as African American multiracial. With regard to sexual orientation, 75% ($n = 30$) of participants self-identified as gay, and 25% ($n = 10$) as bisexual. All participants were behaviorally infected with HIV through sexual intercourse. Time since diagnosis ranged from 1 to 89 months ($M = 26.8$, $SD = 24.6$). Fifty-three percent of youth were currently prescribed antiretroviral medications. Highest grade completed ranged from eighth grade to 3 years of college ($M = 11.69$, $SD = 1.51$). Forty-eight percent ($n = 19$) of youth reported being unemployed, while 53% of youth reported working part-time or full time. To participate, youth were required to have reported to clinic personnel that they had sex with men and describe themselves as having African American ethnicity. Participants were also required to be English speaking and without cognitive or psychiatric difficulties that impeded their ability to participate, although no potential participants were excluded based on these criteria. All participants provided written informed consent for this study, which was approved by the hospital’s Human Subjects Committee of the Institutional Review Board.

Procedure

From 2008 to 2009, research staff approached potential study participants during their regular medical visits at the clinic. Of the first 40 potential participants contacted, all 40 gave informed consent to be part of this study. Once consent was obtained, a trained research assistant administered all questionnaires by interview format in a private clinic office. Youth received a \$20 gift card for their time.

Measures

Demographic information. A demographic questionnaire was administered to collect information about participants' race/ethnicity, age, gender, sexual orientation, educational level, religious beliefs, housing, income, and work status.

HIV stigma. The HIV Stigma Scale (HSS)³⁰ is a 7-item scale designed to assess perceived stigma among individuals living with HIV. The HSS was developed for use in a secondary HIV prevention study among young people living with HIV, modified from an earlier stigma scale by Sowell and colleagues.³¹ This scale includes items to evaluate three dimensions of HIV stigma, determined by factor analysis, with respective α of 0.83, 0.67, and 0.69; the items of these factors explained 75% of the variance in scores.³⁰ Subscales included: (1) social avoidance, (2) rejection, and (3) shame. Specific items ask whether respondents have ever felt avoided by others, feared rejection from others, or felt blamed or ashamed as a result of their HIV-positive status. Dichotomous responses to the items were used to enhance reliability of responses and to reduce assessment burden. The 7-item, dichotomous response format of the questionnaire used for the current study did not allow for reliability analyses.

Sexual minority stigma. Sexual minority stigma was evaluated using a modified version of the HIV Stigma Scale,³⁰ which was designed to evaluate perceived sexual minority stigma in a way that would permit direct comparisons of sexual minority stigma and HIV stigma. Specifically, items from the HIV stigma scale were reworded to create a comparable 7-item scale assessing perceptions of social avoidance, rejection, and shame related to being "not straight." As with the HIV Stigma Scale, dichotomous responses were used and the 7-item, dichotomous response format of this measure did not permit reliability analysis.

Sexual risk behaviors. The Sexual Behavior Scale (SBS)⁴³ is an 18-item behavioral survey designed to evaluate sexual practices during the respondent's last sexual encounter and over the past 30 days. For the current study, the original scale was adapted for use by MSM. Specifically, items referring to vaginal sexual "intercourse" were modified to include both anal and vaginal intercourse. Additionally, questions examining the frequencies of both insertive and receptive anal intercourse during the past 30 days were added to the measure. The current study utilized specific items from this modified SBS to assess youth's sexual practices during the past 30 days, including: (1) the number of times engaging in sexual intercourse without a condom, (2) the number of times engaging in sexual intercourse without a condom while high or drunk, (3) the number of times engaging in insertive anal intercourse, and (4) the number of times engaging in receptive anal intercourse.

Markers of disease status, progression and treatment. Markers of disease status, progression, and treatment were obtained via medical chart review. Time since initial HIV diagnosis was calculated by subtracting the date of initial HIV diagnosis (as recorded in the medical chart) from the date of study participation. Two biologic markers of HIV disease progression, most recent CD4 count and most recent viral load (in relation to study participation date), were obtained to describe the sample. Additional information was collected with regard to whether or not participants had initiated antiretroviral medication treatment.

Data analytic plan

Descriptive analyses were first performed for all demographic and study variables. Preliminary analyses were then conducted to examine differences in primary demographic variables across the measures of stigma, sexual risk behavior, disease progression, and antiretroviral medication use. Four paired-samples *t* tests with Bonferroni adjustment (criteria: $p < 0.01$) were used to investigate differences between HIV stigma and sexual minority stigma across the total stigma scores and the three separate dimensions of stigma measured by the instrument (i.e., social avoidance, social rejection, and shame). Pearson product-moment correlation coefficients examined how HIV stigma and sexual minority stigma related to measures of sexual behavior and length of time since diagnosis. Independent samples *t* tests compared ratings of stigma for individuals taking antiretroviral medications with those for whom medication had not been initiated.

Results

Preliminary analyses

Means, standard deviations, and ranges for all study variables are shown in Table 1. Prior to examining study hypotheses, preliminary analyses assessed for differences in primary demographic variables (i.e., age, highest grade completed, religious beliefs, sexual orientation, employment, housing, income, and work status) across the measures of stigma, sexual risk behavior, disease progression, and antiretroviral medication use. Results indicated that time since initial HIV diagnosis was positively associated with age, ($r = 0.62$, $p = 0.001$), and highest grade of education ($r = 0.32$, $p = 0.04$). Religious beliefs, sexual orientation, employment, and housing status were not significantly related to any study outcome variables.

Perceptions of HIV stigma and sexual minority stigma

Results indicated that, although overall levels of both HIV and sexual minority stigma were moderate, a substantial portion of youth endorsed stigma related to their non-heterosexual status (90%) or their HIV status (88%). Additionally, 78% of youth endorsed both sexual minority stigma and HIV stigma. Paired-samples *t* tests indicated that youth's overall ratings of HIV stigma and sexual minority stigma were comparable, $t(39) = 0.55$, $p = 0.59$, $r = 0.09$. Thus, as hypothesized, youth perceived similar levels of stigma for their HIV-positive status and their sexuality.

Exploratory analyses revealed differences in HIV stigma and sexual minority stigma across the three dimensions of stigma. Specifically, participants reported experiencing more

TABLE 1. MEANS, STANDARD DEVIATIONS, AND RANGES OF STUDY VARIABLES

Variables	Mean	SD	Range
Stigma			
Sexual minority stigma	3.05	1.65	0–6
HIV stigma	3.15	1.93	0–7
Sexual risk behaviors in the past 30 days			
Sexual intercourse without a condom	1.83	4.01	0–20
Sexual intercourse without condom while high/drunken	0.28	0.85	0–4
Insertive anal intercourse	2.47	5.00	0–25
Receptive anal intercourse	2.13	4.26	0–20
Disease Progression Variables			
Years since initial HIV diagnosis	2.23	2.05	0.11–7.42
CD4 count	494	246	23–1,379
Viral load	21,112	42,568	0–189,900

social avoidance by others related to their sexuality than related to their HIV status, $t(39) = 5.06$, $p = 0.001$, $r = 0.63$. However, participants were more likely to report feelings of shame related to HIV than related to sexuality, $t(39) = 3.97$, $p = 0.001$, $r = 0.54$. Perceptions of sexuality-related and HIV-related rejection were not significantly different, $t(39) = 1.42$, $p = 0.16$, $r = 0.22$.

Stigma and sexual risk behaviors

Table 2 displays bivariate correlations between both domains of stigma (i.e., HIV related, sexuality related) and participants' frequency of sexual behaviors during the past 30 days. Some, but not all, study hypotheses were supported. Stigma indices were not associated with total frequency of unprotected sexual intercourse, but individuals reporting higher levels of HIV stigma reported more unprotected sex while under the influence of drugs or alcohol.

With regard to exploratory analyses of anal intercourse practices, individuals endorsing higher levels of sexual minority stigma engaged in less insertive anal intercourse. Individuals endorsing more HIV stigma reported more receptive anal intercourse during the past 30 days. Unplanned *post hoc* analyses were conducted in order to further examine links between stigma and anal intercourse practices. Participants were grouped as endorsing either (1) only receptive

intercourse, (2) only insertive intercourse, or (3) both receptive and insertive intercourse during the past 30 days. Two one-way analysis of variance (ANOVAs) were conducted to examine group differences in sexual minority stigma and HIV stigma. Results revealed significant differences across the groups for both HIV stigma, $F(2,24) = 8.44$, $p = 0.002$, and sexual minority stigma, $F(2,23) = 3.63$, $p = 0.043$. Bonferroni-adjusted multiple comparisons indicated that those engaging exclusively in insertive anal intercourse endorsed less HIV stigma than those engaging only in receptive intercourse, $p = 0.01$, or in both types of intercourse, $p = 0.003$.

Stigma and progression of HIV disease and treatment

Bivariate Pearson correlations were calculated to explore links between sexuality related and HIV related stigma, and disease progression variables (including time since initial diagnosis; see Table 2). Stigma indices were not associated with time since initial diagnosis. However, t tests revealed that individuals who had begun taking antiretroviral medications endorsed higher levels of HIV stigma than those who had not, $t(38) = 2.21$, $p = 0.03$.

Discussion

This study is among the first to examine both HIV stigma and sexual minority stigma among African American young MSM infected with HIV. Results suggest these youth are at risk for experiencing multiple domains of stigma, with 78% of those in the current sample endorsing stigma related to both their HIV and their sexual orientation. Although youth reported moderate levels of both HIV stigma and sexual minority stigma, results suggest nuanced differences between these two domains. In particular, perceptions of social avoidance by others appeared to be characteristic of sexual minority stigma, while HIV stigma was associated with more internalized processes of shame.

Differences between sexual minority stigma and HIV stigma could stem from several factors. Youth's elevated levels of shame related to HIV may reflect attributions of self-blame, since all participants in the study were behaviorally infected with HIV through high-risk behaviors. Sexual orientation, on the other hand, may be viewed as beyond one's own control, consistent with increasingly widespread beliefs about the biologic basis of homosexuality.⁴⁴ Youth's varying degrees of disclosure regarding their sexuality and their HIV-positive

TABLE 2. PEARSON CORRELATIONS OF STIGMA WITH SEXUAL BEHAVIORS AND DISEASE PROGRESSION VARIABLES

	Sexual minority stigma	HIV stigma
Sexual risk behaviors		
Sexual intercourse without a condom	0.01	0.25
Sexual intercourse without condom while high/drunken	0.16	0.34 ^a
Insertive anal intercourse	–0.41 ^b	–0.30 ^a
Receptive anal intercourse	0.16	0.43 ^b
Disease progression		
Time since initial HIV diagnosis	0.02	0.15
CD4 count	0.13	0.03
Vital load	–0.04	0.13

^a $p < 0.05$.

^b $p < 0.01$.

status may represent a second factor shaping their perceptions of stigma. In particular, past research suggests that individuals who hide their stigmatized identities may be especially susceptible to internalized feelings of shame, although they may escape overt social consequences such as being avoided by others.²⁹ Higher levels of disclosure and openness about sexuality, coupled with concealment of one's HIV-positive status, could contribute to the pattern of findings in the current investigation. Thus, future studies should specifically examine youth's attributions about the causes of their sexuality and HIV-positive status, as well as the extent to which they have disclosed these two stigmatized identities to those around them.

Contrary to hypotheses and prior studies of adult MSM,^{20,22} we did not find associations between sexual minority stigma or HIV stigma and the overall frequency of unprotected sexual encounters during the past 30 days among this sample of young MSM. However, HIV stigma was found to be associated with higher frequency of unprotected sex while using drugs or alcohol. Because these substances lower inhibitions and increase risk-taking, use of drugs or alcohol while engaging in sexual activity represents a well-known risk factor for HIV transmission among MSM,^{45,46} particularly among young MSM.⁴¹ Research with larger samples will be essential in elucidating possible linkages between stigma and drug and alcohol use, as well as their relative contributions to sexual risks among young HIV-positive African American young MSM. Innovative international research on stigma among young people living with HIV also holds promise for informing future research on stigma and sexual health risk.⁴⁹

The current study is innovative in its examination of links between stigma, sexual health risks, and specific anal intercourse practices. Emerging evidence suggests that insertive and receptive anal intercourse practices may be differentially related to sexual risk behaviors that include unprotected intercourse and the use of substances and/or alcohol prior to sex.^{20,40} However, to our knowledge, this study is the among the first to demonstrate links between stigma and anal intercourse practices among African American young MSM. Although findings were based only on participants' sexual practices during the past 30 days, results suggest that individuals engaging exclusively in receptive anal intercourse may be at increased risk for experiencing HIV related and sexuality related stigma in comparison to those engaging only in insertive anal intercourse or in both types of intercourse. These exploratory findings suggest the need for further research examining the interplay between anal intercourse practices, unprotected sexual encounters, and stigma, as well as variables that may explain these linkages.

Although not a primary aim of the study, exploratory analyses examined links between stigma and contextual factors related to HIV disease progression and treatment. Results indicated that perceptions of stigma were not associated with time since initial HIV diagnosis. This incidental finding stands in contrast to prior studies, which suggest that perceptions of HIV stigma may decrease over time following an initial HIV diagnosis.^{11,36} Similarly, biologic markers of disease progression (i.e., CD4 count, viral load) did not relate to stigma variables in the current study, despite past research suggesting that HIV stigma may become exacerbated by increased disease progression and symptomatology. The current study was not designed to examine these linkages, and null findings

may reflect power limitations of the small sample size. It is noteworthy, however, that participants who had started antiretroviral medication perceived higher levels of HIV stigma than those who had not. Following initiation of retroviral medication, individuals face daily reminders of their HIV in the form of a strict treatment regimen. Additionally, some youth may be burdened with the task of hiding these medications in order to prevent friends and family members from discovering their diagnosis, an event that could itself precipitate further stigma. Although limited by the cross-sectional study design, these exploratory findings suggest that initiation of antiretroviral medication may represent a challenging milestone, accompanied by potential increases in HIV-related stigma.

Several important limitations to the current study should be noted. The small sample size represents a significant limitation, particularly since null findings may actually reflect smaller effect sizes that were not detected due to lack of statistical power. However, this population is particularly challenging to access within the broader community, and the sample size for this study is comparable to those in other recently published studies of African American HIV-positive young MSM.^{11,41,47} Additionally, results of the current investigation may not generalize to all African American young MSM infected with HIV, particularly those living in nonurban areas, those who do not identify as gay or bisexual, or those not actively engaged in HIV treatment. Another limitation involves the use of retrospective self-report for assessing several key variables (i.e., stigma, sexual risk behaviors), introducing possible recall bias, response bias, or shared method variance. There are also important limitations with regard to the measurement of stigma in the current study. HIV-related and sexuality-related stigma scales consisted of 7 dichotomous items, while each dimension of stigma (i.e., avoidance, rejection, shame) consisted of only 2 to 3 items, precluding adequate tests of their reliability in this sample. It is also important to note that post-hoc analyses examining specific dimension of stigma (i.e., avoidance, rejection, shame) were based on scales consisting of only 2 to 3 items. Thus, the preliminary nature of these findings must be highlighted. Future studies should use multidimensional measures of stigma that include Likert-type response formats and larger numbers of items. Studies utilizing longitudinal designs would also be particularly valuable in evaluating causal relationships between stigma and youth outcomes, while larger sample sizes would allow for the examination of possible mediating or moderating factors that were not included in the current investigation.

Results of the current investigation hold implications for prevention and intervention with young African American MSM infected with HIV. First, because a substantial portion of these young people experience multiple forms of stigma related to both their sexuality and their HIV-positive status, stigma-informed approaches to prevention and intervention are needed. Stigma may be particularly relevant to interventions targeting the co-occurrence of substance use and risky sexual behavior, and may be especially salient for youth following the initiation of antiretroviral medication. Finally, comparisons of HIV related and sexuality related stigma suggest that differing approaches may be necessary to address these two domains of stigma. For example, youth experiencing sexual minority stigma may benefit from assistance in managing social experiences, such as being

avoided by others. HIV stigma, on the other hand, may require intervention efforts that target internalized feelings of self-blame and shame. We hope that these preliminary findings will stimulate further research on the role of stigma in the lives of African American young MSM infected with HIV. Future investigations in this area will be essential in developing more effective HIV prevention and intervention programs for this at-risk population of young people.

Author Disclosure Statement

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Address correspondence to:
 Jerilynn Radcliffe, Ph.D., ABPP
 The Children's Hospital of Philadelphia
 3400 Civic Center Boulevard
 CHOP North 1461
 Philadelphia, PA 19104
 E-mail: Radcliffe@email.chop.edu