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The Intersectionality of Stigmas among Key Populations of Older Adults Affected by HIV: A Thematic Analysis

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Abstract

Objectives: The present study examined the intersectionality of stigma across varying groups of older persons living with HIV (PWH).

Methods: Four focus groups of older PWH (gay/bisexual men, heterosexual men, heterosexual and bisexual women, and Spanish-speaking) were audio-recorded transcribed. Inductive thematic text analysis was used to identify qualitative themes.

Results: Five major themes emerged from the data: 1) disclosure of HIV status; 2) types of stigma experienced; 3) discrimination experienced; 4) other outcomes associated with experiencing stigma; and 5) influence of aging on social isolation experienced due to stigma. Findings indicate women did not suffer from the intersection of stigmas. Other groups suffered from the intersection of stigma due to HIV status and age (gay/bisexual males); HIV status and perceived stigma of sexual orientation or drug use (heterosexual males); and HIV status and culture/ethnicity (Spanish-speaking).

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Compliance with Ethical Standards

The authors have no financial other interests or conflicts to report. All research was collected with IRB approval from participating institutions and the accepted principles of ethical and professional conduct has been followed. All research participants provided informed consent prior to engaging in study procedures.

Declaration of Potential Conflicts of Interest.

The authors have no financial interests or conflicts to report.

Research Involving Human Participants

All procedures performed in studies involving human participants were in accordance with ethical standards of the institutional and/or national research committee and with the 1965 Helsinki declaration and its later amendments or comparable ethical standards. Informed consent was obtained from all individual participants included in the study.

Conclusions: Results indicate that many at-risk groups, including heterosexual men, homosexual men, and Spanish-speaking individuals, experience an intersection of stigma between aging and their sexuality, HIV status, or real or perceived drug use.

Clinical Implications: Results highlight the need for HIV support, especially social support, to address intersection of stigmas for unique groups of individuals disproportionately affected by HIV

Keywords

HIV stigma; ageism; gay/bisexual; heterosexual male; discrimination; loneliness; social isolation

Introduction

Although HIV/AIDS affects a number of individuals, there are key populations who are disproportionately affected by HIV. In 2015, according to the Centers for Disease Control and Prevention (CDC), the populations most affected by HIV included: gay/bisexual men (82%), women (19%) and racial and ethnic minorities, namely African Americans and Hispanics/Latinos (Centers for Disease Control and Prevention (CDC), 2015). Another group more recently affected by HIV stigma is older adults (Bhavan, Kampalath, & Overton, 2008). These key populations often experience intersecting or layered stigmas due to their sexual orientation, age, race and ethnicity, gender, or drug use (Earnshaw, Bogart, Dovidio, & Williams, 2013; Stangl, Lloyd, Brady, Holland, & Baral, 2013). Because of the burden caused by stigma, it is critical to understand how these key populations are affected by the intersectionality of HIV and other stigmas.

Stigma, which is defined as the negative evaluation of an individual due to an attribute that is perceived to be significantly discrediting (Goffman, 1959), is a frequent experience of people with HIV (PWH), a well-established phenomenon (Mahajan et al., 2008), and can occur at the level of society, institutions, and individuals (Mahajan et al., 2008; Parker & Aggleton, 2003). For PWH, HIV stigma often leads to enacted or perceived stigma (from others) as well as internalized stigma (guilt, blame of self) (Earnshaw & Chaudoir, 2009). Negative affect (e.g., feeling ashamed, worthless) is often experienced from stigmatizing encounters (Major, Kaiser, & McCoy, 2003), which can lead many individuals to experience anticipated stigma (Quinn & Chaudoir, 2009). Anticipated stigma is the belief that one will be socially stigmatized if they reveal their identity and is commonly experienced by PWH (Earnshaw & Chaudoir, 2009).

When stigma is enacted towards PWH by another individual in an explicit way, *discrimination* occurs towards PWH. Due in large part to the social nature of stigma, HIV stigma (Mak et al., 2007) is negatively associated with individuals' social relationships, social support, psychological well-being, and ability to access medical care (Bos, Schaalma, & Pryor, 2008; Chesney & Smith, 1999; Conner et al., 2010; Mak et al., 2007; Mawar, Sahay, Pandit, & Mahajan, 2005; Rüsch, Angermeyer, & Corrigan, 2005).

Stigma experienced by older PWH often exacerbates the negative social outcomes associated with HIV stigma because it often leads them to engage in stigma management

(hiding or selectively disclosing) or partial disclosure (Poindexter & Shippy, 2010) of their HIV status. This lack of disclosure can lead to even less social support amongst this population. In fact, older PWH are less likely to disclose their status to relatives or other loved ones than younger adults (Emlet, 2006a), more likely to live alone (Emlet, 2006a, 2006b), and less likely to seek out social support from family and friends (Schrimshaw & Siegel, 2003).

Although HIV stigma is well established (Mahajan et al., 2008), it is less clear how groups most vulnerable to HIV experience the intersectionality of multiple stigmas. Less clear is how intersecting or multiple stigmas affect older PWH (Foster & Gaskins, 2009), who represent an increasingly more common cohort of PWH (Goodroad, 2003). As they age, older PWH experience the intersection of age-related stigma, referred to as ageism (Nelson, 2004), as well as stigma due to HIV status, gender, race/ethnicity, drug use, sexual orientation, etc. Ageism, much like other forms of stigma, is linked to increased social isolation and loneliness among older adults (Cattan, White, Bond, & Learmouth, 2005). As a result, older PWH often experience the intersection of stigma due to HIV status and age (Emlet, 2006b) in which the deleterious social and health effects of HIV stigma are compounded for older adults (Emlet, 2007; Shippy & Karpiak, 2005).

Intersectionality of stigma may have differing effects on individuals. Namely, differing combinations of stigmatized identities can produce distinctive advantages and disadvantages (Purdie-Vaughns & Eibach, 2008). For instance, some groups of individuals affected by HIV may have greater levels of resilience to the multiple stigmas they face, a term referred to as “crisis competence” (Halkitis, Krause, & Vieira, 2017). Crisis competence is a term that indicates certain individuals who are able to successfully work through a crisis period in their lives they are more able to overcome future challenges (Vance & Robinson, 2004). For example, gay and bisexual older men (compared to heterosexual men and women) may be more equipped to deal with stigma, and thus experience it to a lesser degree, due to their ability to deal with the crisis of these compounding stigmas (Emlet et al., 2013).

Alternatively, intersecting or multiple stigmas can lead to challenges in accessing support structures or social networks due to the stigmatization of multiple identities (Earnshaw et al., 2013). For example, prior research has shown that gay/bisexual men may feel even higher levels of threat or demoralization due to the stigma they feel from their HIV status and sexual orientation (Stanley, 1999). Similarly, another study found older PWH who were a racial or ethnic minority were more at risk for social isolation (54%) than the general older adult population (38%) (Emlet, 2006b), suggesting they may also experience or suffer from social isolation due to multiple stigmas. Clarity is needed regarding how intersectionality of stigmas among older HIV positive adults influences varying interpersonal and intrapersonal outcomes.

Examining the potential intersectionality of multiple stigmas may provide a fuller and clearer understanding of the impact of stigma on PWH. Moreover, understanding how these multiple stigmas affect older PWH, who also suffer from ageism, may better elucidate their complex experiences of stigma. To address this critical issue, the present study aimed to assess the following research question: “What does the intersectionality of stigma look like

across groups of older PWH and how is this intersectionality related to outcomes such as depression, social losses, and isolation?”

Methods

Study Procedures

Participants (N=32) were recruited primarily from New York Presbyterian Hospital/Weill Cornell Medicine's Center for Special Studies (CSS) HIV clinic to participate in face-to-face focus groups about aging with HIV. Enrollment in the study was also open to individuals not receiving services from CSS; 9 of the 32 participants were not seen at the CSS clinic. Eligibility criteria included being 50 years of age or older, HIV positive, and willing and able to share one's experiences related to aging with HIV in a confidential group setting. A total of 52 participants were scheduled for the focus groups, and 32 participated. Recruitment efforts included flyers, referrals from providers at CSS, and word of mouth. Potential participants called the research coordinator, were screened, and were given an appointment time and location for the focus group effort. All focus groups were conducted in November, 2015.

Four focus groups were conducted with specific populations to obtain information on differing perceptions of aging with HIV. The four groups reflected differences in sexual orientation (gay/bisexual men (n=9) and heterosexual men (n=6)), gender (heterosexual and bisexual women; n=9), and preferred language/culture (Spanish-speaking only, n=8).

Sample Characteristics

Participants (N=32) were predominately male (69%), which was due to the inclusion criteria of the four focus groups. Participants were an average of 61 years old (Range: 50–79 years). The majority of participants self-reported being Black or African-American or Caribbean (68%), and an additional 13% self-identified as being White or Caucasian, 3% self-identified as being Asian or Asian-American/Pacific Islander, and 16% self-identified as being some other race. Regarding ethnicity, 37% self-identified as being Latino. Of note, Latinos also identified as Caucasian on the race item. Regarding sexual orientation, 34% identified as heterosexual/straight, 34% gay, 16% bisexual, 9% same gender loving, and 6% said they were questioning. The majority of participants reported that they were single/not married (66%), while 16% reported that they were widowed/partner deceased, 6% were married or had a life partner, and 9% said they were divorced or separated.

Focus Groups

The focus groups were conducted in order to advise programs for older adults with HIV and to inform a quantitative needs assessment for this population. Each focus group was conducted in-person with two facilitators using a series of eight questions/probes (see Appendix for the interview guide). Facilitators had prior experience and training in qualitative methods and conducting focus groups. Participants were given a brief overview of the purpose of the study and provided a written informed consent form. Participants were then asked to complete a brief demographic questionnaire before the focus group commenced. Each focus group lasted two hours. Participants were compensated with a \$40

gift card and a round-trip public transportation fare card. Light snacks were provided during each group session. The focus groups followed a semi-structured format, which was approved by the Weill Cornell Medical and Gay Men's Health Crisis Institutional Review Boards.

Two audio recorders were used to capture each group's discussion for transcription. Before beginning the focus group session, the facilitator provided a number of ground rules (i.e., participants were asked not to use names during the session, to keep everything that was discussed in the group confidential and anonymous, direct all comments to the group [i.e., no cross-talk], and to respect all opinions expressed, even if they disagreed). At the conclusion of each focus group, participants were debriefed and given the option to receive a formal summary of focus group findings by mail or email. Participants were also asked if the research coordinator could contact them in the future regarding programming and educational opportunities developed based on the focus groups data.

Analytic Procedure

Audio-recordings for each group were transcribed by a professional transcription service and validated by study investigators. Validation occurred by study investigators listening to audio recordings of focus groups while reviewing transcriptions to ensure accuracy. For the Spanish-speaking focus group, transcribed interviews were translated into English by a professional service. Each focus group was reviewed using inductive thematic text analysis in which conceptual findings emerge through an iterative process of transcript review, interpretation and coding, and consensus discussions among coders (Bernard, 2005; Boyatzis, 1998; Creswell, 1998; Green & Thorogood, 2004; Michael Quinn Patton, 2002). This form of analysis is consistent with prior qualitative work (Michael Quinn Patton, 2002). The analysis procedure consisted of several phases and was completed by a pair of research study members who are authors. This report focused on describing and interpreting participant comments on stigma resulting from HIV status, age, sexual orientation, gender, culture, and the resultant social isolation that occurs.

In Phase 1 of coding, analysis team members read each transcript, highlighted content deemed relevant to the study questions, and created an initial code book consisting of descriptive concepts identified during focus group transcript review (Miles & Huberman, 1994). During this process the research team conducted an iterative process of open coding a subset of the transcripts. Each team member independently developed codes capturing their interpretation of the underlying meaning of participant comments. After each team member completed their coding, the team met to review the coding, mutually agreed to final codes and their definitions, and reached consensus as to how to apply the generated codes to the data. This process was repeated for each focus group. In Phase 2, team members utilized the finalized codebook created in Phase 1 to recode all transcripts by applying finalized codes. This iterative process was repeated until the transcripts of all focus groups had been coded and the two coders reached consensus on the final codes applied to the focus group transcripts. Consensus was reached through meetings in which codes that appeared across coders were kept and differing codes were discussed to determine which code was most appropriate and accurate. In Phase 3, the analysis team members reviewed the final codes

produced for each transcript and generated higher-order descriptive and interpretive themes. The prominence of the findings identified in Phase 4 were further assessed in two ways: 1) did both analysis team members reach similar conclusions regarding final themes (and corresponding codes) (Michael Q Patton, 1999; Warren & Karner, 2005) and 2) to what degree did thematic findings recur or differ across the focus groups. To understand how these themes varied by focus groups, they are presented by group type (gay/bisexual men, heterosexual men, women, and Spanish-speaking). This allowed for identifying which themes occurred across multiple groups and which were unique to specific focus groups (Guba, 1978; Michael Q Patton, 1999).

Results

Five thematic areas associated with stigma emerged from the focus group data. These themes, along with exemplary quotes, are presented in Table 1 and discussed in detail below. Quotes are included in a table to allow for comparison of similarities and differences across the four focus groups. Because each focus group represented a unique subset of older PWH, differences and similarities between groups are discussed below.

Theme 1: Disclosure of HIV status.

One theme that emerged centered on concerns regarding disclosing one's HIV status as well as other stigmatizing statuses (e.g., sexual orientation) as a result of the stigma already experienced or anticipated stigma (see Table 1). This fear of disclosure was significant enough for participants to have avoided disclosing their HIV status as well as sexual orientation status to others including friends, family members, and loved ones. For the Spanish-speaking group, fear or avoidance of disclosure seemed specifically tied to cultural differences in attitudes toward HIV. Women represented the only group that explicitly denied experiencing fear or avoidance of disclosure. On the contrary, women reported experiencing empowerment and fulfillment by disclosing their status and advocating for PWH.

Those who experienced stigma often avoided disclosure to prevent a negative reaction or encounter or to maintain an important social bond. This fear of losing important relationships was most prominent among the heterosexual male group but also existed within the gay and bisexual group. Both gay/bisexual males and heterosexual males highlighted a strong concern about disclosing to potential romantic partners. That concern caused them to avoid disclosure of their HIV status altogether, even if it meant entirely eschewing romantic relationships as a solution. Thus, in their avoidance of disclosure, many also experienced a loss of social bonds.

Some individuals highlighted the complexity of disclosing one's HIV status, noting that the decision to disclose and the burden experienced by this decision was very dependent on the context. Safety and companionship appear to influence the decision not to disclose, and by trying to protect these social bonds, many individuals who have kept their status a secret have experienced internal guilt, shame, or stress. This highlights the severe burden disclosure decisions alone can generate in older PWH.

Theme 2: Types of stigma experienced.

Multiple types of stigma and associated experiences were identified across the four groups, highlighting the presence of intersecting or multiple stigmas. Notably, individuals experienced stigma associated with real or perceived prior drug use, sexual orientation (being gay or bisexual), and their HIV status (see Table 1). Each of these stigmas was linked to perceptions that their behavior (e.g., having sex with men, drug use) resulted in their HIV status. Although the overarching experience of stigma was linked to individuals' HIV status, the Spanish-speaking group appeared to link stigma directly to views individuals within the church (congregation) held and of not offering forgiveness for them being a PWH. These stigmas were experienced in several ways, most referring to an individuals' HIV status. Participants reported experiencing anticipated stigma (fearing or anticipating negative reactions due to their status in social encounters), internalized stigma (guilt, blame, shame for their HIV positive status), and enacted stigma (actual experiences of stigma from other individuals). Enacted stigma was experienced both as a perception of negative reactions from others regarding their HIV positive status or, in some cases, as being defined solely as being HIV infected, regardless of other qualities that define the person.

Theme 3: Discrimination experienced.

Many individuals reported encountering discrimination because they were stigmatized by others (see Table 1). Discrimination in this context, as described earlier, is differentiated from stigma in that it represents the unjust or prejudiced treatment of a person based on certain factors such as HIV status whereas stigma refers to feelings such as judgment, guilt, or blame. Again, pointing to the existence of intersecting or multiple stigmas, individuals reported experiencing discrimination due to their age, sexual orientation, or HIV positive status. Multiple types of discrimination were encountered, including institutional discrimination (withholding resources at an institutional level due to HIV status) and social discrimination (isolation or unfair treatment due to HIV status).

Whereas experiences of discrimination due to sexual orientation and HIV status are well-documented, some individuals experienced discrimination due to their age. Often discrimination due to age was experienced from individuals' own peers (e.g., other individuals with HIV positive status). As evidenced in the exemplary quotes (Table 1), one source of age discrimination that individuals mentioned was a pre-existing culture of presuming that PWH are younger.

Theme 4: Other outcomes associated with experiencing stigma.

Individuals stated that HIV-associated stigma led to negative consequences, including several psychological outcomes typically associated with stigma, such as embarrassment and shame about their HIV status (see quotes in Table 1). Experiencing stigma due to HIV status and age was associated with reports of feeling more socially isolated than perhaps younger PWH. Namely, some individuals in the focus groups specifically attributed this to generational differences in experiences of HIV stigma (see Table 1). In addition, many men reported opting to withdraw or isolate themselves from others due to their HIV status. While social isolation was prevalent among most of the groups, it did not emerge as a theme for women.

The group that most commonly reported choosing to withdraw socially was the heterosexual male group. They were most burdened by their disease status, and their social withdrawal caused great suffering. Finally, several individuals said they felt depressed. This was, in most cases, directly tied to being diagnosed with HIV or experiencing stigma from being HIV positive.

In summary, the negative outcomes experienced by stigmatized individuals were linked to internalization of that stigma (embarrassment, shame) as well as social consequences of that stigma such as social isolation and withdrawal and avoiding disclosure of one's HIV status. In short, there may be a series of negative outcomes resulting from the initial internalization of stigma.

Theme 5: Influence of aging on social isolation experienced due to stigma.

Extending our finding that some individuals reported being discriminated against for their age, individuals in the gay/bisexual male, heterosexual male, and Spanish-speaking group all noted that age specifically contributed to the social isolation they experienced. In some cases, individuals were isolated by others who were also HIV positive. This occurred among heterosexual males as well, as noted in the discrimination example previously identified (see quotes in Table 1). However, this social isolation seemed most prominent among gay/bisexual men (in the gay/bisexual and Spanish-speaking groups), who indicated there may be something unique to gay or bisexual culture that makes aging more difficult. Much of the isolation was associated with generational differences in how gay and bisexual men experienced their HIV status. For instance, many participants perceived that social isolation was caused by being an older male in a culture dominated by young men [HIV negative and HIV positive gay/bisexual men].

Not only did gay and bisexual men report feeling isolated by their own peers, they also mentioned that the lack of acceptance of not only their HIV status but of their sexual orientation as gay among their own generation led to fewer opportunities for social support than younger men.

Discussion

The present study extends insight into the frequently powerful impact of HIV stigma among older PWH by examining the intersectionality of multiple stigmas experienced by older PWH, including those due to HIV status, age, gender, sexual orientation, and race/ethnicity. Similar to prior research, all groups reported experiences of both stigma (Mahajan et al., 2008) and discrimination associated with living with HIV (Mawar et al., 2005; Parker & Aggleton, 2003). Additionally, the majority of groups also reported experiencing the intersection of stigma due to their HIV status and their older age (Emlet, 2006c). Unique to the present study, however, is the finding that stigmas of groups that are disproportionately affected by HIV intersected between HIV status and age.

As suggested by prior research, different groups in the present study had differing advantages and disadvantages of intersecting or multiple stigmas (Purdie-Vaughns & Eibach, 2008). For instance, women were the only group that did not report an added effect of age to

their experiences of HIV stigma. This finding indicates that women may benefit more than the other groups from “crisis competence” (Kimmel, 1978; Vance & Robinson, 2004) in that they are better able to deal with the stigma of aging. This ability to deal with HIV stigma may be due to having experienced other stigmas such as their HIV status, identification as a former drug user, or sexual orientation as a lesbian. Our present results indicate that women living with HIV may have a buffered effect of age on social isolation. In fact, overall, the women’s focus group in the present study reported the lowest levels of experiencing HIV stigma and ageism and the fewest negative outcomes associated with this stigma, further highlighting that they may have the highest levels of resilience in handling multiple stigmas due, in part, to their ability to overcome the crisis period in their lives of having an HIV positive diagnosis (Halkitis et al., 2017).

One cohort that may have experienced multiple stigmas was the gay/bisexual male group. Themes that emerged from the present data among gay/bisexual males indicated that they reported multiple instances of experiencing ageism within their own cohort. This finding seemed linked to the cultural norm among this group of men of being a “young” or “youthful” culture. As such, these men seemed to be highly at risk for experiencing the intersectionality of stigma due to HIV status and age (Nelson, 2004). This is in line with prior research by Wight and colleagues which indicates that midlife and older gay-identified men are uniquely jeopardized by stress due to a compounded effect of their sexual minority identity and age (Wight, LeBlanc, De Vries, & Detels, 2012).

The Spanish-speaking cohort, which was comprised largely of individuals whose self-reported ethnicity was Latino/Hispanic, seemingly experienced higher outcome burden from multiple stigmas due to their HIV status and ethnicity as well as cultural norms. For instance, individuals in this focus group reported experiencing stigma specifically from church and also noted that they avoided disclosure of their HIV status due to the cultural norms from their home countries surrounding HIV/AIDS. This finding highlights the need to attend to the cultural norms of PWH to determine how best to target and reduce HIV stigma.

All focus groups, with the exception of the women’s group, reported avoidance or fear of disclosure due to concerns related to loss of social bonds. This highlights that concerns regarding anticipated stigma, the concern one will be stigmatized due to disclosure of HIV status (Earnshaw & Chaudoir, 2009), existed and often triggered an avoidance or lack of social engagement regarding one’s HIV status. The heterosexual male group experienced anticipated stigma more commonly than other HIV positive groups. Interestingly, this group seemingly experienced an anticipation of multiple stigmas including stigma due to their HIV status as well as false stigma due to a perception that they were a sexual minority (gay/bisexual) or a drug user. The heterosexual male group vocalized major concerns about disclosing their HIV status, particularly to heterosexual women who might be of sexual interest. Unfortunately, this lack of disclosure to heterosexual women led to high levels of social isolation. Thus, heterosexual males may be the most at risk for social isolation due to an anticipated intersectionality of stigmas, including stigmas related to groups they do not identify with. This extends on prior research which indicated that individuals who are not in groups traditionally considered “at risk” by the common public (e.g., gay or bisexual) may experience higher levels of stigma (Stanley, 1999). Thus, gay/bisexual social networks may

provide a protective effect whereas heterosexual males may experience negative social outcomes due to HIV stigma, pointing to the potentially differing effects of intersecting stigmas based on which groups one identifies with (Earnshaw et al., 2013; Purdie-Vaughns & Eibach, 2008).

In summary, findings from the present study illuminated prior work on older PWH (Emlet, 2006a, 2006b; Grov, Golub, Parsons, Brennan, & Karpiak, 2010; Schrimshaw & Siegel, 2003) by indicating how the intersectionality of stigma looks across varying groups of older PWH based on gender, sexual orientation, and race/ethnicity. Findings from the present study highlight a few key points. The first is that the combination of HIV stigma and ageism may affect women less, and women may not experience as much social isolation, depression, or loneliness as their male counterparts due to stigma. Second, heterosexual males may be the most at risk of having negative social outcomes due to an anticipated intersectionality of stigma due to their HIV status and perceived belonging to another stigmatized group such as gay/bisexual men. As such, this group of individuals may be most in need of interventions to reduce HIV stigma and improve social support. Third, gay and bisexual men may be the most at risk for experiencing the intersection of stigma due to HIV status and age. This may be due in large part to the cultural norm and celebration of youth among gay men. Finally, Spanish-speaking older adults may face unique cultural challenges in dealing with HIV stigma including stigma from the church and avoidance of disclosure due to cultural norms. The present study highlights the need to better understanding these intersecting stigmas and potentially tailor HIV stigma interventions for older PWH with regard to gender, sexual orientation, and race/ethnicity.

Despite its strengths, the present study has limitations. First, because the focus groups did not specifically probe for experiences of HIV stigma or ageism, our results are likely a conservative estimate of the actual experiences of individuals in these groups and may not wholly encompass all experiences of HIV stigma and ageism. Nevertheless, it is notable that these experiences emerged, in the absence of specific probes, indicating they are significant among older PWH. Second, the focus groups examined in this study confounded gender and sexual orientation in two groups (women and Spanish-speaking), preventing us from determining if differences across certain groups are related solely to gender, sexual orientation, or a combination of both. However, information shared within these focus groups illuminated when the participants felt particularly stigmatized due to gender or sexual orientation. Third, although the present focus groups contained a large number of African-American adults, this was not a single focus group. Thus, we cannot determine the extent to which race/ethnicity affected the current findings. Finally, the present results are qualitative and thus cannot be used to test hypotheses formally. Although qualitative data allows for exploration of themes and helps to generate hypotheses, it should be noted that the present sample was incompletely representative (as noted previously), which limits the generalizability of the findings.

One major implication of the present study is that varying groups of older PWH may experience outcomes from stigma differentially from varying advantages and disadvantages of their multiple stigmas (Purdie-Vaughns & Eibach, 2008). Thus, it is critical the medical professionals working with older PWH to assess for both strengths and weaknesses in older

PWH support structures. Another important implication in the present study is that gay/bisexual and heterosexual males may be most at risk of experiencing negative outcomes due to the intersection of HIV stigma and ageism. Additionally, heterosexual males may experience the highest burden from the intersection of HIV stigma and perceived other stigmas due to assumed sexual orientation or drug use. As such, these individuals may experience the most negative outcomes such as increased social isolation, depression, and lack of social support. Currently, most HIV programs in the U.S. target gay/bisexual males, leaving other groups such as heterosexual males to feel that they have no services being offered to them (Stanley, 1999). Due to the changing landscape of HIV as including a variety of individuals including older adults, heterosexual men and women, and others, support services need to be developed that are not gay/bisexual specific but rather target broader groups of interest and need.

Another major finding from this study is that older PWH from different cultural backgrounds such as Spanish-speaking PWH may need more culturally tailored programs to address their culture-specific needs in coping with their HIV status. As such, future programs would benefit from culturally tailored programs which reach individuals from underrepresented minorities (e.g., Hispanics/Latinos, African Americans, etc.). This will allow for a broad range of HIV support services and programming to reach individuals from multiple racial/ethnic backgrounds.

Finally, the present study indicates that women seem to experience the deleterious effects of HIV stigma the least among all group studied. As such, it may be beneficial to look at what support services, programming, or self-initiated activities women engage in that provides this protective buffering. This could be applied to larger scale programming in order to adapt materials to help reduce stigma and improve social outcomes.

Conclusion

In summary, the present study highlights how the intersectionality of stigma across groups most affected by HIV looks and begins to highlight which groups are most critical to target in reducing multiple stigmas and improving social support. Future research should focus on developing targeted interventions that reduce HIV stigma and other stigmas and improve individuals' ability to seek out and find social support by addressing the unique needs of each of these groups. Using more tailored approaches could more effectively reduce stigma and improve social supports. This, in turn, could improve outcomes such as reducing depression, improving mental health, and improving medical help seeking among older PWH.

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Appendix

Focus Group Questions

1. Are you aging? Do you feel you are aging well?
2. What do you feel you need to maintain your health and well-being as you grow older?
3. What kind of services does CSS (or your own provider) offer now to address these needs?
4. What new services might help you?
5. What barriers do you face when accessing health or social services?
6. Do you feel that programs that increase opportunities to socialize would help so, what kinds of programs do you propose?
7. Do you have concerns that your needs of caregiving will be met as you get older?
8. What has been helpful to you in coping with aging with HIV?

Biography

Biographical Statement: Dr. Shen is assistant professor at Weill Cornell Medicine (WCM); Ms. Freeman is a social worker at Hennepin County Human Services; Drs. Karpiak and Brennan-in are HIV/AIDS researchers at ACRIA; Liz Seidel is a social worker at ACRIA; Dr. Siegler is a practicing geriatrician on the faculty at WCM.

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Clinical Implications

- Be sensitive to and assess the multiple stigmas (HIV sexual orientation, drug use, ageism) that patients may be facing and help them address support needs around these stigmas.
- Assess older PWH's social support structures to identify potential needs and strengths/resource
- Develop and/or provide support services that are not gay/bisexual specific given the broader older PWH patient population.
- Assist older PWH find the proper social support needed to deal with their HIV status and potential loneliness and stigmatization by connecting them with other older PWH.

Table 1.

Summary of qualitative results.

Theme	Gay/BisexualMales	Heterosexual Males	Women	Spanish-Speaking
Theme 1 : Disclosure of HIV status <u>Summary:</u> Individuals reported struggling with disclosing their HIV status to others, namely due to experienced or anticipated stigma	Disclosure of HIV status was often connected to disclosure of sexual orientation; most experienced anticipated stigma. <i>In a perfect world it would be great to come out; it's great to assert who you are in totality. But, it's circumstantial for each person. And, each person has to make a decision about how safe it is for them to be open and out about anything concerning themselves. "It took me maybe a decade or two to come out to my mother because I was afraid that she would react negatively. "I can't come out to my family and I have to keep it a secret, it made me feel kind of like I hate myself a little bit for being gay and for having HIV and it's...I haven't come to grips with that yet because I have a lot of negative things going on. "</i>	Fears of disclosure of HIV status were predominately tied to concerns regarding anticipated HIV stigma, misperceptions about sexual orientation, and concerns regarding the loss of social bonds. <i>"I've had women actually come up to me and say, "Is anything wrong with you?"...They say, "Are you gay?" I say, "No, I'm not gay."...I just can't, I just can't bring myself to tell them, you know, I'm HIV positive. "I'm really not willing to disclose because I know, in my mind once I tell them I'm positive they gone, so why put myself through that?" "Disclosing my status to people was my biggest depression. It's so depressive. "Covering up your lifestyle or covering up, you know what I'm saying, what you have, you can't get rid of. You can't even, be with somebody and not say, you know hey, I can't contaminate you, but I'm feeling guilty myself, especially if there are any type of emotions. But I'm just saying no, I wouldn't tell."</i>	Disclosure of HIV status was connected to empowerment or positive outcomes. <i>"That's why I continue to work today, I have a job and I work with people that areHIV positive because there is something fulfilling about and empowering about and I let the people that I work with know and it is very important for me to let them know that I am positive and it's something comforting in that we don't have to just stop living and stop living dreams and having goals just because we are positive. "</i>	Disclosure of one's HIV status was hidden, due to cultural norms preventing disclosure of the specific disease. <i>"My family is almost all in Colombia, so they know I'm sick but they don't know with what because people there have difference way of thinking."</i>
Theme 2: Types of stigma experienced <u>Summary:</u> Most stigmas experienced were tied to how one contracted HIV. Individuals reported experiencing anticipated stigma, internalized stigma, and perceived stigma.	Multiple stigmas were experienced, including HIV stigma and stigma of sexual orientation. These stigmas created a burden and often internalized (self) stigma. <i>"...felt such a stigma about it [HIV positive status] still to such a degree that they hide it from their family, from any potential friend. And, the overall sense that the gay community as a whole would not be accepting of them. "It's like the burden and the weight of hiding something is like, reinforcing and adding to your own self of sense stigma"</i>	Although HIV stigma was experienced, heterosexual males were also concerned with misperceived stigmas of sexual orientation or drug use. <i>"You gotta get over the stigma of, you know what I'm saying, worrying about what somebody will think about you" "Soon as I tell somebody, somebody may assume just like you, oh you been shooting needles?"</i>	The predominant stigma experienced was HIV stigma. <i>"...there is more to me than HIV"</i>	Both HIV and sexual orientation stigma were experienced as anticipated or perceived, but perceived stigma was the most commonly experienced form of stigma. <i>"Not specifically to HIV, but they say that you have to ask forgiveness for some things that they can't forgive, and so for me I don't like it...but if there's something that you take in your blood then you're marked for life. "</i>
Theme 3: Discrimination experienced <u>Summary:</u> Individuals reported experiencing discrimination, through the withholding of resources of social isolation, for their HIV positive status.	Concerns arose regarding withholding of resources (housing, safety, etc.) due to discrimination based on one's HIV status. <i>"There are real safety issues in housing and so forth, discrimination, where somebody could reveal your status and somebody's going to discriminate against you and do something terrible. "</i>	In addition to discrimination due to HIV status, heterosexual men also felt discriminated against for their older age. <i>"Yah, and I went to the thing called...I forget the name of it, but when I met the group of young, young people, 21 years old, you know, 24, 25 years old, I was like...as soon as I got there it's "Oh, we got a grandpa. "When they called me grandpa, I said that's it, done. "</i>	Most discrimination was experienced in the context of the medical health care setting, where patients were treated negatively due to their HIV status. <i>"I would stand there and hear some people at the receptionist make negative comments about me and the person that they wanted me to go to</i>	Discrimination was experienced predominately in the form of treating individuals as potentially contaminating (i.e., avoidance of physical contact). <i>"I was going to massages, but when you arrive where the massage therapist is, and they put on gloves in order to touch you, come on.... [if] the only thing you see is a woman arrives to</i>

Theme	Gay/BisexualMales	Heterosexual Males	Women	Spanish-Speaking
			<i>his unit when my unit closed. “</i>	<i>touch you with gloves, that's very stressful. “</i>
Theme 4: Other outcomes associated with experiencing stigma <u>Summary:</u> Individuals reported a multitude of negative outcomes due to experiencing stigma including, embarrassment, shame, social isolation, withdrawing from others, and depression.	Shame and guilt were experienced due to stigma surrounding HIV status. <i>“I think a lot of us older guys, we have a lot of shame around this [HIV status].”</i>	Due to the anticipated or perceived HIV stigma experienced, most heterosexual males suffered social losses including social isolation and loss of dignity. <i>“I had no teeth, I mean I'm walking around the street with a handkerchief on my mouth, I mean some people don't give a shit, you know, at least give me some dignity over here. “</i> <i>“So after a while after I reported it, I started seeing that my fellow coworkers, they started treating me a whole lot different, quiet, keeping away from me, they didn't wanna deal with me.”</i> <i>“I stopped going to bars, I stopped going to clubs, even some restaurants. I don't even eat out in restaurants. I just buy my food and bring it home. I just eat at home.”</i>	Depression was a commonly experienced outcome due to experiencing HIV stigma. <i>“I was depressed and all of that was the other doctors made me feel like concerned. “</i>	Social isolation and social loss were common outcomes due to experiencing HIV stigma. <i>“I stayed in my house, but what happens if I stay in my house? I end up watching television. “</i>
Theme 5: Influence of aging on social isolation experienced due to HIV stigma <u>Summary:</u> Individuals reported how aging exacerbated the effects of social isolation due to having an HIV positive status.	Due to the youthful culture of gay/bisexual men, social isolation was experienced due to lacking a place within the social structure of the gay/ bisexual community. Individuals reported feeling “invisible.” <i>“Younger people today they're all free and out, but we have a hard time because we grew up when It [HIV] wasn't accepted that much. “</i> <i>“So where does that leave the older homo men? Because I feel that I'm becoming more and more Invisible. “</i> <i>“And I emphasize the point about how In general gay culture celebrates youth and I don't want to feel Invisible and I don't think that anybody really wants to feel Invisible. “</i>	Individuals suffered feeling social disconnected or excluded due to their older age in HIV support groups or other supportive settings. <i>“Yah, and I went to the thing called...I forget the name of It, but when I met the group of young, young people, 21 years old, you know, 24, 25 years old, I was like...as soon as I got there It's “Oh, we got a grandpa. “When they called me grandpa, I said that's It, done. “</i>	Individuals noted being treated differently and judged due to their combined status of older adult and being HIV positive. This was connected to feelings of loss of self or individual identity. <i>I get particularly frustrated when people see me on paper and assume whatever they assume which Happens often...she's 63 years old, she's HIV positive, so they expect a particular kind of person. “</i>	The youthful culture of gay/bisexual communities led to feelings of social exclusion and loss due to one's age. <i>“I thought the worst thing that could happen is I'm gay...but all gays...I don't know how to not get older. “</i>