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## Internalized stigma and HIV status disclosure among HIV-positive black men who have sex with men

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### Abstract

Black men who have sex with men (BMSM) are severely affected by the HIV epidemic, yet research on the relationship between HIV stigma and status disclosure is relatively limited among this population. Within this epidemic, internalized HIV stigma, the extent to which people living with HIV/AIDS (PLWHA) endorse the negative beliefs associated with HIV as true of themselves, can negatively shape interpersonal outcomes and have important implications for psychological and physical health. In a sample of HIV-positive BMSM ( $N = 156$ ), the current study examined the effect of internalized stigma on HIV status disclosure to sexual partners, which can inform sexual decision-making in serodiscordant couples, and HIV status disclosure to family members, which can be beneficial in minimizing the psychological distress associated with HIV. Results revealed that greater internalized stigma was associated with less HIV status disclosure to participants' last sexual partner and to family members. Findings from this study provide evidence that internalized negative beliefs about one's HIV status are linked to adverse interpersonal consequences. Implications of these findings are discussed with regard to prevention and intervention efforts to reduce HIV stigmatization.

### Keywords

HIV; internalized stigma; Black; men who have sex with men; disclosure

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Men who have sex with men comprise just over half of people living with HIV/AIDS (PLWHA) in the United States, and are therefore the group most severely affected by the country's HIV epidemic (*HIV among Gay, Bisexual and Other Men Who Have Sex with Men (MSM)*, 2010). Black men who have sex with men (BMSM) are particularly affected, having the highest HIV prevalence among all racial/ethnic groups of men who have sex with

men (Smith, Miles, Le, Finlayson, Oster, & DiNenno, 2010). However, limited research has addressed how HIV stigma impacts social relationships and HIV status disclosure among HIV-positive BMSM. The current study addresses this gap by examining the relationship between internalized stigma and HIV status disclosure, an outcome critical to maintaining the health of HIV-positive BMSM and their sexual partners.

HIV-positive BMSM possess at least three co-occurring stigmatized identities (i.e., HIV-positive, racial minority, sexual minority) and oftentimes more (e.g., low socio-economic status). HIV-positive BMSM may experience discrimination within multiple communities based on these stigmas. For example, they often face discrimination due to racism (Banks, Kohn-Wood, & Spencer, 2006; Sellers & Shelton, 2003), which has been associated with non-adherence to antiretroviral treatments in HIV-positive BMSM (Bogart et al., 2010). They face discrimination within black communities, including black churches, where homophobia is often strong (Malebranche, 2003). They also may face discrimination within gay communities where HIV stigma results in rejection of HIV-positive gay men by HIV-negative gay men (Courtney-Quirk et al., 2006). Thus, HIV-positive BMSM are severely socially devalued within the U.S. As a result of this social devaluation, HIV-positive BMSM may come to internalize stigma by associating the negative stereotypes and beliefs associated with their stigmas with themselves. Thus, it is important to examine how internalized stigma can affect the health and behavior of BMSM. We specifically focus on the impact of internalized HIV stigma in this multiply marginalized group.

Internalized HIV stigma can adversely impact interpersonal outcomes and have important implications for psychological and physical health. Negative feelings (e.g., shame) about one's HIV status make it difficult for PLWHA to tell others about their disease (Earnshaw & Chaudoir, 2009; Lee, Kochman, & Sikkema, 2002) and may impact decisions to seek help and support from close others (Chesney & Smith, 1999). A recent review of the disclosure literature suggests that stigma is an important factor in people's decisions to disclose to others, often acting as a barrier to disclosure (Chaudoir & Fisher, 2010). Moreover, several longitudinal studies have found that stigma is associated with lower likelihood of disclosure to sexual partners, friends, and family (Chaudoir, Fisher, & Simoni, 2011). However, this review included no studies focused specifically on BMSM. Thus, it is necessary to explore whether BMSM who have internalized HIV stigma are also less likely to disclose their HIV-status to sexual partners and family.

Identifying the extent to which stigma impacts disclosure among HIV-positive BMSM may help to illuminate disparate rates of HIV infection among MSM (Millett, Peterson, Wolitski, & Stall, 2006). In a sexual context, knowing a partner's sexual status is critical. Eaton, Kalichman, and Cherry (2010) found that MSM use serosorting (i.e., limiting unprotected sexual encounters to partners with the same HIV status) as a key factor in sexual risk decision-making. Using serosorting as a risk reduction strategy among serodiscordant couples requires status disclosure. However, Eaton and colleagues (2010) found that BMSM were less likely than White MSM to know the status of their last sexual partner, which draws attention to understanding important factors that can hinder discussion and disclosure about HIV status with sexual partners in BMSM. When status is not disclosed, HIV-negative

partners may be basing their decisions to have unprotected sex on misinformation that puts them at risk of contracting HIV.

Understanding the effect of internalized stigma on HIV status disclosure also has important implications for the mental health outcomes of HIV-positive BMSM. Among the general population of PLWHA, internalized stigma is related to depressive symptomatology (Simbayi et al., 2007), feelings of loneliness and social isolation (Crandall & Coleman, 1992; Sayles et al., 2007), and shame and embarrassment (Lee et al., 2002). Beyond these intrapersonal consequences, internalized stigma may also hinder social relationships. In a sample of HIV-positive Black women, greater internalized stigma was associated with less perceived support (Vyavaharkar et al., 2010). Greater perceived social support from family and friends, whether instrumental (e.g., borrowing money from a friend) or emotional (e.g., having someone to confide in), can minimize psychological distress for PLWHA (Catz, Gore-Felton, & McClure, 2002). A viable pathway to perceiving greater social support lies in HIV status disclosure to family and friends (Kalichman, DiMarco, et al., 2003). If internalized stigma acts as a barrier to status disclosure, it is possible that HIV-positive BMSM may not be receiving adequate social support. Thus, there is a need to consider how internalized stigma impacts HIV status disclosure to family members in HIV-positive BMSM.

The current study examined the impact of internalized stigma on disclosure in HIV-positive BMSM. We specifically focused on the role of internalized stigma on HIV status disclosure to sexual partners and family members. We hypothesized that HIV-positive BMSM who internalize greater stigma are less likely to disclose their HIV-status to their sexual partners and family.

## Method

### Participants

Participants were 156 Black men living with HIV/AIDS who indicated that they had sex with men during their last sexual encounter. This subset of participants took part in a study in which male and female PLWHA were recruited from a variety of agencies and organizations in inner-city areas of Atlanta, Georgia (author information omitted). Participants were eligible for the study if they were at least 18 years of age, had proof of HIV-positive status, and were currently taking ARV medications. Data collection took place between January 2006 and May 2008. Ethics approval for the larger study was granted from the University of Connecticut Institutional Review Board.

### Measures

**Demographics**—Participants reported their age, race/ethnicity, income, highest level of education completed, employment status and relationship status.

**Status Disclosure to Family Members**—Participants indicated whether they had the following family members: mother, father, older brother, younger brother, older sister, younger sister, children, aunt/uncle, and cousin. Participants then indicated their status disclosure to these family members. We computed a proportion of disclosure by dividing the

total number of participants' disclosures by the total number of participants' family members.

**Status Disclosure to Sexual Partner**—Participants also indicated whether their sexual partner knew of their HIV status at the time of their last sexual encounter. Participants answered the following question: “Did this person (i.e., their last sexual partner) know your HIV status at the time?” Participants' responses were coded 0 (*No*) or 1 (*Yes*) to this question.

**Internalized Stigma**—The Internalized AIDS-Related Stigma Scale was used to measure internalized stigma associated with one's HIV-positive status (Kalichman, Simbayi, Cloete et al., 2009). Six items assessed internalized stigma (e.g., “Being HIV positive makes me feel dirty”, “It is my own fault that I am HIV positive”). These items were rated on a scale from 1 (*Strongly Disagree*) to 4 (*Strongly Agree*). Items were averaged into a composite score ( $\alpha = .76$ ).

**Depression**—The Center for Epidemiological Studies-Depression Scale (CES-D) was used to assess current depressive symptomatology (Radloff, 1977). Participants rated the frequency with which they have experienced 20 depressive symptoms over the course of one week (e.g., “I felt that I could not shake off the blues even with help from my family or friends”, “I thought my life had been a failure”). The response frequencies for the 20 symptoms were rated on a scale from 0 (*0 days*) to 3 (*5–7 days*). Items were summed into a composite score. Possible scores range from 0 to 60 with scores of 16 to 26 indicative of mild depressive symptoms and scores of 27 or more indicative of major depressive symptoms (Zich, Attkisson, & Greenfield, 1990).

## Data Analyses

To examine how internalized stigma was related to HIV status disclosure, we conducted two regression analyses. In the first analysis, we conducted a hierarchical linear regression with disclosure to family as the dependent variable and internalized stigma as the independent variable. In the second analysis, we conducted a binary logistic regression with disclosure to sexual partner as the dependent variable and internalized stigma as the independent variable. We controlled for participants' depressive symptomatology to examine whether HIV status non-disclosure is a function of negative mood or the extent to which people come to endorse the negative feelings and beliefs associated with HIV/AIDS about themselves. These analyses also controlled for participant age, education, and income.

## Results

Sociodemographic characteristics of the sample are displayed in Table 1. Participants self-identified as African American/Black; however, participants were not given the option to specify whether they were of Caribbean or African descent. The mean age of the sample was approximately 42 years of age. A majority of the sample completed high school, reported disability or unemployed as their working status, and earned \$20,000 per year. Approximately 20% of the sample reported being married or in a committed relationship and three-quarters indicated that their sexual partner knew of their HIV status. Additionally,

participants reported disclosing their HIV status to 67% of their family members. On average, participants' internalized stigma score was at the mid-point of the scale and a majority reported mild depressive symptoms.

### **Internalized Stigma and HIV Status Disclosure to Family**

In the first analysis, a hierarchical linear regression was conducted with status disclosure to family members as the dependent variable. In the first step of the model, we included the covariates CESD, age, education, and income as predictors of HIV status disclosure and in the second step of the model, we included internalized stigma as a predictor of HIV status disclosure controlling for these covariates. Table 2 displays the relevant statistics. The first step of the analysis, regressing HIV status disclosure on the covariates was not statistically significant. However, the inclusion of internalized stigma in the second step of the analysis resulted in a significant change in the overall regression equation. Results revealed that internalized stigma was negatively associated with HIV status disclosure to family members. Specifically, greater internalized stigma was related to a lower proportion of HIV status disclosure to family members.

### **Internalized Stigma and HIV Status Disclosure to Sexual Partners**

In the second analysis, a logistic regression was performed with status disclosure to sexual partner as the dependent variable. In the first step of the model, we included our covariates, CESD, age, education, and income, as predictors of HIV status disclosure. In the second step of the model, we assessed whether internalized stigma predicted HIV status disclosure controlling for these covariates. The addition of internalized stigma resulted in a statistically significant model,  $\chi^2(1) = 4.72, p = .03$ . Table 3 displays the logistic regression coefficients, Wald statistics, and estimated change in odds of sexual partners knowing participants' HIV status given these variables. In the first step of the analysis, the covariates were not significant predictors of HIV status disclosure. The second step of the analysis revealed that internalized stigma was a statistically significant predictor of HIV status disclosure to one's sexual partner after controlling for the covariates, such that the more internalized stigma participants reported due to their HIV-positive status, the less likely it was that their current sexual partners knew of their HIV status.

## **Discussion**

Our findings revealed that internalized HIV stigma is associated with costs to interpersonal relationships in HIV-positive BMSM. The more internalized stigma BMSM reported, the less likely it was that their current sexual partners knew of their HIV status. Internalized stigma was also related to status disclosure to family members. We found that greater internalized stigma was associated with less HIV status disclosure to family members. These findings were reliable after controlling for the CESD, which suggests that the negative beliefs internalized about one's HIV status is uniquely related to status non-disclosure above and beyond depressive symptomatology. Our findings are consistent with the literature on stigma and disclosure (e.g., Chaudoir, et al., 2011) and further elucidate the consequences of stigma in an understudied population.

Within a sexual context, decisions to have unprotected sex based on non-communication between partners about status may increase transmission of HIV to HIV-negative partners. Understanding factors that hinder open discussions about HIV status becomes extremely relevant given findings that BMSM were more likely than White MSM to report having unprotected anal intercourse with a partner of unknown HIV status and were also more likely to report not knowing the HIV status than their last sexual partner (Eaton et al., 2010). The current research shows that internalized stigma among BMSM is associated with less disclosure to sexual partners. Thus, negative beliefs around one's HIV status may reduce the likelihood that HIV status is disclosed in a sexual context.

This study examined how internalized stigma impacts disclosure; however, BMSM often experience co-occurring stigmatized identities. Thus, researchers should also consider how internalized stigma associated with other identities (e.g., race, sexual orientation) impacts important outcomes. Research on perceived discrimination among BMSM, suggests that discrimination due to race, sexual orientation, and HIV-serostatus are all associated with adverse mental health outcomes (Bogart et al., 2011). Future research should examine whether internalization of negative beliefs about one's race and sexual orientation (in addition to perceived discrimination) can also result in negative intra and interpersonal consequences in BMSM. For example, internalized stigma associated with sexual orientation may undermine disclosure of sexual orientation. Moreover, researchers should examine the intersectional stigmas that BMSM face simultaneously (author information omitted) to better understand the extent to which experiencing multiple stigmas impact important outcomes.

There are limitations to consider when interpreting the results of the current study. The study used a convenience sample of PLWHA and a majority of participants were recruited from a major metropolitan area. Thus, the generalizability of our findings to BMSM in other areas is limited. The validity of the disclosure to sexual partner measure should also be interpreted with caution. Participants were asked to report whether their last sexual partner knew of their HIV status; however, this question did not specifically ask participants if they told their sexual partner about their HIV-positive status. Participants who might have indicated 'yes' to this question may have felt that they have subtly made their sexual partner aware of their HIV status (e.g., by leaving out HIV medications), yet their partner remains unaware of their status (Simoni & Pantalone, 2005). Future research should consider whether those who feel greater internalized stigma engage in subtle methods of disclosure that are not captured by verbalizing one's HIV-positive status. This miscommunication between partners can also skew risk perceptions in a sexual context.

In conclusion, we examined internalized stigma among HIV-positive BMSM. This multiply stigmatized population is particularly vulnerable, yet the relationship between stigma and disclosure of HIV status is relatively understudied. We found that internalized stigma is associated with negative interpersonal consequences that have important implications for the well-being of HIV-positive BMSM and their sex partners. It is critical for researchers to continue to develop understandings of how stigma impacts HIV-positive BMSM and their social relationships, and to work to reduce internalized HIV stigma among HIV-positive

BMSM within interventions. Work that focuses on disclosure among HIV-positive BMSM with the goal of curbing the HIV epidemic among BMSM is long overdue.

## References

- Banks KH, Kohn-Wood LP, Spencer M. An examination of the African American experience of everyday discrimination and symptoms of psychological distress. *Community Mental Health Journal*. 2006; 42:555–570. [PubMed: 16897412]
- Bogart LM, Wagner GJ, Galvan FH, Klein DJ. Longitudinal relationships between antiretroviral treatment adherence and discrimination due to HIV-serostatus, race, and sexual orientation among African-American men with HIV. *Annals of Behavioral Medicine*. 2010; 40:184–190. [PubMed: 20552416]
- Bogart LM, Wagner GJ, Galvan FH, Landrine H, Klein DJ, Sticklor LA. Perceived discrimination and mental health symptoms among Black men with HIV. *Cultural Diversity and Ethnic Minority Psychology*. 2011; 17:295–302. [PubMed: 21787061]
- Catz SL, Gore-Felton C, McClure JB. Psychological distress among minority and low-income women living with HIV. *Behavioral Medicine*. 2002; 28:53–59. [PubMed: 12613286]
- Chaudoir SR, Fisher JD. The disclosure processes model: Understanding disclosure decision making and postdisclosure outcomes among people living with a concealable stigmatized identity. *Psychological Bulletin*. 2010; 136:236–256. [PubMed: 20192562]
- Chaudoir SR, Fisher JD, Simoni JM. Understanding HIV disclosure: A review and application of the disclosure processes model. *Social Science & Medicine*. 2011; 72:1618–1629. [PubMed: 21514708]
- Chesney MA, Smith AW. Critical delays in HIV testing and care: The potential role of stigma. *American Behavioral Scientist*. 1999; 42:1162–1174.
- Courtney-Quirk C, Wolitski RJ, Parsons JT, Gomex CA. Is HIV-related stigma dividing the gay community? Perceptions of HIV-positive men who have sex with men. *AIDS Education and Prevention*. 2006; 18:56–67. [PubMed: 16539576]
- Crandall CS, Coleman R. AIDS-related stigmatization and the disruption of social relationships. *Journal of Social and Personal Relationships*. 1992; 9:163–177.
- Earnshaw VA, Chaudoir SR. From conceptualizing to measuring HIV stigma: A review of HIV stigma mechanism measures. *AIDS and Behavior*. 2009; 13:1160–1177. [PubMed: 19636699]
- Eaton LA, Kalichman SC, Cherry C. Sexual partner selection and HIV risk reduction among Black and White men who have sex with men. *American Journal of Public Health*. 2010; 100:503–509. [PubMed: 20075328]
- Herek GM. AIDS stigma and sexual prejudice. *American Behavioral Scientist*. 1999; 42:1130–1147.
- HIV among Gay, Bisexual and Other Men Who Have Sex with Men (MSM). 2010. Retrieved December 1, 2011 from <http://www.cdc.gov/hiv/topics/msm/index.htm>
- Kalichman SC, DiMarco M, Austin J, Luke W, DiFonzo K. Stress, social support and HIV-status disclosure to family and friends among HIV-positive men and women. *Journal of Behavioral Medicine*. 2003; 26:315–332. [PubMed: 12921006]
- Kalichman SC, Simbayi LC, Cloete A, Ginindza T, Mthembu P, Cherry C, Cain D. Measuring AIDS Stigmas in People Living with HIV/AIDS: The Internalized AIDS-Related Stigma Scale. *AIDS Care*. 2009; 21:87–93. [PubMed: 19085224]
- Lee RS, Kochman A, Sikkema KJ. Internalized stigma among people living with HIV-AIDS. *AIDS and Behavior*. 2002; 6:309–319.
- Malebranche DJ. Black men who have sex with men and the HIV epidemic: Next steps for public health. *American Journal of Public Health*. 2003; 93:862–865. [PubMed: 12773340]
- Millett GA, Peterson JL, Wolitski RJ, Stall R. Greater risk for HIV infection of Black men who have sex with men: A critical literature review. *American Journal of Public Health*. 2006; 96:1007–1019. [PubMed: 16670223]
- Radloff LS. The CES-D scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement*. 1977; 1:385–401.

- Sayles JN, Ryan GW, Silver JS, Sarkisian CA, Cunningham WE. Experiences of social stigma and implications for healthcare among a diverse population of HIV positive adults. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*. 2007; 84:814–828. [PubMed: 17786561]
- Sellers RM, Shelton JN. The role of racial identity in perceived racial discrimination. *Journal of Personality and Social Psychology*. 2003; 84:1079–1092. [PubMed: 12757150]
- Simbayi LC, Kalichman S, Strebel A, Cloete A, Henda N, Mqeketo A. Internalized stigma, discrimination, and depression among men and women living with HIV/AIDS in Cape Town, South Africa. *Social Science & Medicine*. 2007; 64:1823–1831. [PubMed: 17337318]
- Simoni, JM.; Pantalone, DW. HIV disclosure and safer sex. In: Kalichman, SC., editor. *Positive prevention: Sourcebook for HIV prevention with people living with HIV/AIDS*. New York, NY: Kluwer; 2005. (pp. 65e98)
- Smith A, Miles I, Le B, Finlayson T, Oster A, DiNunno E. Prevalence and awareness of HIV infection among men who have sex with men – 21 cities, United States, 2008. *Morbidity and Mortality Weekly Report*. 2010; 59:1201–1207. [PubMed: 20864920]
- Vyavaharkar M, Moneyham L, Corwin S, Saunders R, Annang L, Tavakoli A. Relationships between stigma, social support, and depression in HIV-infected African American women living in the rural southeastern United States. *Journal of the Association of Nurses in AIDS Care*. 2010; 21:144–152. [PubMed: 19879778]
- Zich JM, Attkisson CC, Greenfield TK. Screening for depression in primary care clinics: The CES-D and the BDI. *International Journal of Psychiatry in Medicine*. 1990; 20:259–277. [PubMed: 2265888]



**Table 1**Sociodemographic characteristics of sample ( $N = 156$ )

	<b>n</b>	<b>% of sample</b>	<b><i>M</i></b>	<b><i>SD</i></b>
Age			42.42	6.78
Education			12.94	1.98
Employment Status				
Disability	91	58		
Unemployed	39	25		
Working	16	10		
Other	6	4		
Student	4	3		
Income				
\$0–\$10,000	112	72		
\$11–\$20,000	36	23		
Over \$21,000	8	5		
Committed Relationship				
Yes	31	20		
No	123	79		
Partner knew HIV status				
Yes	113	72		
No	43	28		
Status Disclosure to Family			.67	.37
Internalized Stigma			2.07	.71
CESD			16.36	9.95

**Table 2**Hierarchical Linear Regression Analysis: Predicting HIV Status Disclosure to Family ( $N = 141$ )

Predictor	Step 1 $\beta$	$t$	Step 2 $\beta$	$t$
CESD	-.01	-.08	.11	1.06
Age	.10	1.11	.07	.79
Education	-.02	-.22	-.00	-.01
Income	.10	1.06	.09	.97
Internalized Stigma			-.22	-2.19*
$R^2$	.02		.05	
$F$	.64		1.49	
$R^2$			.03	
$F$			.03*	

*Note.*\*  $p < .05$

**Table 3**  
 Logistic Regression Analysis: Predicting HIV Status Disclosure to Sexual Partner ( $N=144$ )

Predictor	Step 1			Step 2		
	<i>B</i>	Wald Chi-Square	Odds Ratio	<i>B</i>	Wald Chi-Square	Odds Ratio
CESD	.02	1.09	1.02	.05	3.95	1.05*
Age	.00	.02	1.00	-.01	.06	.99
Education	-.10	.88	.91	-.08	.59	.92
Income	.53	2.07	1.70	.51	1.89	1.66
Internalized Stigma				-.71	4.59	.49*

*Note.*

\*  $p < .05$