



Published in final edited form as:

Community Ment Health J. 2016 May ; 52(4): 457–465. doi:10.1007/s10597-015-9879-z.

Disclosure of HIV Serostatus and Sexual Orientation Among HIV-Positive Men Who Have Sex with Men in China

Xiuyun Lin¹, Peilian Chi², Liying Zhang³, Yan Zhang⁴, Xiaoyi Fang¹, Shan Qiao³, and Xiaoming Li³

¹Beijing Key Laboratory of Applied Experimental Psychology, School of Psychology, Beijing Normal University, Beijing, China

²Department of Psychology, University of Macau, Macau, China

³Department of Pediatrics, Wayne State University, Detroit, MI, USA

⁴Department of Medical Psychology, Peking University, Beijing, China

Abstract

This study addressed the issue of disclosing HIV status and sexual orientation, and explored the consequences of such disclosures among HIV-positive men who have sex with men (MSM) in China. In-depth individual interviews were conducted with 37 HIV-positive MSM. Of these participants, 3 (8.1 %) disclosed neither their HIV status nor their sexual orientation to anyone; 24 (64.9 %) voluntarily disclosed both their HIV-positive status and their sexual orientation; 7 (18.9 %) voluntarily disclosed their HIV status only, and 3 (8.1 %) involuntarily disclosed their HIV status and sexual orientation. Parents, partners, siblings and close friends were the most common disclosure targets. HIV-positive MSM were less likely to disclose their sexual orientation than their HIV status. The positive consequences of disclosure included receiving support, acquiring family care, reducing stress, improving mood and developing more positive values and beliefs. The negative consequences included the participants' perception of rejection and stigma toward themselves and their families. However, the stigma mainly comes from "outsiders" rather than family members and close friends. We did not find any differences with respect to consequences between participants who disclosed their HIV status only and those who disclosed both their HIV status and sexual orientation. In conclusion, partners, siblings and friends were main disclosure targets, and HIV positive MSM preferred to disclose their HIV serostatus than their sexual orientation. Voluntarily disclosing one's HIV status to significant others resulted in more positive consequences than negative consequences. These results were informative for developing mental health and coping interventions.

Keywords

Disclosure; HIV-positive MSM; HIV status; Sexual orientation; Consequences

Introduction

The number of HIV-positive men who have sex with men (MSM) accounts for the largest proportion of newly reported HIV infections worldwide: approximately 61 % in the United States, 44 % in Canada and 86 % in Australia (Harold et al. 2007; US CDC 2010; Public Health Agency of Canada 2010; The Kirby Institute 2011). In China, the proportion of HIV-positive MSM has risen rapidly in recent years, reaching 32.5 % of an estimated 48,000 new HIV infections in 2009 (Ministry of Health of China 2009; Guo et al. 2011). However, the disclosure of HIV serostatus proportion remained relatively low among HIV-positive men. The majority of studies reported that the HIV disclosure rate among HIV positive men was about 28 % to approximately 50 % (Lee and Oberdorfer 2009). Particularly, MSM were less likely to disclose their HIV status to their sexual partners compared to HIV-positive heterosexual men (Sullivan 2005). For example, a study conducted in Taiwan found that only 36 % of MSM disclosed their HIV serostatus to family members and/or friends (Ko et al. 2007). In China, HIV positive serostatus disclosure proportion among MSM is only 39.3 % (Fan et al. 2012). Some studies revealed that nondisclosure of HIV serostatus was associated with increased sexual risk practices and number of casual sexual partners, thus resulted in a potentially increased HIV prevalence (Kalichman and Nachimson 1999). Therefore, HIV disclosure among MSM remains a public health concern, the research on what factors facilitate or hinder disclosure is valuable to inform services and preventive intervention programs.

HIV disclosure proportion varies depending on the targets (Zea et al. 2005; Calin et al. 2007; García et al. 2012). Some studies found that individuals preferred to disclose HIV positive serostatus to their main sexual partners and family members (Mayfield et al. 2008; Li et al. 2007). Other studies documented that disclosure occurred more frequently to friends and male partners than to parents (Kalichman et al. 2003; Zea et al. 2005). Latino HIV positive gay men preferred to disclose to committed partners than casual partners (Zea, et al. 2004). The rate of disclosure varied even within families. People living with HIV (PLHIV) in China choose to first disclose their HIV status to a sibling (27 %), followed by a parent (17 %) and spouse (13 %) (Li et al. 2007).

Previous research showed both positive and negative consequences of actual HIV disclosure. The low rate of HIV disclosure might be due to the fear of negative consequences of disclosure (Parsons et al. 2004; Gorbach et al. 2004; Zhou et al. 2013). Among the negative consequences, stigma or discrimination was the most frequent mentioned in previous studies of HIV disclosure (Carr and Gramling 2004; Parker and Aggleton 2003; Cloete et al. 2008). HIV disclosure sometimes indeed lead to rejection, isolation, loss of intimacy (Derlega et al. 2002; Parsons et al. 2004), which can cause negative feelings such as fear and isolation in individuals (Li et al. 2007). Further, increased emotional stress of anxiety and depression was found as a negative reaction to specific disclosure targets (Kalichman et al. 2003). For instance, for both men and women, disclosure to fathers and brothers was associated with higher level of depression. Conversely, some studies found positive consequences of HIV disclosure (Derlega et al. 2002; Serovich 2001). Increased HIV disclosure was associated with better physical health and psychological well-being (Hult et al. 2012), increased

participant's social support (Holt et al. 1998; Li et al. 2007), and increased intimacy between partners (Parsons et al. 2004).

Cultural background was also a major factor affecting disclosure. Compared to white men, Latinos and men of color had less likelihood to disclose HIV positive serostatus in the United States (Mansergh et al. 1995). Asian MSM had particularly low levels of disclosure in comparison with other racial groups (Zea et al. 2004). People from ethnic minority group were less likely to disclose their HIV positive serostatus and homosexual activities to others (Glick and Golden 2010). PLHIV in China were more reluctant to disclose their HIV status to others than those in other countries (Fan et al. 2012; Zhou et al. 2013).

Disclosure of an individual's sexual identity is always a dilemma in China. Non-disclosure may help MSM avoid stigmatization, whereas disclosure may reduce stress associated with making efforts to keep the secrets from family members and close friends (Legate et al. 2012). Whether gay men disclose their sexual orientation greatly depends on their cultural context, such as an individualistic oriented context versus a collectivistic oriented context (Legate et al. 2012). Traditionally, gay men were unacceptable in China. Being homosexual is a reason of marginalization of MSM even before the HIV infection (Zhang et al. 2011). Furthermore, Chinese culture emphasizes filial piety. Having no descendants is the worst conduct against filial piety and adults are expected to get married at a certain age (Yoshioka et al. 2001). Previous study revealed that nearly 90 percent of Chinese gay men have already married to or will eventually marry heterosexual women (Xing 2012). Considering the above mentioned social norms in societies emphasizing filial piety, such as Chinese community, disclosing sexual orientation might be even more difficult than disclosing HIV status among HIV-positive MSM.

To date, limited data are currently available with regard to the rates, targets and consequences of HIV and sexual orientation disclosure among MSM living with HIV in collectivistic societies, such as China. However, to understand the meaning and context of HIV and sexual orientation disclosure is extremely important for mental health services improvement for this population, particularly in collectivistic cultural context. To address this research gap, the current study employed in-depth interview to explore disclosure content (i.e., HIV status, sexual orientation or both), targets (i.e., family members, sexual partners or friends) and the consequences (i.e., positive or negative) of disclosure among HIV-positive MSM in China.

Methods

Study Site and Procedure

This study was conducted at a hospital in China that provides medical treatment for the patients with HIV, hepatitis B. People with HIV and hepatitis B all over the country seek to see a doctor in this hospital because the doctor is prestigious in dealing with these medical cases. MSM living with HIV who sought medical services in this hospital (either HIV testing or treatments) were invited to participate in the study. The eligibility criteria for potential participants included aged 18 years or above, diagnosed with HIV for at least 3 months, and infected with HIV because of homosexual behavior. In total, 50 individuals

were invited. Among those, three moved away from the research site before interview, ten refused to participate because of busy schedule or other reasons. The final sample includes 37 individuals.

We trained two MSM volunteers who work in the hospital to recruit the participants and conduct one-to-one interview. We intensively trained the interviewers in communication and qualitative interview skills (e.g., being respectful and empathetic, proper probing, and opening questions). The two reviewers were evaluated and retrained if necessary until they were qualified to conduct the interviews. MSM volunteers randomly selected and contacted HIV-positive MSM listed in the hospital records via telephone. Once a potential participant was identified, the volunteers introduced the purpose and procedure of the current study, the potential risks and benefits of participation, the voluntary participation, the right of refusal and withdrawal and incentives for participation. The individuals were also assured of the confidentiality of their participation. Written informed consent and self-administered demographic information forms (including age, marital status, employment, and education level) were collected when a participant volunteered for this study. The informed content and all study protocol were approved by the Institutional Review Boards at Beijing Normal University.

In order to make participants feel comfortable and talk as much as possible, we did the following three things. Firstly, they were told very clearly that they could quit or withdraw if they did not want to continue the interview or they felt uncomfortable. Any of private information was promised not to present in any way. Secondly, the interviews were conducted by trained MSM volunteer. Participants maybe feel more comfortable talking with “peers” in the same subculture than talking to researches. Apart from these, the interview was conducted in a privacy room one to one. The whole interview process would not be interrupted by anyone else.

Data Collection

Between March 2009 and March 2010, in-depth individual interviews were conducted with the 37 HIV-positive MSM using a semi-structured interview guide. Two researchers experienced in the field of HIV/AIDS and MSM first developed the interview guide. This guide was then revised according to the information and feedback attained from a pre-interview with five HIV-positive MSM. Four major research questions were addressed in the interview guide: (1) basic information of HIV infection; (2) psychological and physical changes after knowing HIV infection; (3) process and targets of disclosure of HIV serostatus and homosexual orientation; (4) consequences of disclosure of HIV serostatus and homosexual orientation. The interview guide was revised according to the feedback of the interviewing: one major question regarding stress from nondisclosure was added. The interviewers were allowed to change the question order, sentence phrasing and word choice during the interview process. Each interview was digitally recorded with the participants' consent. Thirty-seven interviews were collected and ranged in length from 15 to 59 min, for an average of 31 min. The participants received a small monetary incentive (equivalent to \$3) for their participation and their transportation expenses (equivalent to \$8).

Participants

Participant characteristics are presented in Table 1. Participant age was ranged from 23 to 42 years, with a mean age of 31.66 years. The majority (56.8 %) of participants were between 25 and 35 years old. Thirty-two HIV-positive MSM (86.5 %) were unmarried. Of the 37 participants, 28 (75.7 %) were employed, 2 (5.4 %) were students, and 1 (2.7 %) was retired. The majority of participants (75.7 %) had a high education. One-fifth of the participants had completed middle school, whereas only one had a primary school level of education. The average time since they were diagnosed with HIV infection was 18.38 months, with a range from 3 to 60 months. More than half of the participants (51.4 %) had been infected with HIV for less than 12 months. More than half (51.4 %) of the participants were from urban areas.

Data Analyses

All interview records were transcribed verbatim. The transcripts were more than 200,000 Chinese words totally. Based on grounded theory, the transcripts were coded by two authors using NVivo7.0 software (Anselm and Juliet 1998; Strauss and Corbin 1990). Qualitative data analysis was employed using iterative process with consensual qualitative research strategies. A disclosure code was created when participant made comments about telling other person about their HIV status and sexual orientation. Subsequently, themes of disclosure were identified. Based on Serovich's (2001) consequences theory, codes were derived for both positive and negative consequences of disclosure., Themes were modified and refined repetitively according to the new data during the analysis.

Results

Disclosure Content and Target(s)

In the current study, three participants did not disclose their HIV status or sexual orientation to anyone. Of the 34 participants who disclosed their HIV status or sexual orientation, 31 MSM disclosed voluntarily, whereas 3 MSM did so involuntarily (the local Center for Disease Control [CDC] disclosed this information to their family members and village leaders). Of the 31 MSM who disclosed voluntarily, 24 participants disclosed both their HIV status and sexual orientation, whereas 7 participants disclosed only their HIV status. Parents, partners and siblings/friends of HIV-positive MSM were the three major disclosure targets. Participants were less likely to disclose their sexual orientation than their HIV status to others, particularly if their parents were from rural areas (Table 2).

Consequences of Disclosure

After disclosure, participants experienced both positive and negative consequences. Positive consequences included receiving social support, acquiring family care, reducing stress, and developing positive beliefs and values. Negative consequences included perceived rejection and stigma toward themselves and their families.

Receiving Social Support—The majority of participants (27/34, 79.4 %) reported that they received social support, particularly psychological support after disclosure. Participants perceived much more understanding from their parents, partners, siblings/friends or some combination after disclosure. This understanding helped increase relationship quality

between participants and the target(s) of their disclosure, which in turn helped participants cope with difficult times. In the current study, 52.9 % (18/34) of participants mentioned that they received psychological support from their parents, sexual partners, siblings/friends or some combination after they disclosed their HIV status to those individuals.

A 30-year-old participant reported that he wanted to commit suicide at one point after learning of his HIV-positive status. However, he accepted the fact of his HIV-positive status and experienced a better quality of life after his disclosure by gaining psychological support from his family.

“I think I am a lucky guy because I have a very nice family. I appreciate my father and other family members’ support, encouragement, and understanding; they even accepted my career [as a manager in a NGO]. They frequently phone me or send me text messages reminding me to take care of my health, life and work, wishing me happiness every day”(A participant who disclosed both HIV status and homosexual identity to his parent).

In addition to parental support and understanding, homosexual partners were also important sources of support, particularly when both the participant and his partner were infected with HIV. In the current study, five participants (14.7 %) had HIV-positive partners. They became deeply concerned about one another’s health, and each was the most important source of psychological support to the other after disclosure.

“We often remind each other [homosexual partner] to take medicine on time. We send warm text messages to each other when we are at work. When he is depressed, I tell him to think more happy things in life, and offer him psychological support and love. When I am depressed, he also tries his best to make me happy” (A participant who disclosed HIV status to his partner).

Close friends were also an important source of social support, providing comfort, encouragement, compassion and acceptance. For example, a 24-year-old participant who migrated to and worked in Beijing chose to tell his best friend rather than his family:

“When I was in hard time, my close friend helped me. Once I called him, he would come over right away to comfort and encourage me. Friends gave me more support than other loved ones [family members and relatives]” (A participant who disclosed both his HIV status and homosexual identity to his friend).

The HIV-positive MSM in this study also received financial support after disclosure. Of the 34 MSM who disclosed their status, 5 (14.7 %) reported being provided with economic aid after they disclosed their HIV status, sexual orientation or both to their family members or close friends.

Acquiring Family Care—Of the 34 participants in the current study who disclosed their HIV status, sexual orientation or both, 24 (70.6 %) mentioned that their families cared for them and that no family members separated the living equipments used in daily life from the HIV-positive MSM. Rather, the parents, partners, siblings/friends of an HIV-positive MSM were even more caring for the MSM’s daily life and health. Disclosure targets reminded the MSM to take their medications on time, to rest sufficiently and to eat a nutritious diet.

Family members, partners and close friends also physically cared for HIV-positive MSM almost daily.

“[My sister] treats me better than before, doing things such as giving me a call a lot, caring about my physical health, reminding me to put on clothes.....” (A participant who disclosed both HIV status and homosexual identity to his sister).

Reducing Stress—The interview data showed that 6 of 31 participants (19.4 %) disclosed their HIV status to their family members or friends with the purpose of reducing psychological pressure, particularly with regard to marriage and children. The majority of participants (23/31, 74.2 %) felt that their stress had been effectively reduced after disclosure, making them more capable of facing the double stressors of HIV infection and their homosexual identity.

“If only my father was told of these matters [i.e., HIV infection and/or sexual orientation], he would be the only one dealing with the stress. If I also told my mother, she could share [some of the stress] with my father. Now my whole family knew the fact, all my family members could share the stress, so my stress reduced drastically. Furthermore, I could receive much more support as well” (A participant who disclosed his HIV status to his family).

In the current study, 3 married participants of 34 (8.8 %) reported that their wives did not divorced with them after disclosure; rather, they increased their intimacy, which greatly helped participants reduce their stress.

“Since I disclosed my HIV infection to [my wife], she has stayed with me and comfort me when I was depressed, or when I was under great pressure. She never expressed that she would leave me. What she has done makes me feel warm in my deep heart.” (A participant who disclosed HIV status only to his families).

Importantly, two participants originally from rural areas felt that the pressure to get married was reduced after their disclosure. After they disclosed their HIV-positive status to their parents, their parents did not urge them to marry, which relieved a portion of the participants’ psychological pressure.

“My parents are traditional-minded. I believe that they would be under great pressure if I always delay marriage. HIV infection could be an excuse for not getting married and my parents thought it was understandable. So I felt a pressure relief on getting married.” (A participant who only disclosed HIV status to his family).

Developing Positive Values and Beliefs—After disclosure, the beliefs and values of HIV-positive MSM changed. Among these MSM, 5 out of 31 (16.1 %) reported that they were more focused on their families but job after disclosure, with more active communication and positive beliefs.

A 33-year-old participant reported that he obtained a more positive perspective after disclosure because he paid more attention to the quality of his relationship with his partner than to materialistic and job concerns. After disclosure, some participants gained a new

appreciation for life and even expressed a willingness to use their experiences to help other HIV-positive MSM.

“[One change is that after the disclosure,] I think we [the participant and his boyfriend] have a very intimate relationship now. Although our quality of life (the social economic status) has declined, we have changed our beliefs: we need to stay together and make efforts to do what we need to do.” (A participant who disclosed both his HIV status and homosexual identity to his partner).

After disclosure, some participants cherished their present life more than before their HIV disclosure. Furthermore, they expressed a willingness to help other HIV positive MSM to go through the hard time using their experiences. A 27-year-old participant disclosed both HIV status and homosexual identity to his parent stated:

“[Disclosure is a] blessing in disguise. My personality and way of communicating with people are becoming positive. Now, I offer more help to others since I’ve already perceived much help from others.”

In addition to these positive consequences, disclosure also resulted in negative consequences. The negative consequences mainly included rejection and stigmatization for both HIV-positive MSM themselves and their families.

Social Rejection/Discrimination Against MSM—In the current study, 3 of 34 disclosers (8.8 %) experienced discrimination and rejection from their families. They told the interviewers that they were suffering the anguish due to their parents’ rejection. In addition to stigma from family members, some friends also kept their distance from participants due to concerns about HIV infection.

A 26-year-old participant who only disclosed his HIV status to his parent told the interviewer that his mother could not understand him and do not want to accept him. His mother even expressed the intention to break off their mother–child relationship:

“My mother then made a conclusion that I was abnormal. She come to my hospital (the work place of the participant) and claimed that she was breaking off her relationship with me. Mother still refuses to talk to me, hanging up my phone each time.”

In addition to the stigma from family members, some supposed good friends also kept distance from participants to avoid being HIV infected after these friends were disclosed the HIV positive serostatus.

A 27-year-old participant could not accept his best friend’s reaction after he disclosed his HIV positive. He stated:

“My close friend was shocked after hearing the news and was afraid of touching me, and had never contacted me again, which made me feel terrible.” (A participant who only disclosed his HIV status to his family and friends)

Stigma Related to Involuntary Disclosure—The medical staff at the local CDC disclosed the HIV status of 3 participants (of the 34 [8.8 %] whose status was revealed) to

family members or their community without their permission. This involuntary disclosure negatively affected not only the lives of participants but also their families. A 36-year-old participant who only disclosed his HIV status to his parents said,

The local CDC dealt with the issue improperly, which led to a huge strike to my parents. With the stigma from villagers, my parents felt shame. Actually, I'm not worried about myself. What really bother me is how my parents continue to live in the village and whether my younger sister be affected when she has a boyfriend.

Discussion

In the current study, 34 participants disclosed their HIV status, accounting for 92 % of the sample ($n = 37$). The disclosure rate in this study is higher than the rate reported in other countries and in China (Zea et al. 2005; Li et al. 2007; Zhou et al. 2013). This discrepancy might be because family and friends are the major sources of support for individuals in Chinese culture (Li et al. 2007). Because China is a family oriented society, individuals often share what they experienced with their family (Muller and Desmond 1992), show respect to their parents and other elders (Lee et al. 2005). In addition to providing psychological and financial support, family members might also be caregivers for HIV-positive MSM (Lee et al. 2005).

Although the disclosure of HIV status and sexual orientation disclosure resulted in both positive and negative consequences for HIV-positive MSM in China, the majority of participants experienced mostly positive consequences after disclosure. This finding is consistent with many previous studies, either in China or the other countries (e.g., Li et al. 2007; Parsons et al. 2004). Interestingly, in our study, some participants stated that their HIV-positive disclosure reduced the pressure to marry and to have children. Chinese is a family orientated culture emphasizing “filial piety”; as the famous Chinese philosopher Mencius states, “There are three forms of unfilial conducts, of which the worst is to have no descendants” (Yoshioka et al. 2001). Within this culture, parents usually impose great pressure on children’s marriage and look forward the birth of grandchildren. Now, they are less likely to put these stresses on children in considering the HIV disease. Consequently, some participants who did disclose their status were greatly relieved from the stress of being expected to be married. Disclosing and share one’s secret and deep emotions can also reduce stress so that benefit one’s health (Pennebaker 1997).

In this study, 20.6 % of HIV-positive MSM disclosed their HIV-positive status but not their sexual orientation. This finding indicates that homosexuality might remain unacceptable in Chinese society. The term “Gay” is associated with the terms “abnormal”, “promiscuous” and “immoral”. Gay men are often labeled “psychotic people” who are rejected and even fired from work in China (Zhang et al. 2011). Thus, gay men might be more hesitant to disclose their sexual orientation than their HIV status. Three participants out of 37 (8.0 %) disclosed neither HIV positive serostatus nor homosexual orientation in current study. Living in a family oriented culture, individuals are worried about creating stress to their families, particularly their parents. Telling parents the truth of HIV infection and homosexual orientation might disappoint parents’ expectation on marriage and offspring (Yoshioka et al.

2001). In Chinese culture, particularly in rural areas, dealing with negative consequences of HIV disclosure and homosexual orientation is a serious issue (Chandra et al. 2003). Due to shortage in HIV knowledge and fear of HIV infection, villagers often treat an entire family discriminatorily. Withholding HIV status could protect family from shame (Yoshioka et al. 2001). In the urban areas, stigma also occurred in workplaces, which the workers with HIV were fired or expelled.

However, participants who had their HIV status involuntarily disclosed were more likely to report negative consequences. Among those who disclosed, three were involuntary disclosure to their family members and villagers by medical workers. To avoid creating psychological stress on patients, a family member of the PLWHA is usually the first to be informed by medical workers in China (Li et al. 2007). Informing the family member but not PLWHA himself/herself somehow help the participants avoid the struggling on whether to disclose. However, according to our data, the disadvantages are apparent if both PLWHA themselves and family members are not prepared well. The key issue is that medical workers' disclosure is without patients' permission. Furthermore, the negative consequences come from mainly "outsiders" rather than family members and close friends, other than aforementioned positive consequences generally coming from mainly "insiders" in family and intimate person. In order to protect the MSM with HIV from negative consequence of disclosure, a proper protocol should be developed for HIV disclosure for health providers. Health providers need to realize that HIV disclosure is a complicated process. Other than considering the importance of family's role in HIV disclosure, individual's right need to be considered. Interventions in HIV disclosure for medical workers and family members are necessary, regarding whom to disclose first, when to disclose and what content to disclose.

There are several limitations in this study. The current study did not reveal any significant differences with respect to reported consequences between participants who only disclosed HIV status and those who disclosed both HIV status and sexual orientation. Additional qualitative research regarding this issue should be conducted. Furthermore, there is no sufficient data to separately analyze the effect of content of disclosures (i.e., HIV vs. sexual orientation) and the effect of disclosure targets (i.e., family members vs. friends) on disclosure consequences. Thirdly, the disadvantages and disadvantages of non-disclosure both HIV positive serostatus and homosexual orientation remains unclear. Finally, all of the interviews were conducted by trained MSM volunteer who had bachelor degree. Even though they are well trained, the information obtained from their interview may not compare with interviews conducted from experienced qualitative researchers. The pros and cons of having "peers" to be interviewers need further research focusing on qualitative research methodology.

Despite these limitations, the results of this study support that, in the collectivistic culture, the encouragement of voluntary disclosure in HIV prevention programs might be applicable. These programs are promising to help PLWHAs consider personal situations of disclosure and make a plan on what, when and how to disclose. Multilevel intervention can also be introduced to their family members and friends after disclosure. In such programs, Family members and friends can cope their stress being the targets of disclosure and be educated on how to provide support to HIV positive MSM. Stigma remains the primary barrier to HIV

and sexual orientation disclosure, stigma reducing programs is still urgently needed, especially for this population, who face double stressors, HIV infection and homosexuality.

Acknowledgments

Sixth Global Fund from the China Global Fund Principle supported this study. The authors thank Jun Wang and Rui Xin for their assistance in data collection. The authors also thank Meng Zhang, who helped edit this manuscript in English language.

Appendix:: Interview Guide for HIV Positive MSM

1. Please introduce yourself.
2. How do you know your HIV infection? How long is it from that you have known your HIV infection?
3. After knowing HIV infection, what changes happened to your life, career et al.,?
4. How about your psychological status after knowing HIV infection? What is the process of the changing? How is it now?
5. What stresses do you encounter after HIV infection? How do you cope with these stresses?
6. To be a homosexual orientation man, what stresses do you encounter? How do you cope with these stresses?
7. Who knows your HIV infection? How do they know your HIV infection?
8. Who knows your sexual orientation? How do they know your sexual orientation?
9. What were the consequences after disclosure of HIV positive to others?
10. What were the consequences after disclosure of sexual orientation to others?
11. How do you feel after your disclosure?
12. What did the persons who know your HIV status do for you after they knowing your HIV infection?
13. What did the persons whom you disclosed sexual orientation to do for you after they knowing your sexual orientation?
14. Are there/what are any changes in the way your families and friends treat you after disclosure HIV status?
15. Are there/what are any changes in the way your families and friends treat you after disclosure sexual orientation?
16. What are the stresses of nondisclosure?
17. Do you talk about your HIV infection again with families and friends after disclosure? What do you talk about? How about their attitude?
18. Do you talk about sexual orientation again with families and friends after disclosure? What do you talk about? How about their attitude?

19. When you talking about disclosure HIV status to others, do you have any experience sharing to us how to disclose HIV status to others? Especially to family members?
20. When you talking about disclosure sexual orientation to others, do you have any experience sharing to us how to disclose HIV status to others? Especially to family members?
21. About the topic, what is more do you want to talk about?

References

- Anselm S, & Juliet C (1998). Basics of qualitative research: Techniques and procedures for developing grounded theory (2nd ed.). London: Sage Publication.
- Calin T, Green J, Hetheron J, & Brook J (2007). Disclosure of HIV among black African men and women attending a London HIV clinic. *AIDS Care*, 19(3), 385–391. [PubMed: 17453574]
- Carr R, & Gramling LF (2004). Stigma: A health barrier for women with HIV/AIDS. *Journal of the Association of Nurses in AIDS Care*, 15(5), 30–39.
- Chandra PS, Deepthivarma S, & Manjula V (2003). Disclosure of HIV infection in South India: Patterns, reasons and reactions. *AIDS Care*, 15(2), 207–215. [PubMed: 12856342]
- Cloete A, Simbayi LC, Kalichman SC, Strebel A, & Henda N (2008). Stigma and discrimination experiences of HIV-positive men who have sex with men in Cape Town, South Africa. *AIDS Care*, 20(9), 1105–1110. [PubMed: 18608067]
- Derlega VJ, Winstead BA, Greene K, Serovich J, & Elwood WN (2002). Perceived HIV-related stigma and HIV disclosure to relationship partners after finding out about the sero-positive diagnosis. *Journal of Health Psychology*, 7(4), 415–432. [PubMed: 22112752]
- Fan S, Lu H, Ma X, Sun Y, He X, Li C, et al. (2012). Behavioral and serologic survey of men who have sex with men in Beijing, China: Implication for HIV intervention. *AIDS Patient Care STDS*, 26(3), 148–155. [PubMed: 22248333]
- García L, Lechuga J, & Zea M (2012). Testing comprehensive models of disclosure of sexual orientation in HIV-positive Latino men who have sex with men (MSM). *AIDS Care*, 24(9), 1087–1091. [PubMed: 22690708]
- Glick SN, & Golden MR (2010). Persistence of racial differences in attitudes towards homosexuality in the United States. *Journal of Acquired Immunity Deficiency Syndromes*, 55(4), 516–523.
- Gorbach PM, Galea JT, Amani B, Shin A, Celum C, Kerndt P, et al. (2004). Don't ask, don't tell: Patterns of HIV disclosure among HIV positive men who have sex with men with recent STI practising high risk behavior in Los Angeles and Seattle. *Sex Transmission Infection*, 80(6), 512–517.
- Guo Y, Li X, & Stanton B (2011). HIV-related behavioral studies of men who have sex with men in China: A systematic review and recommendations for future research. *AIDS Behavior*, 15, 521–534. [PubMed: 21053064]
- Harold WJ, Ronald OV, & Kevin MD (2007). The reemerging HIV/AIDS epidemic in men who have sex with men. *The Journal of the American Medical Association*, 298(20), 2412–2414. [PubMed: 18042919]
- Holt R, Court P, Vedhara K, Nott KH, Holmes J, & Snow MH (1998). The role of disclosure in coping with HIV infection. *AIDS Care*, 10(1), 49–60. [PubMed: 9536201]
- Hult JR, Wrubel J, Bränström R, Acree M, & Moskowitz JT (2012). Disclosure and nondisclosure among people newly diagnosed with HIV: An analysis from a stress and coping perspective. *AIDS Patient Care and STDs*, 26(3), 181–190. [PubMed: 22256856]
- Kalichman SC, DiMarco M, Austin J, Luke W, & DiFonzo K (2003). Stress, social support, and HIV-status disclosure to family and friends among HIV-positive men and women. *Journal of Behavior Medicine*, 26(4), 315–332.

- Kalichman SC, & Nachimson D (1999). Self-efficacy and disclosure of HIV-positive serostatus to sex partners. *Health Psychology*, 18(3), 281–287. [PubMed: 10357509]
- Ko NY, Lee HC, Hsu ST, Wang WL, Huang MC, & Ko WC (2007). Differences in HIV disclosure by modes of transmission in Taiwanese families. *AIDS Care*, 19(6), 791–798. [PubMed: 17573600]
- Lee B, & Oberdorfer P (2009). Risk-taking behaviors among vertically HIV-infected adolescents in northern Thailand. *Journal of the International Association of Physicians in AIDS Care*, 8(4), 221–228. [PubMed: 19596866]
- Lee RPL, Ruan D, & Lai G (2005). Social structure and support networks in Beijing and Hong Kong. *Social Networks*, 27, 249–274.
- Legate N, Ryan R, & Weinstein N (2012). Is coming out always a “good thing”? Exploring the relations of autonomy support, outness, and wellness for lesbian, gay, and bisexual individuals. *Social Psychological and Personality Science*, 3(2), 145–152.
- Li L, Sun S, Wu ZY, Wu SL, Chun Q, & Yan ZH (2007). Disclosure of HIV status is a family matter: Field notes from China. *Journal of Family Psychology*, 21(2), 307–314. [PubMed: 17605553]
- Mansergh G, Marks G, & Simoni JM (1995). Self-disclosure of HIV infection among men who vary in time since seropositive diagnosis and symptomatic status. *AIDS*, 9(6), 639–644. [PubMed: 7662205]
- Mayfield AE, Rice E, Flannery D, & Rotheram-Borus MJ (2008). HIV disclosure among adults living with HIV. *AIDS Care*, 20(1), 80–92. [PubMed: 18278618]
- Ministry of Health of China. (2009). UNAIDS, World Health Organization (WHO). 2009 estimates for the HIV/AIDS epidemic in China. Beijing, China: China Ministry of Health; 5 31, 2010. <http://www.unaids.org.cn/download/2009%20China%20Estimation%20Report-En.pdf>. Accessed 15 Aug 2010.
- Muller JK, & Desmond B (1992). Ethical dilemmas in a cross-cultural context. A Chinese example. *Western Journal of Medicine*, 157(3), 323–327. [PubMed: 1413778]
- Parker R, & Aggleton P (2003). HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action. *Social Science and Medicine*, 57(1), 13–24. [PubMed: 12753813]
- Parsons JT, VanOra J, Missildine W, Purcell DW, & Gomez CA (2004). Positive and negative consequences of HIV disclosure among sero-positive injection drug users. *AIDS Education and Prevention*, 16(5), 459–475. [PubMed: 15491957]
- Pennebaker JW (1997). Writing about emotional experiences as a therapeutic process. *Psychological Science*, 8(3), 162–166.
- Public Health Agency of Canada. (2010). HIV and AIDS in Canada: Surveillance report to 2 25, 2010. <http://www.phac-aspc.gc.ca/aids-sida/publication/epi/2010/9-eng.php/>. Accessed on July 2010.
- Serovich JM (2001). A test of two HIV disclosure theories. *AIDS Education and Prevention*, 13(4), 355–364. [PubMed: 11565594]
- Strauss A, & Corbin J (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage Publications.
- Sullivan KM (2005). Male self-disclosure of HIV-positive serostatus to sex partners: A review of the literature. *Journal of the Association of Nurses in AIDS Care*, 16(6), 33–47.
- The Kirby Institute. (2011). Blood borne viral and sexually transmitted infections in Aboriginal and Torres Strait Islander People: Surveillance and Evaluation Report 2011. The Kirby Institute, the University of New South Wales, Sydney, NSW <http://www.kirby.unsw.edu.au>. Access on 2 Aug 2012.
- US Department of Health and Human Services, Centers for Disease Control and Prevention. (2010). Cases of HIV infection and AIDS in the United States and dependent areas, 2010. <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2010report/default.htm>. Accessed 28 Feb 2010.
- Xing F (2012). Report of living situation of Gay wives among China. Chengdu Time publication http://www.danlan.org/disparticle_32393_2_1.htm.
- Yoshioka MR, & Schustack A (2001). Disclosure of HIV status: Cultural issues of Asian patients. *AIDS Patient Care and STDs*, 15(2), 77–85. [PubMed: 11224933]

- Zea MC, Reisen CA, Poppen PJ, Bianchi FT, & Echeverry JJ (2005). Disclosure of HIV status and psychological wellbeing among Latino gay and bisexual men. *AIDS and Behavior*, 9(1), 15–26. [PubMed: 15812610]
- Zea MC, Reisen CA, Poppen PJ, Echeverry JJ, & Bianchi FT (2004). Disclosure of HIV-positive status to Latino gay men's social networks. *American Journal of Community Psychology*, 33(1–2), 107–116. [PubMed: 15055758]
- Zhang Y, Lin XY, & Fu Y (2011). To tell or not to tell: The status and impact of homosexual men's disclosure of HIV-positive and sexual orientation to others-a qualitative study. *Chinese Journal of Clinical Psychology*, 19(5), 628–632.
- Zhou Y, Zhang L, Li X, & Kaljee L (2013). Do Chinese parents with HIV tell their children the truth? A qualitative preliminary study of parental HIV disclosure in China. *Child: Care, Health and Development*, 39(6), 816–824.

Table 1

Individual characteristics of the sample

Characteristics	<i>n</i>	%
Age		
25	4	10.8
26–34	21	56.8
35	12	32.4
Marital status		
Married	5	13.5
Unmarried	32	86.5
Education		
Primary	1	2.7
Middle school	8	21.6
High education	28	75.7
Employment		
Employed	28	75.7
Unemployed	6	16.2
Student	2	5.4
Retired	1	2.7
Months since positive HIV result		
3–12 months	19	51.4
13–24 months	9	24.3
25 months	9	24.3
Residence		
Rural	18	48.6
Urban	19	51.4

Table 2

Disclosure content and targets among HIV-positive MSM

Disclosure content	Disclosure target (%)								Total
	Parents	Partners	Siblings/ friends	Parents and Partners	Parents and siblings/ friends	Partners and siblings/ friends	Parents and partners and siblings/friends	No one	
Voluntary disclosure	4 (12.9)	10 (32.2)	6 (19.4)	2 (6.5)	5 (16.1)	2 (6.5)	2 (6.5)	–	31
HIV status and sexual orientation	1 (4.2)	10 (41.7)	4 (16.7)	2 (8.3)	3 (12.5)	2 (8.3)	2 (8.3)	–	24
Only HIV status	3 (42.9)	0 (0.0)	2 (28.6)	0 (0.0)	2 (28.6)	0 (0.0)	0 (0.0)	–	7
Involuntarily disclosure	3 (100.0)	–	–	–	–	–	–	–	3
Nondisclosure	–	–	–	–	–	–	–	3 (100.0)	3
Total participants	7 (18.9)	10 (27.0)	6 (16.2)	2 (5.4)	5 (13.5)	2 (5.4)	2 (5.4)	3 (8.1)	37