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## Exploring Resilience Among Black Women Living With HIV in the Southern United States: Findings From a Qualitative Study

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## Abstract

Black women living with HIV (WLWH) face individual and sociostructural challenges. Despite these challenges, many exemplify remarkable levels of resilience and coping. Yet, research on resilience and coping in this population is limited. Twenty Black WLWH in the Southern United States completed semi-structured interviews that explored challenges facing WLWH. We identified six themes related to resilience and coping: self-acceptance, disclosure, self-compassion, social support, will to live, and service. Of these, social support was a driving protective element and an essential component to building and sustaining resilience and coping. Women who experienced positive support often expressed a will to live as well as a desire to support other WLWH. Resilience and social support were characterized by patterns of reciprocity, in that they were mutually sustaining, stabilizing, and strengthening.

## Keywords

Black; coping; HIV; qualitative; resilience; social support; women living with HIV

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Black women are disproportionately affected by HIV in the United States. Comprising 7% of the U.S. population (U.S. Census Bureau, n.d.), they account for 14% of all people living with HIV (PLWH; Centers for Disease Control and Prevention [CDC], 2017.) and 55% of new HIV infections among women (CDC, 2021). The cause of the inequitable burden of HIV among Black women is multifactorial and frequently explained by the cumulative effects of individual, social, and structural factors on HIV-related behaviors and outcomes (Godley & Adimora, 2020). Geography also contributes to HIV-related disparities because 55% of Black women living with HIV (WLWH) reside in the Southern United States (CDC, 2020), where poverty, poor access to HIV treatment, structural racism, HIV-related stigma and discrimination, and medical mistrust are particularly elevated (CDC, 2019; Ingram et al., 2019). Disproportionately high rates of poverty and unemployment, for example, have been linked to poor HIV outcomes among PLWH in the South (Reif et al., 2017).

Black WLWH face many challenges associated with engaging in the HIV treatment continuum and include HIV-related stigma (Earnshaw et al., 2013; Geter et al., 2018; Lipira et al., 2019; Relf et al., 2019), treatment regimen fatigue (Claborn et al., 2015; Nyaku et al., 2019), unmet mental health needs (Peltzer et al., 2017), social isolation (Grodensky et al., 2015), and socioeconomic limitations (Geter et al., 2018). Although all

women may be subjected to gender discrimination and microaggressions that negatively affect their health outcomes, Black WLWH in the Southern United States are subjected to unique and persistent forms of racism and racial discrimination (Prather et al., 2018), where historical roots of slavery and remnants of Jim Crow laws continue to oppress, leading to disparate outcomes (Bradley et al., 2018). Much of the research concerning this population disproportionately focuses on treatment-related barriers and sociostructural vulnerabilities (see Geter et al., 2018, for review), thus limiting our understanding of factors that help Black WLWH to be resilient, or survive and thrive, despite adversity and/or trauma (Ungar, 2008). Accordingly, research explicates the mechanisms of resilience and coping among Black WLWH is warranted.

Resilience is a multidimensional construct describing the process through which individuals or groups functionally adapt after exposure to or experiences with negative life events (Janssen et al., 2011; Ungar, 2008). De Santis et al. (2013) developed the Motivation, Management, and Mastery (MMM) Theory of Resilience to describe the process through which PLWH develop resilience. According to this theory, people begin by accessing intrinsic (e.g., sense of spirituality, desire to survive, desire for knowledge) and extrinsic sources (e.g., disclosure with acceptance, psychosocial support) of motivation, which enables them to manage the mental and physical aspects of HIV. Next, they advance to mastery, which enables them to feel that they have more control over their lives and destinies. Mastery enables them to serve as advocates for others and helps to facilitate positive HIV-related health outcomes, finally leading to a self-perception of being resilient.

Although the extant literature on resilience and coping among Black WLWH is evolving, emerging evidence suggest that it has a protective effect, such that those high in resilience have better HIV-related outcomes (Dale & Safren, 2018; Fang et al., 2015). A study of Black mothers living with HIV, for example, found that those with higher resilience experienced fewer co-occurring adversities (i.e., substance abuse and violence) than those with lower resilience, highlighting the role of resilience as a protective factor within this population (Thurston et al., 2018). A quantitative study of 226 Black WLWH found that, among those with higher levels of religiosity, there was a weaker association between HIV-related stigma and depression than among those with lower levels of religiosity (Lipira et al., 2019). As such, religiosity appeared to be protective against psychological harms associated with HIV-related stigma, facilitating resilience.

To date, much of the research on resilience within this population has sought to characterize it using closely related constructs, such as self-efficacy, self-acceptance, optimism, self-awareness, and religiosity (Brody et al., 2016; Dale & Safren, 2018; Subramaniam et al., 2017). Other studies have focused on identifying sources of resilience (e.g., social support networks) or places that could facilitate resilience (e.g., community-based organizations or HIV-related health facilities; Lambert et al., 2018; Qiao et al., 2019). One qualitative study, for example, found that, among Black women who had lived with HIV for at least 10 years, coping with HIV was most similar to Kübler-Ross' stages of grief, which involved the initial shock that accompanied the revelation of their HIV diagnosis and progressed nonsequentially to anger, devastation, depression, denial, and concluded with HIV acceptance (Smith et al., 2015). The women reported that diverse sources of social

support (e.g., familial, support groups, and religious affiliations and beliefs) were key to their ability to be resilient and continue fighting for their survival post-HIV diagnosis.

Although such studies have offered important insights into resilience outcomes among Black WLWH, most of these studies have focused on women residing in the Northeastern or Midwestern areas of the United States, with few focused on characterizing resilience and HIV-related coping among Black WLWH in the Southern United States. Because Black WLWH face historically rooted, sociostructural challenges that are uniquely exacerbated in this geographic region, the purpose of this study was to explore coping and resilience among these women because they may differ from their peers in other regions (Ingram et al., 2019; Qiao et al., 2019).

## Methods

### Study Design

This was a secondary analysis of qualitative data from a sequential mixed methods (QUANTITATIVE→QUALITATIVE) study exploring medical distrust; experiences with everyday discrimination; anticipated, enacted, and internalized stigma; disclosure; depressive symptoms; antiretroviral therapy adherence; engagement in care; and quality of life among WLWH (please refer to Relf et al., 2019, for more information about the mediated structural equation model identified through the quantitative aim of this sequential mixed methods study, which influenced the conceptualization of the qualitative study). Under the lens of the Adaptive Leadership Framework for Chronic Illnesses (ALFCI; Anderson et al., 2015; Bailey et al., 2012), the qualitative aim of the mixed methods study explored the technical and adaptive challenges associated with constructs previously described. Although resilience and social support were not a specific focus of the qualitative study, these codes emerged during analysis of qualitative data. Thus, the findings related to resiliency and social support presented here were derived from the data. As such, a resiliency theory, framework, or model was not used in the development of the parent study's specific aims.

### Participants

Participants in the qualitative interviews were a convenience sample from the North Carolina site of the Women's Interagency HIV Study (WIHS), the largest longitudinal prospective cohort study of women living with, and at risk for, HIV in the United States, designed to explore the progression of HIV disease among women (Adimora et al., 2018). WIHS participants were eligible for the qualitative study if they were living with HIV, aged 18 years or older, spoke English, and able and willing to provide written informed consent.

### Data Collection

Participants in the qualitative study were recruited by a member of the WIHS study team, who contacted them by phone, email, short message service, or U.S. mail, according to their expressed preferences during recruitment into the WIHS prospective cohort study. The WIHS study team member contacted WLWH who had expressed interest in participating in other studies for which they were eligible. All participants who had a WIHS study visit

during the data collection period were told about the study. Between July and October 2016, the principal investigator (PI: M. V. Relf) of this study conducted individual, in-depth qualitative interviews with participants in a private room at one of two clinical locations. Interviews were digitally recorded to facilitate transcription. The PI checked each transcript against the digital recording for completeness and accuracy and worked with the transcriptionist until verbatim transcripts were obtained. Participants received \$75 in compensation, \$25 for transportation costs and \$50 for their involvement in the study.

Recognizing the sensitive nature of the topics being explored, the PI reflected on position and status before starting the project and during the period of data collection (reflexivity). Further, in collaboration with the staff of the parent WIHS study, conversations about appropriateness of a White male (the PI) conducting the interviews were held because most of the WIHS study participants were women from diverse racial and ethnic backgrounds. On the recommendation of the WIHS staff, it was decided that this individual would conduct the interviews as planned. To enhance the credibility of the findings from the qualitative interviews, the PI met with the WIHS staff on several occasions before conducting the interviews to understand the experiences of the population of interest.

To help facilitate exploration of the technical and adaptive challenges associated with the key concepts and theoretical pathways identified in the quantitative aim of the study, the PI and another study team member (D. E. Bailey, Jr.) developed three stories of WLWH. These stories were developed to assist with the exploration of the domains of interest in a nonthreatening manner (Guillemin, 2004; King et al., 2013). In building the stories, multiple photo sets of three different Black women were purchased from Shutterstock Stock Images. These images were then layered with “thinking clouds,” which included narrative statements or “the thoughts” of the women related to the phenomenon of interest. The first story, comprising eight slides, was that of a woman in her 60s who was a mother and grandmother who had been diagnosed with HIV 6 years earlier. This story explored medical distrust, stigma, and disclosure among older women and challenges associated with engaging in care. The second story was that of a younger Black woman, although age and length of time she was living with HIV were not specified in the story. This story, comprising four slides, explored the technical and adaptive challenges associated with depressive symptoms, antiretroviral therapy adherence, HIV disclosure, and the future as a WLWH. The third story, comprising four slides, was that of a 52-year-old woman who had been living with HIV for 20 years. This story explored the technical and adaptive challenges associated with stigma and quality of life as women age with HIV.

In alliance with the ALFCI, we developed a priori probes to explore what information, knowledge, and/or skills might be needed to address the technical and adaptive challenges associated with the domain of interest in each slide. Additionally, probes explored how a health care worker could help a WLWH to address a challenge in one or more of these domains. We used a set of standardized probes associated with each slide to guide the interviews. For more details about the actual interview guide, please see Bailey et al., in press and view the supplemental digital content. Saturation was identified at 17 interviews (which included the two interviews deleted for this secondary analysis), but five additional

interviews were conducted to enhance trustworthiness of the findings and informational redundancy/theoretical saturation.

### **Ethical Considerations**

The Duke University Health System Institutional Review Board (# Pro00067256) approved this study. Study participation was completely voluntary. Written informed consent was obtained after the consent form was read to study participants and all questions answered. To protect the anonymity of the participants, none of the study forms, except the written consent document, had any identifying participant information. Only the study's project director and PI had access to the password-protected file that linked the study participant's unique ID to the study participant. All study-related forms were kept separate from data files and stored in a locked file cabinet located in a private office.

### **Data Analysis**

Collaborative qualitative analysis leverages existing research, theory, and experience to apply procedures that enable researchers to develop consistency and achieve agreement in the coding process without the need to quantify qualitative data, which are often misleading (Pope et al., 2000). To balance trustworthiness, rigor, and transparency, we adopted a six-step collaborative qualitative analysis approach to our data, which included: (a) a priori organization and planning, (b) deductive and inductive coding, (c) developing a preliminary codebook, (d) piloting the codebook, (e) revision and final coding, and (f) reviewing the codebook and finalizing themes (Patton, 2015; Richards & Hemphill, 2018). NVivo 12.0 was used to organize and manage the data, with two members of the research team coding each transcript. A codebook for the qualitative portion of the sequential mixed-methods study was developed a priori, using the elements of the Adaptive Leadership Framework for Chronic Illness (Anderson et al., 2015; Bailey et al., 2012). A secondary set of HIV-specific codes, also developed a priori, focused on stigma and disclosure and the HIV care continuum (engagement in care, ART adherence), as well as the concepts of medical distrust, discriminatory experiences, and mental health challenges.

During the coding of the transcripts, team members worked in dyads to apply the ALFCI codes to four transcripts using the codebook developed a priori. After this initial coding process, the full team reconvened to discuss the a priori codebook and resolve any discrepancies. One team member had noted the presence of themes of resilience, coping, and self-compassion in a transcript. During the ensuing group discussion, we confirmed that these themes were present in other transcripts as well. The team agreed to add the emergent codes of resilience, coping, self-compassion, and self-acceptance and amended the a priori codebook to include them. Using the amended codebook, the dyads recoded the initial four transcripts, and the group reconvened and resolved any discrepancies. The revised codebook was added to NVivo and used to code all remaining transcripts. No other emerging codes were identified during regular team meetings. After all data were coded, four small working groups were formed to analyze the data and explore emerging analytic themes in relation to technical and adaptive challenges, patient-provider relationships, stigma and disclosure, and resiliency and coping.

## Results

### Descriptive Information

The sample consisted of 22 WLWH. Their mean age was 52.2 years; 31.8% ( $n = 7/22$ ) were younger than 50 years. The analysis presented in this article focuses on the participants who self-identified as Black ( $n = 20$ ). Black participants had a mean age of 51.65 years, and 35% ( $n = 7/20$ ) were younger than 50 years.

### Themes

Data analysis revealed six major themes highlighting coping and resilience among Black WLWH—self-acceptance, disclosure, social support, self-compassion, will to live, and service.

### Self-acceptance

Self-acceptance, the act of embracing both positive and negative aspects of oneself (Morgado et al., 2014), was identified as an important component of the resilience process. Participants expressed self-acceptance in two ways, either directly by expressing their love for themselves or indirectly by rejecting self-blame for their HIV status and acknowledging that living with HIV did not make them a bad person. Some participants also emphasized the importance of viewing themselves as whole people, with HIV constituting only one part of their lived experience. For example, one participant aged 52 years (age hereafter designated by number of years only), participant number (hereafter indicated by #) 11, stated, “I learn to love me by living my life.” Another woman expressed, “It’s a part of me, but not all of me. I have so much more than HIV” (50, #19). For some participants, self-acceptance was contingent on their ability to place greater value on their self-perceptions rather than on the views of others. One participant expressed her rejection of shame in favor of self-acceptance, stating,

I had to get to “I don’t care” at one point. “I don’t care what you think, I [don’t] care what you say because this is still me.” Then the shame is not there... You have to get tired of the shameful feeling. It is just a part of me. If you can’t accept it, then I feel sorry for you. But I can help educate you. Some people just get shut off, but if you’re not that type of person... you have to internally be okay with living with HIV, with not being ashamed, and just let everybody know “I am still me. This is a part of my life, you can accept me or you don’t. If you have questions, ask me.” (44, #10)

### Self-compassion

Self-compassion emphasizes self-kindness over self-judgment and common humanity over isolation; it involves being caring and compassionate toward oneself in the face of hardship or perceived inadequacy (Neff, 2020). Self-compassion has been described as being a friend to the inner core of oneself without being self-critical or causing feelings of guilt (Tiwari et al., 2020). Among some study participants, self-compassion was linked to coping with HIV-related stigma and shame. For those reporting coping responses consistent with self-compassion, they were able to overcome the negative effects of HIV-related stigma and

shame. Conversely, lack of self-compassion was associated with shame and internalized HIV-related stigma. As one participant explained, “I felt like [my life] wasn’t worth living. I felt like I was nasty, just nasty” (48, #16).

Some women were teetering between shame and self-compassion. For example, one participant stated, “I don’t think I’m a bad person. [But] I’m ashamed” (47, #20). Other participants linked self-compassion to addressing HIV-related stigma. For example, some women reported feeling more empowered and self-compassionate after hearing others speak openly and without shame about living with HIV. Expressions of self-compassion appeared to align with beliefs indicating better coping and resilience. One woman, for example, shared a fantasy about openly rejecting shame and embracing her HIV status, although simultaneously dispelling HIV myths concerning infectiousness and seeking support from other PLWH to build self-compassion, stating,

I deal with this, but I’m not contagious...sometimes I want to have a T-shirt that [says], “I am HIV-positive and I am proud.” I...talk to people who can motivate and encourage me. You need to find a support group with other people living with HIV. (50, #7)

One participant (53, #15) offered advice to other PLWH regarding the importance of being kind to self when she stated, “Don’t ever put yourself down. That’s the wrong thing to do.”

For some participants, expressions of self-compassion accompanied those of self-acceptance, as evidenced by one participant who stated, “I finally come to the realization that I can live with this and be alright with myself. I have to be alright with myself and I have to love myself” (53, #15). Self-compassion facilitated confidence for some, building a protective barrier against the negative effects of HIV-related stigma. As one participant stated, “Being confident in yourself, no matter how other people see you...[can] show your intelligence and that you are equal” (38, #7). This, and similar statements from other participants, reflects the process through which some participants developed resilience.

## Disclosure

Several participants expressed reluctance to disclose their HIV status for fear of negative reactions, including HIV-related discrimination, social rejection, and involuntary social isolation. For these women, secrecy was necessary to avoid stigma, which is illustrated in the following exemplars, “You just really don’t want nobody to know. You real secretive, you know. You shy away from relationships” (58, #8), and “I haven’t disclosed it to my immediate family” (55, #14). Some participants attributed shame and HIV-related stigma as drivers of lack of HIV disclosure. For example, participant #11 (age 52 years) stated, “Even after living with HIV for 6 years, I still feel very ashamed and judged. I still find it very difficult to talk about myself and my diagnosis.” Reluctance to disclose their status was often due to a mixture of shame and fear, which conflicted with the open expression of self-acceptance illustrated by the following two quotes:

I didn’t want nobody to know, didn’t tell a soul...I’m tired of keeping it a secret, but I’m more afraid of letting it out...It will probably be my secret until the day I die. (47, #20)



A lot of people judge us and are mean. You just can't blurt out, "I'm HIV-positive." You don't know how [people are] going to take that. Because they think we are so dirty...[but] we are not. (52, #11)

One woman expressed the anguish of fearing that her family members would learn of her HIV status, exemplifying the conflict between self-acceptance and shame when she stated,

When I got around the other family that didn't know, it was like, "Please don't say anything."... You don't want anybody to bring it up, and it became debilitating and frustrating. And after a while, when you get comfortable with your own self, you get tired of the hiding. You have to get tired of the shameful feeling. (44, #10)

Disclosure, regardless of its reception, was identified by participants as an avenue toward self-acceptance, leading to greater resilience. One woman explained that her experience of disclosure had positively influenced her self-acceptance, stating, "Telling my family brought me great pride and respect, made me want to live. I'm not pretending. I don't have anything to pretend for...my family is my family" (53, #15). Another participant described the ideal person to whom she thought HIV status could be confided to enable self-acceptance and self-compassion, stating, "Someone who they [the WLWH] can really confide in, and just be who they are. Tell the real truth without judgment, without feeling confined. It's like a breath of fresh air. It's like a weight lifting off" (49, #19). Although secrecy felt safer for some women, HIV disclosure was identified as a means of enhancing self-compassion and self-acceptance for others, facilitating opportunities for social support and the development of resilience.

### Social Support

Overwhelmingly, study participants highlighted the importance of social support to their resilience and long-term adjustment to living with HIV. Two types of social support were identified as being particularly useful during difficult periods and transitions: emotional (i.e., caring, encouragement, active listening, or affection; Dale et al., 2014) and informational (i.e., sharing knowledge, advice, suggestions, and information; Guan et al., 2021). One woman, for example, spoke of the importance of opportunities to share, connect with, and learn from other WLWH, stating, "I started building a circle...with people who had to deal with the same thing I was dealing with [HIV]...and [it] motivated me" (38, #7). Another participant said,

Don't be ashamed of yourself...you're not in this alone, you're not the only one with HIV. There are support groups...you can go and talk to people...[who] are dealing with HIV too. (53, #15)

In addition to emotional and informational support, participants emphasized the role of appraisal (i.e., self-reflection or evaluation; Guan et al., 2021) and instrumental support (i.e., tangible aid or service; Guan et al., 2021) for facilitating self-acceptance and resilience. One woman suggested that her relationships with other WLWH provided emotional and instrumental support, stating, "If I am going through issues and stuff, they [are] right there... a couple of them will call me and say, 'Hey, you take your medicine today?' I was able to open up" (49, #18). Another woman spoke of how the compassionate and affirmative support provided at the location where she receives her HIV treatment helped her to combat

shame and improved her self-acceptance and self-compassion, enabling resilience. She stated,

At my visits, I am known, and they say “there she goes y’all.” Every time I go, there is this warmth, and it’s this warmth that I may not have gotten from my father or mother. [Health center name] helped me feel whole because...they empowered me and made me feel important. [They ask me], “Do you know who you are?...you are important, and you are important to us.” And then I begin to think, these people are strangers, and they care for me, and they love me, and they embrace me and give me gift cards, and they offer me coffee, and they said, “Where are you living? Are you struggling...do you need cash?” They cared for the total person. And for the first time in a very long time, I realized that I matter, I count. These people are strangers, they are not related to me. And if they are doing a job such as HIV/AIDS, they have to be doing it because they care. (50, #19)

It was helpful for Black WLWH to experience social support from their health care providers as well as within their wider personal social networks.

Participants described lack of social support in various ways. Some identified it as the lack of a social life due to their HIV status. For example, one participant stated, “In the beginning, I was just like my life was over. My life is done; I mean I got no social life anymore” (59, #3). Another woman referred to her lack of social support as a lack of people on whom she could depend, “I don’t have a lot of people that I can depend on, to come to my rescue” (59, #1).

### **Will to Live**

Despite challenges, participants demonstrated resilience by reflecting on their desire to live, which required them to actively resist negative sentiments that could overwhelm their ability to remain empowered and in control of their lives. One participant stated, “I got to stay healthy, and that’s what I do. I came to a realization that this is my life, and I want to live today. So therefore, I do what I have to do to live” (55, #15). After accepting their HIV status and receiving support, many women were able to describe themselves as good people who were worthy of self-compassion, which strengthened their will to live. As one participant stated, “I’m still a person. [I] still deserve to live. I still deserve to be happy” (50, #19). One participant who was a mother offered advice to other women and persons living with HIV; her statement exemplifies the reciprocity between self-acceptance and a will to leave. She stated,

Don’t give up. Don’t stop doing what you doing. Don’t let HIV rule your life. Rule it. Don’t let it take over your life. Just love yourself. It takes you to love yourself. It ain’t always going to be peaches and cream. It might not feel good one day, but there’s always tomorrow. It might rain today. But the sun will shine tomorrow. Just keep up the good work. (53, #15).

### **Service**

The desire to support other WLWH emerged as a key component in the process of developing resilience. One woman shared that her experiences living with HIV helped her to

identify new life goals, including starting a women's group in her community; she stated, "I feel like there is a deep calling [on my life], and I am supposed to make a large impact on the world or society" (50, #19). As the study's interview guide did not specifically ask about service or advocacy-related activities, not all of the women in our study indicated whether they were involved in service to others.

Participants whose children were living with HIV wanted to help their child develop self-acceptance, self-compassion, and the will to live. One woman explained, "I wanted to start a support group where parents of positive kids could interact...[to] build their social circle now for them, so they don't have to deal with the stigma" (38, #7). Mothers did not want their children to feel the stigma they had felt or to experience the shame that had plagued their lives. They wanted to provide support to nurture resilience in others.

## Discussion

These six themes identified in this study align with the components and processes of the MMM Theory of Resilience identified by De Santis et al. (2013). Specifically, self-acceptance, self-compassion, and will to live are aligned with the intrinsic motivators of the MMM Theory of Resiliency, and disclosure and social support are aligned with the extrinsic motivators. Participants' expressions regarding the desire to support other WLWH was consistent with the theory's conceptualization of mastery, which is a component of the resiliency development process that benefits the community and expands the social network (Emler & Harris, 2020).

Our findings are consistent with previous research highlighting key coping strategies, as well as components of the process of developing resilience, among Black WLWH. Mosack et al. (2016), for example, identified informal social support as an important facilitator of resilience among Black PLWH in Wisconsin and Ohio. Like the women in this study, the fear of contagion by others, judgment and rejection, and the disregard for privacy were areas of concern. Further, the importance of facilitating connections between PLWH, as identified by the women in this study, was also prioritized as social network intervention by Mosack et al. (2016).

Similar to findings by Brion et al. (2014), this results of this study showed that positive social connections, including support from groups, peers, and health care providers, contributed to self-compassion for Black WLWH. The importance of social connections between individuals, especially individuals living with HIV, offers support and healing connections and leads to healthier and more productive, fulfilling lives (Lowther et al., 2018; Murthy, 2020). Lowther et al. (2018) found that support by health care providers can also play an effective role in alleviating HIV-associated stigma, especially if a person living with HIV lacks family or social support; similarly, lack of health care provider support can further perpetuate stigma. In this study, participants reported receiving positive emotional support from their health care providers, which helped to decrease shame and promote their self-compassion and will to live, thus contributing to resilience.

Some of the study participants expressed fear of disclosing their status to their family or community, describing the burden of secrecy and fear of anticipated stigma. Similar to previous reports (Sangaramoorthy et al., 2017), participants in this study described experiences of rejection from family members who refused to accept their HIV diagnosis or blamed them for their HIV status. Disclosure of HIV may be more difficult for individuals who are subject to discrimination unrelated to their diagnosis, including sexism, racism, and classism. In a study by Rice et al. (2018), the issues of sexism, racism, poverty stigma, incarceration stigma, and weight stigma were also identified as significant challenges and barriers to resilience and coping among WLWH. It is also important to remember that gender-based violence and economic insecurity are documented outcomes of HIV disclosure for some women (Logie et al., 2018).

### Limitations and Future Directions

Our study was not without limitations. Because interviews were completed during a 4-month period, the experiences described by participants were a point-in-time expression of thoughts, experiences, and feelings. Because all participants were from the Southeastern United States, the transferability of findings to women to other geographic regions of the United States or other countries should be done cautiously. Similarly, because this study focused on the experiences of Black WLWH, the transferability of findings to WLWH from other racial and ethnic groups is cautioned. In this study, the length of time that participants had been living with HIV was not measured, making it difficult to understand the trajectory of these experiences; thus, future research should consider this variable. Going forward, further research exploring the intersectional stigma and discrimination experiences, and their relationship to resilience and coping, of WLWH are needed. Conceptually, the literature has traditionally viewed being resilient as a positive characteristic and even something of which to be proud. However, resiliency has the potential to cause stress in ways previously not recognized or acknowledged. A focus on resiliency and coping strategies for Black women with or without HIV, without a focus on the root causes of why Black women even must be resilient and cope, warrants critical attention (Allen et al., 2019). As stated by Manke (2019, first paragraph), “Many Black women in America report feeling pressured to act like superwomen, projecting themselves as strong, self-sacrificing, and free of emotion to cope with the stress of race- and gender-based discrimination in their daily lives.” Thus, future research needs to integrate an intersectional approach that allows for the examination of structural racism and sexism faced by women of color at risk for and living with HIV. Further, longitudinal studies testing stigma, resilience, and coping interventions, and their relationship to care continuum outcomes, are also needed. Finally, we also recognize a potential power difference between the White male interviewer and the participants, who were primarily women of color. Although multiple intentional methodological steps to reduce any power imbalances were enacted, this may have influenced data responses by the participants.

### Conclusion

As the fifth decade of the HIV epidemic begins, it is critical to understand the intersection of stigma, disclosure, and discrimination and their relationship with resilience and coping

among WLWH. As the participants in this study highlighted, support groups remain an important strategy in helping WLWH learn to accept an HIV diagnosis and move toward self-acceptance.

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### Key Considerations

- Among Black women living with HIV, developing and building resilience is a process that affects, and is affected by, social support.
- Self-acceptance and self-compassion may be key components of resilience among Black women living with HIV.
- Support groups remain a vital component of supporting resilience and coping among Black women living with HIV.