

## IS HIV/AIDS STIGMA DIVIDING THE GAY COMMUNITY? PERCEPTIONS OF HIV-POSITIVE MEN WHO HAVE SEX WITH MEN

Cari Courtenay–Quirk, Richard J. Wolitski, Jeffrey T. Parsons, Cynthia A. Gómez, and the Seropositive Urban Men’s Study Team

Stigma surrounding HIV/AIDS has existed since the beginning of the epidemic, but little is known about HIV/AIDS stigma within the gay community and how it affects men who have sex with men (MSM) living with HIV. A better understanding of the effects of stigma on this population is needed to reduce it and its harmful effects. Our study used quantitative data from 206 HIV-positive MSM and qualitative data from 250 to document beliefs about HIV/AIDS stigma within the gay community and to measure its effects on sexual risk behaviors, substance use behaviors, serostatus disclosure, and mental health. Stigma was associated with increased levels of anxiety, loneliness, depressive symptoms, engaging in avoidant coping strategies, and history of suicidal ideation. HIV/AIDS stigma exists within the gay community and has a negative effect on the mental health of people living with HIV. HIV/AIDS stigma should be monitored closely so that we may better understand how to address it.

Stigma has been defined as any characteristic, real or perceived, that conveys a negative social identity (Crocker, Major, & Steele, 1998; Goffman, 1963). Stigmatizing attitudes toward HIV-positive persons and the blame ascribed to gay men for the disease have been well documented since the beginning of the epidemic, when HIV/AIDS was initially labeled “gay-related immune deficiency” (Epstein, 1996). These stigmatizing attitudes continue to be widely held. For instance, a national survey conducted by the Centers for Disease Control and Prevention (CDC, 2000)

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Cari Courtenay–Quirk and Richard J. Wolitski are with Division of HIV/AIDS Prevention, National Center for HIV/STD, TB Prevention, Centers for Disease Control and Prevention, Atlanta, GA. Jeffrey T. Parsons is with Hunter College, City University of New York. Cynthia A. Gómez is with the University of California, San Francisco.

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Address correspondence to Cari Courtenay–Quirk, 1600 Clifton Rd. NE, Mailstop E-37, Atlanta, GA 30333; e-mail: ccourtenay-quirk@cdc.gov

showed that 19% of respondents agreed with the statement “People who got AIDS through sex or drug use have gotten what they deserved.”

An important factor in the public’s attitudes toward HIV-positive persons is the mode of transmission of HIV (Capitanio & Herek, 1999; Cobb & de Chabert, 2002; Crandall, 1991; Herek & Capitanio, 1999; Herek et al., 2002; Hunter & Ross, 1991; Manetti & Pierro, 1991; Schellenberg & Bem, 1998). Herek and Capitanio (1999) found that blame, increased anger, and decreased sympathy toward an HIV-positive person occur more frequently if that person is a gay or bisexual man. Schellenberg and Bem (1998) presented to heterosexual college undergraduates vignettes of persons living with HIV/AIDS and found that the persons in the vignettes were blamed more when they were described as teens or adults (i.e., not children) and identified as homosexuals or injection drug users.

Until recently, the bulk of research on HIV/AIDS stigma has focused on its prevalence in the general population (e.g., Capitanio & Herek, 1999; CDC, 2000; Herek & Capitanio, 1999; Herek, Capitanio, & Widaman, 2002) or on modeling the social psychological processes that are associated with stigmatizing attitudes in highly selective groups such as college undergraduates (e.g., Lee, Campbell, & Mulford, 1999; Schellenberg & Bem, 1998). Some research has also described ways in which HIV-positive persons cope with or manage the stigma associated with their illness (e.g., Siegel, & Krauss, 1991; Siegel, Lune, & Meyer, 1998; Weitz, 1990) and how stigma may affect the risk behavior and HIV-testing practices of high-risk populations such as men who have sex with men (MSM) (e.g., Preston et al., 2004; Stall et al., 1996; Valdiserri, 2002).

Other important aspects of HIV/AIDS stigma remain to be explored. For instance, stigma may be associated with transmission risk behaviors, serostatus disclosure, and the mental and physical health of HIV-positive persons. Swendeman, Comulada, and Rotheram-Borus (2002) reported that HIV-positive youth who experienced greater amounts of stigma were more likely to engage in sex for money or drugs, were more likely to use illegal drugs, and were less likely to disclose their serostatus to sex partners. Swendeman and colleagues also found that HIV-positive youth who experienced greater levels of stigma reported higher levels of depression, anxiety, and negative coping strategies and were more likely to have attempted suicide.

These studies have largely addressed stigma as it is presented outside of the gay community. However, HIV/AIDS stigmatization also exists within the gay community and may have specific effects on risk behavior and mental health of HIV-positive MSM. Sheon and Crosby (2004) have suggested that when the HIV antibody test became available in 1985, the gay community became divided according to serostatus: one was either HIV-positive or HIV-unknown. Others have documented ambivalent attitudes among MSM toward AIDS and persons living with HIV/AIDS (e.g., Flowers, Duncan, & Frankis, 2000; Kowalewski, 1998).

Díaz (2003, in press) has begun to address such issues within the Latino gay community. In qualitative and quantitative research, Díaz (2003) documented the presence of HIV/AIDS stigmatizing attitudes among HIV-negative Latino MSM and has explored the effects such attitudes have on HIV-positive men. When HIV-negative Latino MSM were asked “Do you believe HIV-positive people are responsible for having gotten infected?” and “Do you believe that HIV-positive people are more sexually promiscuous?,” 57% and 52%, respectively, affirmed such statements. Overall agreement with expressions of stigma with regard to HIV/AIDS ranged from 18% to

82%. When Díaz (2003) asked HIV-positive Latino MSM “Has being HIV-positive made it more difficult for you to trust other people?” and “Do you think that sexual partners would reject you if they knew you were HIV-positive?” 64% and 82%, respectively, agreed. Among HIV-positive Latino MSM, agreement across eight items pertaining to the perceived impact of HIV/AIDS stigma in their lives ranged from 45% to 82% (Díaz, 2003). Higher perceived impact of HIV/AIDS stigma was significantly related to poorer mental health outcomes such as increased social isolation, lower self-esteem, and increased psychological symptoms (Díaz, in press).

We used qualitative and quantitative data to describe perceptions of HIV/AIDS stigma among a diverse sample of HIV-positive MSM and to examine whether perceived stigma is related to increased HIV transmission risk behavior, increased substance use, decreased serostatus disclosure, and poorer mental health.

## METHODS

### PARTICIPANTS

Participants were 456 HIV-positive MSM who participated in the Seropositive Urban Men’s Study (SUMS) (Wolitski, Parsons, & Gómez, 2004). SUMS was a cross-sectional study that examined factors contributing to men’s initiation and maintenance of safer sex behavior. SUMS participants were recruited in New York (61%) and in San Francisco (39%) through three venue types: AIDS service organizations, mainstream gay-identified venues, and public sex venues. Recruitment quotas for each venue type were established to obtain approximately equal numbers of African American, Latino, and white men from each venue and across the sample.

### PROCEDURE

The SUMS study protocol was approved by the institutional review boards of the participating institutions and by local community advisory boards and review panels. SUMS was completed in two phases.

The first phase (SUMS I) was conducted between June and November 1997. In this phase, 250 participants completed a paper-and-pencil questionnaire and a semistructured interview and received \$30 for each. The SUMS I questionnaire did not address HIV/AIDS stigma; findings from this research can be found elsewhere (Parsons, Halkitis, Wolitski, & Gómez, 2003; Wolitski, Parsons, & Gómez, 2004). The SUMS I interview consisted of 58 open-ended questions and took approximately 1 hour and 30 minutes to complete. It addressed topics such as men’s experiences of living with HIV, dating and sexual relationships, recent sexual encounters, and other issues pertaining to HIV transmission risk. The content from these interviews was transcribed and coded, using a series of codes developed a priori by the researchers and refined during analysis to reflect emergent themes (see Halkitis, Wolitski, & Gómez, 2005). From these, a subset of 32 codes was identified as potentially relevant to experiences and perceptions of HIV/AIDS stigma. This subset was the source of quotations for the present study.

The second phase (SUMS II) was conducted between May and September 1998. In SUMS II, 206 participants completed an enhanced paper-and-pencil questionnaire, which expanded upon the earlier version to address new information gleaned from the semistructured interviews. Participants received \$30 for spending approximately 1 hour completing the questionnaire. All SUMS questionnaires and interviews were conducted in English.

Because the SUMS II questionnaire asked about HIV/AIDS stigma in the gay community, quantitative analyses of this enhanced questionnaire was possible. Linear associations with HIV/AIDS stigma were identified in a series of Pearson correlations, simple regression equations, and analyses of variance. Variables with a significant bivariate association with HIV/AIDS stigma were reanalyzed in follow-up tests to control for social desirability. Selected quotations from the earlier semistructured interviews were included to provide illustrative text for the quantitative results.

## MEASURES

Participants were asked for basic demographic information such as their age, race, gender, education level, sexual identity, and when they first received positive HIV test results. Participant's sensitivity to the effects of social desirability was measured with the 13-item Marlowe-Crown Social Desirability Scale—Short Form (Crowne & Marlowe, 1964; Reynolds, 1982). Participants indicated "true" or "false" for each of 13 statements; total scores were computed by summing the number of "true" responses. Internal consistency for the present study was  $\alpha = .71$ .

*Perceived Stigma in the Gay Community.* Quotations from the SUMS I qualitative interviews were used to develop items for the SUMS II questionnaire. These items emphasized the extent to which HIV-positive men perceived HIV/AIDS stigma to be expressed by HIV-negative men. Six items were developed to address this construct on a Likert scale ranging from 1 = strongly disagree to 5 = strongly agree. An example is, "HIV negative men treat you differently if they know you're positive." These items demonstrated good internal consistency ( $\alpha = .79$ ). Principal components factor analysis extracted a single factor with an eigenvalue of 2.97, which represented 49.2% of item variance. All items loaded strongly on this factor ( $> .67$ ), and eigenvalues of all subsequent factors were less than 0.80, which suggested there were no other meaningful factors. Scale scores were computed by dividing the sum of item scores by the number of items.

*Sexual Behavior.* SUMS II participants were asked the serostatus of their main partner and how frequently they had engaged in four sexual behaviors (receptive oral sex, insertive oral sex, receptive anal sex, insertive anal sex) with this partner. The participants were asked how frequently they had and had not used a condom with each behavior and how frequently each act did and did not involve ejaculation. These sexual behavior questions were repeated for all partners other than main partners (casual partners), according to serostatus (HIV-negative, HIV-positive, and unknown serostatus). The reported frequency of each behavior was summed across all partners (main and casual) of negative or unknown HIV serostatus. These frequency scores were dichotomized to indicate the presence or absence of having engaged in any of three unprotected sexual behaviors (receptive anal sex, insertive anal sex, and insertive oral sex) with a partner of negative or unknown HIV serostatus partner during the past 3 months.

*Venues for Meeting Sex Partners.* Participants were asked how frequently they attended gay bars, sex clubs, public cruising areas, and private sex parties to meet new sex partners during the past 3 months. Response options were 1 = never, 2 = once a month or less often, 3 = about once every other week, 4 = about once a week, and 5 = more than once a week. Because responses were highly skewed toward the less frequent end of the response range, these variables were dichotomized to represent having ever attended each venue type during the past 3 months.

*Substance Use.* Participants were asked whether they had used any alcohol or recreational noninjection drugs during the past 3 months. A dichotomous variable was created to compare those who had recently used alcohol or drugs with those who had not. Those who had recently used alcohol or recreational drugs were also asked how frequently they had used alcohol before or during sex and how frequently they had felt high from using any recreational drug during sex. These responses were measured on a 5-point scale ranging from 1 = never to 5 = always.

*Partner Awareness of HIV Serostatus.* Participants who reported having a main sex partner were asked whether their partner knew the participant's HIV serostatus "before you had sex for the first time." Participants who reported having partners other than a main partner were asked how many of these partners knew the participants' HIV serostatus before having sex for the first time. These questions were asked with regard to HIV-positive partners, HIV-negative partners, and partners whose HIV status they did not know. For analytic purposes, these partner awareness responses were combined across partner types (main and casual) to obtain a disclosure frequency score for each partner serostatus: HIV-negative, HIV-positive, and unknown. These scores were categorized into 0 = no partners of this serostatus were aware of participant's HIV status, 1 = some partners of this serostatus were aware of participant's HIV status, and 2 = all partners of this serostatus were aware of participant's HIV status (Hart et al., 2005). Additional variables were computed similarly to measure the awareness of participants' serostatus among all of their sex partners of HIV-negative or unknown serostatus and among all of their sex partners regardless of partner serostatus.

*Psychosocial and Mental Health.* Internalized homophobia was measured using five items. Each item measured the degree of discomfort with one's own homosexuality on a scale of 1 (strongly disagree) to 5 (strongly agree). Most items were reverse-coded (e.g., "I feel extremely comfortable about being sexually attracted to men"). The scale demonstrated acceptable internal consistency ( $\alpha = .78$ ).

Coping was measured on a 20-item scale based on an instrument by Folkman and Lazarus (1988). Response options ranged from 1 ("I never do it") to 4 ("I always do it") scale. Eight items assessed active coping (e.g., "I talk to my friends or family about it"), and 12 items measured avoidant coping (e.g., "I keep to myself, do not go out"). Cronbach alphas were .75 and .72, respectively.

Loneliness was measured using four items taken from the UCLA Loneliness Scale (Russell, Peplau, & Ferguson, 1978). The Cronbach alpha for these items was .64. Depressive symptoms (seven items), anxiety (six items), and hostility (five items) were measured with subscales of the Brief Symptom Inventory (Derogatis & Melisaratos, 1983). Participants were given a list of problems (e.g., thought of ending life, feeling lonely) and were asked to indicate how much each of these problems had bothered them during the past week (1 = not at all, 5 = extremely). Cronbach alphas were .91 for depression, .87 for anxiety, and .85 for hostility.

Finally, participants were asked whether they had ever seriously considered or tried to commit suicide.

## RESULTS

Characteristics of participants are summarized in Table 1. Chi-squared tests revealed no significant differences between SUMS I and SUMS II participants with regard to race/ethnicity, educational background, sexual identity, or income. Ages of participants from the two samples ranged from 20 to 67 years ( $M = 38.2$ ,  $SD = 8.1$ ). Partici-

TABLE 1. Demographic Characteristics of SUMS Participants

	SUMS I ( <i>n</i> = 250) %	SUMS II ( <i>n</i> = 206) %	Total ( <i>N</i> = 456) %
Race/ethnicity			
White	30	30.6	30.3
Hispanic/Latino	23.6	23.8	23.7
African American	28.8	29.6	29.2
Other (Alaska Native, American Indian, Asian/Pacific Islander, mixed heritage)	17.6	16	16.9
Sexual identity			
Gay/queer/homosexual	82	84.7	84.5
Bisexual	9.2	10.3	9.9
Straight/heterosexual	0.8	2	1.3
None of above/not sure	5.2	3	4.3
Education			
High school or less	17.1	31	26.8
Some college/associate degree	36	40.8	38.5
Bachelor's degree	27.2	18.9	23.7
Master's or doctoral degree	12.4	9.2	11.1
Income			
Less than \$10,000	43.2	46	45.4
\$10,000–\$19,999	22.4	27.7	25.3
\$20,000–\$29,999	14	11.9	13.3
\$30,000–\$39,999	8.4	6.4	7.7
\$40,000–\$49,000	3.6	3.5	3.6
\$50,000 and higher	4.8	4.5	4.7

pants had had a diagnosis of HIV for a mean of 6.8 years ( $SD = 4.0$ ). More than 44% ( $n = 201$ ) reported having received an AIDS diagnosis.

### QUALITATIVE RESULTS

Although SUMS I participants were never directly asked about their perceptions of HIV stigma within the gay community, many discussed a general sense of division within the gay community and described specific instances of prejudice. As one man noted, “Well, the gay community . . . in general, I sense a kind of division between those that are positive and those who are not. And a hostility between the two.” (#1228).

Many participants discussed having the sense that HIV is not a welcome topic in the gay community and that it is a reason to avoid developing close relationships, particularly with HIV–negative men. In the comments of one:

I think people support you to a certain extent, and then they kind of back off from you. It's like taboo to them. So on the one hand, they're always there to help and they're concerned, but when it comes down to getting to know you, if they're not HIV–positive, then it's different. There's some sort of block there. (#2247)

Some men discussed avoiding relationships in the gay community altogether because they feared nonacceptance. As another participant stated:

I don't think HIV really kills. It's . . . the rejection that kills . . . As far as the gay community of HIV, I haven't been [accepted] too much at all. As a matter of fact, I haven't socialized with a fear of rejection from other people. So right now, I'm just hanging around with my Asian community. (#2220)

Participants reported that they sense fear among HIV-negative men regarding HIV/AIDS and that many uninfected men avoid the topic of HIV and will avoid potential sex partners if the topic does arise. As one put it:

They are afraid of being involved with somebody who has it or being attracted to somebody who has it and then risking getting it themselves. And it's a lot of just not wanting to think about it, and so please, don't bring it to my attention. Let's not talk about it, and, you know, we'll be fine. (#1294)

This sense of rejection from HIV-negative men in the gay community was often expressed with a certain amount of surprise and frustration, as evidenced in the following comment:

Because I mean there are some people that if they know, even as a gay, if they know you're positive, they don't want to be bothered with you. Even though they are gay! Even though, you know, you may have seen everything. You think people will be all together. They're not! They only want other negative people. (#1008)

In some instances, participants reported feeling outright discrimination and a sense that men within the gay community judged or criticized them for having HIV. In describing an experience with an ex-lover, one man stated:

Nobody knew his status. And he chose not to tell anyone. And I would hear like a lot of little remarks because he started losing weight, you know. And it wasn't in a sort of nice way. I don't know, but catty gossip, you know? Like, so yeah. I think that sometimes you can find prejudice among your own people. (#1327)

Some men reported that judgmental attitudes can even come from other HIV-positive men. In the words of one:

I find that there are people who are positive themselves who are even more prejudiced, I guess is a good word for it, against people who are positive. It's not a good thing to be positive . . . I think it's more of a self-reflective quality because I think they're not accepting it about themselves; so therefore, if they see it, they don't want to accept it [in others] either. (#1102)

Participants described numerous ways in which they had experienced social isolation within the gay community. Often this was related to choosing to not disclose their serostatus to anyone outside of their immediate support network of family and close friends. At other times, isolation was externally imposed in ways that would strongly reinforce the avoidance of future disclosures. In one vivid account from a participant:

I had a really fucked up experience with these two guys and we had become friends . . . and at one point, I felt that we'd become close enough friends where I could tell them. And this was after a long period where I didn't tell anyone at all. And . . . they didn't say anything at first for a couple of weeks, and then one day I hurt my back and asked one of them to walk my dog for me, and I didn't hear back from him. The next day, I got a letter under my door saying . . . "I'd say I was sorry for not helping you out yesterday, but I'm not. I just want you to know that [he] and I . . . we know that you will need a lot of help some day, and we want you to know now that we won't be the ones to give it to you." (#1149)

## QUANTITATIVE RESULTS

*Perceived Stigma in the Gay Community.* Responses from SUMS II participants indicated that perceived HIV stigma within the gay community was prevalent (Table

TABLE 2. Perceptions of HIV/AIDS Stigma in the Gay Community ( $n = 206$ )

Item	Agree/ Strongly Agree %	Neither %	Disagree/ Strongly Disagree %
Men who are HIV negative don't really understand what it is like to have HIV.	64.1	24.8	11.2
Even among men who have sex with men, there is discrimination against people with HIV.	61.6	24.8	13.6
Most men who are negative are afraid to get involved with someone who is positive.	50.5	31.9	17.6
There is a split in the community between men who are negative and those who are positive.	45.1	40.8	14.1
HIV-negative men treat you differently when they know you're positive.	40.8	33.5	25.7
HIV-negative men judge you if they find out that you are positive.	36.0	43.8	20.2

2). For instance, nearly two thirds of the participants agreed that “Men who are HIV-negative don't really understand what it's like to have HIV” and “Even among men who have sex with men, there is discrimination against people with HIV.” SUMS II participants were least likely to agree that “HIV-negative men judge you if they find out that you are positive” and that “HIV-negative men treat you differently when they know you're positive.” The mean scale score was 3.4 ( $SD = .7$ ), slightly above the scale midpoint of 3.

*Demographics, Sexual Risk Behaviors, and Substance Use.* Bivariate analyses of the SUMS II questionnaire data showed no association between perceived HIV/AIDS stigma in the gay community and the following: demographic variables, sexual HIV transmission risk behaviors, and substance use behaviors (including any use of alcohol or recreational drugs in the past 3 months). However, having attended private sex parties  $F(1, 193) = 6.83, p < .05$ , and having gone to sex clubs,  $F(1, 193) = 5.09, p < .05$ , in the past 3 months were associated with higher levels of perceived HIV/AIDS stigma.

*Disclosure of HIV Serostatus.* Rates of sex partners' awareness of the participant's serostatus were high among partners known to be HIV-positive and partners known to be HIV-negative and much lower among partners whose HIV status was unknown; 73%, 61%, and 17% of all such partners, respectively, knew the participant's HIV status. Partner awareness of the participant's HIV status was not associated with perceived HIV/AIDS stigma, however, regardless of the partner's serostatus.

*Psychosocial and Mental Health Perceived.* HIV/AIDS stigma was not related to internalized homophobia or hostility. However, HIV/AIDS stigma was significantly related to anxiety ( $r = .15, p < .05$ ), loneliness ( $r = .16, p < .05$ ), and depressive symptoms ( $r = .23, p < .01$ ). Perceived HIV/AIDS stigma was also related to engaging in avoidant coping strategies ( $r = .21, p < .01$ ) and to having attempted or seriously contemplated suicide,  $F(1, 199) = 6.47, p < .05$ . Approximately 30% ( $n = 61$ ) of SUMS II participants had attempted or seriously considered suicide at some point in their lives.

Social desirability was positively correlated with perceived HIV/AIDS stigma. After controlling for social desirability, perceived HIV/AIDS stigma remained significantly related to attending sex clubs and private sex parties, increased depressive symptoms, increased use of avoidant coping strategies, and having ever considered or attempted suicide (Table 3).

TABLE 3. Bivariates of Perceived HIV/AIDS Stigma in the Gay Community after Controlling for Social Desirability ( $n = 206$ )

Outcome Variables	Multiple Regression		Logistic Regression
	$\beta^a$	$\Delta R^{2b}$	Odds Ratio (95% Confidence Interval)
Depressive symptoms	.155	.024*	—
Avoidant coping strategies	.156	.024*	—
Anxiety	.072	.005	—
Loneliness	.123	.015	—
Suicidal ideation	—	—	1.62 (1.03, 2.55)*
Attending private sex parties	—	—	2.25 (1.22, 4.12)**
Attending sex clubs	—	—	1.64 (1.12, 2.58)*

<sup>a</sup>Beta for HIV/AIDS stigma, controlling for social desirability, is presented. <sup>b</sup>Change in  $R^2$  represents the variance accounted for by the HIV/AIDS stigma measure after controlling for social desirability. \* $p \leq 0.05$ , \*\* $p < 0.01$ .

## DISCUSSION

Our results, qualitative and quantitative, indicate that many HIV-positive MSM perceive a division within the gay community related to HIV/AIDS. Their perceptions that HIV-negative men held stigmatizing attitudes toward HIV-positive men included feelings of sexual rejection and discrimination.

Our study also showed that, among HIV-positive MSM, perceived HIV/AIDS stigma in the gay community is related to numerous aspects of mental health, including depressive symptoms, the use of avoidant coping strategies, and suicidal ideation. Our findings are correlational and therefore cannot indicate the direction of the association between stigma and mental health. These findings are consistent, however, with the effects of HIV/AIDS stigma found by Swendeman et al. (2002) and with findings on the effects of other forms of stigma (e.g., Link, Struening, Rahav, Phelan, & Nuttbrock, 1997). To the extent that HIV/AIDS stigma does in fact impact the mental health of HIV-positive MSM, interventions should be developed to mitigate such effects.

Although our qualitative data indicated a potential association between HIV/AIDS stigma and disclosing one's HIV status to potential friends and sex partners, our quantitative analysis indicated that HIV-related stigma in the gay community was not associated with sex partners' awareness of HIV serostatus. Results from other studies on the effect of stigma on disclosure patterns have been mixed (e.g., Chesney & Smith, 1999; Sheon & Crosby, 2004; Swendeman et al., 2002). Differences in how stigma was measured in these studies may account for the divergent findings. More research is needed to determine which circumstances and sources of HIV/AIDS stigma have the greatest effect on serostatus disclosure.

Our study showed that perceived HIV/AIDS stigma in the present sample was unrelated to sexual risk behavior, including unprotected anal sex with partners of negative or unknown serostatus. This is encouraging because, despite perceptions that uninfected men do not understand or want to get involved with them, HIV-positive MSM were not reacting in ways that put their partners at additional sexual risk. HIV/AIDS stigma was also unrelated to substance use, including having sex while under the influence of drugs or alcohol. This is also encouraging, as it suggests that HIV-positive MSM who perceive HIV/AIDS stigma in the gay community are not differentially putting their health at risk by using more alcohol or other drugs and are not

at greater risk for engaging in risky sexual behavior as a result of drug or alcohol use, which has been associated with risky sexual practices (Purcell, Parsons, Halkitis, Mizuno, & Woods, 2001).

However, those who perceived higher levels of HIV/AIDS stigma in the gay community were more likely to seek partners in settings that facilitate anonymous sex, such as private sex parties and sex clubs. HIV-positive MSM may be less likely to perceive themselves as having personal responsibility to protect their partners in these settings than in other settings (Wolitski et al., 2003). Parsons and Vicioso (2005) reported that men who attend these venues associate it with a desire to avoid thinking about HIV and to avoid disclosure. Indeed, strong norms for silence in such settings have been described (Elwood, Greene, & Carter, 2003). Settings that facilitate anonymous sex may be used by some men to protect themselves from emotional involvement with sex partners and expectations to share personal information such as HIV status. If this is true, the use of such venues for seeking sex partners may be another form of emotional withdrawal related to avoidant coping strategies and poorer mental health among men who are living with HIV/AIDS.

Our findings may not generalize to all HIV-positive MSM because SUMS involved a purposive, nonrepresentative sample. Furthermore, the cross-sectional design of SUMS precludes assertions of causality. Finally, these data were collected before recent rises in risk behavior were reported (Chen et al., 2002; Wolitski, Valdiserri, Denning, & Levine, 2001) and before the intervention community started emphasizing HIV prevention programming for HIV-positive persons (CDC, 2003; Janssen et al., 2001). These subsequent developments may have affected attitudes and beliefs held by members of the gay community toward HIV/AIDS and persons living with HIV.

At the time of the SUMS, there were no published measures of HIV/AIDS stigma experienced by persons living with HIV. Some efforts at scale development have since emerged (e.g., Berger, Ferrans, & Lashley, 2001). The SUMS measure is among the first to have been reported for HIV/AIDS stigma perceived specifically within the gay community. This measure addressed perceptions only in relation to HIV-negative men in the gay community. More tests verifying these items' reliability and validity should be conducted, and future research should examine whether this measure encompasses all relevant dimensions of HIV/AIDS stigma. The extent to which some HIV-positive men may internalize and contribute to the HIV/AIDS stigma experienced by HIV-positive MSM in the community, for instance, was not assessed in the present study.

Our data have demonstrated that HIV-positive MSM perceive a division within the gay community related to HIV/AIDS. The perception of this division, moreover, is associated with attendance in venues for meeting sex partners that promote anonymity and with a number of negative mental health indicators. We believe it is vital to conduct more research on how HIV stigma presents itself in the gay community, how it is experienced by HIV-positive MSM, how it is perceived and expressed by uninfected MSM, and how it may affect the lives of HIV-positive persons who are not members of the gay community. Such information will allow us a better understanding of how to create both policy and programmatic interventions to mitigate its harmful effects.

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