


Experiences of Stigma and Spirituality of Older Black Men Living with HIV

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ABSTRACT

Previous research on HIV stigma and the use of spirituality by people living with HIV/AIDS is scarce. Moreover, the research with older Black men who have sex with men is scant. This study aimed to investigate experiences of HIV stigma and the use of spirituality among older HIV positive Black men who sleep with men. In-depth interviews were conducted with a sample of ten men. Data were analyzed utilizing to the modified van Kaam data analysis method. Three major themes were identified that explores the participants lived experiences with HIV stigma and use of spirituality: experiences of stigma reinforcing the use of spirituality; defining spirituality as a functional concept; and self-empowerment through the use of spirituality. The findings could guide social workers and other helping professionals in developing informed assessments and interventions regarding HIV stigma and the use of spirituality. Future qualitative and quantitative research is needed to achieve generalizable knowledge about the relationship between stigma on the use of spirituality.

KEYWORDS

HIV; aging; spirituality; stigma; men who have sex with men; sexual minority stress theory

Introduction

The number of people living with HIV has increased to an estimated 1.1 million in the United States (Centers for Disease Control and Prevention [CDC], 2016). While HIV has decreased among various population groups, including African Americans, the prevalence of HIV in the Black gay and bisexual community has increased over the past decade for older age groups (CDC, 2016). Black men who have sex with men (BMSM) accounted for 58% of new diagnosis with BMSM, 50 years of age and older accounting for 43% (CDC, 2016). Advances in HIV treatment have rapidly evolved over the past 30 years from treatment regimen that were challenging to people living with HIV to regimen that have established HIV as a manageable chronic disease (Earnshaw, Lang, Lippitt, Jin, & Chaudoir, 2015).

Progressive antiretroviral treatment and social and psychological services across the nation have helped people living with HIV live longer. However, challenges persist with finding innovative ways to treat BMSM 50 years of age and older living with HIV specifically as it relates to successfully aging

with the disease (HIV/AIDS, Hepatitis, STD, and TB Administration [HAHSTA], 2016). Previous researchers have suggested different mechanisms such as strengthening social support networks and reducing social isolation as ways of effectively working with Black people over the age of 50 living with HIV (Blake, Taylor, & Sowell, 2017; Webel et al., 2014). In developing social support networks, the use of spirituality is shown to be a strategy with working with Black women living with HIV and reducing experiences of social isolation and stigma encounters (Dalmida, Holstad, DiIorio, & Laderman, 2012). The lack of evidence for the aging BMSM living with HIV is limiting in developing the capacity for helping professionals and researchers to work with this population effectively. A plethora of literature exists regarding social work and spirituality, but not much literature concerning social work, spirituality, and HIV stigma. The social work profession has been involved in the field of HIV/AIDS since the early 1980s (Emlet, Fredriksen-Goldsen, Kim, & Hoy-Ellis, 2017; Emlet, 2007; Galambos, 2004); however, the literature is scarce regarding aging individuals, specifically, older BMSM living with HIV. Advanced age, along with an HIV

diagnosis, increases the risk of experiencing stigma (Mahajan et al., 2008). Illuminating experiences of stigma may potentially impact social and psychological functioning and coping mechanisms such as spirituality (Haile, Padilla, & Parker, 2011).

The HIV Stigma and Spirituality Context

More than 30 years of HIV research, care, and treatment is available, but stigmatization continues to be a stable challenge to reduce and effectively manage HIV. Stigma is a broad and multifaceted concept. In Goffman's (1963) seminal work, he defined stigma as "An attribute that is deeply discrediting ... A situation of an individual who is disqualified from full social acceptance" (pp. 2–5). More recently, HIV stigma has been defined as abuse, prejudice, and negative attitudes toward people living with HIV/AIDS (Emlet, 2007; Herek, Gillis, & Cogan, 1999; Phelan, Link, & Tehranifar, 2010; Porter, Brennan-Ing, Burr, Dugan, & Karpiak, 2017). Experiences of HIV stigma may position people living with HIV in a stigmatizing role due to a number of factors (e.g., the contraction of HIV considered being immoral, HIV as an incurable disease, level of stigma attached because it is an illness, and having symptoms associated with the disease in different advanced stages (Herek, 1999). Additionally, older BMSM living with HIV hold identities in other marginalized groups (e.g., sexual and ethnic minority, health status, and people 50 and over), which creates another level of potential experience of stigma and discrimination. Research on HIV stigma is abundant (e.g., Carrasco, Arias, & Figueroa, 2017; Earnshaw & Chaudoir, 2009; Earnshaw, Smith, Chaudoir, Amico, & Copenhaver, 2013; Herek, 1999; Herek et al., 1999; Parker & Aggleton, 2003; Sengupta, Banks, Jonas, Miles, & Smith, 2011). However, no phenomenological research exists that explores HIV stigma on coping resources such as spirituality among older BMSM living with HIV.

Spirituality is oftentimes described as a personal quest for understanding existential questions and answers about the meaning of life, relationship to what is personally sacred, and a connection that may (or not) lead to the development of rituals (Canda, 2013; Garg, 2017; Koenig, McCullough, &

Larson, 2001). Spirituality is a coping resource identified as a significant component in the lives of older people living with HIV (Porter et al., 2017). People living with HIV use spirituality with the hope of ensuring positive outcomes in their lives. A number of studies have documented the utility of the use of spirituality as it is related to HIV (Porter et al., 2017), positive impact on making life decisions on HIV care (Lorenz et al., 2005), and reduction of mental illness and physical pain (Brown, 2016; Holt, Clark, Debnam, & Roth, 2014; Koenig, 2012; Levin, Chatters, & Taylor, 2005; Musgrave, Allen, & Allen, 2002; Skalski et al., 2015; Tuck, McCain, & Elswick, 2001). Spirituality has also served a significant role in the Black community, and it provides a means of coping, improvement of quality of life, managing risk factors for contracting HIV and managing psychosocial stressors (Armstrong & Crowther, 2002; Bowen-Reid & Smalls, 2004; Brown, 2016; Dalmida et al., 2012; Hendricks, Bore, & Waller, 2012; Himelhoch & Njie-Carr, 2016; Lewis, 2008; Mattis, 2000; Mattis & Jager, 2001; Szaflarski, 2013; Taylor & Chatters, 2010).

Although there is a wealth of research available related to spirituality and HIV, information on the associated aspects of HIV stigma and the use of spirituality among older BMSM living with HIV is limited. Although a handful of studies have examined spirituality, stigma, and HIV (e.g., Chaudoir et al., 2012; Grodensky et al., 2015; Nadia, Leelavathi, Narul Aida, & Diana, 2017; Sanicki & Mannell, 2015), the majority focused on aspects of each construct with various populations (e.g., white males, heterosexual males and females, and African American women). None of the studies examined the lived experiences of older BMSM living with HIV as it relates to the effects of HIV stigma on the use of spirituality. Spirituality is a coping mechanism that has been deemed as necessary in the lives of people aging with HIV across population groups (Emlet, Shiu, Kim, & Fredriksen-Goldsen, 2017; Kelly, 2004). However, the concept of HIV stigma has not been included in these studies. Also, a gap in the literature exists for overall experiences of older BMSM living with HIV. For this purpose, this study addressed the following questions: (a) How do older BMSM living with HIV describe their

Table 1. Demographics of participants.

Participant	Age	Education	Employment	Orientation	Marital status	Years with HIV	Status
1	54	Bachelors	Full-time	SGL	Single	33	UND
2	63	High School	Part-time	BISEX	Single	31	UND
3	59	Some College	Retired	SGL	Single	39	UND
4	67	Bachelors	Retired	SGL	Single	32	AVL
5	54	Masters	Full-time	SGL	Single	30	AVL
6	62	High School	Full-time	SGL	Partnered	30	UND
7	50	High School	Unemployed	SGL	Single	15	UND
8	68	Masters	Retired	BISEX	Married	25	AVL
9	53	Some College	Full-time	SGL	Single	30	UND
10	66	Ph.D.	Part-time	BISEX	Partnered	33	AVL

Note. ($n = 10$). SGL = Same Gender Loving. BISEX = Bisexual. UND = Undetectable. AVL = Active Viral Load.

experiences of HIV stigma? (b) How do older BMSM living with HIV describe the effects of HIV stigma on their use of spirituality? Therefore, the aim of the present study was to explore the lived experiences of older BMSM living with HIV in the context of understanding the effects of HIV stigma on their use of spirituality.

Framework

Meyer's (2003) minority stress theory (MST) was utilized to frame the role of stigma on coping resources in the lives of older BMSM living with HIV. MST proposes that health challenges are exacerbated among minority sexual populations by stressors that perpetuate experiences of stigmatization, homophobic culture, internalized homophobia, and external prejudices (Dentato, Halkitis, & Orwat, 2013; Meyer, 2003). MST partially connects the experiences of HIV-related stigma on the use of spirituality of older BMSM living with HIV. The theory is predicated on the importance of understanding the cultural and social context of stressors experienced by sexual minority populations. The MST framework was used to understand the social and cultural meaning of stigma on the use of spirituality of older BMSM living with HIV through the themes.

Methods

Findings from a qualitative study of older BMSM age 50 and over in a North-eastern Metropolitan area are presented. This study involved a cooperative effort between the researcher and the AIDS service organization that provides social services to aging BMSM living with HIV. A transcendental phenomenological method was used to gain an

depth understanding of the lived experiences of BMSM, aged 50 and older living with HIV on the effects of HIV stigma on their use of spirituality. A phenomenological approach and design focus on the meaning, structure, and essence of the lived experiences of individuals on a specific concept. This approach allows the researcher to gain an in-depth understanding of a phenomenon (Sheehan, 2014). Therefore, this study explored the lived experiences of ten BMSM aged 50 and older living with HIV by using inductive and descriptive processes.

Sampling and Recruitment

The researcher utilized purposive sampling strategies (Padgett, 2004) to recruit participants who met the requirements for inclusion which were: (a) age 50 and older; (b) self-identified as Black or African American; (c) living with HIV; (d) in treatment for the past 12 months; (e) man who have sex with men; (f) spoke and read English; (g) absent of having any severe mental and/or cognitive challenges; and (h) identify having experiences with HIV stigma and use of spirituality. Participants learned of the study through advertisements at the sole AIDS service organization. The potential participants were invited to contact the researcher directly through a private Google voice number and e-mail. A total of ten men were selected to participate in the study. Participants received a \$30 gift card for reimbursement for their time and resources used to participate.

The ten participants ranged in age from 50- to 68-year old, with a mean age of 60-year old (Table 1). All participants identified as cisgender males and Black. Seven men identified as same-gender-loving and three as bisexual. The average years of living with HIV was 30 years (range = 15–39).

Table 2. Questions and prompts used.

1. As an older BMSM living with HIV, tell me about what it meant to you when you were diagnosed.
2. Talk to me about your experience with aging and living with HIV.
3. What are your experiences with HIV stigma?
4. Please describe your experience with stigma as it relates to aging with HIV.
5. Tell me about the positive and negative aspects of your experience(s) with HIV stigma.
6. How do you define spirituality?
7. How do you use spirituality in your life with HIV? Spirituality use and being over 50?
8. Please talk to me about your experiences of the effects of HIV stigma on your spirituality use.
9. What challenges (if any) have you encountered with HIV stigma on spirituality use?

Seven participants identified as single, and seven reported education past high school. Four participants reported working full-time, one unemployed, three reported being retired, and two reported working part-time. Six reported an undetectable status while four reported active viral load statuses. Study recruitment ended when no new themes emerged in the data.

Instrument

In phenomenological research designs, the researcher is the instrument for gathering data, which requires identification of biases and assumptions at the onset of the study. Moustakas (1994) maintained that the use of in-depth interviews wherein the researcher acted as a co-researcher with participants is important in collecting primary data. Therefore, the researchers' personal biases and assumptions were clearly identified and noted at the onset of the study. In addition, to further understand the lived experiences of older BMSM living with HIV regarding stigma and spirituality, and the development of the interview questions, the researcher thoroughly reviewed prior research, reports, and government organizations infographics that dealt with HIV stigma and spirituality. Interview prompts, and questions explored topics such as defining spirituality, use of spirituality while living with HIV, and any experiences of the effects of HIV stigma on the use of spirituality (Table 2).

Procedures

Ten semi-structured, individual, in-depth interviews were conducted and digitally recorded

between January 2018 and March 2018. Interviews were conducted to explore and extrapolate the lived experiences of the human condition concepts under study (Chan, Fung, & Chien, 2013). Participants were identified by numbers in the study to maintain confidentiality. Interviews were conducted at the research site (i.e., AIDS service organization) at a mutually agreeable date and time.

Data collection involved semi structured, individual, in-depth interviews with questions that were informed from the literature on HIV stigma. One interview and one contact were conducted with each participant, with the interview consisting of completing the consent form, demographic questionnaire, and the interview questions. The contact meeting involved a review of the transcribed interviews for accuracy and credibility. The interviews averaged 90 minutes to complete. The contact meeting ranged between 20-30 minutes via telephone. The interviews were reviewed and transcribed immediately after each interview and saved on an external hard drive with a password locked in the researchers' home office that could be accessed only by the researcher. Prior to completing the interviews, all participants were informed about the study, orally and in writing, and signed a consent form with a chosen pseudonym. The study received ethical approval from the institutional review board of the university where the researcher graduated (01-03-18-0472131).

Data Analysis

This study used Moustakas (1994) modified van Kaam method analysis. Moustakas presents an analysis model for phenomenological research that instructs researchers to follow a series of steps: (a) conduct verbatim transcription; (b) read and re-read transcripts; (c) divide data into units and sections; (d) integrate the sections with similarities; (e) revisit the raw data to help justify the interpretations; and (f) provide a critical analysis of your work in the research study (Kleiman, 2004; Moustakas, 1994). Data analysis focused entirely on the experiences of the research participants. An open coding system was used to explore the data for meaningful

connections. After open coding, axial coding was used in reconstructing the connected data in a new way that lead to thematic analysis. The thematic analysis included a thorough line-by-line analysis of the transcripts and categories that emerged from the narratives that described the representation of experiences through critical themes. A reflexivity journal was used to document expressions and connections related to the interviews, and this was also available and used for analysis.

Findings

The themes found were employed to gain a better understanding of the lived experiences of older BSM living with HIV as it relates to HIV stigma and the use of spirituality. The researcher drew over 400 meanings from the experiences of ten participants. The meanings were then divided and isolated into themes. The themes are stigma reinforces the use of spirituality, the definition of spirituality should be functional, and empowerment through spirituality. The data are presented with quotes from the participants identified by participation numbers.

Theme 1: Stigma Reinforces the Use of Spirituality

When the participants were confronted with experiences of HIV stigma, they felt that it reaffirmed their use of spirituality. When faced with internalized stigma, participant five told of times when he would participate in spiritual practices such as prayer, meditation, and using his work as a mental health counselor to connect in difficult times with stigma. He said “When I’m feeling stigmatized, I go to my higher power, my spirituality. I do this through prayer, meditation, and the work I do as a counselor.” Participant six recalled a specific experience that reinforced his spirituality from institutional stigma. He shared,

...I was devastated, shamed, and felt guilty about living with HIV due to the way I was treated early on by places that was supposed to help like hospitals, doctor offices, etc. I remember when I found out, the doctor came into the hallway, no privacy, and just said that my friend and I was going to die in 6 months, so we should get our affairs in order. It was horrible. And if that wasn’t the worst... they had

special days for people diagnosed with HIV and had to go to the back of the building to an area that wasn’t much bigger than this room through an unmarked door. I had to truly go inside and access a spiritual power to keep me going. The stigma was just horrible. There is no way I would have survived if I didn’t have it.

Participant four added,

For me, coping with HIV and the stigma is directly related to my identity as a spiritual person who understands the power of being a spiritual person and who uses it very flagrantly in my life. It’s what I share with people. I have this way of sharing myself with others through the things that they find beautiful in my home. If someone comes to my house and eyes a piece of art or specific item, I later gift it to them. I do that because it creates a space in my life to share positivity and love to them. It also helps me stay in a positive place with having a past of issues with stigma but living in a world full of strife, stigma, and other issues.

When challenged with stigma experiences, participant ten stated,

I immediately turn to my higher power to rectify feelings that breed contempt and misunderstanding. In 2018, it is no reason for stigma to be alive and well, but it is. So, when I feel it, I pray for the person or institution, and keep pressing my way.

Theme 2: Definition of Spirituality

Most of the participants viewed spirituality as a personal choice with personal power. Some participants added a functional dimension to spirituality that goes beyond the personal choice of belief in a higher power, but how personal activities define spirituality. Participant two defined spirituality as “...A connection with God or higher power. Something bigger than me, outside of me, but still in me that makes the inside work.” Supporting, participant nine defined spirituality as “It’s a connection to a higher power that is outside of your internal world. It really is what you believe. It’s not religion per se, but it can be found in religion.” Participant eight, who works in ministry, defined spirituality as “Something that is bigger than ourselves that helps create a deeper connection to humanity.” Participant four definition agreed with participant

eights' and took it a step further by defining it as "sense of self." He explained,

Everything in my life that has seen me make it from one point to the next is based on my acceptance of myself as a spiritual person and having a connection to God. Am I religious? No. Religion is not something serves a purpose for me. My spirituality comes directly from God, understanding the things that I've learned. Spirituality is about how you identify, and how you imagine who you are, and how you accept your possibilities, and how you deal with the challenges of coping with troubled times. Having a sense of self. My coping with HIV and the stigma is directly related to my identity as a spiritual person.

Participant five spoke of a functional level of spirituality when coping with HIV. He stated "I use my spirituality with my clients, not talking about higher powers and stuff, but with the hope and the encouragement I hope to impart. It gives me hope and spiritual reassurance when I can do that." Participant one noted that there was not a definition of spirituality for him, but he also described spirituality on a functional level. He said, "I just try to be as conscientious of me being the best person I can be, which I fall short of doing every day, but being thankful and praying for others ... sending out positive energy and attending church."

Theme 3: Self-Empowerment

Subtheme: Medication Use Dictated by Spirituality

Self-empowerment through using spirituality was a theme that was prevalent throughout the interviews. Many of the participants believed that using spirituality gave them feelings of trust and closeness to their higher power to guide them on their journey living with HIV and coping with stigma. Participant ten stated, "Using my spiritualism allowed me to feel empowered with innate abilities to take care of myself during the hard times." Participant seven agreed with Participant ten's experience in that he believed that "When it comes to coping with HIV stigma, my spirituality empowers me to understand who I am, to stay positive, and focused." Participant six described an experience that led to self-empowerment. He stated,

I went to [a major church in the area] with all these queens, who were supposed to be straight. Well, back in those days you didn't say anything about it to anyone because of the stigma. One day the bishop decided to give an AIDS speech on Adam and Eve and not Adam and Steve. I was like, "Girl, you don't want to go there." He said "If there are any people in here that have issues who don't want to hear, you can leave." I was on the usher board and the choir. I slid myself out of the seat. Dropped the usher gloves on the ground and walked down the aisle and never went back. I stood up for myself and others who didn't feel they could stand up.

Some of the participants also connected self-empowerment experiences through spirituality when faced with stigma and general issues. Participant three stated,

... the only thing I can say is that whatever stigma people have about my HIV is their business. My relationship with my God and spirituality helps me have that point of view. Even when faced with general life issues such as struggling with housing, my mental health, and other health issues, I turn to my spirituality to keep me going. It empowers me to reconnect with myself to understand that I'm loved, and I am worthy.

Medication use dictated by spirituality. Many of the participants explained that they let their grounding in spirituality dictate when to take what medications. Participant five shared,

When my doctor wanted me to take meds, I told her how I took meds over the past 30 years, which is to listen to the spiritual connection in my body. And if a certain medication didn't feel right with me, spirituality, I wouldn't take it. And AZT was one of those medications that I would not take. I had a lot of guilt by not taking it back then when it first came out. It was so many people getting sick and dying, and they were talking how toxic it was, but pressing us to take it. But, spiritually, something told me not to take it.

Participant two added,

I wasn't on medicine and some doctors would get mad at me and say, "We understand your spirituality, but we want you on meds" and I would say "No, not yet." I think spirituality and faith and believing and trusting in the spirit helped me make that decision.

Participant six described an experience that he felt led him to people in his life that helped him decide to begin medication treatment, which he attributes to his spirituality. He said,

My doctor thought I was having some problems with my heart at one time and I went in and it turned out to be about a three-week stay in the hospital. I was set to be released one day and they wanted to run a diabetes check on me which called for them checking my limbs and feet with a tiny pin. Well, that turned into a mess because my legs had swollen after that and I developed something called “Red man’s syndrome.” Well, anyway, this doctor came in and it was a host of medical students and residents in the room, she ordered them to leave. She said, “I know you have HIV and I know you aren’t taking medications, but your Black ass is going to start taking medications, aren’t you?” So, I started taking medications 5 years ago after living with HIV over 30 years. I believe my faith in God and spirituality brought that doctor to me. I will never forget, love her dearly.

Participant seven shared,

I started taking medications when I was first diagnosed. Medications have improved from the first round of meds that were out before. But, I listened to that inside voice, maybe that was spirituality, but I heard that voice tell me to get on meds.

Participant nine added,

Medications were killing of people, specifically, black folks, so I did not take them, and I was severely sick at times. But, something spiritually told me to hold off until medications were helping and not harming. That’s what I did. My doctors kept pushing me to take meds because it was a huge push for treatment as prevention movement, but spiritually, I wasn’t ready to do so.

Participant seven reported how spirituality led him to stop taking medication that he believed was “killing” him. He said,

I think that my spirituality saved me. I was on a combination of medications that were making me increasingly ill, and I was wasting away because of the heavy side effects. It was killing me. I prayed and prayed and sought spiritual guidance from elders in my community, and I went off meds. It was scary but by that time they had come out with Atripla, a pill to take once a day. I started taking it, and my life got so much better. So, my spirituality really helped me in making that decision. It saved my life.

Discussion

Individuals who are 50 years of age and older in the USA make up almost 50% of the HIV population (CDC, 2015). With challenges and changes

of maintaining a social support network, managing stigma and health comorbidities, mental health, and self-medicating, it is essential for social service providers to understand how older BMSM use spirituality as a coping resource. Research in earlier years of HIV and spirituality have not kept pace with the growth of the unique experiences of older BMSM living with HIV (Brennan, 2008; Doolittle, Justice, & Fiellin, 2016; Haile et al., 2011; Hampton, Halkitis, Perez-Figueroa, & Kupprat, 2013; Porter et al., 2017).

Participants reported moving closer to the use of spirituality in the time of need to cope with HIV stigma, standing out from the known literature. Current literature supports the use of spirituality as a coping resource for older BMSM living with HIV (Brown, 2016; Doolittle et al., 2016; Haile et al., 2011; Himelhoch & Njie-Carr, 2016; Lutz, Kremer, & Ironson, 2011; Szaflarski, 2013). However, no known literature or research supports this finding. When participants were faced with difficult and challenging times, they accessed their spirituality through practices of spirituality (e.g., prayer, meditation, giving back to loved ones, and the utilization of their professional work).

The findings raise essential interest in conceptualizing spirituality since it is an ongoing process for different groups and populations. The findings from this study enriched the conceptualization of spirituality for this group. The participants defined spirituality as a personal choice with the representation of a higher power and as a functional process. While part of the participants’ definition of spirituality confirms what is presented in current and past literature (Canda, 2013; Gomi, Starnino, & Canda, 2014; Skalla & McCoy, 2006; Starnino, 2016), they highlight the importance of the functionality of spirituality in the lives of the participants. The emphasis on occurrences of using spirituality through their professional work to help connect with a personal higher power. Most of the participants shared that their definition of spirituality helped develop a deeper connection with self. A deepened sense of connection to self is seen in the journey of experiences with coping with stigma and finding a way to continue to feel connected to spirituality. This reinforces Emlet et al.’s (2017) finding of the importance of having a connection

with spirituality and self. Most of the participants identified spirituality as separate from religion. As described in a study of 30 older adults living with HIV on the role of religion and spirituality on aging well, differentiating spirituality from religion was a prominent theme (Emlet et al., 2017).

Feeling empowered by spirituality allowed the participants to advocate and be kind to themselves, handle challenging situations with psychosocial issues such as housing, mental health, and employment issues. In instances of strife, especially with stigma, participants could empower themselves through their spiritualism. Antiretroviral medications are part of the equation of allowing individuals to live longer with HIV. In the formative years of the disease, medications had adverse side effects (De Cock, Jaffe, & Curran, 2012). Many of the participants reported that spirituality led them in making decisions to begin medication at the time of diagnosis and throughout the years living with the disease. Participants explained experiences of how spirituality helped shape the decisions to take medications, change medications that were harmful, and maintain treatment adherence.

The MST helped frame how older BMSM living with HIV cope with HIV stigma experiences, stress reactions, and stigma mechanisms. Stigma directed toward sexual minorities is a foundational tenet of MST. When sexual minorities are introduced to stigma experiences, researchers have found that adverse health outcomes such as diminished quality of life, mental health issues, and physical health issues persist (Cramer, Burks, Plöderl, & Durgampudi, 2017; Meyer, 2003). Participants of this study explored their experiences of stigma, prejudice, and discrimination and how those experiences impacted their lived experiences with HIV stigma and use of spirituality. The tenets of MST that focus on the racial and sexual minority processes of prejudice and stigma validates the information gleaned from the participants.

Strengths and Limitations of the Study

Although this study is unique in that it is the first study exploring experiences of HIV stigma on the use of spirituality of BMSM, and successfully recruited these men, there are limitations to

this study. First, there was a limitation with the representative sample size and of the geographical location. The experiences of stigma, spirituality, and living with HIV may be different in other geographical regions or agencies. Participants were recruited from one AIDS service organization in a large, Eastern metropolitan area for this study; thus, making generalizability to other BMSM living with HIV and aged 50 and older limited to the participants of this study. It is possible that older BMSM living with HIV who are not associated with an AIDS service organization may be more isolated and report experiences of HIV stigma and spirituality differently. Transferability could be significantly increased with other research with access to larger geographic locations.

Another limitation is the unstructured nature of phenomenology. Risk of introducing bias always exist. The researchers' ability to bracket bias is one way to help mitigate this limitation. The likelihood was always present of showcasing one participant over another or overstating the experiences of an articulate participant. Lastly, there was a lack of inter-rater reliability in this study. Although there were other means of trustworthiness and credibility, the sole author transcribed and coded the interviews for this study. Despite these limitations, this study contributes important and useful information into social work practitioners' understanding of HIV stigma and the use of spirituality for older BMSM living with HIV.

Implications for Social Work Practice and Education

Several implications for social work education, practice, and policy are offered to continue the dialog about the HIV stigma on the use of spirituality for older BMSM living with HIV. Social workers should use informed culturally appropriate instruments and assessments when practicing with older BMSM living with HIV that explores stigma and spiritual experiences with clients. Identifying the role of stigma and spirituality for the client will be significant in ascertaining unique past and present experiences that inform coping with the adverse reactions of stigma. The

proximal stress process of MST can be applied to social work practitioners developing cultural competent care practices (Meyer, 2003). Information gleaned from this study will allow social work practitioners to develop targeted practices that would attempt to address the issues of sexual orientation, internalized stigma/homophobia, and rejection sensitivity (Alessi, 2014) as it relates to race, age, and HIV status. Social work practitioners must increase their understanding of the relevant application of spirituality and stigma-reducing methods. An essential need exists for the emergence of an interprofessional relationship among members of faith communities to help develop culturally sensitive practices that target stigma.

Continuing education is essential for social workers to access on the topic of HIV/AIDS and stigma with older BMSM. Learning and maintaining cultural competencies when working with this particular population, may serve to be helpful in practice (Emlet et al., 2017). Understanding the unique experiences of the participants of this study may help develop curriculum for social work educators to prepare social work student development by working with this population. With more training, education, and seminars on stigma and HIV, there may be a reduction of stigma perpetuated by social work professionals.

Conclusion

The purpose of this study was to gain insight into the experiences of older BMSM living with HIV concerning HIV stigma on the use of spirituality. The data focused on the participants' lived experiences. Although the USA is the leading country in advancing HIV treatment and prevention (HAHSTA, 2016), no studies have been conducted on HIV stigma on the use of spirituality. The current study was developed to explore the gap of knowledge in the literature of the missing information of the lived experiences of older BMSM living with HIV as it pertains to HIV stigma and their use of spirituality. In preparation for a population of individuals living longer lives with HIV, it is essential to have qualitative research that informs education, practice, and policy towards older BMSM living with HIV. Thus, the inclusion of

experiences of HIV stigma on coping mechanisms like spirituality is critical to improving public health. Older BMSM living with HIV face unique challenges such as ongoing issues with various forms of stigma, difficulties with aging, disclosure, health and mental health, race, loneliness, and isolation. The current study has added to the discussion of HIV stigma and the use of spirituality. Although the participants and their experiences are not representative of all aging BMSM living with HIV, the information ascertained from this study has critical implications for social work, social service research, and other helping professionals who have an interest in understanding the effects of HIV stigma on the use of spirituality.

Current research does not include a focus on the experiences of this population. Therefore, this study is an initial investigation and offers a research process for accessing the unique lived experiences of older BMSM living with HIV. With the delimitation of the geographical location, it would be essential to engage in qualitative research that captures the experiences in various geographical locations to help shed light on the phenomenon of HIV stigma on the use of spirituality of older BMSM. The experiences described in this study represent ten men from an area that has a robust list of HIV services and a positive experience with HIV. Gaining a more in-depth understanding of the experiences of potential participants in other locations is critical.

Previous researchers have suggested that HIV stigma may have negative impacts on the lives of people living with HIV (Porter et al., 2017; Rueda, Law, & Rourke, 2014; Slater et al., 2013). However, in this study, the participants added that their experiences with HIV stigma moved them closer to their spirituality by accessing ways to cope and feeling empowered. Additionally, it allowed them to feel empowered and assured enough to choose when medication was appropriate for them to use, which from their perspectives, allowed them to live longer with HIV. Future studies could intentionally explore these findings.

Acknowledgment

The author wishes to express his gratitude to the participants for sharing their experiences.

Disclosure statement

No potential conflict of interest was reported by the author.

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