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Understanding Stigma and Suicidality among Gay Men Living with HIV: A Photovoice Project

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Abstract

Gay men living with HIV (GMHIV) are at relatively high risk for suicide. To inform tailored suicide prevention interventions, we conducted a photovoice study with 22 GMHIV with a history of suicidality. Our study findings revealed three discrete but connected themes characterizing suicidality among GMHIV: first, HIV stigma featured prominently in participants' narratives who described accumulating experiences of prejudice that triggered their hopelessness. Second, many participants perceived their HIV as a personal failure and felt shamed and blamed, heightening men's suicidality. Third, to avoid disgrace, men withdrew from social interactions, resulting in isolation. However, the subsequent dearth of social interaction weighed heavily, as men admitted longing for social, sexual and romantic connections. All themes contributed in complex ways to participants' experiences of suicidality. The findings affirm the need for tailored suicide prevention efforts focused on promoting social connectedness and public health efforts to de-stigmatize HIV and mental illness.

Keywords: Suicide, HIV/AIDS, HIV stigma, MSM, Gay and bisexual men

Introduction

In the era of effective HIV treatment, more than half of the deaths among HIV positive individuals are attributable to non-AIDS related causes, including chronic diseases, cancers and accidental drug overdose(Cheung et al., 2016). High rates of suicide have also been described among people living with HIV since the onset of the HIV epidemic (Catalan et al., 2011; Do et al., 2014; Gurm et al., 2015). While suicide rates among this population have decreased alongside a corresponding increase in the availability of effective HIV treatments during the last three decades, suicide rates remain about three times higher among people living with HIV than among the general population(Gurm et al., 2015; Ruffieux et al., 2019).

In high-income countries such as Australia, Canada, the UK and the USA, between 30% and 70% of individuals living with HIV are gay, bisexual and other men who have sex with men (Brown et al., 2018; McGregor, McManus, & Gray, 2016; Public Health Agency of Canada, 2018; Sullivan et al., 2021). Gay men irrespective of their HIV status, are at increased risk of suicide compared to the heterosexual male population due to historical and ongoing discrimination rooted in heteronormative expectations (Ferlatte, Dulai, Hottes, Trussler, & Marchand, 2015); two systematic reviews concluded that gay and bisexual men are four times more likely than heterosexual men to attempt suicide in their lifetime (Hottes, Bogaert, Rhodes, Brennan, & Gesink, 2016; King et al., 2008). A recent investigation of suicide risk within a large population of gay and bisexual men reported that 5% of gay men living with HIV (GMHIV) attempted suicide in the last 12 months, a rate 1.5 times higher than among HIV negative gay men (Ferlatte, Salway, Oliffe, & Trussler, 2017) and over 12 times the rate reported among the general male population (Public Health Agency of Canada, 2020).

Early on in the epidemic suicidality (i.e., plans, intent, thoughts about suicide and attempts) and among people living with HIV was understood as stemming from the poor prognosis of AIDS before effective antiretrovirals were introduced in the late 1990s (McManus et al., 2014). However, given that effective HIV treatment has now greatly improved the life expectancy GMHIV (Montaner et al., 2014), an alternative hypothesis about relatively high suicidality has emerged which focuses on the challenging social conditions that GMHIV endure including experiences of stigma, discrimination, disclosure concerns and social exclusion – all of which further aggravates the marginalizing conditions associated with minority sexuality and HIV status (Rendina et al., 2017; Smit et al., 2012). This hypothesis is supported by emerging theoretical models including minority stress (Hatzenbuehler, 2009; Meyer, 2003), syndemic theory (Ferlatte et al., 2015; Stall, Friedman, & Catania, 2009) and stigma (Herek, 2007; Herek, Chopp, & Strohl, 2007) that consistently point to fundamental psycho-social factors as causal mechanisms for inequities and heightened suicide risk among gay men.

Stigma has been defined as a social process in which a particular characteristic, real or perceived, is linked to a discredited social identity (Deacon, 2006; Link & Phelan, 2001). The function of stigma is that it serves to reinforce social norms by defining deviance (Taylor, 2001). Power relationships are central to stigma and stigmatization constitutes an exercise of power over people, a means to a social control ends by marginalizing and excluding a group based on characteristics that are deemed undesirable (Gilmore & Somerville, 1994; Sontag, 1991). In the context of the HIV epidemic, HIV stigma has complex origins in the fears that people have about epidemics in general, the links between HIV to sexual and injecting drug use taboos, as well as death, and the ways in which AIDS was originally sensationalized in the media as a "*gay plague*" (Hedge, Devan, Catalan, Cheshire, & Ridge, 2021). The impacts have been profound and ongoing, in terms of internalized stigma and the negative community attitudes towards people living with HIV (Mahajan et al., 2008; Parker & Aggleton, 2003). HIV stigma can be experienced in a myriad ways by people living with HIV including enacted stigma which constitutes experiences of discrimination from others, anticipated stigma which is the awareness of negative social perceptions and the expectation of discrimination from others, and internalized stigma which represents the negative emotions directed at oneself (Earnshaw & Chaudoir, 2009). In the context of GMHIV, HIV stigma has layering effects and intersections (Lekas, Siegel, & Leider, 2011; Novick, 2003), as the majority of GMHIV have been exposed to stigma and discrimination prior to their HIV status due to their sexuality, and continue to simultaneously experience homophobia and HIV stigmas. Consequently, the compounding impact of stigma and discrimination for GMHIV can be especially devastating.

Researchers have indicated that the level of stigma connected with HIV has decreased considerably since the beginning of the HIV epidemic (Adrien, Beaulieu, Leaune, Perron, & Dassa, 2013; Pitasi et al., 2018); yet stigmatizing attitudes and behaviors towards GMHIV continue, including from HIV negative gay men (Burnham et al., 2016; Ferlatte et al., 2017; Rendina et al., 2017; Skinta, Fekete, & Williams, 2019). GMHIV might be particularly affected by HIV stigma because they are often seen as personally responsible for acquiring HIV due to engaging in what is constructed as risky sexual behaviors that many members of society consider socially unacceptable (Herek & Capitanio, 1999; Watts & O'Byrne, 2019). HIV stigma is associated with an array of negative health outcomes and mental health challenges (Chambers et al., 2015; Logie & Gadalla, 2009; Mak, Poon, Pun, & Cheung, 2007; Rueda et al., 2016) and has also been linked with suicidal ideation and attempts in several epidemiological studies (Capron, Gonzalez, Parent, Zvolensky, & Schmidt, 2012; Carrico, 2010; Ferlatte et al., 2017; Zeng et al., 2018). For example, a recent study of suicide among GMHIV in Canada found that recent suicide attempts were associated with multiple forms of HIV stigma such as rejection by sexual partners, social exclusion, verbal abuse and physical abuse (Ferlatte et al., 2017). Furthermore, this investigation found that men experiencing multiple forms of HIV stigma were at increased risk of suicidal ideation and suicide attempts (Ferlatte et al., 2017).

While these results are important, no study has explored in detail the complex interconnections between stigma and suicidality among GMHIV, including how HIV stigma is embodied by GMHIV to increase their risk of suicidality. The aim of the current study is to distill how stigma features in the experiences of suicidality among GMHIV in addressing the research question: *What are the connections between stigma, HIV and suicidality among GMHIV?*

Methodology

This study combines photovoice – a research method in which participants take and then narrate photographs to share their experiences and perspectives (Wang & Burris, 1997) - with a grounded theory methodology (Charmaz, 2014). Photovoice was selected because it can enhance the accessibility and facilitate the sharing of perspectives in ways that do not rely solely on words, and that shift authority and power from the researchers to participants, including by beginning the conversation with participants photographing what they believe is most important about their experiences (Catalani & Minkler, 2010; Ferlatte & Oliffe, 2019; Oliffe & Bottorff, 2007). The process of taking photographs can be empowering and transformative (Liebenberg, 2018; Wang & Burris, 1997). Participants can gain critical insights about their experiences by taking photographs (Han & Oliffe, 2016; Sitvast, Abma, & Widdershoven Guy, 2010) and can share their stories in a way that brings a sense of safety (Ferlatte & Oliffe, 2019). By coupling photovoice with grounded theory, we address the aforementioned research question and describe the social processes through which stigma connects to HIV and suicidality among GMHIV. The inductively derived research question was informed by the consistent referencing amongst participants to the marginalizing effects of stigma in their lives, and our interest to better understand the factors that underpin men's experiences.

Recruitment and samples

Following ethics approval from the Behavioral Research Ethics Board of the University of British Columbia (#H13-02592), we worked with community-based organizations to disseminate information about the study through flyers, newsletters, and posters. Online advertisements were also shared on Facebook and Twitter by community partners. Potential participants were invited to contact the project coordinator by email or telephone and were screened for eligibility. Men were eligible if they met the following criteria: 1) self-identified as gay, 2) living with HIV; 3) spoke English; 4) resided in the Canadian province of British Columbia, 5) had experienced suicide ideation since their HIV diagnosis; and 6) were not currently suicidal. Men who disclosed current suicidality were excluded and referred to one of the partner agencies where they were provided with free professional counselling and appropriate referrals.

A total of 22 gay men participated in the study. The mean age of the participants was 50-years-old (ranging from 24 to 71 years-old). The majority of the participants identified as White (n=15), and 7 identified as an ethnic minority (Indigenous n=1, Latino n=2, mixed-ethnicity n=4). Regarding educational attainment and employment, 15 had a university or college degree and 7 were employed at the time of the study. On average, participants had been living with a diagnosis of HIV for 15 years (ranging from 1 to 38 years). All participants had a history of suicide ideation since their HIV diagnosis as per the study inclusion criteria. Fifteen had a history of making a suicide plan, eight had attempted suicide prior to their HIV diagnosis, and nine had attempted suicide after their HIV diagnosis.

Procedures

Participation in the study included two stages. First, eligible participants were invited to meet with the project manager wherein information about the study and photovoice assignment was provided. If participants agreed to participate in the study, they signed a consent form and completed a short demographic questionnaire. Then participants were offered a new digital camera (which they kept as honorarium) or a $100 CAD honorarium if they opted to use their own camera (the value of the digital camera). The participants were invited to take photographs and write accompanying captions to illustrate their experiences with suicidality including the cause of their suicidality, their experiences with seeking help and their perspectives about suicide prevention for GMHIV. Participants were informed that there were no wrong pictures or wrong ways of taking their photographs. However, they were instructed to not take photographs of others without their written consent and to not take photographs of illegal activities or images that were sexually explicit. Participants took photographs over a 2-week period, and were provided with a list of mental health resources they could access if they experienced distress during or after their participation.

When the photovoice assignment was completed, participants were invited to contact the project manager to schedule an interview. Interviews were guided by photo-elicitation techniques (Oliffe & Bottorff, 2007) and initiated by participants describing their photographs and the meaning(s) behind the images. Next, a semi-structure interview guide was used to inquire about the participants' experiences with suicidality, including causes, triggers and contributing factors. Participants received a second honorarium of $100 CAD after the interview. The interviews were digitally recorded, transcribed verbatim, anonymized, and checked for accuracy.

Data Analysis

NVivo 11qualitative software was used to manage and organize the anonymized transcripts. The photographs were not subject to a separate or semiotics analysis. Rather, the photographs were inserted to the transcribed interviews alongside the corresponding narratives to be coded and analyzed with the text (Oliffe, Bottorff, Kelly, & Halpin, 2008). We used a constant comparison approach to code and interpret the data which entailed comparing emerging concepts to prior ones (Corbin & Strauss, 2012). During initial coding, each interview was read closely, and codes were assigned to all content that appeared relevant to the research question. After an initial read of each interview, analytic and reflexive memos were drafted to summarize the interview and data wherein data were open coded and assigned to preliminary categories. Comparing data from each interview, we proceeded with second-level coding focused on making propositions about connections between open codes and reassembling them into 'tentative themes' to form a more precise and complete explanation of the connections between stigma, HIV and suicidality (Corbin & Strauss, 2012). Both during and after coding, memos were written to describe emergent findings, highlight contextual relevance, and inform subsequent phases of data analysis. The interview transcripts were read and re-read to ensure that the analysis remained closed to the data, and tentative theoretical categories were developed. Through ongoing memo-writing, maintaining a focus on actions and processes within the application of constant comparison, analytic possibilities were checked, explored, and refined. The 'tentative themes' were discussed by the research team to drive consensus for the interpretation of social processes, patterns and explanations for the variations on those themes. This process resulted in three themes explicating the relationship between stigma, HIV and suicidality.

Positionality statement

The authors are an interdisciplinary diverse research team – representing public health, nursing, counselling and social sciences - invested in advancing health equity for populations living in marginalizing conditions including gay men and other sexual minorities, and people living with HIV. All the authors are White. Four identify as gay/lesbian and two as straight. All authors have a long history of allyship with the gay community and people living with HIV. Two were formerly involved in HIV activism. We recognize that GMHIV continue to experience discrimination and stigma associated with sexuality and HIV, and which may also increase intersectionally, e.g., as experienced by those who are also racially minoritized. We also recognize that HIV stigma is a major cause of - and response to - health inequities among GMHIV. We also acknowledge that, despite any legacy of the HIV epidemic (including stigma), the nature of HIV is changing. GMHIV now have a similar life expectancy as anyone else, and with Undetectable= Untransmissible, now more than ever, stigma belongs in the past. So, we celebrate the resilience of GMHIV, as evidenced in the strength and courage of study participants who took photographs to discuss their suicidality: A topic too that is still unhelpfully shrouded in taboos and stigma.

Results

Our findings are broadly organized into three discreet but interdependent themes: (1) accumulating experiences of prejudice, (2) feeling shamed and blamed, and (3) avoiding disgrace and longing for connection. Together, these themes highlight the role of stigma in shaping the experiences of - and connections between - HIV and suicidality among GMHIV. In the following section, we detail each theme, providing evidence in the form of participant produced photographs and narratives. To protect the confidentiality of the participants, pseudonyms were assigned by the research team.

Accumulating experiences of prejudice

Experiences of stigma featured predominantly in the photographs and narratives of the participants, with descriptions of accumulating experiences of prejudice including the effects of violence, harassment and rejection rendering them hopeless and contributing to suicidal thoughts. Illustrating the connections between stigma, HIV and suicidality, Jordon (52-years-old) narrated a photograph of a dumpster (Figure 1) titled, *Garbage*:

Figure 1: Garbage

> "*Sometimes when you're feeling low, you feel like garbage. You know, HIV, it's just ... how do I say it? People look at you like you're nothing, like you are a dumpster. Like you just throw them away and they're just forgotten; nobody cares.*"

The reference to garbage in Jordon's picture references feelings of worthlessness and brokenness that many other participants also described experiencing due to their HIV infection. These feelings stemmed from the ubiquity of stigmatizing social messages towards HIV positive individuals that many participants described as dehumanizing. They detailed the many ways that society generally, including societal structures such as health care and media bombarded them with reminders that they did not fit in, or were lesser because of their HIV status. However, instances of stigma that were personally directed towards participants were described as the most upsetting and damaging to their mental health. Clement (44-years-old) explained: "*There's still a lot of judgment and criticism from people who are HIV negative. I've had people literally run away from me screaming, 'stay the hell away from me.'*"

Irwin (70-years-old) who had been living with HIV for over three decades described the myriad instances of HIV stigma he experienced with family, friends and individuals in his community. During his interview he recounted a memory from an Alcoholics Anonymous meeting which he had attended:

> "*I'm at an AA meeting, and if you've ever gone to an AA meeting, at the end of the meeting, everyone forms a circle, and hold hands. But, they got one guy, he looks down at my hands, and he won't hold my hand, and then he moves down so he doesn't have to.*"

Evident in Irwin's narrative was the prejudice he experienced and his unmet need for support and camaraderie which was particularly damaging in the context of an ostensibly peer led intervention. As also described by many other participants, Irwin was marginalized by individuals from whom he specifically sought understanding, compassion and acceptance. The refusal to be touched layered his experiences of stigma entailing a particularly strong feeling of being unworthy and contaminated. Irwin described being othered, as he found himself outside the circle, both literally and symbolically, imbuing stigma that weighed heavily on him.

Participants described how experiencing enacted stigma from HIV negative gay men could be triggering for feelings of hopelessness and suicidality, particularly in the context where many men expected members of the gay community to be more understanding. Several participants lamented stigmatizing attitudes from some HIV negative gay men and described how experiencing a lack of support from their gay peers was especially painful. For example, Bram's (36-years-old) experience was of general disappointment in his community: "*I think that there is a lack of a sisterhood in the gay world*". He went on to conclude that his HIV status led to him being excluded and treated differently by other gay men: "*I've related to The Scarlet Letter very much*", referencing the themes of shame and social stigmatizing central to the 1850 novel by American author Nathaniel Hawthorne. Bram highlighted the public humiliation and private shame that he harbored in being outcast by a community to which he previously felt more aligned, and from which he previously derived a sense of belonging.

Similarly, Val (43-years-old) shared a photograph of a dead bird he titled "Fallen" to share his experiences of stigma and how his social status within the gay community was negatively impacted after he was diagnosed with HIV:

> "*The picture is grotesque, but it made me, the idea of Fallen is just… becoming HIV positive. I can't explain it. You're definitely looked upon differently, not that I had such great stature or anything before, but automatically, you're demoted if you will, to a lower caste of gay people."*

Figure 2: Fallen

Evident in Bram, Val and other participants' narratives was their diminished social standing, and the hierarchies within gay communities wherein marginalizing forces were both unexpected and deeply wounding. Given the discrimination and stigma gay men are subject to due to non-adherence to heteronormative hegemonies, the fact that discrimination was directed from within the gay community was particularly damaging. Many participants indicated that the perpetrators of their injuries knew the hurt they were inflicting, because they had likely experienced stigmas linked to their sexual minority status. The combination of thwarted belongingness and the weight of the stigmas inflicted by gay who themselves knew that pain profoundly impaired participant's self-worth and heightened their suicide risk.

Some participants talked about gay geospatial dating apps and sex-seeking websites, which have increased in popularity in recent years, replacing bars and bathhouses as a way to meet, socialize, and find dates for many gay men. Several men expressed a degree of frustration about the ubiquity of stigmatizing messages from other men on these platforms. For example, Trevor (70-years-old) described:

> "*If you've ever gone on some of the meeting services for gay men, some of them are fairly hurtful with the stigmatization delivered, I think, from fear. The standard, "I'm HIV negative, you be, too?" "Only interested in healthy guys. No STI's." Stuff like that.*"

The effects of these virtual microaggressions were evident in the participant's accounts wherein they weathered accumulative effects of discrimination, which could lead to compounded despair and hopelessness. Indeed, the pain of being rejected, particularly by other gay men, was described by many participants as heightening their suicidality. When asked why gay men living with HIV are more likely to attempt suicide, Dane (56-years old) offered the following answer:

> *"I think it is because our community rejects this. You think you're going to be welcomed and you're not. My experience with HIV was rejection from the gay community I wanted to be part of and participate in. Even my offers of friendship outside of sex rejected. I don't trust gay men, and it makes me depressed."*

The relationship between stigma from other gay men and the mental health challenges was particularly evident in Micah's (24-years-old) description of his experience trying to forge intimate partnerships:

> "*There were probably a few times where I told someone about my status and they rejected or rebuffed me, it was raw hell. It was probably one of the most wretched sensations that I ever experienced, because rejection is a very uncomfortable sensation for human beings. And it is certainly, undoubtedly amplified by the knowledge that my rejection has nothing to do with who I am as a person, or how I conduct myself, but something that I have no control over at this current point*."

In summary, participants affirmed the centrality of stigma in their HIV status and the role of cumulative prejudices on heightened suicidality. What weighed heavily on the participants was the cumulative effects of all those instances where they were rejected and made to feel less than and contaminated because of their HIV status. Particularly upsetting to participants and key to their suicidality narratives were stigmas flowing from other gay men, a community where they expected safety and belonging, and a greater sense of acceptance and understanding.

Feeling blamed and shamed

Feeling blamed and shamed were harbored and often concealed by many participants. Participants felt an omnipresence of stigma from which flowed feelings of being judged and blamed by others for bringing HIV on themselves. Several participants described how their positive HIV status reflected negatively on their personal character and practices. Rocky (51-years-old) suggested that: "*some people like to refer to someone HIV positive as being dirty. I felt like that before*."

Feeling blamed and shamed was especially heightened in the first few months and years post-diagnosis. The word "*dirty*", which was strongly illustrated by the earlier picture of garbage, appeared repeatedly in the participants' narratives for how they initially felt when they were first confronted by the news of their HIV diagnosis and speaks to the embodiment of a stigmatizing conditions. For example, Micah (24-years-old) who had lived with HIV for a year at the time of the interview described this feeling as follows:

> "*When I first had the diagnosis, I expected my blood and my ejaculate to be like black, pitch black or something. Or viscous, or kind of acrid or something. Because I almost wanted to have the confirmation of my sullied-ness.*"

Micha's retrospection detailed how he embodied his HIV status wherein there were interactions between the cause of his infection, and his potential to transmit it to future sexual partners, both deeply shaming for past acts and the need to police his sexual activities in the future.

The connections between shame and suicidality were also evident as Brice (48-years-old) narrated figure 2, entitled *Looking Down*, which depicted his downward gaze as symbolic of the shame he felt, and the grim outlook he embodied:

> *"I called this photo "looking down" because that's how I felt when I was first diagnosed. A lot of depression. All the time, my mind was blind, blank, depression, lots of depression. So no energy, always like this. Not my head up. I was ashamed with lots of confusion and a little bit of anger and helplessness, feeling helpless".*

Figure 3: Looking down

Central to the feeling of shame expressed by Brice and many other participants was how they specifically internalized stigma. Indeed, several participants described how they themselves held negative views of HIV positive individuals before they learned they were HIV positive themselves. Such retrospectives intensified participant's shame as they grappled with their reality of living with the infection – a condition they had previously considered unfavorably. Bram (36-years-old) lamented: "*HIV did actually make me feel this way, worthless.*"

Participants' worthlessness centered around two intricately connected elements which effectively reinforced their feelings of worthlessness. First, worthlessness was linked to a feeling of severance from society as a whole, wherein HIV was viewed as a marker signifying failure. As Micah (24-years-old) put it, the feeling that, "*you're kind of now a little separated from the normal group of society*" as someone living with HIV. Second, was the participants' belief that living with HIV meant they would no longer fit within the gay community, leading to a loss of love and connection. This belief was described by Loyd (53-years-old) who shared a photo (figure 4) with two prohibition signs he titled "No life, no love and no hope" which he narrated as follow:

> *"I felt I was now tarnished. So I would not be accepted back into the gay community. And, I was damaged goods. There's still a stigma that goes with HIV and AIDS. And I thought my standing in the community will change. My attractiveness to others is going to change. So, no love, no life, no hope."*

Figure 4: No love, no life, no hope

Some participant bought into the historically constructed ‘guilty versus innocent victims’ dichotomy in lamenting their HIV status as entirely their own doing. Loyd (53-years-old) described:

> “*Becoming sick was my fault. I'm not an IV drug user. But it must have been through sex. It was not through a blood transfusion or any of the other ways that I could've gotten it, so it had to have been unsafe sex*.”

Evident in these descriptions were sentiments of an overall lack of self-compassion for GMHIV, and that participants often blamed themselves, and concurrently felt blamed for their HIV status. Indeed, several participants discussed in their interviews how they felt shame for shirking protection, amid contrasting societal constructions of illness as self-inflicted (guilty) vs. imposed (innocent). This was evident in Bram’s (36-years-old) discussion of HIV and cancer:

> “C*ancer's seen as something like, ‘Oh my God, you poor thing.’ Like, we have to come and help you, whereas HIV was never like that, and it's like, ’Why?" Because why? Because you're a slut,’ or something.”*

The connections between shame and mental health difficulties were also articulated by Dane (56- years-old):

> "*The reality is that we are discriminated, and we are thought a little bit less of and maybe it is why I'm depressed but I am also embarrassed as well. It was totally behavioral choice that I could have avoided.*"

The connections between shame and suicidality were also evident in Dane's description of his history of suicide ideation. While Dane struggle with suicide ideation started prior to his HIV diagnosis, he described how his suicidality intensified after his HIV diagnosis due to his feelings of shame and being blamed:

> "*I always had thoughts of suicide. But it wasn't until I was diagnosed that I thought of ways to do it. After that, I felt like damaged goods, unworthy and unsellable, unmarketable, unpalatable. Fuck it, I should kill myself. How do you recover from HIV? It leads to death. It doesn't lead to a better future. It's like assisted suicide, make the end quicker before you're unattractive or more unattractive. And the rejection was relentless.*"

Taken together, participants feeling shamed and blamed revealed dynamic processes in which the cause and effect of sexual practices for contracting HIV were interwoven with society's assignment of men's culpability. Combined, these forces heightened men's suicidality risk. Shame was especially difficult to talk about, and perhaps impossible to reconcile for some participants. Blame and the ruminating of social stigmas for how participants contracted HIV also reverberated, deepening men's burdensomeness and suicidality.

Avoiding disgrace and longing for connection

Many men discussed their efforts for avoiding disgrace, suggesting solitude and self-isolating were common practices for coping with living with HIV. Many participants coped by distancing themselves from gay communities and lived solitary lives to avoid the societal stigmas accompanying their HIV status. Forest (46-years-old) described his photograph titled shutting myself (figure 4) to highlight his bedroom window blinds being drawn:

> *"So the blinds are shut and the bedroom door closed to shut myself from the world. I don't want to deal with anyone. It's a way to feel secure. Just to shut yourself off from the whole world, you don't want to talk or share how you're feeling. You don't want to talk to no one."*

Figure 5: Shutting myself

Herein Forest's self-concealment rendered him hidden from the societal stigmas and disgrace he endured for his HIV status, but via isolation he aggravated ruminating thoughts, which contributed to his suicidality. In this retrospective view he also suggested he was closed, but still hopeful, for some form of life saving connection.

Similarly, Roger (71-years-old) said: "*I'd rather just be alone and lonely than ... I just struggle with friendships right now because of being HIV positive.*" Evident in Roger and other men's narratives were cost-benefit analyses that inevitably saw participants avoid the injuries others directly inflicted; yet the desire for connection is palpable in their narratives. When it came to engaging in sexual relationships and dating there were efforts for avoiding disgrace and satiating the need to connect with others. Jonah (56-years-old) described how he kept his HIV status secret to avoid damaging his social network. Though ultimately, he felt a responsibility, in part due to the criminalization of HIV, to tell his sexual partners, "*I don't tell everybody, of course I tell any sexual partners I'm going to have. It's the hardest thing to do. And a lot of times you just say, 'Forget it. It's not worth it.'* Similarly, Val (43-years-old) described how he preferred meeting other men online and how he avoided meeting in person to shield himself against rejection:

> *"I almost never meet anyone if it's not through social media of some sort, like a cruising line of some sort, just so that I can avoid that, I guess essentially that rejection from somebody being like, 'Oh, you're positive,' like they don't want to have anything ...:"*

Experiencing rejection online was somehow less personal and personalized for some men perhaps due to the physical distancing that technology introduces; however, the ostracization for disclosing HIV status sill invoked profound isolating effects. In feeling misunderstood by others and wanting to shield themselves from harm, men often chose to avoid relationships, sexual or platonic, seeing aloneness as a lesser evil. Indeed, many men described accepting that their HIV status meant they were destined for a life of solitude. This sentiment was summated by Zac (60-years-old) as follows: *"At the end of the day, when I'm thinking about what my experiences are, I always come back to the reality that, it's a solitary life."*

While avoiding social connections may have been a successful strategy for many participants, the loneliness could be profoundly damaging. Indeed, the avoidance of social contact contributed to their suicidality. Forest (46-years-old) submitted a photograph, figure 4 titled, *Old and Unwanted*, in aligning his life to an abandoned house: "*I took a picture of this house because it's old, it's empty, and it's alone. Well, it's* *how I feel. I feel old, unwanted, and lonely. And I am HIV positive which is the reason why I am lonely."*

Figure 6: Old and unwanted

Several participants also described solitude as a widespread and significant problem among GMHIV that explains the high rate of suicide in this community. Jonah (56-years-old):

> "*I find people with HIV want to hide it, they don't want to be out there telling people about, which keeps you isolated. And isolation is not good for anybody. With enough isolation, you'd want to do something to end it. That's how I would think, anyway."*

Layering these effects, mental illness and suicidality were also marginalizing. As Jonah reflected, HIV and suicide both isolate individuals:

> *"I think suicide's one of those things that's like a hidden thing, kinda like HIV. You might think it, you might want to do it, might come close to doing it, but you don't really want people to find out."*

Evident in Jonah's narrative were the intertwining's of HIV and suicidality, both imbued with stigmas that drove many participants towards interiority and solitude as a means to avoiding the disgrace that accompanies both HIV and suicide. Amplifying, the stigmatizing effects grew, and while craving connection there was both an ease and danger in self-isolating.

In sum, while avoiding disgrace and longing for connection were awkwardly entangled, they may have served to afford some protection against stigma from others, including from HIV negative gay men. However, self-isolation increased participants risks of self-stigmas and led to profound aloneness that fueled their suicidality.

DISCUSSION

The current study findings provide much-needed discernments about the relation between HIV stigma and GMHIV's experiences of suicidality. While quantitative research has highlighted the association between experiences of HIV stigma and suicide (Capron et al., 2012; Carrico, 2010; Ferlatte et al., 2017; Zeng et al., 2018), this study by combining photovoice and grounded theory garnered inductively derived insights to factors and processes underpinning suicidality shared by GMHIV with lived experiences. It revealed stigma as a major force driving suicidality, and the findings advance understandings of this phenomenon by elaborating on how HIV stigma is intertwined with blame, shame, and social isolation to offers important insight to the processes through which stigma is embodied by GMHIV, heightening their suicide risk. Participants underscored how they weathered the accumulative experiences of prejudice, focusing closely on their experiences with HIV negative gay men, and the links to suicidality. Enacted stigma within the gay male community often played out as sexual or romantic rejection due to having HIV, which was a unifying reality experienced by those interviewed. These results echo other researchers' findings who described other gay men as an important source of stigmatization that is intensely felt by GMHIV (Berg & Ross, 2014; Courtenay-Quirk, Wolitski, Parsons, & Gómez, 2006; Smit et al., 2012).

Evident in the narratives of the participants was that their experiences of HIV stigma and the ubiquity of negative messages regarding HIV positive individuals undermined their self-esteem and self-confidence. Indeed, the findings demonstrate that HIV stigmatization influences GMHIV experiences with HIV and was the source of deep feelings of being sullied and shame. Particularly striking from the participants' descriptions is that they all had at some point internalized HIV stigma from social messaging prior to their own infection with HIV. Thus, they initially assumed a "soiled identity" characterized by shame and self-blame for their HIV infections. These feelings of being "dirty" and of indignity were particularly strong in the few years after their HIV diagnosis and were expressed as causing much emotional distress and highlighted shame as a key determinant of suicide among GMHIV. These results add to previous research reporting shame as detrimental to the mental health of people living with HIV (Bennett, Hersh, Herres, & Foster, 2016; Li et al., 2010; Rodkjaer, Laursen, Balle, & Sodemann, 2010).

What characterized shame is a desire to escape potentially exacerbating situations (Bennett, Traub, Mace, Juarascio, & O'Hayer, 2016; Van Vliet, 2009). Evident in the narratives of participants was their desire to avoid situations where they would have to disclose their HIV status and then be discriminated, rejected, marginalized and shamed. In a study of HIV stigma among GMHIV rejection as a sexual or romantic partner was the most common form of stigma experience with over half of respondents reporting having been rejected as a sexual partner in the past 12 months (Ferlatte et al., 2017). Therefore it is not surprising that rejection from sexual partners following disclosure of HIV status had been previously identified as one of the greatest concerns of GMHIV (Bourne, Dodds, Keogh, Weatherburn, & Hammond, 2009). Consistent with these findings many participants related how they lived a relatively solitary life and particularly avoided sexual and romantic situations that might invoke and amplify stigmas. While this strategy may have reduced painful experiences of rejections and discrimination, it did little to protect them emotionally as many participants were starved of company and affection and struggled with intense feelings of loneliness fueling their suicidality as a result from this self-induced withdrawal.

The present study results have implications for the design of interventions to address HIV stigma among gay and bisexual men, and society more broadly. An increasing number of HIV stigma reduction initiatives have been deployed, yet a meta-analysis revealed these interventions have only small effects in changing attitudes towards people living with HIV (Mak, Mo, Ma, & Lam, 2017). Participants' narratives however suggest that improving knowledge about HIV transmissions, HIV infectiousness, and understandings about living with HIV could help reduce the stigma they currently face. Some new opportunities for stigma reduction may be afforded by the recent scientific consensus that individuals on antiretroviral therapy can reduce viral load to an undetectable level and that transmission for HIV is not possible for individuals who have an undetectable level (Calabrese & Mayer, 2019). This consensus has been conveyed at the community level by the slogan U=U (undetectable = untransmittable)

(Eisinger, Dieffenbach, & Fauci, 2019). In a survey of GMHIV across the United States, approximately 80% reported that U=U was beneficial for their self-image and societal HIV stigma (Rendina, Talan, Cienfuegos-Szalay, Carter, & Shalhav, 2020) highlighting the potential of the U=U message to reduce both stigma and feelings of shame. Encouragingly, it appears that the majority of gay men are aware of the U=U message but more information is required as to how this impacts men's perspectives and practices (Card et al., 2021). Additionally, further empirical investigation is warranted to understand the potential of U=U messages in reducing stigma and in bettering GMHIV psychological well-being.

Beyond addressing stigma at the community level, it is also important to address structural and systemic HIV stigma. The most systemic manifestation of HIV stigma in Canada (as it is in many parts of the world) is the criminalization of HIV non-disclosure to one's sexual partner (Adam, Elliott, Corriveau, & English, 2014; Krüsi et al., 2018). While discussions of criminalization were not prominent in the participant's narratives, criminalization approaches to HIV have been associated with heightened HIV discrimination, forced disclosure of HIV status and internalized stigma (Breslow & Brewster, 2020) (and evidence suggests that they do not reduce transmission of HIV) (O'Byrne, 2012). As such, reforming such laws, especially in light of the U=U consensus, could potentially have a substantial impact on supporting safe disclosure of HIV status as well as reducing enacted experiences of HIV stigma among GMHIV.

Findings from this investigation also affirm the need for targeted prevention efforts focused on promoting social connections to reduce loneliness concurrent to efforts to redressing societal stigma. Our results, similar to others (Greene et al., 2018; Grov, Golub, Parsons, Brennan, & Karpiak, 2010), suggest that loneliness among HIV positive individuals diminishes the mental health of this population. Social supports are particularly needed among gay men living with HIV given the overrepresentation of mental health challenges among this population. A comprehensive and tailored approach incorporating screening for loneliness and suicide is necessary to reduce loneliness and improve mental health outcomes in this population. HIV/AIDS and gay men's organizations are well positioned to offer services to mitigate the loneliness experienced by GMHIV and to foster supportive communities. Emotional support via peer-led counselling and support groups that provide opportunities for social interaction have been successful in reducing loneliness and its consequences among other populations (Bessaha et al., 2020). Internet-based interventions also offers an interesting avenue for loneliness interventions as several online programs to address loneliness among stigmatized populations have shown promising results (Bessaha et al., 2020).

LIMITATIONS

Our findings are subject to several limitations. First, our combination of grounded theory and photovoice methods deliberately centered the voices, perspectives, and knowledge of the participants; yet these insights were not validated by member checking. Second, the generalizability of the findings are limited the modest sample size of English-speaking men, most of whom were living in an urban setting and White. It is particularly important to note the specificity of our sample experiencing stigma may not be representative of all gay men living with HIV. Participants described multiple mental health challenges which can introduce unique challenges, particularly when compounded with navigating a chronic illness such as HIV. From the data, it is also difficult to determine how the experiences of those who survived suicidality differ from those GMHIV who die by suicide. It is plausible that GMHIV who complete suicide present some different characteristics. Future research may need to sample individuals who make near-fatal suicide attempts to predict other risk factors and inform tailored prevention interventions for GMHIV. Individuals who make near-fatal suicide attempts are difficult to access and recruit in research (Biddle et al., 2010) and as such more work is needed to facilitate the recruitment of such individuals in qualitative studies amid ensuring participant safety and the well-being of researchers who engage these challenging topics risking vicarious trauma (Creighton et al., 2018).

CONCLUSIONS

In this article, we have described processes through which HIV stigma lead to suicidality among GMHIV. The interconnected processes accumulating prejudice, feeling blamed and shamed, and avoiding disgrace and longing connection are especially evident in the findings and explain how HIV stigma is experienced, felt, embodied and resisted to produced feelings of hopelessness and thoughts of suicide. In the context where suicide has been understudied in this population, these findings underscore the need for tailored interventions to prevent suicide with an emphasis on ending HIV related stigma and discrimination. Herein community involvement and efforts to build social connections and to foster resilience among GMHIV communities are critical.

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- Gay men living with HIV (GMHIV) are at high risk of suicide but under-researched.
- HIV stigma features prominently in GMHIV with a history of suicidality to suggest an accumulation of discriminatory experiences.
- Stigmas amplified GMHIV perceptions of their HIV as a personal failure accompanied by shame and blame and heightening hopelessness.
- To avoid HIV stigma, GMHIV may self-isolate which can, by extension, heighten their suicide risk.
- There is a need for tailored suicide prevention efforts focused on promoting social connectedness and efforts to de-stigmatize HIV.

Dear Dr. Stefan Timmermans:

Please accept the submission of our manuscript entitled, "Understanding stigma and suicidality among gay men living with HIV: A photovoice project", which we would like to have considered for publication as a Regular Article in *Social Science and Medicine – Qualitative Research in Health*.

Each person listed as an author meets criteria for authorship and has approved the submitted paper. None of the authors have any conflicts of interest to declare.

Informed consent was obtained from all study participants after a full description of the study. Ethics approval was obtained for the collection of data used in this study.

The manuscript is not being considered for publication elsewhere. It has not been published in whole or in part elsewhere.

Thank you for considering this manuscript for publication. We look forward to hearing from you following the review process.

Yours very truly,

Declaration of interests

☒ The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

☐The authors declare the following financial interests/personal relationships which may be considered as potential competing interests: