

Identity, Physical Space, and Stigma Among African American Men Living with HIV in Chicago and Seattle

Judith L. Singleton^{1,3} · Manuela Raunig² · Halley Branstetter² · Michelle Desmond² · Deepa Rao²

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Abstract African American men have the highest rates of HIV in the USA, and research has shown that stigma, mistrust of health care, and other psychosocial factors interfere with optimal engagement in care with this population. In order to further understand reducing stigma and other psychosocial issues among African American men, we conducted qualitative interviews and focus groups with African American men in two metropolitan areas in the USA: Chicago and Seattle. We examined transcripts for relationships across variables of stigma, anonymity, self-identity, and space within the context of HIV. Our analysis pointed to similarities between experiences of stigma across the two cities and illustrated the relationships between space, isolation, and preferred anonymity related to living with HIV. The men in our study often preferred that their HIV-linked identities remain invisible and anonymous, associated with perceived and created isolation from physical community spaces. This article suggests that our health care and housing institutions may influence preferences for anonymity. We make recommendations in key areas to create safer spaces for African American men living with HIV and reduce feelings of stigma and isolation.

Keywords HIV · Social stigma · African Americans · Masculinity · Focus groups · Qualitative research · Health care

✉ Deepa Rao
deeparao@uw.edu

¹ Department of Medical Social Sciences, Northwestern University, Chicago, IL, USA

² Department of Global Health, University of Washington, Box 359931, 325 9th Ave, Seattle, WA 98104, USA

³ Present address: School of Urban Public Health, Hunter College, City University of New York (CUNY), New York, NY, USA

Introduction

People with HIV sometimes choose to publicly disclose their status and use the opportunity as a strategy to overcome internalized and public stigma associated with HIV [1]. Choices of disclosure rather than anonymity are often based on acceptance of a particular identity including one's position or status within society and experiences in the public sphere that can lead to voluntary or involuntary self-isolation. We used the term space to indicate one's community, along with access to social and economic resources, activities, and institutions [2]. For all of these constructs, we relied upon participants' responses to help us define and understand their perspectives on stigma, anonymity, self-identity, and space. This approach was aligned with the purpose of our study, which was to explore and understand strategies that African American men use to overcome stigmas and analyze the role of identity and space in these discussions.

HIV-Related Stigmas

Many psychologists and anthropologists have defined stigma in terms of differences in power structures and social inequalities [3]. Parker and Aggleton [4] themselves trained in public health, anthropology, psychology, and sociology and explained that stigma is difficult to overcome because it is embedded within basic hierarchical social structures within a society, operating at the crossroads of "culture, power, and difference." Psychologists study stigma with a focus on developing ways to cope with social isolation, ostracism, and rejection on the individual level. Psychologists conceptualize stigma as a negative *attitude*, with cognitive, affective, and behavioral aspects and theorize that stigma can take the form of stereotypes or beliefs, prejudicial attitudes or emotions, and discriminatory behaviors [5, 6].

HIV is a condition that has become the target of multiple stigmas. HIV-related stigmas often overlap with stigmas associated with factors such as sexual orientation, sex work, and poverty [7, 8]. HIV stigma has been tied to people living at the margins of society, who often struggle with multiple stigmatizing conditions, such as being poor, female, and an injection drug user; this is sometimes referred to as *intersectional stigmas* [7]. Reidpath and Chan [8] argued that the effects of multiple stigmas are additive, making these experiences more severe and difficult to overcome than experiences of a singular stigma. Thus, HIV stigma often are experienced by people who already experience stigmas associated with other conditions or identities. Once HIV stigmas that are present among members of the public are experienced or perceived by a person living with HIV, the stigma can then be *internalized* by the individual and have the potential to profoundly impact his or her own mental health, medication adherence, health care service utilization and, ultimately, negatively impact health outcomes [9–11].

Many people living with HIV experience internalized or self-stigma and do not disclose their status because of fear of ostracization by friends, relatives, and members of the community. Anonymity is particularly problematic when already stigmatized populations do not test for HIV or do not seek care in a timely manner [12–14]. Implications for delayed testing include unsuccessful treatment or poor adherence to medications. For purposes of this study, we will refer to the term “anonymity” as a state of being unnoticed or unidentified.

Corrigan [5] states that internalized stigma occurs when one identifies as a person with a stigmatizing condition and also agrees that negative stereotypes surrounding the condition apply to himself or herself. A lack of identification with a stigmatizing condition such as HIV may be protective—a person that does not accept his or her HIV status may be able to avoid facing perceptions and experiences of stigma. Throughout this article, we will refer to these concepts of anonymity and identity as connected to the acknowledgment of a sense of self-identity and physical space. Self-identity is signified through designations such as race, class, gender, and sexuality. Space is noted through one’s living arrangements (e.g., housing), health care institution, and region (e.g., Pacific Northwest or Midwest, rural and urban).

Anonymity in Practice: Identity, Marginalization, and Physical Isolation

Marginalization and subsequent isolation are two issues associated with anonymity, self-identity, and physical space. Several researchers have examined the role of stigma associated with physical space and its impact on health [15–18]. Further, the topics of race and class segregation are forms of marginalization with extensive consequences for many African Americans. Marginalization occurs when observable characteristics or behavior shared by a group of individuals is

systematically used within the larger society to signal the inferior and subordinate status of the group [19]. A shared history of oppression rooted in ideologies of racial hierarchies is one facet of marginalization that may impact African American men living with HIV.

Context of Identity: Race, Sexuality, and Masculinity

Theories about masculinity address marginalization associated with gender and sexuality. Raewyn Connell [20] argues that being a man confers power, although not all men share this power equally and not all men are individually exploitative [21]. Connell suggests that masculinities are dependent on changes in social and political power and shows that some men dominate and subordinate other men in a way that supports masculinity as hegemonic [21]. These masculinities are binding and create cultural images of what it means to be a “real man” among men [21]. Raewyn Connell and James Messerschmidt [22] later reshaped the formulation of this theory in four areas: the geography of masculine configurations, gender hierarchy, the process of social embodiment, and the dynamics of masculinities [22].

In Connell’s analysis, “marginalization” refers to the relations between masculinities in dominant and subordinated classes or ethnic groups [21]. Connell suggests that race relations are an integral part of the dynamic between masculinities. Minorities defined in terms of race, class, and ethnicity have all characteristically construed their manhood differently than members of the ruling class or elite. This paper illustrates the differences between hegemonic and non-hegemonic power and how it can lead to marginalization for African American men living with HIV.

Methods

Participants and Setting

We recruited a convenience sample of focus group participants in two urban research hospitals in Chicago and Seattle, eliciting HIV patients’ experiences of stigma and feedback for the adaptation of a stigma reduction intervention. In Chicago, African Americans make up 33 % of the population; yet, they make up 61 % of all AIDS cases in Chicago and 59 % of HIV infections. In Seattle, African Americans make up 8 % of the population and nearly 20 % of those living with HIV [23].

All participants of this study identified as (1) a registered outpatient in the HIV clinics at a large metropolitan hospital in Chicago or Seattle; (2) self-identifying as from non-Hispanic, African American racial or ethnic background; (3) able to provide informed consent; and (4) at least 18 years of age. The multisite design aided in capturing regional and cultural

variation. Participants provided informed consent before beginning study procedures.

Data Collection Procedures

We used focus group methodology to nurture the discussion of issues that are triggered by others' experiences and viewing components of the intervention [24]. Institutional review boards approved all procedures before the study commenced. Trained moderators facilitated each focus group in Seattle and Chicago in 2010 and 2011. The Chicago focus groups were conducted in a room within the medical center. The Seattle focus groups were conducted at a local community-based organization for people living with HIV. A moderator's guide was developed according to Krueger and Casey guidelines [25] and provided structure for each focus group discussion. The principal investigator (D.R.), a South Asian American female clinical psychologist, co-led focus groups at each site in Chicago and Seattle. In Chicago, the first author (J.S.), an African American woman trained in anthropology, co-led focus groups with an African American woman who was also a nurse research coordinator in the clinic. In Seattle, a White female social worker (M.D.) co-led focus group sessions.

We allowed for small focus groups in order to ensure that each participant had an opportunity to discuss their personal experiences in-depth, as we anticipated high emotional involvement in the topic of living with HIV [25]. We also wanted participants to have more time to feel comfortable around each other in the context of self-disclosure. Participants were encouraged to discuss their experiences and understanding of stigma, openness around disclosure of HIV status, and specific questions to elicit feedback on how to adapt a stigma reduction intervention (after viewing intervention materials). Each focus group lasted approximately 2 h and was audio taped and transcribed verbatim by the lead author of this article.

Data Analysis: Qualitative Analysis

Two focus groups with African American men living with HIV were conducted in Chicago, and two focus groups with African American men living with HIV were conducted in Seattle. In addition to these two groups, one African American man living with HIV was interviewed alone with moderator-guided questions. He expressed sincere interest in participating but concern about discussing his experiences in the presence of others. This participant's interview transcript was analyzed alongside focus group transcripts. We dedicated our examination of the data to passages that focused on issues of disclosure and secrecy.

Two members of our team (J.S., H.B.) coded all transcripts. A Seattle-based research assistant (H.B.) served as the primary coder and independently coded the transcripts in Atlas Ti,

identifying themes and sub-themes in an iterative process over multiple readings of the material [26]. The first author of this article (J.S.) was the secondary coder, using the themes the primary coder developed and coding the transcripts in Microsoft Word. The authors (J.S. and H.B.) then met to discuss themes that developed and clarify any unclear structure of themes and sub-themes. The researchers calculated a kappa score (0.7) for the overall transcription comparing how many instances particular themes were identified in each transcript coded by the primary coder with that coded by the secondary coder [27]. The kappa scores ranged from 0.48 based on participants' rationale for joining the group, to 1 for familial relations, inclusion/exclusion, stigma reduction intervention, misconceptions of people living with HIV, and race. Themes with the highest kappa calculation included race, kinship (family), misconceptions/perceptions of people living with HIV, support groups/stigma reduction intervention, and in-group/out-group meaning notions of exclusion and "otherness." Most of these themes intersect with issues of space, identity, stigma, and HIV. Notes from the aforementioned and two successive discussions between the primary and secondary coders as well as the coded transcripts provided the principal framework for this analysis.

Results

Seventeen African American men living with HIV participated. In Seattle, three men attended the first group and nine men attended the second. In Chicago, two men attended the first, two attended the second, and one man answered questions in an individual interview. In the context of these two metropolitan areas in the USA, desire for anonymity due to stigma appeared to be a prominent factor in the context of self-identity and space and the social, political, and economic dimensions of everyday life experiences of these African American men living with HIV. We observed a positive association between participants' individual reactions and interactions within the group and their overall reaction to the intervention. The names of participants used in this article are pseudonyms.

The burden of secrecy and silence appeared more evident among African American men in Chicago. Three out of five male participants (60 %) in Chicago reacted to the group format with skepticism and expressed a lack of interest in participating in a group-based program in the future. Only two participants attended the first focus group in Chicago, and each arrived late. They both expressed hesitations in joining a focus group to discuss experiences of stigma in the presence of other men and with females supervising the study. One participant suggested that if we were developing a stigma reduction program, an internet-based program might be more feasible, given his preferences for anonymity. One participant expressed his wish to participate in a private one-on-one interview rather

than a focus group because of his concerns about loss of confidentiality that would occur in a focus group. We accommodated this preference.

Coping with Stigma

We observed differences in attitudes, reactions, and responses, including silence and self-identity. In the first group in Chicago, Sean and Matthew (pseudonyms) were between the ages of 40 and 60 years of age. When asked if they would participate in a program such as our intervention, Matthew responded: “I can’t imagine going to a support group with a bunch of strangers and talking about my personal problems.” When discussing a specific intervention module, he added: “I just think everybody has secrets and they should remain our very own secrets.” Matthew’s response illustrates how his desired secrecy coincides directly with preferred anonymity and limited self-identification within the community of African American men living with HIV. His words suggest that he may be isolated and not fully accepting of his HIV status.

One of our concerns with these focus group meetings was that they were held within the institutional spaces and settings of large urban medical centers. Participants may have sensed the power dynamics inherent within large institutions, despite our efforts to mute these influences. These factors may influence behavior, including speech and tendency toward silence, body language, and other forms of expression.

Our third participant, Bill, who preferred the private interview format, stated that since learning about his HIV-positive status in 2004, he had only shared this with his health care providers. Bill acknowledged that the private interview conversation was the first time he openly discussed his HIV status with anyone outside of the treatment setting. While expressing his preference for privacy, Bill expressed frustration with his self-imposed isolation, acknowledging stigma affecting his identity within his community and society.

In Seattle, focus groups were conducted at a community-based organization, and the institutional environment seemed to make less of an impact on the overall focus group discussion. The presence and intersection of community identity in terms of position, race, and gender were clearly acknowledged as Dave, a participant, directly asked the facilitator, a White female social worker, why she is interested in learning about the experiences of African American men living with HIV. Dave’s candor in asking the question during the session suggests a level of comfort in the environment or “space” in which the discussions occurred.

In Seattle, some participants spoke candidly of the burden of secrecy in relationships with relatives and sexual partners. For example, Mark stated that for him, secrecy has become a way of life. “You just carry it with you and you learn to deal with it. Some stuff you don’t tell nobody but you and God.” He spoke further about the complications of disclosure when

he spoke about a 4-year relationship with a former partner. “He left me when I found out I was HIV-positive. After that, I was in a relationship with a person for four years and I never told that person that I was HIV-positive and I never did anything with that person in the four years that we were together to jeopardize infecting that person.”

Other participants in Seattle spoke about the difficulties of disclosing to their families once again underscoring stigma and its impact on their sense of identity within society and their community. Christopher talked about his regrets that he told his brother about his HIV status, as when his brother is upset, his brother insults him about his status. This example illustrates the vulnerability leading to their preference for anonymity in relation to their HIV status. While some participants, like Sean and Matthew in Chicago, illustrated the heavy burden of secrecy suggesting anonymity through an online forum to share their HIV-related stigma experiences, others chose to speak openly about their desire for secrecy. Others remarked how they embodied secrecy since finding out about their positive HIV status. Furthermore, all of the participants revealed the complications surrounding disclosure to friends and family members and decisions of sharing secrets with them. This evidence underscores that desire for secrecy influenced them to remain anonymous in the spaces within their communities.

Space and Identity: Isolation, Marginalization, and Disconnectedness

Some men who participated recalled other experiences of isolation in their community particularly those expressed through speech. During a focus group in Seattle, Damien poignantly defined and described the experience of isolation as “knowing no love.” His identification with isolation, alienation, and marginalization illustrate the lack of social support within the local public sphere or his physical space. It also describes his perception of his social, economic, and political position.

James who lives in Seattle also described his sense of disconnectedness to community. He spoke of the isolation and fear that he experienced living with HIV that has now progressed to AIDS. James explained that the only person that knows about his condition is his mother. He prefers not to identify as living with HIV.

I, um, try to avoid conversations about HIV. They rarely come up, though. But, I always have that back thought – like – (to himself): ‘I hope these people don’t talk about HIV.’ Or rather, ‘I hope these people don’t find out I have AIDS.’ So, I’m always in a, in a defensive – defensive hiding mode.

In Chicago, some participants focused on institutional elites in the black church and the conservative and homonegative views expressed from the pulpit. Sean spoke of the difficulty in finding a black church that accepts people

with minority sexual orientations. He emphasized that in some black churches, the stigma is not only focused on HIV but on homosexuality. Some participants exercised agency in challenging homonegative remarks expressed from the pulpit. Jonathan who lives in Seattle pointed out how he no longer passively sits in church and listens to these kinds of statements. As a result of these multiple stigmas, he removed himself from the church spaces within his community.

Feelings of isolation and disconnectedness were also discussed in terms of physical spaces, specifically neighborhoods and health clinics. In Seattle, Maurice pointed out that being Black, male, and living with HIV in his neighborhood was analogously perceived as living with leprosy. Seattle participants discussed their understanding of physical isolation with comments like “even amongst ourselves” implying that they were in an “out-group.”

When asked if he feels connected to the people who live in his neighborhood or on his block in Chicago, Matthew said: “No, they’re just neighbors. I mean when I see them I wave. I might know them by name – [but otherwise] usually it’s ‘Hey,’ ” and that’s about it.” Although this isolation may be self-imposed, Matthew’s response reflects a lack of “belonging” in the space of his community.

In Chicago, the clinic was also a space described as isolative. While most patients wait for services related to HIV treatment, one may assume the creation of a sense of community (i.e., a group of people with shared experiences and values who interact with one another). But, some participants described the health clinic as a space of loneliness and alienation, a physical space where they preferred anonymity. Two participants in Chicago, John and Michael, spoke about the silence they experienced while in the waiting room of the clinics they attend. “When you walk in the clinic, it’s so frickin’ quiet,” John said. Michael added, “When I walk in the clinic, I make a point of speaking to everyone! Everybody looks at you as if there’s something wrong with you!” Sean in Chicago has been visiting the HIV clinic for 15 years. He described his experience as: “I come to the clinic. I go through the treatment. I go back to the garage. I leave. Very private. You know what I’m saying?”

The HIV clinic at the public hospital in Chicago was also a space described by participants as particularly isolating and where they preferred anonymity in terms of interactions with physicians and other health care professionals. Michael spoke about how grateful he was that he received health care from the Veterans Hospital rather than the public health care system in Chicago. “I need the same doctor for every visit. You can’t just give me one doctor one week and another doctor the next week. That’s what they do at [public hospital name]. I can’t have that!” Michael’s comment reveals the importance of seeing the same doctor on a consistent basis, which would speak to his preference for control and a strong relationship between patient and physician.

Some Seattle participants resided in a house managed by a public/private partnership for homeless women and men affected by HIV, mental illness, and addiction. These participants discussed their experiences with stigma and living with HIV in this space. Two participants, David and Nicholas, claimed that it is perceived as a house for those with HIV. David pointed out that some people in Seattle refer to it as the “lie down building,” referring to it as a place where people with HIV go to die. Others complained about the lack of available services to those living with the disease. Robert noted the lack of support groups immediately available that focused on educating people about adherence to medication. James described a “lack of community” and sense of alienation as his primary experiences living in this particular space of housing.

Um, I mean it’s....it’s really scary cause, I don’t know if people are going to do harm to me or just say something about me. If they say something about me, then that drops my confidence. But, uh, it’s a dangerous world out there and having HIV don’t make it better.

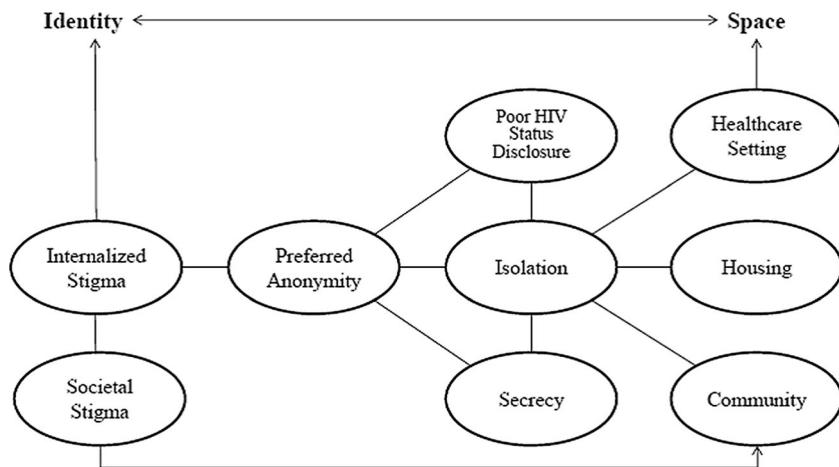
Other residents perceived the space as an opportunity to build a sense of community by providing support to each other without formal programs initiated by the institution. During the discussion, Tom told Robert that he noticed his reserved behavior and his decision to be alone, separating himself from everyone.

I didn’t know how to come to him and let him know that it’s o.k. because we all in the same situation – you know. And the loneliness is to separate yourself from everybody else. That can be a mental strain, you know and it’s... You know it’s bad enough that other people are out in the world [who] put us down. But we put our own self down that’s even worse and that’s why I wanted to try to give him support but like he say he has the wall. I’m glad that we’re here to talk about it. You know, [if] you’re feeling lonely, knock on the door. If I say ‘Come sit down and have dinner’ come sit down and have dinner! I ain’t talkin’ about sex, I’m just trying to let you know that we ain’t in this world alone.

Tom’s emphasis on the human need for social interaction and relationships illustrates the importance of community, support, and human connection rather than the lack thereof, which may lead to preferences for anonymity and further (self-imposed) isolation.

The Seattle building program represents a case that encompasses a designation of dominant and subordinate groups: The state with a private partner represents the dominant group, while the poor residents infected with HIV represent a subordinate group. While some residents talked about the building as a place to bring people together with common problems and struggles, others felt that it represented a place of marginalization and isolation. Furthermore, some participants discussed the public stigma that they experienced while living in the building. While the intent of providing housing for

Fig. 1 Negative impacts of stigma on identity and space



those living with HIV is admirable, incorporation of residents and potential residents' preferences was not considered.

Discussion

This paper details an examination of discussions of HIV-related stigma among African American men living with HIV. We conducted this research in two metropolitan areas in the USA: Chicago and Seattle and found that there were many similarities between experiences of stigma across the two cities. We examined group discussions about experiences around stigma and feedback on potential methods to reduce stigma and examined the power of identity and space and how stigma experiences had an impact on the health of African American men living with HIV in our study. Participants' responses illustrated underlying preferences for anonymity within the context of identity and space for African American men living with HIV. Figure 1 outlines the relationships between these concepts in a conceptual model of the findings. The men in our study often preferred that their HIV-linked identities remain invisible and anonymous. The evidence presented shows a relationship between self-identity, physical space, isolation, and preferred anonymity because of stigma associated with HIV. As described in more detail below, our analysis lent some support for the notion that our health care and housing institutions may influence preferences for anonymity.

Our participants described some discomfort with their housing situation, particularly those in housing set aside for people with HIV. Acevedo-Garcia [28] defines residential segregation as "the spatial differentiation between dominant and subordinate racial/ethnic groups. (Pg.1144)" She specifically uses the term "spatial differentiation" to emphasize differences in residential patterns between dominant and subordinate racial groups and the conditions under which these spatial differences may occur. Circumstances may include isolation

or the concentration of a subordinate group into a particular space [29]. The reference to "dominant" and "subordinate" groups suggests that residential segregation is a practice forced on the subordinate group, in our case people with HIV, by the dominant group, which in our case would be the larger society [29].

Notions of dominant and subordinate groups are also crucial in understanding residential segregation and perhaps their relation to infectious diseases. In the USA, there has been an increase in studies examining the correlation between segregation and health disparities. Some scholars argue that direct and indirect social determinants, such as segregation and economic inequalities, continue to have an impact on infectious disease acquisition and outcomes [30, 31]. Acevelo-Garcia [28] argues that segregation concentrates poverty and limits quality access to health care to minority populations. In relation to sexually transmitted diseases such as HIV, segregation and insularity affect social networks and impact patterns of sexual contact, leading to the spread of STDs [32]. Similarly, Rodrick Wallace [30, 33] suggests that the effects of urban decay contribute to the marginalization of communities and impacts public health and individual health. He argues that the loss of low-income housing itself contributes to rising mortality because of the loss of social networks and structures. Thus, segregation and marginalization can be thought of as closely tied to morbidity and mortality among African American men living with HIV. It will be critical to further study migration patterns and geography as they shift and adjust to socioeconomic changes over time.

While all African American male participants in our study described experiences of isolation, there were differences in Chicago and Seattle. Men in Chicago experienced more discomfort about discussing their experiences living with HIV than those in Seattle. They also expressed a strong preference for anonymity, particularly relating to any social interventions. Our interpretation of this difference was that Chicago participants might have been influenced by the hospital institutional

setting within which the focus groups were held, as opposed to the community-based setting where the Seattle focus groups took place. However, these differences may also reflect regional distinctions. Comparatively speaking, Seattle's African American population is much smaller than in the city of Chicago. As a result, this could all lead to distinct experiences of stigma for African Americans living in a dominant White society. Gender differences, specifically discomfort in discussing experiences around living with HIV with female facilitators, may have also contributed to uneasiness.

On a positive note, some participants outlined the benefits of social support and programs targeted toward stigma reduction. They emphasized the need for an intervention program to discuss the daily struggles with stigma while living with HIV among others who shared these kinds of experiences. In fact, some men in the Seattle focus groups stated that this was the first time they had discussed the subject of stigma or had the opportunity to talk about their experiences with stigma openly with other men living with HIV. Others discussed the nuances with multiple intersecting stigmas of being African American, gay, and HIV positive. Additionally, confronting these intersections complicates issues of disclosure, seeking treatment, and navigating social situations. The gratitude that many participants demonstrated during focus groups while discussing these issues further reinforces the need for a program that creates a safe space to articulate the effects of stigma for people living with HIV.

In both Chicago and Seattle, participants expressed descriptions of the desired qualities of an intervention leader. Responses included "someone who cares" and "someone like us" rather than a trained professional, such as a psychologist, nurse, or social worker. These descriptions from participants suggest a preference for working with peers who exhibit empathy or demonstrate the ability to relate to their experiences of living with HIV rather than a trained professional. During one focus group in Seattle, participants expressed a desire to learn the results of the study and to become better informed about how the data would address issues of stigma. This level of interest was met with encouragement from the facilitators, and all participants were invited to attend a public discussion of the results and its implications for further action. Many of our participants acknowledged that an emphasis on boosting self-esteem and empowerment is important to their overall well-being and interest in engaging in care at their health care institutions.

We suggest short- and long-term recommendations to allow African American men living with HIV to lead their daily lives minimizing stigma and reducing the needs for anonymity. We suggest two short-term recommendations: (1) offer more opportunities for African American men living with HIV to connect with peers, contact with others offers social support and helps people learn coping mechanisms for the stigmas that they may face [34] and (2) safe and integrated

housing for those living with HIV and able to access few resources. For people living with HIV, affordable housing is challenging and often depends upon one individual's circumstances (e.g., Were they not permitted to stay with family? Are they living in specialized substance abuse facilities?) In one example from our participants, Seattle has one (stigmatized) distinctive location specifically for people living with HIV. Housing for people with HIV integrated with others not living with HIV would help to decrease stigma. Overall, many of the problems experienced by African American men living with HIV are linked to the marginalization and deep segregation of African American communities. These communities have become more isolated economically, socially, and politically over time. Long-term recommendations include providing programs and services to alleviate inequality, poverty, and segregation that many African American communities experience.

Our study did have limitations. For one, we held groups in a hospital setting in Chicago and in a community-based organizational setting in Seattle. It was impossible for us to disentangle resulting responses with respect to differences by city and setting. Furthermore, those who attended were likely at some ease speaking about their issues in a public, focus group setting, and thus, their responses should be considered in light of their own willingness to share personal information. In addition, as is often the case with qualitative research, we had a small sample size, and thus, the generalizing of these results should be interpreted with caution.

Our study had strengths in that we were able to tie the responses of African American men living with HIV to issues around identities, anonymity, housing situations, and guidance around stigma reduction interventions. Our participants expressed how important personal and community identity and space were to their perceptions of HIV stigma and its consequences for their lives. Given their responses, we presented two possible short-term strategies for stigma reduction: the first enabling peer contact and the second facilitating safe and integrated housing for African American men living with HIV. Future studies would benefit from further explorations and understandings of how HIV-related stigma impacts people with HIV in settings such as churches, clinics, and other community settings.

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Conflicts of Interest Judith Singleton, Manuela Raunig, Halley Brunsteter, Michelle Desmond, and Deepa Rao declare that they have no conflict of interest.

Informed Consent All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and with the Helsinki Declaration of 1975, as revised in 2000 (5). Institutional review board approvals and informed consent were obtained from all patients for being included in the study. No animal studies were carried out by the authors for this article.

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