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FOCUS

A Guide to AIDS Research and Counseling

Racial and Ethnic Disparities in HIV Infection in the United States

Julie Kraut-Becher, PhD, Marlene Eisenberg, PhD, and Sevgi O. Aral, PhD

In the 2008 surveillance report from the Centers for Disease Control and Prevention (CDC), the HIV prevalence rate for Black men was six times the rate for White men and the rate for Hispanic men was more than twice the rate for White men.¹ Among Black women, the rate was nearly 18 times the rate of White women, and among Hispanic women, the prevalence rate was more than four times that of White women.¹ These racial differences are substantial and have been recognized for nearly 20 years, yet few studies have been designed specifically to test hypotheses that might explain these disparities.

This article examines factors identified in the sexually transmitted infection literature in order to explain the existence of racial and ethnic disparities in STIs including HIV and AIDS.² The determinants are grouped into general categories depending upon whether they provide behavioral, biological, or social explanations of differential rates of STI transmission and infection. Most of the findings discussed in this article relate to disparities between Black and White Americans because there are many more studies comparing these groups than studies comparing White people and Latino people in the United States.

Behavioral Determinants

Some observers of the racial and ethnic disparities in the prevalence and incidence of STIs, HIV infections, and AIDS diagnoses in the United States have concluded that these disparities exist because prevention messages, interventions, and supplies such as

condoms or clean needles have not effectively reached those at greatest risk of infection. Such explanations define racial disparities in HIV infection in primarily behavioral terms. That is, Black Americans must be engaging in either more frequent or more “risky” sexual and drug-using behaviors. In fact, the data suggest that the opposite may be true.²

Studies have repeatedly found that Whites report much higher rates of HIV-related risk behaviors than do other racial and ethnic groups. For example, among men who have sex with men surveyed in seven U.S. cities, White men were more likely than Black or Latino men to report having more than 20 lifetime sex partners; sex within the past six months with a nonsteady partner, an IDU male partner, and an HIV-positive male partner; and a lifetime history of using injection and non-injection drugs and sharing needles. Yet, HIV prevalence was 16 percent for Black men, 6.9 percent for Latino men, and 3.3 percent for White men.² A recent study of a representative sample of young adults in the United States showed that White youth were more likely to be infected with HIV or other STIs if they engaged in sex for money, used injection drugs, had male-to-male sexual activity, or used marijuana or other drugs, but Black youth had a higher STI prevalence even when they had few sexual partners and less drug use.³

All of these data suggest that factors other than individual-level behaviors are necessary to explain the racial and ethnic disparities in STI and HIV rates. Recent research has shifted from individual characteristics and behaviors to population-level factors to predict STI and HIV transmission and prevention. This shift emphasizes sexual and drug-using networks, for example, the characteristics and behaviors of an individual's sex and drug-using partners and the characteristics and behaviors of their partners' partners.

Editorial: Chronic Disparities

Michelle Cataldo, LCSW, Clinical Editor

HIV is now a chronic, manageable illness, but only for some. While the rising tide of antiviral therapy has lifted many boats, some are still sinking: AIDS is now the leading cause of death for Black women ages 25 to 34, and the second leading cause of death for Black men ages 35 to 44.

But the story begins long before these alarming death rates. As Julie Kraut-Becher, Marlene Eisenberg, and Sevgi Aral underscore in their article, the difference between Black and White HIV infection rates in the United States is staggering. For HIV prevention and care professionals, many of whom are trained to help individuals make changes to their behavior, the question has long been “How can we help people adopt safer behaviors?” But according to Kraut-Becher, there is little evidence that individual “risk” behaviors are the sole force driving up HIV infection rates.

Instead, research is now beginning to focus more on the context of these behaviors: forces such as racism, lack of access to health care, and incarceration that define choices and thus shape the behaviors of communities. Biological determinants, too, may be playing a role. In the last year, researchers discovered that an antigen that helped protect some people of African descent from an antiquated type of malaria also makes them more vulnerable to HIV infection.

This growing recognition of factors that go beyond individual choice in creating vulnerability to HIV suggests a stepped-up community response. Diseases often tell us where the fissures in society are—who is set apart by color or class, sexual orientation or some other characteristic. Our communal and governmental response to diseases always tells us where our priorities lie.

Illness re-creates identities, turning people into “risk

groups.” Communities already marked by stigma are re-stigmatized through their association with illness. Diseases like HIV, other STDs, and hepatitis C, which are associated with sex and illicit drugs, still carry a special stigma, a moral one. People with mental health problems often carry a strangely similar burden—society can’t quite decide if mental illness is a medical disease, a sign of personal weakness, or a failure of upbringing. As Jennifer Alvidrez and Sita Patel discuss in their article, the stigma regarding mental illness extends from the individual to the family. For Black people who seek mental health treatment, stigma often multiplies.

It is much more comfortable (for those who are not affected) to set people living with mental illness or HIV apart than to realize that we are all part of the same community. HIV and mental illness are both in many ways chronic, treatable diseases. Yet stigma remains as one of the chief barriers to such treatment. It is a chronic condition of its own. Whether it is cured or merely managed is up to us. ■

Among the population-level factors that research has shown to be important determinants of STI rates are the composition and mixing patterns within a population. Data can suggest the extent to which members of a population have sex and drug-using connections with members of similar populations (assortative mixing) and different populations (disassortative mixing), and the extent to which members of a population have simultaneous (concurrent) sexual partnerships. For example, data show that young women who have sex with older men (disassortative mixing by age) are more likely to report STIs than women who have sex with male partners close in age.² Sexually transmitted disease risk is also higher among individuals who have multiple sex partnerships that overlap in time (concurrent) than individuals who have monogamous relationships in sequence.²

Location within a network is also a determinant of risk for STIs including HIV. According to network theory, the small number of individuals in a network who have large numbers of sex and drug-using contacts form the “core” group. Often, these individuals have HIV or other STIs. Network members at the “periphery” have only one sex or drug-using partner at a time, and generally have low rates of HIV and other STIs.

Key characteristics of core groups have been found to be important predictors of STI and HIV transmission. In particular, the size of the core group and each core group member’s average level of risk matters. The bigger the core group relative to the size of the network and the higher each core group member’s average level of risk, the greater the opportunity for disease transmission. The extent to which core group members have

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sex and drug-using contacts outside of the core group, and the amount of sexual interaction between core group members and others outside of the core group (“bridges”) are also important determinants of the spread of HIV and other STIs.

Mixing patterns among individuals in the United States vary according to race and ethnicity, and rates of concurrent sexual partnerships are much higher for Black people than for White people.⁴ Furthermore, among people who engage in low-risk sexual behaviors, Black people are more likely than White people to have partners with high-risk sex behavior.²

For example, one study using a nationally representative sample of reproductive-age adults found that sexual mixing between core and periphery subpopulations is much more common among Black people than White people, thus facilitating spread of infection through the network, in this case the Black population.⁵ That is, people on the periphery, the people with the least likelihood of having HIV or an STI, are more likely in Black networks than White networks to have sexual contact with people in the core group of the network. This theory suggests that Black people may have higher HIV prevalence rates not because they engage in more or different HIV-related behaviors as White people or have less access to prevention tools, but because they associate differently within communities.

Biological Determinants

Since differences in rates of HIV risk-related behavior do not appear to explain the racial disparities in HIV infection between Blacks and Whites in the United States, some researchers have proposed that biological factors be examined as reasons for the disparity. Among these factors are the high prevalence of some sexually transmitted infections in Black Americans, lower rates of circumcision among Black men than among White men, and the presence of

genetic characteristics that might facilitate HIV infection. Studies that examine the role of STIs in sexual transmission of HIV find that nonulcerative STIs (for example, gonorrhea and chlamydia) and ulcerative STIs (for example, syphilis and chancroid) increase

HIV risk from two to five times. All of these STIs are more prevalent in minority populations than in majority populations.⁹

Studies of male circumcision suggest that it may be a protective intervention for STIs including HIV. Removal or reduction of the foreskin may decrease the number of immunologic cells through which HIV or other STIs could potentially enter the body. In addition, since the foreskin may be prone to tearing during sexual intercourse, it may provide additional entry and exit points through which transmission of STIs includ-

ing HIV could occur.

Rates of circumcision in the United States vary by racial and ethnic group; in a 1992 national study of men aged 18 to 59 years, White men (81 percent) were more likely to be circumcised than Black men (65 percent) or Hispanic men (54 percent).¹⁰ Lack of circumcision has been associated with increased risk for gonorrhea, syphilis, and chancroid, but not with increased risk for chlamydia and genital herpes.² Although research about the role of male circumcision in vulnerability to particular STIs is inconsistent, in Africa, cross-country differences in circumcision rates have been cited to explain cross-country differentials in HIV rates.² Circumcision is also currently being considered as a HIV/AIDS prevention intervention in the United States.

Lastly, researchers are seeking to identify genetic factors that may offer protection from or enhance susceptibility to HIV. For example, the CCR5 receptor is the most common pathway for viral entry into immune cells. Some people of European descent have a mutation of the CCR5 receptor that makes their immune T-cells partially or fully resistant to HIV infection. The mutation is thought to affect about 10 percent of Whites.¹¹ Although its prevalence is too low to fully explain racial disparities, the finding does demon-

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strate that race-related genetic characteristics may influence HIV prevalence.

More recently, the presence of a genetic mutation in the gene for the Duffy antigen receptor for chemokines (DARC) on red blood cells has been found to increase susceptibility to HIV. The mutation affects about 90 percent of Africans and it could account for as many as 11 percent of HIV infections on that continent. About 60 percent of African Americans are also affected by this mutation and it could partially explain why HIV is more common among Black people than White people in the United States.¹² Clearly, the further exploration of genetically determined host factors will continue to be an important direction for future research regarding racial disparities.

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Social Determinants

Social determinants seem to play a key role in explaining the differential U.S. HIV infection rates.⁶ These determinants include structural factors such as the economic environment and components of the health care environment, perceptions and beliefs constructed from racism and segregation, and political factors such as the likelihood of incarceration.

Socioeconomic status is one of the most important social determinants of sexual health.⁶ Poverty and lack of employment are associated with residential instability, segregation, and migration, and can influence sexual and social networks, which in turn may affect HIV risk. Poor people are less likely to have jobs that provide health insurance. Minority populations in the United States have suffered disproportionate poverty and fewer employment and educational opportunities than White people as a result of racism and segregation.⁶

Having no or inadequate health insurance reduces the likelihood of obtaining preventive care. Racial and ethnic minorities make up more than half (52 percent) of the uninsured people in the United States.² In addition, racial and ethnic minorities are less likely than White people to have a regular source of medical care, and their choice of medical care is often more restricted and more expensive than what is available to White people.^{2,12} The quality of care provided in communities of color is often not as high as that found in White neighborhoods, resulting in poorer doctor-patient relationships.⁷ When people have no access

to or poor relations with the medical system, they will not seek care when they have HIV or another STI and therefore many of these infections remain untreated. The extent to which STIs, including HIV, are treated in a population contributes to the extent of their transmission.

One-quarter of all HIV-infected Americans pass through the correctional system annually, and the inmate population is at least two and a half times as likely as the general population to be infected with HIV.¹³ Even after release, a former inmate's history of incarceration places him or her at a further economic disadvantage.⁶ The disproportionate effect of incarceration on the health of racial and ethnic minorities (and, by extension, on their health status) should not be underestimated. In 2005, almost half of the prison population (47 percent) was African American, yet this minority group comprised only 13 percent of the overall U.S. population.²

In addition, the disproportionate burden of incarceration rates for minority men may cause a skewed ratio of available men to women in a community. This results in simultaneous (or concurrent) sexual partnerships. These concurrent partnerships in turn serve to spread infection efficiently.

Conclusion

More research is needed to determine how the complex interplay of biological, behavioral, and social factors work together to heighten racial disparities in HIV infection. Variations in individual behavior are not sufficient to explain the differentials. Instead, these behaviors must be considered within a broad social and ecological perspective that includes community-level and structural characteristics and emphasizes the social context within which individual risk behaviors occur.

The focus of future research should be on minority status as a proxy for economic, social, biological, and other problems related to status in society rather than a focus on racial categories as meaningful entities in themselves. It is these other problems, rather than race itself, which create vulnerability to health disparity. Racializing the problem of health disparities can divert attention away from the concrete political, economic, and social factors that affect life experience and produce differential health outcomes. ■

Stigma and Resilience: Experiences of Black Mental Health Service Consumers

Jennifer Alvidrez, PhD, and Sita Patel, PhD

Many Black Americans do not receive adequate treatment for mental health problems. Black people are less likely than White people to seek help for psychiatric problems, and, after receiving a mental health diagnosis, are less likely to receive psychotropic medications or psychotherapy.¹ When they do receive outpatient mental health treatment, Black people attend fewer sessions of therapy than White people and are more likely to drop out prematurely.¹ Numerous structural barriers, such as lack of insurance coverage and availability of services, contribute to these problems.¹ However, disparities between Black and White Americans persist after taking such factors into account.²

One reason for this lingering disparity may be the greater stigma Black Americans may feel when they seek and receive mental health services.^{1,3} Stigma refers to negative personal or societal responses toward individuals identified as belonging to socially undesirable groups. Stigma may be either enacted (differential treatment of or discrimination against “labeled” individuals) or felt (when labeled individuals avoid particular situations, people, or roles to prevent anticipated stigmatization).⁴ Felt stigma also includes self-stigma, in which individuals internalize negative stereotypes about the group to which they belong, and consequently experience shame, embarrassment, and lowered self-esteem.⁵

Both enacted and felt stigma may play a role in deterring people from seeking mental health treatment.⁶ Stigma research indicates that although public perceptions of mental illness have improved over time, beliefs that people with mental illness are incompetent, unpredictable, and dangerous remain prevalent.⁷ These views translate into stigmatizing treatment of mental health consumers, who commonly experience being avoided, shunned, or belittled.⁸

Unfortunately, existing studies tell us little about how Black Americans experience and cope with stigma, and how it affects their help-seeking behavior. Stigma research in the United States has largely focused on White, middle-class mental health consumers. The goal of the African American Mental Health Information Project (AMHIP) was to address

this gap. A small, qualitative study, AMHIP explored the real-life experiences of 34 Black consumers of the San Francisco public mental health system, and used these experiences as the basis for the development of a psychoeducational stigma intervention.⁹

This article summarizes themes from interviews with Black mental health consumers regarding their concerns about and experiences of stigma. Rather than focusing solely on deficit and disparity, the study results highlighted resilience, and this article reports on strategies that Black mental health consumers used to overcome the stigma barrier and seek treatment.¹⁰

While the AMHIP study did not ask participants their HIV status, or focus on HIV-related issues, the experiences of stigma that consumers reported and the resilience they demonstrated are nonetheless important for HIV service providers to understand. A disproportionate number of Black Americans are living with and at risk for HIV disease. Therefore, it is critical for providers to be aware of the barriers some of their clients may face in accessing not only HIV-specific treatment, but mental health services as well. Some HIV service providers may note parallels between the experiences of different stigmatized identities among their clients, including stigma directed at clients because of their race, sexual orientation, use of substances, or HIV or mental health status.

Identifying the Problem

Thirty-four Black consumers of San Francisco public mental health services completed interviews. Consistent with the population served in the public sector, most were male, unmarried, and not working. Ages ranged from 25 to 60 years old, with a mean of 44. Most participants had mood or psychotic disorders, and almost half had co-occurring substance use problems. About three-quarters of the participants were currently receiving outpatient mental health treatment, and most had received treatment in the past. Three overarching stigma-related themes emerged from the interviews: consumers' exposure to stigmatizing views of mental illness and treatment, stigma as a barrier to mental health treatment, and strategies to cope with stigma.

Consumers reported that their families and communities believed that mental illness was shameful and not appropriate to discuss outside of the family. Mental illness was seen as a sign of weakness that was

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inconsistent with the traditional values of maintaining strength during adversity:

[In] the African American community, [mental illness is] not talked about a lot. It's like, "People don't get depressed! That's like a White people thing. We don't got time for that." ... There's a lot of African-American stoicism, too. It's like stiff-lip everything. It's like, "Somebody, cut off my arm. It's all right. I got another one, it's all good."

For some stigmatized groups, such as those marginalized for their race or ethnicity, social class, or religious beliefs, the entire family shares the stigmatized status. In the cases of mental illness and HIV status, in contrast, other family members may not have the same stigmatized condition. In fact, the family may itself be a primary source of stigmatization. Despite this, most Black consumers in the San Francisco study worked hard to sustain their existing family support networks. Since each situation is unique, learning about family history and current family context are critical elements of providing culturally sensitive HIV counseling to Black clients. Providers can then help clients navigate, and negotiate conflict in, these relationships.

Isolation and Community

Although mental illness was viewed negatively in their communities, consumers said that seeking mental health treatment was even more stigmatized. The act of seeking help—rather than the condition of having mental health problems—was seen as a sign of weakness. Consumers said that Black family members were often resistant to a relative seeking treatment, because it indicated the family's failure to handle problems internally, and because the entire family would be forced to share the stigma.

Perhaps as a result, the great majority of consumers (76 percent) felt that stigma played some role in initially preventing them from seeking mental health treatment. Some said that, because of the taboo of talking openly about mental illness, they possessed little capacity to recognize specific mental health problems or available treatments:

If I had known that this was part of what mental health was all about, I probably could have encouraged myself to go earlier and wouldn't have been so afraid to go at the time I did.

When consumers ultimately recognized that they might need professional help, stigma continued to be a significant treatment barrier. Nearly two-thirds of consumers said

they or people they knew were reluctant to seek help because of stigma-related concerns, including the fear of being judged, rejected, or actively discriminated against. As one respondent said, "I felt bad about that, me getting a psychiatrist. ... I felt shamed over what I thought other people would think ... I'm thinking like that they'd prejudice me on that, like they would prejudice on me having HIV."

Consumers found that their initial fears were justified. A majority (68 percent) said that they did, in fact, experience stigmatization after becoming mental health consumers. Stigmatization took the form of social judgment, social rejection, and discrimination. Most reported being mocked, disparaged, and gossiped about by friends, family, and acquaintances. Many consumers faced not just disapproval from others but active discouragement from entering or remaining involved in mental health treatment:

I would stop taking medications thinking ... I could do it on my own, because sometimes some of my friends tell me, "Oh, you don't need this." ... They try to change my mind and tell me, "You don't need this, you don't need that. Girl, you all right. Here, have this drink. Ain't nothing wrong with you."

Co-occurring conditions also contributed to experiences of stigmatization. Some subjects felt unable to be fully accepted in mental health treatment groups because of a criminal justice history, while many felt marginalized within substance abuse treatment groups because of their mental health problems. "[At AA meetings or NA meetings,] they look down on people in the mental health system. ... They call you loony tunes or things like that," one participant remarked.

Internalizing these stigmatizing experiences, consumers reported feeling embarrassed and ashamed about their need for treatment, even in supportive environments. As one 25-year-old Black man said:

Comments and Submissions

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“Maybe the idea of coming to someplace and asking for help makes you a little bit less of a man, maybe even somewhat of a non-person, and the one thing you can’t take away from a Black man is his manhood.”

In addition, Black mental health consumers experienced a sense of isolation, because they lacked peers who could relate to their experiences. When shown the psychoeducational booklet developed from their interviews, many of the San Francisco consumers said they felt empowered and connected to other Black individuals facing mental illness for the very first time.

Similar experiences likely arise for Black individuals dealing with HIV, as they may receive inadequate support from family, church, or community, and may also feel disconnected from mainstream HIV advocacy support groups.¹¹ These findings emphasize the importance of being aware of multiple layers of stigma that clients face.

Black mental health consumers described feeling isolated because they lacked peers who could relate to their experiences.

Strategies to Deal with Stigma

Stigma clearly shaped experiences, by preventing consumers from seeking help in a timely manner, making them feel embarrassed or ashamed, or prompting them to become secretive about use of services. However, nearly all consumers discovered ways, including attitudinal and behavioral strategies, to deal with the reality that they needed mental health treatment and with the negative reactions of others. The most commonly expressed attitude was that their health and well-being were more important than the opinions and reactions of others:

“It’s okay, and screw what everybody else thinks. ... You want to get better for yourself, and then you could possibly help somebody else along and keep it, keep it going. But you can’t, you can’t just worry about what other people think. Shoot, ‘cause that that’ll keep you stuck.”

Other prominent coping attitudes included the view that problems were experienced by all kinds of people and were just a part of life, so there was nothing inherently shameful about having mental health problems or getting help for them:

“I just want to be the example for my children to let them know that it’s okay to seek that [help]. ... That it’s okay, and it’s not abnormal. It’s normal. It’s a part of living and breathing.”

The most common behavioral coping strategies included seeking social support and controlling the disclosure of information about their illness and treatment. Although many consumers encountered negative reactions from their family and friends for seeking mental health treatment, most found some understanding and supportive individuals within their existing social networks. Most consumers described a complex process they used to assess each relationship individually for the family member’s or friend’s receptiveness to hear about their mental health history and treatment. This process of “selective disclosure” enabled consumers to retain their existing social support networks. For example, one woman described how she divulged her mental health history:

“I’ll kinda like ease it in after, after I’ve tested them a little bit to see what they think. I even throw in that I might have been in the hospital, or I was depressed, or they may see some cuts on my hands, old cuts and scars, or whatever, from me slicing my wrists and doing stuff to myself ... as much as they can handle, ‘cause I don’t want to do it all at once.”

As they persevered with treatment, consumers found it easier to disregard negative messages and feel secure in their decisions to engage in health-promoting behaviors. This may be because consumers experienced for themselves the benefits of treatment. When asked what advice she would give to others who were afraid of getting mental health treatment, one woman said:

I would tell them my experience with it and how fearful I was about it, to try to get them to see that you really need these services. ... It doesn’t matter what anybody else thinks. It’s about you and what you think about yourself. ... You need to take care of yourself first before you think about what everybody else is thinking about you.

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Conclusion

Stigma has a significant impact on the way that many Black individuals experience

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mental illness and treatment. In the African American Mental Health Information Project study, consumers reported growing up with the belief that mental illness was a topic to be avoided. As a consequence, most suffered for many years with untreated mental health problems in an attempt to avoid the internal and external stigma of being “crazy.” Once in treatment, consumers commonly experienced negative reactions from the people in their lives. Yet study participants demonstrated, through their incredible resilience, the possibility of overcoming these obstacles.

In clinical practice, treatment barriers are generally only a focus of attention when cli-

ents miss appointments or are non-adherent to treatment plans. For the African American Mental Health Information Project consumers, mental health treatment was an ongoing struggle, as they dealt with continued negative reactions from others or even active encouragement to go off medications or stop psychotherapy. In response to these insights, clinicians should assess and address factors that make it difficult for Black clients to participate in treatment throughout the course of treatment. Clinicians should also find ways to recognize the strength and resilience of clients who persist despite these challenges. ■

Related Resources

Web Sites

Black AIDS Institute. <http://www.blackaids.org/>. Nonprofit policy center dedicated to reducing HIV-related health disparities by engaging Black institutions and individuals in efforts to confront the epidemic in their communities. Site offers a Clinical Trials Resource Center, HIV-related policy news, and several reports on the state of Black America with regard to HIV.

National Minority AIDS Council (NMAC). <http://www.nmac.org/>. NMAC works with communities of color to develop leadership that can address the challenge of HIV. Site includes the NMAC Download Library, which features publications on addressing HIV-related health disparities and HIV and incarceration.

Journal Articles

Millet GA, Flores SA, Peterson JL, et al. Explaining disparities in HIV infection among black and white men who have sex with men: A meta-analysis of HIV risk behaviors. *AIDS*. 2007; 21(15): 2083–2091. Reviews data from 53 quantitative studies of HIV risk among men who have sex with men. Researchers found that Black men reported less overall substance use than White men, and reported similar rates of unprotected anal intercourse, commercial sex work, and sex with HIV-positive partners as White men. Despite engaging in behavior that was not significantly more “risky”

than that of White men, Black men had significantly more sexually transmitted diseases. The authors advocate a shift in research emphasis away from examination of individuals’ HIV risk behaviors and toward social network explanations of racial disparities in HIV infection. ■

Next Issue

HIV prevalence among older adults continues to increase. In 2005, people over the age of 50 accounted for nearly one-quarter of all of the people living with HIV in the United States.

In our Summer issue, **Mark J. Simone, MD**, Geriatric Fellow at Harvard Medical School’s Division of Gerontology, and **Jonathan Appelbaum, MD**, Director of Internal Medicine Education and Associate Professor at Florida State University College of Medicine, examine the epidemiology of HIV in older adults, and explain how HIV interacts with other illnesses such as cardiovascular disease, glucose intolerance, and psychiatric illness.

Also in the Summer issue of *FOCUS*, **David Vance, PhD, MGS**, and **Teena McGuinness, PhD, CRNP**, both of the University of Alabama at Birmingham’s School of Nursing, discuss the psychosocial concerns that many adults aging with HIV face, including stigma, loneliness, social withdrawal, and more fragile social networks.