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HEALTH PSYCHOLOGY | RESEARCH ARTICLE

Identity, Threat and Coping among Gay Men Living with HIV in Finland

Rusi Jaspal^{1*}, Panda Eriksson² and Peter Nynäs²

Abstract: A qualitative interview study was conducted to understand the psychological impact of living with HIV among gay men in Finland. Seventeen gay men living with HIV were recruited at HIV support charities in Finland. The data were analyzed using qualitative thematic analysis. The analysis yielded three themes: (1) Self-Stigma and Threatened Self-Esteem; (2) Managing the Assimilation-Accommodation of HIV; and (3) Reconstructing of HIV, Its Meaning and Implications. Self-stigma was pervasive across participants' accounts and appeared to impede the assimilation-accommodation of HIV in identity. The ability to reconstruct the meanings of HIV and its implications (from something negative to something positive) can facilitate the assimilation-accommodation of HIV in identity, restoring self-esteem, continuity and self-efficacy. The ability to reconstruct HIV may be an important determinant of psychological wellbeing. This should be the focus of behavioral and clinical interventions for enhancing psychological wellbeing in this population.

Subjects: HIV/AIDS; Infectious Diseases; Behavioral Medicine

Keywords: HIV; identity; coping; wellbeing; gay; Finland

1. Introduction

The Joint United Nations Program on HIV/AIDS (UNAIDS) has set ambitious targets to ensure that at least 90% of HIV-infected people are diagnosed, that 90% are taking antiretroviral therapy (ART), and that 90% have an undetectable HIV viral load. Finland is quite a way from achieving the 90–90–90 target. As in many Western countries, Finland's epidemic is small and has historically been

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PUBLIC INTEREST STATEMENT

This study shows that HIV self-stigma was pervasive in our participant sample and that this may stop people from accepting their HIV status and incorporating it in their identity. The ability to reconstruct the meanings of HIV and its implications (from something negative to something positive) may, conversely, help them accept their HIV status and incorporate it in their sense of identity. This in turn may reduce the likelihood of experiencing threats to one's sense of self-esteem, continuity and self-efficacy. Thus, the ability to reconstruct the meaning and value of HIV may be an important determinant of psychological wellbeing. Therefore, this should be a key focus of behavioral and clinical interventions for enhancing psychological wellbeing in this population.

concentrated in the gay male population. Yet, there is very little knowledge about the experience of living with HIV among gay men in Finland, that is, the psychological impact of an HIV diagnosis, how they construct their identity in view of a diagnosis and, crucially, how they cope with possible psychological stressors associated with their diagnosis. Understanding these issues is crucial for the psychological wellbeing of people living with HIV. It will also influence the likelihood of achieving the UNAIDS target, since it is known that decreased psychological wellbeing can lead to disengagement from care, discontinuation of ART and HIV transmission behaviors (Jaspal, 2018).

1.1. HIV in Finland: an epidemiological snapshot

Finland is a Northern European country with a population of just over 5.5 million people. The country is considered to have a low HIV prevalence—0.1% of the population aged between 15 and 49. In 2019, 4190 people were living with HIV in Finland, of whom 1284 (31%) were men infected through sex with other men (“Finnish Institute of Health and Welfare,” 2020). In 2019, there were 143 new HIV diagnoses, of which 35 (24%) were among men infected through sex with other men. Although gay men are not the only group affected by HIV, they are a significant group in the epidemic and, in the early stages of the HIV epidemic at least, were over-represented in the HIV incidence figures (“National Institute for Health and Welfare,” 2013; Hanttu, 2017).

It is estimated that 91% of people living with HIV know their status, that 76% of people with HIV are on ART, and that 67% have a suppressed viral load, indicating that Finland has not yet achieved the UNAIDS target of 90–90–90 (UNAIDS, 2018). It has also been suggested that immigration from high HIV prevalence countries has contributed to the HIV epidemic in recent years, particularly as levels of HIV knowledge appear to be poorer in migrant populations compared to the general population (Tiittala et al., 2018). HIV care in Finland is free of charge, and patients can initiate ART upon diagnosis. There have been clinical studies of physical health outcomes among HIV patients in Finland and of HIV epidemiology in the country (e.g., Holmberg et al., 2019). However, social sciences empirical research into the experience of living with HIV in low prevalence countries, such as Finland, has been lacking.

1.2. Empirical research into HIV in Finland

There have been some studies of HIV and sexual health knowledge in the Finnish population, which generally suggest that HIV knowledge is high and that the Finns have an adequate understanding of the virus and key modes of transmission (Korhonen et al., 2012; Suominen et al., 2017). Despite relatively high levels of HIV awareness, social attitudes towards HIV and, in particular, the prevalence of HIV stigma in Finnish society are not properly understood.

Existing research has focused on attitudes toward HIV among healthcare professionals, rather than the general population in Finland, although one study of Finnish university students did reveal a generally positive attitude toward people living with HIV across the participant sample (Korhonen et al., 2012). Suominen et al. (2010) studied nurses’ knowledge of, and attitudes toward, HIV/AIDS in Finland, Estonia and Lithuania. Of all three countries, HIV knowledge was highest and attitudes most favorable among Finnish nurses. Similarly, in their study of nursing and midwifery students in the same countries, Välimäki et al. (2010) showed a general willingness among future nurses and midwives to care for HIV patients, which further reiterates the absence of HIV stigma in healthcare. In general, studies suggest that experience of treating an HIV patient is associated with more positive attitudes toward HIV. Given the absence of empirical research into social attitudes toward HIV in Finnish society, it is difficult to ascertain the social and cultural backdrop against which gay men living with HIV in Finland derive a sense of identity and psychological wellbeing.

Globally, there has been considerable research into gay men living with HIV, which generally shows lower levels of self-esteem and higher levels of anxiety and depression due partly to the high prevalence of HIV stigma (Earnshaw et al., 2015; Varni et al., 2012). Conversely, there has been only limited work on psychological wellbeing among people living with HIV in Finland and none focusing specifically on gay men. In their study of 440 patients, Nobre et al. (2018) found that those with severe self-stigma reported overall lower quality of life and health-related quality of life. Both cohabitation with a partner and disclosure of one's HIV status to others were associated with less self-stigma. They found that economic factors, such as unemployment and financial difficulties, were associated with greater self-stigma. Nobre et al. (2016) studied the social networks of nine older adults living with HIV in Finland. Their qualitative interview study revealed that social support, particularly from friends and family, was deemed to be the most important strategy for coping with their HIV diagnosis. There were concerns about ageing with HIV and the adverse impact that this may have on the availability of social support in the future.

1.3. Identity process theory

This study focuses on how identity is constructed and protected in view of an HIV diagnosis and, accordingly, draws on identity process theory (Breakwell, 1986; Jaspal & Breakwell, 2014), which provides an integrative framework for understanding identity, threat and coping. The theory postulates that individuals construct their identity by engaging in two processes:

- *Assimilation-accommodation* refers to the process of absorbing and creating space for new information in identity. This would include coming to terms with an HIV diagnosis and incorporating one's new HIV status into the identity structure.
- *Evaluation* refers to the process of attributing meaning and value to identity elements. For instance, the newly diagnosed individual may perceive social stigma in relation to HIV and, thus, view this as a flaw in their identity.

These identity processes are in turn guided by various motivational principles which essentially specify the desirable end-states for identity: self-esteem, self-efficacy, distinctiveness, continuity and coherence. Identity process theory proposes that we construct our identities in ways that provide us with appropriate levels of these principles. When the principles are challenged, for instance, by changes in one's social context, identity is said to be threatened. Identity threat is aversive for psychological wellbeing (Assi et al., 2020).

Gay men living with HIV may face a dual stigma on the basis of both their sexual orientation and HIV status. The psychological challenges associated with constructing and disclosing a gay identity in a heteronormative world can lead to identity threat and poor mental health (Jaspal, 2018, 2019). HIV stigma is a significant cause of identity threat in those living with the condition. Goffman (1963) defines stigma as "an attribute that is deeply discrediting", which reduces the stigmatized individual "from a whole and usual person to a tainted, discounted one" (p. 3). Consequently, stigma can expose gay men living with HIV to threats to identity, which are manifold and can include the imposition of negative change in identity, that is, people seeing themselves differently (Flowers et al., 2011); the loss of self-esteem as a result of stigma (Lee et al., 2002); and the need to conceal identity elements due to fear of stigma (Jaspal & Williamson, 2017). Under some circumstances, the individual may engage in self-stigmatization, that is, uncritically accept and internalize the stigma associated with their sexual orientation and/or HIV status (Lee et al., 2002).

The individual will use varied coping strategies to eradicate, or at least minimize, the threat to identity. Breakwell (1986) defines a coping strategy as "[a]ny activity, in thought or deed, which has as its goal the removal or modification of a threat to identity". The coping strategies operate at psychological, interpersonal and intergroup levels and can include *inter alia* denial,

reconceptualization, self-isolation, self-disclosure, and the derivation of social support from group memberships. Put simply, individuals strive to enhance, and restore appropriate levels of, the identity principles when they are abrogated.

Drawing on identity process theory, first, the psychological impact of living with HIV among gay men in Finland is explored; second, the ways in which individuals construct their identity in view of an HIV diagnosis is examined; and, third, how they cope with possible psychological stressors associated with their diagnosis is outlined.

2. Method

2.1. Participant selection and data generation

Semi-structured individual interviews were conducted with 17 gay men living with HIV in Finland between September 2017 and February 2018. Although some of the participants reported bisexual relationships previously, at the time of the study, all of them self-identified as male and as gay. Participants were aged between 36 and 72 ($M = 50.2$, $SD = 11.2$). Fifteen participants identified as ethnically Finnish, one as being of mixed heritage, and one as Latin American. A sample of 17 individuals is considered satisfactory for qualitative thematic analysis studies as the objective is to generate an in-depth holistic understanding of psychological experience, rather than empirical generalizability beyond the sample (Lyons & Coyle, 2007).

All participants confirmed that they were living with diagnosed HIV and that they were diagnosed between 1.5 and 26 years ago ($M = 14.4$, $SD = 9.1$). Five participants were diagnosed in the pre-ART era when HIV was a life-limiting condition. However, the design of the study did not allow for the detection of systematic differences between those diagnosed in the pre-ART and post-ART eras. Participants were all taking ART and had achieved viral suppression. Five participants reported being single; two as “dating” somebody; and the remaining 10 as being in a relationship.

Sixteen interviewees were recruited and interviewed by the second author at either the Finnish HIV Foundation/Hivpoint, which is a Helsinki-based charity that aims to prevent HIV and to support those affected by HIV in Finland, or Positiiviset ry HivFinland, which is a Helsinki-based charity that provides peer support and counselling services for people living with HIV in Finland. One interview was conducted on Skype by the first author. The study was promoted digitally and through word-of-mouth by the HIV charities, with which the second author had links, and prospective participants contacted a member of the research team to express interest in taking part.

The individual interviews were guided by a semi-structured interview schedule that focused on the following areas: self-description, self-categorization, identity, the experience of HIV diagnosis, HIV knowledge, the post-diagnosis period, HIV disclosure, stigma, coping, and engagement with HIV care and treatment. Interviews lasted between 50 and 90 minutes. The interviews with the Finnish participants were conducted in Finnish, and the interview with the Latin American participant was conducted in Spanish. Interviews were digitally recorded and transcribed verbatim. The study was designed in accordance with the British Psychological Society (2014) Code of Human Research Ethics and approved by De Montfort University's Health and Life Sciences Faculty Research Ethics Committee.

2.2. Analytic approach and procedure

The data were analyzed using an inductive, interpretative variant of thematic analysis. Thematic analysis is a flexible methodological approach which enables the analyst to capture both experiential and discursive elements of participants' accounts (Jaspal, 2020). This is useful in the context of identities which are complex, dynamic and both internally represented and externally performed (Warner & Shields, 2013). Initial analysis was carried out by the first author who then

conferred with the other authors in order to discuss the emerging codes. This process helped curb any potentially idiosyncratic interpretations of the data.

During each reading of the transcripts, preliminary impressions and interpretations were noted. These preliminary analyses were informed by tenets of identity process theory (Jaspal & Breakwell, 2014) and Goffman's (1963) theoretical account of stigma. The initial codes focused on *inter alia* participants' interpretations of their experiences, particular forms of language, and apparent contradictions and patterns in the data. Subsequently, these initial codes were collated into potential themes with subsequent higher-level interpretative work. The three themes were developed in response to the original research questions which focused on the psychological impact of an HIV diagnosis, the construction of identity in view of a diagnosis and strategies for coping with HIV-related stress. The data extracts below are not intended to be representative, but illustrative, of participants' observations—those that were considered vivid, compelling and illustrative of the themes, have been selected for presentation below. Pseudonyms have replaced participants' real names. The analysis was guided by the four principles outlined by Yardley (2000) for ensuring the quality of qualitative research, namely sensitivity to context; commitment and rigor; transparency and coherence; and impact and importance.

3. Results

In this section, the following three themes are discussed: (1) Self-Stigma and Threatened Self-Esteem; (2) Managing the Assimilation-Accommodation of HIV; and (3) Reconstrual of HIV, Its Meaning and Implications.

3.1. Self-Stigma and Threatened Self-esteem

Interviewees in this study reported experiences that reflected HIV-related stigma, discrimination and rejection from sexual partners, friends and family members, and healthcare practitioners. However, a more significant theme in participants' accounts was that of self-stigma, that is, HIV stigma internalized by individuals and directed at themselves, and the adverse impact that this had on self-esteem:

You kind of felt that you were dirty in a way ... that you have something that is so bad and dangerous, so I didn't have as much desire as I used to, to pick up guys. (Toni)

I was feeling dirty, like a second-class citizen ... I really felt like 'oh my god, I'm worse than radioactive waste' ... especially in the beginning, since I was feeling like nuclear waste, my sex life disappeared ... I have also during the years realized myself and also in others like getting the HIV diagnosis decreased self-esteem, self-image. (Elias)

There was a clear theme of self-stigma and, as observable in the accounts of Toni and Elias, epithets such as "dirty", "bad" emphasized the intrapsychic dimension of this and "dangerous" were used for self-definition in the aftermath of their HIV diagnosis. Elias described himself as a "second-class citizen" to capture his perceived loss of social status following his HIV diagnosis and noted metaphorically that he felt like "radioactive waste" and "nuclear waste". These epithets were used to convey both the threatened sense of self-esteem and the "danger" that interviewees believed they might pose to other people. In essence, they were afraid of transmitting HIV to others. Indeed, this was the key reason for Toni's disengagement from the gay scene following his diagnosis and his lack of desire to "pick up guys". Similarly, Elias reported a complete lack of sexual desire.

Participants were afraid of transmitting HIV to others, which could adversely affect both sexual self-esteem and sexual function. This belief too was underpinned by pervasive self-stigma:

The way in which HIV affected my own routine was that my own sex life basically ended. Even though I did, you know, have my ex-spouse who was also HIV-positive. I did not really have sex with him all that often ... practicing sex after having received my own diagnosis really did not feel as good anymore. (Mirko)

I think my sex life really got undermined at the time because of that ... because I was always afraid that I would [infect] somebody. (Toni)

My biggest fear was 'how can I have sex and be 100% sure that I don't transmit the virus to others?' (Elias)

I don't know if my libido went down [after his diagnosis] or I just didn't feel the same interest anymore ... I didn't feel discrimination. It came from inside me I can't tell you where it actually came from, from within myself, I guess. (Toni)

Individuals appeared to have assimilated-accommodated the stigmatizing belief that they were infectious and that they posed a risk to their sexual partners, which had a negative impact on both their self-esteem and their sexuality. For Mirko, sex no longer provided pleasure while, for Toni, his sex life was undermined. Toni emphasized the intrapsychic dimension of this belief—it was not necessarily rejection from sexual partners (that is, social or interpersonal experience) that led him to believe that he posed a threat but rather his own personal beliefs “from within”.

Self-stigma also reinforced the belief that one would be unable to establish a romantic relationship, which in turn undermined self-esteem:

It meant for me like maybe I would be alone for the rest of my life. And it would mean that I wouldn't be able to date or I would be an outcaste, but and back then I was also depressed so it was also more like evidence that I was like worthless in a way. And then actually ... my depression went much worse in the following year and I got like isolated. I isolated myself. And that was very, very tough. (Juri)

Like Elias who perceived himself to be a “second-class citizen”, Juri believed that he would be an “outcaste” and that his HIV status would inhibit the formation of a romantic relationship. He feared loneliness and paradoxically isolated himself further in an attempt to cope with threats to self-esteem. After all, self-isolation reduces the risk of rejection from others and of mistreatment by others (Breakwell, 1986). Crucially, self-stigma resurfaced as his predicament (that of being diagnosed as HIV-positive) came to constitute evidence of his perceived worthlessness—in his mind at least. Both his self-stigma and isolationist coping strategy in fact appeared to aggravate the threat to self-esteem, especially as this coping strategy is the antithesis of social support which conversely is protective against identity threat.

The insidious effects of self-stigma extended beyond the romantic domain to engagement with healthcare:

Regarding my own HIV diagnosis, it's still something which I feel, you know, shy and sensitive about. For me, it's something which I haven't yet had the courage to bring up in all different kinds of contexts, for instance, when I'm visiting my psychiatrist. (Pessi)

Patient quality of care is dependent on a sound relationship between practitioner and patient, who must feel empowered to discuss all aspects of their psychological health. Yet, Pessi's self-stigma impeded open and transparent discussion with his psychiatrist. In reflecting on the antecedents of their self-stigma, Pessi and other interviewees described isolated incidents of stigma from

healthcare practitioners, some of which may seem relatively innocuous to the outsider observer but which, for interviewees themselves, reflected stigma. Yet, some did acknowledge misattributing events and situations to stigma due to an anticipation of stigma from others:

But there's so much of self-stigmatization. People are thinking, thinking and doing-, that's one thing we're trying to do next year together, to gather awareness of how much it [actual stigma] really happens. And how much is something about self-stigma. I think a lot. Also, the doctor can do like this, and people think 'oh, he doesn't care'. He's, he will make a lot of interpretations. (Aleksi)

Like Toni, some interviewees attributed the origins of stigma to themselves, that is, to their own internalized stigma:

To be honest, I don't really know if there is [HIV stigma] or not, but like I said, I personally do have that kind of a stigma in the back of my own head still ... it's up here [points at his own head], namely within me. (Mirko)

What I do think is that that particular stigma which I've developed in my own head over time, the idea that no one would accept me as I am, and I mean if I still were able to develop a new relationship with someone, I would still have that kind of a fear for rejection, you know, because of my HIV ... and then there's also this idea in my head that, when I first would start dating someone, then one of the first questions that my new partner would be stating to me would be whether I am healthy or not. (Mikko)

Interviewees acknowledged that other people may not necessarily stigmatize them due to HIV but that they themselves had created an internal image of HIV stigma: “in my own head”, “within me”. This image and anticipation of HIV stigma served as a lens for self-perception, interactions with others and for interpreting events and situations. Some individuals are essentially primed to anticipate HIV stigma simply because they have internalized it. This can be difficult to dispel—indeed Mirko metaphorically described the stigma as being “in the back of my head”, suggesting that it is ever-present, yet difficult to access. Mikko had assimilated-accommodated the belief that he would not be accepted by others, that any future relationship would be characterized by fear of rejection, and that he would be at a disadvantage in romantic relationships due to his HIV status. Like other interviewees, Mikko attributed these negative core beliefs to HIV stigma which he himself had developed and sustained at a psychological level.

3.2. Managing the Assimilation-Accommodation of HIV

Consistent with identity process theory, significant life events and changes, such as an HIV diagnosis, must be assimilated and accommodated in identity. Some of the interviewees had been diagnosed and lived in more populous countries with larger communities of gay men living with HIV. For them, moving back to Finland as an HIV-positive individual required a reconstrual of identity:

I have a lot of friends there that are HIV-positive, so in that way it was also not a big part of my identity, because everyone else was, as well. So the biggest change was when I moved to Finland. (Jesse)

Although HIV did clearly constitute a group membership for Jesse, it was not construed as providing individual distinctiveness given that all of his friends and acquaintances abroad were in fact HIV-positive. However, being a gay man living with HIV led Jesse to derive feelings of distinctiveness and he experienced what he described as “the biggest change” to his identity as he began to assimilate and accommodate his HIV status in the identity structure.

Most interviewees did describe HIV in terms of an identity element, and acknowledged that their HIV status defined their overall sense of identity, suggesting that their HIV status had indeed been assimilated-accommodated:

To a great extent, I would have to say that HIV defines my own sense of identity as well. Even though I obviously would not, you know, want it to be that way, it still feels to me like all these societal and social kinds of, well, factors do render HIV something identity-related anyway. (Mikael)

Currently I do experience it being a part of myself, although I have not actually done so in the past. So HIV for me has basically been this type of a creep that has been following me around ... it has basically been this scary kind of a creep within my own life. (Mikko)

It's just been tagging along in my life since then basically, and one thing that I have later on become proud of is the fact that I am no longer capable of infecting anyone with it. (Jon)

HIV diagnosis clearly still represented a negative event in participants' lives—Mikko referred to it a “type of creep” and “scary creep”, while Jon described it negatively as “tagging along in my life”. HIV was personified in terms of an imposter or villain in participants' lives, but an ever-present, inescapable one—it therefore constituted an undesirable but unavoidable element of identity. This acknowledgement came with an element of reluctance. Indeed, Mikael noted that he “would have to say” that it defines him, while Mikko indicated that he had gradually come to experience it as an identity element. This could be attributed to the psychological distress initially experienced in relation to HIV diagnosis and the self-stigma that continued to bedevil individuals:

It was a complete shock. I remember I laughed. Because I couldn't handle it. It was too much for, like, the, for the young brain to understand and the understanding and acceptance came much, much later. (Juri)

The assimilation-accommodation of a negative, stigmatized element, such as HIV, in identity can be challenging not least due to the negative impact for self-esteem and continuity (“a complete shock”). Yet, as indicated in Jon's account, HIV became easier to assimilate and accommodate in identity in view of the scientific evidence that virally suppressed patients cannot transmit HIV to their sexual partners, which is also referred to as “undetectable = untransmittable” or “U = U” (Grace et al., 2015). This reduced the stigma associated with HIV, which in turn enabled individuals to construe it less negatively and, thus, to assimilate-accommodate it in identity.

Conversely, some interviewees downplayed the significance of HIV as an identity element:

It's just something that is part of me I don't think about. (Toni)

I do not personally really think of HIV as comprising a part of my own identity so it's really more a matter of it tagging along. (Tuomas)

I happen to be also HIV-positive. It's not really a big part of my identity. Not as everyday life, it's more like some situation that I have to think about it. (Jesse)

Tony described HIV as “part of me” but appeared to downplay its significance in the identity structure. It existed but was reportedly not salient. Similarly, Jesse referred to it as “not really a big part of my identity” but rather as a “situation” that occasionally required his attention. Tuomas highlighted the notion of HIV as “tagging along” in his life and not as an integral identity element. Participants appeared to be suggesting that, while HIV was physically a part of their bodies, it was not a part of their identities. Interviewees attenuated what was clearly construed as a negative event in their lives

and therefore avoided bestowing on it the more “permanent” status of identity. This may constitute an attempt to avoid the assimilation-accommodation of HIV which might be intended as a strategy to reduce identity threat. After all, it was simply not acknowledged as part of the identity structure.

Juri was especially resistant to HIV as an identity element, and focused on its status as a chronic illness:

I don't consider myself to identify [with HIV] when I explain who I am, I don't, that's not part of my identity. It's just like an infection that I, like, have. I have other permanent illnesses, chronic illnesses, and I don't consider myself to be identified through those either. (Juri)

HIV is not really me, not the real me. It's a bad part of my life that I just want to forget but it is with me for life but not really me. If you understand me. (Miguel)

Clearly, Juri did not wish to foreground his HIV status in self-presentation and emphasized the various other elements which were better descriptors of his identity. Like other interviewees, he did not want his identity to be dominated by HIV. Juri compared HIV to other chronic illnesses in order to argue that HIV was not an element with which he *should* identify. Miguel differentiated between the “real me” and a less authentic identity of which HIV was a part—for him, HIV represented a negative chapter in his life, rather than his “real” identity. The previous section of this article sheds light on why some interviewees resisted self-identification with HIV. For some, it represented a frightening, potentially life-limiting condition, which also exposed them to (self-)stigma. Mikko's account illustrates the psychological challenges in the assimilation-accommodation of HIV in identity:

At some point, I did experience HIV as being a part of my own identity, but then again I've also been quite frightened of it, and by the time when that whole beginning phase of the disease started to fade, then those kinds of feelings of self-guilt started to roll in instead. You know, I did obviously blame myself previously for having been so, you know, gullible. (Mikko)

Interviewees described feelings of psychological distress and self-stigma in relation to their HIV diagnosis. Mikko appeared to have assimilated—accommodated HIV in identity but revealed the psychological disruption that this had caused, in view of the negative emotions that his diagnosis evoked. More specifically, living with HIV initially induced fear because of its association with mortality and onward transmission. As mortality anxiety began to wane in the era of effective ART, Mikko experienced guilt, as he viewed himself and his “gullible” behavior as the causal factors in his infection. These strong negative emotional experiences led him to disidentify from HIV and essentially to reverse the process of assimilation-accommodation. For both those who did and those who did not assimilate-accommodate HIV in their identity, self-stigma and decreased self-esteem played a significant role.

3.3. Reconstrual of HIV, Its Meaning and Implications

Living with HIV is associated with self-stigma, decreased self-esteem and challenges in the assimilation-accommodation of HIV in identity. Accordingly, there was a tendency in the sample to reconstrue the meanings of their HIV diagnosis so that it no longer posed as significant a threat. Interviewees described the positive implications of their diagnosis at the intrapsychic, interpersonal and group levels. At an intrapsychic level, HIV was said to provide novel perspectives on one's life:

HIV has brought I would say suffering to me, but thanks to HIV I have also experienced very wonderful things which I wouldn't without HIV. (Elias)

On the whole, it [his HIV diagnosis] was this big process of spiritual growth for me and I would have to say that I have come off as a better and more complete person as a result of all that. You know, after all of those fears from the past have finally faded away. (Tuomas)

Somehow it's [HIV] given good things to my life as well, some sort of freedom ... I thought about what I wanted to do in the rest of my life, and I thought I wanted to be in Finland. What I wanted to do was go to [another city] and so it wouldn't have been possible so easily without being HIV-positive. (Jesse)

Elias noted the psychological distress engendered by his HIV diagnosis but also acknowledged that HIV had brought him “very wonderful things”. Tuomas described his HIV diagnosis as a trigger for spiritual growth, resulting in a “better and more complete person”. This growth was reportedly facilitated by the loss of fear—of HIV acquisition, illness and death. His infection was deemed to put things into perspective, resulting in a form of psychological liberation. Similarly, Jesse described the “freedom” that his HIV diagnosis had conferred upon him. On the one hand, HIV represented sexual freedom—in the accounts of both Jesse and Tuomas—which is discussed later in this section. Moreover, there was also a sense of empowerment in relation to realizing one’s aspirations which might have seemed excessive or inappropriate if one were HIV-negative. Jesse, for instance, had long wished to migrate to another city in Finland, which he accomplished following his diagnosis. In short, for some, HIV appeared to bring about a liberation of thought and action, which was sometimes attributed to their “near-death” experience of HIV, mortality salience and death anxiety:

Living with HIV has indeed made me more open as a person, and then also, that near-death experience which I was talking to you about earlier, it has basically made me ... once you have been visiting the gates of death, you come to realize that your time on this earth is limited. And that you are actually willing to put as much effort as possible into living your own life. (Tuomas)

Some interviewees looked forward to future accomplishments as a result of their HIV diagnosis:

I do actually have a bit more brighter view of my own future compared with earlier ... I continuously strive for thinking forward ... And what that also means in practice for me is that I have to look after my own health, you know, like that. So yeah, the HIV diagnosis has actually been affecting my own daily life in various positive ways. (Jaako)

I don't feel any crisis over age. It's, for me, it was like one year more, yes! Yes! I live one year more! So that's HIV ... I would never have been thinking about that if I didn't have HIV. So it was like, happy. And then I kind of realized how many, how old I am. Because it's like okay one year! I survived one year! I survived one year! So it was more like a celebration, not a crisis. (Aleksi)

There was an observation that HIV had been reinvigorating by inducing a forward-thinking perspective and a desire to celebrate life. Jaako reportedly engaged in greater self-care than he had previously done because he now valued his life. Similarly, Aleksi no longer feared or lamented ageing but rather valued his life more and celebrated his survival. HIV diagnosis appeared to encourage a revision of priorities in life and to instill optimism concerning the future.

The reconstrual of HIV must be regarded within the broader context of participants’ lives. A key source of self-stigma associated with HIV was the fear of onward HIV transmission and this had led to decreased sexual self-esteem and, in some cases, to the avoidance of sex. Yet, some individuals reconstrued the meaning of their HIV diagnosis from inhibiting sex to facilitating uninhibited sex:

After having been diagnosed with HIV, it could in many cases release you from pretty much all those kinds of sex-related inhibitions which you previously might have had, for instance, like

I've told you before, there really aren't all that many HIV-positive males out there who would be willing to use protection while having sex, instead, one's own sex life might actually become more vivid, you know, a bit more wild after having been diagnosed. (Mikko)

When there was, first when I went there [in HIV-positive gatherings] it was like a shock, because sex was coming, the sexual atmosphere, the sexual energy was coming on the walls, because everybody was hiding, it was so stigmatized so when all of a sudden hundreds of HIV people come together, they don't have to hide anything. So there was like 'Yeaaaah, freedom'. Sexual freedom was, like, it was a wonderful feeling. (Aleksi)

HIV diagnosis enabled Mikko and Aleksi to engage in condomless sex, in spite of the long-standing coercive norm of condom use in the HIV era, and also to explore other sexual activities, which may be construed as high-risk, such as “fisting”, group sex and drug use in sexualized settings (“chem-sex”). The type of sex available to gay men living with HIV was described as “vivid” and “wild” and as being characterized by “sexual energy”, highlighting its psychological gratification. Yet, there was a more psychological dimension to this reconstrual of HIV—Aleksi and indeed other interviewees described their ability to engage in the type of sex they desired without the social stigma that habitually characterized it and the common need to conceal one's HIV status. In short, HIV reportedly brought men together, enabling them to have uninhibited sex without fear.

There was evidence of participants having resorted to self-isolation as a prime strategy for protecting self-esteem which led to a risk of marginalization. Paradoxically, HIV—despite being a major source of identity threat—was reconstrued as having provided greater opportunity for emotional intimacy, self-disclosure and the derivation of social support:

You know, as strange as that may sound, it does feel to me as if my own diagnosis would have actually brought the two of us closer to each other and enhanced our own relationship in the process ... as the two of us went through these things together ... you could say that him and I are sort of, well, in the same boat in that sense. (Mikael)

Mikael reflected on his relationship with his former partner who was HIV-negative at the time of his own diagnosis. Although he had anticipated the breakdown of his relationship, his former partner responded with acceptance and support which reportedly enhanced the quality of their relationship. Although they had an HIV serodiscordant¹ relationship, Mikael believed that HIV unified them as a couple. Similarly, Mikael and others noted the benefits that their HIV diagnosis had had for his ability to interact with others:

HIV for me is something which I've actually come to experience as something empowering over time, namely in the sense that I know not to be alone with it, but instead there is this community of people from whom I'm able to receive support, and I'm able to share my own experiences with them ... having this kind of a community around myself in which some people have been coping with the disease for decades, that's something which really brings me hope and comfort as well ... the HIVs ... I have been attending these different sorts of camps and through doing so I have also started living a more active lifestyle like that. (Mikael)

It must be reiterated that gay men living with HIV constitute a very small group in Finnish society. This demographic fact, coupled with the stigma that can inhibit self-disclosure and self-association with other people living with HIV, can inhibit a sense of community. Yet, in his reflections on the impact of HIV on his life, Mikael construed his diagnosis as “empowering” because it enabled him to derive feelings of acceptance and inclusion from other gay men living with HIV. It appeared to enhance the self-efficacy principle of identity. Amid despair and hopelessness, Mikael was able to derive “hope and comfort” through his ability to self-disclose, to exchange confidences and to derive support from

others who shared his predicament. Mikael referred to this new “community of people” as “the HIVs”, suggesting that his HIV status was reconstrued as the basis for a new social identity.

4. Discussion

The experience of being diagnosed with HIV was, or had been, distressing for interviewees. In view of the stigma appended to HIV, the self-esteem principle of identity was most susceptible to threat. There was some evidence that the continuity principle was challenged as individuals reported various negative changes as a result of their diagnosis, such as shock at their diagnosis, breakdown in personal relationships, and loss of sex drive. The threat to self-efficacy was clearly observable in participants’ accounts of their helplessness in relation to their infection, the associated side effects, and its impact on others. Some interviewees therefore resisted the assimilation-accommodation of HIV in identity and downplayed its significance in their lives.

Yet, as individuals begin to reconstrue HIV as something positive, some of the identity principles became less susceptible to threat and, in some cases, HIV came to be understood as a positive event in their lives. For instance, HIV diagnosis was transformed into an event that could restore and enhance relationships with others; facilitate enjoyable sex; and empower people because of the unprecedented life decisions it enabled them to take. This may be especially possible for individuals who achieve viral suppression and can construct themselves as HIV undetectable (Brondani et al., 2016). Indeed, U = U is beneficial for both the individual health outcomes of the person living with HIV and their partners given the negligible risk of onward transmission. Yet, this too may entail a social and psychological “pressure” to remain undetectable and to experience shame, guilt and decreased self-esteem when this is not sustained or not possible (for whatever reason) (see Cormier McSwiggin, 2017). In any case, our research suggests that the reconstrual of HIV, its meanings and its implications can facilitate the assimilation-accommodation of HIV in identity, that is, HIV is more readily absorbed into identity when it is able to represent something positive, rather than something exclusively negative.

4.1. Self-stigma

A key finding in this study was the pervasiveness of self-stigma in relation to HIV among participants and its centrality to their identities. While social stigma refers to “an attribute that is deeply discrediting”, which reduces the stigmatized individual “from a whole and usual person to a tainted, discounted one” (Goffman, 1963, p. 3), self-stigma refers to the uncritical acceptance and internalization of this stigma. In other words, one comes to believe that one’s HIV status is discrediting and that one’s identity is tainted or discounted as a result of it. Indeed, this undoubtedly underpinned the decreased self-esteem observable in participants’ accounts, as there is an established inverse relationship between self-stigma and self-esteem (Turan et al., 2017). Interviewees discussed their self-stigma in relation to sexual opportunities in the future, abandonment, and loneliness. Moreover, because they uncritically accepted HIV stigma, they could not see how they would be accepted by others at an interpersonal level. It is noteworthy that existing research into social attitudes toward HIV in Finland suggests that social stigma is low and that attitudes are actually quite favorable (e.g., Korhonen et al., 2012). In view of our findings, this suggests that interventions for enhancing wellbeing in HIV patients should focus principally on reducing self-stigma and promoting more favorable self-construal this population.

The few studies of attitudes and experiences among people living with HIV in Finland point to the significance of self-stigma in their lives and its inverse relationship with quality of life (Nobre et al., 2016; Nobre et al., 2018). These studies suggest that cohabitation with a romantic partner and disclosure of one’s HIV status may be protective against threats to self-esteem, which in turn can have adverse outcomes for both psychological and economic wellbeing. Our study exhibits the content of such self-stigma—more specifically, gay men living with HIV may fear onward HIV

transmission to intimate partners, append negative epithets to themselves as people living with HIV, and isolate themselves from potential sources of social support. Indeed, self-stigma is likely to be perpetuated by self-isolation since the individual is unlikely to gain exposure to more affirmative images of their HIV status when contact with others is limited. Evidently, self-disclosure and the derivation of social support are essential for coping with psychological adversity, such as an HIV diagnosis (Earnshaw et al., 2015). Yet, self-stigma and the self-isolation that tends to accompany it are antithetical to self-disclosure and the pursuit of social support.

According to identity process theory, assimilation-accommodation is an important process in the construction and regulation of identity. Assimilation-accommodation enables individuals with threatened identities to begin to engage in the psychological process of acceptance by making subsequent cognitive, emotional and behavioral changes in their lives (Breakwell, 1986). For instance, only assimilation-accommodation of one's HIV status can subsequently enable the individual to derive a sense of belongingness and solidarity on the basis of their HIV status, which many find psychologically beneficial (Earnshaw et al., 2015).

4.2. Coping with self-stigma

Yet, self-stigma can inhibit the assimilation—accommodation of positive HIV status in identity, which in turn appears to be associated with two possible outcomes. Some individuals may downplay the significance of HIV in identity and perceive it solely as a chronic condition or as something they “have” rather than something that they “are”. Despite the physical and psychological health risks associated with “chemsex” and substance use (e.g., Bourne et al., 2015), some interviewees did perceive their HIV infection as facilitating this type of behavior given that they no longer had to worry about becoming infected. In some cases, this constitutes a form of deflection given that HIV, its meanings and its implications are downplayed or denied. This may also constitute a strategy for managing feelings of shame associated with living with HIV, which has also been noted previously (Bennett et al., 2016).

Others perceive their HIV status as an aspect of identity, albeit as a negatively evaluated one, with which they have had to come to terms. This is essentially an acceptance strategy, which is designed to “bring about change with the minimum amount of damage” (Breakwell, 1986, p. 93). Acceptance strategies undoubtedly lead to better, more fruitful psychological outcomes (Nakamura & Orth, 2005). Indeed, the assimilation-accommodation of one's HIV status may plausibly be regarded as a first step toward the acquisition of social support which is crucial for effective coping and for reducing feelings of shame that may come with the recognition that HIV is now an element of one's identity.

The challenge for researchers, practitioners and policymakers is to ascertain the social and psychological conditions that are conducive to the assimilation-accommodation of one's HIV status in identity. Our data suggest that self-stigma in relation to HIV can inhibit assimilation-accommodation but that the positive reconstrual of HIV (from being something solely negative to something with positive dimensions) can facilitate this key psychological process. In other words, HIV is transformed into a phenomenon that can be absorbed into identity and perceived in positive terms. If HIV is reconstrued and the focus is shifted from the solely negative aspects of the condition, it may no longer possess the capacity to threaten identity. Our research suggests that it may even come to enhance the very principles that are initially challenged by an HIV diagnosis.

5. Limitations

Future research should address the limitations of this preliminary study. First, the results of this qualitative interview study cannot be generalized to the wider population of gay men living with HIV in Finland. The results should be triangulated using other methodological approaches, such as quantitative surveys, which might enable us to produce generalizable findings. Second, the experiences of gay men newly diagnosed

with HIV may be different from those living with long-term HIV given that the latter are also at greater risk of comorbidities and of conditions associated with ageing with HIV (Slomka et al., 2013). The latter group will need to be a focus of future research into HIV in Finland, especially as we enter the fifth decade of HIV. Third, these data provide some insight into HIV in a low prevalence country. It will be important to examine other countries with a similar epidemiological profile in order to draw more robust conclusions about the experience of living with HIV in low prevalence countries.

6. Conclusions

The results of this study suggest that the pervasive self-stigma and identity threat experienced by gay men living with HIV may inhibit the assimilation-accommodation of HIV status in identity, which is a precursor to effective attitudinal and behavioral change. Furthermore, self-stigma and identity threat may undermine psychological wellbeing, which is related to decreased engagement with healthcare services and low uptake of, and adherence to, ART (Jaspal, 2018). This demonstrates the utility of an identity-based approach to examining the experience of living with HIV not only among gay men but also in other populations.

The findings suggest that it would be beneficial to promote greater awareness, understanding and visibility of HIV in Finland and in other low-prevalence countries. Furthermore, we should disseminate the findings of this study, especially concerning the ways in which HIV is reconstrued by patients, to clinicians in order to promote better clinical understanding of the factors that can challenge, and potentially enhance, identity and wellbeing in this population. More generally, behavioral and clinical interventions to reduce social stigma in the Finnish society and self-stigma in patients, respectively, might facilitate the assimilation-accommodation of HIV, thereby promoting better psychological wellbeing outcomes in those affected. Clinical and cultural contexts in which self-disclosure and social support in relation to HIV are possible might encourage the adoption of adaptive coping strategies and discourage deflection and self-isolation.

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Note

1. Serodiscordant relationships are those in which one individual is HIV-positive and the other HIV-negative.

Declaration of interest statement

The authors have no interests to declare.

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