NATIONAL LGBTQIA+ HEALTH EDUCATION CENTER

A PROGRAM OF THE FENWAY INSTITUTE

Understanding and Addressing Barriers to HIV Self-Care Among Men Who Have Sex with Men with Substance Use Disorders

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March 19th, 2021

Our Roots

Fenway Health

- Independent 501(c)(3) FQHC
- Founded 1971
- Mission: To enhance the wellbeing of the LGBTQIA+ community as well as people in our neighborhoods and beyond through access to the highest quality health care, education, research, and advocacy
- Integrated primary care model, including HIV and transgender health services

The Fenway Institute

- Research, Education, Policy

LGBTQIA+ Education and Training

The National LGBTQIA+ Health Education Center offers educational programs, resources, and consultation to health care organizations with the goal of providing affirmative, high quality, cost-effective health care for lesbian, gay, bisexual, transgender, queer, intersex, asexual, and all sexual and gender minority (LGBTQIA+) people.

- Training and Technical Assistance
- Grand Rounds
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- We very much appreciate receiving feedback from all participants.
- Completing the evaluation is required to obtain a CME/CEU certificates.

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Other HealthProfessionals	Confirm equivalency of credits with relevant licensing body.

Learning Objectives:

- After this webinar, participants will be able to:

1. Describe the background and theoretical frameworks of HIV self-care among men who have sex with men (MSM) with substance use disorders
2. Recognize intervention strategies for addressing internalized stigma and shame among people with substance use disorders (Awareness and Compassion in Self Care (ACEs), proof of concept study)
3. Apply promising and best practices for refining interventions for gay, bisexual and other MSM who use substances
    - INSIGHT: Mixed methods study to inform refinement of intervention for MSM

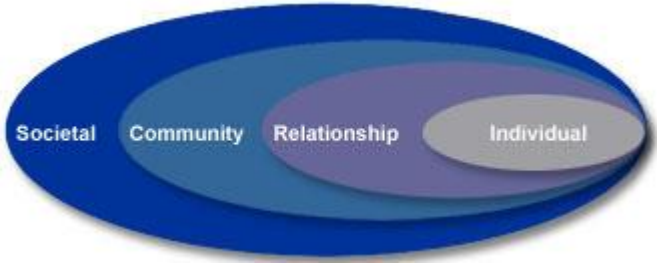
Personal Background

- Longstanding focus on health disparities and public health.
- Started working with people living with substance use disorders and HIV in 2007.
- Worked in urban substance use and HIV clinics with limited resources.
  - Focus on HIV and HCV
- Repeatedly heard that stigma, shame, and low levels of self-worth were barriers to engagement in HIV-related self-care.[1-3]

1. Batchelder et al., 2013; 2. Batchelder et al., 2015s; 3. Batchelder et al., 2015b

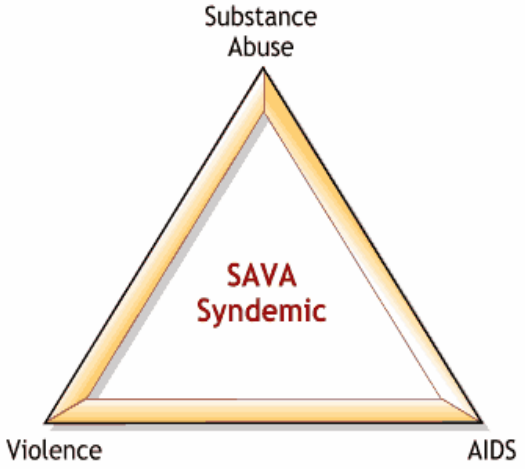
General Theoretical Perspective

- **Ecological perspective:**[1]
  - Need for multi-level interventions.



- **Trans-conceptual model of empowerment and resilience** suggests need to focus on individual-level interventions.[2]

- **Syndemic Theory** states that afflictions interact synergistically to perpetuate disease burden in vulnerable populations.[3-6]



1. Bronfenbrenner, 1990; 2, Brodsky & Cattaneo, 2013; 3. Singer 1996; 4. Stall et a., 2004; 5. Batchelder et al., 2015; Batchelder et al., 2016

Intersectionality Framework

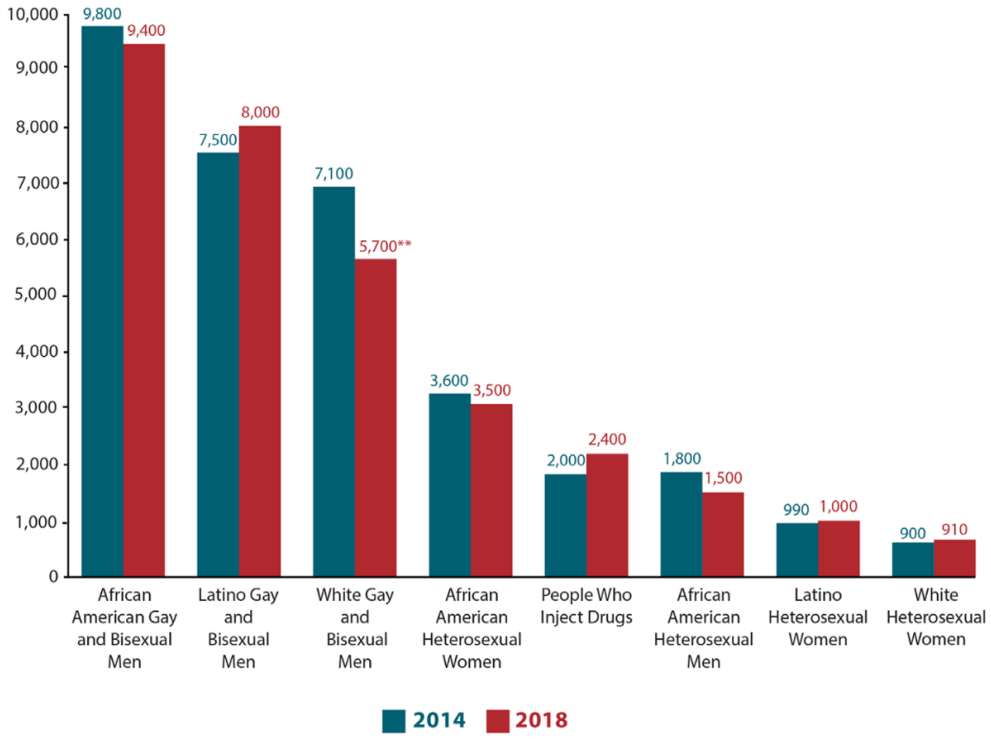
- Born out of Black feminist thought.[1-2]
- Lens for understanding how different identities intersect at the individual level and *interact* with social and structural contexts of privilege and oppression.[1-4]
  - Identity is not the addition of many layers – rather, it's the mutual interaction.[3]
- Known methodological challenges and limitations.[3,5]

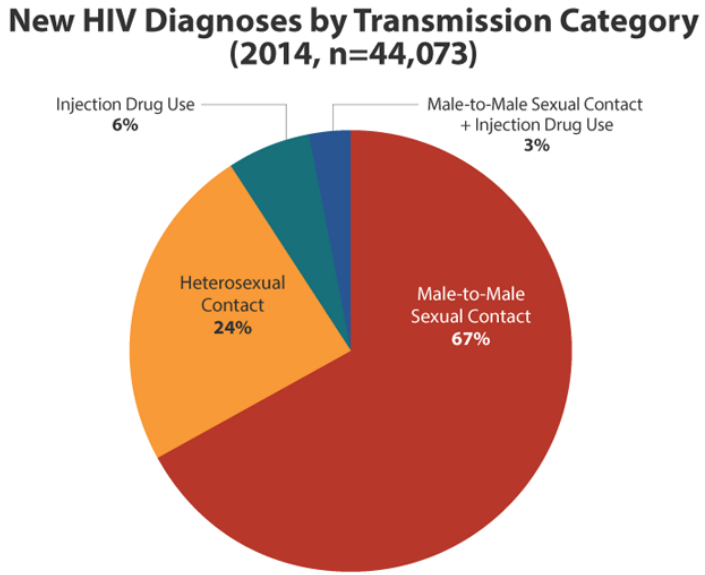
1. Collins, 2000; 2. Crenshaw, 1995; 3. Bowleg, 2012; 4. Warner, 2008; 5. Mereish & Bradford, 2013

Populations Impacted by HIV

- **38 million** people worldwide and **1.2 million** people in the United States were living with HIV at the end of 2018.

- Estimated New HIV Diagnoses in the United States



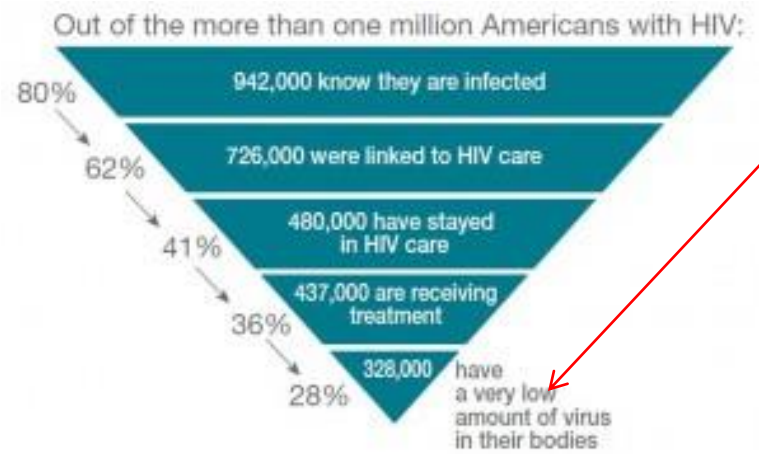


1. hiv.gov, 2020; 2.CDC, 2020

HIV Care Cascade

- Multiple points of intervention for improving HIV outcomes:
  - •Prevention
  - •Testing
  - • Linkage to care
  - • Retention in care
  - • Initiating ART
  - • Adhering to ART
  - • Viral Suppression

Multiple points where socio-behavioral and social interventions can improve HIV treatment outcome.

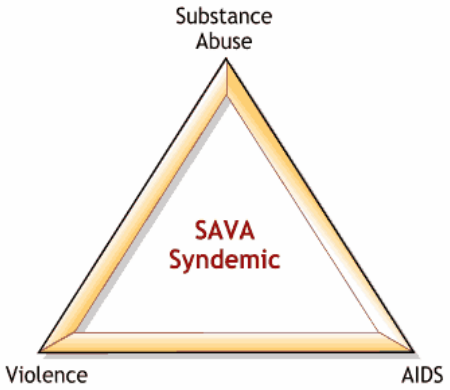


Behavioral and social strategies are needed to address barriers for these individuals - e.g., Treatment as Prevention (TasP).

1. Gardner et al., 2011

HIV & Substance Use

- HIV diagnoses attributed to injection drug use has decreased[1]
  - Although, seeing outbreaks in Boston area[2]
- Alcohol and other substance use associated with sub-optimal HIV-related self-care behaviors and transmission risk.[1]
- **Syndemic Theory –** afflictions interact synergistically to perpetuate disease burden in vulnerable populations.[3]
  - Including other psychosocial challenges associated with HIV, including stigma and discrimination.[4-5]
  - Substance use associated with stigma and discrimination among sexual and gender minorities.[5]



1. CDC, 2017; 2. Boston Public Health Commission; 3 Singer, 1996; 3. Stall et al., 2003; 4. Batchelder et al., 2015; 5. Hafeez et al., 2017

Evidence-Based Treatment Platforms Addressing HIV Prevention/treatment Outcomes in the Context of Mental Health and Substance Use Disorders

Mental health

- Project THRIVE (O'Cleirigh: NIH/NIMH)
- Project TARGET/TRIAD (Safren: NIH/NIMH)
- Project BUILD (Blashill: NIH/NIMH)
- Project ENHANCE (Mayer/Safren)

Substance use

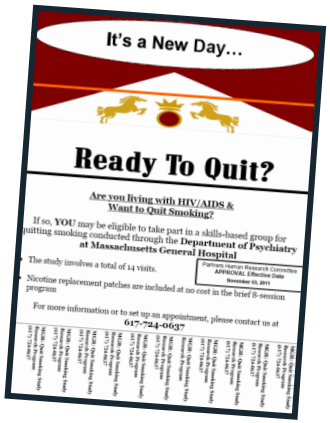
- Project IMPACT (Mimiaga: NIH/NIDA)
- Project QUIT (O'Cleirigh: NIH/NIMH)
- ACES (Batchelder: NIH/NIMH: UCSF CAPS)
- Project Matter (Batchelder; NIH/NIDA)
- Project RISE (Boroughs: Harvard CFAR)

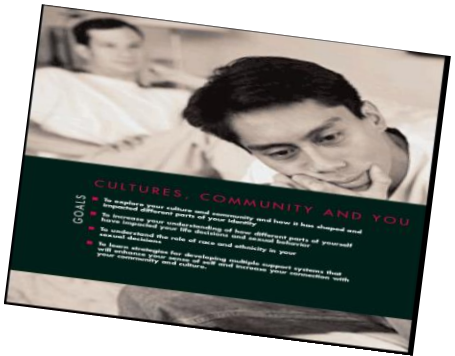
Sexual health / HIV prevention

- Project PrEPare (Mayer/Safren: NIH/NIMH)
- Thrive With Me (Horvath: NIH/NIDA)
- App+ (Horvath)
- GPS (Hart)

Multiple syndemics

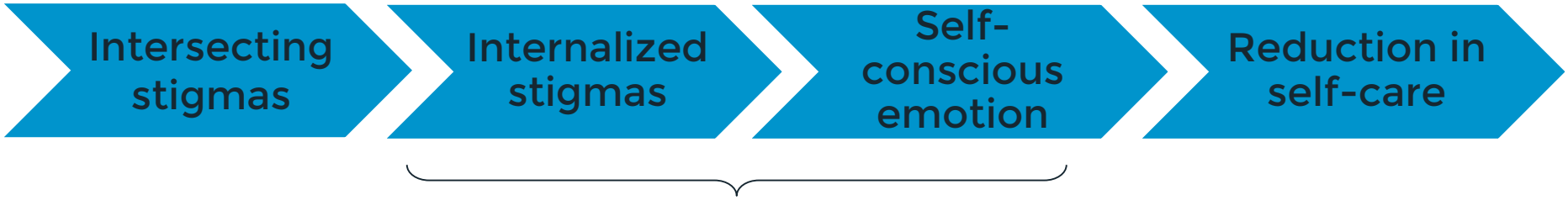
- ESTEEM (Pachankis)
- Project ENGAGE (O'Cleirigh: Harvard CFAR)





Social Model of Health Disparities: Moving Beyond Minority Stress Theory

- Repeatedly heard that stigma, shame, and low levels of self-worth were barriers to engagement in HIV-related self-care.[2-4]



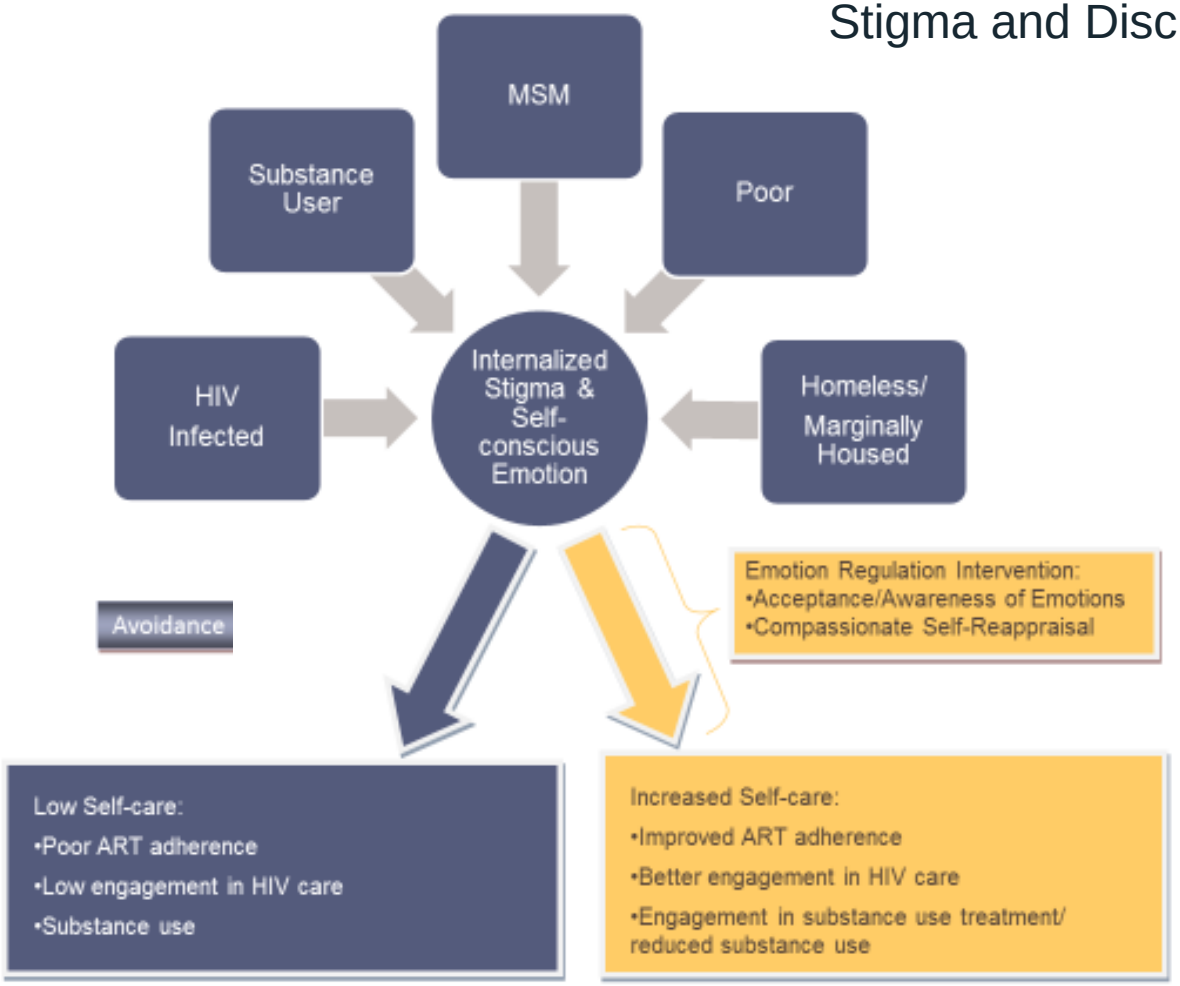
1. Meyer, Schwartz, & Frost, 2008; 2. Batchelder et al., 2013; 3. Batchelder et al., 2015a; 4. Batchelder et al., 2015b

Stigma, Related Emotion, and HIV Self-Care

- Psychological variables associated with lower levels of HIV-related self-care (e.g., medication adherence and appointment attendance).[1-4]
- Internalized stigma, and to a lesser extent related emotions (e.g., shame), have been identified as barriers to HIV-related self-care and reductions in substance use.[5-7]
  - **Internalized stigma** involves the adoption of others' stigmatizing opinions.
    - **Anticipated stigma** involves expecting others will stigmatize.
    - **Enacted stigma** involves experiencing stigma or discrimination.
  - **Self-conscious emotions** involve the affective experience of self-reflection and self-evaluation (i.e., shame, guilt, embarrassment, and pride).
- Need for interventions to improve HIV self-care for people with substance use disorders
  - Acknowledging an intersectional perspective (e.g., HIV+ and sexual minority).[8]

1.Gonzalez, Batchelder et al., 2011; 2. Blashill et al., 2011; 3. Bennett et al., 2015; 4. Tagney & Tracy, 2011; 5. Batchelder et al., 2013; 6. Batchelder et al., 2015; 7. Batchelder et al., in press; ; 8. Mereish & Bradford, 2013.

Working Conceptual Model



Batchelder et al., 2011, 2015a, 2015b, 2016

ACES Pilot: Awareness and Compassion in Self Care

Supported by **UCSF's Center for AIDS Prevention Studies (CAPS) Innovative Early Investigator Pilot Resource Allocation Grant B18121R, Parent Award A118121, NIMH**

PI: Abigail Batchelder, Ph.D., M.P.H.

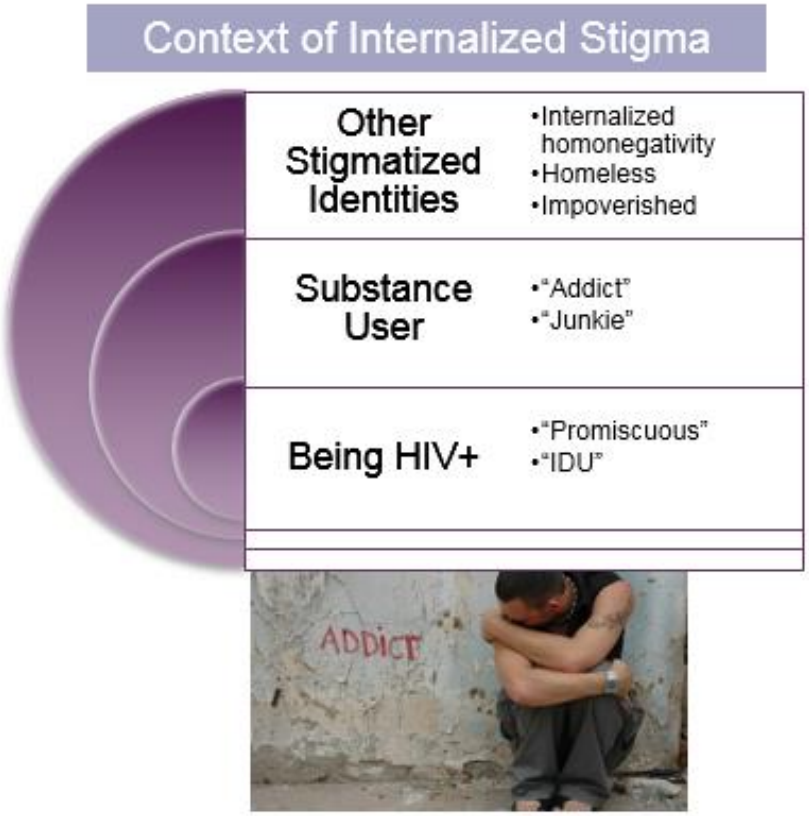
Mentors: Adam Carrico, Ph.D., Rick Hecht, M.D. & Judith Moskowitz, Ph.D., M.P.H.

NCCIH T32AT003997, PI Hecht

UCSF
University of California
San Francisco

ACES

(AWARENESS AND COMPASSION IN SELF-CARE)



- Aimed:
  1. To iteratively develop and refine an *intentionally low-cost* intervention to address stigma and shame as barriers to HIV self-care among people living with substance use disorders.
  2. To test the acceptability and feasibility of the intervention.

Batchelder et al., 2016; Batchelder et al., in press

Supported by UCSF's Center for AIDS Prevention Studies (CAPS) Innovative Early Investigator Pilot Resource Allocation Grant B18121R (Abigail Batchelder, PI), Parent Award A118121, NIMH

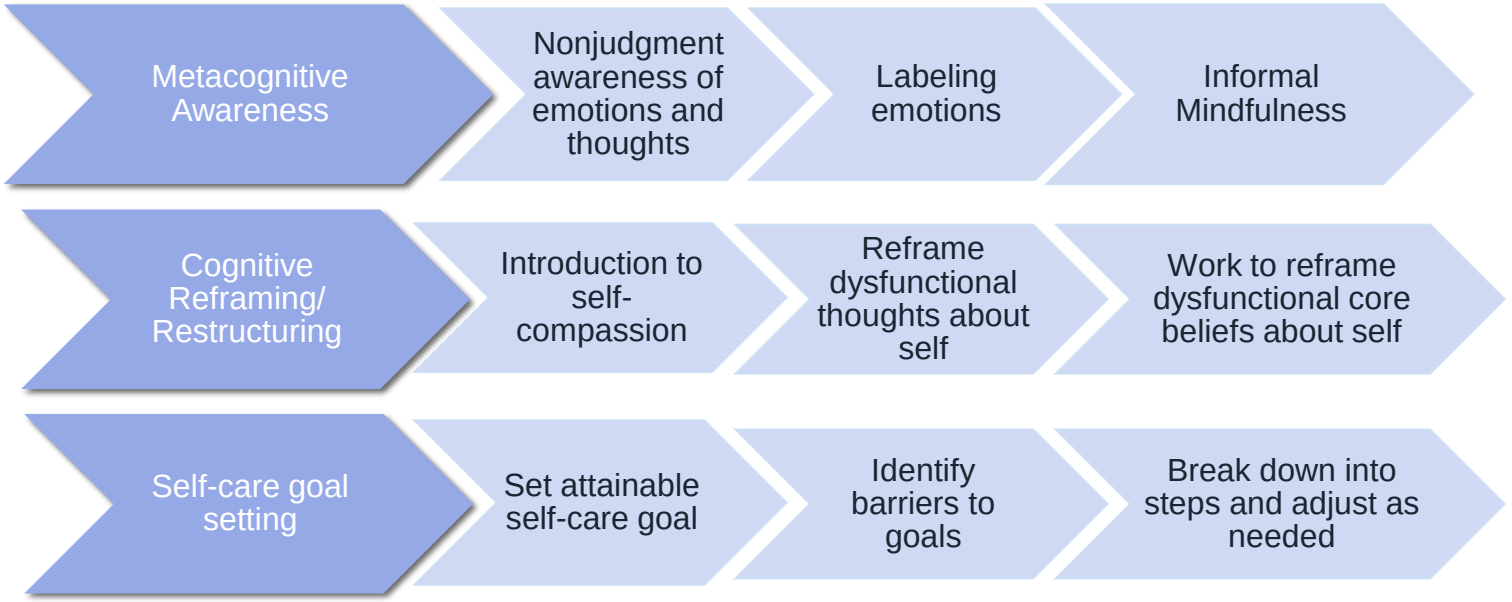
Leveraged Evidence-Based Content

- Informed by:
  - CBT-Adherence and Depression[1]
  - Life-Steps[2]
  - Mindful Self-Compassion[3]
  - Mindfulness-Based Relapse Prevention[4]
  - Revised Stress and Coping Theory[5-6]

1. Safren et al., 2009; 2 Safren et al., 2001; 3. Neff & Germer, 2013; 4. Bowen et al., 2014; 5. Folkman et al., 1988; 6. Moskowitz et al.,

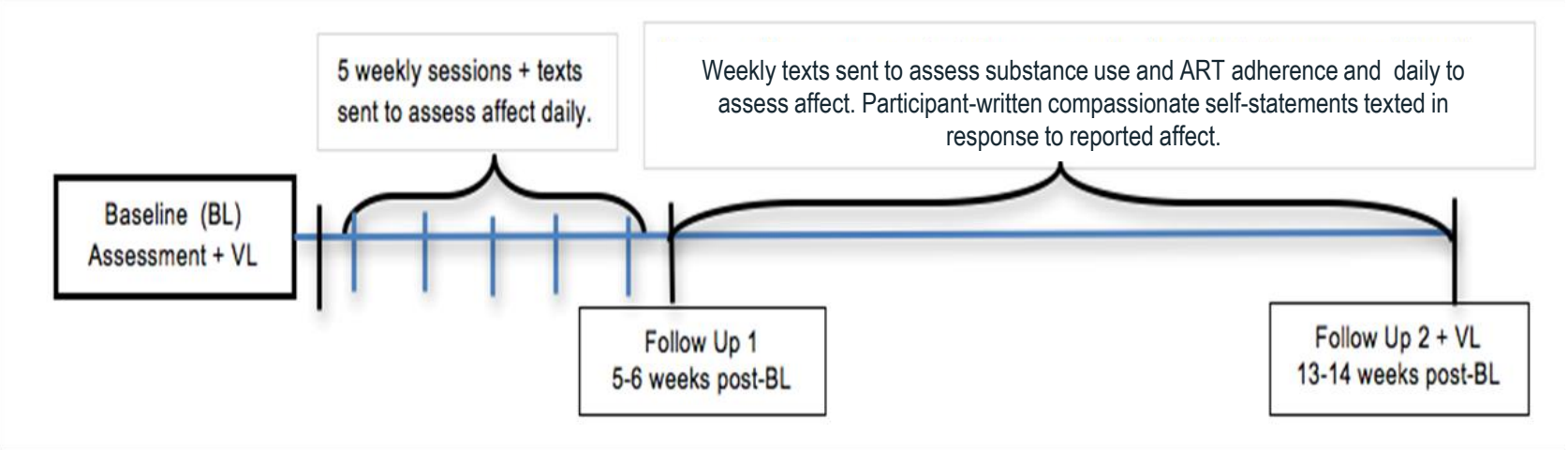
Face to Face Component

- **Flexible three-pronged approach to address internalized stigma and shame among people living with HIV and active substance use**



Described in detail in Batchelder et al., 2020 in *Cognitive and Behavioral Practice*

Open Pilot Study Outline



Described in detail in Batchelder et al., 2020 in *Cognitive and Behavioral Practice*

Proof of Concept Result

Recruitment

- LGBT and HIV-focused community health setting.

- Public hospital substance use and HIV treatment clinics.

N=10	N(%)
Age (Mean(SD))	43.2 (9.6) Range (28-60)
Race & Ethnicity	
Black/African American	4 (40%)
White Non-Hispanic	4 (40%)
Hispanic	2 (20%)
Education	
≤ High school graduate	8 (80%)
> High School	2 (20%)
Sexual Orientation	
Homosexual	5 (50%)
Exclusively Heterosexual	5 (50%)
Ever Homeless	5 (50%)
Polysubstance use	
Alcohol + stimulants (amphetamine or cocaine)	5 (50%)
Alcohol + Benzodiazepines + opioids	1 (10%)
Alcohol + opioids + stimulants	3 (30%)
Stimulants + opioids	1 (10%)

Described in detail in Batchelder et al., 2020 in *Cognitive and Behavioral Pr*

Feasibility and Acceptability

- 8 of 10 participants attended all 5 individual intervention sessions.
- Participants responded to an average of:
  - 77.3% (SD=16.0%; range 46.2-97.7%) of the queries during the individual sessions
  - 70.0% (SD 28.0%; range=8.9-100%) during the follow up
- Likelihood of recommending to a friend (0=not at all -10=definitely)
  - Mean= 9.3 (SD= 2.0), Median= 10 (IQR:10-10)
- Likelihood of recommending to a friend who uses substances (0=not at all - 10=definitely)
  - Mean= 9.7 (SD=0.8), Median=10 (IQR:10-10)
- Preliminary evidence for improvement in adherence.

Described in detail in Batchelder et al., 2020 in *Cognitive and Behavioral Practice*

Next Steps

- Increase understanding of intersecting internalized stigmas in relation to engagement in care among HIV+ MSM with substance use disorders.
  - Harvard CFAR Development Award (INSIGHT; PI Batchelder)

- Pilot RCT of revised ACES intervention.
  - NIDA K23 (PI Batchelder)

INSIGHT Study

(Intersecting Stigmatized Identities & Engagement in HIV Treatment)

Supported by Harvard University Center for AIDS Research Development Award (NIH/NIAID fund 5P30AI060354-13)

PI: Abigail Batchelder, Ph.D., M.P.H.
Co-Mentors: Conall O'Cleirigh, Ph.D. & Ken Mayer, M.D.

INSIGHT Study

Goal: To better understand how three intersecting internalized identities impact HIV-related self-care:

- Person living with HIV
- Person with problematic substance use
- Being gay, bisexual, and a man who has sex with men (MSM)

Aims:

- Conducted 33 qualitative interviews with MSM living with HIV and problematic substance use who are poorly engaged in HIV care.

- Collected self-report data from 207 MSM living with HIV and problematic substance use:

HU CFAR Development Award (PI Batchelder) NIH/NIAID fund 5P30AI060354-13

Recruitment

- Community settings
  - Boston Living Center
  - Multicultural AIDS Coalition
  - HealthCare for the Homeless
  - Codman Square Health Center
  - Fenway Health Center
- Substance use clinics, shelters and HIV/LGBT oriented support services
- Online websites/apps
  - Craigslist
  - Scruff
  - Facebook

Qualitative Interviews

- Semi-structured interviews lasted 30-75 minutes.

- Interviews inquired about:
  - Identity
  - Internalized stigmas
  - Substance use
  - HIV self-care behaviors
  - Relationship between identity, internalized stigma, substance use, and self-care behaviors

Batchelder et al., in press *Social Science and Medicine*

Demographics

N=33	N(%)
Age (Mean(SD))	51.3 (11.03) Range (26-68)
Race	
Black/African American	20 (60.6%)
White	12 (36.4)
Other	1 (3%)
Ethnicity	
Hispanic/Latino	1 (3%)
Education	
≤ High school graduate	12 (36.4%)
Some college/college graduate	15 (45.5%)
> College	5 (15.2%)
Sexual Orientation	
Gay/homosexual	19 (57.6%)
Bisexual	9 (27.3%)
Other	5 (15.2%)
Income	
$10,000 or less	14 (42.4%)
$10,001 to $20,000	11 (33.3%)
$20,001 and above	8 (24.2%)

Qualitative Data – Substance Use

N=33	N(%)
Substance Use	
Alcohol only	6 (18.2%)
Alcohol + stimulants (cocaine/crack + amphetamines)	12 (36.4%)
Alcohol + stimulants + sedatives/benzos	5 (15.2%)
Alcohol + stimulants + opioids + sedatives/benzos	4 (12.1%)
Alcohol + stimulants + opioids	2 (6.1%)
Stimulants + sedatives/benzos	2 (6.1%)
Alcohol + opioids + sedatives/benzos	1 (3.0%)
Stimulants	1 (3.0%)
Marijuana	22 (78.8%)
Tobacco	25 (75.8%)
Club drugs	13 (39.4%)

Analytic Methods

- Used Thematic Analysis,[1] informed by Grounded Theory.[2]

- Iteratively developed coding structure.
  - Refining based on discussions of discrepant interpretations.

- Double coded all 33 interviews using final coding structure.
  - Discussing discrepancies.

- Iteratively analyzed the results, following the steps of Thematic Analysis.[1]

1. Braun & Clarke, 2006; 2. Glaser & Strauss, 1967

Summary of Primary Qualitative Results

- 30 participants included content consistent with "internalized stigma."
- Internalized stigma related to:
  - *Substance use reported by almost all participants*
  - HIV-status reported by the majority
  - Sexual orientation reported by approximately one third
- Most non-white participants described race and discrimination in relation to other internalized stigmas.
- Several participants described internalized stigma related to mental illness, femininity, religiosity, and trauma histories.

Batchelder et al., in press *Social Science and Medicine*

Internalized Stigma & Substance Use

- Most described internalized stigma and related emotions → substance use.

"A little bit of shame, a lot of self-hatred, and embarrassment. Why? It's like very negative things, and it's all because I'll put myself off… Like, I'm a happy okay person. But when I get involved with drugs and alcohol, I'm doing that because I do not like myself. I'm not feeling good about myself. I'm lonely. I'm angry." * 55-year-old White non-Hispanic gay male

- Several explicitly described using to avoid negative emotions.

"You use drugs because you're miserable. But you're miserable because you use drugs. It's like a Catch-22." *53-year-old White non-Hispanic bisexual male

"I think what happened to me when I started using was the very reason that I've plummeted even more into it… because I was trying to numb every aspect of my emotions… I was trying to kill anything that felt vulnerable, anything that felt soft, like emotions. I was trying to get rid of it. And I mean, I went from just puffs, to at one point using the needles.

*30-year-old Black bisexual male

Batchelder et al., in press *Social Science and Medicine*

Internalized Stigma & Substance Use

- Most participants described relationships between avoidance of judgment and rejection, isolation, and substance use.

"Why can't they just accept me for who I am? … and then from there, it's just ..downhill, because I start feeling bad about myself… I don't want to feel that pain, so I'm going out to use. I'm going out to drink." -54 year old Black bisexual male

"I didn't want anyone to know that I was using crack and I didn't want anybody to know that I was HIV positive. So I was going home and locking doors and I was pushing people away." - 68 year old Black gay male

Batchelder et al., in press *Social Science and Medicine*

Internalized Stigma, Substance Use & HIV Self-care

- Most participants reported that internalized stigma → substance use →poor HIV self-care.

"And sometimes … I don't even like pills. I'll do crack. That'll solve it. (laughs) I'll do alcohol. In my mind, that'll solve it. But in reality, it doesn't… Because I don't have to think about anything. It takes me away from thinking about me and my life, and living with HIV, being gay, all that… It takes me away from myself so I don't have to deal with myself."

*54-year-old Black bisexual male

- Themes of avoidance and isolation were described by many participants.

"I'll go get high and I won't take my meds, and it's just like I'll destroy– because I won't talk to people. And …people will be calling me and I'll avoid people. And then I won't care. I won't care about myself, but I damn sure won't care about other people either…"

*50-year-old Black bisexual male

Batchelder et al., in press *Social Science and Medicine*

Quantitative Aims

- Assess levels of 3 types of internalized stigma in sample:
  - Internalized HIV Stigma
  - Internalized Homonegativity
  - Internalized Substance Use Stigma

- Evaluate relationships between internalized stigmas and:
  - Missed HIV-related appointments
  - Avoidance coping

- Explore indirect relationship between internalized stigmas and missed appointments, via avoidance coping

Batchelder et al., 2020 *AIDS & Behavior*

Demographics

N=202		N(%)
Age (Mean(SD))		47.06 (12.08) Range (22-75)
Race	Black/African American	61 (30.7%)
	White	112 (56.3%)
	Other	26 (13.1%)
	American Indian/Alaskan Native	10 (5%)
	Asian	7 (3.5%)
	Native Hawaiian or Pacific Islander	1 (0.5%)
	Unknown	8 (3.9%)
Ethnicity	Hispanic/Latino	28 (13.9%)
Education	≤ High school graduate	61 (30.3%)
	Some college	53 (26.4%)
	College graduate	44 (21.9%)
	> College	43 (21.4%)
Sexual Orientation	Gay/homosexual	161 (79.7%)
	Bisexual	28 (13.9%)
	Other	13 (6.4%)
Income	$10,000 or less	62 (30.8%)
	$10,001 to $20,000	62 (30.8%)
	$20,001 and above	77 (38.3%)

Batchelder et al., 2020 *AIDS & Behavior*

Self-Reported Substance Use

N=202	Use in past 3 months	> 1-2 times in past 3 months	Ever Problematic
Alcohol	183 (93%)	139 (70%)	75 (38%)
Cocaine or crack	70 (36%)	Crack 28 (14%) Cocaine 18 (9%)	57 (29%)
Amphetamines (meth, speed, crystal)	75 (38%)	Crystal 39 (20%) Amphetamines 20 (10%)	48 (24%)
Opioids or opiates	29 (15%)	Heroin 24 (12%) Opiates 20 (10%)	Heroin 14 (7%) Opiates 12 (6%)
Sedatives/benzos	65 (33%)	30 (15%)	10 (5%)
Other drugs (poppers, nitrous oxide, etc.)	84 (42%)	43 (22%)	12 (6%)
Marijuana	137 (70%)	94 (47%)	30 (15%)
Club drugs (ecstasy, ketamine, GHB)	55 (28%)	--	--

Batchelder et al., 2020 *AIDS & Behavior*

Bivariate Associations with Missed HIV Appointments

	OR (95%CI)	p-value
HIV Internalized Stigma		
Stereotypes	1.12 (0.78, 1.58)	.513
Disclosure	1.33 (1.00, 1.76)	.051
Social Relationships	1.24 (0.91, 1.69)	.180
Self-Acceptance	1.10 (0.80, 1.52)	.546
Internalized Homonegativity	1.30 (0.97, 1.75)	.083*
Internalized Substance Use Stigma	1.47 (1.15, 1.87)	.002

Batchelder et al., 2020 *AIDS & Behavior*

Multivariate Relationship with Missed HIV Appointments

	OR (95%CI)	p-value
HIV Internalized Stigma		
Stereotypes	0.87 (0.53, 1.35)	.847
Disclosure	1.41 (0.95, 2.11)	.089
Social Relationships	0.86 (0.54, 1.35)	.504
Self-Acceptance	0.89 (0.59, 1.35)	.592
Internalized Homonegativity	1.16 (0.83, 1.62)	.397
Internalized Substance Use Stigma	1.44 (1.08, 1.91)	.012

Batchelder et al., 2020 *AIDS & Behavior*

Bivariate Associations with Avoidance Coping

	B (95%CI)	p-value
Internalized HIV Stigma		
Stereotypes	0.09 (-0.02,	.115
Disclosure	0.21)	.031
Social Relationships	0.10 (0.01, 0.20)	<.001
Self-Acceptance	0.29 (0.19, 0.36)	.878
	0.01 (-0.10, 0.12)	
Internalized Homonegativity	0.26 (0.18, 0.35)	<.001
Internalized Substance Use Stigma	0.22 (0.14, 0.29)	<.001

Batchelder et al., 2020 *AIDS & Behavior*

Indirect Effect of Internalized Substance Use Stigma on Missed Appointments via Avoidance Coping

- Avoidance coping partially accounted for the relationship between internalized stigma and missing any HIV related appointments in the past 6 months.
  - However, bootstrapping* indicates indirect effect do not meet significance (.11 (SE=0.05), 95%CI: -0.002, 0.212).

* Bootstrapping is a statistical procedure that resamples a single dataset to create many simulated samples.

Batchelder et al., 2020 *AIDS & Behavior*

Substance Use Stigma

Substance Use Stigma		Mean (SD)
(1= never -5 = very likely)	Internalized	2.60 (1.23)
	Enacted	2.12 (1.03)
	Anticipated	2.27 (1.12)

Bivariate Associations with Missed HIV Appointments			
		OR (95%CI)	p-value
Substance Use Stigma		1.47 (1.15, 1.87)	.002
Internalized		2.08 (1.52, 2.84)	<.001
	Enacted	1.44 (1.11, 1.88)	.006
	Anticipated		

Bivariate Associations with Avoidance Coping			
		B (95%CI)	*p-value*
Substance Use Stigma		0.22 (0.14, 0.29)	<.001
Internalized		0.29 (0.21, 0.38)	<.001
	Enacted	0.23 (0.15, 0.31)	<.001
	Anticipated		

Batchelder et al., 2020 *AIDS & Behavior*

Indirect Effect of Anticipated and Enacted Substance Use Stigma on Missed Appointments via Avoidance Coping

- Avoidance coping accounts for the relationship between anticipated stigma and missing any HIV related appointments in the past 6 months.
  - Bootstrapping indicates indirect effect are significant (.12 (SE=0.06), 95%CI: 0.015, 0.248).
- Avoidance coping did not account for the relationship between enacted stigma and missing any HIV related appointments in the past 6 months.
  - Bootstrapping indicates no indirect effect are significant (.08 (SE=0.08), 95%CI: -0.07, 0.234).

Batchelder et al., 2020 *AIDS & Behavior*

Limitations

- Cross-sectional
- Relatively small sample size
- Heterogeneous sample in relation to substance use
- Sample was collected anonymously
- Internalized stigma may be underreported

Conclusions

- Among this sample of MSM living with HIV and problematic substance use:
  - HIV stigma and internalized homonegativity were not associated with missed appointments.
  - Internalized, anticipated, and enacted substance use stigma were associated with missed HIV appointments.
- Avoidance coping:
  - Partially accounts for the relationship between internalized substance use stigma and missed HIV appointments.
  - Accounts for the relationship between anticipated substance use stigma and missed HIV appointments.
  - Does not account for the relationship between enacted substance use stigma and missed HIV appointments.

Batchelder et al., 2020 *AIDS & Behavior*

Clinical Implications

- Anticipated and enacted substance use stigma may be a barrier to engagement in HIV and primary care practices among MSM.

- Intervening on avoidance coping tendencies may reduce the impact of anticipated and internalized substance use stigma on engagement in healthcare.
  - Including cognitive behavioral therapy strategies, such as behavioral activation or opposite action.[1-3]
  - However, addressing avoidance coping may not be sufficient to affect the relationship between enacted, or experienced, substance use stigma and missed HIV-care appointments.

- Providers and those working in clinical contexts need to be cognizant of reducing enacted substance use stigma, or discrimination, against people living with HIV who use substances.
  - Including being aware of unintentional displays of perceived stigma.

1. Safren , Blashill, & O'Cleirigh, 2011; 2. Stotts & Northrup, 2015; 3. O'Cleirigh & Safren, 2008

Refinement of Intervention

- Refined existing intervention focused on improving HIV care cascade indicators for MSM living with HIV and substance use disorders who are poorly engaged in care in Boston.
  - Integrated results from:
    - INSIGHT study:
      - Qualitative Interviews
      - Self-report Data

    - Qualitative feedback on refined intervention content

Project MATTER

Supported by NIDA/NIH (K23DA043418)

PI: Abigail Batchelder, Ph.D., M.P.H.

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Project Matter

About:

- A text-enhanced therapy intervention for MSM living with HIV and active substance use disorders.
- Aims to improve HIV self-care behaviors by increasing emotion regulation and coping strategies to overcome stigma and related emotions.

Sample size:

- n=60 (30 intervention, 30 control)

Participants are compensated for all study visits (up to $332) and travel

Supported by NIDA/NIH (K23DA043418)
PI: Abigail Batchelder, Ph.D., M.P.H.

Future Directions

- Continue program of research to intervene on stigma and shame as barriers to self-care behaviors among MSM and other people who use substances living with HIV.

- Multilevel interventions are needed to concurrently address individual, provider-level, and structural barriers to self-care among people living with substance use disorders and HIV.

- Efforts are needed to reduce stigma and discrimination against people with stigmatized identities including sexual minorities, people with HIV, and people who use substances.

Questions?

- Special Thanks to:
  - Conall O'Cleirigh, PhD
  - Kenneth Mayer, MD
  - Adam Carrico, Ph.D.
  - Judy Moskowitz, Ph.D., M.P.H.
  - Sara Rodriguez, BA
  - Jesse Najarro Cermeno, BA
  - Aron Thiim, BA
  - Elsa Sweek, MS
  - Samantha Marquez, LCSW

Supported by:

- ❑ UCSF Innovative Early Investigator Pilot Resource Allocation Grant (NIH/NIMH fund B18121R, Parent Award A118121), PI Batchelder
- ❑ Harvard CFAR Development Award (NIH/NIAID fund 5P30AI060354-13), PI Batchelder
- ❑ NIH/NIDA (K23DA043418), PI Batchelder

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