



Original Article

The experience of double stigma among LGBT people living with HIV in Lampung, Indonesia: A qualitative study

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ABSTRACT

Background & Aim: Lesbian, gay, bisexual, and transgender (LGBT) people living with HIV in Indonesia experience double stigma related to HIV status and sexual or gender identity across family, community, and health-care settings. Sociocultural and religious norms in Indonesia reinforce moral judgment and social exclusion, and these pressures reduce psychological well-being, social safety, and continuity of HIV care. Indonesian studies mostly examine HIV-related stigma and LGBT-related stigma separately, so evidence remains limited on how both forms of stigma interact as double stigma.

Materials & Methods: A qualitative study with a descriptive phenomenological design used purposive sampling to recruit 18 LGBT people living with HIV from community-based settings in Lampung, Indonesia. Data were collected using semi-structured interviews between August and October 2025. The researchers conducted in-depth face-to-face interviews and analyzed manually using Colaizzi's method to identify core themes of lived experience.

Results: The analysis identified three main themes and eight interrelated subthemes reflecting participants' experiences of dual stigma. The themes included Identity Struggles Under HIV and LGBT Stigma, Family Responses to HIV and LGBT Identity, and Community Reactions to HIV and LGBT Identity.

Conclusion: Individuals living with HIV from LGBT backgrounds experience intersecting forms of stigma that affect their identity, family dynamics, and community participation. Addressing both HIV-related and identity-based stigma is essential to reduce psychosocial distress and promote inclusive support systems. These findings underscore the urgent need for family- and community-engaged interventions to safeguard holistic well-being and sustain HIV care among LGBT people living with HIV.

Introduction

Human immunodeficiency virus (HIV) remains a major global public health concern, with sexual and gender minority populations including lesbian, gay, bisexual, and transgender (LGBT) people (1). Recent global evidence shows a substantial HIV burden among transgender populations and other key populations, and this burden reflects persistent social marginalization and limited access to prevention and treatment services (2). Among LGBT people living with HIV, health challenges extend beyond clinical management and include double stigma, namely the

combined impact of HIV-related stigma and sexuality- and gender-related stigma (3). Double stigma increases psychological distress, reduces safety in status disclosure, weakens social support, and undermines engagement across the HIV care continuum (4). The impact of double stigma becomes more pronounced in settings where heteronormative norms, moral judgment, and structural discrimination shape everyday social life (2, 5).

In Indonesia, stigma surrounding both HIV and LGBT identities is strongly shaped by

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sociocultural and religious norms, which can influence family expectations, social belonging, and perceived moral legitimacy. Studies in Indonesian contexts have shown that HIV-related stigma may be enacted across families, communities, and health services, driven by fear of transmission, misinformation, and moralized interpretations of HIV (6). Among men who have sex with men (MSM) living with HIV, qualitative evidence from Indonesia further underscores how stigma and social pressures can shape daily life and health engagement, particularly when disclosure is perceived as threatening to family relationships and social standing (7). Stigma within health-care encounters may add another layer of vulnerability, including confidentiality concerns and judgmental attitudes that discourage timely help-seeking and sustained adherence (7).

Family and community environments are central to Indonesian social life and have the potential to function as both protective systems and sources of harm. Emerging evidence indicates that supportive family relationships are associated with improved treatment engagement and psychological adjustment among sexual minority people living with HIV, while rejection and fear-driven responses can deepen distress and social withdrawal (7, 8). At the community level, stigma can appear through gossip, social avoidance, workplace discrimination, and exclusion from collective activities, reinforcing concealment and limiting access to supportive resources (9). Nevertheless, LGBT people living with HIV frequently develop resilience strategies such as connecting with peer networks and trusted counselors that help restore self-worth, strengthen coping, and rebuild meaning within everyday community life (10).

Despite these insights, contextually grounded qualitative evidence remains limited regarding how LGBT people living with HIV in Indonesia experience and negotiate double stigma within community contexts, particularly across the interconnected spheres of identity reconstruction, family dynamics, and community interaction. Understanding these

experiences is essential for strengthening community-based nursing responses that are culturally sensitive, stigma informed, and inclusive. Therefore, this study aimed to explore the experience of double stigma in community contexts among LGBT people living with HIV in Indonesia.

Methods

Study design

This qualitative study employed a descriptive phenomenological design to explore the lived experience of double stigma among LGBT people living with HIV in community contexts in Indonesia. This design was appropriate because the study aimed to describe the essence and meaning of participants' experiences. In addition, descriptive phenomenology supports methodological rigor by emphasizing careful description of the phenomenon and reflexive bracketing of researchers' preconceptions. The study followed Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines.

Study setting

The study was conducted in urban and peri-urban community across three cities: Tulang Bawang, Pringsewu, and Bandar Lampung in Lampung Province, Indonesia. The study involved one community-based organization and three HIV care clinics. These sites were selected purposively because they were trusted access points for LGBT people living with HIV and routinely provided psychosocial support and HIV-related services in stigmatizing social environments.

Participants and sampling

Participants were recruited using purposive sampling with maximum variation to capture diverse experiences across gender identity, sexual orientation, age, duration of HIV diagnosis, and living arrangements. Inclusion criteria were self-identification as LGBT, age of 18 years or older, having lived with HIV for at least six months, experience accessing HIV-related care in community

contexts, and willingness to participate in an in-depth interview. Individuals experiencing acute illness or severe psychological distress at the time of recruitment were excluded. A total of 18 participants were enrolled.

Recruitment continued until informational adequacy was achieved. The principal investigator and two trained qualitative researchers evaluated adequacy through iterative post-interview debriefing, comparison of analytic memos, and preliminary coding of each transcript. Redundancy of experiential themes was observed by the 15th interview, and three additional interviews were completed to confirm thematic stability, resulting in a final sample of 18 participants with no substantively new themes.

Data collection

Data collection took place between August and October 2025. Data were collected through in-depth semi-structured interviews lasting approximately 60–90 minutes. Interviews were conducted in Bahasa Indonesia to ensure linguistic and cultural appropriateness and took place in private rooms within community organizations or HIV clinics. All interviews were audio-recorded with participant consent and transcribed verbatim by the research team. A semi-structured interview guide was developed based on the study aims and qualitative literature on stigma, identity, and HIV among sexual and gender minorities, and explored emotional responses to HIV diagnosis, family reactions and relational changes, experiences of stigma within community contexts, coping strategies, and future expectations.

Study instrument

An interview guide was developed and pretested by the researchers through pilot face-to-face interviews with individuals who matched the study profile but were not included in the final sample. The pretesting assessed question clarity, cultural appropriateness, sensitivity of wording, and interview flow. Findings from pretesting informed revisions to the guide, including refinement of item

wording, reordering of questions from less sensitive to more sensitive topics, and addition of neutral follow-up probes to support in-depth and safe data collection.

The interview guide consisted of two sections. Section A included participants' socio-demographic characteristics, such as age, gender identity, sexual orientation, educational background, duration of HIV diagnosis, and living arrangements. Section B comprised a grand tour question designed to initiate the interview and allow participants to freely describe their experiences of living as LGBT individuals with HIV within their family and community contexts. The grand tour question was open-ended and enabled participants to narrate their experiences in a relaxed and natural manner. This question was followed by probing questions that emerged from participants' initial responses to address the research objectives. The probes focused on participants' experiences following HIV diagnosis, changes in self-perception, family responses after HIV status disclosure, and interactions within the community. The probing questions assisted in gaining deeper insight into participants' lived experiences. Examples of probes included: (1) *Can you describe your experience when you first learned about your HIV status as an LGBT individual?* (2) *How did your family respond after they learned about your HIV status and your LGBT identity?* (3) *What kinds of reactions or support have you experienced from people in your community regarding your HIV status and LGBT identity?*

Researcher reflexivity

Interviews were conducted by a nurse researcher with formal training in qualitative methods and experience working with HIV affected and marginalized populations. The researcher had no prior therapeutic or personal relationship with participants before data collection. Reflexivity was maintained throughout the study through reflexive journaling and bracketing of assumptions related to HIV, sexuality, and stigma, as well as regular peer debriefing within the research team to critically reflect on data interpretation

and minimize researcher influence on the analytic process.

Ethical considerations

Ethical approval was obtained from the Research Ethics Committee of the Faculty of Nursing, Universitas Indonesia (Approval No. KET-251/UN2.F12.D1.2.1/PPM.00.02/2025). All procedures adhered to the Declaration of Helsinki and international ethical standards for research involving human participants. Written informed consent was obtained from all participants prior to data collection. Confidentiality was ensured through the use of pseudonyms and secure storage of all data on encrypted, password-protected devices.

Data analysis

Data analysis manually followed Colaizzi's descriptive phenomenological method to systematically capture the essence of participants' lived experiences. The analytic process involved (1) repeated reading of all transcripts to achieve immersion and holistic understanding, (2) extraction of significant statements related to experiences of double stigma, family dynamics, and community interactions, (3) formulation of meanings grounded in participants' original narratives, (4) clustering of formulated meanings into categories based on conceptual similarity, (5) synthesis of categories into overarching thematic structures, (6) development of an exhaustive description integrating all themes into a coherent account of the phenomenon, and (7) participant validation by returning

synthesized findings to selected participants to confirm accuracy and resonance (11).

Trustworthiness

Methodological rigor was ensured using established qualitative criteria of credibility, dependability, confirmability, and transferability. Credibility was enhanced through prolonged engagement with community contexts, participant validation, and peer debriefing. Dependability was supported by maintaining an audit trail documenting analytic decisions. Confirmability was strengthened through reflexive journaling and independent analytic review. Transferability was facilitated by providing rich descriptions of participants, settings, and sociocultural context to enable assessment of applicability to similar populations (12).

Results

A total of eighteen LGBT individuals living with HIV participated in this study. Participants varied in age, gender identity, sexual orientation, educational background, duration since HIV diagnosis, and living arrangements. Most participants identified as men who have sex with men (MSM). Of the 18 participants, 11 identified as MSM, 4 as heterosexual, and 3 as bisexual, indicating that MSM represented the largest subgroup. The mean age was 31.11 years, and the mean duration since HIV diagnosis was 5 years. An overview of the participants' socio-demographic characteristics is presented in Table 1.

Table 1. Characteristics of Participants (n = 18)

Participant	Age	Gender identity	Sexual orientation	Duration of HIV diagnosis	ART status	Living situation	Education	Occupation
P1	24	Gay man	MSM	1 year	On ART	Alone	High school	Barista
P2	31	Transgender woman	Heterosexual	3 years	On ART	Boarding house	High school	Make-up artist
P3	27	Bisexual man	Bisexual	2 years	On ART	With family	Bachelor's	Freelancer
P4	35	Gay man	MSM	5 years	On ART (returned)	With friends	Diploma	Private employee
P5	22	Gay man	MSM	8 months	On ART	Alone	High school	Student
P6	29	Transgender woman	Heterosexual	4 years	On ART	Boarding house	Junior high school	Informal worker
P7	33	Gay man	MSM	7 years	On ART	With family	High school	Entrepreneur
P8	41	Bisexual man	Bisexual	10 years	On ART	With partner	Bachelor's	Civil servant

Participant	Age	Gender identity	Sexual orientation	Duration of HIV diagnosis	ART status	Living situation	Education	Occupation
P9	26	Gay man	MSM	3 years	On ART	Alone	High school	Motorcycle taxi driver
P10	37	Gay man	MSM	12 years	On ART	With family	Bachelor's	Lecturer (contract)
P11	28	Transgender woman	Heterosexual	6 years	On ART	With colleague	Junior high school	Salon worker
P12	30	Gay man	MSM	5 years	On ART	Alone	Bachelor's	Graphic designer
P13	23	Gay man	MSM	9 months	On ART	Boarding house	High school	Barista
P14	32	Bisexual man	Bisexual	4 years	On ART	With partner	Bachelor's	Self-employed
P15	45	Gay man	MSM	15 years	On ART	With family	High school	Street vendor
P16	38	Transgender woman	Heterosexual	7 years	On ART	Alone	High school	Tailor
P17	34	Gay man	MSM	3 years	On ART	Boarding house	Diploma	Shop attendant
P18	25	Gay man	MSM	1.5 years	On ART	With friends	High school	Content creator

ART: Antiretroviral therapy; MSM: Men who have sex with men

Main findings

Analysis of the interview data resulted in three interrelated themes, reflecting participants' lived experiences of living with HIV within family and community contexts. These themes describe participants' struggles with identity and self-acceptance after HIV

diagnosis, the complex dynamics of family relationships following disclosure, and experiences of stigma, coping, and resilience within the community. Each theme comprises several subthemes that capture the depth and variation of participants' narratives. An overview of the themes and subthemes is presented in Table 2.

Table 2. interpretative framework: themes, subthemes, and quotes from participants

Theme	Subthemes
1. Identity Struggles Under HIV and LGBT Stigma	1.a Emotional Shock from HIV Diagnosis and LGBT Stigma 1.b Moral and Religious Conflict Related to HIV and LGBT Identity
2. Family Responses to HIV and LGBT Identity	2.a Family Rejection Due to HIV and LGBT Stigma 2.b Blame and Moral Judgment from Family 2.c Emotional Distress from Family Discrimination
3. Community Reactions to HIV and LGBT Identity	3.a Social Rejection and Double Stigma in the Community 3.b Social Avoidance and Exclusion 3.c Stigmatizing Labels Linking HIV to LGBT Identity

Theme 1: Identity struggles under HIV and LGBT stigma

This theme reflects participants' internal struggles in negotiating their identity after receiving an HIV diagnosis while simultaneously managing stigma related to their sexual or gender identity. Participants described how these two dimensions were not experienced separately but rather intertwined, creating a complex emotional and psychosocial burden. The diagnosis of HIV often intensified pre-existing concerns related to LGBT identity, leading to emotional shock, inner conflict, and challenges in self-acceptance.

Two interrelated subthemes emerged within this theme: emotional shock following HIV diagnosis in the context of LGBT stigma, and moral and religious conflict associated with HIV status and sexual identity. These subthemes illustrate how participants navigated personal meaning, self-worth, and identity reconstruction under dual layers of stigma.

Sub theme 1.a : Emotional shock from HIV diagnosis and LGBT stigma

This subtheme captures the immediate emotional reactions participants experienced after learning their HIV-positive status, particularly how this diagnosis intersected with

their LGBT identity. The emotional shock was not limited to fear of illness but also included concerns about identity, self-acceptance, and the perceived burden of managing both HIV status and sexual identity simultaneously. Participant 3 expressed: *“When I found out I was HIV positive, I felt completely overwhelmed. I struggled to accept not only the diagnosis but also how it related to my identity as an LGBT person. It felt like I had to face two difficult truths about myself at once.”* (P3). This statement indicates that the diagnosis triggered dual psychological challenges: coping with a chronic health condition while reassessing personal identity. The phrase “two difficult truths” suggests an intersection of health-related stigma and identity-related stigma, which intensified emotional distress.

Similarly, participant 1 stated *“I experienced a lot of emotional turmoil after the diagnosis. I felt vulnerable and uncertain about my future. Accepting myself as someone living with HIV while also embracing my sexual identity was emotionally challenging.”* (P1) This reflects ongoing emotional vulnerability rather than a one-time reaction. The participant highlights the difficulty of integrating HIV status into an already complex identity framework. The emotional turmoil described suggests that dual stigma may complicate adjustment processes and self-acceptance.

Sub theme 1.b : Moral and religious conflict related to HIV and LGBT identity

This subtheme reflects participants’ internal moral and spiritual conflicts following HIV diagnosis, particularly within sociocultural contexts where both HIV and LGBT identities may carry moral stigma. Participants described feelings of guilt, shame, and perceived spiritual struggle, often interpreting their condition through moral or religious frameworks. Participant 7 stated *“After the diagnosis, I felt intense guilt. I questioned myself not only because of HIV, but also because I was raised to believe that my sexual identity was sinful. I felt like God was punishing me twice.”* (P7). This statement illustrates internalized moral stigma, where both HIV status and sexual identity are

interpreted through religious beliefs. The perception of “punishment” suggests a deep moral conflict that may affect psychological well-being and spiritual coping.

Participant 13 expressed *“I felt ashamed when I prayed. I thought my illness was a consequence of my lifestyle. The stigma from society and the religious expectations made me doubt my worth as a person.”* (P13) This reflects how societal stigma and religious expectations intersect with personal identity, influencing self-worth and spiritual experience. The participant’s sense of shame indicates internalized stigma that may contribute to emotional distress and challenges in self-acceptance.

Theme 2: Family responses to HIV and LGBT identity

This theme describes how participants experienced family reactions after disclosure of their HIV status alongside their sexual or gender identity. Family responses emerged as a critical factor influencing participants’ emotional well-being, identity acceptance, and coping processes. Participants reported that reactions from family members were often shaped not only by HIV-related stigma but also by pre-existing attitudes toward LGBT identity. These combined responses created a layered form of stigma that affected participants’ sense of belonging within their families.

Three subthemes were identified within this theme: family rejection related to HIV and LGBT stigma, blame and moral judgment from family, and emotional distress resulting from family discrimination. These subthemes illustrate how family dynamics may reinforce dual stigma and contribute to psychological challenges among participants.

Sub theme 2.a: Family Rejection Due to HIV and LGBT Stigma

This subtheme reflects participants’ perceptions of distancing, rejection, or reduced acceptance within their families after disclosure of both HIV status and LGBT identity. The rejection was not always explicit but often manifested through emotional distance, reduced openness, or a perceived loss

of familial belonging. Participant 2 stated “*I sensed rejection from my family not only because of HIV, but also because of my sexual identity. It made me feel like I didn’t fully belong in my own family anymore.*” (P2). This statement suggests that dual stigma influenced the participant’s sense of inclusion within the family. The feeling of not fully belonging indicates emotional alienation that may affect psychological stability and identity development.

Another participant 18 stated “*After my family learned about my HIV status, I felt a distance growing between us. It became harder for me to be open about both my health condition and my identity as an LGBT person.*”(P18) This account highlights how perceived rejection can reduce communication and openness within families. Such distancing may limit emotional support and hinder coping with chronic illness and identity-related stress.

Sub theme 2.b: Blame and moral judgment from family

This subtheme captures experiences in which participants perceived their HIV diagnosis as being morally interpreted or attributed to their sexual identity by family members. Participants described feelings of being blamed, judged, or morally evaluated in ways that linked their health condition with their identity. Participant 12 stated: “*My family often implied that my HIV diagnosis was the result of my sexual identity. Hearing that made me feel blamed, as if my condition was seen as a moral failure.*”(P12) This statement reflects internalized moral stigma, where participants perceived their illness as being framed within moral judgment. Such perceptions may intensify guilt and complicate self-acceptance.

Participant 4 stated “*There were moments when I felt judged by my family. They questioned my life choices and connected my HIV status to my identity, which made me struggle with guilt and self-worth.*”(P4) This illustrates how moral judgment from family may affect self-esteem and emotional well-being. Linking HIV status with identity can reinforce stigma and create additional psychological burden.

Sub theme 2.c: Emotional distress from family discrimination

This subtheme reflects the emotional consequences participants experienced when they perceived discriminatory attitudes or differential treatment from family members after disclosure of HIV status and LGBT identity. Emotional distress manifested as sadness, anxiety, and feelings of diminished self-worth. Participant 11 stated “*After my family knew about my HIV status and my identity, they started treating me differently. I felt emotionally hurt and anxious, as if I had lost my place in the family.*” (P11) This statement indicates how perceived differential treatment can lead to emotional insecurity and reduced sense of belonging within the family unit.

Another participant 5 stated “*The way my family reacted made me question my worth. Managing HIV while feeling judged for my identity created a constant emotional burden for me.*” (P5) This highlights how discrimination within family settings may produce ongoing psychological strain. The combination of managing a chronic health condition and navigating identity-related stigma appears to intensify emotional distress.

Theme 3: Community reactions to HIV and LGBT identity

This theme describes participants’ experiences of community responses following disclosure or perceived awareness of their HIV status alongside their sexual or gender identity. Participants reported that reactions from the broader community were shaped by intersecting stigma related to HIV and LGBT identity, which often influenced their social participation, sense of acceptance, and psychological well-being. These responses were not limited to overt discrimination but also included subtle social distancing, labeling, and changes in interpersonal interactions.

Three subthemes emerged within this theme: social rejection and double stigma in the community, social avoidance and exclusion, and stigmatizing labels linking HIV to LGBT identity. Together, these subthemes illustrate

how community-level stigma may reinforce internal distress and complicate social integration for individuals experiencing dual stigma.

Sub theme 3.a: Social rejection and double stigma in the community

This subtheme reflects participants' perceptions of rejection within their social environments following awareness of both their HIV status and LGBT identity. Participants described how these intersecting identities influenced acceptance in social settings and contributed to feelings of marginalization. Participant 6 stated *"After people became aware of my HIV status and my identity, I felt a noticeable change in how I was treated. It seemed like both aspects made it harder for me to feel accepted."*(P6) This statement suggests that participants perceived combined stigma related to HIV and sexual identity as shaping social interactions. The difficulty in feeling accepted indicates potential challenges in maintaining social belonging and emotional security.

Participant 9 explained *"I experienced rejection that felt linked not only to HIV but also to how people perceived my identity. That combination made social interactions more difficult for me."*(P9) This highlights how intersecting stigmas may compound social barriers. The participant's experience indicates that dual stigma can influence everyday interactions, potentially affecting social participation and well-being.

Sub theme 3.b: Social avoidance and exclusion

This subtheme captures participants' experiences of social distancing, avoidance, or exclusion following awareness of their HIV status and LGBT identity. Such avoidance was often subtle but perceived as meaningful by participants. Participant 11 stated *"I noticed that some people started keeping their distance after they knew about my HIV status and my identity. That made me feel socially isolated."*(P11) This indicates perceived behavioral changes in social relationships that contributed to feelings of isolation. Social

distancing may reduce opportunities for support and increase emotional vulnerability. Participant 14 stated *"I became more cautious socially because I often felt avoided once both my HIV status and identity were known."*(P14) This statement suggests adaptive behavioral changes in response to perceived avoidance. Increased caution may represent a coping mechanism but may also limit social engagement and reinforce isolation.

Sub theme 3.c: Stigmatizing labels linking HIV to LGBT identity

This subtheme reflects participants' experiences of labeling that directly connected HIV status with their sexual or gender identity. Such labeling appeared to influence self-perception, confidence, and social interactions. Participant 15 stated *"I sometimes heard assumptions that linked my HIV status directly to my identity. Those labels made me feel misunderstood and judged."*(P15) This highlights how stigmatizing assumptions may affect personal identity and social confidence. The perception of being misunderstood suggests challenges in communicating identity beyond stigmatized narratives.

Participant 2 stated *"Those stigmatizing labels affected how I saw myself and made it harder to feel confident socially."*(P2) This indicates internalization of stigma, where external labels influence self-perception. Such processes may contribute to reduced self-esteem and social withdrawal.

Discussion

This study identifies three main themes that reflect the intersection of HIV-related stigma and LGBT identity stigma. Identity struggles emerge prominently after HIV diagnosis within the context of sexual and gender identity. Family responses appear as influential factors affecting emotional adjustment and identity acceptance. Community reactions manifest through social rejection, avoidance, and stigmatizing labeling. The interaction between health-related stigma and identity-based stigma

creates a complex psychosocial burden. Such an intersection contributes to broader challenges in psychological adaptation and social integration among LGBT people living with HIV.

Identity struggles emerge primarily through emotional shock following HIV diagnosis combined with LGBT identity stigma (13). Emotional responses develop through vulnerability, uncertainty, and difficulty accepting dual identity realities. Identity negotiation processes occur within personal psychological and sociocultural contexts (14). Emotional conflict arises when HIV diagnosis reinforces pre-existing identity stigma. Psychological adjustment becomes more complex under intersecting stigma conditions (15). This condition reflects the need for supportive psychosocial frameworks that facilitate identity integration (16).

Moral and religious conflict also emerges as a significant dimension of identity struggle. Moral interpretation of HIV status appears within sociocultural belief systems. Religious values influence perceptions of illness and sexual identity simultaneously (17). Internalized stigma develops through perceived moral judgment and spiritual struggle. Self-worth perception becomes vulnerable under moral and religious pressure. This dynamic illustrates how spiritual frameworks shape psychological responses to HIV diagnosis in LGBT contexts (18).

Family responses represent another important dimension shaping the experience of dual stigma. Rejection within family relationships appears after disclosure of HIV status and LGBT identity (19). Emotional distance develops within family communication patterns. Moral judgment emerges through perceived associations between HIV status and sexual identity (20). Reduced openness influences psychological security and emotional support availability. Such relational dynamics highlight the central role of family acceptance in sustaining psychological well-being (21).

Blame and moral judgment within family contexts further contribute to emotional distress (18). Attribution of HIV

status to sexual identity appears within family narratives. Feelings of guilt and shame develop through moral evaluation processes (22). Identity conflict intensifies under perceived judgmental family environments. Emotional resilience weakens when support systems become conditional or uncertain (23). This pattern emphasizes how family-based stigma may reinforce internalized stigma and complicate long-term coping (24).

Community reactions also influence experiences of dual stigma beyond family contexts (25). Social rejection appears through changes in interpersonal interactions. Social avoidance emerges through distancing behaviors in community settings (26). Stigmatizing labels connect HIV status with LGBT identity in public perception. Social participation decreases under perceived stigma conditions (27). This environment reflects how community stigma can shape social isolation and psychological vulnerability (28). Strengthening interprofessional collaboration among healthcare providers, counselors, social workers, and community-based support systems is therefore essential to improve comprehensive care (29, 30).

Overall, the findings highlight an interconnected system of identity struggle, family response, and community reaction within the context of HIV and LGBT stigma. Dual stigma influences psychological well-being, social belonging, and identity integration processes. Supportive family and community environments become essential for adaptive coping. Inclusive healthcare approaches become necessary for sustained HIV management. Integrated stigma-reduction strategies become important for promoting holistic well-being. Such approaches contribute to more equitable and supportive environments for LGBT people living with HIV.

Strengths and limitations

This study offers an in-depth understanding of the lived experiences of LGBT individuals living with HIV, providing rich insights into identity reconstruction,

family dynamics, and community stigma through a phenomenological approach. The inclusion of participants with diverse backgrounds and the use of prolonged engagement and verbatim quotations strengthened the credibility and depth of the findings. However, the study was conducted within specific community-based settings, which may limit the transferability of the findings to other sociocultural contexts. In addition, participants were recruited through community networks, potentially underrepresenting the experiences of individuals who are more socially isolated or disengaged from support services. As with qualitative research in general, the findings reflect subjective experiences at a particular point in time and are not intended to be statistically generalizable.

Conclusion

This study demonstrates that double stigma shapes the lives of LGBT people living with HIV by influencing identity, family relations, and social participation at the same time. The findings show that stigma disrupts self-concept and relational security, while support from peers and meaningful social roles strengthens coping, self-acceptance, and hope. These results indicate that nursing practice must integrate stigma-sensitive, community-based, and family-engaged strategies that address social and relational dimensions alongside clinical management. This study therefore provides evidence to guide holistic HIV care and future stigma-reduction research in similar sociocultural settings.

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Conflict of interests

The authors declare that they have no competing interests.

Authors' contributions

conception and design (IA, AW, MAA, and DLR), data analysis and interpretation (IA and AW), manuscript draft (RHP, NA, DLR, and IA), critical revision of the manuscript (MAA, WA, NA), final approval of the manuscript (all authors).

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