The Lived Experience of HIV Anxiety among HIV-Negative Men in Hong Kong:

A Reflexive Thematic Analysis

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Table of Contents

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Abstract

Human immunodeficiency virus- (HIV) related stigma and discrimination against people living with HIV (PLHIV) are prevalent in various cultures. In the Chinese collectivistic cultural context, PLHIV are under threat of familial rejection in addition to the physical and emotional consequences of stigma that are shared across cultures. Data from online discussion forums in China and Hong Kong that focus on the fear of HIV show that citizens of China and Hong Kong are sharing and discussing their fears around contracting HIV when there is no medical evidence of HIV infection. User data shows that most active users of these discussion forums are men. In my clinical practice, these highly anxious men often experience difficulties in daily and social functioning because of their worries surrounding HIV. This suggests that HIV-anxiety is a significant concern for some (HIV-negative) men in Hong Kong, one that has yet to be addressed in research. This study qualitatively explores the lived experience of seven HIV-negative Hong Kong men who had experienced intense worry about contracting HIV. Interviews with the men were analysed using reflexive thematic analysis. Six themes and one overarching theme were generated. Overall, participants experienced HIV anxiety as an anticipated "social death" with a strong sense of guilt, moral shame, and a profound sense of responsibility for others' welfare. These emotional experiences were influenced by stigma around HIV/AIDS, restrictive sex education, and deeply rooted Chinese traditional cultural values shaped by Confucian beliefs. To manage their distress, participants engaged in various coping strategies including both avoidance and reassurance seeking (e.g., repeated testing). All participants reflected on having the need for and benefitting from the emotional- and/or knowledge-based support offered by healthcare professionals who responded to their concerns with an empathetic and non-judgmental manner. The link between the Hong Kong sociocultural context and

men's sense-making of their emotional experiences highlights the need for developing psychological formulations and interventions that can be culturally adapted to clients from diverse backgrounds. This study also sheds light on the impact of stigma on the well-being of people with multiple marginalised identities in Hong Kong. It is imperative that counselling psychologists commit to and practice destigmatising HIV-related concerns.

The Lived Experience of HIV Anxiety among HIV-Negative Men in Hong Kong: A Reflexive Thematic Analysis

This research is motivated by my past clinical practice in the delivery of human immunodeficiency virus (HIV) testing and counselling service in a non-government organisation in Hong Kong. It focuses on HIV-negative men's stories related to their lived experience of HIV anxiety. There are two main clinical observations that inform the research aims. First, I have noticed that profound HIV anxiety is common among male HIV testers regardless of sexualities. Many men engage in repeated medical consultation, frequent HIV testing, and spend a large amount of time searching the internet for HIV-related information without realising that they are facing a mental health challenge rather than a physical one. When their HIV anxiety remains unresolved, it usually results in excessive utilisation of health services and poor overall well-being. Thus, I believe it is crucial to address the distress and psychological barriers experienced by HIV-anxious men of all sexualities to improve quality of life on individual and social levels.

Second, government-funded counselling services offered in the sexual health sector often focus on risk reduction as their primary purpose. As a result, the prevalence and impact of HIV anxiety among HIV-negative men in Hong Kong have been overlooked. Based on my previous work experience, some workers experienced burnout when interacting with repeated callers and testers who are at low HIV-risk. It is common to feel frustrated at failing to eliminate these men's anxious thoughts associated with HIV infection. As such, practitioners and service users share a sense of helplessness and struggle to make sense of this extreme HIV anxiety. This shared sense of helplessness that I and other practitioners have experienced prompted my interest in enhancing understanding of this "hard-to-treat" condition in the Hong Kong context.

The way people experience and react to HIV is shaped by a complex interaction of various dimensions, such as HIV prevalence and awareness, local context and personal risk factors (Deacon et al., 2006). To contextualise my research, this introductory section outlines the global and Hong Kong HIV/AIDS context, different dimensions of stigma, the relationship between stigma and the psychosocial well-being of Hong Kong Chinese men who are at risk of contracting HIV, and different theoretical understandings of health anxiety. The complex definitions and sociocultural aspects of stigma associated with HIV and mental health will be discussed with reference to cross-cultural literature.

A note on terminology

Previously, scholars used terms such as “HIV worried well” (Forstein, 1984), “pseudo-AIDS” (Miller et al., 1985), “AIDS neurosis” (Cabaj, 1988), “AIDS phobia” (Glass, 1993) and “AIDS hypochondria” (Wirth, 2003) to refer to a state of constant concern about HIV/AIDS in the absence of medical evidence of HIV infection (O’Brien, 1987; Riccio & Thompson, 1987). Since these terms do not reflect various degrees of anxiety (Riccio & Thompson, 1987) and the continuous development of mental health language, the term “HIV anxiety” will be used throughout this thesis to refer to the HIV fear and worry experienced by people who are known to be uninfected.

The global context of HIV/AIDS

It has been more than forty years since the first cases of HIV infection and acquired immunodeficiency syndrome (AIDS) were detected, and to this day HIV/AIDS remains a global public health threat. According to the World Health Organization (WHO, 2024), there were an estimated 39.9 million people living with HIV (PLHIV) at the end of 2023. Today, there is still no realistic cure for HIV/AIDS, but it has been transformed from a fatal disease to a manageable chronic health condition in countries where HIV treatment - antiretroviral therapy - is widely available (WHO, 2024). HIV can be diagnosed through rapid testing that produces same-day results and many PLHIV in countries with sufficient resources have easy access to treatment and HIV care (WHO, 2024). Given these medical advancements, PLHIV have a much longer life expectancy and AIDS-related deaths have reduced significantly (WHO, 2024; Hayes, 2023). In terms of preventive measures, over the past decade, preventive medication is increasingly accessible through public health systems or national health insurance schemes in some countries or regions, such as the UK, the US, and Australia (Department of Health and Social Care, 2020; *Status of PrEP by Country*, n.d.). People who are HIV-negative are provided with pre-exposure prophylaxis (PrEP) before potential exposures to HIV and post-exposure prophylaxis (PEP) after a potential exposure to HIV. In some places, such as Hong Kong and China, PrEP is not yet available in the public health systems. People in Hong Kong and China who are at risk of HIV infection often access PrEP via clinical trials, local or overseas private clinics or via informal PrEP buyers who import PrEP from overseas (Kasadha, 2023; *Status of PrEP by Country*, n.d.). Despite significant clinical improvements in HIV care, socio-cultural issues, such as stigma, marginalisation and various dimensions of discrimination (e.g., relating to race/ethnicity, sexuality, HIV status) remain a concern for PLHIV (Malama et al., 2023; Nawawi et al., 2023; Payagala & Pozniak, 2024).

Global HIV stigma

Scholars across Western and Asian societies have reported that the HIV/AIDS epidemic has disproportionately affected socially marginalised groups, such as individuals who engage in same-gender sexual relationships, sex work, injection drug use or non-monogamous sexual practices (e.g., Altman et al., 2012; Chan et al., 2008; Erasmus, 2024; Lyons et al., 2020). It is evidenced that HIV-related stigma has negative impacts on HIV prevention and treatment outcomes (Barstow, 2019; Chong et al., 2017; Kerr et al., 2024;

Lau et al., 2024; Neves & Davies, 2023). Governments in many countries have supported HIV anti-stigma campaigns. For example, the large-scale "Undetectable = Untransmittable" (U=U) campaign, which was first promoted by the US Centre for Disease Control and Prevention (CDC) in 2016, delivers a message that: "A person living with HIV who is on treatment and maintains an undetectable viral load has zero risk of transmitting HIV to their sexual partners" (CDC, 2024, Overview section). This campaign aims to reduce stigma and discrimination against PLHIV by shifting the wider public's beliefs and attitudes (CDC, 2024). Yet, after decades of indoctrinated fear of the virus (Thornber, 2020), it may be challenging for the public to understand that PLHIV who adhere to HIV treatment no longer constitute a risk to their sexual partners. Additionally, it has been argued that differentiating HIV/AIDS patients into subgroups in terms of infection routes (e.g. illegal drug use, blood selling, and commercial sex) or by social status in official statistical reports has been the root of maintaining stigma associated with HIV/AIDS-positive individuals in some countries, like China (Guo, 2016). The impact of this epidemic continues to vary considerably between countries and regions (WHO, 2024). Below, a brief background on the recent HIV situation in Hong Kong is followed by a discussion of the broader concept of stigma and the impact of HIV stigma on marginalised groups in Hong Kong.

HIV in the context of Hong Kong

Hong Kong has a low HIV prevalence rate (4-7%) among sexually active men who have sex with men, the major at-risk group (Department of Health [DH], 2012, 2018). As of June 2024, the cumulative number of reported HIV infected people in Hong Kong was 12,223, with approximately 82% of these males and 18% females (DH, 2024a; GovHK, 2024). It has been reported that sexual contact contributed to about 80% of all the reported cases in 2023 (DH, 2023). In the quarterly and yearly STI/AIDS caseload statistical reports published by the DH, the exposure categories among individuals who contracted HIV via sexual transmission were labelled in terms of sexual identity as follows: “heterosexual”, “homosexual”, and “bisexual” (DH, 2023, 2024a). Of the reported cumulative HIV/AIDS cases, about 42% identified as “homosexual”, 32% identified as heterosexual and 5.9 % identified as bisexual (DH, 2024a). Classifying PLHIV into subgroups based on sexual identity is potentially problematic as whether the individuals concerned understand and perceive their behaviours as “homosexual”, heterosexual or bisexual varies considerably (Cover, 2018). Goodenow et al. (2008) demonstrated that a person’s self-defined sexual identity and the sex of their sexual partners are often different. Hence, sexual identity categories are often not a reliable indicator of sexual contact. Therefore, in this thesis, I adopt the term men who have sex with men (MSM) to encompass self-identified gay and bisexual men as well as individuals who do not identify as with these labels but nonetheless engage in same-gender sexual behaviour (Salomaa & Matsick, 2020). The term MSM is commonly used in the context of HIV/AIDS research to include a wider variety of men who are vulnerable to HIV transmission as a result of sexual contact with other men (WHO, n.d.).

In the ‘Recommended HIV/AIDS strategies for Hong Kong 2022-27’ document produced by Hong Kong Advisory Council on AIDS ([ACA], 2022), initiatives on prevention, intervention and education are prioritised on six identified key populations: 1) MSM; 2) people living with HIV; 3) ‘ethnic minorities’; 4) transgender people; 5) people who inject drugs; and 6) female sex workers and their male clients (DH, 2024). HIV infection among MSM has consistently represented a high proportion of newly infected cases (DH, 2024). There has been a decrease in the number of infections related to sex between men since 2015, while the number of newly infected cases through transmission through heterosexual sex have remained stable in the years 2017 to 2023.

Regarding existing HIV-related support and service provision in Hong Kong, there has been emphasis on reaching young MSM, sex workers and the transgender community, who are at higher levels of risk based on statistical data (ACA, 2022). The Council for the AIDS Trust Fund (ATF) has been providing financial support to HIV/AIDS research, publicity and public education, which contributes to HIV prevention and supporting PLHIV and their families (ATF, 2023). Funded projects have focused on issues such as drug use among MSM, HIV/STI testing, and financial and social support for PLHIV (ATF, 2024). Strategies are developed primarily from a public health perspective with risk reduction as the main goal (ACA, 2022). For example, safer sex education, HIV self-testing, and increasing the accessibility of PrEP and PEP are proposed by ACA. While these projects and strategies are designed and implemented largely from a medical perspectives with MSM as the main targets, considerably less attention and resources have been given to the prevention and psychological interventions for other high-risk populations, such as male clients of female sex workers (MCFSW) who are also vulnerable to HIV infection (ATF, 2024).

Defining stigma and its relevance to HIV

In addition to the significance of local sex education and accessibility to medical service, stigma has profound effects on individuals' practices, medical care and well-being in the context of HIV/AIDS (Chaudoir & Fisher, 2018). It is essential to explore the broader meaning and function of stigma, which is a universal phenomenon across cultures and societies (B. Link et al., 2004) in order to understand the mechanisms through which stigma affect individuals who perceive themselves as vulnerable to HIV infection. The definition of stigma varies and has evolved over the years. Goffman (1963) first defined stigma as "an attribute that is discrediting" (p. 3) and it refers to "situation of the individual who is disqualified from full social acceptance" (p. 154). From Goffman's (1963) perspective, stigma is a social label that negatively affects people’s perception of themselves and how others perceive them. When individuals fail to meet socially normative expectations because of their differences in characteristics or behaviours, people are devalued, regarded as unacceptable and are dismissed.

Over the years, definitions and theoretical models of stigma have developed extensively. In a sociological model developed by Link and Phelan (2001), stigma is constructed of several psychosocial components. It exists “when elements of labelling, stereotyping, separation, status loss, and discrimination co-occur in a power situation” (p. 367). This definition suggests that stigma is a social process that happens within a power discrepancy (Ruesch, 2022). Several social psychologists have introduced a more social and less individual perspective on stigma which emphasises that various societal aspects, such as Government implemented healthcare systems and societal values around mental health, impact the formation of stigma (Corrigan et al., 2004; Yang & Kleinman, 2008). Hence, stigmatisation happens within a social context that identifies attributes that mark individuals as different from the dominant group in societies and that lead them to be devalued (Crocker et al., 1998; Major & O’Brien, 2005). More recently, scholars view stigma as a moral experience because a person’s moral status is determined by the extent to which they meet social norms and obligations in local context (Kleinman & Hall-Clifford, 2009; Yang et al., 2007). In short, stigma is a cultural, social and moral process by which a society discourages specific practices and conditions (Kleinman & Hall-Clifford, 2009).

Many chronic illnesses, such as multiple sclerosis and epilepsy are stigmatised (Earnshaw et al., 2012; Idemudia et al., 2018; Kessler, 2022). Social psychological researchers have argued that illness represents a deviation from the “norm” or the standard (Crandall & Moriarty, 1995). This physical difference often leads to social exclusion (Crandall

& Moriarty, 1995). Some diseases, such as sexually transmitted illnesses (STIs), are considered by societies as the products of deviant behaviour (Alonzo & Reynolds, 1995). Specifically, health-related stigma is defined by Weiss et al. (2006, p. 280) as:

> A social process, experienced or anticipated, characterized by exclusion, rejection, blame or devaluation that results from experience, perception or reasonable anticipation of an adverse social judgment about a person or group. This judgment is based on an enduring feature of identity conferred by a health problem or health-related condition, and the judgment is in some essential way medically unwarranted.

Over the past decades, research has demonstrated that stigma and discrimination around HIV/AIDS exists because PLHIV are often perceived as engaging in behaviours deemed as less socially acceptable, such as same-gender sexual practices and substance use (e.g., Genberg et al., 2009; R. A. Hayes et al., 2002; Lieber et al., 2006; Mak et al., 2006; Mo & Ng, 2017; Rao et al., 2008; Singh et al., 2011; Turan et al., 2017a). HIV/AIDS-related stigma and discrimination among PLHIV and their families are prevalent in various cultures and countries (e.g., Lau et al., 2007; Mak et al., 2006; Mo & Ng, 2017; Olley et al., 2016; Singh et al., 2011; Turan et al., 2017a; Wang et al., 2019; Williams et al., 2019). The degree of stigma experienced by individuals with HIV/AIDS has been shown to vary by social identities (Alonzo & Reynolds, 1995). For instance, transfusion recipients and infants of HIV-positive mothers are considered as ‘innocent’ whereas less educated men or men who are members of gay communities are more likely to be rejected and evaluated negatively (Alonzo & Reynolds, 1995). Considering the complexity of the manifestation and effects of stigma, a broader discussion of HIV stigma with an understanding of the larger social and cultural context is essential for highlighting how stigma acts upon the Hong Kong Chinese men in this study.

HIV stigma in Hong Kong Chinese culture

From a cross-cultural perspective, the manifestation, practices, meanings and consequences of stigma can vary across different contexts (Koschorke et al., 2017; Yang et al., 2007). For instance, Steward et al. (2013) has suggested that the decision regarding sexuality disclosure among Chinese MSM is likely to be influenced by HIV stigma and collectivist moral considerations (e.g., in-group loyalty). Thus, experiences surrounding HIV among a particular cultural group is partially shaped by specific culture beliefs and norms (Wong et al., 2017; Yang & Kleinman, 2008; Yeo & Chu, 2017). Unpacking HIV stigma in Hong Kong Chinese culture can provide an important context for understanding the lived experience of HIV-negative men experiencing HIV anxiety.

A Hong Kong study has reported that the general population's stigmatisation of HIV/AIDS is significantly greater when compared with the stigmatisation of other infectious diseases, such as severe acute respiratory syndrome (SARS) and tuberculosis (TB) (Mak et al., 2006). Scholars in Hong Kong have shown that the general population have believed that PLHIV are sexually "promiscuous" and are blameworthy (Lau & Tsui, 2005; Mak et al., 2006). This echoes previous literature that suggests that people from both Western and Chinese societies generally believe that HIV is contracted through behaviours that are understood as socially deviant such as drug use and "promiscuity" (Guo, 2016; Mak et al., 2006; Steward et al., 2013).

Despite this shared belief with Western societies, Chinese culture is predominantly collectivistic – people perceive themselves as belonging to collectives, and they are driven by the norms and ascribed obligations of the collective (Oyserman et al., 2002). Group cohesion, social exchange, hierarchical authority and conformity are highly valued (Chun et al., 2006; Kleinman et al., 1995; J. Li et al., 2004; Y. Li et al., 2022; Yang & Kleinman, 2008).

Thus, one's failure to fulfil the obligation to consider others' emotional responses is regarded as an immoral act (Yan, 2003). Yang and Kleinman (2008) proposed a culturally sensitive stigma model for Chinese society that comprises a social and collective component – face concern. Face is the term used to describe a person's social worth and image that are acquired from one's performance in an interpersonal setting (Mak et al., 2009). In general, a person's face is determined by their social standing within a certain community (D. Y. F. Ho, 1994). Hu (1944) proposed two forms of face concern – social face (mianzi) and moral face (lian). Social face refers to an individual's reputation and prestige through conforming to social roles, whereas moral face refers to one's adherence to social standards so that the individual is accepted by society (Mak et al., 2015). When a family member is infected with HIV, family ties become threatened because of the loss of face (Yang & Kleinman, 2008). For example, in Lau et al.'s (2003) study, the PLHIV in the sample, reported being discriminated by family members and received limited social support in navigating this discrimination. More than one-third of the PLHIV reported having no one to turn to or to confide in during difficult times (Lau et al., 2003). In sum, in the Chinese cultural context, HIV stigma exerts a negative impact on a person's network and social resources. PLHIV in Hong Kong are under threat of losing face and familial rejection in addition to the physical and emotional consequences of stigma that are shared across cultures (Yang & Kleinman, 2008). This means that for Chinese men, HIV infection is closely associated with the experience of shame and fear.

Literature on social and moral stigmatisation of men at risk for HIV infection in different countries

Men who have sex with men

Evidence across different cultures shows that MSM often face different forms of stigma because of their sexual identities, practices and relationships (Altman et al., 2012; Choi et al., 2017; Goldenberg et al., 2018; Ha et al., 2014; X. Li et al., 2021; Wagner et al., 2013). When the first cases of AIDS were discovered among the gay male community in the United States in the 1980s, HIV/AIDS was initially regarded as a 'gay disease' (Hancock & Haldeman, 2020). Despite clear evidence from the US CDC suggesting that sexual orientation is not a predictive factor for HIV transmission risk, there seems to be a continuous association between HIV/AIDS and homosexuality from the public's perspectives across the world (e.g., Andrade-Rivas & Romero, 2017; Mak et al., 2006; Vincent et al., 2016). Research conducted in the US and China has reported a common perception that same-sex sexual behaviour is a contributing factor for HIV infection (Arnold et al., 2014; Mo & Ng, 2017; Zhou, 2006). One of the reasons is that MSM are a population that have been disproportionally affected by HIV/AIDS (Beyrer et al., 2012; CHP, DH, 2024a). Other factors, such as institutional and legal regulation regarding HIV exposure and transmission, serve as impediments toward the understanding of HIV/AIDS in the wider population (Dodds et al., 2015; Stangl et al., 2022). As a result of the interplay between anti-gay and HIV/AIDS-related stigma, MSM continue to face prejudice, marginalisation, and various forms of discrimination as well as internalised homophobia (internalising the message that sexuality other than heterosexual is wrong) (Frye et al., 2015; Pachankis et al., 2015; Salomaa & Matsick, 2020)

In a qualitative study by Alonzo and Reynolds in the US (1995, p. 307), HIV-negative MSM reported feeling stigmatised for being at risk and they experienced “pre-stigmatic fear”. Being in an “at risk” group not only suggests an association with some forms of “deviance”, but it is threatening because of the potiental for rejection by family, partners and significiant others (Alonzo & Reynolds, 1995). Recent studies have shown that MSM in many counties continue to face inequalities and challenges in society (e.g. Kushwaha et al., 2017; Wanyenze et al., 2016). This is evident through, for example, attitudes toward the legalisation of same-sex marriage in Hong Kong, which serve as a proxy for societal attitudes to homosexuality more broadly (Cheng, 2023). Surveys in relation to Hong Kong residents’ views on same-sex marriage were carried out in 2013, 2017 and 2023. Results showed that only 38% and 50.4% of participants in 2013 and 2017 respectively expressed agreement with the legislation of same-sex marriage (Cheng, 2023). Although the proportion of Hong Kong residents that agreed with same-sex marriage increased to 60% in 2023, there is a lack of legal protection against sexuality discrimination (Cheng, 2023). With such societal stigma and unequal legal policies around gender and sexually divergent individuals in Hong Kong, MSM and other members of the LGBTQ people are prone to encounter discrimination and marginalisation within the Hong Kong Chinese community (Suen et al., 2016). As such, MSM tend to face an additional social challenge when accessing HIV care and testing in heteronormative settings (Arnold et al., 2014; Choi et al., 2017).

Male clients of female sex workers

Globally, scholars have reported that sex work is strongly linked to stigma (e.g., Vanwesenbeeck, 2001) and men who buy sex are often viewed as “pathological” (Brooks-Gordon & Gelsthorpe, 2003; Lau et al., 2007; Xantidis & McCabe, 2000). It is documented that female sex workers experience violence whilst working (Sanders & Campbell, 2007), and commercial sex has long been considered as a violation of public morality (Immordino & Russo, 2015; Silver et al., 2022). MCFSW tend to face moral judgment around buying sex as they are perceived as perpetrators and women as victims (Silver et al., 2022; Watson & Vidal, 2011). Also, the non-reproductive nature of paid sex is viewed as a threat to marriage (de Beauvoir, 1997; Nussbaum, 1999). Giusta et al. (2009) argued that the stigma associated with commercial sex centres on reputational loss, which affects the social statuses of both clients and sex workers.

The legal framework around sex work in Hong Kong has potentially contributed to stigmatisation of and discrimination against female sex workers and their male clients. Today, selling sex is not illegal in Hong Kong. However, many activities associated with sex work are prohibited by law (Amnesty International, 2016). In Hong Kong legislation, certain commercial sex-related behaviours, such as “soliciting for an immoral purpose” and displaying signs advertising commercial sex work are considered an offence (Amnesty International, 2016). To avoid being prosecuted, many sex workers work in individual apartments and therefore, MCFSW are a hidden group. In 2016, a qualitative study revealed that MCFSW in Hong Kong/China believed that there has been a strong moral stigma against them in the wider society; their perceived risks ranged from contracting STIs to moral and legal risk (Kong, 2016).

Kong's (2016) study examined the experiences of Hong Kong heterosexual men who buy sex, and concluded men buying sex is a form of escape and resistance to normative model of compassionate sexuality, which emphasises fidelity, monogamy and commitment. This voluntary risk-taking behaviour involves a negotiation of risk-taking and pleasure while maintaining a balance of order and chaos (Kong, 2016). This suggests that while gaining a thrill and excitement from engaging in commercial sex, Hong Kong MCFSW experience the fear and threat associated with this behaviour because of a cultural expectation of committing to conjugal and family duties (Kong, 2016). In other words, the potential consequences of their MCFSW identity being discovered extend beyond HIV infection and health concerns. In a traditional Chinese cultural environment, their non-conforming sexual practices might lead to the loss of face and moral condemnation (M.-H. Chen, 2017). In essence, men's moral experience of different forms of stigma likely plays a significant role in their mental health. HIV stigma often intersects with other types of stigma associated with men's multiple identities. The concept of intersecting identities is discussed below.

Intersectionality within the context of HIV and Chinese culture

A substantial number of studies have addressed the interactions between various disadvantaged social identities (e.g., Black gay and bisexual men), practices (e.g., substance use), and the processes of marginalisation linked to HIV stigma and discrimination (e.g., Chen et al., 2024; Earnshaw et al., 2015, 2021; Logie et al., 2011; Mukerji et al., 2023). These interactions can be conceptualised through the lens of intersectionality (Collins & Bilge, 2016), which informs how multiple socially oppressed characteristics are interdependent and may interact with each other to influence people's practices and well-being (Cole, 2009). In other words, human experiences are not determined by one dimension of social identity, but they are shaped by a combination of interacting social positions like gender, race, class, and sexuality (Cole, 2009).

As discussed earlier, men at risk for HIV infection often hold other marginalised identities that are stigmatised, such as being gay or being clients in commercial sex. Logie et al.'s (2011) conceptualisation of intersectional stigma highlighted the intersectional effects of HIV-related stigma, discrimination, and different forms of structural inequities, such as homophobia and sexism. Within the context of HIV, LGBTQ individuals living with HIV reported experiencing enacted stigma, such as exclusion and violence, due to the convergence of anti-gay and HIV stigma (Logie et al., 2011). For Chinese MSM living in a collectivistic culture, prior literature has suggested that the intersectional effects of anti-gay and HIV stigma are influenced by the traditional family-oriented values which emphasise heterosexual marriage, filial piety, and fertility (Sun et al., 2020; Yang et al., 2020). As a result of the cultural characteristics, Chinese MSM have distinct minority stress experiences that contribute to poor psychosocial well-being (Sun et al., 2020; Yang et al., 2020).

In Kong Kong, the traditional Chinese cultural pressure not only affects the MSM community, but it also has implications for men who engage in non-conventional sexual practices, particularly men who buy sex. Prior literature has illustrated that a more conservative view about sex is associated with greater perceived moral stigma of buying sex among MCFSW (Kong, 2016; Pitpitan et al., 2015). Given the emphasis on norm conformity and moral rules in Chinese society (Wilson, 1981), Chinese MCFSW who have concerns about being infected with HIV may also experience anticipated intersectional stigma (i.e., being perceived as morally deviant and as HIV-positive). Despite the different forms of anticipated/ perceived intersectional stigma experienced by MSM and MCFSW, they share the fear and threat of being socially devalued because of the intersection between HIV stigma and their marginalised identities. Both groups of men may face significant emotional challenges arising from the complexity of intersectional stigma. To understand the potential impact of their anticipated intersectional stigma, it is important to review the relationship between HIV stigma and the mental health of HIV-negative men based on existing research studies.

HIV stigma and HIV-negative men's well-being

Scholars across different cultures have shown that HIV-related stigma is related to adverse mental health consequences among PLHIV and "at-risk" HIV-negative individuals, including MSM and MCFSW (e.g., Algarin et al., 2021; Chaudoir et al., 2012; Crockett et al., 2019; Felker-Kantor et al., 2019; Ferlatte et al., 2017; Lau et al., 2007; Logie et al., 2013; Turan et al., 2017a). It is evidenced that HIV/AIDS stigma among HIV-positive MSM is associated with low self-esteem, depression and behaviours that negatively impact their well-being and quality of life (Aunon et al., 2020; Logie et al., 2013; Rzeszutek et al., 2021; Turan et al., 2017b). Although a majority of prior literature has researched the impact of HIV/AIDS stigma on PLHIV (e.g., Genberg et al., 2009; Mak et al., 2006; Mo & Ng, 2017; Placek et al., 2019), recent studies have demonstrated that HIV stigma also affects HIV-negative men, such as Brazilian heterosexual male soldiers, MSM in the US, and MSM in China, who have reported experiencing anticipated HIV stigma (Balán et al., 2013; Catelan et al., 2020; C. Liu et al., 2020).

Anticipated HIV stigma refers to the belief that one will experience social rejection, discrimination and prejudice in the future if given an HIV diagnosis (Camacho et al., 2020; C. Liu et al., 2020). It has been evidenced that anticipated HIV stigma among uninfected men is associated with various negative psychological outcomes and readiness for HIV testing (Camacho et al., 2020; Gamarel et al., 2018; Liu et al., 2020; Starks et al., 2013; Tan et al., 2020). Furthermore, the level of anticipated HIV-related stigma experienced by MSM is particularly high as compared to the level experienced by other social groups (Arnold et al., 2014; Lutete et al., 2022). HIV-negative MSM have a higher prevalence of depression, anxiety and comborbidity, compared to the general population (Altman et al., 2012; Pan et al., 2018; Parker & Aggleton, 2006; Parker et al., 2015; Sun et al., 2020; Tomori et al., 2016).

These findings can be explained by the fact that these men are more likely to know PLHIV from their community and they have observed how PLHIV are treated by the wider society (Liu et al., 2020). These findings echo the minority stress model, which proposed that experiences of external prejudice events and internal stress processes can lead to an elevated risk of psychological distress among sexually minoritised groups (Meyer, 2003; Meyer & Frost, 2013). Thus, in the context of HIV risk, MSM are likely to feel marginalized from the general population, potentially leading to poorer mental health.

Many HIV test-seekers have experienced generalised anxiety disorder (GAD), major depression and post-traumatic stress (Kagee et al., 2017; Saal et al., 2019; Sahay et al., 2007). A study in South Africa indicated that the prevalence rate for suicidal ideation among HIV test-seekers with GAD was 7 times higher than that among the general population (Bantjes et al., 2017). In 2019, another study in South Africa used the Beck Anxiety Inventory to assess the anxiety levels of 500 HIV test-seekers in HIV clinics: 13.6% of the sample experienced moderate anxiety and 8.2% of the sample reported severe anxiety. Also, several case studies and practitioners' reports in Western societies have shown the existence of HIV/AIDS anxiety or phobia and emotional distress among HIV-negative test seekers (Al. Alawi & Al. Senawi, 2015; Joseph et al., 2011; Logsdail et al., 1991; Muthusamy et al., 2009; Sahay et al., 2007; S. Taylor & Asmundson, 2004). Bor et al. (1989) reported that people who presented with AIDS-related "worries" accounted for about half of the number of referrals to counsellors in a clinically-based AIDS counselling unit in the UK.

Currently, the psychological needs of HIV test-seekers in the Chinese community are unclear. Yet, there are a high number of Chinese men who are actively engaged in an online community forum - "Fear of HIV Bar" of Baidu Tieba [百度贴吧 "恐艾吧"] where Chinese people discuss and share information on topics associated with HIV/AIDS (Zhao, 2023). Zhao reported that among 160,000 active users of this forum, 92.5% were men who discussed their worries surrounding HIV/AIDS as of November 2023. There were 17,665,190 posts discussing their worries surrounding HIV/AIDS as of November 2023. This suggests that HIV anxiety is a potentially common form of distress experienced by Chinese men. A previous study in China (Gu, 2007) indicated that 30% of service users who sought HIV services in China met the criteria of AIDS "phobia". The term phobia was defined as "marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation" (p. 449) in the fourth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994). Little research has addressed the prevalence of HIV anxiety among the Chinese population. One possible reason for this might be the difficulty in recruiting participants and obtaining accurate data as people may conceal negative information about themselves because of their fear of rejection and social exclusion.

Although HIV stigma seems to be less associated with heterosexual men, a Chinese study in 2019 reported that among the active users who disclosed their sexuality and created posts on the 'Fear of HIV bar' online forum, 86% were self-identified as heterosexual men (Xiao et al., 2019). This echoes the results of a study of HIV-test seekers in London, in which about half of the repeat test seekers were heterosexual men. That means that fear and worry about HIV infection exists in both MSM and heterosexual men. Given the low prevalence rate of HIV infection among heterosexual men in China, the disproportionally high rate of heterosexual help seekers suggests that there is an incongruence between their perceived health threat and their actual health risk, which is a potential indicator of health anxiety. The following section summarises conceptualisations of health anxiety with reference to different theoretical models.

Cultural influences on stigma associated with mental illnesses

Specific sociocultural beliefs held by and within a culture can impact people's perceptions of an individual's attributes and shape what "normal" should look like (Ruesch, 2022). Cross-cultural stigma literature has evidenced that differences in stigma associated with mental illnesses exist between group-oriented East Asian regions/countries (e.g., China, Hong Kong and Japan) and individual-oriented countries in Western Europe (e.g., United Kingdom and Germany), North America and Australia (e.g., Krendl & Pescosolido, 2020; Yu & Mak, 2022). Quantitative and qualitative studies suggest that people from collectivistic-oriented cultures are more likely to stigmatise those who suffer from mental illness than those in individual-oriented cultures (Yu & Mak, 2022). For example, in a study that compared the attitudes of college students in the UK and Hong Kong toward individuals with schizophrenia, Hong Kong students viewed people with schizophrenia as more dangerous and "abnormal" than did British students (Furnham & Chan, 2004).

Yu and Mak (2022) addressed three potential factors that contribute to cultural differences in mental health stigma. These factors are supernatural beliefs, face concern, and strong preference for conformity and group cohesion within East Asian cultures. Regarding supernatural beliefs, research shows that Chinese people commonly believe that mental illness is punishment for the bad deeds of an individual or their family and ancestors (D. F. K. Wong et al., 2004). Thus, people with mental illness are likely to be blamed and stigmatised. The second factor, face concern, as discussed earlier, is a practice and belief commonly evident in East Asian societies and influenced by Confucian culture. In a Hong Kong study on substance use, Mak et al. (2015) revealed that both social face and moral face had a negative impact on individual's self-stigma and self-conscious moral emotions (shame and guilt). A strong preference for conformity and group cohesion means that people's preference is for group harmony and adherence to group norms (Yu & Mak, 2022). Thus, social rejection and exclusion of social minoritised groups are more likely to occur in group-oriented cultures as compared to individual-oriented cultures (Yu & Mak, 2022). That is to say that Hong Kong men who suffer from HIV anxiety may be unwilling to seek help from mental health professionals or feel reluctant to make sense of their bodily symptoms through a psychological lens due to the potential threat of social exclusion. To understand the manifestation of this specific form of health anxiety among men, it is crucial to review the concept and different conceptualisations of health anxiety.

Health anxiety

Health anxiety (HA) is defined as “severe and persistent anxiety about serious illness or health problems despite professional reassurance” (Sunderland, 2013, p.560). This condition is often triggered by a negative life event (e.g., witnessing a family member’s suffering from a chronic illness) and is frequently found in conjunction with panic disorder, obsessive compulsive disorder, general anxiety disorder, and somatic disorders (S. Lee et al., 2011; Starcevic, 2013; P. Tyrer & Tyrer, 2019). A preoccupation with having a medical illness can have a detrimental effect on one’s daily, social and physical functioning as shown in several case studies (e.g., Al. Alawi & Al. Senawi, 2015; Fisman & Walsh, 1994). One of the important manifestations of health anxiety that has been discussed in many studies is increased health care utilisation among individuals with HA (Gedik et al., 2023; S. Lee et al., 2015; Sunderland et al., 2013).

The term HA derives from the term “hypochondriasis” that originated from DSM-IV (American Psychiatric Association [APA], 1994). In the fifth edition of the DSM (DSM-V; APA, 2013), the term “hypochondriasis” has been replaced by two disorders: somatic symptom disorder and illness anxiety disorder. The first criterion for hypochondriasis in DSM-IV is "preoccupation with fears of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms" (APA, 1994, p. 465). This criterion emphasises the assumption that individuals have increased attention to and misinterpretation of bodily sensation that leads them to believe they have a physical illness; thus, the diagnosis was based on a cognitive perspective. By contrast, the first criterion of illness anxiety disorder in DSM-V is "preoccupation with having or acquiring a serious illness" (APA, 2013, p. 315), which does not require the presence of misinterpreting bodily symptoms (APA, 2013). It is also worth noting that avoidance as a response to illness fears, which was not present in the DSM-IV criteria for hypochondriasis, has been added as a diagnostic criterion for illness anxiety disorder (APA, 2013). Hence, there has been a shift in perspective on the conceptualisation of HA-related disorders. In this study, the term HA will be used instead of using the psychiatric diagnosis because this phenomenon exists on a continuum, from mild and transient to severe and chronic (Taylor & Asmundson, 2004), and participants self-identified as experiencing anxiety related to their HIV status.

Regarding past case studies and reports, "AIDS anxious" individuals seek help for a wide range of reasons, some may have had unprotected sex or engage in intravenous drug use, others may have experienced low-risk same-sex sexual activities (Bor et al., 1989; Miller et al., 1988). Relationship problems, a past history of mental health issues, transition in individual and family life-cycles, as well as misunderstandings of health education materials have also been found to be related to the fear of AIDS (Bor et al., 1989). A broad range of presentations among this group are evident - some may be worried about getting infected, whereas others may believe that they have acquired symptoms of HIV/AIDS (Scragg, 1995). Hence, they vary in terms of their insight into the extreme nature of their health concerns (Abramowitz & Braddock, 2011). It is also evidenced that anxiety can range from mild to severe, and be experienced differently among health-anxious individuals with concerns about the same health condition (Fergus & Asmundson, 2019; Longley et al., 2010). Therefore, the manifestation of HIV anxiety appears to be complex and cannot be explained by a single theoretical model. In the next subsection, I outline an overview of various theories that have been proposed to explain the origin of HA.

Theoretical models and treatments of health anxiety

The conceptualisation and understanding of HA stems from a variety of theoretical positions and the existing range of evidence-based treatments are primarily based on cognitive theory, psychoanalytic theory, and interpersonal theory. In this section, I also discuss potential biological and social explanations of HA based on prior literature.

Cognitive model. The cognitive model of HA suggests that objectively healthy individuals tend to misinterpret benign bodily sensations and symptoms as signs of underlying serious illness (Tyrer et al., 2017; Warwick & Salkovskis, 1990). Misinterpretations are often associated with unpleasant outcomes, such as an inability to engage in paid employment (Tyrer, 2013). This model emphasises that health-related anxiety is developed and maintained through biased information processing and specific assumptions about an illness that might be influenced by prior experiences and knowledge associated with the illness (Tyrer, 2013). The fear of having an illness is elicited when an individual perceives the consequences of the illness as a disturbance or a threat to their life functioning (Leonidou & Panayiotou, 2018; Tyrer, 2013). Cognitive behavioural therapy (CBT) has been shown to be an effective intervention for HA (Axelsson & Hedman-Lagerlöf, 2019; Tyrer, 2013).

CBT is a structured approach in exploring the interconnectedness between thoughts, emotions, bodily sensations and practices (Clark, 2011; Fenn & Byrne, 2013). According to the National Institute for Health and Care Excellence (NICE, 2011) guidelines, CBT is the first-line treatment for anxiety as it is the most well-researched and empirically supported form of psychotherapy (Fenn & Byrne, 2013). It is effective to treat anxiety across various delivery formats (Baker et al., 2021; DiMauro et al., 2013; Fenn & Byrne, 2013; Lunkenheimer et al., 2020). In CBT, the therapist and client work as a team to identify the client's current unhelpful ways of thinking and understand how their thoughts and emotions are associated with their practices (Fenn & Byrne, 2013). In the treatment for anxiety, 'Behavioural experiments' are often used to help client to collect evidence against the use of 'safety behaviours', such as avoidance (Fenn & Byrne, 2013). Other tools and techniques, such as longitudinal formulation and thought record, are usually employed to understand factors and client's belief system that contribute to client's distress (Beck et al., 1979; Fenn & Byrne, 2013). Subsequently, client's well-being is improved as they learn to modify their unhelpful thoughts about the self, the world and the future (Fenn & Byrne, 2013).

Psychoanalytic model. From a psychoanalytic perspective, persistent bodily symptoms are associated with unconscious motives, aggressive drives and defense mechanisms against guilt or low self-esteem (Barsky & Klerman, 1983; Lipsitt, 1974, 2014). According to Freud et al. (1962), the unconscious sense of guilt imposed by the superego on the ego, often acts as a resistance to treatment. The reluctance in accepting reassurance is associated with unconscious guilt over sexual and hostile wishes, thoughts and feelings while having a fear of retaliatory punishment. This is because the maintenance of physical symptoms, which are sometimes a feature of HA, often leads to secondary gain and allows the expression of the repressed fear (Glass, 1993; Starcevic & Noyes, 2014). Lipsitt (2014) also proposed that one may have a need to disguise one's unacceptable feelings or fantasies, and persistent clinging to bodily symptoms can be understood as a form of self-punishment.

In clinical practice, therapists foster the process of disclosure and allow client's anxiety to divert into a productive direction (Zerbe, 1990).

The interpersonal model. The interpersonal model posits HA as a form of care-eliciting behaviour that is presented through persistent, unexplained physical complaints (Noyes et al., 2003a; Stuart & Noyes, 1999). Care-eliciting behaviour arises from insecure and anxious attachment that is often developed when a person is exposed to inadequate parental care and/or adverse early experiences (Hotopf et al., 1999; Katon et al., 2001; Stuart & Noyes, 1999). The concept of insecure attachment, which originated from the work of Bowlby, captures the idea that when a person feels insecure, there is a lack of trust in relationships with others (Bowlby, 1988). Insecurely attached individuals seek emotional and personal support from significant others through somatising and care-seeking behaviours due to their maladaptive interpersonal and communication skills (Birnie et al., 2013; Stuart & Noyes, 1999). Unlike other models, the interpersonal model places great emphasis on interpersonal difficulties in people with HA (Birnie et al., 2013). Interpersonal psychotherapy aims to improve interpersonal functioning instead of the client meeting their interpersonal needs through the expression of health anxiety or complaints (Stuart & Noyes, 2006). The essence of this approach is that the psychotherapeutic relationship is viewed as an opportunity for clients to internalise new experiences that may counter earlier, less healthy interpersonal experiences (Stuart & Noyes, 2006).

Other factors influencing the development of health anxiety. Researchers have explored various influencing factors that contribute to the development and maintenance of HA (e.g., Benke et al., 2022; Peng, 2022). Some studies have shown that excessive online health information searching exacerbates HA due to exposure to conflicting, biased and inaccurate information (e.g., McManus et al., 2014; Peng, 2022). Other studies have found that people with HA are more prone to having a less accurate and biased heartbeat perception, as well as distressing mental images of getting a life-threatening disease (Benke et al., 2022; Krautwurst et al., 2014). This evidence suggests that HA is a complex response to psychological and biological parts of self.

Despite the substantial body of literature dedicated to understanding HA, many studies focus on a specific form of illness that is less socially stigmatised, such as cancer, dementia, and COVID-19 (Fenstermacher et al., 2020; Knudsen et al., 2015; Mahdavifar et al., 2023). In terms of HIV-related anxiety, some case reports have focused on the aetiology and diagnosis of the fear of HIV/AIDS (Fisman & Walsh, 1993; Glass, 2008; Scragg, 1995; Wirth, 2003). Additionally, a handful of studies have explored psychological interventions and strategies to alleviate HIV-related anxiety or fear (Bor et al., 1989; Logsdail et al., 1991; Muthusamy et al., 2009). However, none of these case reports or studies have placed emphasis on the nuance and depth of people's experiences of HIV fear and anxiety. Even though some quantitative studies have investigated degrees of HIV-related anxiety in relation to specific factors, such as the involvement of participants in churches and their PrEP usage (Keen et al., 2020; Stewart, 2017), no Western or Eastern qualitative research has offered insight on uninfected people's subjectivities regarding their HIV-related fear and anticipated sigma.

Research questions and aims

The experience of HIV anxiety involves a diverse array of medical and sociocultural aspects. Shifts in the HIV pandemic alongside advancements in treatments and emerging technologies in recent decades may impact the meaning of HIV infection for individuals. For instance, prior studies have addressed the impact of survivor guilt on the mental health concerns of HIV-negative gay men when HIV was one of the most fatal infectious illnesses in

Western industrialized countries (Koetting, 1996; Sicherman, 1996). Today, HIV-infected individuals can live a normal life span if they obtain the right treatment and if there is treatment adherence (Ernst, 2017). Over the past few decades, there has been education and advocacy that has addressed issues relating to HIV such as discrimination, gender inequality, and human rights to health (UNAIDS, 2015). Yet, there has been a lack of research attempting to understand the experience of continuous HIV-anxiety among at-risk populations. Furthermore, much of what is currently known about HIV-associated anxiety has been predominantly studied from a positivist/quantitative framework. As a result, the depth and meaning of this experience have not been captured.

With evidence of cross-cultural difference in mental health stigma, I have held collectivistic cultural influences in mind when formulating the aims of the study and during research design and data analysis. My primary goal is to explore the subjective experiences and meaning making of HIV-negative men in Hong Kong who report having experienced feeling worried and fearful about HIV transmission at some points in their lives. My goal is to contribute to current literature by providing an exploratory qualitative, nuanced and detailed understanding of HIV anxiety that will enable practitioners and researchers to gain insight into this complex experience via participants' own voices.

The main research questions are:

1) What experiences contribute to the development of HIV anxiety in Hong Kong HIV-negative men?
2) How do HIV-negative men in Hong Kong understand or perceive the maintenance of their HIV anxiety?
3) In what ways does HIV-negative men's role within the family, and the wider society, contextualise and shape their experiences of HIV anxiety?

The first two questions are intended to explore participants' sense making around their experiences. The third question will help me to understand how sociocultural factors interact with and shape these experiences.

Relevance to counselling psychology

An important part of counselling psychology's mission is to engage in conflicting viewpoints and worldviews, such as challenging the assumptions of traditional scientific research methods and using qualitative research methods to explore the diverse experiences of unique populations in specific contexts (Milton, 2010). I have noticed that existing knowledge about men's psychological distress mainly comes from research related to physical or mental health diagnoses (e.g., Brain et al., 2006; Roth et al., 1998). This study values the phenomenological experience of mental distress without drawing on diagnoses based on medical models, it encourages counselling psychologists to move away from the traditional concept of "psychopathology", decontextualised assessments and interventions for psychological distress.

Additionally, this study will contribute to the social justice agenda in counselling psychology (CP) – to acknowledge the systemic nature of oppression and to seek to alter it, and to understand how cultural, social, political and economic injustices adversely affect the welfare of people and the communities (Cutts, 2013). It addresses the association between HA and important societal concerns, such as HIV stigma, anti-gay stigma and discrimination against individuals who engage in non-traditional practices, such as non-monogamous relationships. Thus, this research will support and contribute to existing literature that advocates for equality of general treatment and opportunity (Tribe & Bell, 2017).

Laungani (1997) argued that there was a gap between Western counselling and psychotherapy, and the mental health needs of South Asian clients. Regarding ethnic difference in treatment outcomes, a multicultural counselling research in the US (Zane et al., 1994) indicated that compared to White-Americans, Asian American clients were likely to exhibit worse treatment outcomes when both groups were offered same type and duration of Western evidence-based psychotherapy. Thus, there is a need of bridging the gap between Western counselling psychology and the needs of culturally diverse individuals, and to incorporate cultural elements into psychological practices (Laungani, 1997; Moodley et al., 2010). Through studying a specific condition among an East Asian collectivist community, this study aims to expand counselling psychologists' understanding of people's perception and fundamental assumptions from a non-Western stance. Further, this study aims to equip practitioners to discuss the influence of power, privilege and oppression relating to clients' presenting issues in therapy, and to offer an inclusive and affirmative psychological practice that aligns with the agenda of multicultural counselling - recognises and respects the rights, values, autonomy and experiences of a diverse population (Fowers & Richardson, 1996; Sue et al., 1998).

Lastly, this study aims to build practitioners' confidence in working with sexual health related issues. Specialist training related to sex-related problems is rare in psychology doctorate training programmes (Hanzlik & Gaubatz, 2012; Mollen et al., 2020). Some studies have suggested that many clinical professionals, including psychologists and doctorate psychology trainees, are uncomfortable discussing sexual topics in clinical contexts (e.g., Hanzlik & Gaubatz, 2012; Risen, 1995). It has also been reported that female psychologist trainees are less comfortable than male trainees when communicating about sexual issues with male clients (Hanzlik & Gaubatz, 2012). Considering the prevalence of sex-related issues faced by men and the high proportion of women within the psychology professions (Hanzlik & Gaubatz, 2012), it is important to conduct research that contributes to clinical guidelines and best practices with regard to supporting women practitioners in the provision of gender-sensitive therapeutic work.

Methodology

Research design overview

My ontological stance is aligned with critical realism (Bhaskar, 2008), which is a philosophical position that recognises that there are material realities that exists independently of humans' perceptions and descriptions of them (Braun & Clarke, 2022b; Pilgrim, 2014). Simultaneously, critical realism assumes that there are things in the world, such as people's unconscious mind, that go beyond the currently observable, and how each individual views the world is inevitably shaped by their subjectivity and culturally contextualised aspects of experiences, such as language (Madill et al., 2000; Pilgrim, 2014). My epistemological positioning is within contextualism (DeRose, 2017), which is broadly compatible with critical realism (Braun & Clarke, 2013). This stance proposes that knowledge is shaped in a wider socio-cultural context (Braun & Clarke, 2013; Henwood & Pidgeon, 1994). The process of revealing the subjective experience and meaning making of a specific ethnic group – Hong Kong Chinese men - cannot be separated from my own experiences and socially influenced personal values (see researcher personal statement below). In contextualism, knowledge is viewed as "local, situated and therefore always provisional" (Braun & Clarke, 2013, p. 31).

Research design rationale

Reflexive thematic analysis (TA) is qualitative research method that involves a process of critical reflection on the researcher's values, assumptions and practices across different phases of the research. I considered it as an appropriate method for this study as it allowed me to take an active role in interpreting the data and shaping the data analysis while acknowledging of the ways in which my own experiences, values, beliefs and assumptions shaped the research process. Additionally, the reflexive stance in reflexive TA is coherent with my ontological and epistemological positions, and my values as a practitioner-researcher – including ourselves and our individual experiences in the field of research (Etherington, 2017).

Reflexive TA is a theoretically flexible method for “developing, analysing and interpreting patterns across a qualitative dataset” (Braun & Clarke, 2022, p.4). It is one of the distinct schools of TA that places great emphasis on the researcher’s reflexivity (Braun & Clarke, 2022b; Joy et al., 2023). The researcher’s subjectivity is viewed as a resource and strength, rather than a problem (Braun & Clarke, 2022b). Thus, the use of this method offers me the space to critically reflect on and be transparent about what I bring to the analytic process. TA is widely used in research in counselling, psychotherapy and health psychology, to interpret the views and perspectives of specific groups of clients, patients or therapists (e.g., Braun & Clarke, 2019, 2023). It is a “rigorous, powerful, and yet straight-forward way of engaging with qualitative data” (Terry & Hayfield, 2021, p. 3). To ensure the rigour of this study, I review and discuss my decisions across the study in the following paragraphs.

The analytic process of TA methods involves the researcher’s active participation in data coding to generate themes (Braun & Clarke, 2022b, 2023). Unlike the other two main approaches to TA (as defined by Braun & Clarke) - coding reliability and codebook approaches - reflexive TA sits firmly within Big Q qualitative research, which emphasises the subjectivity of research and the researcher (Braun & Clarke, 2022b, 2023). The process of coding is organic and evolving; researchers can choose to focus on semantic (explicit and surface) meaning and/or latent (hidden, underlying, implicit) meaning. Themes capture a pattern of shared meaning united by a central idea (Braun & Clarke, 2022b; Joy et al., 2023). Reflexive TA offers the possibility of analysing data with an inductive orientation (Braun & Clarke, 2022b, 2022a, 2024) - where coding and theme development are driven by the data, rather than being shaped by pre-existing theories (Braun & Clarke, 2022b). This is the approach I take in this study.

Connelly and Peltzer (2016) highlighted the importance of producing rich and detailed data for TA that includes stories that illustrate aspects of human experience. To achieve this, I chose an interactive data generation method – in-depth interviews. The use of in-depth interviews to investigate sensitive topics, such as commercial sex work, concerns around disclosure of HIV-positive status, is common (e.g. Abdullah et al., 2012; Mkwanazi et al., 2015). Also, scholars have proposed that interviews are particularly useful for examining participants' understandings and perceptions on topics in which they have a personal stake (Braun & Clarke, 2013). Given the sensitive topic and research questions in the present study, I chose individual semi-structured interviews because of their alignment with the non-positivist underpinnings of reflexive TA (Braun & Clarke, 2013, 2024; Power, 1998).

Semi-structured interviews are one of the most common qualitative data generation methods used to address complex social-behavioural research questions (Adeoye-Olatunde & Olenik, 2021). An interview guide with questions is developed to facilitate a natural flow of conversation (Adeoye-Olatunde & Olenik, 2021). The interview guide typically consists of a list of open-ended questions that facilitates in-depth and spontaneous responses (Kallio et al., 2016; Ryan et al., 2009). The flexible nature of this type of interview allows the interviewer focuses on their predetermined agenda and leads a discussion that encompasses key areas related to the research questions, while research participants to have the space to explore and to make sense of their experiences (Adeoye-Olatunde & Olenik, 2021). Key features of this interactive approach include resembling naturalistic conversation so that both interviewer and interviewee feel more comfortable in the interactions, and having space to clarify the meanings of complex answers and any ambiguities in participants’ responses through improvising verbal and non-verbal probes as well as asking follow-up questions (Braun & Clarke, 2013; Kallio et al., 2016; Madill, 2011; Reinharz, 1993; Wooffitt & Widdicombe, 2006). Another benefit of semi-structured interview is the accessibility of participants’ tone and pace of speech, hesitation, silence and emotions. This extra information can help to develop a fuller picture of participants’ meaning making and life stories (Denham & Onwuegbuzie, 2013).

Participants and recruitment

Participants were recruited through purposive and convenience dataset strategies. To advertise this study, recruitment posters (see Appendix E) were put up in a community-based HIV testing centre in Hong Kong, where volunteers, counsellors and social workers introduced this study to eligible service users who sought HIV testing and counselling services. Electronic copies of the poster were also disseminated on a community Facebook page (有種部隊 guts army) managed by the staff of AIDS Concern, a health charity specialising in HIV/AIDS-related community services. To maximise the diversity of participants, I also reached out to the potential participants who were not active service users of AIDS Concern at the time of recruitment. I promoted the study via my personal contacts on Whatsapp, Linkedin and Facebook. My personal contacts shared my poster on their personal social media pages; some of them proactively invited their friends to participate in this study. Individuals who were interested in participating were invited to access and complete a *Qualtrics* online survey that contained an information sheet, privacy notice, consent form, demographic information and space for participants to leave contact information for the purposes of arranging an interview (see Appendices F-H). The information sheet included information about the study’s purpose, use and protection of data, interview procedures and participants’ right to withdraw. Participants were instructed to create a pseudonym as an anonymity measure. Their self-created pseudonyms are used in reporting the data analysis.

Inclusion criteria were that participants should be Cantonese-speaking HIV-negative males aged 18 or above, who have been a Hong Kong resident long enough to understand the culture and have experienced HIV anxiety at any point in their lives. During recruitment, the concept of HIV anxiety was presented as “HIV fear or worries” to the potential participants. Both cisgender and transgender men were welcome to participate, as were men of all sexualities. Including men of all sexualities was important as it ensured that the findings would reflect the diversity of male experiences and highlight any disparities in mental health experiences. Participants were not required to have obtained a diagnosis for illness anxiety disorder to ensure that the voices of men who have experienced lower levels of HIV anxiety were not excluded from the study.

Regarding exclusion criteria, these were developed from considering comorbidity and differential diagnosis according to DSM-V (APA, 2013). HA is often comorbid with anxiety disorders and depressive disorders (APA, 2013). Although there are overlapping symptoms, such as abnormal bodily sensations and somatic delusion, between HA and psychosis (Rimvall et al., 2019), it is clear that the nature of HA is different from psychotic episodes as individuals with HA are aware of the chance that the feared illness does not exist (APA, 2013). As such, this study excluded individuals who had previously experienced symptoms of hallucinations (i.e., hearing, seeing, smelling, tasting or feeling things that appear to be real but only exist in the mind) or delusions (i.e., having an unshakeable belief in something untrue). It ensured that the participants’ HIV anxiety occurred independently of psychotic symptoms.

Before scheduling an interview date and time, each participant was invited to have an online introductory meeting with me. During the introductory meeting, they were asked five quick screening questions for psychotic symptoms (Centre for Addiction and Mental Health, n.d.) (see Appendix J). This introductory meeting also offered the space for discussions of participants' concerns, any possible difficulties, and solutions to these, during the interview, such as the loss of internet connection and privacy issues. According to Patton (2002), there are no standard rules for "sample size" in qualitative research. Given the complexity and time needed for transcribing and translating interview transcripts, deciding on the number of participants for this study was complicated. Malterud et al. (2016) introduced the concept of information power, which guides adequate dataset size based on various factors, such as a study's aims, the specificity of the experiences of interest, the use of established theory, quality of dialogue, and so forth. Given that my recruitment strategies enabled me to recruit participants with diverse experiences, and the fact that I had substantial experience of working with men who have had experience of HIV anxiety, I judged that recruiting six to 10 participants would be adequate to provide sufficient information power. While my supervisor reviewed the translated data and I reviewed the whole data set, we determined the final number of interviews by considering both information power and practical issues around translation. I stopped recruiting after conducting eight interviews.

Of the eight participants who met the criteria, five participants were referred by AIDS Concern and three participants were invited to participate in this study by my personal contacts. Initially, I invited all participants to conduct interviews virtually via Microsoft Teams because of the geographical distance between me and the participants; however, a trip to Hong Kong enabled me to conduct one interview in person. Participants taking part in virtual interviews were given the choice of attending a virtual interview in a private space of their own choice or to use a room and computer provided by AIDS Concern if they had difficulty finding a private space. One participant participated in a virtual interview at AIDS Concern, six at their homes, and the in person took place at a sexual health clinic operated by AIDS Concern. During transcribing, one interview was excluded. This is discussed in the data generation section below.

With regard to participant demographics, of the seven interview participants included in this study, three identified as heterosexual, three identified as gay and one identified as bisexual. All identified as cisgender. At the time of interviews, their age was ranged between 23 and 53 years. Their relationship statuses varied, and all reported having no children. A detailed overview of the participants' demographics is presented in Figure 3 in the analysis chapter.

Data generation process

Prior to the interviews, I developed an interview guide with reference to prior literature, such as case reports of HIV anxiety and qualitative studies of health anxiety (e.g., Al. Alawi & Al. Senawi, 2015; Singh et al., 2016). I also applied my understanding of the concept of health among the Chinese community and my past clinical experience to ensure that the questions were appropriate to the sociocultural aspects of the Hong Kong context. The interview guide included broader questions covering the experience of HIV anxiety (when and how the trigger(s) occurred), the participants' perception of themselves and the world during that experience, their sense-making around this specific anxiety, the experience of HIV testing (including differences in feelings and thoughts pre- and post-testing), the overall impact of this experience on their current lives, and their observation and understanding of others' and social perceptions of HIV. At the end of the interview, participants were asked a “clean-up” question (e.g., “Is there anything else you would like to share with me”) so that participants had the space to raise any issues that had not been explored by my questions (Braun & Clarke, 2013). The duration of the interviews was between 50 minutes to 90 minutes. All interviews were audio recorded and then transcribed verbatim by me.

In one interview, an unexpected situation arose that led to me excluding that interview. The participant’s family visited the participant’s home just before the interview. Due to the time difference between me and my participant, it was not easy to reschedule the meeting, and the participant convinced me that he had a private space that was appropriate to complete the interview as scheduled. He primarily focused on his positive views on facing HIV and he reported having temporary anxiety which I considered to be a valid reaction in time of distress rather than an experience of HA. More importantly, I thought that the lack of privacy in the interview environment seemed to have greatly influenced the extent to which he was willing to disclose details of his story. After discussing my concerns with my supervisor who had read the translated transcript, we decided to exclude this data because the interview did not provide relevant and meaningful data.

During the interviews, I found myself oscillating between roles – a researcher, an HIV expert (from the participants’ perspective), and a therapist. Due to my previous clinical experience in HIV counselling and testing, it was inevitable to shift between roles while trying my best to stick with the interviewer role to ensure I was generating relevant information. When participants’ difficult emotions were brought up during the interviews, I offered the choice of pausing the interview and checked if it was emotionally safe to continue the interview. This evidences good research practice while conforming to the values of the profession of counselling psychology – to work creatively, compassionately, collaboratively, and ethically (British Psychological Society Division of Counselling Psychology, 2005).

Language and translation decisions in this research

Translation of data was a crucial process in conveying non-English speaking participants' original meanings to the readers (Gawlewicz, 2020). Temple (2002) highlighted that translators are active producers of research and knowledge. The existing body of literature notes that translation decisions in non-English data inevitably shape the process and final results of qualitative research (e.g., Abfalter et al., 2021; Ho et al., 2019; Qoyyimah, 2023; Santos et al., 2015). There are often obstacles in performing translation in qualitative research. For instance, there may be untranslatable expressions when discussing sensitive ideas, and it is sometimes difficult to produce translated data that captures participants' voice in a way that reflects their social and cultural contexts (Turhan & Bernard, 2022). Meaningfully rendering other creative forms of verbal expression, such as the use of metaphor and idiomatic sayings, have been reported as another common challenge in translating data (Helmich et al., 2017).

Translation may take place at different stages of the research process, including: 1) prior to data generation (e.g., when developing the interview guide); 2) at data generation (e.g., during real-time conversation with participants); 3) during data preparation (e.g., transcripts translation); 4) during data analysis (e.g., translating codes); and 5) presenting findings (e.g., translating extracts) (Helmich et al., 2017). Researchers in different research contexts have reported introducing translation into the research process at various phases (Santos et al., 2015; Yunus et al., 2022). In earlier studies, such as Brislin (1970) and Larkin et al. (2007), translation was introduced prior to data generation. Whereas other researchers (e.g., Chen & Boore, 2010; van Nes et al., 2010) executed translation during or after data analysis. There are different perspectives and considerations regarding the timing of translation (Santos et al., 2015). For instance, Regmi et al. (2010) argued that late-phase translation only captured key concepts and categories so that mistranslations tended to happen. Yet, other scholars have addressed that the importance of considering practicalities such as the availability of time and funding when making translation decision (H. Chen & Boore, 2010; Lopez et al., 2008). With different perspectives on the stage at which language translation should happen in cross-language studies, there is a lack of agreement about the most appropriate time to transition from the interview language to the target language of the research (Abfalter et al., 2021; Santos et al., 2015). In the paragraphs below, I explain how I made my decision based on considerations of the unique features of my mother tongue, my linguistic capacity and the practicalities of time and resources.

Ethnolinguistic identity of Hongkongers and language considerations in this study

Hong Kong is a former British colony and therefore, it is a bilingual city where Cantonese (the native Chinese dialect) is often interspersed with English elements, especially single words (Chan, 2018; Li, 1999). Although Cantonese-English code-switching is a common feature in every day communication, pure Cantonese is often used while the use of English at the spoken level is usually limited (Setter et al., 2010). Therefore, the interview language could be either monolingual (pure Cantonese) or bilingual (Cantonese-English code-switching), depending on the participants' language preference and acquired proficiency in English. Sharing a nationality, native language, language experience, and sociocultural background with the research participants enabled me to facilitate an authentic responses from the participants (Nowicka & Cieslik, 2014). Additionally, participants felt at ease when communicating in their native language so that an adequate emotional depth of their experiences could be captured.

The possibility of involving a professional translator and which language should be used in each phase of the data analysis, were not straight-forward when determining the research design of the current study. Several researchers (e.g., Barrett, 1999; Simon, 1996; Spivak, 1992) have commented that translating the text in a qualitative study cannot be accomplished by just simple translation because “meaning is constructed through a discourse between texts” (Temple & Young, 2004, p.165). Although it is common that bilingual researchers translate the data from their native language into English by themselves (e.g., Abfalter et al., 2021; Qoyyimah, 2023; Santos et al., 2015; Temple & Young, 2004), I was aware that my lack of translation/linguistic knowledge and experience could shape the rigour of this study as the meaning of the participants’ words as captured in the interview transcripts could easily be distorted or lost in translation (Smith et al., 2008). I recognised the possible disadvantages of being the translator myself on the one hand, but also recognised that it would be equally difficult to engage a professional translator who might not be conversant with the specific jargon or terminologies used by the participant communities in a sexual health context on the other hand.

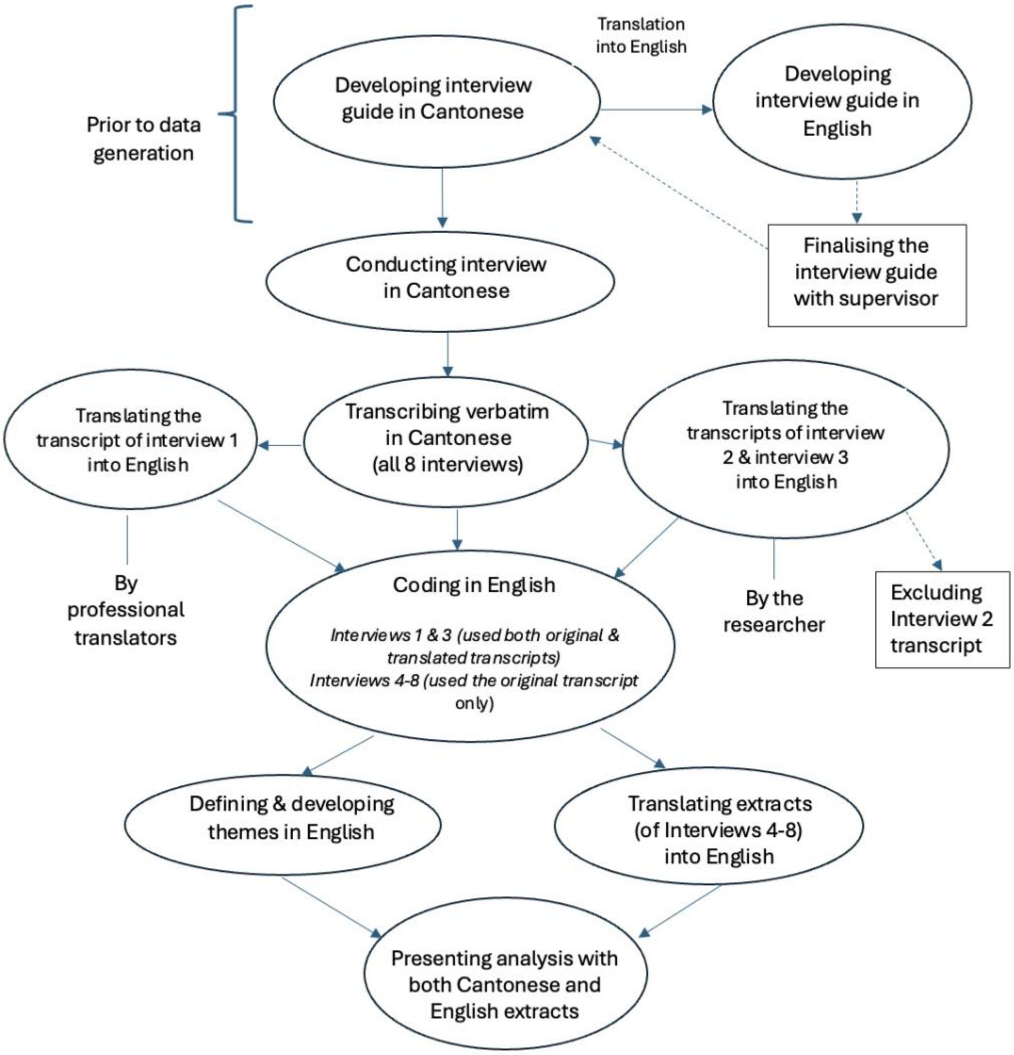
Initially, I decided to hire a professional translator, and they completed a translation of the full transcript of the first pilot interview so that my English-speaking supervisor could give feedback on my interview skills and strategies before I proceeded to conduct further interviews. After conducting the pilot interview, no amendments were made in the interview guide. Yet, my supervisor’s feedback facilitated my reflection and evaluation on my interview skills as an interviewer-researcher. In retrospect, I perceived that my male participant was holding more power than I did during the interview when he expressed his need of shortening the interview duration. My anxiety associated with the gender and/or researcher-participant power dynamics resulted in my resistance to probing and asking follow-up questions, even when there was missing information in the participant’s response. I avoided seeking clarification to minimise the risk of causing further discomfort and tension in our interactions. This led to noticeable information gaps in the narratives of the first participant. After realising how data generation is influenced by the imbalanced power between the participant and me, I became more assertive in exploring the nuances of participants’ stories while paying attention to and respecting each participant’s personal boundaries in the other interviews for this study. For example, I asked more follow-up questions where appropriate to ensure that I could delve deeper into my participants’ responses, and gained a more comprehensive understanding of their experiences.

When I read the translated transcript of the first interview, I noticed two main problems with hiring a translator who had little or no prior knowledge about the culture and experiences among MSM and male clients in commercial sex. Firstly, the translator expressed difficulty in comprehending or giving word-for-word translation when my participants did not express sensitive matters explicitly. I was concerned about the way the translator interpreted and censored the content. I was also mindful about the potential influence and power of the professional translator’s social positioning, values and beliefs on qualitative data interpretation. Secondly, I considered that some translated terms carry stronger negative connotations and social stigma, such as the use of “disease” instead of “infection”. This translated transcript made me recognise the potential advantages in performing the translation by myself and using my cultural knowledge as the resource. Thus, I attempted to translate two interview transcripts in full by myself, but due to the time limitations, my supervisor and I decided that I would only translate excerpts of the remaining interviews. With regard to the project as a whole, the translation process started prior to data generation. I first translated the screening questions into Cantonese, and I developed the interview guide in Cantonese (see Appendix C) followed by translating it into English (see Appendix D) so that I could discuss with my supervisor before finalising the interview questions. During the interview process, I probed and asked unplanned follow-up questions bilingually when I noticed participants were comfortable in switching between Cantonese and English. After each interview, I generated codes in English from the Cantonese transcripts (and the translated transcripts of two interviews), and then, as noted, only translated selected participants' quotations for data presentation based on the initial themes. I chose not to generate codes and themes in my mother-tongue as I feel more comfortable in using written English to express social science ideas given that I obtained my psychology education in English-speaking countries. Figure 1 depicts the steps for the translation decisions and process across different stages of this study.

When presenting the data analysis, I provided extracts in both Cantonese and English since there are several potential benefits with this reporting approach (Younas et al., 2022). Firstly, it allows multilingual readers to evaluate the consistency between the extracts and the analysis of the participants' experience. Readers can also contextualise participants' views and experiences within a wider social and cultural framework. Secondly, language is a symbolic system of communication shaped by social norms, values, beliefs, identities and world views of a given social group (Angel, 2013). The inclusion of the original Cantonese data excerpts could avoid the loss of the true essence of meaning and relevant sociocultural factors. This in turn helped support my interpretation and generation of meaning. Thirdly, the essence of the participants' views and experiences could be accurately captured in their own words. Lastly, this study could help promoting cross-cultural understanding by giving examples of and discussing the analogies, metaphors and words that have multiple meanings across languages (Younas et al., 2022).

Figure 1

Translation Decisions and Procedures



Note. Figure shows all the translation work across different stages in this study.

Reflexivity of the researcher

Researchers' practices of reflexivity have been increasingly recognised as a resource and a valuable strength in the research process (Berger, 2013; Braun & Clarke, 2022b; Luttrell, 2019; Wilkinson, 1988). To demonstrate how my identity is involved in knowledge production in this study, I share my personal and functional reflexivity.

Personal reflexivity

Personal reflexivity involves the researcher's continuous interrogation on their personal positionings (e.g., gender, values and assumptions), and how these shape the research and production of knowledge (Braun & Clarke, 2022b). As I investigated my own ethnic community in my mother tongue while being a mature doctoral student in a British institute, I recognised my specific social positionality as a Hong Kong, middle-class cisgender female with the experience of living in Western society as a migrant. Qualitative researchers have discussed the issue of gender differences between interviewers and interviewees (e.g., Arendell, 1997; Lee, 1997). Historically, some female researchers have experienced oppression and perceived that woman researcher- man participant interview dynamics were controlled by the male interviewees (Broom et al., 2009; McKee & O'Brien, 1983; Smart, 2012) . A number of feminist researchers have pointed out the existence of a gender hierarchy and power imbalance in cross-gender interviews (e.g., Arendell, 1997; Broom et al., 2009; Lee, 1997; Vogels, 2019). Therefore, I was prepared to experience power imbalance during recruitment and interviews. I also held a belief that the power dynamics between researcher and participants are always complex and two-sided. Given the multiple positions (e.g., social class, gender and age) I embodied, the power dynamics between me and my participants were "multi-dimensional and fluid" (Grenz, 2005; Pini & Pease, 2013, p. 8). My opportunity to study abroad and to conduct academic research put me in a powerful and privileged social position compared with the participants. Conversely, I was mindful that research participants also held power to a certain extent as my research data was shaped by their degree of openness to share and how much detail they were willing to disclose. I also believed that my student status may have led me to be perceived as needing the participants' help. Hence, the student identity became a barrier to embody my assertiveness as a researcher to work toward productive outcome.

In terms of research positioning, I considered myself as both an 'insider' and 'outsider' researcher. The fact that participants were informed that I share the same ethnic identity and native language with them during recruitment helped me to recruit participants who resided in Hong Kong. This 'insider' role also helped in overcoming the challenges of the participants' indirect way of expressing culturally sensitive or taboo subjects, such as sexuality and sexual practices. As I previously had five years of work experience in an HIV/AIDS organisation in Hong Kong, I had acquired culturally specific knowledge to understand any jargon, hidden meanings, metaphors, local idioms and euphemistic terms used by men to describe their sexual and HIV testing experiences. Some terminology that participants used in the interviews were not part of everyday language. My privilege in understanding the culture and language use in sex-related issues locally helped establishing trust and rapport with the participants so that discussion of sensitive issues was more easily elicited. When participants consciously chose not to verbalise explicitly, my pre-existing knowledge and assumptions were used as tools to enhance the meaning-making process.

I left Hong Kong and moved to the UK not long after the Hong Kong's Anti-Extradition Law Amendment Bill movement in 2019-2020. Most active participants in the movement were young people, who had intense anger and distrust towards the Hong Kong social justice system. Since I am a member of the "younger" generation and the fact that my doctoral study in the UK started in 2021, some participants might have made assumptions about my political beliefs and values consciously or unconsciously. During data analysis, I was mindful that this "insider" role might be the reason why the younger participants had verbally expressed their frustration with and dissatisfaction towards Hong Kong sex/public health education more explicitly, in comparison to the participant who was aged 50+.

Within this male-dominate space, being a female researcher who had not experienced HIV anxiety made me an ‘outsider’. However, as a former sexual health educator and mental health practitioner who delivered HIV testing and counselling services, I had the opportunity to listen to various stories of men who were at risk of HIV infection prior to this research. My past work experience not only stimulated my interest and curiosity in understanding topics related to sexual and relationship issues, but it also shaped my views on masculinity and marginalised groups of men. It made me aware of men’s vulnerabilities and their day-to-day difficulties associated with dominant societal expectations around gender. The lens through which I interpret men’s sexuality and needs might be different from most women in my culture due to my past opportunity to listen to men’s emotional struggles in counselling and sexual health settings. I held an assumption that there were often unspoken stories and relationship challenges behind their “wrong” or “impulsive” actions or decisions that led to a potential exposure to HIV infection. Hence, I interpreted and reflected on participants’ stories from a broader lens that enabled me to explore how various sociocultural factors shaped the men’s accounts. At the same time, it was difficult for me not to see the participants’ narratives through an educator’s and practitioner’s lens. For instance, I could not stop noticing the discrepancies between the actual risk and their HIV anxiety. Yet, my medical assessment and evaluation acted as a tool that might mirror healthcare professionals’ attitudes towards my participants’ anxiety. It enhanced my understanding of my participants’ sense of helplessness and frustration when seeking professional help.

Functional reflexivity

Functional reflexivity refers to the researcher reflecting on how their design and method choices shape the research and knowledge constructed (Wilkinson, 1988). At different stages of the research process, I identified multiple challenges regarding translation. First of all, I questioned my competence to evaluate the quality and accuracy of translation performed by a professional translator. The grammatical mistakes, mistranslation or missed translations in the first English transcript resulted in the loss of meaning. For this reason, I decided to hire a second professional translator to redo the translation of this transcript. Secondly, in the early phase of this study, it was hard when I realised I had underestimated the time and difficulty in transcribing and translating. Another challenge was the selection of English words for Chinese characters that have multiple meanings. For example, the Chinese character 驚 can be used as a verb or as an adjective and it has different meanings in different contexts. It could be interpreted as worried, scared, frightened, startled and panicked. In terms of language and translation, my “insider” position was both helpful and unhelpful. As a native speaker of Cantonese, I hadn’t before reflected on how or why I use certain words to describe certain things. Given my lack of professional training in translation, noticing phrases and terminologies that might be unfamiliar to English-speaking readers was a challenge. Sometimes I only realised the need for additional explanations when my supervisor understood the extract differently. Lastly, there were euphemistic terms and terms that were untranslatable across the dataset. This increased the challenge in explaining and presenting my analysis. To tackle these difficulties, during translation, I used resources such as online dictionaries, thesauruses, and online translation engines to paraphrase some words and terminologies to explore a list of options for the same word.

Ethical considerations

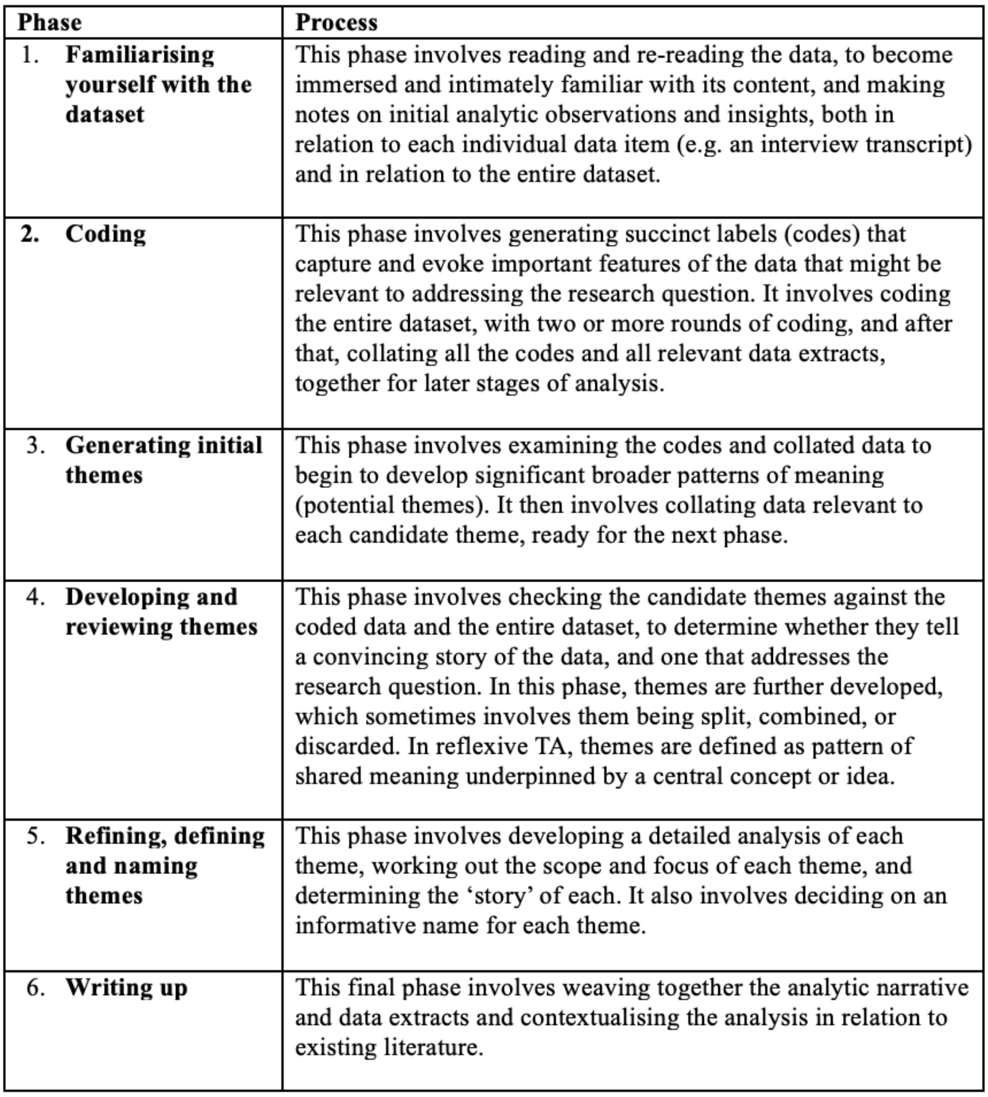
This research was reviewed and approved by the Faculty of Health and Applied Sciences Research Ethics Committee of the University of the West of England. I adhered to the British Psychological Society's Code of Human Research Ethics (BPS, 2021) throughout the research. The BPS's Code highlights that researchers should identify the potential risks and psychological harms associated with the research and develop protocols for risk management (BPS, 2021). When designing this research, there were two main ethical considerations. Firstly, I managed the issue of confidentiality in the translation process by sending a transcript to the professional translators without the original audio recording to protect the participant's anonymity. Translators were required to sign a confidentiality agreement (see Appendix I). Secondly, I anticipated some psychological discomfort for the participants resulting from taking part in this study, given that the participants were invited to recall and reflect on potentially sensitive topics, which are often associated with unpleasant meanings and emotions, such as feelings of shame. As such, participants were signposted to local sources of support at the end of the online participant information and consent survey (see Appendix K). I also offered an optional debrief session for advice on mental health issues if any difficult emotions were brought up as a result of the interview.

Process of data analysis

Data were generated through a six-phase process of the reflexive TA (see Figure 2 below), which was introduced by Braun and Clarke in 2006 and further refined since then (Braun & Clarke, 2021). It is a "progressive but recursive process" (Braun & Clarke, 2021, p.36) of analysis rather than a linear approach. Below, I demonstrate how I produced a contextualised story from the dataset by outlining how I engaged with the analytic process in each phase.

Figure 2

Six phases of reflexive TA



Phase	Process
1. **Familiarising yourself with the dataset**	This phase involves reading and re-reading the data, to become immersed and intimately familiar with its content, and making notes on initial analytic observations and insights, both in relation to each individual data item (e.g. an interview transcript) and in relation to the entire dataset.
2. Coding	This phase involves generating succinct labels (codes) that capture and evoke important features of the data that might be relevant to addressing the research question. It involves coding the entire dataset, with two or more rounds of coding, and after that, collating all the codes and all relevant data extracts, together for later stages of analysis.
3. **Generating initial themes**	This phase involves examining the codes and collated data to begin to develop significant broader patterns of meaning (potential themes). It then involves collating data relevant to each candidate theme, ready for the next phase.
4. **Developing and reviewing themes**	This phase involves checking the candidate themes against the coded data and the entire dataset, to determine whether they tell a convincing story of the data, and one that addresses the research question. In this phase, themes are further developed, which sometimes involves them being split, combined, or discarded. In reflexive TA, themes are defined as pattern of shared meaning underpinned by a central concept or idea.
5. **Refining, defining and naming themes**	This phase involves developing a detailed analysis of each theme, working out the scope and focus of each theme, and determining the 'story' of each. It also involves deciding on an informative name for each theme.
6. **Writing up**	This final phase involves weaving together the analytic narrative and data extracts and contextualising the analysis in relation to existing literature.

Note. This table – with minor edits – is reproduced from Braun and Clarke (2022b)

I familiarised myself with the dataset by repeatedly listening to the audio-recording while transcribing each interview myself. My strategy in transcription was to capture every audible word and some non-verbal information, such as longer pauses, crying, internet disconnection and so on. This information served the purpose of reminding me of the tone and the emotions of the interview, which reflected the participants' resistance to my questions, hesitation and emotions that could be useful for informing how I made sense of their overall stories. As the interviews took place over eight months, I completed the transcription as soon as I could after each interview and used a reflective journal to record my feelings, thoughts and observations during and after the interview. As explained earlier, full English translated transcripts for the first and third interviews were generated by a professional translator and me after generating the Chinese (Cantonese) transcripts. I re-read and made brief notes on anything that I noticed by looking at both Chinese and English transcripts at the same time. The notes were made using the 'comment' function of Microsoft Word (examples are shown in Appendix P). For the other five transcripts, my notes and comments were based on the Chinese transcripts only.

Then, I moved onto the coding phase. I revisited the transcripts line-by-line and paid equal attention to each part of the data, including incomplete or fragmented speech. I created both semantic and latent coding that captured aspects of the data relevant to the research questions. Reviewing the Chinese transcript with the generated codes in English was an extra process that allowed me to make sense of the data. I put the codes in a column in the Word document next to the data. After doing the coding of the first transcript, I had a meeting with my supervisor who offered a different perspective from mine on some codes. The difference in perspective further motivated me to reflect on the role of my subjectivity and cultural knowledge, and to question the possibility of inaccurate translation. Once the coding for all interview transcripts was completed, I looked for codes with similar meaning across the dataset and checked whether the same code could be applied to different extracts while making amendments in the word choice in the codes.

Before moving into phase three, I drew a picture (see Appendix L) that depicted the overall story across the data and subsequently generated initial themes and subthemes as showed in Appendix M. Next, I created my first thematic map through which I came up with an overarching theme and alternative theme names that led to different versions of thematic maps. During this phase, I repeatedly reviewed the fit between each code and theme and re-organised them where appropriate. When I was convinced that the thematic map captured the overall story of the lived experience of my participants, I stopped generating new versions of the thematic map. Three examples of my hand-drawn thematic maps are displayed in Appendix N.

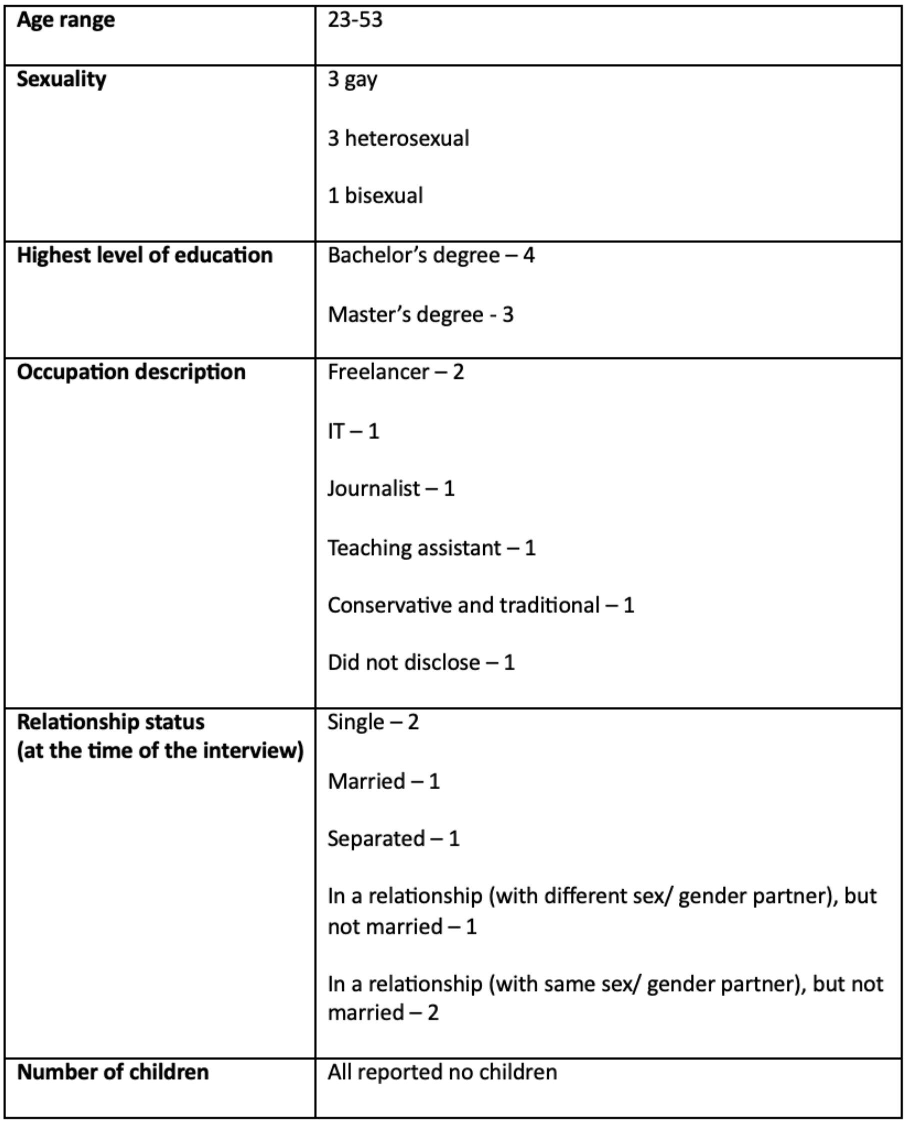
Next, I moved back and forth between phase four and five, where I explored the possibility of changing themes or combining themes by re-reading the data and identifying extracts that illustrated individual theme. Simultaneously, I drafted my understanding of the story of each theme followed by a discussion with my supervisor who asked for clarification when something related to the cultural and language aspects of the story was not clear to her. Since my supervisor looked at my themes and interpretation through a western lens, I gained an insight on what was missing in terms of my presentation to a western audience. To ensure that my analysis was presented clearly to audiences of all cultural backgrounds, I shifted between the eastern and western lens while writing up my final analysis.

Analysis

Six themes including one overarching theme were generated from the data, as summarised in Figure 4. All themes and subthemes are presented below with participants' original quotations in Cantonese alongside the translated English quotations, with pseudonyms for the participants used throughout. To help contextualise the analysis, an overview of the participants' demographics is presented in Figure 3.

Figure 3

Summary Table of Participants Demographics



Age range	23-53
Sexuality	3 gay 3 heterosexual 1 bisexual
Highest level of education	Bachelor's degree – 4 Master's degree - 3
Occupation description	Freelancer – 2 IT – 1 Journalist – 1 Teaching assistant – 1 Conservative and traditional – 1 Did not disclose – 1
Relationship status (at the time of the interview)	Single – 2 Married – 1 Separated – 1 In a relationship (with different sex/ gender partner), but not married – 1 In a relationship (with same sex/ gender partner), but not married – 2
Number of children	All reported no children

An overview of the overarching theme, themes and subthemes

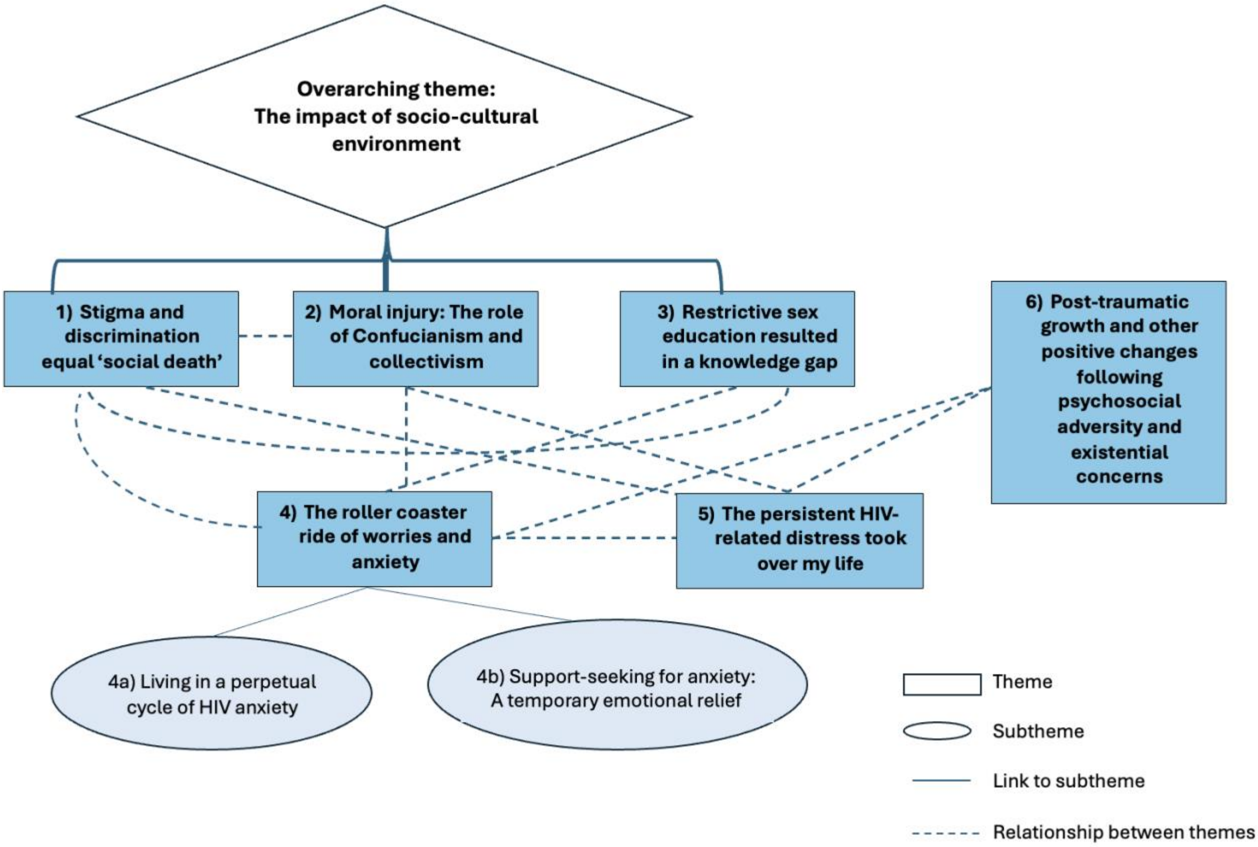
The analysis includes an overarching theme - “The impact of the socio-cultural environment” – under which three themes are nested. It captures the participants’ understanding of the significant impact of the sociocultural setting in which they were educated, lived and experienced HIV-related anxiety, detailing the cultural barriers and challenges that participants reported in the interviews in relation to their experience of HIV anxiety. The three themes nested under this overarching theme are: 1) stigma and discrimination equal “social death”, 2) moral injury: the role of Confucianism and collectivism, and 3) restrictive sex education resulted in a knowledge gap. These constitute the first three themes to be reported.

The first theme, stigma and discrimination equal “social death”, reflects a core struggle consistently expressed by the participants regarding anticipating stigma, prejudice and discrimination if they were infected with HIV. The second theme, moral injury: the role of Confucianism and collectivism, explains the relationship between socially normalised moral values in the Hong Kong context and the men’s feelings of shame and guilt. The third theme, restrictive sex education resulted in a knowledge gap, captures participants’ recognition of the lack of comprehensiveness of Hong Kong sex education, which was perceived as the root cause of their anticipated “social death” and fear of HIV.

The remaining themes give an overall picture of participants’ emotional distress and their reflection on the short- and long-term impacts of their experience of HIV anxiety. These dimensions of their lived experience sit outside of the overarching theme. The fourth theme, the roller coaster ride of worries and anxiety, described the men’s anxiety journey and the difficulties they experienced in managing their HIV-related distress. This theme consists of two subthemes: 1) living in a perpetual cycle of HIV anxiety, 2) support-seeking for anxiety: a temporary emotional relief. The fifth theme, persistent HIV-related distress took over my life, explores the detrimental impacts of HIV anxiety on participants' physical and interpersonal well-being. The last theme, post-traumatic growth and other positive changes following psychosocial adversity and existential concerns, details the positive changes the men experienced in their attitudes and life priorities, and their desire to strive for positive meanings in life after experiencing HIV anxiety.

Figure 4

The final thematic map



Note. This thematic map illustrates the overarching theme, themes and subthemes of the final analysis.

Theme 1: Stigma and discrimination equal "social death"

This theme captures how participants' awareness of stigma and discrimination surrounding HIV and non-traditional sexual identities and/or practices induced their fear of social exclusion and potential losses in life associated with becoming HIV positive. The participants' expected negative outcomes associated with stigma and discrimination were linked to their prior life experiences, their observations of social norms and values in the Hong Kong Chinese context. As a result of an extreme fear of social isolation, they perceived a need to conceal their stigmatised identities.

A fear of being isolated, rejected and disapproved of were conveyed explicitly by different participants. Both MSM and heterosexual participants reported experienced or anticipatory rejection from others, including their parents, current intimate partner, future intimate partners, friends, co-workers, and healthcare professionals. The following three extracts from Ben's interview, showed that Ben, who is heterosexual, held a strong belief in the potential for social exclusion and social isolation if he were to become HIV positive:

> *如果你中HIV嘅，多數人都會覺得你抵死㗎嘛，同埋…同埋佢冇嘢可以幫到你，佢只能夠歧視你囉，多數人都係。[…]即係我驚自己會係成為被排斥嘅一份子囉。*
>
> *if you were infected with HIV, most people would think that you deserve it. There is nothing they can do to help except to discriminate against you, and that's how most people will act. […] I'm just scared that I'll be isolated.*

> *即係嗰個社會標籤嘅問題，即係你唔會歧視一個有 cancer 嘅人㗎嘛，但係你會歧視一個有愛滋病嘅人。[…] 我講緊嘅係社會大部份嘅人，咁呢度已經有好大嘅分別啦。即係已經唔係個病本身囉，係大家社會點睇囉。*
>
> *that is the problem with social labelling. You will not discriminate against a person suffering from cancer, but you will discriminate against a person with AIDS. […] I'm talking about the majority of people in society, so there is already a huge difference. It is no longer about the disease itself, but it is about social perception.*

> *即係唔似肺炎咁… 可以亂咁… 可以隨意講囉，因為你知道你講完呢你就會俾人 judge 緊囉成件事，即係你心底裏會審判你嘅其實。*
>
> *That is not like pneumonia [potentially refers to COVID-19]... which... you can talk about freely, because you know that once you tell them, you will be judged, and they will judge you deep down.*

Through comparing the public's attitudes toward HIV versus cancer and pneumonia, Ben articulated the perspective that the impacts of HIV stigma on one's social status are different compared with those associated with other potentially life-threatening physical illnesses. Elsewhere in his interview, he used the term "social death" to summarise his sense of fear. This term evocatively captured the degree of perceived social threat to the self, resulting from stigma and discrimination.

The concept of social death has been used by scholars in various disciplines, including sociology, nursing, death studies and slavery studies to describe how subpopulations in the society are treated differently (Borgstrom, 2017; Králová, 2015). The unifying idea across different uses of this concept is to describe the profound and significant loss experienced by a person or a group (Králová, 2015). Králová identified three types of loss: a loss of social identity, a loss of social connectedness, and losses associated with disintegration of the body. In context of the history of slavery, Orlando Patterson (1990) used this concept to depict the experience and social positions of slaves as the victims of extreme violent domination. Patterson argued that slaves became powerless; they were isolated from their tribe and family they were born to, and from any “formally recognised community” (Králová, 2015; Tadman, 1984). In modern societies, the understanding of social death is multidimensional; it encompasses a wide range of consequences, including financial vulnerability, stigma, and weakened legal support (Ghane et al., 2021). For instance, in health and medicine, social death occurs when chronically-ill and disabled people are neglected by family, and not properly attended to or cared for by medical personnel, and this results in social isolation and a loss of all or part of their social roles (Ghane et al., 2021). This definition of social death echoes Luca’s lived experiences of multiple losses when his gay identity and same-gender sexual activities were discovered by his family. In the following two extracts, Luca recalled losing his kinship and social support system after disclosing his HIV risk to his family and a friend:

> *我屋企人知到喇，跟住就覺得個天好似要諗落嚟喇，即系屋企人又唔 support 我啦。因為屋企人冇諗過我會系 gay 嘅，噉樣跟住之後又冇諗過佢哋，我記得嗰陣時 d exact wordings 系好差嘅，即系話咩：啊？欸欸你咁核突嘅，咁污糟嘅噉樣欸。話你怪獸喎噉樣欸。即系我唔要見到你啊，寧願冇生過你啊。即系再加埋屋企人嘅…即系佢哋嗰個…姿態系 blaming 嘅一個姿態呢，就令到我覺得系世界上冇人再可以支持我喇噉樣咯。就自己一個人去面對呢一份嘅驚同埋焦慮咯。所以就…產生咗我想自殺嘅念頭喇噉樣。*

After my family had known about it [his same-gender sexual practices and his hospitalisation for HIV testing at the age of 16], I felt like the sky was going to fall. I mean… my family didn’t support me because they had never thought that I’m gay and I had never thought that they…I remember their exact wordings at that time were awful. They were like… “You’re disgusting and very dirty.” And something like… “you’re a monster!”, and “I don’t want to see you, I’d prefer not have given birth to you.” That means… on top of that, my family’s…I mean their…attitude was a blaming attitude. That made me felt like there was no one that could support me in this world. I had to face this fear and anxiety on my own. So… I had suicidal thoughts.

我有同其中一個好好嘅friend 講嘅， 係同學仔嚟嘅，嗷誒因為佢都系gay 嘅，嗷所以我都好信佢啦，我同佢講呢件事嗷樣，嗷呢欸之後我就喺其他朋友口中就聽到佢講我壞話咯。即系就聽到話誒誒無啦啦搞著我啊，同我講呢件事做乜啊嗷樣誒，即系類似系講呢一啲嘢咯。跟住我就覺得生無可戀啦嗷樣咯，即系咁多年最信任嘅朋友都會嗷樣啦

I told a very good friend of mind about it [his fear and risk of HIV infection]. He was my classmate, and because he’s also gay so I trusted him and told him about that incident. I then heard from another friend of mine that he had said bad things about me behind my back. He said something like: “He got me involved. What’s the point of telling me this?”. Something along those lines. I felt like there was nothing worth yearning for in this life. Even the friend whom I trusted the most for years betrayed me like this.

The negative judgment and victim-blaming from Luca's family were evidence of prejudice, discrimination and sexual stigma towards MSM through a heteronormative lens. Using terms like "dirty", "disgusting" and "monster" to devalue Luca constituted an extreme rejection and verbal violence that contributed to Luca's sense of loneliness and helplessness. His experience of his gay friend's rejection illustrated the negative attitudes towards PLHIV within the gay community. These extracts indicated that Luca experienced intersectional stigma because of his multiple stigmatised identities (being a gay man who engaged in casual sex and was at risk of HIV infection). The loss of social relations resulted in a lack of future hope in life temporarily as he felt: *"There was nothing worth yearning for in this life".*

The other two MSM participants, Cruella and Bill, who did not disclose their sexual identity, sexual experiences and/or HIV risk to others, also experienced anticipatory losses in kinship and family acceptance. They predicted that their family would react to their gay identity or HIV positive status negatively:

> *Cruella: 我會覺得其實屋企人對呢啲嘢咁反感。 […] 同埋我覺得佢 [老竇]有啲傳統，有啲…how to say that? 有啲封建，傳統到會有啲封建。所以我都會覺得如果終有一日佢真系知道咗嘅話，佢應該會…點講呢？可能唔會再同我聯系咯，即當可能冇咗個仔噉。我相信佢，我相信佢做得到。*
>
> *Cruella: I think my family is indeed against this kind of thing [same-gender sexual acts] […] And I reckon he [Cruella's dad] is a bit traditional, he's a bit… how to say that? A bit feudal, a bit traditional and a bit feudal. So I would think if he knows about it one day, he would…how to say it? He may no longer have any connection with me, that means he may pretend to have lost a son. I believe he… I believe he can do such a thing.*

> *Bill:佢 [媽媽]就系天主教嘅噉，誒亦都會系誒都幾…欸都翻教堂啊，都幾虔誠啊。噉我覺得佢對呢一樣嘢立場，其實我覺得唔接受嘅機會都系非常之高嘅。*
>
> *Bill: she [Bill’s mother] is a catholic and she’s quite…she goes to church and is quite devoted. I think her stand on this matter [being gay or HIV positive] is… I actually think the likelihood of not accepting this is very high*.

Participants’ assumption of family rejection was primarily based on their prior experiences, observations of others’ lived experiences and their perceptions of the personal, cultural and religious values of their family members. Consistent with the findings of Western research studies, participants believed that HIV/AIDS is frequently associated with behaviours that are subject to negative evaluation, condemnation and disapproval by society (Crandall et al., 1997; Herek, 1999, 2002). Similarly, heterosexual participants (Walter and Lee), who were married or partnered while being clients of female sex workers, expected or experienced rejection from their partners because of their perceived betrayal and disloyalty in their intimate relationship or marriage. Walter reported that his ex-girlfriend at that time perceived him as “dirty” and their relationship ended as a result. He was rejected partly because of the stigma around commercial sex and the perceived betrayal. Hence, my participants, regardless of sexual identity, either anticipated or experienced stigma associated with their sexual practices and/or identities.

It is worth noting that most participants expressed more concerns about family exclusion and parental rejection over other forms of exclusion. This phenomenon adheres to cross-cultural literature that proposed that individuals in collectivist cultures prioritise family, interdependence, cohesion and obligations to meet parents’ needs over individual needs (Burholt et al., 2018; Schwartz et al., 2010). Although many Asian and Chinese societies including Hong Kong have experienced processes of acculturation to a Western values, traditional Chinese culture and virtues remain deeply rooted and preserved (Kwan, 2009). Considering this sociocultural context, the impact of the loss of family connection is likely to be more detrimental compared to this loss in individualistic culture. Lykes and Kemmelmeier (2014) compared the degree of loneliness experienced by individuals in collectivistic and individualistic societies. It was found that there is a closer association between a sense of loneliness and the absence of family interaction in collectivistic cultures than in individualistic societies.

In addition to the risk of losing kinship connections, another impact of the anticipated social death was participants' practices of concealment, which were related to the spread of hateful messages directed at gay men and PLHIV on social media. Both Andy and Luca learned about the general public's hostile perception of and discrimination towards gay and HIV-positive individuals online:

> *Andy: 我睇嗰啲連登嗰啲其實都好…欸嗰啲 forum 都系都好歧視…欸呢一類即系同同性戀嘅人，即系有呢個偏好嘅人噉樣。我會覺得佢哋系…對我哋呢啲人有啲偏見，所以我會唔敢講噉樣咯。佢哋啊佢哋就會…佢就會慢慢認定你？如果佢知道咗你係…嘅性取向系點，佢就會歧視你噉樣，噉令到我我我哋更加唔夠膽講咯，即系會驚俾人哋批評啊，即可能會俾人攞上網講。因為果 d Twitter 呢，有時候都會講吓 d 好出名嗰啲…同性戀或者系鐘意男仔嗰啲男仔。*
>
> *Andy: I read posts on LIHKG [an online discussion forum] that were very…those forums are very much …discriminating against this type of people…that means gay individuals… that means people who have this type of preference. I think they are…they would place bias on people like us so I dare not to say anything. They would be like…they would gradually make assumptions on you? If they know you're…your*

sexual identity, they will discriminate against you. This makes me feel concerned about speaking up. I'm scared of being judged, having the potential of being put on the internet and being discussed. Because things like Twitter, sometimes those famous…gay or men with same-sex attraction are being discussed.

Luca:都有好多 post 呀喺度講話乜誒邊個邊個邊個有 HIV 又週圍出嚟同人哋誒誒有性行為啊。要小心佢啊噉樣，又或者佢講欸欸邊個邊個欸有 HIV 正賤人啊，欸不負責任啊，週圍傳染人啊噉樣。[…] 即系你有 HIV 就應該要返屋企自己接埋啦應該，唔好出嚟啦噉樣。即系我會覺得好似有 HIV 就系獻世啦，唔好出嚟噉樣，唔好去 disturb 到人啊噉樣。

Luca: there are many posts that talked about who had HIV and those people had sex with many individuals. Others said we had to be careful about those people, or someone said that people who had HIV were bastards and they were irresponsible. They were spreading the disease around, something like that. […] you should go home and hide when you've got HIV. You shouldn't go out. That means I reckoned that people who've got HIV are a waste of space and shouldn't be out to the public. They shouldn't disturb others.

These quotations show that the participants' perceived need to conceal their sexual identity/HIV status were partially attributed to stigmatising views expressed on social media. Lee for instance, concealed his worries and distress about HIV infection from everyone:

噉嗰陣時又唔可以同屋企人講啦，尤其之後我同我太太住喇。噉啊更加唔可以再講呢啲啦，噉我又冇人可以傾訴喎。

> *At that time, I couldn't tell my family, especially I later lived with my wife so I found it harder to talk about this. I had no one to talk to.*

Luca also reported concealing his HIV-related distress. He thought about concealing a HIV-positive status in the future to prevent damage to valued relationships:

> *當時好驚啦，又唔敢同屋企人講，噉又冇同朋友講 […] 同埋日後嘅，即系如果拍拖嘅，噉點樣同另一半去交代呢，即系我覺得你拍拖定結婚都…我哋都需要向你另一半坦誠嘅嘛。噉如果大家喺已經感情狀態好好啦，又或者大家都有諗住結婚嘅，系一個咁美滿嘅關系嘅基礎下，要去同對方講我相信都好難嘅*
>
> *I was very scared at that time. I dared not to tell my family and I had no friend to talk to. […] And in the future, whether you'll be in a dating relationship or marriage, we have to honest to your partners. If our relationship is stable, or if we plan to get married, on the basis of a happy relationship, I believe it's very difficult to disclose it [HIV-positive status] to the other person.*

Although the primary intent of self-concealment was to prevent the experience of social death, these participants experienced unwanted solitude and isolation as a result. From my perspective, they had already experienced a certain degree of social death through their fear of exposure and decision to conceal parts of themselves from those they were close to. And those who had experienced rejection and hostility from friends and/or family members had experienced a social death.

In sum, this theme sheds lights on the social harms of HIV-related stigma and HIV-negative men's psychological processes around anticipating the loss of a normative life, family connection, social status and a privileged identity. These anticipated losses and changes in life mirrored the struggle reported by PLHIV in other literature, where the incorporation of HIV identity caused a change in other identities, including relationship, work and spiritual identities, and their relationship with the wider society (Baumgartner & David, 2009; Tsarenko & Polonsky, 2011).

Theme 2: Moral injury: The role of Confucianism and collectivism

Moral injury is a concept that refers to "a deep sense of transgression including feelings of shame, grief, meaninglessness, and remorse from having violated core moral beliefs" (Brock & Lettini, 2012, p. xiv). This theme addresses participants' self-stigmatisation, and their feelings of shame and guilt that arose from actions or choices that were in conflict with their internalised culturally-shaped moral obligations and societal norms. They rationalised their sense of responsibility in relation to their social roles within and outside of the family. Four participants mentioned that one of their concerns was the possibility of "affecting" others. The word "affecting" potentially comprised a range of things in the wider social context that went beyond personal health outcomes. The participants' extreme sense of responsibility towards others can be understood as the result of Chinese cultural values shaped by early Confucian beliefs (e.g., filial piety, loss of face and familial obligation), which are a set of deep-rooted philosophical and social ideas offered by an ancient Chinese philosopher called Confucius (Allinson, 1989; Ni, 1999; Slingerland, 2003; M. Wang et al., 2008). Based on the participants' narratives, a culturally shaped sense of obligation and responsibility had led to psychological harm to these participants. For this reason, I framed this dimension of their experiences as a moral injury.

Participants assumed that certain moral rules are naturally learned and shared among the majority in the society. The following quotations showed that they believed that the majority of the general population are ethical and righteous. With this belief, they expected their sexual practice would be judged:

> *Cruella：做呢 d test 通常都基本上都系同 sex 有關㗎喇。系喇，噉就涉及 d 倫理道德嘅問題啊，噉我會驚欸有啲醫生佢可能會 judge 你啊。*
>
> *Cruella: Doing these tests are usually related to sex. Right, this involves ethics and moral issues. I was scared that some doctors might judge you.*

> *Lee: 你正常…當然啦，誒，欸我唔系話企喺道德高地啊。平時梗系講呢啲唔好啦。*
>
> *Lee: You normally…of course…huh… I'm not standing on the moral high ground to say this. Of course, we would normally say these things [buying sex and similar behaviours] are bad.*

Cruella and Lee indicated that the roots of their anxiety and fear were the moral values and principles that were deeply ingrained in people's minds in the Hong Kong socio-cultural context. In Lee's quotation, the phrase "standing on the moral high ground" is a popular saying that Hongkongers use to describe individuals who have a stronger ethical and moral standard than others judging other individuals' acts that are perceived as morally questionable or socially unacceptable. It is interesting that Lee claimed that he was not seeing through the lens of a strong moral character to acknowledge that buying sex is unquestionably viewed as "bad" in the Hong Kong socio-cultural context. In other words, he had internalised the normative stigma against commercial sex. Apart from buying sex, Andy addressed heteronormative perspectives on same-gender sexual practice:

> *Andy:因為佢哋系大多數吖嘛。噉佢哋覺得你呢樣嘢唔符合佢哋嘅既有標準，即系既有嘅框架睇嘅嘢嘅時候，噉佢咪覺得你哋系做嘅呢一…做一樣相同嘅行為，都有相同同感染嘅風險嘅時候，你哋先系錯咯。*

Andy: Because they are the majority, they would think this thing of yours [same-gender sexual practices] does not fit the existing standard, that means the existing framework. That's why they would think that you guys [gay men] engage in the same behaviour and you all have the same risk of infection. You guys are wrong.

In these extracts from Lee and Andy's interviews, words such as "normally", "usually", "wrong" and "bad" reflect the way these participants assumed that people in society hold absolute moral beliefs about particular sexual practices and relationships. They believed that their sexual practices and personal choices would be judged as immoral based on the culturally conferred moral framework.

Three participants reported having a fear of transmitting HIV to others. Even though they were fully informed that HIV could not be passed on to others through social contact, they avoided physical contact with their significant others when they believed that they had already been infected. The following extracts from Andy's and Luca's interviews illustrate their extreme sense of responsibility for the welfare of others:

Andy: 好驚惹到人哋。即系欸即系可能欸食飯嗰陣，我會依依家就主動用啊嗰啲嗽樣咯。即系夾開啲嘢食啦，牙膏會 git *落啲隻手之後再再搵個牙刷嗽再拎起即系拎起個牙膏先刷嗽樣。即好驚佢欸影響到人。*

Andy: I was very scared of infecting others. Now, I'd proactively use serving chopsticks, that means I picked the food and separated it. I'd squeeze the toothpaste onto my hand first, then use the toothbrush to pick up the toothpaste and brush my teeth in this way. I'd be very scared of affecting others.

Luca: 嗽嗰陣時嗰一排都唔敢去遊水啦，因為又唔知會唔會自己可能又欸又有損啊又剩啊嗰啲。我又好驚欸一陣間喺泳池又會唔會呢欸傳染到人啊嗽樣。

Luca: During that period, I dared not to go swimming because I wasn't sure if I had wounds or something like that. I was also scared that I would infect others in the pool.

Andy's and Luca's exceptional efforts in protecting others' welfare reflected their intense fear of breaching acceptable moral standards. I perceived that their obsession in eliminating any chance of HIV transmission was not only a harm reduction strategy, but it was a way of managing feelings of guilt and shame in relation to societal pressure to maintain a good moral character. This is in line with research in Western societies (Hamann et al., 2017), where PLHIV report having a sense of guilt even when they practised safer sex. This suggested that Andy's and Luca's anxiety was to some extent associated with the anticipated feelings of guilt and shame. Similarly, Walter reported moral motivations in physically distancing himself from his girlfriend when he suspected that he was HIV-positive:

你驚如果有啲乜會傳染到畀佢 […] 嗰個驚嗰個原因就系因為驚影響到佢。

You were afraid that you would transmit something to her if you have got it […] the reason behind the fear was because of the fear of affecting her.

噉所以如果我系一個 single 嘅情況，好似而家噉，我係完全唔會有問題。

因為佢系你另外一半呀嘛。噉你要對佢 take a sense of responsibility, 你…你冇可能噉樣唔理啊，即系欸…求其啊噉樣嗰啲，即系你會有少少會…有少少 caution 自己嘅情況。因為好簡單嘅嘛，你中左武肺你都唔會瞓喺佢隔離啦。

So if my status is single, like how I'm now. I won't have any problem, I can relax. Because you… because she's your other half. Then, you've to take a sense of responsibility for her. You…you can't ignore it like this, as in do whatever. That

> *is…huh.. you would have a bit of… a little caution of your own situation. Because it's very simple, like…if you get Wuhan pneumonia [COVID], you won't sleep next to her.*

These quotations not only show Walter's reasonable concern for the well-being of his partner but also illustrates pressure to uphold moral obligations by ensuring his partner's well-being. As a researcher who shares the same cultural and ethnic background as the participants, I was aware that the meaning of obtaining personal health and an absence of illness are closely associated with Chinese people's moral and ethical values that have been influenced by Confucianism. Within the Confucian view of nature and health, being healthy is one of the mortal virtues and illness has been considered as an outcome of personal actions (Arthur & Mair, 2017; Bray, 1999). This explains the reason why Walter used the normative response of Hongkongers in the face of another life-threatening illness - coronavirus disease (COVID-19) - as a reference to rationalise how he should act in response to the risk of HIV transmission. Scholars and authors have emphasised the influence of traditional Chinese Confucian ethics in the COVID-19 pandemic (Escobar, 2020; J. S. Rošker, 2021). They argued that a high degree of cooperation, obedience and collectivism played an important role in controlling the pandemic in China and East Asian societies (Escobar, 2020; J. S. Rošker, 2021). In traditional Confucianism, upholding moral standards, maintaining social harmony and compliance to social rules are the basic principles and primary concerns in society (Kazarian & Evans, 2001). Therefore, I believe that Chinese philosophical ethics played a crucial role in driving Walter to put such moral theories into action due to his anticipated feelings of moral failure and guilt if he infected his partner or significant others.

In line with this conceptualisation of health as a moral virtue in a collectivist culture, the consequences of illness are often evaluated based on the impact of the illness or physical conditions on the macro-level group and social systems (Kazarian & Evans, 2001;

Sazarian & Evans, 2001). Confucian values and norms place emphasis on family and community over individual interest (Inoguchi & Shin, 2009). This idea was revealed in Andy's and Walter's quotations, in which the word "affecting" implied a broader impact than HIV transmission alone. Three participants – Cruella, Luca and Lee - expressed concerns about the shame they would bring to their family if they were HIV positive and their sense of guilt associated with this:

> *Cruella: 我覺得屋企人都算比較保守同埋傳統啊，噉佢哋應該對於呢啲婚前性行為呢啲嘢佢哋應該都接受唔到，所以就會你可能就會欸又覺得我系一個好敗壞嘅…好敗壞嘅後代。*
>
> *Cruella: I think my family is conservative and traditional, from their viewpoints, things like sex before marriage should not be acceptable. So you…they may think I'm a very disgraceful…very disgraceful descendant.*

> *Lee: 如果真系因為噉樣而死咗, 就算太太冇離開你又好乜都好。噉佢可能佢屋企人或者外父或者佢嘅家人都應該先，都會背負住個名。嘩！你你先生系因為愛滋死咗。即系佢佢我諗過佢點之後面對啲人嘅眼光去嘓個生活呢？*
>
> *Lee: If I die because of this, even if your wife doesn't leave you or so, her family or her dad or her family will carry the stigma. 'Wow! Your husband has died of HIV!' [Lee's expectation of others' reactions towards his wife] I have thought about how she could face others' stigmatised views in the future.*

> *Luca: 覺得系對唔住，覺得內疚所以喊咯。即系好似對唔住屋企人啊，做咗一樣咁醜怪嘅事啊噉樣咯。*

Luca: I felt sorry…I felt guilty so I cried. I felt sorry for my family, I did such a shameful thing.

These are examples of the deeply ingrained valuing of familial and intergenerational relationships that is rooted in a Confucian-based collectivistic culture (Kwan, 2009; Ng, 2019). The moral teaching of Confucianism emphasises the importance of maintaining harmony with others, respect for parents as well as loyalty to one’s family (Badanta et al., 2022; Y. Chen, 2001). Filial piety “xiao” (孝), which is central to Confucian family values, is the sense of obligation to parents and the need to fulfil their beliefs and will. The virtue of filial piety is the respect and support of the children for their parents (Allinson, 1989; Y. Chen, 2001; Dong & Xu, 2016). In an ancient Confucian text, one of the direct quotations is: “The body, hair and skin, all have been received from the parents, and no one doesn’t dare damage them – this is the beginning of xiao.” (Zeng, 2008, p. 2) Studies related to Eastern religions, death and health have suggested that this traditional value has affected Chinese people’s health behaviours, attitudes, and medical decisions (Badanta et al., 2022). Damage to the physical body after death could be perceived as disrespectful and disloyal to parents and as a desecration of the ancestors. Also, mental health problems are considered to be the consequences of a lack of self-discipline and personal weakness (Huang & Charter, 1996). With reference to the traditional concept of xiao, protecting one’s physical health is considered as a filial duty of offspring within the Chinese family system. This idea was shown in Walter’s thoughts:

諗返喺覺得好離譜嘅。即系會有一個自己嗰個內疚，反省個想法。誒第二就系誒，因為我自己都好重親情。你屋企人生你出嚟，你搞成噉你欸對唔住佢哋

啊。

Looking back, I reckon I was out of the line. It’s that… there’s a sense of guilt, a self-reflection on my thoughts. Secondly, I very much value my family. It's that your family gave birth to you, and you got into this, so you are sorry for them.

我覺得佢會責備喎。覺得你…你搞啲乜嘢返嚟欸。

I reckoned they would blame you and thought… What have you done and brought back [to the family]?

For Walter, failure to fulfil filial duty and social obligations induced a sense of guilt and shame, which can be understood in relation to literature on Chinese concepts of shame, morality and loss of “face” (in Cantonese: 冇面) (Hu, 1944; Hwang, 2012). According to Hu (1944), the concept of “face” has two sets of criteria. The first set refers to the prestige of one’s success in achieving social reputation, dignity and honour in Chinese culture. The second set is the respect received as a group for an individual who acquires a good moral reputation. The greater the sense of shame, the stronger the feeling of the loss of “face” (Bedford, 2004). It highlights the difference between Western and Eastern culture in terms of the meaning of losing one’s physical health. In accordance with other cross-culture research findings, Chinese people are more self-consciously moral on an interpersonal level as compared to people from an individualistic cultural background (Chang & Chen, 2017). In general, failure to live up to the responsibilities and expectations of one’s social role in Chinese society results in the loss of face, which leads to feelings of guilt, shame and low self-esteem (Bedford, 2004; D. Y.-F. Ho et al., 2004). These emotions were evident in my participants’ self-critical voices and self-judgment about their own past actions across the interview data:

> *Andy: 唉點解自己咁唔小心啊？點解自己明明誒…因為我欸啲…會會會覺得點解欸學…明明可以避免到你…你都唔避免…可能可以買嗰啲藥食，但可能幾千蚊嘅樣。啊點解…覺得自己欸…戇鳩。*
>
> *Andy: Why was I so careless? Why did I do this when I clearly…since I…I would think why…you could have prevented it, and you didn’t prevent…perhaps you could have bought those medicine, but it might cost a few thousands. Why…I think I was fucking stupid.*
>
> *Walter: 我有諗過自己系咪真系太過放蕩，即系覺得自己，啊系咪其實系即系，一個伴侶算呢？即系，即系好似我系好離譜吖。*
>
> *Walter: I questioned if I was being too slutty, I just thought that I…should I actually…just have one partner? It’s just … I seemed to be way out of line.*
>
> *Lee： 如果佢就算決定離開嘅，噉我都覺得呢樣我自己攞嚟嘅[…]*
>
> *Lee: Even if she [Lee’s wife] decides to leave me, I reckon it’s something that I bring it on myself.*

These participants demonstrated profound self-stigmatisation resulted from their stringent moral beliefs. During the interviews, none of the participants questioned their negative views of themselves. Most participants seemed to be focused on the thought that their actions and/or decisions were morally “wrong” from an objective standpoint, and they struggled to let go of their fears around causing interpersonal and physical harm to others. From my viewpoint, their extreme sense of responsibility for others’ welfare can be attributed to culturally normalised moral obligations. I believe there exists a culturally constructed moral injury that influenced the way my participants perceived themselves in terms of health and sexual practice.

Theme 3: Restrictive sex education resulted in a knowledge gap

This theme centres on participants' view of the role that Hong Kong's restrictive approach to school-based sex education played in their lived experience of HIV anxiety. Through experiencing a reduction in fear and anxiety following an increase of knowledge and understanding around sexual health, some MSM and heterosexual men came to a realisation that restrictive sex education was a contributing factor to their HIV fear. Participants' perceptions of restrictive sex education is in line with various past and recent studies and news reports in Hong Kong (Andres et al., 2021; Leung, 2024; Lo, 2011; MWYO, 2021). School-based sexuality education programmes in Hong Kong have long been considered "outdated", conservative and not comprehensive (Andres et al., 2021; Leung, 2024; Lo, 2011; MWYO, 2021). Hong Kong scholars have stressed that mainstream sexuality education focuses on issues that are based on a heteronormative and cisgender perspective, and adopted an "abstinence-only" approach that is closely linked to religious and/or cultural values in Hong Kong (Kwok, 2018; Kwok & Kwok, 2022).

There has been evidence that secondary students in Hong Kong generally have poor sexual knowledge (e.g., Lo, 2011; MWYO, 2021; The Family Planning Association of Hong Kong, 2022). Scholars and educators have argued for the necessity of providing more comprehensive and effective sexuality education (J. K. S. Chan, 2022; Lo, 2011). Lo (2011) pointed out that topics such as homosexuality, contraception and abortion were rarely introduced in schools. He also discovered that many schools used fear to hinder students' engagement in sexual activities. Since 5 out of 7 participants in this study were in their 20s at the time of the interviews, Lo’s (2011) findings reflected the restrictive sexual health-related information that my participants would likely have received in school in their adolescence.

A few of my participants discussed the issue of a sexual health knowledge gap at the collective level. They stressed that many people have inadequate knowledge or misconceptions about HIV for two reasons: 1) sex education in school is conservative and outdated, and 2) incorrect messages and information have been spread between people within the community. When Ben was asked to elaborate on the general public’s stereotypes about HIV-infected individuals, he explained that people’s misconceived HIV knowledge is caused by misinformation:

> *好多人都會認定咗愛滋病呢樣嘢係僅限於同性戀嘅…嘅人啦，咁呢啲係好舊嘅思想啦，但係其實香港係冇咩點做相關嘅教育㗎嘛，咁大家嘅思想大部份人都係停留咗喺嗰度。你都唔會…即係一個正常人都唔會無啦啦去上網 Search 呢啲資料去增值㗎喇其實基本上。咁大家以訛傳訛嘅話，大家思想都係停留喺好舊嘅時代啦，呢啲既有思維就會咁樣一個傳一個落去囉。*
>
> *many people assume that AIDS is only limited to homosexuals. These are old-fashioned ideas, in fact, there is no relevant education in Hong Kong. Therefore, everyone’s mindset remains unchanged. In normal circumstances, nobody would go to the internet to search for relevant information to expand their knowledge. If everybody is just learning based on what others tell them, all of our thinking will remain in the old days, and this kind of thinking will be passed on from one generation to another. I noticed that nobody around me has an ounce of knowledge about these subjects.*

Based on this quotation alone, Ben seemed to set himself apart from others and implied that he had made an effort to develop knowledge outside of the Hong Kong sex education curriculum. Yet, prior to the experience of HIV anxiety, he used to be one of the “many people”; he only started developing knowledge about HIV/AIDS after he had been exposed to a risk of HIV infection. In fact, he was attributing his ignorance, which in turn led to anxiety, to inadequate sex education as he was commenting on the impact of such an inadequate education on others’ thoughts and beliefs.

Walter similarly perceived that Hong Kong sex education is problematic as the curriculum doesn’t reflect current knowledge and morals:

> *我哋喺香港接受嘅一個* sexual education *呢，系一個好保守好，好缺乏正面嘅資訊，同埋同現代跟唔上進度。除非你個人好主動學習，如果唔系你永遠停留喺一啲…「哦，乜系性行為啊？乜嘢系，誒一啲…人嘅器官？」佢冇乜會教你而家呢啲嘢嘅。噉第二就系始終個亞洲社會啊，一講呢啲好保守嘅。噉所以我就系缺乏呢個認知，噉佢永遠都系存在嘅傳遞畀你聽，哦呢個社會都系欸，誒呢啲病系，唔應該嘅，不潔嘅。*
>
> *the sexual education we receive in Hong Kong is a very conservative one that lacks positive information, and it doesn’t keep up with the development and progress of the modern society. Unless you are proactive in learning. If not, you stay at the point where you are still questioning: “Oh! What is sex? What are…human organs?” They don’t teach you about these things now. The second point is about the Asian society, which is very conservative in terms of these issues. That’s why I lacked the knowledge. They always pass a message on to you: In this society, this kind of illness isn’t right, it’s unclean.*

The above extract shows that Walter was frustrated with the narrow content of sexual health public information and education in Hong Kong. Like Ben, he believed that his fear of and negative views towards HIV stemmed from the inadequate sex education he received. Additionally, Walter addressed that there has been a lack of up-to-date information related to HIV prevention, such as the use of PrEP. He said:

> *嗰個關系就在於如果你令到啊…令到好多人去認識呢啲嘢，宣傳佢哋會減低咗對呢啲嘅焦慮。「哦! 我有食 PrEP 嘅，誒…我唔會有…唔會大機會有」*
>
> *The relationship [between the public's knowledge on PrEP and anxiety] is that if you let… let a lot of people to know about these things, to publicise, they will reduce their anxiety about these. It would be like, "Oh! I have taken PrEP, huh… I won't have it, there won't be a big chance to get it."*

Walter believed that his HIV-related fear or worry could have been eliminated or prevented if sex education were more comprehensive and up to date. At this point of the interview, he made sense of his anxiety by understanding the problem from a systemic perspective that involves local social policy and public health strategies. Another participant, Luca similarly commented on the limitations of the sex education offered to young people in Hong Kong. He stated:

> *香港學生嘅性…即系接受性教育嘅嘢太少喇，即系如果可以知道多啲就唔會欸…咁驚咯。*
>
> *Hong Kong students' sex…they receive too little sex education. If they can learn more about it [sex education], they would not be that scared.*

Similar to Walter, Luca perceived that HIV fear was a social phenomenon resulting from deficiencies in the educational system. In the following quotation, he explained how he identified a relationship between his lack of knowledge and fear of HIV:

就因為了解多咗清楚咗知道乜系 HIV，所以就對 HIV 嘅恐懼本質上就唔同咗咯，即系就會冇咁驚佢咯。

I had gained a better understanding, because of the better understanding, it became clearer what HIV is, so the nature of [my] fear towards HIV has been changed. I feel less fearful of it.

Luca made sense of his anxiety through reflecting on the positive impact of the knowledge he had gained on his emotions.

In contrast, Bill, who was 53 years old at the time of the interview, shared a different experience from the younger participants. He first experienced concerns about HIV infection when he was in his early adulthood. He recalled that there was neither a proper education on HIV nor access to relevant information and support, such as HIV testing, in the late 1990s:

其實冇一個正式嘅教育咯。系即系我又可能即系就算嗰陣時上網其實都唔系真系好發達。噉你有好多嘢都未必系咪真系可以搵得到。

There was no proper education. I probably…I mean at that time, internet was not well developed. You might not be able to find a lot of things.

嗰陣時嗰個資訊真系好少。亦都冇冇話系即系點樣欸可以免費驗血啊，諸如此類啊，噉嗰啲。噉所以就話即系都系，誒都冇辦法啦，都做咗啦。噉所以就誒，其實個個個個擔心就系即系，即系一路都隱藏住喺個心裡邊，好似有條刺噉。

Back then, there was very little relevant information. Also, there was no information about how to get free testing or something like that. So that means, there was no

> *solution, and I had already done it [anal sex]. So the…the…the worry was…was continuously hidden in my heart, it was like there was a thorn.*

In the 1990s, the internet and HIV testing services were much less accessible, as such Bill's worries and anxiety were intertwined with a sense of helplessness as shown in the second quotation above. From his perspective, the lack of available social resources restricted his learning, which contributed to his anxiety. This example demonstrated that nearly non-existent sex education and public information had a detrimental impact on the psychological burden experienced by people who were at risk of infection in the late 1990s. Bill commented that the second contributing factor to his fear was the negative information spread by the media during the early years of the HIV/AIDS epidemic:

> *嗰陣時亦都系有啲新聞啊或者啊即系有啲…一啲負面嘅渲染例，例如系話啊愛滋病發病喇，噉跟住發病嗰陣時啊嗰啲相啊，或者系話即系嗰啲血肉模糊啊諸如此類啊，即系即系有一啲噉嘅負面嘅報道出咗嚟。跟住人哋睇咗，嘩喺原來發病嗰陣時就系噉樣樣喇，欵又或者系欵乜嘢啊噉。噉咪變咗一來已經夠恐怖喇，即系即系可能啊蓉蓉爛爛嗰啲嗰啲嘅相，即系即系你你啲皮膚潰爛啊，熔熔爛爛嗰啲已經恐怖，跟住仲要加上一個不治之症。[…]即系衰啲衰啲講句不得好死啊。*
>
> *Back then, there was news or…some kind of negative pathos. For example, when it came to the AIDS onset, then things like photos of onset, or those badly mutilated [images] as such, negative news was released. Then, after people had read it, it was like "Oh! The onset [of AIDS] is like this." or "what's that?". This in turns…it was frightening enough, probably photos of rotten things, your…your rotten skin, those*

> *rotten [images] were really frightening. On top of that, it was an incurable illness. […] speaking in a mean way, [AIDS patients] will die and never rest in peace.*

The information Bill obtained seemed to be limited to late-stage AIDS symptoms rather than offering a fuller picture of what HIV was at that time. To him, contracting HIV was equivalent to an imminent death sentence. Despite the evolution in general publicity and service provision around HIV, Bill's fear of HIV had been maintained for more than two decades. His personal experience echoes Ben's viewpoint about people's unchanged mindset. Research in both Western and Chinese cultures have revealed that many older gay and bisexual men are reluctant to reveal their sexuality and they have lived in secret for their entire lives as a result of prejudice, harassment, anti-gay violence and homophobic attitudes toward the LGBTQ communities (Grossman, 1995; Herek, 1990; B. M. W. Lee, 2022). Older gay and bisexual men have managed stigma by concealing their sexuality (Grossman, 1995). Based on past local literature, the maintenance of Bill's sense of fear in revealing his gay identity was likely to be associated with heterosexism and anti-gay social attitudes, which resulted from a lack of LGBTQ-inclusive sexuality education in Hong Kong over the past two decades (Kwok & Lee, 2018; Lo, 2011). In the Chinese cultural context, heterosexism against the LGBTQ community persists as sexuality education in Asia has been primarily developed from a heteronormative perspective (Kwok & Lee, 2018).

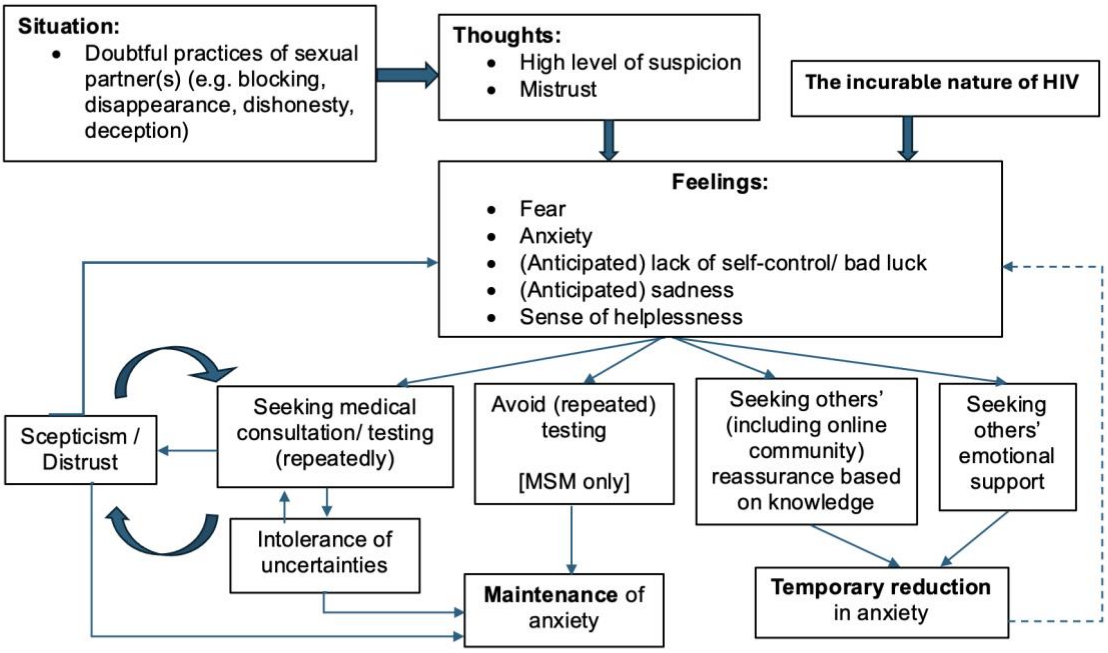
Theme 4: The roller coaster ride of worries and anxiety

This theme depicts my observation that the participants did not feel in control of their fear and anxiety despite their efforts in seeking out some emotional relief. Figure 5 shows how the participants' perceptions and understandings of their sexual partners' actions and the nature of HIV shaped their support-seeking practices which in turn contributed to the development, escalation, and maintenance of their feelings of anxiety around their HIV status. Most participants realised that their support-seeking practices often led to a short-term reduction in anxiety. That is to say, the anxiety usually returned. I observed that the factors maintaining HIV anxiety were different for heterosexual and MSM participants. This related to different societal responsibilities or family pressures associated with being a heterosexual or gay man. Heterosexual participants addressed carrying the responsibilities of not passing HIV to their partners, whereas gay participants focused on preventing from family exclusion by hiding their gay identity. Overall, all men described experiencing difficulty in breaking the cycle of HIV anxiety.

This theme includes two sub-themes: 1) Living in a perpetual cycle of HIV anxiety; and 2) Support-seeking for anxiety: A temporary emotional relief. The first subtheme conveys that some participants encountered difficulties in trusting the test results or healthcare professionals’ assessment of their health status. Their distrust and suspicions of others appeared to be the trigger of HIV anxiety, and their ways of coping contributed to the maintenance of their anxiety and distress. The second subtheme focused on participants’ realisation of the short-term effect of knowledge-based and emotional support seeking. Some participants described how seeking support from certain people, including HIV test workers and counsellors, led to temporary anxiety reduction.

Figure 5

The development, escalation, and maintenance of HIV anxiety



Note. This diagram illustrates the story of the roller coaster ride of worries and anxiety

Subtheme 1: Living in a perpetual cycle of HIV anxiety

The term “perpetual cycle” emphasises the ongoing nature of participants’ feelings of uncertainties and fear, and how they responded to this emotional distress (as indicated by the curved up and down arrows in Figure 5). This subtheme gives an overall picture of how participants’ suspicion, scepticism and distrust contributed to the development and maintenance of their HIV anxiety. Their suspicion and distrust led to repeated reassurance-seeking practices. A few participants reported that the perceived avoiding or dishonest practices of their sexual partners triggered their suspicion about their sexual partners’ integrity and motives, which in turn initiated their distress and anxiety about HIV infection. On reflection, participants believed that their scepticism or distrust towards testing results or healthcare professionals and their avoidance of testing led to the maintenance of anxiety.

Three participants discussed their high level of suspicion about the disappearance or lack of contact from their sexual partners after sexual contact. The lack of contact was not expected prior to sexual contact and therefore they felt suspicious about their sexual partners' actions and motives. Cruella explained that he was worried about the chance of intentional HIV transmission by someone whom he met on a dating app:

> *有啲人喺app度識喇，噉食完可能玩欸…玩完之後散左之後會block咗你噉樣嘅。系啊。仲block咗你之後呢你就，即系等於佢沉咗喺個人…人海入便你唔你唔會再搵返佢出嚟吖嘛，噉呢時候就會就會更加擔心咯。點講呢即系，哦。我覺得有時候信任都系build up係可以contact到對方嘅基礎上咯。即系你連contact都奪走咗都…都…都…都…都…你連contact都唔畀我擁有，噉我點樣可以…相信你唔系一個惡意傳播HIV嘅人士嚟。*
>
> *I met some people on the [dating] app. They blocked you after having fun [a Hong Kong slang that refers to sexual activities]. Right, after being blocked, it was as if he had sunk into the sea of people, you would never be able find him again. At that point, I was more worried. How should I put it? I think sometimes being able to contact each other is the foundation of building up trust. You removed the contact and you didn't even allow me to have your contact, so how can I trust that you were not someone who spread HIV maliciously?*

Cruella believed that being blocked on social media was the trigger of his suspicion about his sexual partner's actions, which induced his initial worry and anxiety about HIV infection. Similarly, Walter's anxiety was triggered by his suspicion about his sexual partner's lack of contact after they had sex:

> *果排又唔覆我信息啦，又乜都唔理。噉我覺得唔對路喎，搞乜呢? 噉啊跟住同埋個次唔舒服係好勁嘅。其實主要系肚屙啊誒頭暈啊噉樣，幾日啦。噉但系過咗排，咦! 佢無啦啦unfollow我Instagram，跟住我諗唔對路喎。*

> *during that period, she [Walter's colleague and sexual partner] didn't reply to my messages, and she didn't seem to care anything. So I felt something wasn't… I was like what was going on? At that time, I was very unwell. In fact, I had diarrhoea and dizziness that lasted a few days. But after a while, she suddenly unfollowed my Instagram and I thought, something wasn't right.*

Walter's attention on his bodily sensations further confirmed his hypothesis that his sexual partner had passed HIV on to him. As such, his anxiety was exacerbated. From the interview data, the root cause of the participants' suspicions about intentional HIV transmission was not clear. I assume that their concern about intentional HIV transmission came from messages spread by the media over the past few decades. For example, in 2022, it was reported that three Chinese males hid their HIV-positive status and spread HIV to female sex workers in Japan (Wu, 2022). Other news has depicted that some people obtain a sense of gratification by maliciously transmitting HIV via causal sex (Health Information, 2018). I believe that news around this topic introduced the general population to the possibility of HIV non-disclosure and intentional transmission amongst people who engage in sexual activity that takes place outside a long-term romantic and sexual relationship.

Luca suspected that his sexual partner had planned to transmit HIV to him in a different scenario. He revealed that he did not plan to have sex with a man who initially invited him to his house to play video games. This man later invited Luca to have sex, and he had sex with this man. When he reflected on the incident afterwards, he perceived that this man was untrustworthy based on his lack of openness and absolute honesty at the beginning of their encounter:

> *我記得一完咗呢件事嘅時候呢，即系同佢有關係之後呢，已經即刻SMS 佢啦，好似 WhatsApp。Whatsapp 問佢：「我想問你有無HIV㗎？你會唔會有啲乜嘢*

> *性病㗎？無啦啦除套我好驚喎噉樣。」噉就佢就話自己冇啊，欸欸欸好健康噉樣。噉但係我心諗我唔信 lor，即系我會覺得欸欸呃鬼咩噉樣。[…] 唔 assume 係有性行為嘅條件下，噉你都可以冇去…即系你都講大話噉樣啦，噉我已經覺得佢個人系唔可信啦噉*
>
> *I remember right after this incident, as in after I had had a sexual relationship with him, I sent a SMS to him immediately, I think it was WhatsApp. I asked him via WhatsApp: ‘Do you have HIV? Is there any chance you may have some kind of sexually transmitted illnesses? You removed the condom suddenly, I’m so scared.’ He said that he didn’t have them, and he was very healthy. But I didn’t believe it. I felt like he was deceiving me. You did that even though we had not assumed that there would be sexual activity. Since you lied about it, I believed that he was not trustworthy as a person.*

It seemed that Luca rationalised his negative view and assumptions about that man based on general moral principles. He perceived that man’s initial lack of openness about sex was a sign of a flaw in his sexual partner’s moral character. The commonality of the above three extracts was that the development of anxiety was rooted in participants’ suspicion or distrust of others. The suspiciousness presented by these three participants aligns with evidence from prior research studies that show that mistrust might be one of the personality dimensions in individuals who display hypochondriac concerns and somatic distress (Noyes et al., 2005; Starcević, 1990). Based on the interpersonal model, mistrust is associated with insecure attachment style (Martinez et al., 2021; Mikulincer, 1998). Scholars have discovered that health anxiety symptoms are closely associated with anxiously attached individuals (Schmidt et al., 2002) and those who have a fearful attachment style (Noyes et al., 2003b).

Anticipating a lack of control because of the incurable nature of HIV was presented as another root cause of anxiety by Andy and Bill:

Andy: 點解我會擔心係因為佢要長期食藥同埋醫唔好，跟住又令我真係驚啊

Andy: The reason I was worried was because for HIV, long-term medication was needed and it was incurable, then I was really scared.

Bill: 我唔系唔係話驚死，嗽但係就即系你欸喺…喺一個你自己控制唔到嘅地…嘅時間，亦都唔知道要捱幾耐先死。嗰個嗰個無助感，系好誒…都幾幾幾恐怖嘅一件事嚟嘅。

Bill: I'm not afraid of death, it's just that you…you would be in a…you can't take control of the time and you wouldn't know how long you would be suffering. The sense of helplessness is quite…huh…it's quite…quite a scary thing.

In these examples, Andy and Bill show concerns about their future quality of life if they were HIV positive. They explained that their fear stemmed from an anticipated sense of helplessness regarding physical health and treatment as a HIV patient.

Seeking medical consultation and testing services were the common immediate response to fear, anxiety and a sense of losing control. However, scepticism about the ethics of testing clinics and distrust of healthcare professionals reinforced feelings of fear and anxiety for some men. For example, Ben stated that:

即係事發後嘅一個月後啦，俾咗啲 RNA 啊抗原抗體佢睇，佢都話唔使再測㗎啦咁樣啦。咁自己當…當時就唔完全信嗰個醫生啦，但係明明人哋就係呢個範疇做咗幾呀年㗎嘛，咁但係自己就信自己囉，覺得一定要去到三個月呀咁樣囉 […]

> *咁就唔信醫生講囉。覺得個醫生可能係草率了事咁樣啦，但其實唔係嘅，應該要相信人哋嘅專業嘅。*
>
> *It was one month after the incident and I showed him my RNA [Ribonucleic acid] and antigen test results, he told me there was no need for me to test again. I didn't completely trust that doctor at the time even though he had been working in this field for decades. I still chose to trust myself and thought I must wait for three months [window period – time between HIV infection and the point when a test will give an accurate result for a certain percentage of samples] to be sure. I didn’t believe what the doctor told me. I thought he was just being sloppy but that wasn’t true. I should’ve trusted their professionalism.*

The RNA test that Ben mentioned is an early detection test that provides accurate result 10 days after a potential exposure (Whelan, 2021). The doctor’s high certainty about Ben’s HIV-negative status was incongruent with Ben’s assumption that the low accuracy or reliability of the RNA test was because of the shorter window period of this test compared to that of other tests which usually have a three-month window period. The discrepancy in certainty levels between him and the doctor made him suspect that the doctor was unprofessional. As a result of Ben’s distrust, his worry and anxiety were maintained.

Despite experiencing a lack of reassurance, some participants engaged in repeated consultations and testing. This created a perpetual cycle of reassurance-seeking and anxiety. For instance, Lee visited nine medical specialists and did several blood tests within three months. He had suspicion about the medical ethics of clinics and HIV organisations:

> *我由第四個禮拜系開始我基本上，每隔一個禮拜都 check 一次，都抽一次血。噉呢我仲要擔心啊噉…有一次有間醫療機構度呢，我 10 點鐘去 check ，佢 1 點*

> *鐘已經俾 report 我，我直頭諗：「哇！你有無 check 過㗎？」即系你…有種懷疑…*
>
> *Since week 4, I basically started checking [HIV] every other week by doing a blood test. I was worried that…there was one time, I did a test at 10am in a medical centre, they gave me the report at 1pm. I literally thought: 'Wow! Did you actually check it [run a test on the blood sample]?' You…had a suspicion.*

Even though Lee himself requested and paid extra money to a private medical clinic that offered a same-day HIV test reporting service, he interpreted the short testing time as a sign of unreliability. It is noted that the private medical clinic he visited is one of Hong Kong's leading medical clinics that uses advanced technology for sexual health examination. Apart from the short testing time, Lee did not report any observable issues during the testing process that led to his heightened worries and anxiety about having false negative results. As he experienced difficulty in letting go of his concern about the accuracies of the test result, he engaged in repeated testing and compulsive reassurance-seeking behaviours. He went on to explain that his uncertainty about different aspects of the tests impacted his perception of the reliability and accuracy of the test results:

> *我覺得冇嘢系 hundred percent ，冇嘢系 make sure㗎，包括抽左血之後，欸嗰部機器準唔準，或者操作人準唔準，甚至乎我會懷疑嗰個機構，其實系咪純粹想坤錢，即系即系求其畀個 negative 嘅 report 你，即系即收你幾嚿水噉樣。*
>
> *I think nothing is a hundred percent, nothing is certain, including things happened after doing a blood test. Was that machine accurate? Or did the operator perform accurately? I would even suspect whether that organisation was a scam and took the*

> *money from you, so they just randomly gave you a negative result in the report and got a few hundred dollars from you.*

Lee identified different possibilities that could influence the accuracy and reliability of test results. His concern was mainly around human error or unethical practice. Like Ben, Lee also made negative assumptions about the professionalism of healthcare professionals. Therefore, he did not feel reassured after medical consultations:

> *誒你睇得到醫生多呢反而仲麻煩 […] 即系我自己可能有疑病症啦。即系我都覺得: 「啊呢個系咪㗎？係咪求求其其答我啊？」點樣剩。系嘞，就系呢樣嘢就問題喇，即系姑勿論呢度系社工啦，或者系醫生啦，都畀到個答案令到你冇辦法好好肯定。*
>
> *The more doctors you consulted with, the more disturbing. […] I probably have hypochondriasis so I would think 'Is this [answer] okay? Did he answer my question in a sloppy manner?' Right, this is the problem. Whether they were social workers or doctors, their given answers did not make you rest assured.*

According to Noyes et al. (2005), a potential explanation of Lee's mistrustful attitude is low self-esteem. His resistance to healthcare professionals' reassurance might be a consequence of his self-image of unworthy of care (Starcević, 1990). In addition to scepticism and mistrust, the men's intolerance of the lack of absolute test accuracy and the waiting time for results were barriers to feeling immediate reassurance. For Lee, the more he attempted to find certainty via repeated testing or consultation, the harder it was to stop the HIV anxiety. The following extracts from Ben, Andy and Lee further demonstrate their difficulties in tolerating uncertainty:

Ben: 我啱啱知道 Results 嘅時候，咁即係 Negative ，開心咗一陣啦，個人放鬆咗啦，但係好快…一兩個鐘頭後又翻返嚟啦嗰個恐懼，擔心頭先嗰個測試唔準確啊，或者自己就係上網睇到嗰啲準確率 99 點幾漏左嗰零點幾 percent 呀，咁樣囉。

Ben: When I first learnt of the result, which was negative, I was happy for a while, and I felt relieved. But soon after... about one or two hours later, I gave in to fear again, worried that the test result was not accurate. I went online and read that the accuracy rate was not 100% and there was a less than 1% chance of inaccuracy.

Andy: 即系 test 完之後，就算…即系之前佢 test 完，就算佢講過話其實個風險好低啊，咁低都系一樣有嘛個人覺得。

Andy: After the test was done, even though it was done and even though he [healthcare professional] said that the risk was very low, but no matter how low the risk was, I reckoned the risk still existed.

Lee: 有啲話有一個 percent 嗰啲人 ，呢叫做欸叫做乜嘢 elite HIV。就系即系有一個人呢，即系果啲人一定要第 13 個禮拜先 check 到嘅，跟住我又驚會唔會就係果 1 個 percent 嘅人呢。[…]我由第四個禮拜系開始我基本上，每隔一個禮拜都 check 一次，都抽一次血。

Lee: Some people [on the internet] said there's one percent of the population was labelled as something like elite HIV, which means someone who could only be detected at week thirteen. Then, I was scared whether I was one of those one

> *percent. […] Starting from week four, I basically checked it by doing a blood test every other week.*

These three examples were consistent with findings from western scholars who have suggested that people with HA struggle to feel 100% reassured that they are not medically ill (Hoffmann et al., 2019). Feelings of uncertainty appeared to be a common symptom of the participants' HIV anxiety in this study.

In contrast, two gay participants, Luca and Bill, avoided testing for long periods as their way of coping with their HIV-related anxiety. Their long-term avoidance of testing contributed to the maintenance of their HIV anxiety for several years. For Luca, after his first experience of HIV anxiety associated with an unpleasant testing experience, he chose to avoid HIV testing completely:

> *覺得都有啲 traumatised 嘅嗰一樣嘢，因為欸嗰個恐懼嘅感受太深刻喇，所以去到日後就算欸即系日後唔會想再經歷翻同一樣嘅恐懼嗰度，所以我都好欸拒絕要去 check，即系自己驗手指又好，去 check HIV 嘢 test 又好，真系會好打從心地裡拒絕 lor，因為我好驚又要再去面對。*
>
> *I believe I was a bit traumatised by that [the previous testing experience]. Since that fear was too profound, I don't want to experience the same fear again in the future. That's why I strongly rejected the need of checking. No matter doing self-testing through finger prick, or go checking with other HIV tests, I really rejected it from the bottom of my heart because I'm very scared to have to face it [the fear of a positive result] again.*

Luca had been avoiding HIV testing even though he had been sexually active. The "traumatised" part of testing that Luca referred to in this extract was the frightening emotional experience while waiting for the test result. That is to say he was fearful in facing the subsequent consequences. Also, he explained how he rationalised his decision of not testing over a long-period of time:

> *隔咗五年都冇做過test噉樣咯。但系我又…欸欸噉之後呢，其實又都有keep住成日都病噉喎，噉我覺得欸成欸噉我發燒發到成38、39度都死唔去啦，噉即系我唔會有HIV喇。即系我會噉樣去理解咯，當然唔科學啦成件事我會覺得，但系就自己會有少少誒，會有少少想逃避，唔想去check嘅其實。*
>
> *I haven't done any tests in five years. But I... and then, actually I've been ill all the time. So I thought the fact that I didn't die even when I had a fever with body temperature of 38 or 39 degrees, it means that I haven't got HIV. That's how I make sense of it. Of course, I feel like this whole idea isn't scientific, but I'm a little bit… a bit wanting to avoid. I just don't want to check it [the presence or absence of HIV antibodies].*

Clearly, Luca had concerns about the risk of HIV infection, but he justified his avoidance of HIV testing by finding evidence that supported that he was HIV-negative. Although he believed that the disengagement from testing helped reduced his fearful feelings, later in the interview, Luca reflected that he was deceiving himself and others. In fact, his concern about his HIV status persisted. It has been suggested that "disengagement coping", which involves escaping from particular thoughts and emotions, can lead to high stress (Finkelstein et al., 2007).

Bill, a 53-year-old gay man, had avoided HIV testing for over 20 years because he did not want to risk his gay identity being exposed. He had his first HIV test after he had become severely ill in 2022. The HIV test offered by the hospital was an essential testing procedure during the diagnosis of cancer. He described his thoughts about his reluctance to do HIV testing in the following extract:

> *基本上有欵有冇 AIDS，嗽你揭開咗有 AIDS 嘅話嗽你咪要去面對下一個問題就係話:「你點解會有 AIDS 呢? 嗽誒究竟系乜嘢原因呢？」嗽可能啊誒我又唔係共用針筒，嗽好容易會聯想得到就係話你係同志咯。[…] 即係如果係驗得到，真係有嘅話，嗽呢一個我覺得必然我會需要去面對嘅嘅一件事情就係嗽咯。嗽所以就係即係誒我冇驗，唔知道，嗽反而我就就仲唔需要去去面對住，嗽但係就話會唔會係話啊第二啲事情，可能話真係有事嘅，嗽跟住令到病發啊，或者點樣樣跟住先至先至去發現呢？先至去去去乜嘢呢？*
>
> *Basically, the presence or absence of AIDS would reveal…if there's AIDS, you must face the next question ： 'Why do you have AIDS? What's the cause?' Probably…well, I don't get involved in needles sharing so it's easily associated with gay identity. […] I mean if I were tested and I really had it [HIV], I felt that I must face this matter. That's it. So I didn't do any testing [before 2022] and I don't know [his own HIV status]. That way, I don't have to face it yet. But there might be another issue, I might have had it [HIV], then I might discover it [AIDS] or to do something about it only when I have progressed to AIDS or in situations like that.*

A major part of his experience was facing the dilemma between placing his health at risk and facing difficulties and challenges related to stigmatisation. He revealed in the interview that his main concern was his mother's potential rejection. Since Bill chose to conceal his gay identity while having an unknown HIV status, his anticipation of severe health consequence persisted. It is worth considering that Bill first experienced HIV anxiety more than 20 years ago. HIV education and testing service were much less accessible and social attitudes towards homosexuality were different at that time, in particular in non-western societies. Therefore, the degree of intersectional stigma of being HIV-positive and being identified as gay was likely to be higher then. In line with existing western research, for Bill, HIV and anti-gay stigma were the primary barriers to testing (Gamarel et al., 2018; Iott et al., 2022; Lutete et al., 2022).

In sum, suspicion, scepticism, intolerance of uncertainty and avoidance were the main contributing factors to the development and maintenance of HIV anxiety in this group of participants. Interestingly, the factors contributing to the maintenance of HIV anxiety appeared to be different between the heterosexual and gay participants. Heterosexual participants eventually realised that their repeated search for evidence and reassurance not only maintained the anxiety but also exacerbated the level of anxiety and fear they experienced. For gay participants, their avoidance of HIV testing prolonged their experience of HIV anxiety.

Subtheme 2: Support-seeking for anxiety: A temporary emotional relief

This sub-theme emphasised that some participants experienced a sense of emotional relief through knowledge-based support, whereas others perceived that emotion-based support was helpful. Four out of seven participants revealed that the experience of talking to people who understood their situations led to a temporary reduction in distress and anxiety. They emphasised the significance of having a talking space as an emotional outlet. One participant also reported employing spiritual coping. Across all these different forms of support, participants described only experiencing a one-off or short-term sense of relief.

Andy, a bisexual man, attended a one-off combined HIV counselling and testing session offered by trained staff in a charity. From his experience, seeking professional support helped reduce his HIV worries albeit on a temporary basis:

> *因為佢哋嘅佢哋 test 過咁多人咁多知識，噉佢哋一定系清楚過我好多喇，[…] 佢哋嘅認知上便一定系好過我。噉佢俾呢啲意見嘅我嘅時候，話畀我聽，噉我*

> *「哦原來系噉嘅噉樣。」噉我就會好啲咯。畀咗啲專業啲嘅嘢。呢 d 即系專業啲嘅意見唔使你估黎估去*
>
> *Because they’ve tested so many people along with so much knowledge, they must know better than I did. […] I believe their [HIV testing workers] understanding was better than mine. When they offered me feedback, I was like ‘Oh! That was that.’ I then felt better as they offered me something professional. This professional advice stopped me from guessing.*

Andy trusted that the healthcare workers were more knowledgeable than he was, and he valued their professional experience. Elsewhere in his interview, Andy emphasised that he perceived that his family members did not understand him as they knew nothing about his sex life. He was worried that his family would not accept his sex life; therefore, disclosing his fear and worry related to HIV to his family was not an option. As a result, he perceived that seeking advice from healthcare professionals not only fulfilled his information-seeking needs, but he also gained emotional comfort through the process as he had the space to disclose his difficult emotions to a person who offered an empathic understanding of his circumstance. He stated:

> *去咗欵嗰度去搵啲心靈輔導噉樣嚟，即系果陣講我自己完整嘅發生嘅事。[…]問下佢應該點算，噉佢都講到都好安慰我其實個風險又唔系真係好大，噉跟住就安心啲噉樣。*
>
> *I went there [HIV organisation] to seek psychological counselling, I disclosed what happened to me completely. […] I asked him [HIV testing and counselling worker] what to do, then he said that my risk was actually not really high and it was comforting to me, then I felt a bit more relieved.*

> *即係我第時 in case 都系繼續有擔心啊，有驚啊，玩完真係好驚嘅時候，都有人可以俾我問佢。[…] 有人同我 share 呢種驚嘅感覺，令到我好啲咯。 […] 我覺得朋友，屋企人就係冇…聽唔明我講緊啲乜嘢，就算明咗都唔唔了解唔理解嗰個情況。所以誒有人聽我講嘢同埋知道我講緊啲乜嘢都好緊要啊。*
>
> *even if I continue to have such a worry and fear after having fun in the future, there's someone whom I can ask. […] When there's someone who can share this fearful feeling, it makes me feel better. […] I think friends and family wouldn't get what I'm talking about. Even if they get it, they won't understand the situation [sexual practice between men]. That's why it's important to have someone who could listen and understand what I'm talking about.*

In contrast to Ben and Lee, whose motive for seeking help was to get an absolute answer about their HIV status (as presented in subtheme 1), Andy's motivation of seeking professional help was the empathy he received from counsellors. This is consistent with the finding of Gu et al.'s (2015) study that showed that the empathy MSM perceived and experienced from service providers was related to their motives for engaging in HIV re-testing.

Cruella and Walter also reported finding emotional comfort through confiding to people who had relevant knowledge and information:

> *Cruella: 有試過去搵啲學校啲一啲欸負責 social science 方面嘅老師傾下咯，噉噉佢哋都有，其實都有，即係其實佢哋都有安慰到嘅*
>
> *Cruella: I'd talked to schoolteachers who specialise in social science. They were able to …actually they offered me comfort.*

Walter:我識咗嗰個朋友，佢自己係 positive 嘅呢，佢教咗好多嘢呢，反而我就即係冇，即個知識增長咗好多，噉所以就欸...冇...冇...冇乜恐懼。

Walter: I met that friend who is [HIV] positive, and he taught me a lot of things, but I didn't have... I gained a lot of knowledge, so then... I didn’t have much fear.

For them, accessing relevant knowledge and gaining reassurance from people who had knowledge of HIV resulted in temporary relief of their anxiety. Interestingly, Lee, who did not find repeated medical consultations helpful, also reported experiencing short-term emotional relief after speaking to support workers over the phone:

至緊要肯畀我講出嚟。嗯即系因為因為我冇人可以講，因為我本身冇宗教信仰。嗯。即系都冇可能欸即系啊同屋企人講，亦都唔會同朋友講，欸因為覺得欸好難於啟齒。[…] 傾完電話好開心嘅，即系唔系開心，即系個人好似放松咗，即系吐咗出嚟噉，但系之後又系又擔心。

Most importantly, I was able to speak out. Since I had no one to speak to and because I have no religious belief. Also, it was impossible to talk to my family [about HIV worry] and I wouldn’t talk to friends about it because it was something that was too embarrassed to mention about. […] I felt happy after talking on phone. I mean I wasn’t happy, I mean I seemed to be relaxed. It was like venting it out, but then I was worried again.

This extract highlights that seeking emotional support externally did not bring a long-lasting relief for Lee. Yet, he valued the space in which he could talk about his feelings. Also, it appeared that Lee’s fear of prejudice and stigma was a barrier to gaining emotional support from friends and family. Thus, seeking support remotely where his identity was hidden met his needs. Similarly, Luca expressed having a strong urge to get emotional support:

> *因為我好驚，我唔知發生咗乜嘢事，又好驚自己會中* HIV *，所以我都攬住媽媽跟著就喊啊噉樣咯。[…] 我就忍唔住我就喊喇噉樣咯。如釋重負。*
>
> *Since I was very scared, I didn't know what had happened while feeling scared of contracting HIV. So I hugged my mum and cried. […] I couldn't hold my tears. It was a relief.*

As discussed in theme one, Luca's parents rejected him after finding out about his engagement in same-sex sexual practice. It was clear that emotional support from his family was not available to him. This might explain the reason why he sought support from God:

> *嗰一個月成日都好…好焦慮啦，好驚啦，都有啲欸欸自殺嘅諗法嘅當時。[…] 本身我冇宗教背景啦，但系嗰陣時候我哋喺度求啦，欸欸會唔會欸… 可以保佑到我呢，即系「如果願意保佑我嘅，即系之後我信教都得」噉樣。*
>
> *Throughout that month, I was very anxious and terrified. I had suicidal ideations. […] I didn't have any religious background, but at that time, I was begging. Will I…can I be protected [by God]? I was like…'bless me if you [any God] will, I can become a believer in your religion.'*

Luca made a vow in exchange for God's protection to reduce his anxiety. Bargaining and making deals with God was his defense against his feeling of helplessness. He attempted to gain a sense of relief by offering something God couldn't refuse.

This subtheme shows the important role of social, emotional and spiritual support despite the short-term effects these had in ameliorating anxiety. The men had a strong need to seek a safe space to express and disclose their emotional vulnerability to someone who understood their concerns. Based on participants' positive emotional experiences in seeking counselling and consultation, they suggest that mental health practitioners' HIV-relevant knowledge and their ability to apply active listening, offer empathy and express their understanding of client's distress are core elements in forming trust in therapeutic relationships. This finding aligns with recommendations of earlier studies that investigated the role of "doctor-patient relationship" in the treatment of patient with hypochondriasis – acceptance, empathy, understanding and explanation of patient's ongoing symptoms are basic conditions for treatment (Noyes & Stuart, 2004; Starcevic, 2002).

Theme 5: Persistent HIV distress took over my life

This theme centres on how participants realised that the experience of living with HIV distress had led to detrimental impacts on multiple facets of their lives. Their emotional responses to HIV-related distress ranging from fear, depression, withdrawal, agitation, to extreme anxiety, led to interpersonal difficulties, social withdrawals, disruptions in daily functioning and sexual well-being. Six out of seven participants revealed experiencing short-term struggles in more than one dimension of their lives when they were preoccupied with HIV-related thoughts and worries. This included not being able to sleep and an inability in engage in daily and social activities.

Participants struggled with prolonged emotional distress because of the testing windows (the definition is mentioned earlier) for various HIV tests (Palfreeman et al., 2020; *Terrence Higgins Trust*, 2022). A false negative result is possible when a person is tested within the first few days/weeks following a potential exposure. Hence, any negative result obtained within the window period is not considered as a confirmation of a person's HIV status. The following excerpts from Ben's and Lee's interviews illustrate their emotional struggle during the testing window period:

Ben: 其實好辛苦㗎，比死更難受囉咪就係話。等時間過㗎咋，每日都好辛苦囉。

Ben: It was very tough and even worse than death. You could only wait for time to pass so every day was a struggle.

Ben:瞓唔着囉，同埋想時間快啲過囉 ，快啲到三個月囉。其他任何興趣都冇做到囉，每日就瘋狂上網睇有關呢啲嘢嘅資訊囉，即係瘋狂計算有幾多個 percent 準成度咁樣嗰啲囉。

Ben: I couldn't sleep and wanted time to pass quickly. I wanted the three months [testing window period] to pass sooner. I didn't even carry on with any hobbies during that time. I just frantically surfed the internet every day to read related information and could not help calculating the percentage of accuracy [of the test] over and over again.

Lee: 唯一令我系叫做安心啲係時間過咗去[…]其實我喺呢段時間呢，我睇咗五個皮膚科醫生。睇到唔同嘅皮膚科醫生，噉當然啲醫生都…最後…甚至乎耳鼻喉科，我睇咗四個。

Lee: Time passing was the only thing that made me felt reassured. In fact, during this period, I visited five dermatologists; they were five different ones. Of course, those doctors were … at the end, I even visited four otolaryngologists.

Lee; 我諗不過好彩啦，我冇嘢做，如果我有做嘢做嘅話，我諗我都做唔好份嘢嘅，因為個陣一路其實會諗起嗰樣嘢，即係頭先所講，我行行下街，我覺得有啲唔妥，我即刻搵個洗手間去照下有冇問題，噉正常你好難去過一個生活

Lee: I think I’m lucky as I was unemployed. If I had a job, I believed I would not be able to perform well because I kept thinking about that thing [HIV]. As I just said, when I felt something wasn’t right while walking, I had to find a toilet immediately to see if there was a problem [on his genitals]. Normally, you can’t live a life like this.

Ben and Lee shared the sense of helplessness and despair at not able to control the waiting time. Both spent a large amount of time seeking information and reassurance to a point that prohibited their engagement in daily activities. I noticed their choice of words, such as “normally” (Lee) and “frantically” (Ben) at the time of interview; they perceived that their thoughts and reactions did not fit what is socially normal or acceptable. In retrospect, they viewed their lives during that period as deviating from what is perceived as normality.

Andy and Walter suffered from other kinds of illnesses that shared some of the symptoms of HIV/AIDS. They found it challenging to stop associating their bodily symptoms with HIV/AIDS.

Andy: 佢話乜入侵性病毒噉樣啦，跟住我就非常之驚驚。[…]即系幾日都寢食難休噉樣啦。

Andy: He [the doctor] said it was an invasive virus, I was very scared. […] I couldn’t sleep and eat well for a few days.

Walter: 上網亂搵資料，噉咪將好多一啲誒好後期嘅一啲…即系…symptoms，當做系一啲初期嘅 symptoms 噉樣啦…噉咪，噉一開始就亂諗喇，跟住晚晚瞓得唔

好啊。同埋個人好似系真系好似好唔舒服咁成日就欸頭暈啊又攰啊，又集中唔到精神啊噉。

Walter: I searched for information online, and I regarded a lot of late-stage symptoms as early-stage symptoms...then I started having random thoughts and I didn't sleep well every night. And I seemed to be really unwell all the time. I was dizzy and tired, and I couldn’t concentrate.

Walter noted the interconnection between his anxiety-induced actions, thoughts, sleep difficulties and physical symptoms. This highlighted the extent of the impact of his psychological distress on his physical functioning. Later in the interview, Walter shared that he was diagnosed with Dysautonomia, which is “a nervous system disorder that disrupts autonomic body processes”(Cleveland Clinic, 2023). The following extract from his interview provided an extreme example of the impact of persistent HIV anxiety on his physical health. He explained that his HIV anxiety caused an illness:

Walter: 但系就提唔起精神喇。其實就係個問題就係你自己過度焦慮搞到嗰個自律神經失調，係咪呀？噉真係食咗幾個月藥

Walter: I couldn’t lift my spirits. In fact, the problem was that you yourself were overly anxious and resulted in Dysautonomia, wasn’t it? I was on medication for a few months.

Apart from negative impact on daily and physical functioning, for three men, their HIV distress created ruptures in important relationships. As discussed in theme two, both Lee and Walter noted their insistence in avoiding physical contact with their female partners because of their concerns about HIV transmission risk. In the extract below, Walter made sense of the end of his romantic relationship:

> *確實嗰種焦慮啊令到我，令到我同佢分開，因為如果我唔系嗰時太驚太急，喺未 firm 嘅情況之下同佢講嘅話就唔會分開。[…] 佢確實系會影響你嘅人際關系。*
>
> ***that anxiety indeed made me…made me separated from her [the relationship ended]. Because if I were not too scared and agitated at that time and if I did not talk to her when the situation had not been confirmed, we would not have separated. […] indeed, it did affect your interpersonal relationships.***

There was a sense of self-blaming about his inability to regulate emotions. Walter implied that the extreme anxiety was an indirect cause of the end of relationship.

Lee, who had sexual contact with a sex worker, also described how his HIV anxiety affected his connection and interactions with his wife:

> *Lee: 同老婆嗰個內衣褲又要分開洗啊噉樣。[…] 我直頭同我太太呢…除咗我…即係自己小心啲傷口或者乜嘢事之外呢，我直頭飲水嘅杯啊，即系我都刻意分開嘅。但係又做得好小心喎，即係唔可以話欵即係好似同以往嘅生活有唔同噉樣。*
>
> ***Lee: I separated my laundry from my wife. […] my wife and I literally…apart from being careful of my wounds or things like that, I literally separated the cup I used for drinking water from my wife's deliberately. At the same time, I had to do it circumspectly so that she would not notice that I was different from how I usually acted in daily life.***

Lee's distress and anxiety were manifested in two layers. Firstly, his conscious effort in creating a physical distance from his wife reflected his anticipated guilt and the unspoken pressure of adhering to the Confucian ethics – being a good family member (Rošker, 2020).

Secondly, the nervousness in secret-keeping regarding his morally unacceptable sex life outside of his monogamous marriage. To him, concealment was a way to maintain a well-ordered state in his marriage. Yet, it is strongly apparent from these interview extracts that the physical distance had a notable negative short-term impact on his closeness with his wife. Apart from the difficulties in his marriage, Lee also displayed difficulty in engaging in relationships with his friends because of the emotional burden that he was carrying:

> *我以前唔會諗呢啲嘢[…]有陣時我都會去跑步啊，做下運動，行下山，即係噉樣，但係呢樣嘢呢令到我基本上呢五個月呢冇一個正常社交活動啦。我唔想見人啊，即係我唔想同啲朋友，即係啊，就算出去打邊爐啊或者點樣剩。我我我唔喇即係我覺得欸唔好喇，一陣如果…我係嘅話我傳染咗畀你哋啊。*
>
> *I'd never thought about this kind of thing before, […] I sometimes went jogging, did exercise, and went hiking etc. But this thing [HIV anxiety] have hindered me from engaging in normal social activities over the past 5 months. I don't wanna see other people. I don't wanna be with my friends, such as having hotpot or so. I was like…no. I felt like it wasn't good. What if I pass this to you guys.*

> *一個好大嘅burden，因為雖然我稍後時間聽到話依家最新嘅定義係U=U，但系我就我personally就唔buy嘅，even到呢個時候，即系你只不過係undetectable嘛，你唔系代表你嘅body冇或者你會唔會有一日傳染到畀人。因為我最擔心系會唔會傳染到畀人*
>
> *It's a huge burden because I personally don't buy the concept of U=U [Undetectable = Untransmittable, meaning that people living with HIV who are on treatment and have a fully supressed viral load have a zero risk of transmitting the virus to their*

> *sexual partners] despite hearing the new definition of this concept in a later time. Even now, I think you are just being undetectable, it does not mean that it's absent in your body, or you won't transmit it to others. Because my greatest worry is whether I will transmit it to others.*

This is an example of the Chinese people's belief in the prohibition of threatening the well-being of the collective group. From my clinical experience of working with HIV anxious men, disengagement in sport activities and social meals are common phenomena. Many clients of mine believe that they would put others at risk because of the potential for exposure to body fluids while engaging in these interactive activities. Hotpot is a dining experience that involves a group of people who cook ingredients in a single pot of simmering broth. The fact that Lee mentioned it suggested an implicit concern for potential transmission through saliva. Thus, he seemed to have complied strictly with socially normative moral beliefs and notions of ethical order while sacrificing his social well-being.

It is also worth noting that both Lee and Walter self-identified as heterosexual. Their shared thoughts, beliefs and actions potentially suggest that there is an existence of a subculture in terms of the meaning of having HIV among heterosexual men. Their anticipated threat to their families and communities resulted in social withdrawal and self-isolation. By contrast, Luca's experience of social disconnection was unintentional. Based on his story, I believe his social disengagement was an outcome of his inability to regulate emotions:

> *冇翻幾日學啦，跟住之後返到去我又好* depressed *啦，又溫唔到書啦，成個人淨系諗住：「死啦，會出* report *喇。欸會唔會中咗架？中咗點算啊？」噉樣啦，噉就成個考試都搞唔掂就 fail 曬啊噉樣，噉就牽連住埋學業嘅壓力上，噉就成個人更加 anxious ，更加 stressful。*

> *I had not attended school for a few days, then when I returned, I felt depressed, and I couldn't study. All I had in my mind was: 'It's dire. The report is coming out. Will I get it? What if I get it?' something like that. Then, I screwed up the whole exam and I failed. This added on the academic stress. Then, I became more anxious and it became more stressful.*

> *返到嚟又無心向學啦， […]即系咁啱返到去就要考試 […]即係學校嘅成績表，噉嗰陣時呢，欵考屘十幾啦，噉就個班主任就要我留班噉樣。就…即系又要聽到要留班，噉又覺得啊啲同學仔又全部唔同我一級啦* wor*。之後噉又要識過曬所有嘅人啊*
>
> *I was unmotivated in learning when I returned [to school], […] It happened that I had to take an exam when I got back […] the academic transcript came out and my academic performance was ranked one of the last ten or twenty or so at that time. As a result, the head teacher asked me to repeat that academic year. When I realised that I had to repeat that year, I realised that all classmates would not be in the same cohort as me, then I had to meet new people.*

In Luca's descriptions, his distress around HIV had a domino effect, from experiencing depression to academic failure and interpersonal difficulties. He attributed his academic and interpersonal difficulties to his depressive mood and the lack of motivation, which were the primary effects of his anxiety.

Finally, two participants articulated a diminished sexual desire and a loss of sexual interest because of the fearful or unpleasant feelings associated with HIV anxiety. Bill described his erectile dysfunction, whereas Walter lost his sexual interest in women:

Bill: 我有好幾年，即係一想到做…即係一想到肛交嘅，噉佢就會係話即係有軟咗嘅。

Bill: I’ve had a few years, when I thought about doing it…as in when I thought about anal sex, then it [penis] went soft.

Walter: 我出現咗個…類似即係對任何女性都冇乜感覺，驚咗。即但係…我又冇話…冇話變彎啊。我就係好似。啊點解對呢啲女仔系…冇以前咁興奮呢？

Walter: I became... I didn’t have any feelings towards women, I became terrified. But... I didn't... didn't become gay. I was like…I didn’t know why I no longer felt as excited towards these girls as I did in the past.

Research indicates that sexual problems, such as erectile dysfunction, loss of libido and ejaculatory disorder, are more common in HIV-positive men than HIV-negative men (De Vincentis et al., 2021). A decrease in sexual response is related to depression and anxiety along with changes in body image and fear of virus transmission (De Vincentis et al., 2021; Ismail, 2023). These extracts from Bill and Walter illustrate that having thoughts of HIV infection rather than actual infection still led to changes in their mental states that affected their sexual desires and practices. Although only two participants raised the issue of psychosexual difficulties, there was not a specific interview question about this so it may be that the other participants did not feel comfortable sharing this. These two examples suggested that HIV-negative men who experience prolonged HIV anxiety could be at risk of facing challenges in sexual well-being in a similar way to that experienced by HIV-positive men.

This theme details how HIV distress and anxiety negatively affected these participants’ quality of life in different ways. From the men’s point of views, the relationship between anxiety, coping mechanisms, emotion regulation and social outcomes were clear. Some negative consequences were temporary, whereas others, such as Luca's academic failure might have a longer-term impact on his interpersonal relationships and psychological development. Participants who experienced sexual and physiological functioning problems seemed to have difficulties in understanding how these problems manifested in their unconscious. The lack of understanding of the link between their HIV anxiety and the sexual/ physiological functioning problems might have led to feelings of inadequacy.

Theme 6: Post-traumatic growth and other positive changes following psychosocial adversity and existential concerns

This last theme captures four participants' discussions about positive changes and growth processes after experiencing anticipated social threats, existential distress, and/or the experience of being helped by others. Positive changes following adversity and trauma have long been recognised in literature (Calhoun & Tedeschi, 2006; Tedeschi et al., 2018; Tedeschi & Calhoun, 2004). The term post-traumatic growth (PTG) describes the experience of positive psychological changes following trauma or highly aversive life circumstances (Tedeschi et al., 2018; Tedeschi & Calhoun, 2004). Although people cope with major life difficulties in various ways, there is evidence across different cultures that there is the possibility of personal growth arising from the struggle of life stressors (Kristo, 2021; Levin-Dagan & Hamama, 2024; X. Liu et al., 2020). Research studies on chronic health problems and mental health issues have evidenced that survivors present a range of positive changes, such as changes in lifestyle and personality (Connerty & Knott, 2013). Some people deal with negative events by means of reinterpretation and acceptance (Linley & Joseph, 2004). In this study, participants presented various forms of PTG and other positive changes. These included increased empathy and compassion for others, self-compassion, improved health-related behaviour, positive coping, increased maturity in decision-making and problem-solving, increased appreciation of life, and a change in life priorities. These participants considered that these changes were transformative.

Luca demonstrated a positive change in the way he interpreted and coped with social rejection, as described in later part of the interview:

> *當時自己可以俾多啲接納自己咯，即係可以畀多啲愛自己。即係雖然側邊 surrounding 嘅人都唔支持你，都好似離棄你，噉但系誒自己都唔可以咁消沉嘅。即係都唔可以話要放棄生命因為…人哋愛唔愛你係人哋嘅選擇，但係你首先你要愛自己先咯。我會覺得自己欵* positive *咗好多嘅，同埋都會覺得欵…自己係值得被愛嘅噉樣咯。*
>
> *At that time, I could have accepted myself more and I could have loved myself more. Although the people surrounding you did not support you and seemed to have abandoned you, you shouldn’t be depressed. You shouldn’t give up your life because…whether others love you or not, this is their choice. But first, you need to love yourself. I feel like I’ve become more positive, and I feel that I’m deserved to be loved.*

This extract showed that Luca developed self-acceptance and self-compassion following the aftermath of his psychological struggles and self-attack. Another growth in Luca was his search for meaning in life after the experience of being helped during difficult times:

> *噉經歷完之後，都有被幫助嘅經驗，學校嘅社工都有幫過我噉樣，噉所以日後去到大學嘅時候我就揀咗教育系去讀，跟住之後讀* master *嘅時候又揀咗*

> *counselling 去讀，其實都係為咗想即係欸幫多啲青少年，尤其是 LGBT 群組嘅。所以就欸…覺得…係咯，即係自己因為有曾經有個噉樣嘅經驗都希望可以幫到多啲其他人，所以呢個就係我之後嘅人生嘅目標同埋路向咯。*
>
> *After I'd had the experience of being helped, the social worker in school had helped me, so later on when I went to university, I chose to study education. After that, I chose to study a master's course in counselling. Actually, my intention was to help more juveniles, in particular the LGBT community. So I feel like…right, because I had experienced this kind of experience, I was hoping to help more people, so this had become my life goal and direction later on.*

There was a clear connection between Luca's prior positive experience as a help-seeker and his primary motivation in becoming a helping professional at the time of the interview. He focused on how he made use of his experience in a constructive sense. Carl Jung's concept of the 'wounded healer' (Jackson, 2001) can be used to explain how his positive experience of support at a vulnerable time in his life motivated him to help others.

Motives for practicing counselling and psychotherapy has been mentioned in several studies and books (e.g., Bager-Charleson, 2010; Barnett, 2007; Beatty, 1927; Sussman, 1992). In a study carried out by Bager-Charleson (2010), when participants were asked about their motives for becoming a therapist, 75% of the 238 participants reported having personal experiences that were "largely dominated by some form of crisis" (p.32). This echoes Luca's perceived influence of his experience of HIV anxiety on his motivation to enter the counselling field. Also, scholars have suggested that many counsellors and psychotherapists have early experience of loss, again, reflecting the notion of the 'wounded healer' (Barnett, 2007; Beatty, 1927). These findings are in line with the other part of Luca's story around HIV – being rejected and humiliated by his parents when his gay identity and HIV testing were exposed as a 16-year-old young man. According to literature around the concept of the ‘wounded healer’ (Burton & Topham, 1997; Cain, 2000; Sedgwick, 1994), the therapist’s woundedness could have a positive impact on their therapeutic work. I believe Luca had dealt with his own emotional wounds to certain degree and continued to heal within himself through seeking to identify and relating to others’ emotional needs in a helping professional role.

Andy benefited from the experience of being a help-seeker differently:

> *就算我玩完覺得好驚嘅時候，我都可以原來…啊原來知道原來有人，誒，哦原來嘅幫我嘅人明白我講緊啲乜嘢嘅。嘅即係如果第時，即係我第時 in case 都係繼續有擔心啊，有驚啊，玩完真系好驚嘅時候，都有人可以俾我問佢。[…]有個 backup 咁。*
>
> *Even if I feel scared after having “fun” [sex], I could…I know oh actually someone could help and understand what I’m saying. That means in the future, just in case, if the worries continue, if I have the fear after having “fun”, I can consult someone. […] There would be a backup.*

When Andy said “someone could help and understand what I’m saying”, he was referring to the healthcare professionals’ knowledge and awareness of the sex lives and sexual culture of the MSM community. Research showed that Hong Kong Chinese MSM are likely to practice or expect to engage in various forms of non-monogamous intimate relationships (S. Chen et al., 2024; Kong, 2009; Yeo & Fung, 2016). Andy’s positive help-seeking experience had convinced him that some healthcare professionals have an understanding of MSM’s non-traditional sex lives. He also re-evaluated his HIV anxiety experience by looking for evidence of compassion and external resources, and he recognised the accessibility of HIV associated social services that were inclusive with little or no stigma toward MSM. The positive experience had transformed his expectations of others’ attitudes toward him and others in the MSM community. This transformative experience not only changed the degree of trust he felt towards healthcare workers, but it has potentially increased his willingness to access sexual health services and to adopt a help-seeking approach in face of life challenges in the future.

Lee noticed a change in the way he appreciated and prioritised life:

> *我會覺得要珍惜而家嘅...生活，即系...太太啦。因為其實嗰刻好擔心失去咗佢。失去咗佢嘅失去乜呢？第一如果佢知道咗佢離開咗你喇，即係佢唔要你。就覺得話你你你叫雞喎，嗰啲咁嘅剩...第二就係話如果就算佢唔離開你，或者我係十幾年或者所謂十年之後病發死咗，我亦都離開咗佢, 真係離開咗佢，所以會珍惜同屋企人嘅時間，呢個係真嘅，呢個就係即系或者，能夠希望即係能夠真係真係 take care 咯*
>
> *I’ve realised that I need to treasure my existing life, meaning my wife. Actually, because I was worried about losing her. What will I lose if I lose her? Firstly, if she knows, she may leave and abandon you because she’ll condemn you… she’ll be like…you visited a sex worker! Secondly, even if she does not leave you, I may die of AIDS after 10 years or so, I will leave her behind too, I will literally leave her behind. That’s why I will treasure the time I spend with family. This is real. Perhaps, I hope I can…I can really really take care [of myself].*

Lee’s reflections on death and non-existence led him to re-evaluate the meaning of life, which has been reported in existing literature as one of the domains of PTG (Calhoun &

Tedeschi, 2006; Finkelstein-Fox et al., 2020). His relationship with his wife had become more important than ever before after he had struggled with the possibility of losing or ending his marriage. It appeared that he recognised and accepted that uncertainty is part of life. Therefore, he shifted his attention to the presence. Through the process of existential thinking, he changed his life priorities and created new philosophies for life, such changes have been reported in several PTG studies (e.g., Calhoun & Tedeschi, 2006; Liu et al., 2023). Additionally, he shared noticeable changes in his thoughts and attitudes toward interpersonal relationships and other people:

> *有種諗法系我覺得我唔會再太過憎恨一個人。唔知呢，因為欸以前可能你做嘢或者嗰樣就：「哎呀，呢條友咁鬼麻煩嘛鬼煩，麻煩友啊啲乜盛」，欸而家呢我就會覺得，誒每個人自己諗法咯，總之你欸即系總之心平氣和啲做一件事情咯，即系唔知點解會有呢啲呢啲關聯。*
>
> *I’ve noticed a thought. I reckon I no longer hate anyone. I don’t know why. In the past, when you were at work or so, you’d be like ‘Damn it, this person is so bloody annoying, he is a troublesome person.’ Now, I believe everyone thinks differently, you can stay calm to perform a task. I don’t know how this is related.*

Based on his description of the difference in his thoughts pre- and post- his experience of HIV anxiety, Lee seemed to have developed an elevated compassion, empathy and an increased appreciation for the value of human connections. Such changes support existential theorists who have posited that human’s death concerns could lead to an increased in interest in and identification with the human social group (Castano et al., 2002). Previous research has shown that when a person defines themself in relation to a broader group, it helps them manage their heightened death awareness (Castano, 2004; Routledge et al., 2013). Thus, Lee’s elevated social interest was likely to be the result of his unconscious defense mechanisms engendered by thoughts of death (Castano, 2004). Moreover, in my view, Lee’s lived experience in losing connection with people might have provoked his realisation of the importance of human connection.

For Walter, he claimed that the greatest benefit that he gained from his experience of the HIV anxiety experience was stopping smoking:

> *嗰次就令到我戒煙，即係誤打誤撞唔知乜事啊就死嘛。[…]個人係變化好大咯，所以嗰次嘅得著係…最多就係戒煙。*
>
> *that experience made me quit smoking by chance as I thought I was dying without understanding what happened to myself. […] I changed a lot, the best thing I got out of that experience was quitting smoking.*

Walter attributed stopping smoking to his medical trauma induced by HIV anxiety. Like Lee, he had reflected on and reprioritised what is important in life following his experience of death-related distress. Consequently, he made his own physical health a priority and made a conscious decision to protect his physical well-being - smoking has been widely recognised as a risk factor for developing various health conditions (e.g., Carbone, 1992; Jindal et al., 2000; Trap-Jensen, 1988).

Despite the suffering these four men experienced, positive changes and growth resulting from the lived experience of HIV distress spanned across several dimensions, and the lesson each participant learnt from their experience appeared to be unique. Some discovered a more positive meaning of life through new experiences, whereas others achieved growth relating to the internal process of death-related anxiety and existential trauma. These men made sense of their experience of HIV anxiety in ways that led to positive personal development. On another note, the other three participants who were not captured by this theme also reported positive changes in terms of their views and knowledge associated with HIV risk prevention and treatment, including an increased faith in using condoms, an enhanced knowledge in the existing options for HIV prevention, and a deepen awareness about the accessibility to HIV treatment.

Discussion

Summary and overview of the analysis, and unique contribution to research

The analysis provides an account of four dimensions of Hong Kong Chinese men's lived experience of HIV anxiety and their sense-making processes around this: 1) the impact of the sociocultural context on the manifestation of the men's HIV anxiety; 2) the psychosocial problems that HIV-negative men faced; 3) their coping mechanisms and the nature of support needed to cope with their emotional distress, and 4) the PTG and other positive changes following the psychosocial adversity and existential concerns associated with HIV anxiety. The participants' narratives in this study confirmed the findings of existing research in three areas - the psychological issues and practices of individuals with persistent HIV anxiety (e.g., searching for symptoms, repeated reassurance-seeking, negative self-image, anticipated family's negative reactions) (Logsdail et al., 1991; Lombardo, 2004; Valdiserri, 1986), the negative impact of HIV anxiety on psychosocial functioning (e.g., sleep disturbance and relationship problems) (Glass, 1993; O'Brien, 1987; Valdiserri, 1986), and the psychosocial needs of individuals with HA (e.g., attentive listening and knowledge-based support) (Noyes & Stuart, 2004). Even though there are similarities between findings of the current study and those of past research, one new aspect arose from the participants' narratives – the role of Confucianism on men's perceived social and familial obligations, which shaped their experiences of HIV anxiety. For example, one participant noted, "*It's that your family gave birth to you, and you got into this, so you are sorry for them.*" This quotation demonstrates that he considered any acts that harm his physical health as a disappointment or misdeed to his parents who gave him a healthy body. Therefore, he felt obliged to avoid getting any illnesses. I now further discuss the findings of my participants' beliefs and practices in relation to their HIV-related fear and anticipated stigma, and compare them with prior literature.

The overarching theme “The impact of the socio-cultural environment” comprised of three interconnected themes that highlighted the importance and roles of HIV-related stigma, sexual stigma, discrimination, sex education, and normative moral beliefs and values in the experience of HIV anxiety in a collectivistic Chinese culture. Some participants experienced actual social and familial rejection as a result of the disclosure of different behaviours to others that are stigmatised in the Hong Kong context, whereas other participants experienced anticipated social exclusion and rejection because of their awareness of the general stigma towards HIV-related issues. Both MSM and heterosexual men demonstrated beliefs that were shaped by Chinese culture and Confucianism. Their perception of failing to fulfil filial obligations and family responsibilities resulted in a constant sense of shame, guilt, self-stigmatisation and fear of social exclusion. For MSM, their perceived failure was related to their gay or bisexual identities, whereas for heterosexual men, their perceived violation of a moral standard related to their non-monogamous sexual practices and buying sex. Although the feelings of shame and guilt are emotional responses that exist in the context of HIV in both Western and non-Western societies, in this study, participants’ anxiety was not only centred around the fear of being individually stigmatised, but also on the collectivistic idea of affecting and shaming one’s entire family and other people around them.

To my knowledge, this qualitative study is the first of its kind to examine HIV anxiety and distress among HIV-negative MSM and heterosexual men in the Hong Kong Chinese context. By giving a voice to men of all sexualities, the findings have extended the current understanding of the negative impact of heteronormative and non-LGBTQ-inclusive sex education (e.g., Kwok & Kwok, 2022; Kwok & Lee, 2018) on the wellbeing of Hong Kong Chinese men. Prior studies have showed various negative outcomes of non-LGBT-inclusive/less comprehensive school-based sex education across different countries and regions, such as depression, suicidal ideation and feeling of distress and terror among LGBTQ youth (Currin et al., 2017, 2020; Kwok & Kwok, 2022; Kwok & Lee, 2018; C. G. Taylor et al., 2016). In this study, both MSM and heterosexual men attributed their HIV-related fear and anxiety to restrictive sex education in Hong Kong. As a result of the general public's misconception and lack of understanding of sex/ sexuality-associated issues, HIV at-risk MSM in the present study faced double anticipated stigma - being gay/bisexual and being HIV-positive. In other words, they anticipated social exclusion and isolation not only in the context of heteronormativity, but also from inside the gay community if they tested positive for HIV. For instance, one participant in the current study reported social rejection by his gay friend when he simply self-disclosed having a fear around testing positive for HIV. This finding is consistent with prior literature that has highlighted the existence of HIV-related stigma within gay communities (e.g., Courtenay-Quirk et al., 2006; Smit et al., 2012). Heterosexual men in this study also experienced double anticipated stigma because of the stigma attached to men who buy sex and HIV, but their experience would be within the mainstream social context.

Interestingly, the factors that maintained HIV anxiety were different for MSM and heterosexual men, as they responded to their HIV anxiety differently, as discussed in theme four. This can be understood by considering the differences in relationship contexts and types of social stigma between MSM and heterosexual men who are clients of sex workers. All three heterosexual men in this study engaged in high use of HIV testing services when they were in distress. This pattern contrasted with the findings of research that suggested that heterosexual men, who have high anticipated HIV stigma in the U.S. (Gwadz et al., 2018), South Africa (Treves-Kagan et al., 2017) and Brazil (Catelan et al., 2020) generally struggle with aversion to HIV testing and have reported reluctance in knowing their HIV statuses to avoid experiencing HIV-related stigma. The incongruence between these findings and those of my study is possibly related to Confucian concepts of loyalty and family honour in relation to men. These cultural values are deeply embedded in the Collectivistic culture and have been passed down through several generations within the Chinese community. For instance, one participant, Lee, was concerned about damaging the reputation of his wife's family of origin. Therefore, his reassurance seeking practice may be related to his sense of obligation to protect his family's reputation. This suggests that Chinese heterosexual men who are clients in commercial sex often face social stigma related to disloyalty and infidelity. In other words, the HIV fear of Hong Kong Chinese heterosexual men in the current study was centred around the possibility of violating Confucian family values, which emphasise family harmony, roles and duties (Badanta et al., 2022; Chen, 2001). Being morally "right" as a family member was of vast importance to them. This attitude was shown by two participants who repeatedly mentioned their fear of "affecting" family members, not just in terms of HIV transmission. Even though utilising healthcare service may be associated with vulnerabilities and weaknesses that contradict the traditional masculinity norm in western cultures (Vogel et al., 2011), what is "traditionally masculine" in the Hong Kong context is influenced by the adoption of Confucian values.

For MSM in this study, none of them was engaged in a monogamous long-term relationship at the time they experienced HIV anxiety. Two out of four MSM reported avoiding HIV testing due to their fear of the consequences of testing positive, such as involuntary exposure of their gay identities, which would lead to discrimination and familial rejection. This was consistent with findings of previous studies that have reported that fear is a primary barrier to HIV testing in men (e.g., Adam et al., 2014; de Wit & Adam, 2008; Kellerman et al., 2002). Compared to heterosexual men who were clients of sex workers in this study, MSM paid less attention to others' moral judgment toward infidelity. Instead, their worries were primarily linked to social disapproval of their gay or bisexual identities because of anti-gay stigma.

In fact, disparities in men's health and lifestyles across different cultures have been evidenced and analysed in prior cross-cultural studies (e.g. Rochelle, 2019; Sloan et al., 2010). It has been argued that cultural values affect the construction and meaning of masculinity which in turn is linked to men's health practices. The unique pattern of Hong Kong men's health practices was demonstrated in a qualitative study by Rochelle (2019), in which men appeared to "act upon early sign of illness" (p. 76) despite some reluctance to consult a doctor. Echoing Rochelle's study, the heterosexual men in my study proactively engaged in HIV testing when they noticed signs of suspected HIV symptoms. They also demonstrated a sense of having patriarchal responsibilities toward family and the importance of filial piety that were part of their motivation to seek health-related support. The idea is that they felt obliged to take care of their own health so that they could take better care of their parents and partners. Engagement in health check-ups might have enabled them to comply with their domestic role as a husband/partner and a son. This Chinese cultural perspective helps explain some of my participants' favourable attitudes toward help-seeking rather than help-seeking avoidance. It is noted that the only participant, who was aged 50+, never sought HIV testing or consultation when he experienced HIV anxiety in his 20s because he could not access any relevant information due to the lack of public education at that time. Another possible explanation for heterosexual men’s repeated testing is the lack of knowledge about mental health symptoms. They might have failed to recognise that their physiological responses were anxiety symptoms and believed that they needed medical attention rather than mental health support. Additionally, as discussed in the introduction section of this thesis, the relatively strong stigma towards mental health problems in a collectivistic culture might be a barrier to mental-health help-seeking among Chinese men (Furnham & Chan, 2004; Yu & Mak, 2022). As a result, they rationalised their anxiety by attributing their symptoms to a relatively less stigmatised condition – physical illness.

Examining PTG and other positive changes in these men following experiences of adversity and existential concerns was not an original aim of this study. However, this was something discussed by four participants and it was important to include in the analysis to fully represent their experiences. Although these participants did not get a HIV diagnosis, their experience of HIV anxiety provoked emotions and social challenges followed by various forms of transformation and positive changes. This can be linked to literature on PTG (e.g., Calhoun & Tedeschi, 2006; Tedeschi & Calhoun, 2004). It is interesting that the PTG and positive changes among these men were consistent with existing qualitative literature exploring the impact of living with or surviving HIV or other long-term health conditions (Amos, 2023; Connerty & Knott, 2013; Schwartzberg, 1994). With reference to Hefferon et al.'s (2009) systematic review of qualitative studies on PTG and illnesses, reappraisal of life and restructuring priorities, new awareness and development of self and existential re-evaluation were key themes across fifty-seven published articles. Previous PTG literature on chronic illnesses suggests that the process of PTG is fostered by perceived social support from family, friends and partners (e.g., Feng et al., 2024; Kamen et al., 2016; Schroevers et al., 2010). In contrast, the PTG and positive changes experienced by some participants in this study were associated with their positive connection with healthcare workers. Although some participants reported experiencing a sense of uncertainty around the quality of medical care and feelings a mistrust toward healthcare providers at the time, they later identified some positive incidences where they valued having a private space as an emotional outlet and appreciated the experience of being heard and not judged by healthcare professionals. My participants’ voices show that the benefits of delivering medical or mental health services in a non-confrontational and accepting manner go beyond mental health recovery in the context of HIV anxiety. This supports existing literature that emphasises the significance of positive patient-physician/client-therapist relationships in managing health anxiety symptoms (e.g., Brady & Braz, 2023; Persing et al., 2000).

Reflection on and evaluation of the research

My lived experience relating to physical illnesses and pandemics, such as my observation of how people around me managed their anxiety about the COVID-19 pandemic, enabled the development of my understanding of distinct health concepts in Hong Kong culture. My past experiences in seeking emotional and physical support as a patient played a positive role in driving my curiosity around my participants’ feelings and thoughts. The sense of shame and guilt that I experienced in the family context when I have been ill matched the feelings the participants described and thus, I used my own experiences as an interpretative tool to make sense of implicit meanings in the data.

Although language translation was one of the most challenging parts of this research, the continuous amendments in the word choices, grammatical checking, sentence restructuring and re-listening the audio recordings allowed me to identify subtle differences in meanings. When I encountered translation difficulties, it made me reflect and notice what cultural or language elements existed in the Eastern/Chinese culture that might be absent or present differently in western societies. For instance, there are various ways to express anxiety, a term that is translated as “Jiao Lu”（焦慮）in Chinese where the direct meaning of “Jiao” is anxious and “Lu” means worried. Therefore, in my writing, the words worry and worries are used interchangeably across this research and thesis, including in the interview guide, participants’ extracts, my commentaries and analysis. Additionally, the process of presenting and explaining my perspectives to my white British supervisor helped me to notice the ways in which my eastern lens is culturally normalised and shaped my thinking without me realising this.

Implications for research and practice

The present study adds to the growing body of evidence concerning men’s psychological well-being (e.g., Blazina & Watkins Jr., 1996; Johnson et al., 2007). There are different views about men’s emotional experiences across cultures (e.g., Jansz, 2000; Smith et al., 2018). Some propose that men experience less internalising symptoms (Smith et al., 2018), such as depression and anxiety, and experience less intense fear (Arrindell et al., 1987), in comparison to women. Others believe that the difference in emotionality between men and women lies in their overt actions rather than in the internal feelings (e.g., Fischer, 1993; Johnson & Shulman, 1988). It is argued that men and women may be alike regarding their internal feelings, but due to the disparity in power and status associated with gender-based social roles, they express emotions differently (Madden et al., 2000). Men tend to suppress and conceal vulnerable feelings, whereas women tend to express their depressed and anxious feelings verbally and facially (Madden et al., 2000).

My findings show that Hong Kong Chinese men experience a range of difficult emotions, including fear, shame and guilt, in the context of a feared HIV infection. Drawing on prior literature, Chinese individuals generally disclose distressing feelings to immediate family and close friends, but not to people outside of the family, when facing sensitive issues, such as extra-marital affairs and sex (Ow & Katz, 1999). They learn to keep their distressing feelings and family secret to save their own and their family's face (Ow & Katz, 1999). However, some participants in this study hid these emotions from family and friends because of their fear of familial rejection. They instead expressed their vulnerable emotions to and sought mental comfort from healthcare professionals. These men's strong motivation for help-seeking uncovers issues related to practice.

First, these men's reliance on support from non-family members may reflect a restrictive social support system. Since the stigma around HIV/AIDS is higher than that associated with other chronic illnesses, such as SARS and TB (Mak et al., 2006), seeking emotional support regarding HIV anxiety from family members and friends involves a risk of social exclusion. Thus, employing a collectivistic-based coping strategy is no longer a realistic option for many individuals. The role of mental health practitioners is to explore and understand the underlying meaning of help-seeking. In therapy practice, it may be helpful to know whether the clients' reluctance to rely on family support is a sign of self-imposed isolation or an actual lack of social support as a result of family rejection. This information may help practitioners to open a therapist-client discussions about important aspects related to their HIV anxiety, such as social relationships, anticipated and internalised stigma, feelings of shame, and concerns that are associated with the traditional Confucian-based values, such as filial piety and losing face.

Second, my findings demonstrate that repeated HIV testing and/or medical consultation is not only an indicator of prolonged health worries, but it may be a sign of men's lack of awareness of their mental health status and their inadequate coping skills for managing anxiety. Thus, I call for public health policy makers and service providers to consider integrating a combination of psychological-based support, such as psychoeducation on anxiety symptoms and effective coping skills, into future sexual health strategies for HIV at-risk populations in Hong Kong. Highly anxious individuals may benefit from understanding the connection between anxiety and physiological responses, and subsequently reduce their somatic concerns. To meet the psychological needs of highly anxious men, sexual health specialists and HIV testing workers should advance their own mental health knowledge of and notice health anxiety symptoms so that they can make appropriate referrals to psychotherapy and other mental health support for this population.

Lastly, my study highlights the need to include heterosexual men in educational campaigns focused on the prevention of HIV/AIDS. The feeling of frustration toward conservative sex education among the heterosexual participants in the current study indicated that restrictive sex education in Hong Kong not only caused psychological and social harms to sexually marginalised adolescents in school, but it also had an indirect longer-term negative impact on heterosexual men whose sexual practices are non-traditional or socially unacceptable.

Limitations of the research

First, recruiting Hong Kong participants from diverse backgrounds was challenging due to the time zone difference and the technology required to conduct virtual interviews. Most participants in this study were young and had sufficient knowledge of and access to technology; only one participant was aged over 50. Although a few older men aged over 60 expressed interests in participating this study, their limited access to and knowledge of technology was a barrier to participation. Consequently, this study predominantly captures the experiences of younger men. Furthermore, in Chinese culture, it is very common that unmarried adults live with their parents regardless of their age and financial stability.

Individuals who lived with their parents tended to struggle with finding a private space to meet me virtually. Thus, it is possible that the findings of this study might not reflect or only reflect a fraction of the experience of men who have stronger family ties and support.

Contributions to and implications for counselling psychology

Research on cross-cultural work in counselling psychology (CP) has been substantially less extensive than those of other branches of psychology (Douglas et al., 2016). In the global community of today, cross-cultural issues are an inevitably part of therapeutic work as culture variations may affect the process of psychosocial intervention (Naeem et al., 2019; Rathod et al., 2020). Several scholars have criticised that a majority of treatment outcome research is underpinned by Euro-western values (La Roche & Christopher, 2008; White, 2013). Problems such as clients being misdiagnosed due to the misunderstanding of cultural norms and practices and ineffective psychological treatments for specific populations are evidenced (Douglas et al., 2016; Ishikawa et al., 2019; Kazdin, 2002; Kirmayer, 2012). The failure to consider multicultural perspectives in counselling practice and research is a social justice issue that counselling psychologists should acknowledge and advocate for.

This study explores how traditional Chinese values and sociocultural characteristics of Hong Kong impact and shape Hong Kong Chinese men's thoughts and moral beliefs. This research therefore contributes to the literature on multicultural counselling and training (Fassinger & Richie, 1997), and helps strengthen counselling psychologists' multicultural competence to work with Hong Kong/Chinese men experiencing HIV anxiety and develops their knowledge and awareness of the importance of the individualism-collectivism distinction in relation to mental health. In the application of Western approaches to counselling and psychotherapy on health-anxious Chinese clients, counselling psychologists can incorporate the impact of Confucian beliefs and values on individuals' thoughts and assumptions in case conceptualisation and future intervention for health anxiety. For example, it is important to acknowledge that for Hong Kong Chinese men who are collectivistic, the personal meaning of the lack of family support when encountering morally sensitive issues may be different from that of individuals who are raised and live in cultures that value individualism. It is essential to sensitively integrate various concepts embedded in Confucian teachings (e.g., the notion of filial piety, the sense of obligation in upholding family honour, and the uniquely different meaning of illness in Chinese culture), and to incorporate health education into therapeutic practice, which is reflected in my participants' positive experience from knowledge-based support. My participants' preference in knowledge-based support concurs with the results of multicultural counselling research that proposes that a directive, solution-focused approach in healthcare practices fits the Chinese people's worldviews since Chinese people generally respect authority (e.g., Cheung & Jahn, 2017; Foo et al., 2006)

In fact, there is an increase in literature exploring and reporting implementations of cultural adaptations to psychological interventions (Bernal & Scharrón-del-Río, 2001; Cardemil, 2010; La Roche & Christopher, 2008; Naeem et al., 2019). Culturally adapted intervention is defined as "the systematic modification of an evidence-based treatment or intervention protocol to consider language, beliefs, and culture in context in such as a way that is compatible with the client's cultural patterns, meanings, and values" (Bernal et al., 2009, p. 362). Researchers have explored the effectiveness of culturally adapted CBT (CA-CBT) for anxiety disorders and PTSD in Southeast and East Asian populations (Praptomojati et al., 2024; Young & Yat-nam, 2022). It is evidenced that CA-CBT potentially leads to better treatment outcome than non-adapted CBT (Praptomojati et al., 2024). For example, Lau et al. (2010) has discovered that Hong Kong children and parents responded positively to a CBT programme for childhood anxiety that is modified by including Chinese cultural analogies (e.g., kung fu) to deliver key concepts in psychoeducation. This example illustrates the use of culturally relevant examples and language to enhance the effectiveness of psychological intervention in the Hong Kong context. My participants' subjective experiences can potentially be used as a reference in future development, evaluation and dissemination of culturally adapted psychological treatments for clients from Chinese cultural background or from similar collectivist cultures. Instead of imposing rules outside the client's culture, my participants' voices can be adopted by counselling psychologists as a resource to understand, respect, and validate the client's values, culture and worldviews. As discussed in the literature review, part of the key principles of CBT is to facilitate client to identify and modify negative ways of thinking in relation to their distress. When treating health-anxious Chinese clients, counselling psychologists can educate clients about the impact of the dominant cultural norms in the system on their core beliefs and assumptions in relation to illnesses and well-being. Most importantly, psychologists and client can work collaboratively to explore ways to navigate the system norms.

In terms of the implications for training and professional development for counselling psychologists working in the HIV and sexual health sector, this study suggests the significance of including specialised training in intersectional stigma in continuing professional development. This concurs with the findings of other scholars who call for intersectional training that enhances sexual healthcare providers' understanding of intersectional stigma targeting LGBTQ identities, cisnormativity, and HIV and STIs (Flanders et al., 2022; Logie et al., 2019). With the inclusion of intersectional stigma within research and clinical practice, counselling psychologists are equipped to recognise and affirm the multifaceted nature of individuals' experiences and identities. Additionally, the integration of this specialised training into the broader healthcare system aids counselling psychologists and other practitioners in identifying and advocating inequities in the wider society.

In Hong Kong, CP is a relatively young mental health profession, and the defining role of CP seems to be different from that in the US and the UK, where social justice is emphasised in CP practice (e.g., Douglas et al., 2016; Milton, 2010). According to the Hong Kong Psychological Society (*Division of Counselling Psychology, HKPS*, 2024), CP primarily focuses on therapeutic practice, and there is a lack of emphasis on engaging with human rights-based work. This thesis provides an entry point for Hong Kong practitioners to revisit the long-standing psychosocial impact of HIV and sexual stigma in the Hong Kong context. I call on counselling psychologists in Hong Kong to re-examine their existing role in mental health practice, and to take responsibility for destigmatising HIV-related issues to improve the welfare of members of stigmatised groups, such as MSM, sex workers, and people who inject drugs. Despite the different socio-political cultures and values of the West and Hong Kong, there is room for Hong Kong counselling psychologists to consider adopting the social justice and human rights approach of CP in the US and the UK (Motulsky et al., 2014; Tribe & Charura, 2023) – holding a commitment to participate in collective advocacy efforts in responding to the impact of socio-political oppression on clients’ mental health and in creating social change.

Overall conclusion

In conclusion, my study captures Hong Kong HIV-negative men’s sense making around their lived experience of HIV anxiety. In existing literature, stigma and discrimination is typically related to PLHIV only (e.g., Ho & Goh, 2017; Lee, 2022; Tsarenko & Polonsky, 2011; Turan et al., 2017). The current study shows that HIV-negative men can also experience similar psychosocial challenges and growth as those experienced by PLHIV. The variations in experiences among male participants who share the same ethnic and cultural background highlights the importance to understand how various forms of a person's social identity, such as gender, sexuality, and relationship status, interact and intersect (Collins & Bilge, 2020). For professionals working in multicultural clinical settings, this research offers insight into how Confucian-based collectivistic culture affects people's mental health. Further studies are needed to identify effective forms of cultural adaptation in interventions that may lead to effective treatment outcomes for Hong Kong Chinese men experiencing HIV anxiety.

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Appendix A - Glossary of Acronyms

ACA	Hong Kong Advisory Council on AIDS
AIDS	Acquired Immunodeficiency Syndrome
ATF	The AIDS Trust Fund
BPS	British Psychological Society
CA-CBT	Culturally adapted cognitive behavioural therapy
CBT	Cognitive behavioural therapy
CDC	Centre for Disease Control and Prevention
COVID-19	Coronavirus disease
CP	Counselling Psychology
DH	Department of Health
DSM	Diagnostic and Statistical Manual of Mental Disorders
HA	Health anxiety
HIV	Human Immunodeficiency Syndrome
LGBTQ	Lesbian, gay, bisexual, transgender and queer (or "questioning")
MCFSW	Male clients of female sex workers
MSM	Men who have sex with men
PEP	Post-exposure prophylaxis
PLHIV	People living with HIV
PrEP	Pre-exposure prophylaxis
PTG	Post-traumatic growth
SARS	Severe acute respiratory syndrome
STIs	Sexually transmitted infections
TA	Thematic analysis
TB	Tuberculosis
UNAIDS	The Joint United Nations Programme on HIV/AIDS
U=U	Undetectable = Untransmittable
WHO	World Health Organization

Appendix B - Journal article

(potentially submitting to AIDS Care)

A reflexive thematic analysis of the experience of living with HIV anxiety among Hong Kong HIV-negative men

Abstract

Background: Data from online discussion forums in China and Hong Kong that focus on the fear of HIV show that citizens of China and Hong Kong are sharing and discussing their fears around contracting HIV when there is no medical evidence of HIV infection. User data shows that most active users of these discussion forums are men. This suggests that HIV-anxiety is a significant concern for some (HIV-negative) men in Hong Kong, one that has yet to be addressed in research.

Purpose: To provide insight into the emotional and social lived experience of Hong Kong men with HIV anxiety.

Method: Qualitative interviews were conducted with seven men who experienced HIV anxiety, aged between 23 and 53. Of the seven interview participants, three identified as heterosexual, three identified as gay and one identified as bisexual. Reflexive thematic analysis was used to analyse the data.

Results: Two main themes were developed. The first theme, stigma and discrimination equal "social death", reflects a core struggle consistently expressed by the participants regarding anticipating stigma, prejudice and discrimination if they were infected with HIV. The second theme, moral injury: the role of Confucianism and collectivism, explains the relationship between socially normalised moral values in the Hong Kong context and the men's feelings of shame and guilt.

Conclusion: Participants experienced their HIV anxiety as an anticipated "social death" with a sense of guilt, moral shame, and a profound sense of responsibility for others' welfare. These emotional experiences were influenced by stigma around HIV/AIDS and deeply rooted traditional Chinese cultural values shaped by Confucian beliefs.

Introduction

HIV/AIDS-related stigma and discrimination against people living with HIV (PLHIV) and their families are prevalent in various cultures and countries (e.g. Mo & Ng, 2017; Turan et al., 2017a; Williams et al., 2019). Although a majority of prior literature has researched the impact of stigma on PLHIV (e.g. Genberg et al., 2009; Mak et al., 2006; Mo & Ng, 2017; Placek et al., 2019), it is evident that HIV-related stigma also affects "at-risk" HIV-negative individuals, including men who have sex with men (MSM) and male clients of female sex workers (MCFSW) (Alonzo & Reynolds, 1995).

Across many counties, MSM often face different forms of stigma because of their sexual identities, practices and relationships (Choi et al., 2017; Goldenberg et al., 2018; X. Li et al., 2021). There seems to be a continuous association between HIV/AIDS and homosexuality from the public's perspectives across the world (e.g., Andrade-Rivas & Romero, 2017; Mak et al., 2006; Vincent et al., 2016). As a result of the interplay between anti-gay and HIV/AIDS-related stigma, MSM continue to face prejudice, marginalisation, and various forms of discrimination as well as internalised homophobia (Pachankis et al., 2015; Salomaa & Matsick, 2020). In the Hong Kong context, this is evident through, for example, Hong Kong citizens' attitudes toward the legalisation of same-sex marriage, which serve as a proxy for societal attitudes to homosexuality more broadly (Cheng, 2023). Thus, MSM in Hong Kong are likely to feel marginalized from the general population, leading to poorer mental health (Suen et al., 2016, 2021). Across cultures, HIV negative MSM have a higher prevalence of anxiety and depression compared to the general population (Pan et al., 2018; Parker et al., 2015; Sun et al., 2020; Tomori et al., 2016).

Globally, scholars have addressed that sex work is strongly linked to stigma (e.g. Vanwesenbeeck, 2001) and men who buy sex are often viewed as “pathological” (Brooks-Gordon & Gelsthorpe, 2003; Lau et al., 2007). MCFSW tend to face moral judgment around buying sex as they are perceived as perpetrators and women as victims (Silver et al., 2022; Watson & Vidal, 2011). Also, the non-reproductive nature of paid sex is viewed as a threat to marriage (de Beauvoir, 1997; Nussbaum, 1999). Giusta et al. (2009) argued that the stigma associated with commercial sex centres on reputational losses, which affect social statuses for both clients and sex workers. Kong’s (2016) study revealed that MCFSW in Hong Kong/China believed that there has been a strong moral stigma against them in the wider society; they experience the fear and threat associated with this behaviour because of a cultural expectation of committing to conjugal and family duties. In essence, HIV stigma often intersects with other types of stigmas associated with men’s multiple identities. Its negative influence on the well-being of MSM and MCFSW is addressed below.

Several case studies and practitioners’ reports in Western societies have shown the existence of HIV/AIDS anxiety or phobia and emotional distress among HIV-negative test seekers (Al. Alawi & Al. Senawi, 2015; Joseph et al., 2011). “AIDS anxious” individuals seek help for a wide range of reasons, some may have had unprotected sex or engage in intravenous drug use, others may have experienced low-risk same-sex sexual activities (Bor et al., 1989; Miller et al., 1988). Relationship problems, a past history of mental health issues, transition in individual and family life-cycles, as well as misunderstandings of health education materials have also been found to be related to the fear of AIDS (Bor et al., 1989).

A broad range of presentations among this group are evident - some may be worried about getting infected, whereas others may believe that they have acquired symptoms of HIV/AIDS (Scragg, 1995). Hence, they vary in terms of their insight into the extreme nature of their health concerns (Abramowitz & Braddock, 2011).

There are a high number of Chinese men who are actively engaged in an online community forum - "Fear of HIV Bar" of Baidu Tieba where citizens in China discuss and share information on topics associated with HIV/AIDS (Zhao, 2023) . Zhao reported that among 160,000 active users of this forum, 92.5% were men who discussed their worries surrounding HIV/AIDS as of November 2023. Despite the lack of accessible data from another online community forum – LIHKG in Hong Kong, I have noticed that similar online discussions are shared among Hong Kong Chinese men. This suggests that HIV anxiety is a potentially common form of distress experienced by Chinese men. Exploring the sociocultural difficulties that underpin psychological distress is critical to fully understand the experiences of men who had HIV anxiety. The aim of this study was to explore Hong Kong HIV-negative men's experience of living with HIV anxiety.

Methodology

Design

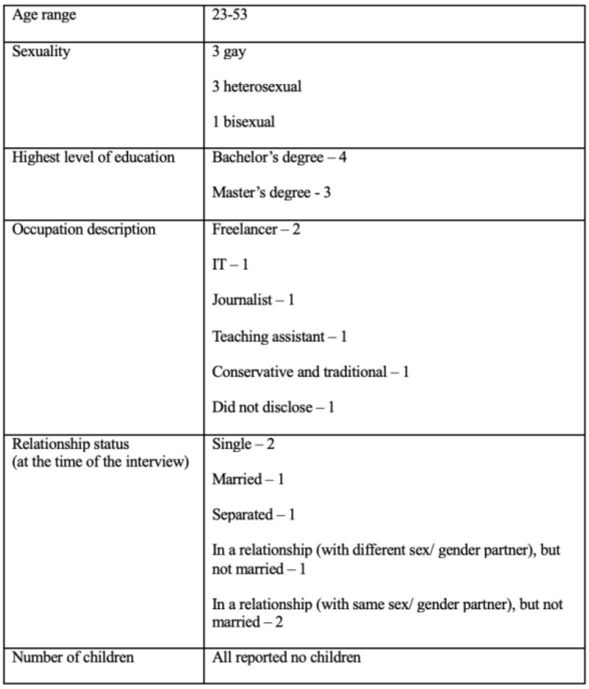
This study used semi-structured interviews with open-ended questions and prompts that allowed me as the interviewer to focus on a predetermined agenda and lead a discussion that encompassed key areas related to the research questions as well as to give participants the chance to raise things that were important to them (Adeoye-Olatunde & Olenik, 2021). Reflexive thematic analysis developed by Braun and Clarke (2022) was used for data analysis.

Participants and recruitment

Participants were recruited through purposive and convenience dataset strategies. Recruitment posters were put up in a community-based HIV testing centre in Hong Kong, where volunteers and staff introduced this study to eligible service users who sought HIV testing and counselling services. Electronic copies of the poster were also disseminated on a community Facebook pages (有種部隊 guts army) managed by the staff of AIDS Concern. Additionally, I promoted the study via my social media networks.

Participants needed to be Cantonese-speaking HIV-negative males aged 18 or above, who had been a Hong Kong resident long enough to understand the culture and had experience of HIV anxiety. During recruitment, the concept of HIV anxiety was presented as "HIV fear or worries" to the potential participants. Men who had previously experienced symptoms of hallucinations or delusions were excluded to ensure the participants' HIV anxiety occurred independently of psychotic symptoms. An overview of the participants' demographics is presented in Table 1.

Table 1 Summary of Participants Demographics



Age range	23-53
Sexuality	3 gay 3 heterosexual 1 bisexual
Highest level of education	Bachelor's degree – 4 Master's degree - 3
Occupation description	Freelancer – 2 IT – 1 Journalist – 1 Teaching assistant – 1 Conservative and traditional – 1 Did not disclose – 1
Relationship status (at the time of the interview)	Single – 2 Married – 1 Separated – 1 In a relationship (with different sex/ gender partner), but not married – 1 In a relationship (with same sex/ gender partner), but not married – 2
Number of children	All reported no children

Interview procedure

Initially, I invited all participants to conduct interviews virtually via Microsoft Teams because of the geographical distance between me and the participants; however, a trip to Hong Kong enabled me to conduct one interview in person. Participants taking part in virtual interviews were given the choice of attending a virtual interview at a private space of their own choice or to use a room and computer provided by AIDS Concern if they have difficulty in finding a private space. One participant participated in a virtual interview at AIDS Concern, six at home, and the in-person interview took place at a sexual health clinic operated by AIDS Concern.

Results

This section provides an outline of two themes generated from the data.

Theme 1: Stigma and discrimination equal "social death"

This theme captures how participants' awareness of stigma and discrimination surrounding HIV and non-traditional sexual identities and/or practices induced their fear of social exclusion and potential losses in life associated with becoming HIV positive. The participants' expected negative outcomes associated with stigma and discrimination were linked to their prior life experiences, their observations of social norms and values in the Hong Kong Chinese context. As a result of an extreme fear of social isolation, they perceived a need to conceal their stigmatised identities.

A fear of being isolated, rejected and disapproved of were conveyed explicitly by different participants. Both MSM and heterosexual participants reported experienced or anticipatory rejection from others, including their parents, current intimate partner, future intimate partners, friends, co-workers, and healthcare professionals. Ben, who is heterosexual, held a strong belief in the potential for social exclusion and social isolation if he were to become HIV positive:

> *if you were infected with HIV, most people would think that you deserve it. There is nothing they can do to help except to discriminate against you, and that's how most people will act. […] I'm just scared that I'll be isolated.*
>
> *that is the problem with social labelling. You will not discriminate against a person suffering from cancer, but you will discriminate against a person with AIDS. […] I'm talking about the majority of people in society, so there is already a huge difference. It is no longer about the disease itself, but it is about social perception.*
>
> *That is not like pneumonia [potentially refers to COVID-19]... which... you can talk about freely, because you know that once you tell them, you will be judged, and they will judge you deep down.*

Through comparing the public's attitudes toward HIV versus cancer and pneumonia, Ben articulated the perspective that the impacts of HIV stigma on one's social status are different compared to those associated other potentially life-threatening physical illnesses. Elsewhere in his interview, he used the term "social death" to summarise his sense of fear. This term evocatively captured the degree of perceived social threat to the self, resulting from stigma and discrimination.

In modern societies, the understanding of social death is multidimensional; it encompasses a wide range of consequences, including financial vulnerability, stigma, and weakened legal support (Ghane et al., 2021). For instance, in health and medicine, social death occurs when chronically-ill and disabled people are neglected by family, and not properly attended to or cared for by medical personnel, and this results in social isolation and a loss of all or part of their social roles (Ghane et al., 2021). This definition of social death echoes Luca's lived experiences of multiple losses when his gay identity and same-gender sexual activities were discovered by his family. In the following two extracts, Luca recalled losing his kinship and social support system after disclosing his HIV risk to his family and a friend:

> *After my family had known about it [his same-gender sexual practices and his hospitalisation for HIV testing at the age of 16], I felt like the sky was going to fall. I mean… my family didn't support me because they had never thought that I'm gay and I had never thought that they…I remember their exact wordings at that time were awful. They were like… "You're disgusting and very dirty." And something like… "you're a monster!", and "I don't want to see you, I'd prefer not have given birth to you." That means… on top of that, my family's…I mean their…attitude was a blaming attitude. That made me felt like there was no one that could support me in this world. I had to face this fear and anxiety on my own. So… I had suicidal thoughts.*
>
> *I told a very good friend of mind about it [his fear and risk of HIV infection]. He was my classmate, and because he's also gay so I trusted him and told him about that incident. I then heard from another friend of mine that he had said bad things about me behind my back. He said something like: "He got me involved. What's the point of telling me this?". Something along those lines. I felt like there was nothing worth yearning for in this life. Even the friend whom I trusted the most for years betrayed me like this.*

The negative judgment and victim-blaming from Luca's family were evidence of prejudice, discrimination and sexual stigma towards MSM through a heteronormative lens. Using terms like "dirty", "disgusting" and "monster" to devalue Luca constituted an extreme rejection and verbal violence that contributed to Luca's sense of loneliness and helplessness. His experience of his gay friend's rejection illustrated the negative attitudes towards PLHIV within the gay community. These extracts indicated that Luca experienced intersectional stigma because of his multiple stigmatised identities (being a gay man who engaged in casual sex and was at risk of HIV infection).

The other two MSM participants, Cruella and Bill, who did not disclose their sexual identity, sexual experiences and/or HIV risk to others, also experienced anticipatory losses in kinship and family acceptance. They predicted that their family would react to their gay identity or HIV positive status negatively:

> *Cruella: I think my family is indeed against this kind of thing [same-gender sexual acts] […] And I reckon he [Cruella's dad] is a bit traditional, he's a bit… how to say that? A bit feudal, a bit traditional and a bit feudal. So I would think if he knows about it one day, he would…how to say it? He may no longer have any connection with me, that means he may pretend to have lost a son. I believe he… I believe he can do such a thing.*

> *Bill: she [Bill's mother] is a catholic and she's quite…she goes to church and is quite devoted. I think her stand on this matter [being gay or HIV positive] is… I actually think the likelihood of not accepting this is very high*.

Participants' assumption of family rejection was primarily based on their prior experiences, observations of others' lived experiences and their perceptions of the personal, cultural and religious values of their family members. It is worth noting that most participants expressed more concerns about family exclusion and parental rejection over other forms of exclusion. This phenomenon adheres to cross-cultural literature that proposed that individuals in collectivist cultures prioritise family, interdependence, cohesion and obligations to meet parents' needs over individual needs (Burholt et al., 2018; Schwartz et al., 2010). Considering this sociocultural context, the impact of the loss of family connection is likely to be more detrimental compared to this loss in individualistic culture.

In sum, this theme sheds lights on the social harms of HIV-related stigma and HIV-negative men's psychological processes around anticipating the loss of a normative life, family connection, social status and a privileged identity. These anticipated losses and changes in life mirrored the struggle reported by PLHIV in other literature.

Theme 2: Moral injury: The role of Confucianism and collectivism

This theme addresses participants' self-stigmatisation, and their feelings of shame and guilt that arose from actions or choices that were in conflict with their internalised culturally-shaped moral obligation and societal norms. They rationalised their sense of responsibility in relation to their social roles within and outside of the family. Four participants mentioned that one of their concerns was the possibility of "affecting" others. The word "affecting" potentially comprised a range of things in the wider social context that went beyond personal health outcomes. The participants' extreme sense of responsibility towards others can be understood as the result of Chinese cultural values shaped by early Confucian beliefs (e.g., filial piety, loss of face and familial obligation), which are a set of deep-rooted philosophical and social ideas offered by an ancient Chinese philosopher called Confucius (Allinson, 1989; Ni, 1999; Slingerland, 2003; M. Wang et al., 2008).

Participants assumed that certain moral rules are naturally learned and shared among the majority in the society. The following quotations showed that they believed that the majority of the general population are ethical and righteous. With this belief, they expected their sexual practice would be judged:

> *Cruella: Doing these tests are usually related to sex. Right, this involves ethics and moral issues. I was scared that some doctors might judge you.*
>
> *Lee: You normally…of course…huh… I'm not standing on the moral high ground to say this. Of course, we would normally say these things [buying sex and similar behaviours] are bad.*

Cruella and Lee indicated that the roots of their anxiety and fear were the moral values and principles that were deeply ingrained in people's minds in the Hong Kong socio-cultural context. In Lee's quotation, the phrase "standing on the moral high ground" is a popular saying that Hongkongers use to describe individuals who have a stronger ethical and moral standard than others judging other individuals' acts that are perceived as morally questionable or socially unacceptable. It is interesting that Lee claimed that he was not seeing through the lens of a strong moral character to acknowledge that buying sex is unquestionably viewed as "bad" in the Hong Kong socio-cultural context. In other words, he had internalised the normative stigma against commercial sex. Apart from buying sex, Andy addressed heteronormative perspectives on same-gender sexual practice:

> *Andy: Because they are the majority, they would think this thing of yours [same-gender sexual practices] does not fit the existing standard, that means the existing framework. That's why they would think that you guys [gay men] engage in the same behaviour and you all have the same risk of infection. You guys are wrong.*

In these extracts from Lee and Andy's interviews, words such as "normally", "usually", "wrong" and "bad" reflect the way these participants assumed that people in society hold absolute moral beliefs about particular sexual practices and relationships. They believed that their sexual practices and personal choices would be judged as immoral based on the culturally conferred moral framework.

Three participants reported having a fear of transmitting HIV to others. Even though they were fully informed that HIV could not be passed on to others through social contact, they avoided physical contact with their significant others when they believed that they had already been infected. The following extracts from Andy's and Luca's interviews illustrate their extreme sense of responsibility for the welfare of others:

> *Andy: I was very scared of infecting others. Now, I'd proactively use serving chopsticks, that means I picked the food and separated it. I'd squeeze the toothpaste onto my hand first, then use the toothbrush to pick up the toothpaste and brush my teeth in this way. I'd be very scared of affecting others.*
>
> *Luca: During that period, I dared not to go swimming because I wasn't sure if I had wounds or something like that. I was also scared that I would infect others in the pool.*

Andy's and Luca's exceptional efforts in protecting others' welfare reflected their intense fear of breaching acceptable moral standards. I perceive that their obsession in eliminating any chance of HIV transmission was not only a harm reduction strategy, but it was a way of managing feelings of guilt and shame in relation to societal pressure to maintain a good moral character. This is in line with research in Western societies (Hamann et al., 2017), where PLHIV report having a sense of guilt even when they practised safer sex. Similarly, Walter reported moral motivations in physically distancing himself from his girlfriend when he suspected that he was HIV-positive:

> *You were afraid that you would transmit something to her if you have got it […] the reason behind the fear was because of the fear of affecting her.*

> *So if my status is single, like how I'm now. I won't have any problem, I can relax. Because you… because she's your other half. Then, you've to take a sense of responsibility for her. You…you can't ignore it like this, as in do whatever. That is…huh.. you would have a bit of… a little caution of your own situation. Because it's very simple, like…if you get Wuhan pneumonia [COVID], you won't sleep next to her.*

These quotations not only show Walter's reasonable concern for the well-being of his partner but also illustrates pressure to uphold moral obligations by ensuring his partner's well-being. Within the Confucian view of nature and health, being healthy is one of the mortal virtues and illness has been considered as an outcome of personal actions (Arthur & Mair, 2017; Bray, 1999). This may explain the reason why Walter used the normative response of Hongkongers in the face of another life-threatening illness - coronavirus disease (COVID-19) - as a reference to rationalise how he should act in response to the risk of HIV transmission. Scholars and authors have emphasised the influence of traditional Chinese Confucian ethics in the COVID-19 pandemic (Escobar, 2020; J. S. Rošker, 2021). They argued that a high degree of cooperation, obedience and collectivism played an important role in controlling the pandemic in China and East Asian societies (Escobar, 2020; J. S. Rošker, 2021). In traditional Confucianism, upholding moral standards, maintaining social harmony and compliance to social rules are the basic principles and primary concerns in society (Kazarian

& Evans, 2001). Therefore, I believe that Chinese philosophical ethics played a crucial role in driving Walter to put such moral theories into action due to his anticipated feelings of moral failure and guilt if he infected his partner or significant others.

In line with this conceptualisation of health as a moral virtue in a collectivist culture, the consequences of illness are often evaluated based on the impact of the illness or physical conditions on the macro-level group and social systems (Kazarian & Evans, 2001; Sazarian & Evans, 2001). Confucian values and norms place emphasis on family and community over individual interest (Inoguchi & Shin, 2009). This idea was revealed in Andy's and Walter's quotations, in which the word "affecting" implied a broader impact than HIV transmission alone. Three participants – Cruella, Luca and Lee - expressed concerns about the shame they would bring to their family if they were HIV positive and their sense of guilt associated with this:

> *Cruella: I think my family is conservative and traditional, from their viewpoints, sex before marriage should not be acceptable. So you…they may think I'm a very disgraceful…very disgraceful descendant.*
>
> *Lee: If I die because of this, even if your wife doesn't leave you or so, her family or her dad or her family will carry the stigma. 'Wow! Your husband has died of HIV!' [Lee's expectation of others' reactions towards his wife] I have thought about how she could face others' stigmatised views in the future.*
>
> *Luca: I felt sorry…I felt guilty so I cried. I felt sorry for my family, I did such a shameful thing.*

These are examples of the deeply ingrained valuing of familial and intergenerational relationships that is rooted in a Confucian-based collectivistic culture (Kwan, 2009; Ng, 2019). The moral teaching of Confucianism emphasises the importance of maintaining harmony with others, respect for parents as well as loyalty to one's family (Badanta et al., 2022; Y. Chen, 2001). Filial piety "xiao" (孝), which is central to Confucian family values, is the sense of obligation to parents and the need to fulfil their beliefs and will. The virtue of filial piety is the respect and support of the children for their parents (Allinson, 1989; Y. Chen, 2001; Dong & Xu, 2016). In an ancient Confucian text, one of the direct quotations is: "The body, hair and skin, all have been received from the parents, and no one doesn't dare damage them – this is the beginning of xiao." (Zeng, 2008, p. 2) Studies related to Eastern religions, death and health have suggested that this traditional value has affected Chinese people's health behaviours, attitudes, and medical decisions (Badanta et al., 2022). Damage to the physical body after death could be perceived as disrespectful and disloyal to parents and as a desecration of the ancestors. Also, mental health problems are considered to be the consequences of a lack of self-discipline and personal weakness (Huang & Charter, 1996). With reference to the traditional concept of xiao, protecting one's physical health is considered as a filial duty of offspring within the Chinese family system. This idea was shown in Walter's thoughts:

> *Looking back, I reckon I was out of the line. It's that… there's a sense of guilt, a self-reflection on my thoughts. Secondly, I very much value my family. It's that your family gave birth to you, and you got into this, so you are sorry for them.*
>
> *I reckoned they would blame you and thought… What have you done and brought back [to the family]?*

For Walter, failure to fulfil filial duty and social obligations induced a sense of guilt and shame, which can be understood in relation to literature on Chinese concepts of shame, morality and loss of “face” (in Cantonese: 冇面) (Hu, 1944; Hwang, 2012). According to Hu (1944), the concept of “face” has two sets of criteria. The first set refers to the prestige of one’s success in achieving social reputation, dignity and honour in Chinese culture. The second set is the respect received as a group for an individual who acquires a good moral reputation. The greater the sense of shame, the stronger the feeling of the loss of “face” (Bedford, 2004). It highlights the difference between Western and Eastern culture in terms of the meaning of losing one’s physical health. In accordance with other cross-culture research findings, Chinese people are more self-consciously moral on an interpersonal level as compared to people from an individualistic cultural background (Chang & Chen, 2017). In general, failure to live up to the responsibilities and expectations of one’s social role in Chinese society results in the loss of face, which leads to feelings of guilt, shame and low self-esteem (Bedford, 2004; D. Y.-F. Ho et al., 2004). These emotions were evident in my participants’ self-critical voices and self-judgment about their own past actions across the interview data:

> *Andy: Why was I so careless? Why did I do this when I clearly…since I…I would think why…you could have prevented it, and you didn’t prevent…perhaps you could have bought those medicine, but it might cost a few thousands. Why…I think I was fucking stupid.*
>
> *Walter: I questioned if I was being too slutty, I just thought that I…should I actually…just have one partner? It’s just … I seemed to be way out of line.*

> *Lee: Even if she [Lee's wife] decides to leave me, I reckon it's something that I bring it on myself.*

These participants demonstrated profound self-stigmatisation resulted from their stringent moral beliefs. During the interviews, none of the participants questioned their negative views of themselves. Most participants seemed to be focused on the thought that their actions and/or decisions were morally "wrong" from an objective standpoint, and they struggled to let go of their fears around causing interpersonal and physical harm to others. From my viewpoint, their extreme sense of responsibility for others' welfare can be attributed to culturally normalised moral obligations. I believe there exists a culturally constructed moral injury that influenced the way my participants perceived themselves in terms of health and sexual practice.

Discussion

Findings

These two themes highlighted the importance and roles of HIV-related stigma, sexual stigma, discrimination, and normative moral beliefs and values in the experience of HIV anxiety in a collectivistic Chinese culture. Some participants experienced actual social and familial rejection as a result of the disclosure of different behaviours to others that are stigmatised in the Hong Kong context, whereas other participants experienced anticipated social exclusion and rejection because of their awareness of the general stigma towards HIV-related issues. Both MSM and heterosexual men demonstrated beliefs that were shaped by Chinese culture and Confucianism. Their perception of failing to fulfil filial obligations and family responsibilities resulted in a constant sense of shame, guilt, self-stigmatisation and fear of social exclusion. For MSM, their perceived failure was related to their gay or bisexual identities, whereas for heterosexual men, their perceived violation of a moral standard related to their non-monogamous sexual practices and buying sex. Although the feelings of shame and guilt are emotional responses that exist in the context of HIV in both Western and non-Western societies, in this study, participants' anxiety was not only centred around the fear of being individually stigmatised, but also on the collectivistic idea of affecting and shaming one's entire family and other people around them.

Contribution to research

To my knowledge, this qualitative study is the first of its kind to examine HIV anxiety and distress among HIV-negative MSM and heterosexual men in the Hong Kong Chinese context. Prior studies shown various negative outcomes of HIV-related stigma on the wellbeing of PLHIV, HIV prevention and treatment outcomes (e.g., Barstow, 2019; Chong et al., 2017; Kerr et al., 2024; Lau et al., 2024; Neves & Davies, 2023; Rzeszutek et al., 2021). By giving a voice to HIV-negative men of all sexualities, the findings have extended the current understanding of the negative impact of HIV-related stigma on mental health of uninfected men. These findings also add to the growing body of evidence concerning men's psychological well-being (e.g., Blazina & Watkins Jr., 1996; Johnson et al., 2007). In contrast to some literature that suggests that Chinese individuals generally disclose distressing feelings to immediate family and close friends, but not to people outside of the family, when facing sensitive issues, such as extra-marital affairs and sex (Ow & Katz, 1999). They learn to keep their distressing feelings and family secret to save their own and their family's face (Ow & Katz, 1999). However, some participants in this study hid these emotions from family and friends because of their fear of familial rejection. This calls for further research on how Chinese people cope with anxiety relating to HIV and moral issues.

Implication for practice

Several scholars have criticised that a majority of treatment outcome research is underpinned by Euro-western values (La Roche & Christopher, 2008; White, 2013). Problems such as clients being misdiagnosed due to the misunderstanding of cultural norms and practices and ineffective psychological treatments for specific populations are evidenced (Douglas et al., 2016; Ishikawa et al., 2019; Kazdin, 2002; Kirmayer, 2012). This study explores how traditional Chinese values and sociocultural characteristics of Hong Kong impact and shape Hong Kong Chinese men's thoughts and moral beliefs. This research therefore contributes to the literature on multicultural counselling and training (Fassinger & Richie, 1997), and helps strengthen counsellors' and psychologists' multicultural competence to work with Hong Kong/Chinese men experiencing HIV anxiety and develops their knowledge and awareness of the importance of the individualism-collectivism distinction in relation to mental health.

In the application of Western approaches to counselling and psychotherapy on health-anxious Chinese clients, counselling psychologists can incorporate the impact of Confucian beliefs and values on individuals' thoughts and assumptions in case conceptualisation and future intervention for health anxiety. For example, it is important to acknowledge that for Hong Kong Chinese men who are collectivistic, the personal meaning of the lack of family support when encountering morally sensitive issues may be different from that of individuals who are raised and live in cultures that value individualism. It is essential to sensitively integrate various concepts embedded in Confucian teachings (e.g., the notion of filial piety, the sense of obligation in upholding family honour, and the uniquely different meaning of illness in Chinese culture) into therapeutic practice.

Limitation of research

First, recruiting Hong Kong participants from diverse backgrounds was challenging due to the time zone difference and the technology required to conduct virtual interviews. Most participants in this study were young and had sufficient knowledge of and access to technology; only one participant was aged over 50. Although a few older men expressed interests in participating this study, their limited access to and knowledge of technology was a barrier to participation. Consequently, this study predominantly captures the experiences of younger men. Furthermore, in Chinese culture, it is very common that unmarried adults live with their parents regardless of their age and financial stability. Individuals who lived with their parents tended to struggle with finding a private space to meet me virtually. Thus, it is possible that the findings of this study might not reflect or only reflect a fraction of the experience of men who have stronger family ties and support.

Conclusion

In conclusion, my study captures Hong Kong HIV-negative men's sense making around their lived experience of HIV anxiety. In existing literature, stigma and discrimination is typically related to PLHIV only (e.g., B. M. W. Lee, 2022; Tsarenko & Polonsky, 2011; Turan et al., 2017a). The current study shows that HIV-negative men can also experience similar psychosocial challenges as those experienced by PLHIV. The variations in experiences among male participants who share the same ethnic and cultural background highlights the importance to understand how various forms of a person's social identity, such as gender, sexuality, and relationship status, interact and intersect (Collins & Bilge, 2020). For professionals working in multicultural clinical settings, this research offers insight into how Confucian-based collectivistic culture affects people's mental health. Further studies are needed to identify effective forms of cultural adaptation in interventions that may lead to effective treatment outcomes for Hong Kong Chinese men experiencing HIV anxiety.

Appendix C - Interview Guide in Chinese (Cantonese)

1. 你可唔可以講吓你第一次擔心感染HIV嘅經歷？
    - 果陣嘅擔心對你有咩影響？影響邊方面最多？例如伴侶關係/ 工作/社交？
    - 你仲有無呢種擔心？而家嘅經驗係點？
    - 當你想到自己感染HIV嘅時候，腦海出現d咩想法或畫面？
2. 同呢種擔心/恐懼共存嘅經歷係點？
    - 同其他嚴重嘅病/性病比較，呢種擔心有無唔同？
    - 你會點理解呢種恐懼？
3. 當你擔心嘅時候，有無一d想法係關於你自己/關於呢個世界？點看你自己？
    - 你覺得呢d想法o係邊度黎？
    - 如果回想當時，你願意/希望點看自己？
    - 你而家對自己嘅看法有無咩唔同？
4. 你覺得你d朋友/屋企人/同事點看HIV感染者？有無同他們傾過呢個話題？
    - 你覺得果d信念/想法o係邊度黎？
    - 你有幾同意/唔同意？
5. 你有無做過HIV測試/諮詢？個經驗係點？
    - 每次做完得到肯定後，你覺得點？你覺得negative嘅結果對你黎講係咩意思？
    - 當你重複做測試後，你嘅想法有無改變？
6. 你覺得如果你無經歷過HIV嘅擔心/恐懼，你而家嘅生活會有咩唔同？
7. 就住擔心HIV呢個話題， 有無其他我地無傾到嘅嘢你想同我share？

Appendix D - Interview Guide (English)

1. Can you tell me about when you first experienced fear of contracting HIV?

   Possible prompts/ follow-up questions:

   - How did the worry affect you at that time?
   - If you are still experiencing the anxiety, how is the experience now?
   - What was in your mind when you thought about contracting HIV?

2. What was/is it like to live with this fear or worry?

   Possible prompts/ follow-up questions:

   - Compared to other serious health or sexual health illnesses, how is this worry different or not?
   - How do you make sense of this fear?

3. How did/does your fear of HIV infection affect your life?

   Possible prompts/ follow-up questions:

   - Which aspect would be affected most? Relationships? Work? Childrearing?
   - How did/does it matter to the people around you? Who did/does it matter most?

4. How do you think your friends/colleagues/family view people living with HIV? Is this something that has ever come up in conversation with them?

   Possible prompts/ follow-up questions:

   - Where do you think their beliefs come from?
   - To what extent do you agree or disagree with their views?
   - If your friends/colleagues/family know that you are at risk of HIV infection, how would they react?

5. When you were/are worried about being infected with HIV, how did/do you view yourself?

   Possible prompts/ follow-up questions:

   - Where do you think these beliefs about yourself came from?
   - Would you like to view yourself differently at that time? Please explain.
   - How do you view yourself now?

6. If you have experience of HIV testing or an HIV medication consultation, what was your experience like?
   Possible prompts:

   - As you reported having done __ HIV tests / medication consultation within ___ days/ months, can you tell me what was it like after each reassurance?
   - How did your thoughts or feelings change as you did more HIV tests / consultations?
   - What did the repeated negative results or repeated reassurance mean to you?

7. Is there anything else that you would like to share with me?

Appendix E - Participant Recruitment Poster (Chinese)

男性參與者招募
對 HIV 恐懼的
研究

如果您對 HIV 感染感到恐懼/擔心並且目前 HIV 陰性，您可能有資格參加一項研究性研究

香港男性怎樣經驗
對感染愛滋病病毒(HIV)的恐懼

這項研究旨在深入了解不同因素（例如香港文化、工作壓力、家庭和人際關係）如何與男性對 HIV 感染的恐懼和擔憂相互作用。 這將通過傾聽您的看法、想法、感受和經驗來完成。

您將被要求參加在線訪問，並根據您擔心 HIV 感染的經歷回答一些問題。

您將獲得時間和交通費的補償。

如果您有興趣參與，您可以掃描二維碼，點擊下面的網址，或給研究人員發送電子郵件。

https://uwe.eu.qualtrics.com/jfe/form/SV_3UUiFGhyxusOtW6

日期和時間

- 彈性
- 60-90 分鐘 (單次面談)

地點

- 網上進行 (使用 MS Teams)
- 選擇任何保密和私密的空間
- 您可在 關懷愛滋預訂房間

您符合資格嗎？

- 會說廣東話的男性
- 18 歲或以上
- 現時不是愛滋病感染者
- 曾經歷過對愛滋病病毒的恐懼
- 已在香港居住足夠長的時間了解和談論當地文化
- 沒有幻覺和/或妄想的經歷（將由研究人員在 MS Teams 進行篩選）

聯繫以獲取更多資訊：

- 易善妍小姐 (Janet) (輔導心理學博士生)
- Sin2.Yick@live.uwe.ac.uk

UWE Bristol University of the West of England

Appendix F - Participant Information Sheet & Consent Form in Chinese

参加者須知

研究項目：香港男性怎樣經驗對感染愛滋病病毒(HIV)的恐懼

誰是研究員？

感謝您有興趣參加我的研究。 我是易善妍(Janet)，英國布里斯托爾西英格蘭大學(UWE) 輔導心理學專業博士課程的實習生。 在修讀研究生課程之前，我在關懷愛滋擔任了 5 年輔導員 ，專門為異性戀男性和男男性行為者提供 HIV 快速檢測、心理輔導和性健康諮詢（例如使用 PrEP 和 PEP）。 這些經驗讓我更意識到，我需要為對感染 HIV 有恐懼和焦慮的男性提供心理健康的支援。我現在為我的博士論文進行這項研究，這項研究由 Victoria Clarke 博士監督（她的聯繫方式見下文）。 你可以在 UWE staff profile 閱讀更多關於她的研究。

研究的目的是什麼？

這項研究旨在深入了解男性對感染 HIV 感到恐懼或擔心的情況。 這將透過聆聽閣下的看法、想法、感受和經驗來完成。 我有興趣了解香港文化、工作壓力、家庭和人際關係等不同因素如何與 HIV 焦慮的經驗相互作用。

誰可以參加？

若您是 18 歲或以上的男性，能用廣東話溝通的非愛滋病感染者，並曾有過擔心感染愛滋病病毒的經歷。歡迎順性別和跨性別男性以及所有性取向的男性參加。 然而，出現幻覺（即聽、看、聞、嘗或感覺看似真實但只存在於您的腦海中的事物）或妄想（即對不真實的事物有不可動搖的信念）症狀的男性將被排除在參與之外。這是為了確保他們對 HIV 感染的恐懼或擔憂與他們的精神病症狀無關。

參與者需要做什麼？

若您決定參與這項研究，我將會與您安排一次以 Microsoft Teams 形式進行的簡短會面，您可以藉此機會就您的參與提出任何問題，其後我亦會進行簡短篩選以確保您是否合適參與。 如果您符合入選標準，我會為您安排日期和時間在 Microsoft Teams 上進行一次性個人在線面談。此次面談需時大約 60-90 分鐘，並將進行錄音以幫助分析。 在採訪中，我會根據您擔心感染愛滋病病毒的經歷，向您提出一系列問題。 您將能夠深入談論任何您認為相關和重要的事情。 您有權隨時停止受訪，並有權不回答任何問題，及不需作任何解釋。

為答謝您參與本研究所花耗的時間，您將在完成訪問後獲得港幣 100 元或 10 英鎊的電子代金券以及 港幣 50 元或 5 英鎊的交通津貼。

數據將如何使用和存儲？

您提供的所有資料將被保密。 您的受訪錄音將僅用於分析，不會用於任何其他目的。 您的受訪錄音將被輸入到採訪記錄中，任何可以識別您的信息（例如人名和地名）都將在記錄中被刪除或更改，您的受訪記錄將會被用於我的研究項目並作出分析。在知情同意書中，您可以選擇是否允許專業翻譯人員翻譯您的訪問錄音。 如果您選擇不同意允許翻譯員使用它，我將是唯一可以使用錄音的人。 您採訪的摘錄可能會包含在我的論文以及研究產生的出版物或演示文稿中。 個人身份信息將與其他數據分開存儲。

所有參與者對“關於你的問題”的回答將匯總在一個表格中，該表格將在我的論文以及該研究產生的任何出版物和演示文稿中報告。 由於我在英國大學讀書，所以面談內容和“關於你的問題”答案都會從中文翻譯成英文，我或者專業的翻譯人員都會轉錄數據。 如果我使用專業翻譯，他們將被要求簽署保密協議。

數據將根據 2018 年數據保護法和通用數據保護條例的要求進行處理和存儲。 該研究在 Qualtrics 在線調查平台上進行，只有我可以獲得 Qualtrics 上的數據； 我的督導將可以獲得匿名翻譯的訪問抄本和總結參與者特徵的表格（外部考官也可能要求獲得訪問抄本，但這種情況很少見）。 數據收集完成後，數據將從 Qualtrics 下載和刪除，並存儲在 UWE 安全的 OneDrive 雲存儲系統中，並使用 OneDrive 系統與我的督導共享。 訪問抄本也將以這種方式與我的督導共享。 任何硬複本都將被安全地存儲（例如在上鎖

的櫥櫃中)。 論文提交後，您的聯繫資料將被銷毀。這些數據將保存到報告我的研究結果的最終學術期刊文章發表後 6 個月，最長保存 7 年。

面談結束後，我可以退出研究嗎？

參與此研究純屬出於自願性質，如您選擇退出將不會受到懲罰，若您決定停止參與，您毋需給予任何理由。 如果您決定退出研究，請通過電子郵件與我聯繫：Sin2.Yick@live.uwe.ac.uk，並引用您在完成研究之前將被要求創建的專屬參與者代碼。 請注意，在某些情況下將無法退出研究，例如，若我已提交論文。 因此，如果您希望撤回您的數據，我強烈建議您在參與後一個月內與我聯繫。

參加這項研究有什麼利益？

您將有機會幫助社會大眾理解和明白經歷 HIV 焦慮人士的親身經歷，亦將有助於研究人員和其他心理健康專業人士能更完善地為與您有相似經歷的人士提供相對有效的服務。我亦希望能提高大眾對未感染愛滋病病毒的男性的關注，因為很多時候，他們的需求往往被忽視。

作為一名在 HIV 領域擁有豐富經驗的實習輔導心理學家和從業者，我能夠應對與 HIV 相關的問題。 如果在面談期間或面談後出現任何與心理健康有關的問題，我可以提供建議或幫助，例如為有需要人士提供適當的轉介。

有沒有潛在的風險？

面談過程可能會讓你想起過去經歷過的不安或痛苦的情緒和想法。 因此，我提供了不同的資源供您在香港使用 (您可以在此參加者須知的底部下載此資料*)。 如果您或研究人員有任何潛在風險，面談可能隨時終止。

誰審批本研究之學術倫理？

該項目已獲得西英格蘭大學健康與應用科學學院研究倫理委員會參考編號 [HAS.22.07.141]的審查和批准。 有關本研究的道德行為的任何評論、問題或投訴可發送至：Researchethics@uwe.ac.uk

如何參與？

若您決定成為本研究的參與者，**請仔細閱讀並填寫下一頁的同意書及問題**，並留下您的聯繫方式，以便我與您聯繫以安排初次會面，然後，如果您符合條件參加，將安排面試。

若您對這項研究有任何疑問或需要任何進一步的信息，請電郵致 (Sin2.Yick@live.uwe.ac.uk) 聯繫我或我的研究督導老師：

研究督導老師姓名： Dr. Victoria Clarke
電郵: Victoria.Clarke@uwe.ac.uk
地址: Department of Social Sciences, Faculty of Health and Applied Sciences, University of the West of England, Frenchay Campus, Coldharbour Lane, Bristol BS16 1QY

感謝您抽出寶貴時間閱讀本參加者須知並考慮參與研究。 您可保留此文件。

Appendix G - Participant Information Sheet in English

Research Project:

How Hong Kong men experience fear of HIV infection

Who is the researcher?

Thank you for showing interest in my research. My name is Sin Yin Yick (Janet) and I am a trainee on the Professional Doctorate programme in Counselling Psychology, at the University of West of England (UWE), Bristol, in the United Kingdom. Before starting this postgraduate study, I had worked in AIDS Concern for 5 years as a counsellor providing HIV rapid testing, counselling, and sexual health consultation (e.g. the use of PrEP and PEP) for heterosexual men and men who have sex with men. I have become increasingly aware of the need of mental health support for men who experience fear and anxiety about HIV infection. I'm completing this research for my thesis and this research is supervised by Dr. Victoria Clarke (see below for her contact details). You can read more about her research on her UWE staff profile.

What is the purpose of the research?

This research seeks to gain an in-depth understanding of what it is like for men to have experienced fear of or worry about HIV infection. This will be done through listening to your perceptions, thoughts, feelings and experiences. I am interested in understanding how different factors, such as Hong Kong culture, work stress, family and interpersonal relationships, interact with the experience of HIV anxiety.

Who can participate?

Cantonese-speaking HIV-negative males aged 18 or above who have experienced worry about being infected with HIV. Both cisgender and transgender men are welcome to participate, as are men of all sexualities. However, men who have experienced symptoms of hallucinations (i.e. hearing, seeing, smelling, tasting or feeling things that appear to be real but only exist in your mind) or delusions (i.e. having an unshakeable belief in something untrue) will be excluded from participating in the research. This ensures that their fear or worry about HIV infection is not associated with psychotic symptoms.

What do participants have to do?

If you decide to participate, I will contact you to arrange a brief meeting on Microsoft Teams in which you will have the opportunity to ask any questions regarding your participation and I will perform a brief screening to ensure the suitability of your participation. If you meet the inclusion criteria, I will then schedule a date and time for a one-off individual online interview on Microsoft Teams. This interview should last roughly 60-90 mins and it will be audio recorded to aid analysis. During the interview, I will ask you a series of questions based

on your experiences of worrying about HIV infection. You will be able to talk in-depth about whatever you think is relevant and important. You have the right to stop the interview at any time, along with the right to not answer any questions, without giving any explanation.
As a thank you for your time, you will receive a HKD100 or a £10 e-voucher along with a HKD50 or £5 travel allowance upon completion of the interview.

How will the data be used and stored?
All the information that you give will be kept confidential. The audio recording of your interview will be used only for analysis and will not be used for any other purpose. The audio recording of your interview will be typed up into an interview transcript and any information (such as people's names and place names) that can identify you will be removed or changed in the transcript, and your interview transcript will be analysed for my research project. In the informed consent form, you can choose to allow a professional translator to access the audio recording or not. If you choose not to consent to allow a translator to access it, I will be the only one who have access to the audio recording. Extracts from your interview may be included in my thesis and in publications or presentations arising from the research. Personally identifiable details will be stored separately from the rest of the data.

The responses to the 'questions about you' for all participants will be summarized in a table, and this table will be reported in my thesis and in any publications and presentations arising from the research. Because I'm studying at a UK university, the interviews and answers to the 'questions about you' will be translated from Chinese to English – either I or a professional translator will transcribe the data. If I use a professional translator they will be required to sign a confidentiality agreement.

The data will be processed and stored in accordance with the Data Protection Act 2018 and General Data Protection Regulation requirements. The study is administered on the *Qualtrics* online survey platform and only I will have access to the data on *Qualtrics*; my supervisor will have access to the anonymised translated interview transcripts and the table summarising participant characteristics (external examiners may also request access to the interview transcripts, but this is rare). Once data collection is complete the data will be download and deleted from *Qualtrics* and stored on the UWE secure OneDrive cloud storage system, and shared with my supervisor using the OneDrive system. The interview transcripts will also be shared with my supervisor this way. Any hard copies will be stored securely (e.g. in a locked cupboard). Your contact details will be destroyed once the thesis is submitted.
The data will be held until 6 months after the final academic journal article reporting the findings of my research is published and for a maximum of 7 years.
Can I withdraw from the research after the interview?
Participation is entirely voluntary and there is no penalty for withdrawing, and you don't need to give a reason if you decide to stop taking part. If you decide you want to withdraw from the research, please contact me via email: Sin2.Yick@live.uwe.ac.uk quoting the unique participant code you will be asked to create before completing the study. Please note that there are certain points beyond which it will be impossible to withdraw from the research – for instance, when I have submitted my dissertation. Therefore, I strongly encourage you to contact me within a month of participation if you wish to withdraw your data.

What are the benefits of taking part?

You will get the opportunity to help others to make sense of and understand the lived experiences of having HIV anxiety. This will help the researcher and other mental health professionals to shape their practice when working with other clients who have similar experiences as you. I also hope to increase the awareness of the neglected needs of men without HIV.

As a trainee counselling psychologist and practitioner with substantial amount of experiences in the HIV field, I am capable of responding to issues associated with HIV. Should any issues related to mental health arise during or after the interview, I am able to provide recommendation or assistance, such as making a referral to counselling services from an appropriate service provider.

Are there any potential risks involved?

The interview process may remind you of uncomfortable or distressing emotions and thoughts that you experienced from the past. For this reason, I have provided different resources that are available for you in Hong Kong (you may download this information*). If there is any potential risk for either you or the researcher, the interview may end at any time.

Who has ethically approved this research?

The project has been reviewed and approved by the University of the West of England University Faculty of Health and Applied Sciences Research Ethics Committee reference number [HAS.22.07.141]. Any comments, questions or complaints about the ethical conduct of this study can be addressed to: Researchethics@uwe.ac.uk

How to participate?

If you decide to become a participant in this research, please read carefully and complete the consent question on the next page, and leave your contact details so that I can get in touch with you to arrange an initial meeting and then, if you are eligible to take part, an interview will be arranged.

If you have any questions or require any further information about this research, please contact me via email (Sin2.Yick@live.uwe.ac.uk) or my research supervisor:

Name of researcher's supervisor: Dr. Victoria Clarke
E-mail: Victoria.Clarke@uwe.ac.uk
Address: Department of Social Sciences, Faculty of Health and Applied Sciences, University of the West of England, Frenchay Campus, Coldharbour Lane, Bristol BS16 1QY

Thank you for taking the time to read this Participant Information Sheet and considering taking part in the study. This Participant Information Sheet is for you to keep.*

Appendix H - Consent Form and Demographics Questions (on Qualtrics)

Research title: How Hong Kong men experience fear of HIV infection

Thank you for agreeing to take part in this research on fear of HIV infection.

My name is Sin Yin Yick (Janet) and I am a postgraduate student in the Department of Social Sciences, University of the West of England, Bristol, United Kingdom. I am collecting this data collection for my Professional Doctorate in Counselling Psychology thesis. My research is supervised by Dr. Victoria Clarke. She can be contacted at the School of Social Sciences, University of the West of England, Frenchay Campus, Coldharbour Lane, Bristol BS16 1QY, UK [Tel: +4411732 82176; Email: Victoria.Clarke@uwe.ac.uk] if you have any queries about the research.

Statement by person agreeing to participating in this study

By consenting to take part you agree to the following:
I am 18 or above
I have read the information sheet
I have had the opportunity to ask questions / email questions
I understand that any identifying information will be removed or changed in my interview transcripts
Do you consent to take part?

○ Yes

○ No

Do you consent to allow the researcher to find a professional translator to perform Chinese to English translation on the transcripts?

○ Yes

○ No

As mentioned in the information sheet, you may or may not allow the researcher to invite a professional translator to type up the interview and to translate into English. Do you consent to allow the translator to access the audio recording?

○ Yes

○ No

End of Block: Block 1

Start of Block: Block 2

Full Name

____

Signature

____

Email address

____

You will be contacted by the researcher within 2 working days. The researcher will schedule a 15-minute virtual meeting with you via Microsoft Teams. The purpose of this brief meeting is to assess your eligibility to participate in this study.

Since your real name will not be mentioned in any part of the thesis, you may choose a pseudonym that you would like the researcher to use to refer you. If you would like to choose one, please input your pseudonym here.

____

Questions about you

In order for me to learn about the range of people taking part in this research, and to describe the broad characteristics of my participant group in my report, I would be grateful if you could answer the following questions. Please write your answer in the space provided. All these questions are optional – if you prefer not to answer a question, please leave the space blank. Please note that the information provided by all participants will be aggregated.

1. What is your ethnic of origin?

○ Chinese (Hong Kong) (1)

○ Chinese (Mainland China) (2)

○ Other (3) ____

2. How old are you?

____

3. How many years have you lived in Hong Kong?

____

4. What is the highest level of education you have achieved?

○ Master's degree or above

○ Bachelor's degree

○ Highschool

○ Other ____

○ Prefer not to say

5. How would you describe your occupation?

____

6. What is your sexual orientation?

○ Heterosexual

○ Gay

○ Bisexual

○ Unknown/ Uncertain

○ Another sexual orientation
____

○ Prefer not to say

7. What is your relationship status?

○ In a relationship (with same sex/gender partner), but not married

○ In a relationship (with different sex/gender partner), but not married

○ Married (with same sex/gender partner)

○ Married (with different sex/gender partner)

○ Divorced

○ Separated

○ Single

○ Prefer not to say

8. How many children do you have?

____

Thank you for spending time providing the above information!

Appendix I - Confidentiality Agreement for Translation Service

Confidentiality Agreement

Transcription and Translation Service in Human Research

Project Details	
Project Title	Exploring the lived experiences of men with HIV anxiety in Hong Kong
Project start date	06/04/2022
Project end date	30/09/2024

Confidentiality Agreement Details	
Name of Researcher	YICK, Sin Yin
Recipient	[Translator’s name]
Disclosed Information	Chinese (Cantonese) transcripts
Purpose	To provide translation and/or transcription service
Commencement Date	21 Nov 2022

Transcription of audio recordings

☐ I understand that I am being asked to transcribe audio recordings relating to the above research project.

Translation services

- ☐ I understand that I am being asked to provide translation services relating to the above research.

By signing the agreement below I agree to:

- ☐ Maintain full confidentiality of all research data received from the researcher related to this research study.
- ☐ Hold in strictest confidence the identity of any individual that may be revealed during the translation/transcription of data,
- ☐ That I will not make copies of any audio-recordings, or other research data, unless specifically requested to do so by the researcher.
- ☐ That I will not provide the research data to any third parties without the researcher's consent.
- ☐ Store all study-related data in a safe, secure location while in my possession. All audio recordings will be stored in an encrypted format.
- ☐ Return all data provided or created for purposes of this agreement, including any back-up records, to the researcher or permanently deleted, pursuant to the instructions of the researcher.
- ☐ I understand that the researcher has the right to take legal action against any breach of confidentiality that occurs in my handling of the research data.

Confirmation	
____ Signature of Researcher	____ Signature of Recipient
____ Print Name	____ Print Name
____ Institute	____ Organisation

______________________________________ Date of Signing	______________________________________ Date of Signing

Appendix J - Screening Question for Psychosis in English and Cantonese

English	Cantonese
1. Have you had any strange or odd experiences lately that you cannot explain?	1. 最近你有無經歷一d解釋唔到嘅事情？
2. Do you ever hear things that other people cannot hear, such as noises, or the voices of other people whispering or talking?	2. 有冇試過聽到d其他人聽唔到嘅嘢， 例如一d噪音或其他人講野？
3. Do you ever have visions or see things that other people cannot see?	3. 有冇試過 見到d其他人見唔到嘅嘢？
4. Do you ever feel that people are bothering you or trying to harm you?	4. 有冇試過感覺到有人騷擾你或想傷害你？
5. Has it ever seemed like people were talking about you or taking special notice of you?	5. 有冇試過覺得有人講緊關於你或特別關注你？
6. Are you afraid of anything or anyone?”	6. 有冇一d你好驚嘅嘢或人？

Appendix K - Sources of Support Included in Qualtrics Online Survey

Sources of Support 資源

The following organisations provide low cost or free counselling services and/or group therapy:

以下組織提供低收費或免費的諮詢服務和/或團體治療：

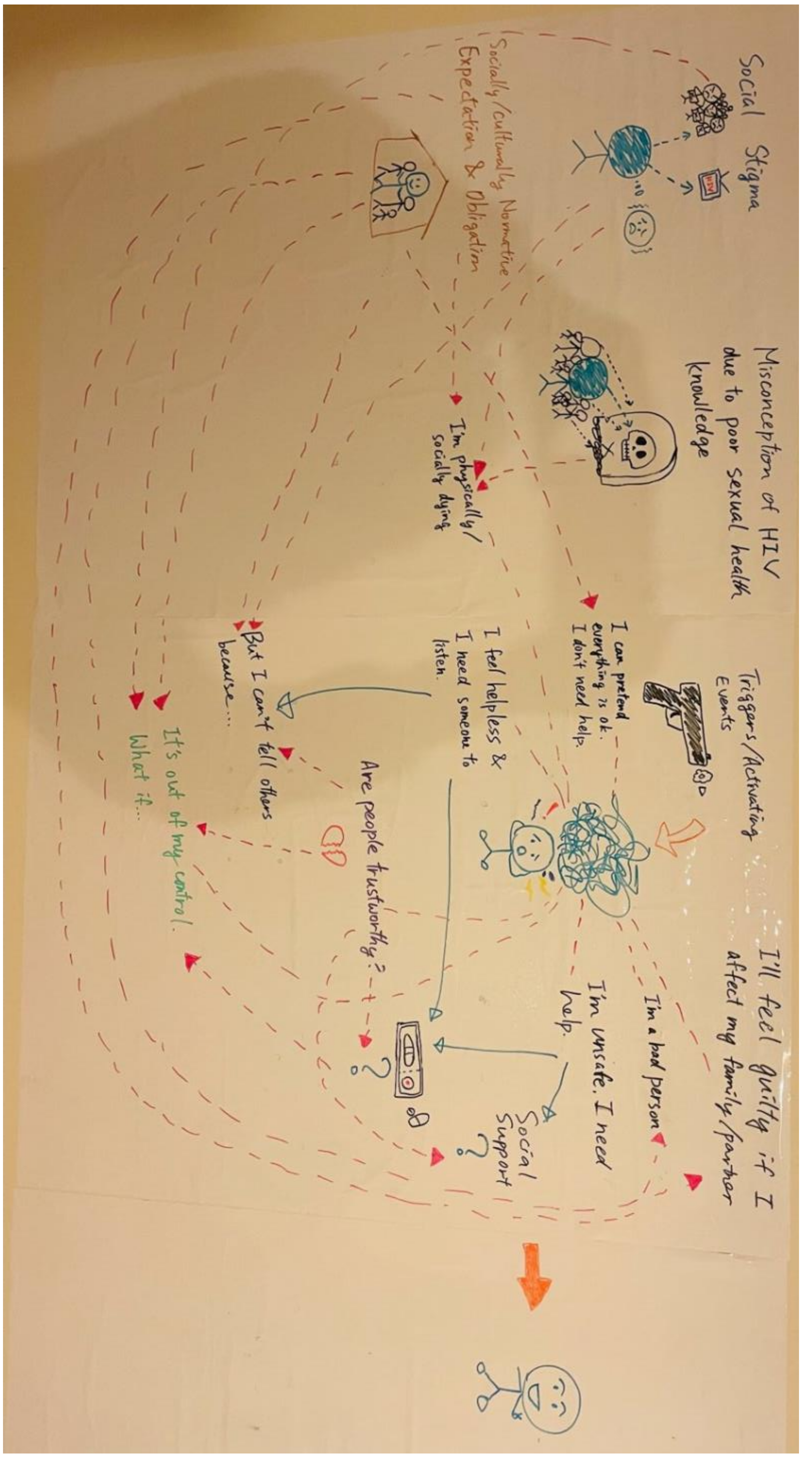
Organisation/Project Name and website 機構/項目名稱和網站	**Types of service 服務類型**	**Eligible service users 符合條件的服務使用者**	**Contact information 聯絡資料**
Mental health service providers for men			
Caritas Supportive Service for Men Caritas Personal Growth 明愛賽馬會思達計畫-男士社交及情緒支援服務 https://www.menhk.org	Educational talks and workshops, single-session consultation by psychiatrist, support groups, hotline services 教育講座和工作坊、精神科醫生單次諮詢、支持小組、熱線服務	Men above 18 years old 18 歲以上的男性	*Address:* 2/F., Tung Tau Community Centre, 26 Lok Sin Road, Tung Wui Estate, Wong Tai Sin, Kowloon **地址：** 香港九龍城樂善道 26 號 *Tel* ：2649 9158 *Fax* ：2417 0378 Email： fsmensproject@caritassws.org.hk whatsapp/Wechat: 5431 5413
Hong Kong Welfare Society (HKWS) – "He.Men – Hear Men" Project 家福會 – 男士家友站	Mutual support group, therapeutic group, fatherhood training, family activities, seminars, and community education	Men above 18 who experience day-to-day stress	*Head office address:* Rm 2010, 20/F, Southorn Centre, 130 Hennessy Road, Wanchai, Hong Kong

http://menservicehk.org.hk/tc/about-us	互助小組、小組形式的輔導服務、親職訓練、家庭活動、講座、社區教育		總辦事處：香港灣仔軒尼詩道130號修頓中心20樓2010室 *Tel:* 2527-3171
Mental health service providers for sexual and gender minority individuals			
Boys’ and Girls’ Club Association of Hong Kong (Project touch) 香港小童群益會性向無限計畫 https://www.newtouch.net	Support groups, individual and couple counselling, substance abuse prevention and counselling, HIV testing for men who have sex with men, education to schools 支持團體、個人和夫妻諮詢、藥物濫用預防和諮詢、男男性行為者的愛滋病病毒檢測、學校教育	Gay and transgender individuals and their parents 同性戀和跨性別者及其父母	*Address:* Room 203, 1/F, Lung Poon Court Commercial Complex, Diamond Hill 地址：香港九龍鑽石山龍蟠苑商場二樓203室 *Tel:* 2321-1103 Whatsapp: 3895-6398 Email: diversity@bgca.org.hk
Gender Empowerment 性別空間 https://genderempowerment.org	Counselling, hotline service and workshops 輔導、熱線服務和工作坊	Transgender individuals 跨性別者	*Address:* Self-Help Development Centre G/F, 3-10 Nam Yat House, Nam Shan Estate, Shek Kip Mei, Kowloon. 地址：南山邨南逸樓G/F, 3-10 *Tel:* 6120-9810 (Only available on Mon, Wed, Fri 6:30-9:30pm) *Whatsapp/Signal:* 6120-9810 (4-10pm on weekdays)

			Email: info@genderempowerment.org
HIV/AIDS and sexual health service providers			
AIDS Concern 關懷愛滋 https://aidsconcern.org.hk/en/	HIV rapid testing and counselling, hotline service, support group, support service for people living with HIV, HIV prevention and education, referral service to doctors 愛滋病病毒快速檢測和輔導、熱線服務、支持小組、愛滋病病毒感染者支持服務、愛滋病預防和教育、醫生轉介服務	Males of all ages, females who are 25 or below 任何年齡的男性，25 歲或以下的女性	*Address:* Flat B, 3/F, Fu Lee Commercial Building, 14 – 20 *Pilkem Street*, Jordan, Kowloon 地址：九龍佐敦 庇利金街 14-20 號富利商業大廈 3 樓 B 室 *Tel:* 2394-6677 *Email:* enquire@aidsconcern.org.hk
Hong Kong AIDS Foundation 香港愛滋病基金會 https://www.aids.org.hk	HIV rapid testing and counselling, support service for people living with HIV, HIV prevention and education, referral service to doctors 愛滋病病毒快速檢測和輔導、愛滋病病毒感染者支持服務、愛滋病預防和教育、醫生轉介服務	Men and women of all ages 任何年齡的男性和女性	Address: 5/F Shau Kei Wan Jockey Club Clinic, 8 Chai Wan Road, Shau Kei Wan, Hong Kong 地址：香港筲箕灣柴灣道 8 號 Email: hkaf@hkaf.com Tel: 2513-0513
The Family Planning Association Hong Kong 香港家庭計劃指導會	Health screening and laboratory tests for men, pre-martial check-up, pre-pregnancy check-up, early pregnancy	Men and women of all ages	Headquarters Address: 10/F, Southorn Centre, 130 Hennessy Road, Wan Chai, Hong Kong

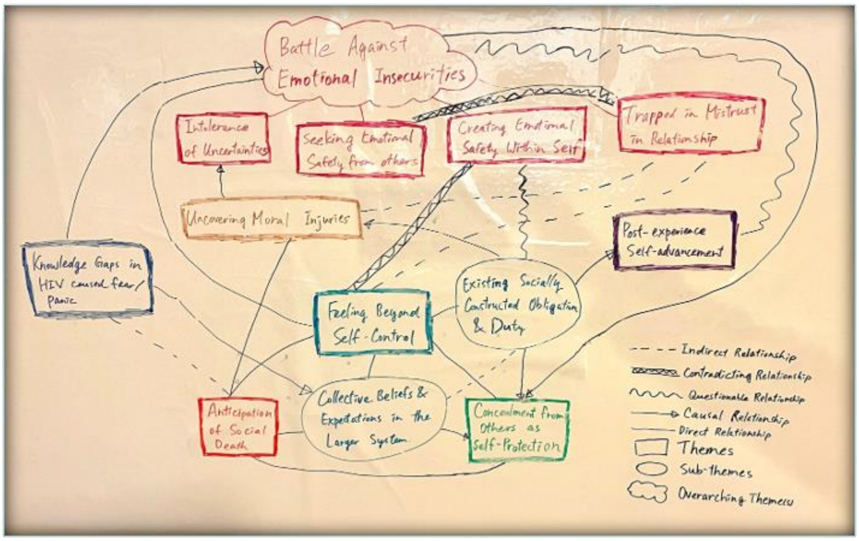
https://www.famplan.org.hk	assessment, sexuality education 男性健康檢查和化驗、體檢、孕前檢查、早孕評估、性教育	任何年齡的男性和女性	總會：灣仔軒尼詩道130號修頓中心十樓 Tel: 2575-4477 Email: fpahk@famplan.org.hk

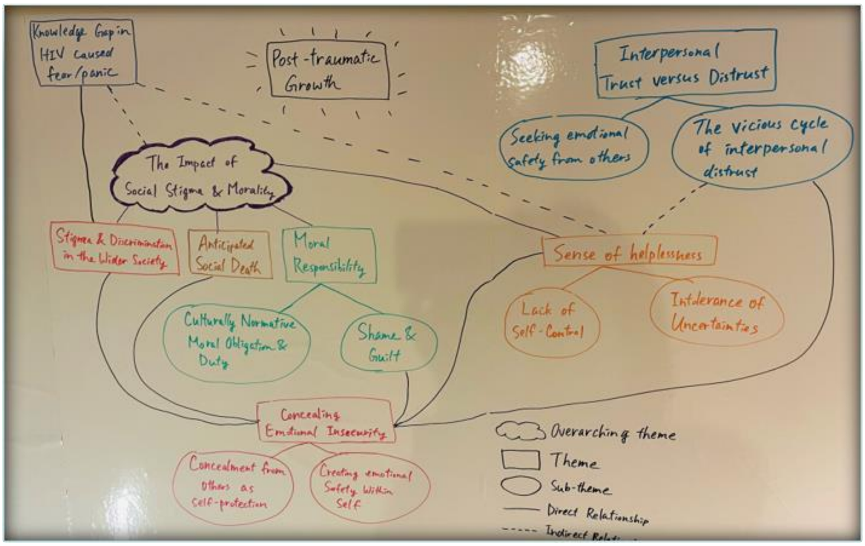
Appendix L - Hand Drawn Picture Depicted the Overall Story Across the Data

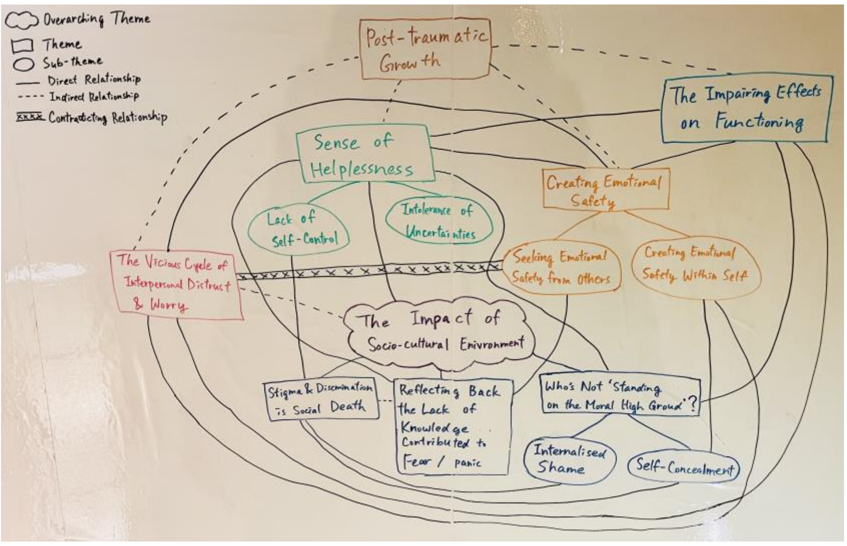


Appendix M - Initial Thematic Mapping

Appendix N - Examples of Thematic Maps Generated During Developing Themes





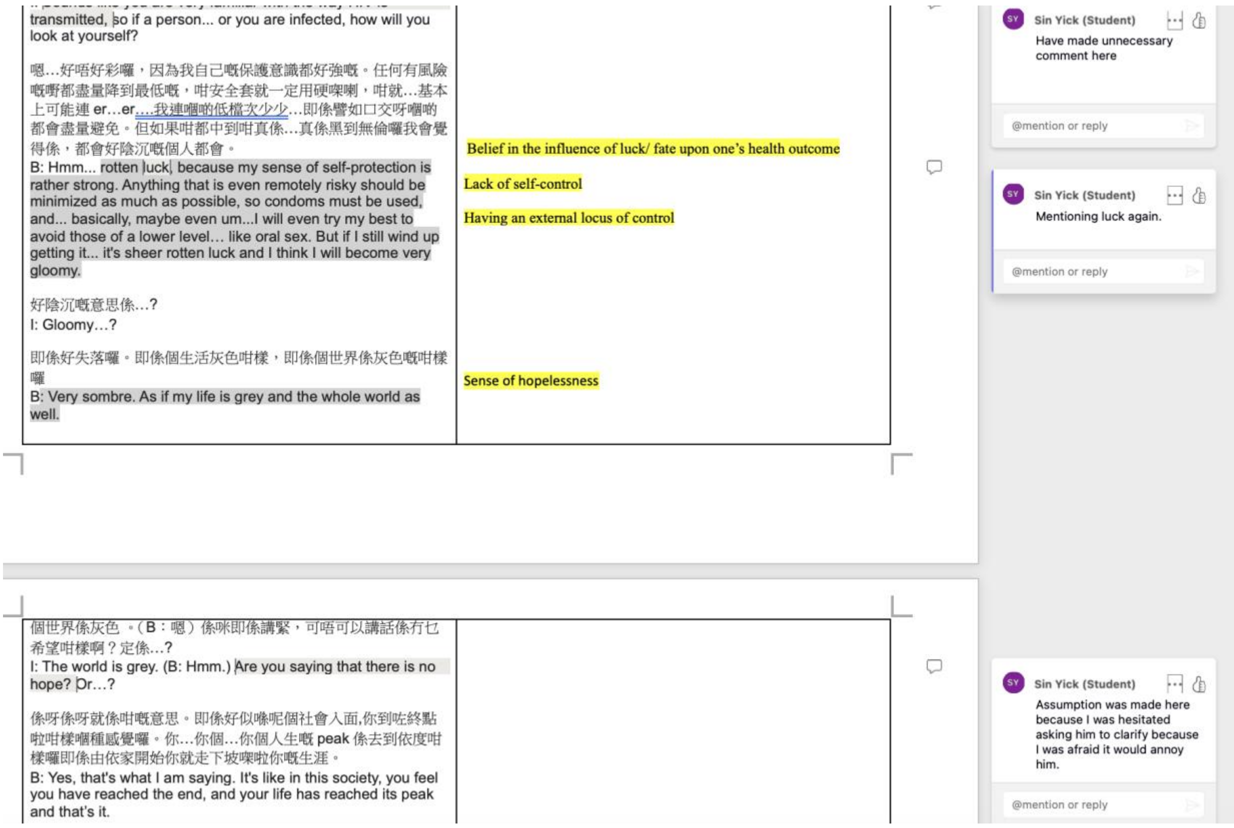


Appendix O - Transcription Notation

Feature	**Notation**
Broken or incomplete speech	… signals a speaker’s broken or incomplete speech.
Self-talk or direct speech spoken to/ by someone (in English extracts)	‘text’ signals a speaker’s expression of internal dialogue or a report of direct speech spoken to/ by someone
Self or direct speech spoken to/ by someone (in Chinese extracts)	「text」 signals a speaker’s expression of internal dialogue or a report of direct speech spoken to/by someone
[Word]	My clarifications

Appendix P - Examples of familiarisation and coding

Example 1



transmitted, so if a person... or you are infected, how will you look at yourself? 嗯…好唔好彩囉，因為我自己嘅保護意識都好強嘅。任何有風險嘅嘢都盡量降到最低嘅，咁安全套就一定用硬㗎喇，咁就…基本上可能連 er…er….我連嗰啲低檔次少少…即係譬如口交呀嗰啲都會盡量避免。但如果咁都中到咁真係…真係黑到無倫囉我會覺得係，都會好陰沉嘅個人都會。 B: Hmm... rotten luck, because my sense of self-protection is rather strong. Anything that is even remotely risky should be minimized as much as possible, so condoms must be used, and... basically, maybe even um...I will even try my best to avoid those of a lower level… like oral sex. But if I still wind up getting it... it's sheer rotten luck and I think I will become very gloomy.	Belief in the influence of luck/ fate upon one's health outcome Lack of self-control Having an external locus of control
好陰沉嘅意思係…? I: Gloomy…? 即係好失落囉。即係個生活灰色咁樣，即係個世界係灰色嘅咁樣囉 B: Very sombre. As if my life is grey and the whole world as well.	Sense of hopelessness

個世界係灰色 。（B：嗯）係咪即係講緊，可唔可以講話係冇乜希望咁樣啊？定係…? I: The world is grey. (B: Hmm.) Are you saying that there is no hope? Or…? 係呀係呀就係咁嘅意思。即係好似喺呢個社會入面,你到咗終點啦咁樣嗰種感覺囉。你…你個…你個人生嘅 peak 係去到依度咁樣囉即係由依家開始你就走下坡㗎啦你嘅生涯。 B: Yes, that's what I am saying. It's like in this society, you feel you have reached the end, and your life has reached its peak and that's it.	

Sin Yick (Student)
Have made unnecessary comment here

Sin Yick (Student)
Mentioning luck again.

Sin Yick (Student)
Assumption was made here because I was hesitated asking him to clarify because I was afraid it would annoy him.

Example 2

sleep well at night. I seemed to be really unwell all the time. I was dizzy and tired, and I couldn't concentrate. Then, while I was on a flight to Nepal... I had never felt so uncomfortable in my life, there was discomfort in every part of my body. It was like I was dying. I felt lack of energy during my stay in Nepal and I felt like I couldn't even breathe. At the end, I could not bear the discomfort and I had to leave early. When I decided not to go to India or Bangladesh, I decided to go back to Hong Kong. I thought I would feel better after going back to Hong Kong. Out of my expectation, things were getting worse, I always felt like I had a fever and I felt sweaty. I kept reading information on the internet and I believed that I was infected (with HIV). By chance, I met a friend who has self-disclosed as an HIV infected person in Hong Kong. After listening to my situation, he said, "Yours are not (HIV symptoms). But I think it's better to go to the hospital than to go to an organisation to do a check-up". Then you know, we are heterosexuals, we don't have any HIV support. (I: Yes.) Then I went to an HIV organisation that supports gay/homosexuals to do tests, pretending to gay/ homosexual. When I went there, the staff actually felt it and saw that I was sweating, my face was blue and my lips were white, so they immediately said, "Don't be scared, it's a tough 20 minutes. It was like the end of the world, but it was ok at the end." (I: Hmm.) I was like... Oh... I let it go. But then... at the end... I kept surfing on the internet, and read those information. For example, some mentioned that the window period could go up to half a year, that made me scared again. (I: OK) And then...well...later, a friend of mine said: "You've been feeling sick for a long time, have you got a neurological disorder? Could it be Dysautonomia?" At that time, I didn't know what it was. He said: "Why don't you go to Taiwan for a visit?" I was	Searched for evidence to support the pre-existing beliefs. Associating inexplicable bodily symptoms with fatal disease/ illness. Intolerance of physical discomfort. Repeated reassurance-seeking behaviours were unhelpful/ hamrful. Reassurance seeking from others (PLHIV) Searched for evidence to support the pre-existing beliefs. Relying on social support. Accessing excessive amount of health-related information increased anxiety. Association between stigma and health inequality Concealment of sexual identity from others/ Fight-or-flight mode was activated. Pre-planning self-presentation for accessing HIV services. Inconsistent information was anxiety-provoking./ Rationalising his fear to make sense of his feelings. / Compulsive reassurance-seeking behaviours were unhelpful/ harmful. Got trapped in a fear-driven thought cycle. Accessing excessive amount of health-related information increased anxiety. Relying on social support. Internalised shame of own sexuality.

Example 3

A：系啊，冇錯冇錯。嗯。嗯。同埋會勁 sensitive。即系會成日望自己有冇啲乜傷口啊。如果即刻有呢就揾個膠布黐住佢啊，掂到其他嗰啲公眾地方嗰的嘢，有機會會唔會感染到啊？即系可能暴露…即系冇貼膠布會乜嘢呢？跟住掂到嗰啲誒…lift 口啊電梯啊。嗯。嗰啲扶手柄啊嗰啲噉嘅嘢…跟住就死啦，會唔會唔會中啊？	Intolerance of uncertainties Compulsive reassurance-seeking behaviours. Occupied with the thought of potential HIV exposure. Hypervigilance towards the surroundings. Got trapped into a fear-driven cycle
I：你講緊系幾時發生啊呢樣嘢？	
A：呢樣嘢就系第一次完之後，即系 test 完之後，就算…即系之前佢 test 完，就算佢講過話其實個風險好低啊，咁低都系一樣有嘛個人覺得。跟住就…就…就系噉成日好 sensitive 到依家都系噉。	Mental resistance to others’ affirmation. Uncertainty caused distress.
I：哦，即系直至到到而家，即系呢幾年都系噉喎，系咪啊?	
A：誒，系咯實即系滲入咗喺你個生活入面都系好 sensitive。對呢樣嘢即系傷口呢一件事，欸要貼膠布啊，如果掂到其他嘢會驚咗一陣啊噉樣咯。即系可能如果你嗰個位算佢裡面結咗焦嘅，你又唔想噉掂到人哋隻手啊嗰啲噉樣，唉人哋真實會諗人哋隻手有無傷口啊，會唔會有病啊噉嘅焦慮系咯。	HIV anxiety negatively affected daily functioning.