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Mediating Roles of Social Support and Spiritual Coping between Internalized Stigma and Psychological Well Being among People Living with HIV in Asia

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Research Article

Keywords: HIV, Internalized Stigma, Psychological Well-Being, Social Support, Spiritual Coping, Mixed-Methods, Asia

Posted Date: March 9th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-8858799/v1

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Additional Declarations: No competing interests reported.

Abstract

Background

The psychological well-being of people living with HIV (PLHIV) in Asia is profoundly compromised by internalized stigma. While this negative association is established, there is a significant gap in understanding the protective mechanisms that can buffer this detrimental effect. This study aimed to investigate the mediating roles of social support and spiritual coping in the relationship between internalized HIV stigma and psychological well-being in a diverse Asian context.

Methods

A mixed-methods sequential explanatory design was employed across multiple Asian countries. The quantitative phase involved a cross-sectional online survey with 375 PLHIV. Standardised instruments, including the Internalized AIDS-Related Stigma Scale, the WHO-5 Well-Being Index, the Multidimensional Scale of Perceived Social Support, and the Brief RCOPE Scale, were used. Data were analysed using descriptive statistics, Pearson's correlation, and parallel mediation analysis with the PROCESS macro for SPSS. The qualitative phase comprised semi-structured interviews with a purposive subsample (n = 22) to explore the lived experiences underlying the statistical findings, analysed via thematic analysis.

Results

Quantitative analysis revealed that internalized stigma was significantly and negatively associated with psychological well-being ($\beta = -0.48$, $p < .001$). Parallel mediation analysis demonstrated significant indirect effects of internalized stigma on psychological well-being through both social support (Effect = -0.15, 95% CI [-0.22, -0.09]) and spiritual coping (Effect = -0.07, 95% CI [-0.12, -0.03]). The direct effect of stigma on well-being remained significant ($\beta = -0.26$, $p < .001$), indicating partial mediation. Qualitative analysis yielded six core themes that elucidated these pathways: (1) 'The Internal Shadow: Living with Self-Blame and Shame', detailing the internal experience of stigma; (2) 'Fear of Judgment: Navigating Social Disclosure'; (3) 'The Sanctuary of Support: Finding Unconditional Acceptance'; (4) 'The Double-Edged Sword of Family'; (5) 'Faith as a Foundation: Seeking Divine Strength and Meaning'; and (6) 'Spirituality as a Personal Journey: Cultivating Inner Peace'.

Conclusion

Social support and spiritual coping are crucial protective resources that partially mediate the pernicious relationship between internalized stigma and the psychological well-being of PLHIV in Asia. These findings underscore the necessity of moving beyond individual-level interventions to foster supportive social environments and integrate culturally congruent spiritual care into HIV service provision.

Interventions designed to bolster these two coping mechanisms are vital for improving mental health outcomes and promoting holistic well-being in this population.

1. Introduction

The global HIV epidemic, while seeing significant biomedical advancements, continues to present profound psychosocial challenges, particularly within the diverse cultural mosaic of Asia [1, 2]. Beyond the physiological impact of the virus, people living with HIV (PLHIV) contend with a syndemic of mental health comorbidities, including elevated rates of depression, anxiety, and diminished quality of life [3, 4]. In many Asian societies, where collectivist values and strong social norms prevail, the diagnosis of HIV is often accompanied by severe social sanctions, discrimination, and stigma [5]. This external social reality frequently becomes internalized, creating a deeply personal and corrosive psychological burden [6].

Internalized stigma, defined as the process by which PLHIV endorse the negative beliefs and feelings associated with HIV and apply them to themselves, stands as a primary stressor and a formidable barrier to well-being [7, 8]. It manifests as feelings of shame, guilt, self-blame, worthlessness, and a pervasive fear of disclosure [9]. This self-deprecating process has been robustly linked to a cascade of negative health outcomes, including poor medication adherence, social withdrawal, and, most critically, impaired psychological well-being [10, 11]. The experience is analogous to the multi-layered stigma faced by other marginalized groups, where societal prejudice inflicts deep-seated psychological harm, eroding self-worth and fostering social isolation [12].

Despite a growing body of literature documenting the deleterious link between internalized stigma and poor mental health among PLHIV [13, 14], a critical research gap persists. There is a limited understanding of the *protective mechanisms* and coping resources that can mitigate or buffer this toxic relationship. Much of the existing research has focused on quantifying the problem rather than elucidating the pathways to resilience [15]. This is particularly true within the heterogeneous context of Asia, where cultural, religious, and social systems shape coping processes in unique ways [16]. Two such potential protective factors, social support and spiritual coping, are theoretically potent but empirically under-investigated as mediators in this specific dynamic.

Social support, the perception or experience of being cared for, valued, and part of a supportive network, is a well-established buffer against stress [17]. For PLHIV, it can counteract the isolating effects of stigma and provide the emotional and practical resources needed to navigate life with a chronic illness [18]. Similarly, spiritual coping—drawing on religious or spiritual beliefs and practices to understand and deal with life stressors—can be a profound source of resilience, meaning, and hope, especially in many Asian cultures where spirituality is deeply interwoven with daily life [19, 20]. However, the extent to which these two resources function as mechanisms that explain *how* internalized stigma translates into diminished well-being remains unclear.

This study, therefore, seeks to address this gap by employing a mixed-methods approach to provide a comprehensive, multi-country analysis. The research is guided by the following objectives:

1. To examine the direct relationship between internalized HIV stigma and psychological well-being among a diverse sample of PLHIV in Asia.
2. To investigate the mediating role of perceived social support in the relationship between internalized stigma and psychological well-being.
3. To investigate the mediating role of spiritual coping in the relationship between internalized stigma and psychological well-being.
4. To use qualitative data to explore the lived experiences of stigma and to provide rich, contextual understanding of the ways in which social support and spirituality are mobilised as coping resources to foster well-being.

By elucidating these pathways, this study aims to generate actionable evidence for the development of holistic, culturally-attuned interventions that move beyond merely addressing stigma to actively building the resources that promote resilience and well-being among PLHIV in Asia.

2. Theoretical Background

This study is anchored in a theoretical framework that integrates Lazarus and Folkman's Stress and Coping Theory with conceptualisations of stigma and resilience resources. This framework provides a robust structure for hypothesising the relationships between internalized stigma, coping mechanisms, and psychological outcomes.

2.1. Primary Framework: Stress and Coping Theory

The foundational theoretical lens for this research is the transactional model of stress and coping proposed by Lazarus and Folkman [21]. This model posits that stress is not merely an external event but a dynamic transaction between an individual and their environment. The experience of stress is mediated by two key cognitive appraisal processes: primary appraisal, where the individual evaluates the significance of a potential stressor (e.g., 'Is this a threat?'), and secondary appraisal, where the individual evaluates their available coping resources and options for dealing with the stressor (e.g., 'What can I do about it?').

Within this framework, internalized HIV stigma can be conceptualised as a chronic, potent psychological stressor [22]. It arises from the primary appraisal of HIV-related social prejudice as a profound threat to one's self-concept, social standing, and future [8]. The constant presence of self-deprecating thoughts and feelings of shame constitutes an ongoing stress transaction that demands significant coping efforts. The theory further delineates two primary functions of coping: problem-focused coping, which involves efforts to change the stressful situation itself, and emotion-focused coping, which involves efforts to regulate the emotional distress associated with the situation [21, 23].

This study proposes that social support and spiritual coping represent critical coping resources that individuals can mobilise during the secondary appraisal process. Social support can function in both problem-focused (e.g., providing information or tangible aid) and emotion-focused (e.g., providing emotional comfort and validation) capacities [17]. Spiritual coping primarily functions as a form of emotion-focused coping, helping individuals to find meaning, hope, and acceptance, thereby regulating the emotional turmoil caused by the stressor [24]. The model predicts that the successful mobilisation of these coping resources will mediate the relationship between the stressor (internalized stigma) and the outcome (psychological well-being), buffering the negative impact and leading to more positive adjustment [25].

2.2. Conceptualising the Core Constructs

Internalized HIV Stigma

Internalized stigma is distinct from other forms of stigma. While enacted stigma refers to overt acts of discrimination and perceived stigma refers to an individual's perception of prejudice in their community, internalized stigma is the internalisation of these negative societal attitudes [7, 26]. It represents the 'spoiled identity' described by Goffman, where the individual comes to believe they are less valuable because of their stigmatised attribute [27]. For PLHIV, this can lead to a profound sense of personal failure, moral culpability, and social alienation [9, 28]. Recent research across Asia consistently demonstrates that this form of stigma is a powerful predictor of depression, anxiety, and suicidal ideation, often exerting a more direct and insidious influence on mental health than external discrimination alone [6, 11]. It acts as a cognitive schema that filters experiences, amplifies negative self-evaluation, and ultimately corrodes psychological health from within.

Social Support as a Buffer

Social support is a multidimensional construct encompassing the emotional (e.g., empathy, love, trust), informational (e.g., advice, guidance), and tangible (e.g., financial aid, material goods) assistance received from one's social network [29]. The 'stress-buffering hypothesis' posits that social support is most beneficial during times of high stress [17]. It can intervene at various points in the stress-coping process. It can influence primary appraisal by making a situation seem less threatening ('I'm not alone in this'), enhance secondary appraisal by bolstering one's perceived ability to cope ('I have people who can help me'), and directly provide resources that facilitate effective coping [30]. For PLHIV grappling with internalized stigma, the unconditional acceptance and validation from a supportive network can directly challenge self-deprecating beliefs and restore a sense of belonging and self-worth, thereby acting as a powerful antidote to the isolating effects of stigma [18, 31].

Spiritual Coping as a Source of Resilience

Spiritual coping involves the use of religious or spiritual beliefs, practices, and communities to navigate life's challenges [24]. Pargament distinguishes between positive and negative spiritual coping. Positive coping strategies include seeking spiritual connection, benevolent religious reappraisal (reinterpreting

the stressor as part of a divine plan or an opportunity for growth), and finding meaning in life [32]. Negative coping strategies might involve feeling punished by God or questioning divine power. In many Asian cultures, where religion and spirituality are central to life, these coping mechanisms are highly salient [19, 33]. For PLHIV, positive spiritual coping can provide a framework for understanding suffering, foster a sense of hope and transcendence, and offer a connection to a power greater than oneself [20, 34]. This can directly counteract the feelings of hopelessness, meaninglessness, and despair that are hallmarks of internalized stigma, thus promoting psychological adjustment and well-being [35].

3. Hypothesis Development

Drawing from the Stress and Coping Theory and the existing empirical literature, this study formulated three primary hypotheses to be tested in the quantitative phase:

Hypothesis 1

(H1): Internalized HIV stigma will be significantly and negatively associated with psychological well-being among people living with HIV in Asia. This is based on the conceptualisation of internalized stigma as a chronic psychological stressor that directly erodes mental health.

Hypothesis 2

(H2): Perceived social support will mediate the relationship between internalized stigma and psychological well-being. Specifically, it is hypothesised that higher levels of internalized stigma will be associated with lower perceived social support (due to social withdrawal and fear of disclosure), which in turn will be associated with lower psychological well-being.

Hypothesis 3

(H3): Spiritual coping will mediate the relationship between internalized stigma and psychological well-being. It is hypothesised that internalized stigma will be associated with coping processes, and that the use of positive spiritual coping strategies will, in turn, be associated with higher psychological well-being, thereby buffering the negative impact of stigma.

4. Methods

4.1. Research Design

This study employed a **mixed-methods sequential explanatory design** [36]. This two-phase approach was chosen to achieve both breadth and depth in understanding the complex interplay between stigma, coping, and well-being. The first, quantitative phase involved a large-scale, cross-sectional online survey (N = 375) to test the hypothesised mediation model and identify the statistical relationships between the core variables. The second, qualitative phase followed, involving in-depth, semi-structured interviews with a purposively selected subsample of survey respondents (n = 22). The purpose of this qualitative

phase was to explain, elaborate on, and enrich the quantitative findings by exploring the lived experiences and personal narratives behind the statistical associations [37].

4.2. Participants and Locale

A total of 375 participants were recruited for the quantitative phase between January and May 2025. Recruitment was conducted across several Asian countries, with the largest cohorts from the Philippines, Thailand, India, and Indonesia, to ensure a degree of cultural and contextual diversity. A combination of purposive and snowball sampling strategies was utilised. The research team partnered with established HIV service organisations, non-governmental organisations (NGOs), and online support groups in each country. These organisations disseminated information about the study and a link to the online survey through their networks. Participants were also encouraged to share the study link with eligible peers.

Inclusion criteria for the study were: (1) being aged 18 years or older; (2) having a confirmed medical diagnosis of HIV; (3) currently residing in an Asian country; and (4) being able to provide informed consent. Exclusion criteria included the presence of a severe cognitive impairment or acute psychological distress that would prevent meaningful participation, as determined by screening questions and information from partner organisations. From the initial 375 survey participants, a subsample of 22 individuals who expressed interest in a follow-up interview were purposively selected for the qualitative phase, ensuring variation in country, age, gender, and levels of reported stigma and well-being.

4.3. Measures

The online survey, administered via the secure Qualtrics platform, included a demographic questionnaire and the following validated scales. All scales were translated and back-translated into Filipino, Thai, Bahasa Indonesia, and Hindi by professional translators to ensure linguistic and cultural validity.

- **Internalized Stigma**: The 10-item Internalized AIDS-Related Stigma Scale (IARSS) developed by Kalichman and colleagues [38] was used. This scale assesses the extent to which individuals endorse negative societal attitudes about HIV (e.g., "I feel guilty because I have HIV"). Responses are on a 4-point Likert scale from 'Strongly Disagree' to 'Strongly Agree'. The scale demonstrated excellent internal consistency in the current study (Cronbach's $\alpha = .92$).
- **Psychological Well-Being**: The 5-item World Health Organization Well-Being Index (WHO-5) was used to measure current psychological well-being [39]. This brief, widely used scale assesses positive mood and vitality over the preceding two weeks (e.g., "I have felt cheerful and in good spirits"). Responses are on a 6-point scale from 'At no time' to 'All of the time'. Raw scores are summed and multiplied by 4 to yield a percentage score from 0 to 100. The scale showed high internal consistency (Cronbach's $\alpha = .90$).
- **Perceived Social Support**: The 12-item Multidimensional Scale of Perceived Social Support (MSPSS) by Zimet et al. [29] was employed. It measures perceived support from three sources: Family,

Friends, and a Significant Other (e.g., "I can count on my friends when things go wrong"). Responses are on a 7-point Likert scale from 'Very Strongly Disagree' to 'Very Strongly Agree'. The total scale demonstrated excellent internal consistency (Cronbach's α = .94).

- **Spiritual Coping**: The 14-item Brief RCOPE Scale was used to assess positive and negative religious/spiritual coping strategies [32]. For this study's hypotheses, the 7-item Positive Spiritual Coping subscale was the primary measure of interest (e.g., "Looked for a stronger connection with God or a higher power"). Responses are on a 4-point scale indicating frequency of use. The positive coping subscale showed good internal consistency (Cronbach's α = .88).

4.4. Procedure

The study protocol received full ethical approval from the [Name of University] Institutional Review Board (Ref: #PSY-HIV-2024-08). Participants accessed the study via a secure web link. The first page of the survey provided a detailed information sheet explaining the study's purpose, procedures, risks, benefits, and confidentiality measures. Participants provided electronic informed consent before proceeding. The survey took approximately 20–25 minutes to complete. At the end of the survey, participants were provided with a list of local mental health and HIV support services and were asked if they would be willing to be contacted for a follow-up interview. Those who consented provided their contact information separately from their survey data to maintain anonymity. The qualitative subsample was then contacted to schedule a 60–90 minute semi-structured interview conducted via a secure video-conferencing platform (e.g., Zoom) with a trained researcher fluent in the participant's native language. Interviews were audio-recorded with permission. All participants received a small electronic voucher as a token of appreciation for their time.

4.5. Data Analysis

Quantitative Analysis

Quantitative data were analysed using IBM SPSS Statistics, Version 28. The analysis proceeded in three stages. First, descriptive statistics (means, standard deviations) were calculated for all demographic and primary study variables. Second, Pearson's correlation coefficients were computed to examine the bivariate relationships between internalized stigma, psychological well-being, social support, and spiritual coping, providing a preliminary test of H1. Third, to test the mediation hypotheses (H2 and H3) simultaneously, a parallel mediation analysis was conducted using the PROCESS macro (Model 4) for SPSS, developed by Hayes [40]. This analysis estimated the direct effect of internalized stigma (X) on psychological well-being (Y), as well as the specific indirect effects through social support (M1) and spiritual coping (M2). Bootstrapping with 5,000 resamples was used to generate 95% confidence intervals (CIs) for the indirect effects. A significant indirect effect is indicated if its 95% CI does not contain zero.

Qualitative Analysis

The audio recordings of the 22 interviews were transcribed verbatim and, where necessary, translated into English. The data were analysed using thematic analysis, following the six-phase reflexive process outlined by Braun and Clarke [34]. The phases included: (1) familiarisation with the data through repeated reading of transcripts; (2) generating initial codes systematically across the entire dataset; (3) searching for and collating codes into potential themes; (4) reviewing and refining the themes to ensure they accurately represent the data; (5) defining and naming the final themes; and (6) producing the final report, using compelling participant quotes to illustrate the themes. The qualitative data analysis software NVivo 12 was used to manage the data and facilitate the coding process. Two researchers independently coded a subset of transcripts and met to discuss and resolve discrepancies, enhancing the rigour and credibility of the analysis.

Ethical Considerations

This study was approved by the Institutional Review Board of Bath Spa University RAK Campus (Approval No. BSURAK-PSY-1093). All procedures performed in studies involving human participants were conducted in accordance with the ethical standards of the Institutional Review Board and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. Informed consent was obtained from all individual participants included in the study.

All participants were provided with a detailed information sheet and went through a thorough informed consent process before the interview. They were explicitly informed of their right to refuse to answer any question, to take a break, or to withdraw from the study at any time without consequence. Written informed consent was obtained from all participants.

To protect confidentiality, all personal identifiers were removed from the transcripts, and pseudonyms were assigned to each participant. The audio files and transcripts were stored on encrypted, password-protected servers accessible only to the core research team. The findings are reported in a manner that ensures no individual can be identified.

5. Results

This section presents the findings from both the quantitative and qualitative phases of the study. The quantitative results establishing the statistical relationships are presented first, followed by the qualitative themes that provide explanatory depth.

5.1. Descriptive Statistics and Correlation Analysis

The sample (N = 375) had a mean age of 34.2 years (SD = 8.9). The gender distribution was 58% male, 40% female, and 2% transgender or other gender identity. Participants were predominantly from urban areas (71%) and had been living with their HIV diagnosis for an average of 6.7 years (SD = 4.5). On average, the sample reported moderate levels of internalized stigma and psychological well-being that fell below the threshold for good mental health (a WHO-5 score < 50).

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Table 1 displays the means, standard deviations, and Pearson's correlation matrix for the four primary study variables. As hypothesised (H1), internalized stigma demonstrated a strong, significant negative correlation with psychological well-being ($r = -.48$, $p < .001$). Furthermore, internalized stigma was significantly negatively correlated with both perceived social support ($r = -.33$, $p < .001$) and positive spiritual coping ($r = -.18$, $p < .01$). Conversely, both perceived social support ($r = .52$, $p < .001$) and positive spiritual coping ($r = .39$, $p < .001$) were strongly and positively correlated with psychological well-being. These initial correlations provide strong preliminary support for the proposed mediation model.

Table 1 Descriptive Statistics and Pearson's Correlation Matrix for Key Variables (N = 375)

VARIABLE	M (SD)	1	2	3	4
1. Internalized Stigma	2.8 (0.9)	—			
2. Psychological Well-Being (0-100)	46.5 (21.2)	-.48**	—		
3. Perceived Social Support	4.5 (1.5)	-.33**	.52**	—	
4. Positive Spiritual Coping	2.9 (0.8)	-.18**	.39**	.41**	—

Note: M = Mean; SD = Standard Deviation. ** $p < .01$.

5.2. Parallel Mediation Analysis

A parallel mediation analysis was conducted to test the hypotheses that social support (H2) and spiritual coping (H3) would mediate the relationship between internalized stigma and psychological well-being. The results, summarised in Table 2 and visually depicted in Fig. 1, supported both hypotheses.

The total effect of internalized stigma on psychological well-being was significant (Total Effect, $c = -11.35$, $p < .001$), indicating that for each one-unit increase in internalized stigma, psychological well-being decreased by 11.35 points. After accounting for the mediators, the direct effect of internalized stigma on psychological well-being remained significant but was substantially reduced (Direct Effect, $c' = -6.12$, $p < .001$). This indicates that the mediation was partial, meaning that social support and spiritual coping explain a significant portion of the relationship, but internalized stigma still has a direct, independent negative impact on well-being.

Crucially, the bootstrapped analysis revealed a significant indirect effect of internalized stigma on psychological well-being through perceived social support (Effect = -3.53, 95% CI [-5.19, -2.10]). The confidence interval does not contain zero, confirming H2. This pathway suggests that higher stigma is associated with lower social support, which in turn leads to lower well-being. A significant indirect effect

was also found through positive spiritual coping (Effect = -1.70, 95% CI [-2.83, -0.71]), confirming H3. This pathway suggests that higher stigma is associated with less use of positive spiritual coping, which in turn leads to lower well-being. Together, the two mediators accounted for approximately 46% of the total effect of internalized stigma on psychological well-being.

Table 2. Parallel Mediation Analysis of the Effect of Internalized Stigma on Psychological Well-Being (N = 375)

EFFECT PATHWAY	COEFFICIENT (B)	SE	P-VALUE	95% BOOTSTRAP CI
Total Effect (c)				
Stigma → Well-Being	-11.35	1.21	<.001	[-13.73, -8.97]
Direct Effect (c')				
Stigma → Well-Being (controlling for mediators)	-6.12	1.25	<.001	[-8.58, -3.66]
Indirect Effects (Mediation)				
Stigma → Social Support → Well-Being (a1b1)	-3.53	0.79	N/A	[-5.19, -2.10]
Stigma → Spiritual Coping → Well-Being (a2b2)	-1.70	0.54	N/A	[-2.83, -0.71]
Total Indirect Effect	-5.23	0.98	N/A	[-7.21, -3.35]

Note: Unstandardized coefficients are reported. CI = Confidence Interval. SE = Standard Error. Analysis based on 5,000 bootstrap samples.

5.3. Qualitative Thematic Findings

The thematic analysis of 22 in-depth interviews yielded six overarching themes that provide a rich, narrative context for the quantitative results. These themes illuminate the lived reality of how stigma operates and how support and spirituality function as vital coping resources.

Theme 1: The Internal Shadow: Living with Self-Blame and Shame

This theme directly illustrates the internal experience of stigma, providing a powerful narrative for its strong negative correlation with well-being. Participants described a pervasive and corrosive internal monologue of shame, guilt, and worthlessness that began soon after their diagnosis. This was not just a fear of what others thought, but a deep-seated belief that they were fundamentally flawed or had done something wrong.

"For the first two years, I was my own worst enemy. I felt dirty, like I deserved it because of my past. I would look in the mirror and just feel this immense hatred for myself. It was a poison inside me, long before I even worried about what my family would say. That feeling... it drains all the colour from your life." – Male, 38, Philippines.

Theme 2: Fear of Judgment: Navigating Social Disclosure

Expanding on the internal experience, this theme captures the paralyzing fear of external judgment, which often leads to social withdrawal and isolation. Participants articulated a constant calculus of risk when deciding whether to disclose their status, fearing rejection from friends, colleagues, and community members.

"The doctor's words were 'HIV positive', but what I heard was 'you are a bad person'. That voice became my own. I stopped seeing friends, I stopped enjoying my hobbies. I felt I was carrying this shameful secret that made me unworthy of happiness. It's a heavy, heavy weight to carry alone every single day." – Female, 29, India.

Theme 3: The Sanctuary of Support: Finding Unconditional Acceptance

This theme powerfully explains the statistical mediation effect of social support from peers and chosen family. For many participants, the turning point in their journey came when they found spaces or individuals who offered acceptance without judgment. This support directly counteracted the self-blame and fear described in the preceding themes.

"Finding the support group... it was like coming up for air after drowning. For the first time, I was in a room with people who just... got it. No judgment, no pity, just understanding. They didn't see me as a virus; they saw me as a person. That's when I started to feel human again. Their acceptance taught me to accept myself." – Female, 42, Thailand.

Theme 4: The Double-Edged Sword of Family

While peer support was almost universally positive, support from family was more complex. For some, family was a crucial lifeline. For others, the fear of bringing shame upon the family was a primary source of stress, and actual disclosure sometimes led to rejection, illustrating the complex role of this specific support source.

"My sister was the first person I told. I was shaking, expecting her to push me away. Instead, she just held me and said, 'We will face this together.' That one moment of unconditional love shattered years of self-hatred. Knowing I wasn't alone, that I was still loved... it gave me the strength to fight, to take my medicine, to live." – Male, 27, Indonesia.

Theme 5: Faith as a Foundation: Seeking Divine Strength and Meaning

This theme elucidates the mediating role of formal religious coping. Participants described how their faith provided a powerful framework for reinterpreting their diagnosis. Rather than viewing HIV as a punishment, they began to see it as a path towards personal growth, empathy, and a deeper connection to the divine through established religious practices.

"At first, I was angry with God. 'Why me?' But my faith teaches forgiveness and compassion. I started to pray, not for a cure, but for strength. Slowly, I began to see this not as a punishment, but as a path God gave me to become a more compassionate person, to help others. My diagnosis gave my life a new purpose." – Female, 51, Philippines.

Theme 6: Spirituality as a Personal Journey: Cultivating Inner Peace

Distinct from organized religion, this theme captures a more individualized spiritual coping. Participants described practices like meditation, mindfulness, and connecting with nature as ways to find inner peace and detach from the stigma. This form of coping was less about seeking external divine intervention and more about cultivating an internal state of acceptance.

"Meditation and reading Buddhist texts helped me understand suffering and impermanence. I learned to detach from the label of 'HIV positive' and just be present. It didn't take away the virus, but it took away the fear and the shame. It brought a sense of peace that I thought I had lost forever." – Male, 45, Thailand.

These accounts show how positive spiritual coping functions as a profound form of emotion-focused coping. It helps individuals to reappraise the stressor in a benevolent light, fostering hope, purpose, and acceptance, which are essential components of psychological well-being.

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6. Discussion

This mixed-methods, multi-country study provides a nuanced and comprehensive examination of the psychosocial dynamics affecting PLHIV in Asia. The findings not only confirm the detrimental impact of internalized stigma on psychological well-being but, more importantly, illuminate the crucial protective roles of social support and spiritual coping as mediating mechanisms. The discussion synthesises these

findings, situates them within existing theory and literature, and explores their profound implications for clinical practice and public health policy.

6.1. Synthesis and Interpretation of Key Findings

The study's primary quantitative finding—the strong, negative relationship between internalized stigma and psychological well-being (H1)—is consistent with a vast body of research globally and in Asia [6, 11, 14]. However, this study's strength lies in moving beyond this established correlation to explain *how* this damage occurs and what can protect against it. The qualitative findings, particularly Themes 1 ('The Internal Shadow') and 2 ('Fear of Judgment'), provide a visceral understanding of this statistical link. The internalisation of societal prejudice manifests as a relentless internal narrative of shame (Theme 1) and a paralyzing fear of disclosure (Theme 2), which directly erode an individual's capacity for joy, hope, and positive functioning—the very essence of psychological well-being [39].

The confirmation of social support as a significant mediator (H2) is a cornerstone of this research. The statistical pathway (Stigma → Lower Social Support → Lower Well-Being) is brought to life by the qualitative data. The self-blame and fear of rejection engendered by stigma lead individuals to withdraw from social networks. Conversely, as powerfully articulated in Theme 3 ('The Sanctuary of Support'), accessing non-judgmental peer support provides a direct antidote. This 'corrective emotional experience' actively dismantles the cognitive distortions of internalized stigma. Theme 4 ('The Double-Edged Sword of Family') adds crucial nuance, showing that while some family support is profoundly healing, the potential for rejection from this primary group can also be a major source of stress, complicating the overall effect of social support.

Similarly, the confirmation of positive spiritual coping as a second, independent mediator (H3) is a critical contribution. The qualitative findings differentiate this into two distinct but related forms. Theme 5 ('Faith as a Foundation') reflects formal religious coping, where participants draw strength from established doctrine and community prayer. Theme 6 ('Spirituality as a Personal Journey') captures a more individualized approach, using practices like meditation to cultivate inner peace. Together, these themes demonstrate the profound resilience-building potential when individuals engage in positive spiritual coping. By reframing their diagnosis (benevolent reappraisal) and finding a new sense of purpose, participants were able to regulate the intense emotional distress caused by stigma [20, 35]. This process of meaning-making is a core tenet of emotion-focused coping and is shown here to be a vital pathway to psychological healing [24].

The finding that the mediation is partial is also highly significant. The persistence of a significant direct effect of stigma on well-being, even after accounting for the powerful roles of social support and spirituality, underscores the insidious and deeply entrenched nature of internalized stigma. It suggests that while bolstering coping resources is essential, it may not be sufficient on its own. Interventions must also directly target and dismantle the internalized negative self-beliefs themselves, alongside broader societal efforts to reduce the external stigma that fuels them [8, 26].

6.2. Comparison with Theory and Existing Literature

The study's findings provide strong empirical validation for the application of Lazarus and Folkman's Stress and Coping Theory [21] to the experience of HIV in Asia. Internalized stigma clearly functions as a chronic stressor, and social support and spiritual coping operate as effective emotion-focused and problem-focused coping resources that mediate the stressor-outcome relationship. The results align with the stress-buffering hypothesis, demonstrating that these resources are not just generally beneficial but are particularly crucial in mitigating the specific harm caused by stigma [17, 30].

When compared with existing literature, our findings both reinforce and extend previous work. The mediating role of social support is consistent with studies conducted in Western contexts [18], but this study confirms its paramount importance within collectivist Asian cultures, where social harmony and interpersonal relationships are often central to identity and well-being [5, 16]. The qualitative data suggest that in these contexts, the threat of social rejection posed by stigma is particularly acute, making the experience of acceptance profoundly therapeutic.

The significant role of spiritual coping distinguishes this study and highlights a culturally specific dimension of resilience. While some Western studies have noted the role of spirituality [34], its emergence as a strong, independent mediator in our diverse Asian sample underscores its centrality in these cultures [19, 33]. This contrasts with more secularised Western settings where spirituality may be a less universally accessed coping resource. Our findings resonate with research by Cotton et al. [20] and Tarakeshwar et al. [35], who found that positive religious coping was associated with better mental health outcomes among PLHIV. However, our study is one of the first to formally model and test this as a mediating pathway between internalized stigma and well-being in a large, multi-country Asian sample, supported by rich qualitative evidence.

The negative correlation found between internalized stigma and the use of positive spiritual coping is an important nuance. It suggests a complex relationship where stigma might initially cause a spiritual crisis, leading individuals to feel abandoned and thus less able to draw on their faith. This highlights the need for interventions that can help individuals navigate these spiritual struggles and reconnect with the positive, meaning-making aspects of their faith [32].

6.3. Practical and Clinical Implications

The findings of this study have significant and actionable implications for designing more effective and holistic HIV care in Asia.

Key Recommendations for Intervention

- **Integrate Stigma Screening and Support into Routine Care**: Clinicians and healthcare providers should routinely screen for internalized stigma using validated scales. A positive screen should trigger a referral to mental health services and, crucially, to peer support programmes. Care should be framed around not just viral suppression, but holistic well-being.

- **Champion and Fund Peer Support Programmes**: The evidence for the power of social support is unequivocal. Public health bodies and NGOs must prioritise funding, developing, and scaling up peer-led support groups. These groups, as described by participants, provide a unique 'lifeline' of unconditional acceptance that professional services alone cannot replicate. Both in-person and online models should be supported to increase accessibility.
- **Develop Culturally-Congruent, Faith-Based Interventions**: Given the strong mediating role of spiritual coping, interventions should be developed in collaboration with community and religious leaders. These could include workshops on positive spiritual coping, support groups hosted by faith-based organisations, or training for clergy on providing non-judgmental, informed support to their congregants living with HIV. Such interventions must be carefully designed to be inclusive and affirming, avoiding any potential for religious judgment.
- **Train Mental Health Professionals**: Therapists and counsellors working with PLHIV should be trained in interventions that specifically target internalized stigma (e.g., cognitive-behavioural therapy approaches that challenge negative self-beliefs) and that help clients mobilise their social and spiritual resources. This includes being competent in discussing matters of faith and spirituality in a therapeutic context.

6.4. Limitations and Directions for Future Research

Despite its strengths, this study has several limitations that must be acknowledged. First, the cross-sectional nature of the quantitative data precludes definitive causal inference. Although the mediation model is based on strong theory, longitudinal studies are needed to track the relationships between stigma, coping, and well-being over time to establish temporal precedence. Second, the use of a non-probability sampling method (purposive and snowball) means the sample may not be representative of all PLHIV in Asia. Participants connected to support organisations may have different experiences from those who are more isolated. Third, the reliance on self-report measures may be subject to social desirability bias, although the anonymity of the online survey was intended to mitigate this.

These limitations point towards several important avenues for future research:

- **Longitudinal Studies**: Prospective cohort studies are needed to confirm the causal directions proposed in the mediation model.
- **Intervention Research**: The findings provide a strong rationale for developing and testing interventions. Randomised controlled trials (RCTs) could evaluate the efficacy of a peer-support intervention or a spiritually-based coping intervention on reducing internalized stigma and improving psychological well-being.
- **Exploring Other Mediators and Moderators**: Future research should explore other potential protective factors, such as self-compassion, resilience, or community engagement. It would also be valuable to investigate potential moderators, such as gender, age, or cultural context (e.g., does the strength of these pathways differ between countries?).

- **Dyadic Research**: Investigating the perspectives of partners, family members, and friends could provide a more complete picture of how social support is provided and received within the context of HIV stigma.

7. Conclusions

Internalized stigma remains a profound threat to the psychological well-being of people living with HIV across Asia. This study provides robust mixed-methods evidence that this destructive relationship is significantly, though partially, explained by the erosion of two vital coping resources: perceived social support and positive spiritual coping. The findings paint a clear picture: stigma isolates individuals and can disconnect them from sources of meaning, thereby paving the way for psychological distress. Conversely, the embrace of an accepting community and the cultivation of a resilient faith provide powerful pathways to healing and well-being.

The ultimate significance of this research lies in its call for a paradigm shift in HIV care—a shift from a purely biomedical focus to a holistic, person-centred approach that actively fosters resilience. To improve health equity and quality of life for this population, it is imperative that public health strategies, clinical practices, and community-based efforts converge to build and sustain the very resources—social connection and spiritual strength—that allow individuals not just to survive with HIV, but to thrive.

Declarations

Ethical Approval and Participant Consent

Ethical approval for this research was granted by the Bath Spa University RAK Campus Institutional Research Review Board [Approval No. BSURAK-PSY-1093]. All procedures performed in studies involving human participants were conducted in accordance with the ethical standards of the Institutional Review Board and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. All participants provided written informed consent to participate in the study.

Clinical trial number

not applicable.

Consent for publication

Not applicable.

Data Availability Statement

The datasets generated and/or analyzed during the course of this study are not publicly accessible because of the sensitive nature of the data and the need to maintain confidentiality of the participants.

However, the datasets can be accessed by contacting the corresponding author and making a reasonable request.

Competing interests

The authors declare that they have no competing interests.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Contributions of the Authors

J.M. conceived the study, developed the research design and methodology, supervised all stages of the project, conducted the data analysis, and drafted the original manuscript. N.N. and F.L. contributed to data collection and assisted with data management and preliminary analyses. E.V. and B.H.R. supported the interpretation of findings and contributed to manuscript review and revisions. All authors reviewed and approved the final manuscript.

Acknowledgements

The authors would like to express their sincere gratitude to the partner community-based organizations and, most importantly, to the participants who generously shared their time and experiences for this research.

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Figures

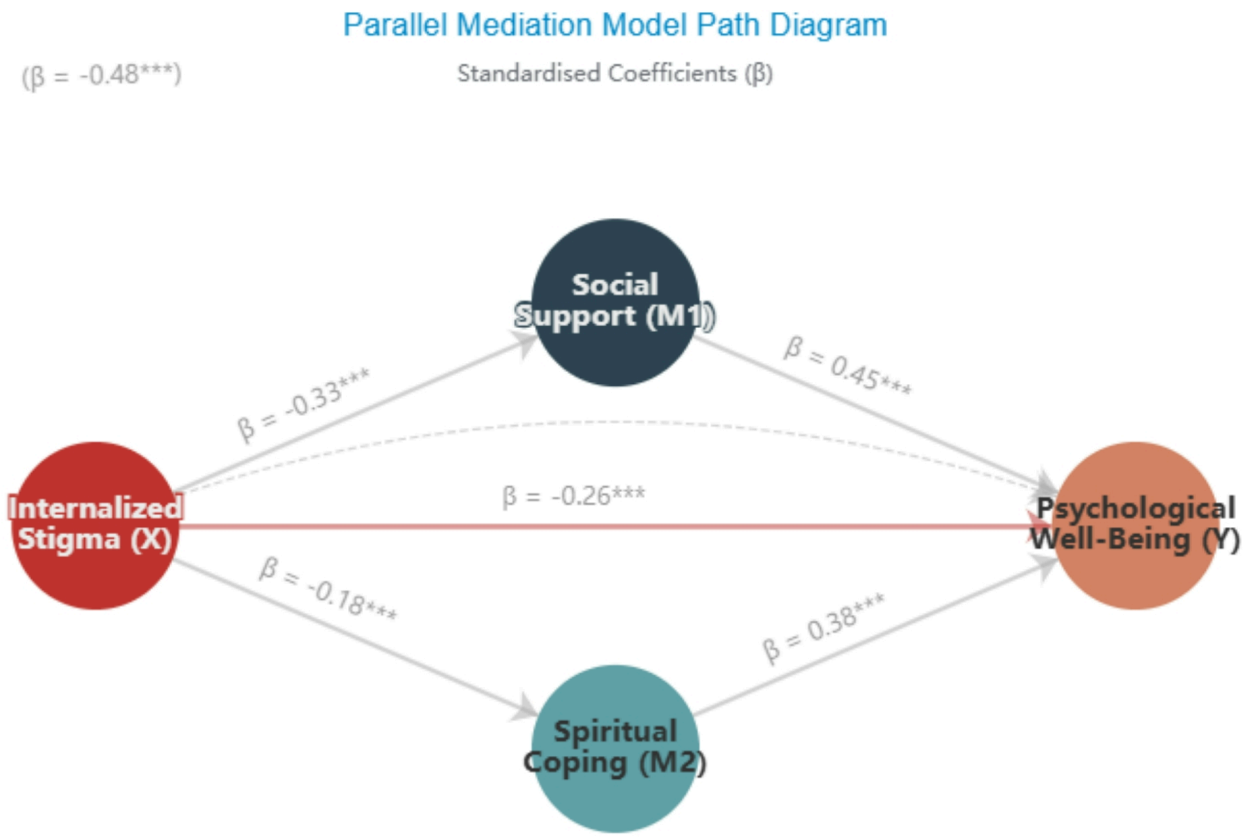


Figure 1

*Path diagram of the parallel mediation model. Standardised coefficients (β) are shown. ***p < .001.*