1

Understanding the Clinical and Social Psychological Aspects of HIV

Introduction

Where there is life, there are viruses. Viruses have probably existed since the beginning of humankind. Many have come and gone and returned—influenza, smallpox and COVID-19 are just three of many millions of viruses on the planet. Human immunodeficiency virus (HIV) is undoubtedly one of the most unique, complex and deadly viruses that humankind has known. In the relatively short period in which it has existed, HIV has infected 74.9 million and killed 32 million people around the world. Moreover, HIV has brought about the stigma, isolation and ostracisation of those it has infected and affected. The short history of HIV has been characterised by hope and despair, as the condition has transformed from being life-limiting to life-changing. It has forced society and political institutions to confront pressing polemical issues, such as sexuality, morality and human rights, in novel ways. It is a condition that generates fear in some and indifference in others. HIV is changing both medically and socially—as more effective treatments emerge, societal perceptions of the condition are shifting. In the era of ever-improving
antiretroviral therapy (ART), the ways in which individuals think about, and behave in relation to, HIV are similarly in flux.

Though a human immunodeficiency virus, some groups in society have been disproportionately affected by HIV. Acquired Immune Deficiency Syndrome (AIDS), which is late-stage HIV, was first observed in gay men who remain one of the most affected groups in Western, industrialised countries. Epidemics were later observed in intravenous drug users, heterosexual Haitians and sex workers, and HIV affects up to 25% of (mainly heterosexual) adult populations in some African countries. Yet, the association of HIV with gay men, in particular, is entrenched in societal thinking. HIV affects so many groups in society and, on both clinical and psychosocial levels, it affects these groups differently.

Today many people continue to die of AIDS when the communities in which they are embedded refuse to acknowledge HIV, stigmatise it and prohibit any discussion about the condition. In these communities, there is often very limited access to social or clinical support. The burden of HIV falls most heavily on the most marginalised groups in society, highlighting the usual fault lines of socioeconomic inequality. It is imperative to support those who are most affected, as many in these often marginalised communities feel stigmatised, disempowered and isolated. In this book, we highlight some of the remaining barriers to ensuring that all of those affected obtain access to effective clinical and psychological support.

This book focuses on the clinical and social psychological aspects of HIV among gay men. Gay men in Britain constitute a heterogeneous community—in terms of ethnicity, religion, social class and many other factors—with a rich history. Gay men have been around for a long time indeed, even though their presence has not always been explicitly acknowledged. They have faced, and continue to face, social, political and psychological ups and downs. Before delving into some of these challenges, it is advantageous to provide some definitions at the outset. After all, HIV, gay men, social psychology and clinical medicine have all been written about from distinct disciplinary, theoretical and epistemological perspectives. We must ensure a common understanding of these issues, which are discussed in the rest of this volume.
Some Definitions

HIV Risk or HIV Outcomes?

In this book, we focus both on HIV risk and on the experience of living with HIV, including clinical outcomes among those living with the condition. The principal aim is to understand the factors that can increase gay men’s risk of HIV so that suitable interventions may be developed in order to mitigate these risk factors, that is, to reduce the incidence of HIV in this key population. Moreover, a key objective of this volume is to discuss the feasibility of Britain’s target to achieve zero HIV infections by 2030.

Yet, we acknowledge that much existing research, theory and practice have focused on the prevention of HIV and sometimes neglected the identities, lives and wellbeing of people living with diagnosed HIV. It is important to examine the lives of people living with HIV in order to develop effective strategies and interventions for safeguarding their physical and psychological wellbeing. HIV medicine has advanced significantly to facilitate a good clinical prognosis for most people who are diagnosed early. We describe the ways in which the benefits of HIV medicine can be fully exploited.

It must also be acknowledged that the success of our HIV prevention efforts is dependent partly on the wellbeing of people living with HIV. After all, people living with HIV must first be tested and diagnosed in order for them to initiate ART. They must subsequently engage with HIV clinical care in order to acquire ART. And they must adhere to ART in order for treatment as prevention (TasP) to be a viable HIV prevention strategy (Maatouk & Jaspal, 2020a). Often, the reasons to test, be treated, and to adhere to ART are social psychological in origin.

The Focus on Gay Men

In this volume, we focus on gay men because this heterogeneous group remains disproportionately affected by HIV in Britain and other Western societies (see Chap. 2). This is not to say that other groups in society, such
as bisexual men and women, trans women, cisgender women and heterosexual men, should not constitute the focus of HIV research. These too are important research foci. It is hoped that research into these communities will continue. However, these communities are not the focus of the present volume.

What exactly do we mean by ‘gay men’? To address this question, it is important to note that there is a difference between sexual orientation and sexual identity. Sexual orientation can be thought of ‘as a trait that predisposes an individual to experience sexual attraction to people of the same sex (gay), to people of the opposite sex (heterosexual), or to people of both sexes (bisexual)’ (Jaspal, 2019, p. 19), while sexual identity refers to ‘the individual’s subjective perception, appraisal and categorisation of their sexual orientation’ (p. 39). The two categories—sexual orientation and identity—are often aligned in that individuals tend to identify in a way that is consistent with their behaviour, but this is of course not always the case. For instance, a man may have sex exclusively with other men but regard himself as bisexual or even as heterosexual (e.g. Maatouk & Jaspal, 2020b).

A diverse range of categories have been used to describe sexual orientation and sexual identity, such as homosexual, gay, bisexual, heterosexual, straight and others. Many more categories have come into existence, and, undoubtedly, many more will be created to capture the nuances of one’s sexual identity. In clinical research, the term ‘men who have sex with men’ (MSM) tends to be used to focus not on sexual orientation or identity but rather on sexual behaviour. It is accepted that some men who define themselves as heterosexual are mostly heterosexual but occasionally have sex with other men. It is understood that the use of sexual identity categories (e.g. gay, bisexual) with which patients do not identify could lead to disengagement from healthcare services. Therefore, a focus on behaviour, rather than identity, obviates some of the challenging tensions between sexual orientation and identity.

The reality is that a separate volume could be written about the HIV epidemic among each sexual orientation/identity group. The risk factors and care outcomes of heterosexual men are quite different from those of gay men, and those of bisexual men are different still. The lived experiences of men who identify with each of these categories appear to differ.
The level of stigma reported by bisexual men tends to be higher than that reported by gay men, for instance (Shilo & Savaya, 2012). In this volume, we focus principally on gay men, that is, same-sex attracted men who define themselves as gay. In Britain and other Western societies—the geographical focus of this volume—the vast majority of same-sex attracted men do self-identify as gay, have some level of involvement in what can loosely be described as ‘the gay community’ and exhibit some elements of shared experience. Most of the observations made in this volume are applicable principally to gay-identified men but may also be transferable to other groups of same-sex attracted men who do not identify as gay. When we discuss research into other groups of same-sex attracted men, such as bisexuals and other men who have sex with men, we make this clear.

Clinical and Social Psychological Aspects

In the title of this volume, we refer to clinical and social psychological perspectives. This is rather unusual—most volumes remain cautiously within the confines of one discipline. However, we believe that the clinical and social psychological dimensions of HIV go hand in hand. There will be only limited success in clinical care if we fail to understand the social and psychological worlds of patients, and the full potential of social psychological research into HIV cannot be fully exploited unless applied to real-world clinical contexts. This book aims to bridge these disciplinary perspectives, examining their convergences, divergences and the creative solutions that they can generate when used in conjunction.

Clinically, HIV is now a long-term manageable chronic disease. Exceptionally high levels of mortality and morbidity were the norm before the advent of effective ART, devastating many communities globally. There was an especially profound impact on gay communities in major cities. From a clinical perspective, the development of effective ART has been nothing short of life-saving for those living with HIV. Moreover, evidence showing that virally suppressed patients cannot pass HIV onto their sexual partners has been life-changing for patients (Tan, Lim, & Chan, 2020). The majority of those living with HIV in the
UK are now on effective ART and are at low risk of potentially fatal opportunistic infections and of infecting others.

We must look at the wider picture which involves identifying and resolving a range of psychological sequelae from HIV. This not only includes mood disorders and anxiety (which are disproportionately high in this group), substance use (which is particularly important in the context of ‘chemsex’ for gay men) including smoking and alcohol, but also the debilitating stigma that can impede access to clinical care and indeed to ART. Therefore, the clinical perspective espoused in this volume focuses on elucidating the social and psychological issues that can inhibit or undermine clinical health, including physical, psychological and social outcomes.

HIV affects people at multiple levels—individually, socially, politically, institutionally and so on. It is both an individual and public health concern. Social psychology is essentially the study of how the individual interacts with the social world—how the individual thinks, feels and behaves is understood to be shaped by society (Jaspal & Breakwell, 2014). Social psychology could be thought of in terms of the meeting-point between sociology (the study of societal structure) and psychology (the study of individual cognition and behaviour). Theories from social psychology enable us to understand, and sometimes to predict, individual thinking, social influence processes, interpersonal relationships and aspects of group behaviour.

As demonstrated repeatedly throughout this volume, these are important foci for the researcher interested in HIV. Social psychologists have a long-standing interest in addressing societal challenges which involve individual cognition. The HIV epidemic is undoubtedly one such challenge, and the ambitious zero-infections target is one that requires a multi-level response. A variety of methods are used in social psychology research to understand the ways in which people think and behave and, crucially, to predict how they will think and behave in particular contexts. Evidently, the ability to understand and to predict HIV risk awareness and behaviour is an important tool in HIV prevention, while the capacity to understand and predict engagement with care and adherence to ART will be vital for enhancing HIV care.
Case Studies

It is useful to begin our discussion of HIV among gay men by describing case studies that exemplify some of the social, psychological and clinical challenges confronted by gay men in the twenty-first century. It is similarly useful to consider how these challenges are in turn associated with HIV, that is, how they might increase one’s risk of infection or one’s risk of poor HIV outcomes. These case studies are intended to illustrate our rationale for focusing on the clinical and social psychological aspects of HIV among gay men, in particular. The cases are real but the individuals’ names have been changed to prevent identification.

Case Study 1: Rob, an HIV-Negative White British Gay Man

Rob is a 23-year-old White British gay man from Sunderland in North-East England. As a child, Rob struggled with his weight and physical appearance and, even though he is clinically underweight, continues to view himself as overweight. He has a diagnosed eating disorder and often eats in secret. Rob has also struggled with anxiety and depression, which improved somewhat when he came out as gay. He no longer felt the need to hide his ‘true identity’ which provided some psychological relief. His family and most of his friends were accepting of his sexual identity and provided support. Last year, Rob decided to move to London which he thought would be more gay-friendly, but he has found the gay scene overwhelming. He has made some friends and often goes to gay bars and nightclubs but, contrary to expectations, finds it impersonal and devoid of a ‘gay community’. In fact, he does not perceive any sense of community at all. His mental health issues have been resurfacing—he is feeling increasingly depressed and anxious, and due to increased social pressure to ‘look good’, his problems with eating have resurfaced. Rob sometimes uses sex to feel better about himself. He does not always enjoy the sex he has or feel particularly attracted to the men he has sex with, but casual sex gives him a temporary boost. He does not always feel confident about negotiating the type of sex he has or even condom use with his sexual partners. Rob is so focused on how he, and especially his body, is perceived by his sexual partners that condom use becomes secondary or even a non-issue in comparison. Having recently been diagnosed with chlamydia and gonorrhoea, Rob has heard about pre-exposure prophylaxis (PrEP) from the health advisor at his local sexual health clinic. He is thinking about it but in the meantime remains at significant risk of HIV.
Prima facie, HIV may not seem a salient theme in these case studies. They invoke many seemingly unrelated issues—body image concerns, eating disorders, self-esteem, homophobia, sense of community, friendship, gay dating applications, identity issues, arranged marriage and others. In the chapters that follow, we argue that these and other social psychological themes are inextricably related to HIV risk and HIV clinical outcomes. Our combined empirical and clinical observations over the years demonstrate unequivocally that, in order for us to understand how to prevent HIV and to treat the condition effectively, we must also acquire...
a detailed understanding of the lives of gay men. The risk factors are multifarious and are intimately associated with the lived experience of being gay in a heteronormative society.

Rob has long-standing mental health issues, which appear to be associated with the concealment of his sexual orientation during childhood. Rob’s preoccupation with his body image relegates HIV prevention to an inferior position in his list of priorities. He is more concerned about what his sexual partners think about his appearance than about his health. Rob is at risk of HIV and may not benefit from the highly effective prevention tools that are available because of this preoccupation. Karim’s life-long struggle with the stigma surrounding his sexual orientation is clearly compounded by the stigma of his HIV diagnosis, which he refuses to accept. He is accustomed to denial, concealment and disengagement in relation to his sexual orientation and now replicates the same coping strategies in response to his HIV diagnosis. Though designed to protect psychological wellbeing, these strategies may have serious consequences for Karim’s physical health. It is clear that the problems that both Rob and Karim face are deep-rooted—not only in their own experiences but also in the shared experience of many other gay men and in the pervasive societal stigma in relation to homosexuality and HIV. Some insight into the experience of being a gay man in contemporary Britain is useful.

Gay Men in Contemporary Britain

These case studies exemplify just some of the social and psychological challenges that gay men face. Empirical research shows that gay men are more likely than heterosexual men to have experienced sexual abuse, bullying and rejection from significant others in earlier life (Jaspal, 2019). Moreover, adult gay males are more susceptible than heterosexual males to experiencing intimate partner violence, negative body image and relationship problems (Finneran, Chard, Sineath, Sullivan, & Stephenson, 2012; Jaspal, 2019). It is noteworthy that, across the life course, gay men are exposed to heteronormativity and, often, overt homophobia, which in turn can result in the internalisation of stigma, that is, its uncritical acceptance in their self-definition. Consequently, many are
psychologically motivated to conceal their sexual orientation from others, to feign heterosexuality and, consequently, may lack a sense of identity authenticity. It is easy to see how these ‘situational stressors’ (situations that can cause psychological stress) and the often ill-fated attempts to protect oneself from them (e.g. concealment) can result in poorer mental health outcomes among gay men—an empirical fact that has been observed in many studies (see Chap. 6).

In order to understand the origins of these situational stressors, psychological self-schemata and mental health outcomes, it is important to consider briefly the history of gay men. Gay men have faced stigma, persecution and criminalisation for many centuries, including capital punishment until the nineteenth century, imprisonment and ‘conversion therapies’ designed to change their sexual orientation (Cook, Mills, Trumbach, & Cocks, 2007). Their lives have been characterised by significant social, political and psychological change in the last few decades. The decriminalisation of homosexuality in the UK in 1967 paved the way for greater openness in relation to gay sexuality, identity and community. It enabled gay men to abandon fear of prosecution in favour of hope for the future. Gradually, social and institutional attitudes began to improve. For instance, in 1973, homosexuality was removed from American Psychiatric Association’s register of mental illnesses. This in turn removed the scientific basis for pathologising attitudes towards homosexuality which constructed homosexuality as a sickness in need of ‘cure’.

Britain held its first Pride Festival on 1 July 1972, in order to coincide with the Stonewall Riots in the US—widely believed to be the beginning of modern lesbian, gay, bisexual and transgender (LGBT) activism. This served to increase the visibility of LGBT people and enabled them to replace long-standing feelings of shame with a sense of pride. In the UK, the twenty-first century saw the repeal of Section 28 (which outlawed the ‘intentional promotion’ of homosexuality in schools but actively served to stifle any acknowledgement or discussion of sexual orientation diversity), the introduction of civil partnerships and then gay marriage, and the Equality Act 2010 protecting people from discrimination on the basis of their sexual orientation and other ‘protected characteristics’.
Yet, centuries of oppression, persecution and criminalisation undoubtedly contributed to a sense of distinctiveness, activism and defiance among many gay men in the years that followed decriminalisation. There was a pervasive sense of sexual liberation among gay men who, for centuries before, had lived under repressive social and political conditions. Gay bars and nightclubs began to emerge. Gay saunas and bathhouses were frequented. Gay cruising spots were visited. Gay men used these spaces not only to seek casual sexual encounters but also to celebrate their newfound sexual freedom and to brandish a distinctive sexual identity from that of heterosexual people. Sex with multiple partners replaced the heteronormative ideal of monogamy and, for many, became a marker of gay identity. In many ways, sexualised spaces became central to gay identity, community and sexuality. When these spaces subsequently came under attack during the early phase of the AIDS epidemic, gay men construed the public health advice not to frequent gay saunas, bathhouses and cruising sites as an attack on their identity. Many defiantly refused to relinquish these spaces—emblematic of gay rights—without a fight.

When the first AIDS cases among gay men began to emerge in New York, San Francisco and London and suspicion grew that this was principally a sexually transmitted infection, these very spaces were recognised as vectors for HIV infection. Public health specialists hypothesised that, if gay saunas and sex shops were closed down and cruising grounds policed more effectively, they would be able to control the spread of HIV and reduce the number of AIDS cases. Policies such as this required the acknowledgement of gay men, their identities and, most importantly, their sexual behaviour. This was politically difficult for the Conservative government of Margaret Thatcher and the Republican administration of Ronald Reagan in the early 1980s. For several years, their government tiptoed around the issue of HIV, whom it affected and how it was spread, leading to political inertia, defiance and paralysis on all sides. This clearly contributed to the growth of the HIV epidemic and many more infections. (This is covered in more detail in Chap. 2.)

Throughout much of the 1980s, 1990s and early 2000s at least, condom use was vigorously promoted across all relevant social, community and institutional platforms. This was largely successful in creating a coercive social norm concerning condom use among gay men, which served
conversely to stigmatise the non-use of condoms as ‘reckless’ (Shernoff, 2006). Yet, many gay men did not correctly or consistently use condoms and many subsequently became infected with HIV. The norm of condom use was simply rejected by some gay men who expressed a preference for sexual freedom. Some reported a preference to die, literally, rather than give up this freedom. Others were very fearful and expressed relief at their eventual diagnosis with HIV because it at least represented closure and removed the long-standing fear of infection.

As exemplified by the case studies above and in the chapters that follow, several social, psychological and technological factors have conspired to create the ‘perfect storm’ for increased HIV incidence among gay men in the UK. Since the early days of the epidemic, new factors have emerged. Social norms in the gay community, psychological issues and technological innovation are just some of the contributing variables. The advent of the Internet in the late twentieth century created unprecedented opportunity for gay men to find sexual partners. The subsequent innovation of geospatial mobile gay social networking applications, such as Grindr and Scruff, have enabled gay men to arrange instantaneous sexual encounters with others in their geographical vicinity. The emergence of ‘chemsex’, drug use in sexualised settings, has created ideal conditions for HIV to spread and thrive.

The history of gay men has been variously characterised by stigma, concealment and freedom. Social, legal and institutional factors have contributed to its vicissitudes. HIV represented a significant setback for gay men, their social development and their physical and psychological wellbeing. There remains an increased risk of infection in gay communities throughout Britain, despite the significant advances in HIV medicine (see Chap. 3). A key tenet of this volume is that the clinical and social psychological aspects of HIV are intimately entwined.

What Is Next for HIV?

The Joint United Nations Programme on HIV/AIDS (UNAIDS) has set ambitious targets in relation to the prevention and management of HIV. By 2020, it hoped to achieve the 90-90-90 target whereby 90% of people living
with HIV would be aware of their HIV status, that 90% of those diagnosed would be in receipt of ART and that 90% of them would have a suppressed viral load. By 2030, UNAIDS hopes to achieve a target of 95-95-95, as well as the total elimination of AIDS, the late stage of untreated HIV. This ambition has underpinned the development of the UNAIDS Fast-Track strategy whose central object is the rapid scale-up of both prevention and treatment efforts throughout the world. There has been momentum and optimism behind the 90-90-90 targets, with some countries, such as Britain, having already achieved them. Yet, there are significant challenges in achieving these targets in both developed and developing countries—analyses have revealed a significant impact of social psychological, political and economic barriers (e.g. Levi et al., 2016; Maatouk & Jaspal, 2020a).

The story in Britain inspires confidence. In 2018, 93% of people living with HIV had been diagnosed, 97% of those diagnosed were in receipt of ART and 97% of those receiving ART had an undetectable viral load. Having exceeded the 90-90-90 target, Britain has now set itself an even more ambitious goal. In 2019, Matt Hancock, the Secretary of State for Health and Social Care, reiterated Britain’s ambition of zero HIV transmissions by 2030. In the same year, leading HIV charities in the UK, the Terrence Higgins Trust and the National AIDS Trust, created the HIV Commission with UK government support, in order to facilitate evidence-based recommendations for achieving the 2030 target. The HIV Commission is chaired by Dame Inga Beale and is supported by a multi-sectoral and multidisciplinary Advisory Board, responsible for collating evidence in support of the zero-infections target.

In Britain, there is optimism that this ambitious goal can be achieved. There was of course a dramatic decline in HIV incidence at the end of 2016 and, since then, there has been a steady fall in new infections each year, and, among gay, bisexual and other men who have sex with men, there was a 71% decrease in HIV transmissions between 2012 and 2018 (O’Halloran et al., 2020). It is clear that we do now possess the clinical tools to achieve zero new transmissions—condom use, regular HIV testing, PrEP and treatment as prevention are all key components. In combination, they work effectively. However, it has also become clear that clinical and biomedical approaches to HIV prevention alone are unlikely to be successful. After all, gay men must be willing to use condoms,
appraise their risk accurately and construe PrEP as personally beneficial. If they test positive for HIV, they must be able to incorporate their positive serostatus into identity, to engage with clinical services and to adhere to ART. Gay men will need to feel empowered to discuss HIV, to share their own HIV status and to negotiate safer sex with their partners. These are all quintessentially social psychological questions with significant clinical implications.

The crucial bridge between clinical medicine and social psychology constitutes the rationale for this volume. We do believe that it is possible to achieve the zero-infections target by 2030. However, we argue that an adequate understanding of the social psychological drivers of particular cognitions, emotions and behaviours among gay men will help us achieve it more quickly and effectively. If we can understand the social psychological ‘blackbox’ of risk behaviour, we will be better positioned to ensure that our clinical tools can be directed at those at risk of, and living with, HIV appropriately. If we understand the identities, histories and well-being of gay men, we might be able to predict who is likely to engage in risk behaviour and under which circumstances this will occur. In some ways, the moment of truth for HIV science has arrived—can we really end HIV transmissions and eliminate AIDS by 2030? We think that this is possible and, in the chapters that follow, explain the preconditions, commitments and actions that will be necessary for this ambitious goal to be achieved.

Why a Multidisciplinary Book on HIV among Gay Men?

HIV is unlike any other virus. It is biologically complex, targeting and hijacking the very cells intended to defend the human body. It is highly stigmatised given its associations with sex, promiscuity and mortality. And it has thrived amid such coercive societal stigma. It is evident that, in order to understand HIV, its impact and its future, a multidisciplinary approach will be necessary. In this volume, we provide such an approach, focusing on both the clinical and social psychological aspects of the
disease. More specifically, we show how social and psychological factors, such as stigma and internalised homophobia, may discernibly impact on clinical outcomes, such as HIV infection, ART initiation and virological outcomes. We argue that the effectiveness of clinical innovations in HIV, such as ART and PrEP, can be predicted only if we understand their social psychological dimensions. We believe that it is impossible to eliminate HIV and to reduce its adverse impact on gay men if either the clinical or social psychological dimensions is neglected. This volume is an attempt to integrate these two crucial dimensions of HIV in research, clinical practice and policy debates. We do so by addressing three prime questions:

• What are the major clinical and social psychological challenges associated with HIV risk, prevention and treatment among gay men?
• How can theoretical, empirical and methodological tools from the clinical and social psychological sciences be bridged in order to address some of these challenges?
• What are the next steps for HIV research, theory and practice among gay men?

Every book has a target readership. Ours is a very diverse one. This book is of course intended to benefit academic research into HIV and particularly its clinical and social psychological dimensions. The theoretical innovations, summaries of empirical research and development of future research hypotheses are provided in an attempt to enhance academic debates about HIV. It is hoped that this volume will similarly benefit practitioners involved in the care of those at risk of, or living with, HIV. Academic research is most powerful when it can be used in a way that enhances clinical practice. The ‘clinical snapshots’ presented throughout this volume are provided principally for the benefit of the HIV clinical practitioner working with gay men. This volume is intended also to demystify HIV for the general reader who will be introduced to both the clinical and social psychological dimensions of HIV, its history and its future. HIV is a condition that concerns us all. Therefore, it is important that we are all informed about it.
Overview of the Book

In Chap. 2, the history, science and epidemiology of HIV are discussed in more detail, and the rationale for focusing on gay men as a key population in the epidemic is provided. Chapter 3 focuses on aspects of gay sexuality and HIV risk in gay men, exploring the biological, social and psychological risk factors for infection in this population. Chapter 4 outlines various methods for preventing HIV infection, including condom use, PrEP, post-exposure prophylaxis (PEP) and behavioural strategies, such as ‘serosorting’. Both the clinical effectiveness and social psychological aspects of HIV prevention are examined. In Chap. 5, major developments in HIV diagnosis, management and prognosis are discussed, focusing particularly on HIV testing, the advent of ART and social psychological drivers of ART initiation and adherence. Chapter 6 examines one of the most significant comorbidities of HIV infection in the era of effective ART, namely, poor mental health. The chapter describes a reciprocal relationship between HIV and mental health, outlining both the role of poor mental health in increasing HIV risk and the adverse impact of HIV infection on mental health outcomes. In Chap. 7, the potential impact of complex intersecting identities on HIV is discussed through the case study of sexuality and ethnicity among Black, Asian and Minority Ethnic (BAME) gay men, a group at especially high risk of poor HIV outcomes. The implications for both HIV risk and HIV outcomes are considered. In the final chapter of this volume, we look towards the future of HIV in Britain and return to the three key questions posed in this introductory chapter. The feasibility of achieving the zero-infections target by 2030 in Britain is discussed, and a series of recommendations for researchers, practitioners and policymakers are offered. Theoretical, methodological and disciplinary flexibility characterise the ethos of this volume—we believe that both clinical science and social psychology should be key components of our strategy to end HIV transmissions and to eliminate AIDS by 2030. In the chapters that follow, we discuss how this ought to be done.
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