

EXAMINING THE IMPACT OF PERCEIVED AND INTERNALIZED
HIV STIGMAS ON HIV-RELATED
CIVIC ENGAGEMENT

by

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ABSTRACT

As the HIV/AIDS epidemic continues to impact the American South, funding, services, and outreach for those affected by the disease is at a premium. Effective advocacy is critical not only to support people living with HIV/AIDS but also to prevent infections. Those living with HIV/AIDS provide powerful advocacy, unmatched by others. However, HIV stigma, which impacts various aspects of the lives of those living with HIV, can also have a negative impact on the willingness of this population to advocate on issues related to HIV. Those who benefit from this funding and services are often clients of AIDS Service Organizations (ASOs) and, in addition to stigma, these individuals face issues of race, poverty, rural-ness, and the like. Literature has often treated stigma as a singular element, not differentiating between the unique manifestations of perceived and internalized HIV stigmas. For this study, it was hypothesized that both perceived and internalized stigmas would negatively impact HIV-related civic engagement, and that the impact of internalized stigma would be stronger than that of perceived. Further, it was predicted that self-efficacy, along with various demographic variables, would moderate these relationships. Clients of 9 ASOs in Alabama were surveyed. Findings revealed no relationship between perceived stigma and civic engagement, however, a significant negative relationship was evident between internalized stigma and civic engagement. Among the moderators, levels of employment and income provided significant effects. Findings indicate that ASOs could possibly increase HIV-related civic engagement among clients by providing programs designed to reduce internalized stigma and by offering opportunities to engage that are not hindered by factors relating to lacking income or employment.

DEDICATION

To my Lord and Savior, Jesus Christ, for blessings without measure.

In honor of Brad Carpenter, my friend in life and academia. This one's for you, buddy.

LIST OF ABBREVIATIONS AND SYMBOLS

α	Cronbach's index of internal consistency
β	Beta: probability of a Type II error
B	Unstandardized regression coefficient
d	Cohen's measure of effect size
df	Degrees of freedom: number of values free to vary after certain restrictions have been placed on the data
F	Fisher's ratio: A ratio of two differences
M	Mean: the sum of a set of measurements divided by the set's number of measurements
N	Total number in a sample
n	Number in a subsample
p	Probability associated with the occurrence under the null hypothesis of a value as extreme as or more extreme than the observed value
r	Pearson product-moment correlation
R^2	Multiple correlation squared; Measure of strength of a relationship
SD	Standard deviation within a sample
SE	Level of dispersion from a population mean
t	Computed value of t test
>	Greater than
<	Less than
=	Equal to

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CHAPTER 1

INTRODUCTION

For six years, this writer has been the Executive Director of West Alabama AIDS Outreach (WAAO), an AIDS (Auto Immuno Deficiency Syndrome) Service Organization (ASO) providing case management services to individuals living with HIV (Human Immunodeficiency Virus) in ten West Alabama counties. This position requires a constant finger on the pulse of federal, state, and local funding for services related to HIV. As specific service delivery techniques gain and lose favor with funding sources, as varied funding sources carry contrasting priorities during troubled economic times, and as ASOs are being asked to provide comprehensive services to an ever-increasing clientele without an increase in dollars, making one's case for HIV funding in the most effective way possible is a critical aspect of the Executive Director's job. The strength of the presentation to funders or funding bodies, including elected officials, is paramount. Having participated in a large number of public speaking engagements related to HIV and the services provided by WAAO, it was thought that such saturation of WAAO's service area with statistical information, description of the clientele, and attempted diffusion of HIV-related myths would decrease stigma within the local community and prove an effective message for greater funding on a state and local level. However, it has become apparent that, while informative, speeches or interactive community dialogues facilitated by the Executive Director – who is neither HIV+, nor is representative of the demographic of the WAAO clientele – were not creating the sought-after changes in perceptions and funding. In contrast, true change began to occur only after dialogue was established between the HIV+

community (clients of WAAO) and the community at-large. The physical, financial, relational, and societal difficulties of living with HIV, as presented by the clients, was the impetus for transformed mindsets and greater willingness to contribute by funding bodies. However, due to external and internal stigmas (whether perceived or actual), along with the poverty- and race-related issues, client willingness to participate has not been optimal.

The research proposed here was designed to address several questions: Does participation in advocacy for HIV-related causes hold value for ASO clients? Do clients perceive enough self-efficacy to believe that they can perform advocacy behaviors? What role does stigma play in the clients' willingness to advocate? A pilot study revealed that, while self-efficacy and willingness to disclose one's HIV status varied greatly among clients, all participants expressed hesitancy to advocate in a truly public forum for fear of others' reactions to their HIV status. Building upon the pilot study, this dissertation seeks to provide greater understanding of the relationship between HIV stigma and HIV-related civic engagement in the specified population. In its most generic form, civic engagement can be described as actions taken by citizens to address matters of public concern.

AIDS Service Organizations

AIDS Service Organizations (ASOs) are in a unique position to facilitate civic engagement among the disenfranchised populations living with HIV. The benefits are mutual, however, as the service-providing capabilities of ASOs are strengthened and stabilized by active civic engagement of clients (Valdiserri, Aultman, & Curran, 1995). However, while ASO staff members encourage and welcome civic engagement from clients, they understand that many clients are not comfortable engaging in activities that publicly expose them as a person living with HIV/AIDS (PLWHA).

ASOs, as nonprofit or citizen-driven organizations, came into existence in the mid-1980s due to the inadequate and insensitive response to the HIV crisis by the medical and social service communities (Hooyman, Fredriksen, & Perlmutter, 1995). Existing services provided no response or slow response, so ASOs were developed to counter any gaps in service faced by those living with the disease (Bielefield, Scotch, & Thielmann, 2000). In time, ASOs produced support services for clients and health information for the public, which decreased the impact of the disease on economic, psychological, and social front and also contributed substantially to what formal health systems offered (Fleishman, Piette, & Mor, 1990).

With these developments, ASOs became hybrid organizations that carry the dual challenge of providing both activism and services (Poindexter, 2007). Indeed, in addition to numerous administrative duties, ASO staff must challenge discrimination and stigma on various fronts (Guenter et al., 2005). ASOs are involved in community primary prevention efforts, such as education and condom distribution, which not only increase knowledge and awareness about HIV disease, but also decrease stigma. Activism also takes the form of advocating for ample funding for services on state and federal levels. Services include an array of offerings, including HIV-specific medical care, case management, housing services, counseling, and financial assistance. To maintain these services, extensive lobbying, grant writing, and fundraising is necessary, especially in an environment in which competition for resources is fierce.

The challenges of activism and service are not static. Since the early diagnoses in the U.S., ASOs have seen massive shifts in populations most affected by HIV, advances in medication which increase the lifespan of those living with the disease and swings in federal and state funding (Demmer, 2002). As the face of HIV has changed, ASOs have been forced to confront issues of culture, discrimination, and poverty in new ways (Myrick, 1999).

An Overview of HIV in the South

Approximately 30 years ago, when HIV was initially diagnosed in the U.S., diagnoses were primarily centered in metropolitan coastal areas (Wapner, 2011). However, in recent years, the southern U.S. has become disproportionately affected by HIV by claiming half of the new cases, yet comprising only 37% of the nation's population. The South also reports the highest rate of new infections and the highest death rate related to the disease (Wapner, 2011).

In the South, "racial prejudice, homophobia, poverty, homelessness, unemployment, lack of insurance and access to affordable health care and substance abuse and mental health challenges are all factors that exceed the national average" (Southern AIDS Coalition, 2012, p. 6). Further, the South possesses the greatest percentage of poverty in the nation (Bishaw, 2011). With HIV infection related to homelessness, joblessness, and low education attainment (Denning & DiNenno, 2010) and with poverty being a strong determinant of HIV infection (Southern AIDS Coalition, 2012), it is reasonable to conclude that the socioeconomic, cultural, and stigma-related factors in the South predispose a subset of citizens to HIV.

The disproportionate impact of HIV/AIDS in the southern African-American community is alarming. In the South, most individuals living with HIV/AIDS, new cases of HIV and AIDS, and deaths related to AIDS are comprised of racial and ethnic minority groups (The Henry J. Kaiser Family Foundation, 2012a). Indeed, 50% of poor, black households are found in the southern U.S. (Wapner, 2011). Mississippi provides an enlightening message on both this population and its youth as "the number of new cases of HIV among black men (in Mississippi) aged 13 to 31 years who had sex with other men rose by 48% from 2005 to 2007." (Wapner, p. 4).

Impact of Political and Economic Processes on HIV in the South

Despite the disproportionate and consistent increase in HIV cases in the South, this same population has access to fewer resources and there is uncertainty about the long-term prospect of retaining the resources that currently exist. For example, the Ryan White C.A.R.E. (Comprehensive AIDS Resources Emergency) Act, federal funding for individuals living with HIV, was insufficient in the South, based on a faulty federal formula, until 2012 (Southern AIDS Coalition, 2012). Federal healthcare reform via the Affordable Care Act could rearrange eligibility requirements for low-income individuals with HIV, shrinking the Ryan White benefits for those in need (American Academy of HIV Medicine, 2010). Ryan White funds must be reauthorized at regular intervals by Congress (American Academy of HIV Medicine, 2011), and the amount of Housing Opportunities for Individuals Living with HIV/AIDS (HOPWA) funding is appropriated on an annual basis (Vos, 2011). Changes in either of these programs could have dire consequences for the specified population. In addition, states have great flexibility over the facilitation of the AIDS Drug Assistance Program (ADAP), an HIV-specific medication payment assistance plan for individuals with low income and little or no prescription drug coverage (The Henry J. Kaiser Family Foundation, 2012b). Though ADAP is attached to Part B of federal Ryan White Funding, each state administers its own program, meaning that, if federal funding is not sufficient, the state can choose to supplement ADAP through its own budget. The combination of economic downturns in many states and ADAP funding that does not rise to meet increased demand forces states to implement cost-saving measures. Due to these factors, many states increase the difficulty of financial eligibility for ADAP, reduce the number of medications available under ADAP, and create waiting lists for individuals in need of life-saving medications (The Henry J. Kaiser Family Foundation, 2012b).

Similarly, Medicaid income eligibility is based on individual state policy. In the South, “the income cutoff for eligibility is lower on average than elsewhere and is a fraction of the federal poverty level, leaving many without the ability to access this medical help” (Armstrong & Marconi, 2012, p. 2). Although the Obama administration released the National HIV Strategy, which in-part, specified the underserved HIV populations in the South, and assured increased funding in February 2011, Medicaid cuts (a joint state and federal venture) may continue to restrict services from those most in need (Wapner, 2011). Although ASOs and clinics exist for low-income individuals with HIV, service coordination can be challenging. But, “in rural areas, where resources may be more widely scattered and the number of PLWHIV (people living with HIV) may be relatively smaller, the coordination challenges may be even more extensive” (Stewart, Phillips, Walker, Harvey, & Porter, 2011, p. 345). Regardless of service availability, and due in great part to the life challenges described above, over 50% of HIV+ individuals in the South are not receiving adequate treatment (Wapner, 2011).

HIV in Alabama

In Alabama specifically, the statistics are alarming. As of March 31, 2013, Alabama has 18,245 documented cases of HIV/AIDS since the start of the epidemic (Alabama Department of Public Health, 2013). The Alabama Department of Public Health (ADPH) estimates that there are another 2,000-4,000 HIV positive individuals in the state who have not yet been diagnosed and are unaware that they have HIV. During 2012, there were 592 newly-diagnosed HIV infections reported in Alabama (Alabama Department of Public Health, 2013). According to the Centers for Disease Control and Prevention (CDC, 2010), Alabama’s new HIV case rate ranked 12th among the 46 states reporting new HIV diagnoses in 2010. This same report ranked Alabama 26th out of 50 states and the District of Columbia in rate of new AIDS cases.

HIV and AIDS continue to disproportionately impact Alabama's African-American population. African-Americans comprise 26% of the state's population, but account for 69% of all Alabamians living with HIV/AIDS in 2011 (Alabama Department of Public Health, 2011). As of 2009, the HIV diagnosis rate is 8 times higher in African-American men and women than in their same-gender white counterparts (Prejean, Tang, & Hall, 2012). Young persons (ages 13-34) accounted for 57% of newly diagnosed cases (Alabama Department of Public Health, 2011). Alabama also has a sizeable rural HIV burden, with 25% of cumulative cases among rural residents (Alabama Department of Public Health, 2011).

On a related note, as HIV+ individuals often struggle with poverty and unemployment, Alabama is the 10th poorest state in the country, with 17% of its residents living below the federal poverty level (FPL) (Alabama Department of Public Health, 2011). The state ranked 25th among states in its December 2012 unemployment rate (United States Bureau of Labor Statistics, 2013). Further, the U.S. Census Bureau's 2011 American Community Survey indicates that there are approximately 700,000 uninsured Alabamians (over 18% of residents under 65 years of age).

The Need for HIV-related Civic Engagement

In the simplest sense, civic engagement, also referred to as citizen participation, describes the public impact that citizen action has on communities and political life (Christiano, 1996). To ensure that sufficient federal, state, and local funding is provided to adequately maintain necessary services, continual lobbying and advocacy is essential. In light of these issues, the importance of advocacy and lobbying should not be underestimated. As will be discussed in the following section, the low-income, HIV population in Alabama faces a multitude of factors that decrease the likelihood of this group engaging in civic engagement, or advocacy, in attempts to

obtain or maintain HIV-related services. However, it is the need that this population has of these services, as well as the poignant personal experiences that result from the undue influence of these factors in their lives, that creates such necessity for this population to advocate on their own behalves.

Benefits of Civic Engagement

The benefits of civic engagement are well recognized. Advocates believe it improves a community's quality of life environmentally, socially, and economically (Mannarini, Fedi, & Tripetti, 2010). Indeed, increased civic engagement increases equality, develops better policies, and encourages the democratic process (Nabatchi, 2010). Further, proponents perceive citizen involvement as a valuable enterprise, which nurtures citizenship values, improves accountability, increases trust in government, and ultimately creates better decisions. (King, Feltey, & Susel, 1998)). In these terms, the proper functioning of civic engagement is essential for the citizenry at-large and especially for disenfranchised groups.

The benefits of civic engagement for disenfranchised groups are substantial as well. Facilitating acts of participation increases the political efficacy for those who do perceive themselves to be well represented in party politics (Ikeda, Kobayashi, & Hoshimoto, 2008). When distrust has developed, providing just one positive advocacy experience can lead to a greater perception by citizens of the responsiveness of public officials (Halvorsen, 2003). The insights provided by these citizens are important, as those with experience related to a certain cause can offer valuable guidance to those making policy decisions (Walters, Aydelotte, & Miller, 2000). So, there is hope that, by providing previously-disengaged citizens with positive civic engagement experiences, such citizens can develop into individuals who are much more

likely to advocate on their own behalf. However, due to stigma, many of those living with HIV/AIDS may not participate civically.

Barriers to Civic Engagement among the Specified Population

Those who wish to encourage the advocacy efforts of this population must recognize the personal and circumstantial factors that enhance or impede civic engagement. This population faces socioeconomic/political barriers to participation, as well as the deleterious effects of HIV stigma. Yang and Pandey (2011) state that “most scholars recognize that citizen involvement is embedded in current institutional arrangements and constrained by many political, social, economic, and individual factors” (p. 880). Due to processes and outcomes that lack saliency with many constituent groups and despite the notion that civic engagement theoretically provides political footing to the at-large citizenry, “citizens tend to participate only when strongly motivated to do so and most of the time, they are not motivated” (Rosener, 1982, p. 343). These notions are especially true regarding the specified low-income population in which civic service and trust in those who serve is lacking (Mosley & Grogan, 2012).

When HIV is added to an already-disenfranchised population, factors that would increase the likelihood of participation shrink further. HIV stigma has been associated with lacking social support, physical and mental health, and income (Logie & Gadalla, 2009). Further, stigma increases the risk of depression (Berger, Ferrans, & Lashley, 2001), negatively affects self-esteem and self-image (Berger et al., 2001), and decreases one’s life satisfaction (Buseh & Stevens, 2006). It is important to note that this population does not benefit from the same collective political voice that benefitted the gay community during the time when the disease was new to the U.S. (Armstrong & Marconi, 2012).

Summary

A multitude of studies have independently examined aspects of HIV stigma and civic engagement as related to the specified population. Housing stability, minority status, and income have been found to positively affect participation in block associations and neighborhood improvement activities (Perkins, Brown, & Taylor, 1996), while a lack of opportunities, a lack of support from government and non-governmental agencies, and public misunderstanding of poverty hinder civic engagement from individuals with low income (Ravensbergen & VanderPlaat, 2009). HIV stigma has been shown to have a negative effect on general social participation (Stevelling, van Brakel, & Augustine, 2011), as well as medication adherence and quality of life (Li, et al., 2011). There remains, however, a dearth of literature which examines the direct relationship between HIV stigma and civic engagement.

Structure of the Dissertation

The next chapter reviews previous literature on issues related to civic engagement and HIV stigma, as well as the identified moderators of generalized self-efficacy and demographic variables. The chapter also presents the proposed model for this study and discusses the theoretical underpinnings for its development. Chapter 3 details the study's design, including the specific measures designed to elicit perceived and internalized HIV stigma, political efficacy, and level of civic engagement. Chapter 4 examines the findings of the study, as well as findings for each hypothesis. Lastly, Chapter 5 discusses the implications of the study's results on how perceived and internalized HIV stigma affect civic engagement and how self-efficacy and demographic variables moderate these relationships.

CHAPTER 2

REVIEW OF THE LITERATURE

As described in the following review of the literature, civic engagement theoretically plays an essential role in American society. In a practical sense, however, a multitude of factors prevent equal participation among all groups and the implementation of initiatives or policies that are efficacious for all. perceived HIV stigma and internalized HIV stigma may manifest themselves in distinct ways regarding civic engagement, and these relationships may, in turn, be affected by self-efficacy and demographic factors.

Civic Engagement

Civic engagement can take the form of politics, advocacy, voting, board memberships, community meetings, and informal community work (Verba, Schlozman, & Brady, 1995). Roberts (2004) promotes the theoretical or optimistic view of civic engagement as “the process by which members of a society (those not holding office or administrative positions in government) share power with public officials in making substantive decisions and taking actions related to the community” (p. 320). Arnstein (1969) provides a definition that is most applicable to disenfranchised groups when describing civic engagement as:

the redistribution of power that enables the have-not citizens, presently excluded from the politics and economic processes, to be deliberately included in the future. It is the strategy by which the have-nots join in determining how information is shared, goals and policies are set, tax resources are allocated, programs are operated, and benefits like contracts and patronage are parceled out. In short, it is the means by which they can induce significant social reforms which enable them to share in the benefits of the affluent society. (p.216)

Barriers to Ideal Civic Engagement

Benjamin Barber (1984) would describe a strong democracy as one in which citizens self-govern “frequently enough and in particular when basic policies are being decided and when significant power is being deployed” (p. 151). However, when public participation fails, it “can leave in its wake a dissatisfied and even restive public, ineffectual decisions, and a weakened if not faltering democracy” (Thomas, 1995, p. 2). The reasons for this failure are myriad.

Some argue that the current system negates the true intent of the democratic process by substituting public participation with obscure analysis from experts (Walters et al., 2000). While participation can lead to better-developed planning and execution, the decisions of officials often repress active participation (Burby, 2003). Citizens can become cynical and distrustful due to ineffectively-managed interactions between the government and its citizens (Berman, 1997).

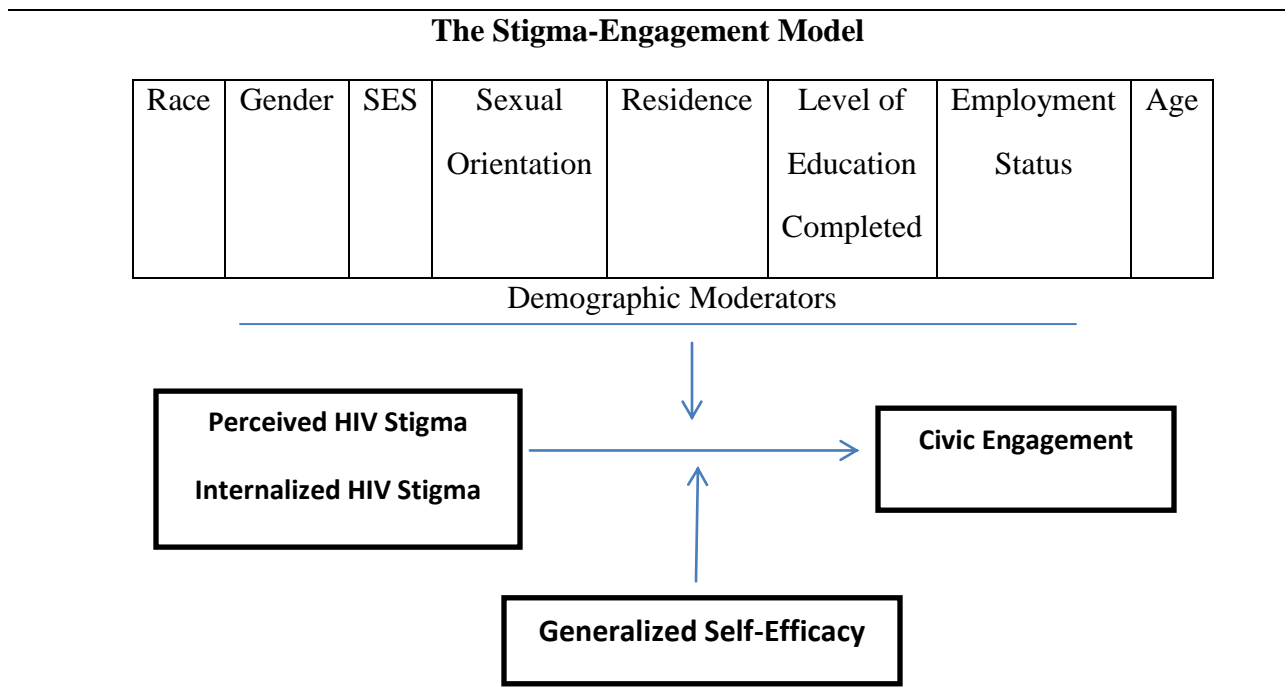
Individual and community factors impede participation as well. Verba, Scholzman, and Brady (1995) found that the type of participation promoted by Barber is strongly predicted by the time, money, and skills possessed by an individual or group. They also found that those who do not participate, do not have the ability, do not have the desire, or have not been asked to participate. This lack of ability and desire may stem from a multitude of factors. As Ramakrishnan and Baldassare (2004) note, “though civic engagement may involve acts of individual choice, these choices are often structured by various social, economic, and institutional factors...thus poverty, education, cultural norms, mental or physical disabilities, family obligations, and other factors” influence civic engagement (p. 14). Additionally, individual participation may be affected by the institutions that are predominant in one’s life (schools or churches), social capital, and the cumulative social cohesion and collective efficacy of the groups with which one identifies (Small & Supple, 2001). Hence, for disenfranchised

groups, low rates of participation may be attributable to lacking resources, social capital, and collective efficacy, as well as perceptions of not being legitimately represented in policy decisions. In addition to disenfranchisement, the population of those living with HIV carries the additional weight of HIV-related stigma and poverty. It is noteworthy that for many, low-income, HIV+ individuals, treating HIV is not their top priority. Rather, the more urgent needs of food, clothes, housing, and healthcare prevail in their minds (Wapner, 2011). Though the need for participation is evident, the aforementioned factors often prevent it. Current research will address the role stigma has on civic engagement and some of the possible moderators of the relationship.

Introduction of the Stigma-Engagement Model

A dearth exists in the literature concerning the impact of HIV stigma on civic engagement. It is due to this deficiency that the current study was undertaken. To assist with defining and exploring this relationship, the following model is proposed:

Figure 2.1. The Stigma-Engagement Model



The model labels ‘Perceived HIV Stigma’ and ‘Internalized HIV Stigma’ as the Independent Variables, ‘Civic Engagement’ as the Dependent Variable, ‘Generalized Self-Efficacy’ as the Main Moderator, and demographics as ‘Demographic Moderators’.

Theoretical Treatise of the Model

Expectancy Theory

The proposed model builds on Expectancy Theory’s notion that expectancy, instrumentality, and valence, as perceived by the specified population, will impact, at least partially, the population’s motivation to engage in civic engagement. In his seminal 1964 book, *Work and Motivation*, Victor Vroom proposed the concept of Expectancy Theory (also referred to as VIE Theory). This theory attempts to explain how individuals make decisions regarding various behavioral alternatives. That is, Expectancy Theory sheds light on the reasons that individuals may or may not be motivated to engage in certain behaviors, including civic engagement. Expectancy Theory has been utilized as a theoretical base for diverse areas of research, such as organizational behavior (Vroom, 1964), coalition formation (Wahba & Lirtzman, 1973), social power (Nagel, 1968), achievement motivation (Atkinson, 1964), decision making (Edwards, 1961), and attitudes (Peak, 1955). Wahba and House (1974, p. 121) refer to Expectancy Theory as “perhaps the most widely accepted theory of work and motivation,” while Connolly (1976) describes it as the “dominant paradigm” for motivation research.

Vroom (1964) viewed motivation as a product of three factors – expectancy, instrumentality, and valence. In the words of Vroom, expectancy is defined as temporary belief regarding the chances that a specific act will be followed by a specific result. In other words, expectancy refers to the belief that one’s effort will result in the attainment of a desired performance goal(s). Motivation will be increased as one believes that one has the ability to reach a particular goal. If one perceives that, regardless of the extent of effort exerted, the goal

cannot be attained, motivation will diminish. Factors associated with an individual's expectancy perception are self-efficacy, goal difficulty, and one's perceived control over performance.

Instrumentality is the belief that a reward will be received if a performance expectation is met. If an individual believes that he or she can successfully complete a certain act, he or she must also believe that the act will be accompanied by a reward or else motivation will be decreased. This reward may come in the form of a pay increase, promotion, recognition, or a sense of accomplishment. Valence refers to the value that an individual personally places on a reward(s) for a given behavior. If an individual can complete a task and knows that a reward follows, the value of that reward to the individual will further determine the extent of motivation. An individual's values, needs, and goals dictate the extent of value held toward a particular outcome. According to Vroom, the cumulative effect of an individual's perceptions of expectancy, instrumentality, and valence toward a given behavior will result in the extent of motivation experienced by the individual. If members of the specified population can be convinced that they can productively take part in civic engagement behaviors (expectancy), that these behaviors will result in an increase of HIV-related resources (instrumentality), and that these increased resources are of value to the individual or to the group as a whole (valence), it could be predicted that civic engagement behaviors may increase. This research utilizes Expectancy Theory as a platform with which to predict the interaction between HIV stigma (perceived and internalized) and HIV-related civic engagement.

Stigma

The pioneering work on stigma was provided by Goffman (1963), who described stigma as "an attribute that is deeply discrediting," as it takes the person "from a whole and usual person to a tainted, discounted one" (p. 3). Attributes that are publicly discredited may be physical

deformities, faults of character, or tribal stigma. Alonzo and Reynolds (1995) accurately describe the plight of stigmatized individuals as “a category of people who are pejoratively regarded by the broader society and who are devalued, shunned, or otherwise lessened in their life chances and in access to the humanizing benefit of free and unfettered social intercourse” (p. 304). These descriptions provide a solid base for describing perceptions of stigma related to HIV.

HIV-related Stigma: Definition and Issues

Stigma is a significant issue for those living with HIV or AIDS (Sowell, Moneyham, & Demi, 1992). Herek, Capitano, and Widaman (2002) define HIV-related stigma as biases and discrimination against individuals with HIV or AIDS. This stigma is specific to HIV and especially aggressive due to several factors. The infected person is blamed for contracting the disease, which is incurable, and contagious with symptoms of infection that are often obvious to others (Green & Platt, 1997; Herek & Mitnick, 1998). In addition, individuals with HIV are viewed as dangerous (Skelton, 2006), the public fears contracting the disease (Bogart et al., 2008) and the public holds negative perceptions of methods of HIV transmission, such as prostitution and injection drug use (Herek & Capitano, 1999). Sexist and racial stereotypes also play into the stigma (Taylor, 2001). Stigma has been expressed through social exclusion, bigotry, avoidance, stereotyping, and violence (Parker & Aggleton, 2003).

Various types of HIV-related stigma have been identified, such as perceived, internalized, enacted, symbolic, and instrumental (Logie & Gadalla, 2009). Among these, perceived and internalized are the stigma types that are developed by the perceptions of those living with HIV/AIDS. Perceived stigma is the “awareness of social attitudes and discriminatory and prejudicial actions toward persons living with HIV/AIDS (Phillips, Moneyham, & Tavakoli,

2011). Internalized stigma refers to “socially constructed views and negative stereotypes about HIV/AIDS and persons with HIV/AIDS that become incorporated into the self-concept” (Phillips, Moneyham, & Tavakoli, 2011). That is, perceived stigma refers to the recognition of negative societal attitudes, while internalized stigma refers to believing those negative presumptions about oneself.

Impact of HIV-related Stigma

The negative impact of stigma is often manifested in every area of one’s life. AIDS stigma is related to depression (Vyavaharkar et al, 2010), physical and mental difficulties (Wolitski et al., 2009), decreased life satisfaction (Greeff et al., 2010), and lessened quality of life (Abboud, Nouredinia, Huijera, DeJong, & Mokhbat, 2010). Due to fears of stigma, PLWHA (People living with HIV/AIDS) often avoid prevention and treatment for lengthy periods of time (Herek, Capitanio, & Widaman, 2003). This avoidance can lead to delayed diagnosis and poor treatment adherence, which may result in drug resistance and greater likelihood of disability (van Brakel, 2006; Weiss, Ramakrishna, & Somma, 2006). Opportunities in marriage, employment, and education are burdened by stigma as well (Tsutsumi et al., 2004). As HIV stigma is related to lower levels of emotional support (Silver, Bauman, Comacho, & Huidis, 2003) and with the process of disclosure being expressed as traumatic (Miller, 2002), stigma often prevents disclosure to family members, medical professionals, friends, and sexual partners (Anglewicz & Chintsanya, 2011). By not disclosing, discrimination is controlled, and yet the need for support remains (Shehan et al., 2005).

Although no research exists exploring the relationship between HIV-related stigma and civic engagement, these aforementioned related issues can assist in inferring a relationship. The differences in how perceived stigma and internalized stigma are manifested behaviorally in

regard to civic engagement have not often been explored, either. It is posited within this current research that both perceived and internalized stigma will share a negative relationship with civic engagement. However, because those with internalized stigma have incorporated negative aspects into their view of self, it is posited that internalized stigma will affect civic engagement more negatively than perceived stigma. This reasoning is applied to all subsequent hypotheses. Based on the assumptions presented above, the following hypotheses were developed:

H1a: A negative relationship exists between participants' perceived HIV stigma and civic engagement.

H1b: A negative relationship exists between participants' internalized HIV stigma and civic engagement.

H1c: The negative relationship between internalized HIV stigma and civic engagement will be greater than the negative relationship between perceived HIV stigma and civic engagement.

Generalized Self-efficacy (GSE)

“People who regard themselves as highly efficacious act, think, and feel differently than those who see themselves as inefficacious.”

Albert Bandura

While studies have examined various areas of specific self-efficacy (i.e., political, educational, coping), generalized self-efficacy (GSE) refers to “one’s estimates of one’s capabilities to mobilize the motivation, cognitive resources, and courses of action needed to exercise control over events in one’s life” (Judge, Locke, & Durham, 1997, p. 153). According to Bandura (1977), self-efficacy is “not a measure of the skills one has but a belief about what one can do under different sets of conditions with whatever skills one possesses” (p. 37). He also asserts that self-efficacy is the core ingredient in adapting well to various areas of functioning in life (Bandura, 1997). Perceived self-efficacy is paramount in the self-regulation of motivation (Bandura, 1993). Low self-efficacy breeds low motivation, which will decrease one’s likelihood to attempt a task if the chances of success are poor (Schunk, 1994).

Self-efficacy and HIV

Self-efficacy can impact a multitude of factors related to civic engagement, retention in healthcare, and sexual safety. Regarding civic engagement, general self-efficacy carries a positive relationship with engagement with healthcare providers (Corless, et al., 2012). And, high internal self-efficacy increases the likelihood of voter turnout (Southwell, 2012). Specific to HIV, health status is affected by one's self-efficacy (First, Spitzer, Gibbon, & Williams (2002), as are levels of depression (Luszczynska, Mohamed, & Schwarzer, 2005), HIV disease progression (Ironson & Hayward, 2008), and medication adherence (Barclay et al., 2007). High self-efficacy is positively associated with condom use (Burns & Dillon, 2005), reduction in HIV risk behaviors (Kang, Deren, Andia, Colon, & Robles, 2004), engagement with healthcare providers (Corless et al., 2012), and social support (Wang et al., 2008).

Self-efficacy and Civic Engagement

Self-efficacy plays a vital role in civic engagement as well. While high internal self-efficacy increases the likelihood of voter turnout (Southwell, 2012), political activity among citizens with disabilities is significantly lower than those without such disabilities (Schur, Shields, & Schriener, 2003).

No research has distinguished between the behavioral manifestations enacted on perceived and internalized stigma by self-efficacy. However, as previously discussed, all related research suggests that self-efficacy will have a positive impact on a desired behavior. Therefore, it is posited that self-efficacy will have a positive relationship with civic engagement. Self-efficacy should carry more of a positive relationship with civic engagement when moderating perceived stigma, as opposed to internalized stigma. That is, those with internalized stigma incorporate negative stigma-related presumptions into their personal views of self, potentially affecting self-

efficacy. It is also plausible that the self-efficacy of those with perceived stigma may remain intact, as the internalization of stigma does not occur and the generalized positive views of one's abilities remains intact.

Based on these assumptions, the following hypotheses were developed:

H2a: The relationship between perceived HIV stigma and civic engagement will be moderated by self-efficacy, such that those with lower levels of self-efficacy will exhibit less civic engagement.

H2b: The relationship between internalized HIV stigma and civic engagement will be moderated by self-efficacy, such that those with lower levels of self-efficacy will exhibit less civic engagement.

H2c: The negative relationship between internalized stigma and civic engagement, as moderated by self-efficacy, will be greater than the negative relationship between perceived stigma and civic engagement, as moderated by self-efficacy.

Several demographic variables have strong potential to impact the negative relationship between stigma and civic engagement. Though these variables are discussed individually (i.e., race, gender, socioeconomic status), it should be noted that the collective contextual effect that these factors have on an individual is of prime concern, and proper discussion requires some overlap. For example, African-American women living with HIV describe “interdependent and mutually constitutive relationships between marginalized social identities and inequities such as HIV-related stigma, sexism, racism and homo/transphobia” and “these overlapping, multilevel forms of stigma and discrimination are representative of an intersectional model of stigma and discrimination” (Logie, James, Tharao, & Loutfy, 2011, p. 1). These effects for all demographic variables are discussed in the following section:

Race & Ethnicity

For African-Americans, elevated rates of HIV are associated with socioeconomic factors, such as poverty (Denning, DiNenno, & Weigand, 2011), dangerous neighborhoods (Latkin,

Curry, Hua, & Davey, 2007), and unstable housing (Aidala, Cross, Stall, Harre, & Sumartojo, 2005). Unfortunately, Harris, Sinclair-Chapman and McKenzie (2005) found that gains in black political empowerment were undermined by negative social and economic factors. African-Americans report less political trust than Whites (Rahn & Transue, 1998) and are less politically efficacious (Abramson, 1977). Verba and Nie (1987) report that, while Blacks participate less than Whites, the gap is not large, especially in terms of voting behaviors. Regarding civic engagement, African-Americans, Asians, and Hispanics participate less and exhibit higher attrition from civic engagement activities from year to year (Foster-Bey, 2008).

Latino immigrants do not participate in nonelectoral political activities as often as their naturalized counterparts (Verba, Schlozman, & Brady, 1995). However, naturalization itself does not create broader inclusion into the democratic process for Latinos (Levin, 2013) and, regardless of naturalization, political trust often remains low (Abrajano & Alvarez, 2010). This is partially explainable by understanding that Latinos may not become naturalized in order to be included, but rather for access to welfare benefits, a U.S. passport, and lessened restrictions on sponsoring the immigration of foreign-born relatives (Alvarez, 1987; Yang, 1994).

For all races and ethnicities, disclosure - which often occurs during HIV-related civic engagement - is positively related to retention in care (Wohl, et al., 2011). For African-Americans, internalized stigma is negatively associated with disclosure and is related to negative interpersonal consequences (Overstreet, Earnshaw, Kalichman, & Quinn, 2013). Latinos exhibit lower rates of disclosure than White possibly explained in part by traditional Latino values that denigrate homosexuality and inhibit open communication regarding sexual behavior (Zea et al, 2004). Relatedly, African-Americans exhibit the highest levels of total stigma, followed by Latinos and Whites (Loutfy, Poppen, Echeverry, Reisen, & biachi, 2012). It stands to reason

that fears of disclosure and high perceptions of stigma would negatively affect participation in civic engagement. Therefore, the following hypotheses were developed:

H3a: The relationship between perceived HIV stigma and civic engagement will be moderated by race/ethnicity, such that African-Americans and Latinos will be less likely to exhibit civic engagement behaviors than Whites.

H3b: The relationship between internalized HIV stigma and civic engagement will be moderated by race/ethnicity, such that African-Americans and Latinos will be less likely to exhibit civic engagement behaviors than Whites.

H3c: The negative relationship between internalized HIV stigma and civic engagement, as moderated by race/ethnicity, will be greater than the negative relationship between perceived HIV stigma and civic engagement, as moderated by race.

Gender

Piccoli and Rollero (2010) suggest that gaps in participation between men and women are related more to context than to specific gender characteristics. For example, women generally engage more in specific local issues, while men more often involve themselves in broader policy issues (Bertelsen, 1974). As Enloe (2002) notes, contextual differences may be partially explained due to traditional sex-role expectations being engrained in men and women and these expectations reinforce women's marginalization in politics. While women are more likely to engage in civic activities (Verba, Schlozman, & Brady, 1995), marginalization is apparent as they are also more likely to doubt their abilities in electoral politics (Fox & Lawless, 2011). Despite this doubt, women are still more likely to vote but are less engaged in various political activities (Marcelo, Lopez, & Kirby, 2007). It is interesting to note, however, that Black women participate more often in electoral politics than Black men (Kaba & Ward, 2009).

The majority of studies present a picture of greater HIV stigma against women than men (Nyblade, et al., 2003; Colbert, Kim, Sereika, & Erlen, 2010). Indeed, Sandelowski, Lambe, & Barroso (2004) found that, although women are predominately infected in heterosexual,

monogamous relationships, they face real or perceived stigma due to presumptions of promiscuity, sex work, and drug use. For women especially, HIV stigma creates barriers to medication adherence, healthcare utilization, and healthy social interactions (Carr & Grambling, 2004). Based on these findings, the following hypotheses were developed:

H4a: The relationship between perceived HIV stigma and civic engagement will be moderated by gender, such that women will be more likely to exhibit civic engagement behaviors than men.

H4b: The relationship between internalized HIV stigma and civic engagement will be moderated by gender, such that women will be more likely to exhibit civic engagement behaviors than men.

H4c: The positive relationship of internalized HIV stigma and civic engagement, as moderated by gender, will be weaker than the positive relationship of perceived HIV stigma and civic engagement, as moderated by gender.

Income

One's level of income carries a positive relationship with civic participation (Levin-Waldman, 2013; Perkins, Brown, & Taylor, 1996), as does family income (Foster-Bey, 2008). Income level also affects volunteering and group membership (Crawford & Levitt, 1999; Rohe & Basolo, 1997). Those who are politically engaged are those "with the biggest stakes in society," generally including those of higher income (United States Census Bureau, 2002, p. 3). Relatedly, one's skills, knowledge, and confidence comprise one's human capital and these attributes are heavily based on one's socioeconomic status (Ferguson & Dickens, 1999). This status predicts one's civic participation as well (Liu, Wright, & Orey, 2009).

HIV stigma has been associated with poverty and is more common among those of low socioeconomic status (Amuri, Mitchell, Cockroft, & Anderson, 2011). Enacted stigma has been found among those who provide medical care to low-income patients with HIV, and this stigma is perceived by the patients (Kinsler, Wong, Sayles, Davis, & Cunningham, 2007). For low-

income Hispanics, HIV stigma is deleterious to psychological and physical functioning, as well as social support (Larios, Davis, Gallos, Heinrich, & Talavera, 2009). Collectively, these factors suggest that low income could impede civic engagement. Based on this reasoning, the following hypotheses were developed:

H5a: The relationship between perceived HIV stigma and civic engagement will be moderated by income, such that those of lower income will be less likely to exhibit civic engagement behaviors than those of higher income.

H5b: The relationship between internalized HIV stigma and civic engagement will be moderated by income, such that those of lower income will be less likely to exhibit civic engagement behaviors than those of higher income.

H5c: The negative relationship of internalized HIV stigma and civic engagement, as moderated by income, will be greater than the negative relationship of perceived HIV stigma and civic engagement, as moderated by income.

Sexual Orientation

While transsexuals and gays are prominent in certain AIDS-specific activities (Jennings & Anderson, 2003), the extent of general homosexual civic engagement, when income and education are controlled for, is unclear (Sturmer & Simon, 2004; Swank & Fahs, 2011). Herek and Capitanio (1999) found that, though blamed is placed on all PLWHAs (people living with HIV/AIDS), gay or bisexual men are assigned more blame for HIV infection than infected heterosexual men or women. Similarly, Logie et al. (2011) found homophobia to be a major concern for lesbian women living with HIV. Stigma has a profoundly negative effect on the self-esteem of men who have sex with men (MSM) and can create an internalized homophobia within the MSM himself (Preston et al., 2007). As one of the assumptions of this study is that stigma negatively affects civic engagement and as stigma is a major concern within the homosexual community, the following hypotheses were developed:

H6a: The relationship between perceived HIV stigma and civic engagement will be moderated by sexual orientation, such that non-heterosexuals will be less likely to exhibit civic engagement behaviors than heterosexuals.

H6b: The relationship between perceived HIV stigma and civic engagement will be moderated by sexual orientation, such that non-heterosexuals will be less likely to exhibit civic engagement behaviors than heterosexuals.

H6c: The negative relationship of internalized HIV stigma and civic engagement, as moderated by sexual orientation, will be greater than the negative relationship of perceived HIV stigma and civic engagement, as moderated by sexual orientation.

Area of Residence: Urban vs. Rural

The differentiations between rural and urban civic engagement depend on a multiple factors and vary depending on the type of activity (Thananithichot, 2012). Specifically, rural residents tend to participate in local issues in which they can have more personal contact with those involved in a particular issue (Putman, 2000). Rural residents are also much less likely to be invited to participate in political activities (Stromblad & Myrberg, 2013).

Perceived stigma and disclosure concerns are related to community size, meaning that rural residents describe greater fear of stigma than those in metropolitan areas (Gonzalez, Miller, Solomon, Yanushka, & Cassidy, 2009). For rural residents with HIV, psychological distress due to HIV status is increased by the prevalence of stigma and social isolation (Basta, Shacham, & Reese, 2009). Indeed, rural women have been found to suffer from depression stemming from perceived and internalized stigma (Vyavaharkar, Moneyham, Murdaugh, & Tavakoli, 2012). The fact that stigma further intensifies healthcare disparities faced by rural residents (Brems, Johnson, Warner, & Roberts, 2010) only exacerbates the HIV-related issues faced by rural residents. Due to high levels of stigma and the larger context (non-local) in which civic engagement is measured in this study, the following hypotheses were developed:

H7a: The relationship between perceived HIV stigma and civic engagement will be moderated by residence, such that those living in rural areas will be less likely to exhibit civic engagement behaviors than those in urban areas.

H7b: The relationship between internalized HIV stigma and civic engagement will be moderated by residence, such that those living in rural areas will be less likely to exhibit civic engagement behaviors than those in urban areas.

H7c: The negative relationship of internalized HIV stigma and civic engagement, as moderated by residence, will be greater than the negative relationship of perceived HIV stigma and civic engagement, as moderated by residence.

Level of Education Attained

Rosenstone and Hansen (1993, p. 14) believe that “educational experience fosters democratic values and nurtures a sense of civic competence, both of which encourage participation.” One’s level of education is an extremely strong predictor of civic engagement (Verba, Schlozman, & Brady, 1995). Despite findings which suggest that education levels weaken national attachment and patriotism (Straughn & Andriot, 2011), education continues to heavily influence several types of social participation, such as voting, associational membership, and giving blood (Putman, 2000).

No prior research has specifically examined the relationship between HIV stigma (perceived and/or internalized) and one’s level of education. However, based on civic engagement data not related to HIV, the following exploratory hypotheses were developed:

H8a: The relationship between perceived HIV stigma and civic engagement will be moderated by level of education attained, such that those with higher levels of education will be more likely to exhibit civic engagement behaviors than those with higher levels.

H8b: The relationship between internalized HIV stigma and civic engagement will be moderated by level of education attained, such that those with higher levels of education will be more likely to exhibit civic engagement behaviors than those with higher levels.

H8c: The positive relationship of internalized HIV stigma and civic engagement, as moderated by level of education, will be weaker than the positive relationship of perceived HIV stigma and civic engagement, as moderated by level of education.

Employment Status

For studies examining the impact of unemployment on civic engagement, conflicting results have been reported. Some find that unemployment has only mild impact on participation (Lorenzini & Giugni, 2012) and creates no differences in volunteering rates (Rotolo & Wilson, 2012). The majority of studies, however, find a negative relationship between unemployment and civic engagement (Wilson & Musick, 1997; Musick & Wilson, 2008). Schur (2003) reports that a lack of resources, a lack of being asked to participate, and debilitating or distressing psychological factors (related to unemployment) prevents participation from the unemployed. Indeed, since social connections fade for the unemployed (Musick & Wilson, 2008) and self-esteem suffers (Dooley & Catalano, 2003), the unemployed may not possess the emotional or practical resources to participate in civic activities (Lasby, 2004). Additionally, low voter turnout and political trust are related to unemployment (Chabanet, 2007).

HIV discrimination in the workplace is extensive, often including unfair hiring practices, promotion systems, and termination without proper cause (Sprague, et al., 2011). For employers, fear of contagion and perceived incompetence can negatively affect decisions to hire people living with HIV/AIDS (Liu, Cauada, Shi, & Corrigan, 2012). Since unemployment is a barrier to civic engagement and HIV stigma is a barrier to employment, the following hypotheses were developed:

H9a: The relationship between perceived HIV stigma and civic engagement will be moderated by employment status, such that those who are unemployed will be less likely to exhibit civic engagement behaviors than those who are employed.

H9b: The relationship between internalized HIV stigma and civic engagement will be moderated by employment status, such that those who are unemployed will be less likely to exhibit civic engagement behaviors than those who are employed.

H9c: The negative relationship of internalized HIV stigma and civic engagement, as moderated by employment status, will be greater than the negative relationship of perceived HIV stigma and civic engagement, as moderated by employment status.

Age

Several authors (Galston & Lopez, 2006; Sander & Putnam, 2006; Putnam, 2000) have found age cohort to be the strongest predictor of civic engagement. Older Americans volunteer, vote, and attend church more than younger ones (Galston & Lopez, 2006; Sander & Putnam, 2006). To this point, evidence shows that older adults participate extensively in civic activities and, in such, provide tangible benefits to their communities (Hinterlong, 2008), while the current young generation is seemingly unconcerned and uninvolved civically (Jenkins, 2005).

Older adults (50 and above) with HIV experience significant perceptions of stigma (Emlet, 2007). The intersection of aging and HIV, as explored by Wallach and Brotman (2013, p. 1212) describes “the experience of premature aging, the impact of HIV on intergenerational relationships, the shrinking of one’s social network, rejection experienced by the older population, a difficult return to work and a deterioration in living conditions.” Also, older adults with HIV are less likely to disclose to others than are their younger counterparts (Emlet, 2006). Though older adults generally engage more civically, it is hypothesized in this study that HIV stigma will be significant enough to reverse this trend among the specified population.

Therefore, the following hypotheses were developed:

H10a: The relationship between perceived HIV stigma and civic engagement will be moderated by age, such that those who are older will be less likely to exhibit civic engagement behaviors than those who are younger.

H10b: The relationship between internalized HIV stigma and civic engagement will be moderated by age, such that those who are older will be less likely to exhibit civic engagement behaviors than those who are younger.

H10c: The negative relationship of internalized HIV stigma and civic engagement, as moderated by age, will be greater than the negative relationship of perceived HIV stigma and civic engagement, as moderated by age.

Summary

Though, in theory, civic engagement is available to all citizens, individual and social conditions often prevent true equality in participation. For those living with HIV, stigma was presented as a major barrier to civic engagement. For many clients of ASOs, issues of poverty and lacking social resources also present barriers. With these issues in mind and with Expectancy Theory as a platform, the Stigma-Engagement Model was developed. As predictors of HIV-related civic engagement among the specified population, perceived and internalized HIV stigmas were hypothesized to be significantly negative. Yet, the impact of internalized stigma was presumed to be stronger than that of perceived stigma. Self-efficacy and demographic variables were predicted to carry significant moderating relationships as well.

CHAPTER 3

METHODOLOGY

This chapter describes a quasi-experimental design that examines the effects of perceived and internalized HIV stigmas on the HIV-specific civic engagement of those living with HIV who are currently served by AIDS Service Organizations (ASOs) in Alabama. This study is also intended to shed light on how self-efficacy and demographic variables moderate this relationship. As described in the detailed procedures in this chapter, this study presents participants with a survey measuring participants' levels of perceived stigma, internalized stigma, and self-efficacy, as well as specific acts of HIV-related civic engagement performed within the past two years. Additionally, the survey notes demographic variables and two qualitative questions related to civic engagement. Statistical analyses for this dissertation are generated using SPSS. Approval of the Institutional Review Board of The University of Alabama was obtained prior to data collection (Appendix C).

Setting and Sample

Nine (9) AIDS Service Organizations (ASOs) in Alabama agreed to offer clients the opportunity to participate in this study. These ASOs represent all ASOs in the state. Collectively, they provide services to each county in the state, leaving no county unrepresented or underserved. Letters of support and permission were obtained from all ASOs. The sample for this study consisted of ASO clients who received medical or case management services in their respective ASO offices during the time period that the surveys were being offered and who accepted the invitation to participate. Two hundred and ten (210) surveys were distributed and a

total of 207 were returned, representing a response rate of 99%. Some respondents chose not to provide information related to demographics or scale items. Of those who completed this information, 68.8% were male (n = 137), 30.7% female (n=61), and 0.5% transgender (n = 1). The mean age was 43.81 (SD = 11.46), and ranged from 14 to 71 years of age. The sample was 75.1% African-American (n = 148), 19.3% Caucasian (n = 38), 2.5% Hispanic (n = 5), 0.5% Asian (n = 1), and 2.5% other (n = 5). Participants identified as 50.8% heterosexual (n = 92), 34.3% gay or lesbian (n = 62), 9.9% bisexual (n = 18), and 5.0% other (n = 9). The sample also included populations of 61.1% urban (n = 102) and 38.9% rural (n = 65).

Data Collection Procedures

Safety of Participant Information

Due to the vulnerability of the population being studied, all attempts were made to secure the confidentiality of the names and information provided by participants. Since surveys contained no identifying information about participants and the only identifying information would have been the signature of participants on the informed consent, a waiver of signed informed consent was requested from and approved by IRB.

Each survey contained an individual code (e.g., WAAO01, AA12, HSC06), representing the AIDS Service Organization (ASO) in which the survey was completed and the order in which the survey was completed at that agency. These codes were used only to differentiate among individual participants during data analysis. As is customary for all client-related data, all information obtained through surveys remains locked in a secure file cabinet in a secure office. Likewise, the computer used to analyze data was password protected and utilized an encrypted server. Data will be stored for no more than one year. Only the PI and dissertation committee

members have access to it. Individual data will not be shared with outside agencies or individuals; however aggregate data may be used in presentations or publications.

Psychological Safety of Participants

In the venues in which surveys were completed, ASOs, the participants' HIV statuses were already known and, in these venues, participants were accustomed to answering questions related to their HIV status. Further, all the demographic information requested on the survey was already in the participants' files in the ASOs. In this setting, questions on the survey were not generally considered overly-sensitive or controversial and, as is standard with consent, participants were made aware that participation was optional and that they were under no obligation to answer any questions which made them uncomfortable. While it was highly unlikely that participants would face any psychological risks while completing the surveys, Case Managers were available to assist. These Case Managers, who already have access to records indicating the HIV-positive status of participants, were bachelor- or master's-level Social Workers, experienced specifically in dealing with the HIV population. Further, Case Managers have been trained in HIPAA compliance and have undergone annual supervision regarding such compliance. At the onset of services by an ASO, clients provided written consent of all services provided by an ASO. Therefore, in this study, only Case Managers, who were already acquainted with clients and who already had approved access to client records, had access to the client/participant.

Recruitment

No special recruitment process or advertising took place. When participants visited their respective ASOs for regularly-scheduled medical or case management services, Case Managers offered participants the opportunity to complete a survey. If interested, and after receiving

instructions from a Case Manager, participants retrieved a copy of the survey from the designated location in the ASO, completed the survey in the previously-designated private area, placed the completed survey in the ‘Completed Surveys’ folder, and received a Wendy’s coupon from a Case Manager. On average, this process required approximately 10 minutes of participants’ time. The overall sample and ASO-specific samples represented convenience rather than randomness.

Inclusion and Exclusion Criteria

Case Managers had previously completed professional psycho-social assessments on participants. They were, therefore, able to refer only those with requisite cognitive abilities to provide legally effective informed consent and with requisite literacy levels to complete the surveys per the instructions. Within these parameters, participants needed only be clients of an ASO in Alabama.

Consent Form

The reading level for the consent form was rated as 8.0 by the Flesch-Kincaid Scale. The consent form was developed using the online template provided by the IRB, and it incorporated all eight fundamental elements necessary for an acceptable informed consent.

Survey Completion Method

Packets containing the following items were made available to each of the AIDS Service Organizations: a) fifteen (15) blank surveys with attached informed consents, b) a Wendy’s coupon for each participant, c) an envelope in which to store yet-to-be-completed surveys, d) an envelope in which participants were to place completed surveys, e) a self-addressed return envelope in which all completed surveys were to be returned to the researcher, and f) general instructions for Case Managers. It should be noted that a facet of the instructions included basic

directions on assisting participants in understanding the survey process. Due to the low literacy level of some participants, Case Managers were also advised on how to provide basic explanations of the survey questions (only when necessary) without ‘leading’ participants to particular answers. Once received, all data were inputted into SPSS for analysis.

Measures for Research Variables

All measures for this research were administered through paper surveys. Each participant encountered a total of 50 questions. These surveys requested the following demographic information from participants: age, race, gender, sexual orientation, level of education completed, employment status, income, and county of residence (to determine urban or rural). Informational items concerning number of dependents, length of HIV diagnosis, use of public assistance, and physical/emotional ability to work were also included. Two qualitative questions regarding civic engagement were included as well: ‘What are the reasons that you are involved in community activities about HIV?’ and ‘What are the reasons that you are *not* involved in community activities about HIV?’ Participant responses to these questions are provided in Appendix B. In addition to the information described above, the survey was also comprised of 4 previously-established scales.

Civic Engagement Scale

A political participation scale, developed by Verba, Schlozman, & Brady (1995), was modified into a generalized civic engagement scale related to issues surrounding HIV/AIDS. The original scale included items concerning voting, campaign work, and campaign contribution. However, these items were considered to share greater alignment with political participation than generalized civic engagement and were eliminated from this survey. The remaining 6 items were included; however, in the original scale, one item questioned respondents’ participation in a

protest, and was revised to include protest or political meeting. Though the original scale required a 'yes' or 'no' response to each item, the response choices for the modified scale were re-cast as '0 times,' '1 time,' '2 times,' '3 times,' and '4 or more times,' with scores ranging from 0 to 4. A copy of the survey used in this study is available in Appendix A. Responses were summed with a possible range of 0 to 24. A Cronbach's alpha of the revised scale used for this research was .88.

Perceived Stigma Scale (PSS)

The Perceived Stigma Scale (PSS), developed by Sowell, Moneyham, and Demi (1992), is a 12-question scale intended to measure how those living with HIV think others perceive them. Items include 'I felt blamed for my illness by others' and 'I felt people avoided me because of my illness.' Although the original PSS utilized a four-point Likert scale, with participants scoring each item from (1) 'never' to (4) 'always,' for this study, the response choices were altered to increase variability and to increase uniformity with the other scales used in the survey. Participant response choices became 'not at all,' 'rarely,' 'sometimes,' 'often,' and 'all the time.' The revised measure can be found in Appendix A. Scores were coded from (0) 'not at all' to (4) 'all the time,' and responses to the 12 items were summed. Reliability of this measure for this study was .91.

Internalized Stigma of AIDS Tool (ISAT)

The Internalized Stigma of AIDS Tool (ISAT), developed by Phillips, Moneyham, and Tavakoli (2011), is a 10-item scale which measures how individuals living with HIV perceive themselves due to their diagnosis. The scale applies a 5-point Likert scale with responses ranging from (1) 'disagree' to (5) 'strongly agree.' One item is reverse coded, and all items are summed.

A copy of the scale is available in Appendix A. This scale is supported by a Cronbach's alpha of .89 for this study.

Generalized Self-Efficacy Scale

A generalized self-efficacy scale, developed by Judge et al. (1998), measures the belief in one's own ability to complete tasks and reach goals. The scale is *generalized*, meaning that it intends to encompass one's self-efficacy within the scope of all of life's activities. It is also intended for use with the general population and, as such, was not designed specifically for those living with HIV. This measure is comprised of 8 items with a 5-point Likert scale, ranging from (1) "strongly disagree to (5) "strongly agree." Five items are reverse scored. Total items are summed to form a generalized self-efficacy score. This scale can be found in Appendix A. Cronbach's alpha for this scale in this study was .76.

In order to test the hypotheses, distinctions needed to be made within each demographic variable. Each variable was dichotomously coded. Race was coded as 'African-American' and 'Other.' As 75% of respondents were African-American, 'Other' was designated as a suitable comparison group, consisting of 'Caucasian,' 'Latino,' 'Asian,' and 'Other.' Although hypotheses specified that Latino responses would be analyzed with African-Americans, Latinos represented only 2.5% of respondents, so keeping the 'African-American' group homogenous was deemed to be a measure of extracting more generalizable results.

Gender was coded as 'Male' and 'Female.' One respondent identified as 'Transgender.' This respondent was removed from analysis.

Income was labeled as 'At or Below 100% Federal Poverty Level' and 'Above 100% Poverty Level.' Federal Poverty Level (FPL) guidelines are the method of preparing estimates of the number of Americans in poverty each year. As a majority (68%) of respondents reported

income (and dependents) which would place them at or below 100% FPL, the distinction was made at this 100% mark in order to gauge the impact of poverty on civic engagement. While the responses on the survey did not match Federal Poverty Level (FPL) guidelines precisely, they were deemed roughly equivalent. The responses included all that were below \$10,000 annually, while FPL is currently \$11,490 for a household of one. Further, FPL is calculated by incorporating one's income and one's number of dependents. Approximately 80% of respondents reported 0 or 1 dependent, which would not dramatically alter the FPL calculation using only one's income.

Sexual orientation was labeled as 'Heterosexual' and 'LGB/Non-Heterosexual.' The LGB/Non-Heterosexual group included 9 who identified as 'Other.'

Residence was coded as 'Urban' and 'Rural.' Distinctions were made by the county of respondent's residence. Rural locations were designated as those outside of counties with census urban areas with populations of less than 50,000 (U.S. Census Bureau, 2010).

Level of employment was coded as 'Employed' or 'Not Employed.' 'Employed' incorporated responses of both full-time and part-time employment. This allowed for a higher 'Employed' sample to be contrasted with an already-large 'Not Employed' sample. It also allowed for an estimate of the impact of any amount of paid employment on civic engagement.

Education was coded as 'High School and Below' and 'More than High School' to gauge the impact of higher education. The 'More than High School' distinction was also developed in order to contrast with an already-large 'High School and Below' group.

Age was coded as '44 and below' and '45 and above.' Though many distinctions of age exist, these have been utilized in numerous studies (Thane, 1989; DeLamater & Moorman, 2007; Sheriff & Chenoweth, 2009).

Summary

In order to assess the respective impacts of perceived and internalized HIV stigmas on HIV-related civic engagement, two hundred and seven (207) clients of nine ASOs in Alabama were surveyed to determine respective levels of perceived stigma, internalized stigma, self-efficacy, and civic engagement. Demographic data were also collected and were formulated into dichotomous variables in order to test the hypotheses.

CHAPTER 4

RESULTS

Overview

Results were generated through regression and moderation analyses using IBM SPSS Statistics 22. Analyses also included reliabilities of scales, frequencies of the demographic variables, correlation tables, and descriptive statistics. All main variables were centered to account for some of the multi-collinearity. A Wilcoxon Ranked Sum Test was performed to determine if significant differences existed between the means of perceived stigma, internalized stigma, and self-efficacy.

The proposed model was designed to incorporate all variables and interactions into a regression analysis. However, due to issues of power and collinearity, several methods of analyses were performed in order to provide a comprehensive description of results. The first analysis was a regression model, which incorporated the main effects as well as all interactions. The second analysis was a set of nine regression models, which included one specific main effect in each model along with its associated interactions. Post hoc analyses included two methods: a) use of a regression model which assessed all variables collectively and b) use of a set of 11 regression models which assessed all variables independently.

Correlational and Descriptive Data

Several significant correlations were revealed in the analyses. Perceived stigma and internalized stigma shared a strong positive relationship ($r(159) = .69, p < .01$). While perceived stigma had no relationship with civic engagement ($r(175) = -.07, ns$), internalized stigma and

civic engagement shared a weak negative relationship ($r(169) = -.26, p < .01$). Self-efficacy shared a weak negative relationship with perceived stigma ($r(162) = -.29, p < .01$), a moderate negative relationship with internalized stigma ($r(163) = -.40, p < .01$), and a weak positive relationship with civic engagement ($r(173) = .15, p < .05$). Correlational data and descriptive statistics for all major variables are presented in Tables 4.1 and 4.2.

Sexual orientation shared a significant relationship with all 4 major variables. This relationship was weak and positive with civic engagement ($r(171) = .24, p < .01$) and self-efficacy ($r(157) = .21, p < .01$) and weak and negative with perceived stigma ($r(163) = -.25, p < .01$) and internalized stigma ($r(155) = -.24, p < .01$). Sexual orientation also shared a weak positive relationship with education ($r(178) = .20, p < .01$) and a moderate negative relationship with employment ($r(177) = -.35, p < .01$). These results are summarized in Tables 4.2 and 4.4.

Education shared weak positive relationships with civic engagement ($r(187) = .16, p < .05$) and self-efficacy ($r(171) = .25, p < .01$), and employment shared a weak and significant negative relationship with civic engagement ($r(181) = -.17, p < .05$). These results are summarized in Table 4.3.

Income held a moderate negative relationship with employment ($r(177) = -.35, p < .01$) and a weak positive relationship with age ($r(115) = .21, p < .05$). Age also held a positive weak relationship with gender ($r(122) = .22, p < .05$). These results are summarized in Table 4.4.

Additionally, three paired-samples Wilcoxon signed rank tests were conducted to determine whether there were significant differences between average scores for perceived stigma and internalized stigma, perceived stigma and self-efficacy, and internalized stigma and self-efficacy. Each of these analyses was not found to achieve statistical significance, indicating no significant median differences between these pairs of measures. Significant median

differences were not found when comparing perceived stigma and internalized stigma ($z = 1.091$, $p = .275$), or when comparing perceived stigma and self-efficacy ($z = .737$, $p = .461$).

Additionally, a significant difference was also not indicated when comparing internalized stigma and self-efficacy ($z = .081$, $p = .936$).

Table 4.1.

Correlations Among Major Variables

	Civic engagement	Perceived stigma	Internalized stigma	Self-efficacy
Civic engagement	_____			
Perceived stigma	-.07	_____		
Internalized stigma	-.26**	.69**	_____	
Self-efficacy	.149*	-.29**	-.40**	_____
** $p < 0.01$ level				
* $p < 0.05$ level				

Table 4.2.

Descriptive Statistics of Major Variables

	<i>M</i>	<i>SD</i>	<i>n</i>
Civic Engagement	3.00	5.50	193
Perceived Stigma	10.36	10.07	175
Internalized Stigma	26.27	9.49	177
Self-Efficacy	29.49	6.44	183

Table 4.3.

Correlations Among Major Variables and Demographics 1

	Race	Gender	Income	Sexual Orientation
Civic engagement	-.05	-.08	.14	.24**
Perceived stigma	-.06	.11	-.11	-.25**
Internalized stigma	-.05	-.03	-.05	-.24**
Self-efficacy	.01	-.08	.10	.21**

** $p < 0.01$ level

* $p < 0.05$ level

Table 4.4.

Correlations Among Major Variables and Demographics 2

	Residence	Education	Employment	Age
Civic engagement	-.11	.16*	-.17*	.12
Perceived stigma	-.07	-.03	.10	-.16
Internalized stigma	-.01	.05	.10	-.14
Self-efficacy	.10	.25**	-.21	.00

** $p < 0.01$

* $p < 0.05$

Table 4.5.

Correlations of Demographic Variables

	Residence	Education	Employment	Age
Race	.07	.08	.00	-.07
Gender	.05	-.10	.10	.22*
Income	.07	.10	-.35**	.21*
Sexual orientation	.02	.20**	-.29**	-.18

** $p < 0.01$

* $p < 0.05$

Direct Relationships

Regression analysis of the direct relationship between perceived stigma and civic engagement revealed no relationship ($\beta = -.07$, ns). Internalized stigma was found to be a strong negative predictor of civic engagement ($\beta = -.23$, $p < .005$). These results are summarized in Table 4.9.

Predicted Moderations

Self-efficacy provided no moderating effect for the relationship between perceived stigma and civic engagement ($\beta = -.10$, ns) or internalized stigma and civic engagement ($\beta = .01$, ns).

Likewise, race ($\beta = .34$, ns; $\beta = .14$, ns), gender ($\beta = .42$, ns; $\beta = .01$, ns), sexual orientation ($\beta = -.11$, ns; $\beta = -.25$, ns), residence ($\beta = .35$, ns; $\beta = .16$, ns), education ($\beta = -.21$, ns; $\beta = -.12$, ns), and age ($\beta = .10$, ns; $\beta = -.32$, ns) provided no moderating effects for either of these relationships.

Income provided no significant moderating effect for perceived stigma and civic engagement ($\beta = .14$, ns) but was a significant moderator for the relationship of internalized

stigma and civic engagement ($\beta = -.28, p < .05$). The interaction between internalized stigma and income was found to be statistically significant and negative. This result indicates that the positive effect of income on civic engagement is reduced as internalized stigma increases.

Similarly, employment was not a significant moderator for perceived stigma ($\beta = -.07, ns$), yet was a significant moderator in the relationship between internalized stigma and civic engagement ($\beta = 1.02, p < .05$). The significant interaction between employment status and internalized stigma, which was statistically significant and positive, indicates that the negative impact of unemployment on civic engagement becomes less negative as internalized stigma increases. These results are summarized in Table 4.7.

Post Hoc Analyses

While the regression analyses summarized in Tables 4.6 and 4.7 were useful in determining the strength of all variables and interactions when assessed collectively or as independent interactions among relevant variables, direct effect analyses were necessary to determine the effect that perceived and internalized stigmas have on civic engagement. The regression summarized in Table 4.8 focused on the main effects of all variables and omitted interaction effects. This analysis was initially run to provide information in regard to perceived and internalized stigma, but it revealed interesting information regarding demographic variables as well. As studies of this population's relationship with civic engagement are scarce, it was deemed necessary to report significant additional findings. Also, the regression models summarized in Table 4.9, which were originally run only for perceived and internalized stigmas, were run for each variable as well.

In this analysis summarized in Table 4.8, statistical significance was indicated with respect to the effect of education ($\beta = .22, p < .05$) as well as internalized stigma ($\beta = -.28, p <$

.05). Specifically, greater civic engagement was found to be associated with higher education as well as reduced internalized stigma.

Table 4.9 summarizes the results of the final set of analyses. Here, statistical significance was indicated with respect to self-efficacy ($\beta = .15, p < .05$), sexual orientation ($\beta = .24, p < .005$), education ($\beta = .16, p < .05$), and employment ($\beta = -.17, p < .05$). Specifically, a greater degree of civic engagement was found to be associated with greater self-efficacy, an LGB sexual orientation, a higher level of education, and being employed. As each of these regression models only included a single predictor variable, the ANOVAs associated with each of the models along with the adjusted R-squared values were not reported.

Additionally, data were drawn from the previous regression analyses. The initial regression, which included main effects with all variables and all interactions, found respondent age to achieve statistical significance. Increased age was found to be associated with greater civic engagement ($\beta = .33, p < .05$). These results are included in Table 4.6.

The second set of regression models, focusing upon the significance of the main effects of the demographic and related variables along with their associated interactions, found statistical significance was indicated with respect to the effect of income ($\beta = .22, p < .05$), urban/rural status ($\beta = -.18, p < .05$), education ($\beta = -.20, p < .05$), and employment ($\beta = -.16, p < .05$). With regard to income, higher income was found to be associated with greater civic engagement. Reduced civic engagement was found to be associated with rural status, while higher education was again found to be associated with increased civic engagement. Finally, this model found unemployment to be associated with reduced civic engagement. These results are included in Table 4.7.

Table 4.6.

Regression Analysis on Main Effects with All Variables, All Interactions Collectively

Variable	B	SE	β	<i>t</i>	<i>p</i>
(Constant)	-8.403	7.114		-1.181	.244
PS * Race	.175	.307	.410	.571	.571
PS * Gender	.435	.338	.963	1.287	.205
PS * Sexual Orientation	-.060	.274	-.164	-.220	.827
PS * Urban/Rural	.365	.321	1.003	1.136	.262
PS * Education	-.093	.302	-.259	-.308	.760
PS * Employment Status	-.260	.330	-.862	-.787	.436
PS * Age	-.203	.288	-.497	-.704	.485
IS * Race	.036	.300	.083	.121	.904
IS * Gender	-.387	.328	-.817	-1.181	.244
IS * Sexual Orientation	-.110	.269	-.286	-.410	.684
IS * Urban/Rural	-.038	.371	-.094	-.103	.918
IS * Education	-.219	.299	-.597	-.731	.469
IS * Employment Status	.208	.315	.656	.659	.513
IS * Age	-.002	.294	-.006	-.008	.993
PS*Self-Efficacy	-.007	.022	-.100	-.324	.748
IS*Self-Efficacy	.001	.021	.017	.062	.951
Perceived Stigma Centered	-.202	1.013	-.370	-.200	.843
Internalized Stigma Centered	.443	1.119	.764	.396	.694
Self-Efficacy Centered	.144	.135	.169	1.072	.290
Gender (Female)	2.415	2.445	.172	.988	.329
Employment (Unemployed)	-1.944	1.882	-.170	-1.033	.307
Race (Other)	-.092	1.510	-.008	-.061	.952
County (Rural)	-2.783	1.655	-.244	-1.681	.100
Education (> High School)	1.981	1.527	.181	1.297	.202
Sexual Orientation (LGB)	2.489	1.974	.224	1.261	.214
Age (in years)	.152	.067	.332	2.258	.029

Note. $F(26, 69) = 1.534, p = .105$; Adjusted $R^2 = .168$.

Table 4.7.

Regression Analyses on Main Effects with All Variables, All Interactions Independently

Variable	B	SE	β	<i>t</i>	<i>p</i>
<i>Model 1^a</i>					
(Constant)	.034	.403		.085	.932
Perceived Stigma Centered	.040	.054	.082	.746	.457
Internalized Stigma Centered	-.143	.057	-.285	-2.514	.013
Self-Efficacy Centered	.063	.068	.080	.924	.357
Self-Efficacy * PS	-.007	.008	-.102	-.856	.393
Self-Efficacy * IS	.001	.009	.011	.094	.925
<i>Model 2^b</i>					
(Constant)	1.340	1.157		1.158	.249
Perceived Stigma Centered	-.107	.169	-.213	-.630	.530
Internalized Stigma Centered	-.226	.162	-.450	-1.393	.166
PS * Race	.133	.136	.342	.982	.327
IS * Race	.054	.124	.143	.434	.665
Race	-.988	.885	-.092	-1.117	.266
<i>Model 3^c</i>					
(Constant)	1.351	1.141		1.184	.238
Perceived Stigma Centered	-.140	.161	-.278	-.866	.388
Internalized Stigma Centered	-.162	.160	-.323	-1.014	.312
PS * Gender	.163	.120	.424	1.356	.177
IS * Gender	.004	.120	.011	.036	.971
Gender	-1.117	.837	-.106	-1.334	.184
<i>Model 4^d</i>					
(Constant)	-1.805	.766		-2.356	.020
Perceived Stigma Centered	–	–	–	–	–
Internalized Stigma Centered	–	–	–	–	–
PS * Income	.068	.056	.139	1.221	.224
IS * Income	-.139	.057	-.277	-2.437	.016
Income	.862	.316	.220	2.724	.007
<i>Model 5^e</i>					
(Constant)	-2.605	1.300		-2.004	.047
Perceived Stigma Centered	.119	.171	.238	.698	.486
Internalized Stigma Centered	-.026	.178	-.052	-.146	.884
PS * Sexual Orientation	-.039	.115	-.112	-.334	.739
IS * Sexual Orientation	-.082	.113	-.249	-.731	.466
Sexual Orientation	1.629	.831	.168	1.960	.052

Table 4.7 (continued).

Variable	B	SE	β	<i>t</i>	<i>p</i>
<i>Model 6^f</i>					
(Constant)	2.490	1.242		2.005	.047
Perceived Stigma Centered	-.112	.188	-.218	-.596	.552
Internalized Stigma Centered	-.223	.191	-.422	-1.169	.245
PS * Urban/Rural	.117	.123	.348	.953	.343
IS * Urban/Rural	.055	.128	.155	.430	.668
Urban/Rural	-1.725	.831	-.176	-2.075	.040
<i>Model 7^g</i>					
(Constant)	-2.624	1.117		-2.349	.020
Perceived Stigma Centered	.159	.156	.320	1.020	.309
Internalized Stigma Centered	-.103	.159	-.206	-.650	.517
PS * Education	-.068	.107	-.207	-.637	.525
IS * Education	-.039	.106	-.120	-.366	.715
Education	1.900	.751	.198	2.531	.012
<i>Model 8^h</i>					
(Constant)	2.713	1.443		1.880	.062
Perceived Stigma Centered	.092	.209	.185	.442	.659
Internalized Stigma Centered	-.639	.216	-1.277	-2.953	.004
PS * Employment Status	-.018	.117	-.065	-.156	.876
IS * Employment Status	.286	.120	1.024	2.380	.019
Employment	-1.686	.819	-.164	-2.059	.041
<i>Model 9ⁱ</i>					
(Constant)	-1.804	1.797		-1.004	.318
Perceived Stigma Centered	.011	.227	.022	.050	.960
Internalized Stigma Centered	-.022	.234	-.040	-.094	.925
PS * Age	.040	.160	.101	.247	.805
IS * Age	-.130	.163	-.322	-.800	.426
Age (in years)	.047	.044	.108	1.067	.289

Note. ^a $F(5, 151) = 2.586, p = .028$; Adjusted $R^2 = .050$; ^b $F(5, 153) = 3.144, p = .010$; Adjusted $R^2 = .065$; ^c $F(5, 153) = 3.021, p = .013$; Adjusted $R^2 = .062$; ^dPerceived Stigma Centered and Internalized Stigma Centered omitted due to collinearity, $F(3, 144) = 5.070, p = .002$; Adjusted $R^2 = .078$; ^e $F(5, 141) = 3.302, p = .008$; Adjusted $R^2 = .075$; ^f $F(5, 130) = 3.074, p = .012$; Adjusted $R^2 = .074$; ^g $F(5, 153) = 3.905, p = .002$; Adjusted $R^2 = .087$; ^h $F(5, 148) = 5.068, p < .001$; Adjusted $R^2 = .121$; ⁱ $F(5, 100) = 2.169, p = .064$; Adjusted $R^2 = .055$.

Table 4.8.

Regression Analysis on Main Effects with All Variables, No Interactions

Variable	B	SE	β	<i>t</i>	<i>p</i>
(Constant)	-4.375	4.460		-.981	.329
Gender (Female)	1.146	1.193	.101	.961	.339
Employment (Unemployed)	-.462	1.089	-.044	-.424	.673
Race (Other)	-1.381	1.048	-.126	-1.318	.191
County (Rural)	-1.836	.967	-.183	-1.899	.061
Education (> High School)	2.209	.951	.222	2.323	.022
Sexual Orientation (LGB)	1.771	1.121	.180	1.580	.117
Income (> 100 FPL)	1.791	1.051	.175	1.704	.092
Perceived Stigma Centered	.109	.069	.210	1.582	.117
Internalized Stigma Centered	-.154	.072	-.284	-2.142	.035
Self-Efficacy Centered	.036	.082	.045	.443	.659

Note. $F(10, 108) = 2.867$, $p = .004$; Adjusted $R^2 = .147$.

Table 4.9.

Regression Analyses on Main Effects Individually

Variable	B	SE	β	<i>t</i>	<i>p</i>
<i>Model 1</i>					
(Constant)	-.084	.352		-.237	.813
Perceived Stigma Centered	-.031	.035	-.066	-876	.382
<i>Model 2</i>					
(Constant)	-.017	.354		-.047	.962
Internalized Stigma Centered	-.109	.036	-.225	-2.998	.003
<i>Model 3</i>					
(Constant)	-.009	.347		-.025	.980
Self-Efficacy Centered	.116	.058	.149	1.982	.049
<i>Model 4</i>					
(Constant)	.737	1.063		.693	.489
Race	-.561	.796	-.052	-.704	.482
<i>Model 5</i>					
(Constant)	1.022	1.045		.978	.329
Gender	-.774	.757	-.075	-1.022	.308
<i>Model 6</i>					
(Constant)	-1.881	1.050		-1.791	.075
Income	1.438	.754	.142	1.906	.058
<i>Model 7</i>					
(Constant)	-3.457	1.126		-3.070	.002
Sexual Orientation	2.267	.706	.238	3.211	.002
<i>Model 8</i>					
(Constant)	1.656	1.173		1.413	.160
Urban/Rural	-1.057	.791	-.106	-1.337	.183
<i>Model 9</i>					
(Constant)	-2.125	1.040		-2.043	.042
Education	1.547	.703	.159	2.202	.029
<i>Model 10</i>					
(Constant)	3.164	1.396		2.267	.025
Employment	-1.814	.785	-.169	-2.311	.022
<i>Model 11</i>					
(Constant)	-1.698	1.380		-1.231	.221
Age	1.291	.982	.120	1.315	.191

Table 4.10 describes the results, according to hypothesis.

Table 4.10.
Results for Hypotheses

Hypothesis	Prediction	Finding
H1a	A negative relationship exists between participants' perceived HIV stigma and civic engagement.	Not supported
H1b	A negative relationship exists between participants' internalized HIV stigma and civic engagement.	Supported
H1c	The negative relationship between internalized HIV stigma and civic engagement will be greater than the negative relationship between perceived HIV stigma and civic engagement.	Supported
H2a	The relationship between perceived HIV stigma and civic engagement will be moderated by self-efficacy, such that those with lower levels of self-efficacy will exhibit less civic engagement.	Not supported
H2b	The relationship between internalized HIV stigma and civic engagement will be moderated by self-efficacy, such that those with lower levels of self-efficacy will exhibit less civic engagement.	Not supported
H2c	The negative relationship between internalized stigma and civic engagement, as moderated by self-efficacy, will be greater than the negative relationship between perceived stigma and civic engagement, as moderated by self-efficacy.	Not supported
H3a	The relationship between perceived HIV stigma and civic engagement will be moderated by race, such that African-Americans and Latinos will be less likely to exhibit civic engagement behaviors than Whites.	Not supported
H3b	The relationship between internalized HIV stigma and civic engagement will be moderated by race, such that African-Americans and Latinos will be less likely to exhibit civic engagement behaviors than Whites.	Not supported

Table 4.10 (continued).

Hypothesis	Prediction	Finding
H3c	The negative relationship between internalized HIV stigma and civic engagement, as moderated by race, will be greater than the negative relationship between perceived HIV stigma and civic engagement, as moderated by race.	Not supported
H4a	The relationship between perceived HIV stigma and civic engagement will be moderated by gender, such that women will be more likely to exhibit civic engagement behaviors than men.	Not supported
H4b	The relationship between internalized HIV stigma and civic engagement will be moderated by gender, such that women will be more likely to exhibit civic engagement behaviors than men.	Not supported
H4c	The positive relationship of internalized HIV stigma and civic engagement, as moderated by gender, will be weaker than the positive relationship of perceived HIV stigma and civic engagement, as moderated by gender.	Not supported
H5a	The relationship between perceived HIV stigma and civic engagement will be moderated by income, such that those of lower income will be less likely to exhibit civic engagement behaviors than those of higher income.	Not supported
H5b	The relationship between internalized HIV stigma and civic engagement will be moderated by income, such that those of lower income will be less likely to exhibit civic engagement behaviors than those of higher income.	Supported
H5c	The negative relationship of internalized HIV stigma and civic engagement, as moderated by income, will be greater than the negative relationship of perceived HIV stigma and civic engagement, as moderated by income.	Supported
H6a	The relationship between perceived HIV stigma and civic engagement will be moderated by sexual orientation, such that non-heterosexuals will be less likely to exhibit civic engagement behaviors than heterosexuals.	Not supported

Table 4.10 (continued).

Hypothesis	Prediction	Finding
H6b	The relationship between perceived HIV stigma and civic engagement will be moderated by sexual orientation, such that non-heterosexuals will be less likely to exhibit civic engagement behaviors than heterosexuals.	Not supported
H6c	The negative relationship of internalized HIV stigma and civic engagement, as moderated by sexual orientation, will be greater than the negative relationship of perceived HIV stigma and civic engagement, as moderated by sexual orientation.	Not supported
H7a	The relationship between perceived HIV stigma and civic engagement will be moderated by residence, such that those living in rural areas will be less likely to exhibit civic engagement behaviors than those in urban areas.	Not supported
H7b	The relationship between internalized HIV stigma and civic engagement will be moderated by residence, such that those living in rural areas will be less likely to exhibit civic engagement behaviors than those in urban areas.	Not supported
H7c	The negative relationship of internalized HIV stigma and civic engagement, as moderated by residence, will be greater than the negative relationship of perceived HIV stigma and civic engagement, as moderated by residence.	Not supported
H8a	The relationship between perceived HIV stigma and civic engagement will be moderated by level of education attained, such that those with higher levels of education will be more likely to exhibit civic engagement behaviors than those with higher levels.	Not supported

Table 4.10 (continued).

Hypothesis	Prediction	Finding
H8b	The relationship between internalized HIV stigma and civic engagement will be moderated by level of education attained, such that those with higher levels of education will be more likely to exhibit civic engagement behaviors than those with higher levels.	Not supported
H8c	The positive relationship of internalized HIV stigma and civic engagement, as moderated by level of education, will be weaker than the positive relationship of perceived HIV stigma and civic engagement, as moderated by level of education.	
H9a	The relationship between perceived HIV stigma and civic engagement will be moderated by employment status, such that those who are unemployed will be less likely to exhibit civic engagement behaviors than those who are employed.	Not supported
H9b	The relationship between internalized HIV stigma and civic engagement will be moderated by employment status, such that those who are unemployed will be less likely to exhibit civic engagement behaviors than those who are employed.	Supported
H9c	The negative relationship of internalized HIV stigma and civic engagement, as moderated by employment status, will be greater than the negative relationship of perceived HIV stigma and civic engagement, as moderated by employment status.	Supported
H10a	The relationship between perceived HIV stigma and civic engagement will be moderated by age, such that those who are older will be less likely to exhibit civic engagement behaviors than those who are younger.	Not supported

Table 4.10 (continued).

Hypothesis	Prediction	Finding
H10b	The relationship between internalized HIV stigma and civic engagement will be moderated by age, such that those who are older will be less likely to exhibit civic engagement behaviors than those who are younger.	Not supported
H10c	The negative relationship of internalized HIV stigma and civic engagement, as moderated by age, will be greater than the negative relationship of perceived HIV stigma and civic engagement, as moderated by age.	Not supported

Figures 4.1 and 4.2 provide interaction effect graphs for levels of employment and income on the relationship between internalized stigma and civic engagement.

Figure 4.1. The Interaction of Level of Employment on the Relationship between Internalized Stigma and Civic Engagement

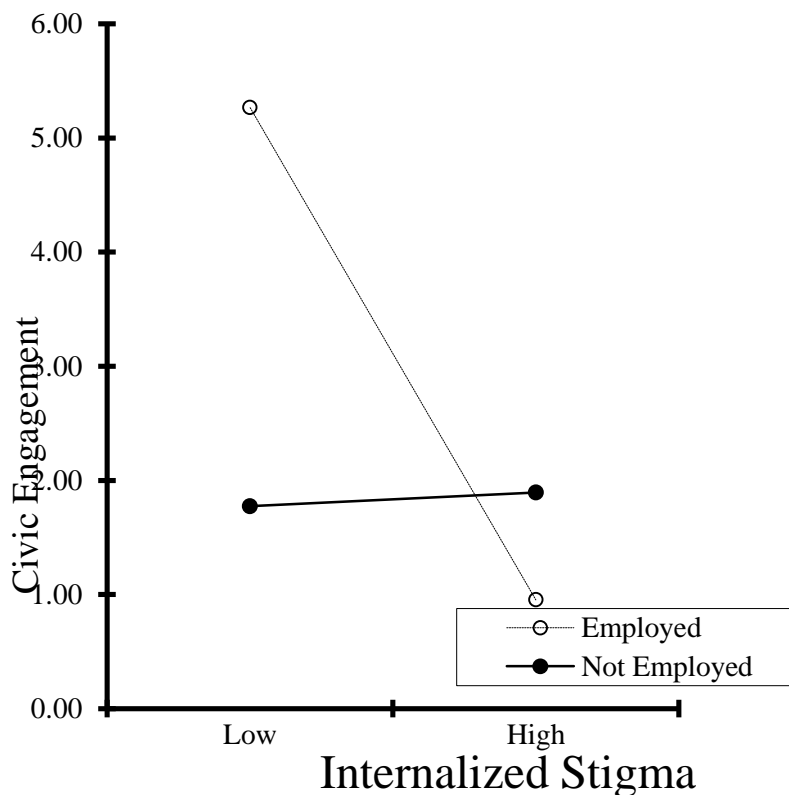
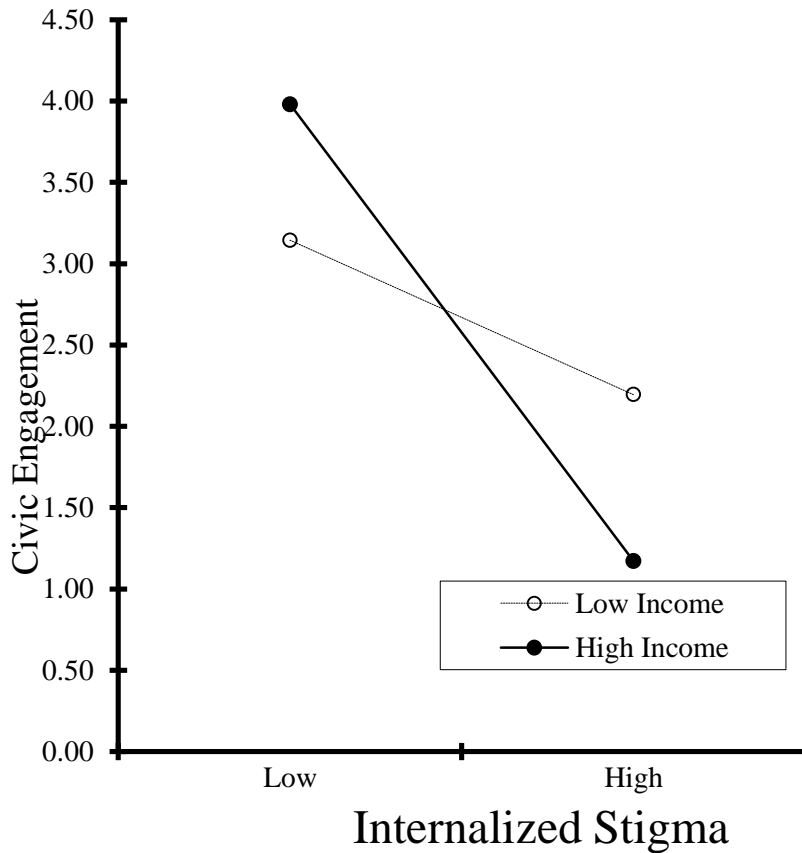


Figure 4.2. The Interaction of Level of Income on the Relationship between Internalized Stigma and Civic Engagement



Qualitative Responses

Two qualitative questions regarding civic engagement were included in the survey: ‘What are the reasons that you are involved in community activities about HIV?’ and ‘What are the reasons that you are *not* involved in community activities about HIV?’ The major themes regarding the reasons that individuals are involved were a desire to help others and a desire to learn. For the reasons that individuals are not involved, major themes were stigma/shame and

lack of awareness of opportunities to participate. All participant responses to these questions are provided in Appendix B.

Summary

The data in this study was assessed using regression and correlational techniques. Four series of regression models were utilized in order to provide comprehensive results. Findings indicated that no relationship exists between perceived stigma and civic engagement, while internalized stigma is a significant negative predictor of civic engagement. Of the predicted moderators, income and employment provided significant results, with those of higher income and higher employment being more likely to engage civically. .

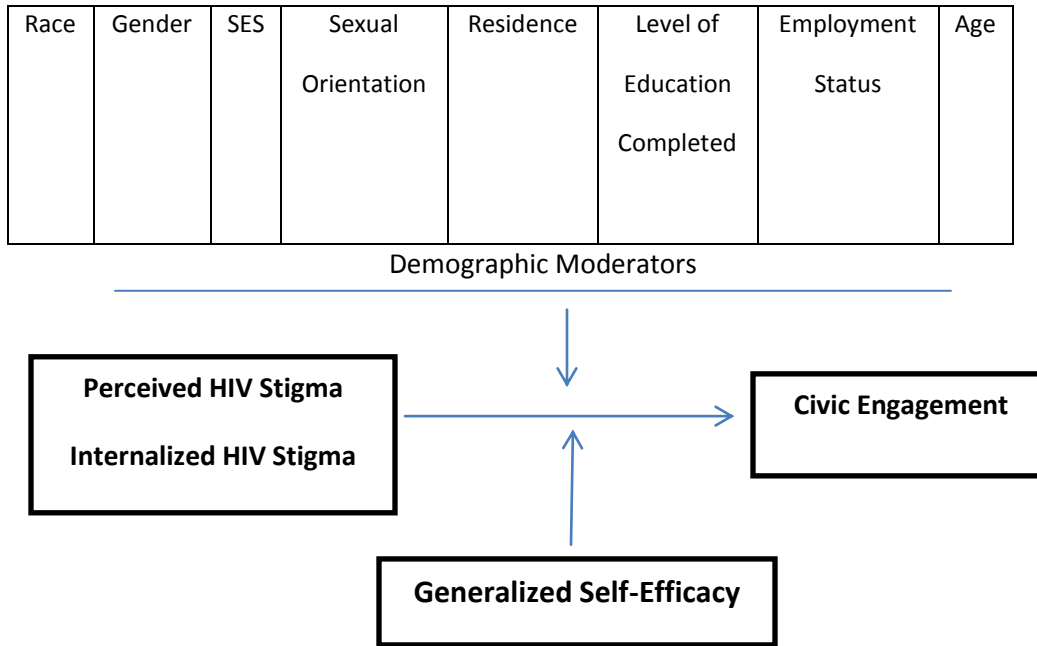
CHAPTER 5

DISCUSSION

Introduction

The purpose of this research was to increase understanding of the impact of perceived and internalized stigmas on HIV-related civic engagement, as well as the moderating effects that self-efficacy and demographics have on this relationship. Epidemic proportions of HIV infection in the South, combined with inadequate and unstable funding on federal, state, and local levels, speak to the importance of advocacy. As clients of AIDS Service Organizations (ASOs) are the direct beneficiaries of the HIV-specific services provided by the various funding sources and as their stories are more potent than lobbyists who are not HIV+, client-led civic engagement toward issues related to HIV is essential. However, stigma, low self-efficacy, and demographic issues were investigated as potential barriers to such engagement. The following model was developed to guide this study:

The Stigma-Engagement Model



In this study, clients of ASOs in Alabama were asked to complete the following scales, which gathered demographic data and measured their respective levels of perceived HIV stigma, internalized HIV stigma, generalized self-efficacy, and HIV-related civic engagement: a modified civic engagement scale (Verba, Schlozman, & Brady, 1995); the Perceived Stigma Scale (PSS) (Sowell, Moneyham, & Demi, 1992); the Internal Stigma of AIDS Tool (ISAT) (Phillips, Moneyham, & Tavakoli, 2011); a generalized self-efficacy measure (Judge et al., 1998).

Due to issues of power and collinearity, the model required several methods of analysis in order to provide comprehensive results. Regressions were run to assess the impact of all variables and all interactions collectively, the impact of each interaction analyzed independently, the impact of each variable collectively with no interactions (post hoc), and the impact of each variable independently with no interactions (post hoc). Correlational methods were also utilized,

as was a Wilcoxon Ranked Sums Test, which revealed no significant differences between the means of perceived stigma and internalized stigma, perceived stigma and self-efficacy, or internalized stigma and self-efficacy.

Clients of nine ASOs in Alabama were the participants in this study. Overall, 207 completed some portion of a survey. Of those who completed this information, 68.8% were male (n = 137), 30.7% female (n=61), and 0.5% transgender (n = 1). The mean age was 43.81 (SD = 11.46), and ranged from 14 to 71 years of age. The sample was 75.1% African-American (n = 148), 19.3% Caucasian (n = 38), 2.5% Hispanic (n = 5), 0.5% Asian (n = 1), and 2.5% other (n = 5). Participants identified as 50.8% heterosexual (n = 92), 34.3% gay or lesbian (n = 62), 9.9% bisexual (n = 18), and 5.0% other (n = 9). The sample also included populations of 61.1% urban (n = 102) and 38.9% rural (n = 65).

Summary and Interpretation of Findings

Perceived and Internalized Stigma

Hypotheses 1a, 1b, and 1c predicted that perceived HIV stigma and internalized HIV stigma would both share a negative relationship with civic engagement, but that the relationship of internalized stigma with civic engagement would be more negative than that of perceived stigma. Perceived stigma had no relationship with civic engagement ($\beta = -.07$, ns). Internalized stigma exhibited a strong negative relationship with civic engagement, such that reduced internalized stigma resulted in increased civic engagement ($\beta = -.26$, $p < .005$).

These results suggest that internalized stigma has a negative impact on HIV+ individuals more so than perceptions of how others view them. The undesirable aspects related to HIV that impact one's perception of self, serve as major barriers to HIV-related civic engagement. The lack of effect posed by perceived stigma is surprising considering perceived stigma's relationship

with disclosure concerns (Gonzalez, et al., 2009), depression (Vyavaharkar, et al., 2012), and the shrinking of one's social network (Emlet, 2006), all of which would seem to impede civic engagement within this population.

Self-Efficacy

According to Hypotheses 2a, 2b, and 2c, self-efficacy should provide a moderated effect on the relationship between perceived and internalized stigmas and civic engagement, such that those with lower levels of self-efficacy should exhibit less civic engagement. Moreover, the relationship between internalized stigma and civic engagement was expected to be more negative than this relationship with perceived stigma. Findings show that self-efficacy did not moderate the relationship between perceived or internalized stigmas and civic engagement ($\beta = .17$, ns). However, as a post hoc analysis, self-efficacy was found to be a significant direct predictor of civic engagement, such that greater self-efficacy resulted in more civic engagement ($\beta = .15$, $p < .05$).

The lack of moderating effect has possible explanations in how self-efficacy was conceptualized for this study. Self-efficacy's clear relationship with civic engagement and lack of moderation with perceived and internalized stigmas speak to its potential role as a mediating, rather than moderating, variable (Nokes et al., 2012). It is possible that, instead of describing the conditions under which civic engagement occurs, self-efficacy is useful in describing why those with stigma eventually engage in civic activities. Relatedly, HIV stigma may be more appropriately perceived as a mediator for self-efficacy (Li, et al., 2011), as opposed to the reverse relationship posed in this study.

The lack of effect may also be due to the fact that self-efficacy varies widely under different sets of conditions (Bandura, 1997). Self-efficacy's very low correlation with civic

engagement may mean that other measures, such as a political efficacy scale, may have been more appropriate moderator. Such a scale may have more carefully gauged the efficacy related to the specific activities listed on the civic engagement scale.

Race

In Hypotheses 3a, 3b, and 3c, predictions were made that race would moderate the relationship between perceived and internalized stigmas with civic engagement, such that African-Americans and Latinos would be less likely to participate in civic engagement than Caucasians. Furthermore, the moderating effect of race was expected to be more negative for internalized stigma than for perceived stigma. Analyses revealed that race did not moderate the relationship for perceived stigma ($\beta = .34$, ns) or internalized stigma ($\beta = .14$, ns)

This general non-effect may be due to situational variables, rather than race. According to Platt (2008), when African-Americans are forced to confront external threats, are engaged in social networks, and are able to garner access to policymakers, they are more likely to participate. As ASOs encourage clients to address funding threats, provide social networks, and provide access to policymakers, it is possible that these efforts encourage greater African-American participation than would have otherwise occurred. Future research should investigate the impact that involvement with ASOs has on these variables.

Gender

The predictions for Hypotheses 4a, 4b, and 4c were that gender would offer a positive moderating effect in the relationship between perceived and internalized stigmas and civic engagement, such that women would be more likely to exhibit civic engagement behaviors than men. This positive relationship was predicted to be weaker for internalized stigma than for

perceived stigma. Gender did not moderate the relationship for perceived stigma ($\beta = .42$, ns) or internalized stigma ($\beta = .01$, ns).

Differences in gender participation may be more effectively conceptualized as differences in which civic engagement activities are enacted by separate genders (Piccoli & Rollero, 2009). Women tend to specialize in voting and private activism while men tend to engage in more overt political activity. The civic engagement scale for the study covered only six activities, with voting excluded. As a result, some activities that could be relevant to a gender difference were omitted from this study. Future research may discover differences by being more inclusive in the civic activities included.

Income

Hypotheses 5a, 5b, and 5c predicted that income level would play a moderating role in perceived stigma's and internalized stigma's relationship with civic engagement, such that those of lower income would be less likely to participate in civic engagement. It was further predicted that the relationship of internalized stigma and civic engagement would be more negative than such a relationship for perceived stigma. Only the relationship between internalized stigma and civic engagement was moderated by income such that those with higher income (above 100% Federal Poverty Level) were more likely to engage ($\beta = -.28$, $p < .05$). The positive moderating effect of income on the relationship between internalized stigma and civic engagement is reduced as internalized stigma increases. These findings are supported with previous literature, which reports income as a predictor of civic participation (Levin-Waldman, 2013) and poverty as a predictor of higher HIV stigma (Amuri, et al., 2011).

Sexual Orientation

The expectations for Hypotheses 6a, 6b, and 6c were that sexual orientation would moderate the relationship between perceived stigma and civic engagement, as well as internalized stigma and civic engagement, such that non-heterosexuals would be less likely to engage civically. This moderated relationship for internalized stigma was expected to be more negative than that for perceived stigma. Sexual orientation was significantly correlated with perceived ($r(163) = -.25, p \leq .01$) and internalized stigma ($r(155) = -.24, p \leq .01$). Analyses also revealed that lesbians, gays, and bisexuals were more likely to engage in HIV-related civic activities than heterosexuals ($\beta = .24, p < .005$). However, sexual orientation did not moderate the relationship of perceived ($\beta = -.11, ns$) or internalized stigmas ($\beta = -.25, ns$) with civic engagement.

Some research shows that for homosexuals, civic engagement is impacted less by sexual orientation and more by fluctuating political environments, level of education, efficacy, length of time since diagnosis, self-esteem, coping skills, and feelings of connectedness to LGBT communities (Swank & Fabs, 2011; Gonzalez, Grover, Miller, & Solomon, 2011; Battle & Harris, 2013). It is possible that, within the studied population, the manner in which these factors affected the lives of LBG participants moved them toward civic engagement.

Urban and Rural Residence

According to Hypotheses 7a, 7b, and 7c, one's area of residence should have a moderating effect on one's civic engagement for both perceived and internalized stigmas. That is, it was predicted that those living in rural areas would be less likely to engage civically than those in urban areas. This relationship with internalized stigma was predicted to be more negative than that of perceived stigma. Area of residence did not moderate the predicted

relationships for perceived ($\beta = .35$, ns) or internalized stigmas ($\beta = .16$, ns). However, analyses found rural status to be associated with decreased civic engagement ($\beta = .18$, $p < .05$).

Research has shown that rural and urban differences in civic engagement are dependent upon type of activity (Thananithichot, 2012), such that rural residents tend to participate in local issues and desire more personal contact with those involved in issues (Putman, 2000). The options on the civic engagement survey were limited and, as a result, some activities that could be relevant to a difference in urban or rural residence may have been omitted.

The lack of effect with perceived stigma is surprising given that perceived stigma is often related to community size (Gonzalez, et al., 2009). However, residents in rural areas also tend to exhibit high levels of internalized stigma (Vyavaharkar, et al., 2012), which parallel the results of the studied population. As participants were all clients of ASOs, it is possible that receiving care from these organizations has lessened the amount of stigma they perceive from others but has not improved how they feel about themselves.

Level of Education

In Hypotheses 8a, 8b, and 8c, predictions were made that level of education should provide a positive moderating effect for perceived and internalized stigmas' relationships with civic engagement, such that those with higher levels of education should be more likely to engage civically. It was also predicted that the relationship between internalized stigma and civic engagement, as moderated by education, should be weaker than that of perceived stigma and civic engagement. Level of education, did not moderate the relationship between perceived stigma ($\beta = -.21$, ns) or internalized stigma ($\beta = -.12$, ns). However, analyses found that those who had high internalized stigma and higher education were more likely to engage civically than those with less education ($\beta = .20$, $p < .05$).

These findings correspond to the literature. Education is commonly viewed as one of the strongest predictors of civic engagement (Verba, Brady, & Schlozman, 1995), and education positively influences participation in various civic activities (Putnam, 2000). It is thought that the strength of this impact is due to education's ability to develop civic democratic values and civic competence (Rosenstone & Hansen, 1993).

Employment Status

Hypotheses 9a, 9b, and 9c predicted that employment status would have a moderating effect on the relationships between perceived and internalized stigmas and civic engagement, such that those who are unemployed would participate less than those who are employed. Internalized stigma was predicted to be affected more negatively by this moderation than perceived stigma.

Employment status did not moderate the relationship between perceived stigma and civic engagement ($\beta = -.07$, ns); however, it was a significant moderator of the relationship between internalized stigma and civic engagement, such that civic engagement was reduced when individuals were unemployed ($\beta = 1.02$, $p < .05$). These findings are supported by the research of Wilson and Musick (1997) and Musick and Wilson (2008), who report employment's positive influence on civic engagement.

A surprising finding was that the negative impact of unemployment on civic engagement becomes less negative as internalized stigma increases. A related explanation is that a threshold exists at which internalized stigma is high enough to become a focal point of one's life, as opposed to other issues, including unemployment. When one's focus is no longer strongly on unemployment, unemployment's negative impact may become less of a deterrent to civic

engagement. It is also plausible that strong internalized stigma may shift one's focus from unemployment to the need to address HIV civically.

Age

In Hypotheses 10a, 10b, and 10c, age was predicted to moderate the relationship of perceived and internalized stigmas with civic engagement, such that older individuals would be less likely to be active in civic engagement. Internalized stigma was thought to carry a more negative relationship, as moderated by age, than that of perceived stigma. Age did not moderate the relationship for perceived ($\beta = .10$, ns) or internalized stigmas ($\beta = -.32$, ns). However, post hoc analyses revealed age to be a significant predictor of civic engagement, such that those of older age were more likely to be engaged civically than those of younger age ($\beta = .33$, $p < .05$).

Given that the literature promotes age cohort as one of the most significant determinants for civic engagement (Galston & Lopez, 2006; Sander & Putnam, 2006), it was unexpected that age was not found to be a stronger predictor of civic engagement in this study. The fact that older age is more indicative of civic engagement fits well with previous literature (Hinterlong, 2008). Because older adults with HIV experience significant perceptions of stigma (Emlet, 2007) and are less likely to disclose their status than those who are younger (Emlet, 2006), the prediction was made that the general trend on age-related civic engagement research would be reversed for this population. However, it seems that, despite stigma and disclosure concerns, the studied population is comparable to the population at-large.

Implications

Examination of Stigma

This study speaks to the need for differentiating between types of stigma, specifically perceived and internalized. In the literature, the term 'stigma' or 'AIDS stigma' is used liberally,

often over-generalizing a complex phenomenon which manifests itself in a variety of ways. This complexity highlights the obligation for research to more accurately denote which types of stigmas have which effects on which perceptions and behaviors. Indeed, though it was hypothesized that both perceived and internalized stigmas would affect civic engagement, only internalized stigma contributed any predictive value. Perceived stigma was wholly inconsequential.

These results may imply that ASO-led activities have been productive in reducing perceived stigma but unproductive in reducing internalized stigma. Advocacy trainings and general case management services, which are standard offerings by ASOs in Alabama, may be allowing clients to perceive the outside world as one in which others perceive them in a generally positive manner. However, these efforts may not be effectively addressing the negative manner in which clients perceive themselves. Trainings and activities, specific to internalized stigma, may be necessary.

Emlet (2007) found that stigma-reducing interventions should be designed to address the individual experiences of stigma of participants. For each participant living with HIV, internalized stigma can be constructed of social, contextual, and personal factors, or a combination of each (United States Agency for International Development, 2006). Indeed, Lee, Kochman, & Sikkema (2002) found some of the factors associated with high levels of internalized stigma to be recent diagnosis, unaccepting families, lack of participation in support groups, and being familiar with fewer HIV+ individuals. ASO efforts to address these issues could have a positive impact on participation in civic engagement activities.

As ASOs have direct and unique access to the specified population, facilitation of stigma-reducing programs would be feasible. Rao, et al. (2012) found stigma reduction groups to be

effective when employing role playing, social support, and contact with others who are HIV+. The Siyam'kela Project (2006) identified counseling, information, and support groups as antidotes to the rejection, judgment, and discrimination perceived or experienced by those living with HIV/AIDS. USAIDS (2006) encourages the inclusion of faith sectors, promotion of positive role models, and attainment of family support as well. As ASOs generally have the capability of facilitating such programs, doing so could reduce internalized stigma and increase civic engagement among the specified population.

The Influence of Internalized Stigma

This study also draws attention to the tremendous influence of internalized stigma on civic engagement. If there is perceived value for civic engagement within this population, it is outweighed by the impact of internalized stigma.

A possible indicator of the strength of internalized stigma is that, though levels of perceived stigma were relatively low ($M = 10.89$, $SD = 10.35$) and levels for self-efficacy were relatively high ($M = 29.5$, $SD = 6.0$), levels of civic engagement were still very low ($M = 2.63$, $SD = 4.74$). One might assume that levels of civic engagement would be higher for a population that perceives stigma at relatively low rates and one that feels capable to accomplish tasks, both of which were reported by the studied population. It is worth considering that the influence of internalized stigma ($M = 26.3$, $SD = 9.89$) was strong enough to deter civic engagement despite the positive perceptions carried by this population.

Interaction Effects

Many of the interactions in this study are noteworthy. While perceived stigma and internalized stigma are highly correlated ($r(154) = .69$, $p < .01$), only internalized stigma affected civic engagement, and only income and employment moderated the relationship between

internalized stigma and civic engagement. While it is fitting to study perceived stigma and internalized stigma together, it is also apparent that they can produce substantially different outcomes. On a similar note, both perceived and internalized stigmas are related to self-efficacy ($r(162) = -.30, p < .01$; $r(163) = -.39, p < .01$), but self-efficacy did not moderate the relationship of these stigmas with civic engagement. Self-efficacy impacts each component of stigma without affecting civic engagement. Post hoc analysis revealed a direct effect of self-efficacy on civic engagement ($\beta = .15, p < .05$). Thus, the role that self-efficacy plays in impacting stigma and civic engagement is an area that needs further exploration.

The interactions of the demographic variables make clear the need to approach the study of this population holistically. The first regression, in which all variables and interactions were analyzed collectively, revealed age as a significant predictor of civic engagement. The second regression independently assessed the main effects with all variables and all interactions and found sexual orientation, residence, and education to be significant. The third set of regressions (post hoc), which analyzed the collective effect of all variables on civic engagement without including interaction effects, found only education as significant. The fourth set of regressions (post hoc), which analyzed each variable independently, revealed education and employment as significant. It is apparent, then, that the demographic variables weighed heavily on each other, demonstrating the futility of accurately studying the demographics of this population in isolation. The perceptions and behaviors of participants are the results of their cumulative experiences with race, sexual orientation, age, and the like.

Addressing Deficiencies

As income and employment moderated the relationship between internalized stigma and civic engagement, utilizing techniques to address the barriers that low income and

unemployment present to civic engagement could lead to increased civic activity among clients. The literature explains the impact of income and education as relating to the opportunities provided by greater social capital and greater opportunities for community involvement (Rohe & Basolo, 1997; Putnam, 2000). If ASOs are to increase civic engagement within this group, they must do so in a manner that compensates for what this group does not possess financially and occupationally. The civic engagement survey assessed the extent to which respondents participated on ASO boards of directors, with 85% reporting '0 times' over the past year. This finding reveals an area in which ASOs may have unintentionally limited opportunities among clients. While ASOs occasionally select clients as board members, the majority of board members are chosen due to their possession of a specific set of resources or community contacts, which generally correspond to higher levels of income and ample employment. As clients of ASOs do not generally fit these criteria (73% unemployment reported by respondents) and as the number of board positions is limited, there is not an abundance of opportunities for clients to serve on ASO boards. ASOs may increase engagement by making concerted efforts to include clients on boards or by developing advisory boards which would provide clients a voice in relevant matters of ASO administration, thereby nullifying the barrier of lacking social capital and opportunities.

The survey also assessed the number of time participants provided money to political causes related to HIV. Given that 68% of respondents reported income below 100% of Federal Poverty Level and 83% reported giving money '0 times', this group would not generally have additional income with which to donate to political causes. By assisting clients to develop non-financial resources or skills with which to advocate on issues related to HIV, ASOs could possibly minimize the negative impact of financial barriers. Such resources might be assistance

with writing letters to legislators, advocacy training and mentorship, and provision of informal work on behalf of the ASO.

Overall, the barriers are deeper than simply assisting clients to attain a job and more money. Under the current welfare structure system, clients receiving assistance from the federal government are severely limited in the amount of paid compensation they can earn annually. Even when healthy, clients perceive too much risk in losing the guaranteed government funding in lieu of a non-guaranteed paycheck from an employer. The result is that, clients often maintain indefinite unemployment and subsist on federal funding, which is not substantial. It behooves ASOs, then, to develop creative strategies for incorporating clients into civic engagement activities, despite the challenges of lacking income and employment.

Additional Findings

Though the hypothesized interactions were the focus of this study, post hoc analyses revealed further useful information regarding the studied population's relationship with civic engagement. Greater self-efficacy, being LGB, urban residence, being older, and having more than a high school education lead to greater civic engagement. Though addressing these issues may not affect the internalized stigma of clients, progress can possibly be made toward higher levels of civic engagement by employing methods to encourage the rural, the young, the HIV+ heterosexual community, and those with low self-efficacy.

Overall Response to Findings

The most surprising finding of this study was the lack of relationship between perceived stigma and civic engagement. While it was assumed that perceived stigma would be relatively high among participants and that this perception of how others perceive them would create a

negative relationship with civic engagement, neither of these assumptions was validated by this study.

For those who develop policies at federal, state, or local levels, the most pertinent implication of this study is the indication that efforts to involve PLWHA in HIV-related policy development would likely garner greater participation if interventions designed to alleviate internalized stigma were implemented. For ASOs, the most significant result is the indication that current services are not effectively alleviating internalized stigma. As 2 of the major facets of ASO missions are providing emotional support for clients and ensuring adequate funding for HIV services, reducing internalized stigma seems to be a manner to accomplish both of these tasks with greater success.

Limitations

Several limitations of the current research can be identified. Although 208 participants completed some portion of a survey, many did not respond to specific items in the demographics and/or scale section. Since demographic variables were important constructs in this research, smaller-than-desired pools were created, which limited the ability to analyze the model adequately.

Due to the number of variables and interactions to be tested, issues of power and collinearity arose. However, by running the model several ways, the data provide substantial information about the relationships of the variables to HIV-related civic engagement. This model, provided optimal conditions, has the potential to be a powerful tool for assessing HIV-related civic engagement.

Participants in this study were those who happened to receive services at an ASO during the time period that surveys were distributed. It is possible that the participants of this study

represent those who have stronger relationships with their ASOs or are more consistent in engaging in HIV-related services. Among the participants, perceived stigma was lower than anticipated, while self-efficacy was higher. It is a matter of future research as to whether the strength of participants' relationships to ASOs and adherence to services are the cause of or result of lower perceived stigma and higher self-efficacy. Further, as ASOs in Alabama work collectively to provide advocacy training and opportunities for clients, those with stronger relationships with ASOs have a higher probability of having participated in these activities. Such training could have not only increased the extent to which these clients have engaged civically, but could have altered levels of perceived stigma, internalized stigma, and self-efficacy.

On a related note, as a much higher percentage of participants were from urban areas (61.1%), the experience of those from rural areas may not have been represented well in the data. Similarly, the number of Latino participants ($n = 5$) was minimal, thus providing less useful information for this study.

Also as mentioned, 2 of the questions on the civic engagement survey (board membership and monetary donations) addressed activities that may have been outside of the control of participants. Future use of this survey would benefit from weighting the questions under the control of participants more heavily than the two others.

Finally, all data were self-report. Possible bias exists. While some of the data could have been collected via ASOs, most of the key variables required self-report answers.

Future Directions

From both practical and research-driven perspectives, this study provides the foundation for more in-depth work which can examine the relationship of those living with HIV toward

civic engagement. Future research could examine the extent to which civic engagement is valued by the specified population, how participation with ASOs affects client engagement, and how geographic location alters results. To do so would require a larger and more diverse sample size, within and outside of ASOs, and outside of the South. A higher number of rural clients would also provide necessary detail.

The results clearly convey the force with which internalized stigma impacts civic engagement. With this understanding, efforts can be made to delve into the specifics of how internalized stigma forms and sustains itself, which interventions are useful in reducing internalized stigma, and how it specifically interferes with civic engagement.

Future research addressing the manner in which perceptions of internalized stigma change over time would also be beneficial. That is, studies could examine whether internalized stigma increases, decreases, or remains stable as time elapses since individuals' initial date of diagnosis. Assessing how these changes, or lack thereof, impact civic engagement would also aid in better understanding this population.

In order to fully assess the impact of internalized stigma on this population, qualitative studies would be necessary. Such studies could incorporate and expand upon the qualitative measures used in this study. In that, inquiries could be made about the specific reasons that civic engagement holds or does not hold value for this population, past experiences that have increased or decreased one's willingness to engage civically, and areas of perceived strength or weakness regarding one's ability to effectively participate.

Ultimately, those who participate with ASOs represent only a portion of those who would be necessary to study in order to gain a solid understanding of how stigma impacts civic engagement. There are those who are HIV+ and who otherwise represent the specified

population, but who, for varying reasons, do not participate with ASOs. In order to engage this segment of the population, an HIV+ peer is necessary to recruit participation. In addition to understanding the disease due to their own HIV status, the most effective peers are well-known and active within the community they serve. The dual skillset of grasping the personal impact of HIV and community efficacy provides a powerful tool for finding and engaging those who would not otherwise participate.

This research started by proposing that perceived and internalized stigmas would both share a negative relationship with civic engagement. Findings indicate that the most important predictor of civic engagement is internalized stigma. ASOs, interested in helping clients to ‘help themselves’, could benefit by learning more about the causes of internalized stigma and how to mitigate it.

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APPENDICES

Appendix A. Survey: HIV-related Stigma and Civic Engagement

<u>The following 6 questions refer to activities you may or may not have been involved in.</u>	0 times	1 time	2 times	3 times	4 or more
1 In the past 12 months, how often have you initiated any contact with an elected official or non-elected official in a government agency regarding HIV/AIDS issues?					
2 In the past 2 years, how often have you taken part in a protest or a political meeting regarding HIV/AIDS?					
3 In the past 12 months, how often have you taken part in informal community work regarding HIV/AIDS issues?					
4 In the past 12 months, how often have you served on a board or been an officer in an organization that deals with issues of HIV/AIDS?					
5 In the past 12 months, how often have you been affiliated with a political organization working on HIV/AIDS issues?					
6 In the past 12 months, how much money have you given money to a political cause associated with HIV/AIDS?					

<u>The following 12 questions ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate by circling how often you felt or thought a certain way. In the last month, how often have you...</u>	Not at All	Rarely	Sometimes	Often	All the Time
1 I felt blamed by others for my illness.					
2 I felt ashamed because of my illness.					
3 I thought that my illness was a punishment for things I've done in the past.					
4 I feared that I might lose my job if someone found out about my illness.					
5 I felt compelled to change my residence because of my illness.					
6 I avoided getting treatment because someone might find out about my illness.					
7 I feared that people would hurt my family if they learned about my illness.					
8 I thought other people were uncomfortable being around me.					
9 I felt people avoided me because of my illness.					
10 I feared I would lose my friends if they learned about my illness.					
11 I feared my family would reject me if they learned about my illness.					
12 I felt I wouldn't get as good health care if people know about my illness.					

Appendix A (continued).

<u>The following 8 statements refer to the overall way you feel about yourself. They are not related to your HIV infection</u>	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1 When I make plans, I am certain I can make them work.					
2 When I set important goals for myself, I rarely achieve them.					
3 If something looks too complicated, I will not even bother to try it.					
4 When I decide to do something, I go right to work on it.					
5 I avoid trying to learn new things when they look too difficult for me.					
6 I feel insecure about my ability to do things					
7 I give up easily.					
8 New jobs are usually well within the scope of my abilities.					

<u>The following 10 statements refer to the way you feel about yourself (not what you think others think about you) since you were diagnosed with having HIV infection. Remember: Your answer should indicate how you feel about yourself since you were diagnosed with having HIV infection.</u>	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1 Having HIV infection is like being branded with shame.					
2 I feel blemished.					
3 I feel ashamed about having HIV/AIDS.					
4 HIV infection hinders my ability to interact with other people.					
5 I feel that I need to hide my illness.					
6 I try to hide that I have HIV.					
7 I feel that I am desirable.					
8 I feel inhibited from making new friends.					
9 I am deceitful when I tell other people about my HIV.					
10 HIV infection hinders me from being intimate with other people.					

What are the reasons that you are involved in community activities about HIV?

What are the reasons that you are not involved in community activities about HIV?

Appendix A. (continued).

Please tell us about yourself.

Age (in years): _____

Race (Please select all that apply):

_____ Caucasian

_____ African-American

_____ Hispanic or Latino

_____ Asian

_____ Other (please explain below):

Gender:

_____ Male

_____ Female

_____ Transgender

_____ Other (please explain below):

Sexual Orientation:

_____ Heterosexual

_____ Gay/Lesbian

_____ Bisexual

_____ Other (please explain below):

Highest Level of Education Completed:

_____ Less than High School

_____ Some High School

_____ Certificate of Completion/Attendance

_____ High School Diploma or Equivalent

_____ Some College

_____ Associate's Degree

_____ Undergraduate Degree

_____ Master's Degree or Above

Employment Status:

_____ Full-Time

_____ Part-Time

_____ Not Employed

Income:

_____ Less than \$5,000 per year

_____ \$5,000 to \$9,999 per year

_____ \$10,000 to \$19,999 per year

_____ \$20,000 to \$29,999 per year

_____ \$30,000 to \$39,999 per year

_____ \$40,000 to \$49,999 per year

_____ More than \$50,000 per year

Which county do you live in? _____

How many dependents do you have? _____

How long have you been diagnosed with HIV? _____

Do you receive public assistance? _____

Do you consider yourself physically and emotionally able to work? _____

Thank you. You have completed the survey.

Appendix B.

Frequencies

Statistics

		What are the reasons that you are involved in community activities about HIV?	What are the reasons that you are not involved in community activities about HIV?
N	Valid	210	210
	Missing	0	0

Frequency Table

What are the reasons that you are involved in community activities about HIV?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	155	73.8	73.8	73.8
At the present I am involved.	1	.5	.5	74.3
Because I am in a treatment center for people with HIV/AIDS that exposes me to activities.	1	.5	.5	74.8
Because I have been positive for the last 6 years and I wanted to help others that were in the same boat as me.	1	.5	.5	75.2
Because I have HIV.	1	.5	.5	75.7
Because it help to learn about keeping my self healthy with having HIV.	1	.5	.5	76.2
Currently, not involved in community activities.	1	.5	.5	76.7
Don't get involved with community activities.	1	.5	.5	77.1
Don't get involved.	1	.5	.5	77.6
Due to the stigma	1	.5	.5	78.1
For the awareness.	1	.5	.5	78.6
Help others find resources and help when they don't own their own	1	.5	.5	79.0
I am involved to let others know that they can live and have a normal life with HIV.	1	.5	.5	79.5

Appendix B. (continued)

What are the reasons that you are involved in community activities about HIV?

	Frequency	Percent	Valid Percent	Cumulative Percent
I am not because I'm not comfortable disclosing my status.	1	.5	.5	80.0
I am not currently involved.	1	.5	.5	80.5
I am not in community activities.	1	.5	.5	81.0
I am not involved	1	.5	.5	81.4
I am not.	1	.5	.5	81.9
I believe it is important to spread education about the virus in order to prevent further infection.	1	.5	.5	82.4
I feel I'm in a comfortable environment when around others that are positive or their friends who are supportive and understand the disease.	1	.5	.5	82.9
I like making the community aware about HIV. Also I let them know the importance of getting tested.	1	.5	.5	83.3
I not.	1	.5	.5	83.8
I want to educate people.	1	.5	.5	84.3
I'm not	1	.5	.5	84.8
I'm not involved.	2	1.0	1.0	85.7
I'm not!	1	.5	.5	86.2
I'm not.	2	1.0	1.0	87.1
live with HIV ant cool!	1	.5	.5	87.6
None.	1	.5	.5	88.1
not active.	1	.5	.5	88.6
Not involved in community activities about HIV.	1	.5	.5	89.0
Not involved.	2	1.0	1.0	90.0
Not really would like to be in the future.	1	.5	.5	90.5
Right now I am not involved in community activities.	1	.5	.5	91.0

Appendix B. (continued)

What are the reasons that you are involved in community activities about HIV?

	Frequency	Percent	Valid Percent	Cumulative Percent
So that others become more aware of the realness of being infected; how it alters your entire life; how you get sick easily than usual	1	.5	.5	91.4
The stigma of the virus and reaction of other without it. Also, ones with the disease usually does whoas me and/or is hassle.	1	.5	.5	91.9
To be with others.	1	.5	.5	92.4
To help educate others.	1	.5	.5	92.9
To help me learn more about it.	1	.5	.5	93.3
To help myself and other and to be with people that understand what I go through.	1	.5	.5	93.8
To help others understand the disease.	1	.5	.5	94.3
To help people understand that it's more to life than their status.	1	.5	.5	94.8
to help when I can	1	.5	.5	95.2
to learn more about HIV and to get to know others that are like me.	1	.5	.5	95.7
To learn more about HIV and to take part in thing others that HIV.	1	.5	.5	96.2
To learn more and to help educate people who don't know about HIV	1	.5	.5	96.7
To learn to teach	1	.5	.5	97.1
To make self stronger.	1	.5	.5	97.6
To make to change or difference or to have a voice	1	.5	.5	98.1
To show support to my community as well as always learning something new.	1	.5	.5	98.6

Appendix B. (continued)

What are the reasons that you are not involved in community activities about HIV?

	Frequency	Percent	Valid Percent	Cumulative Percent
Fear/anxiety of exposure re: HIV status	1	.5	.5	76.7
Feel some gives bad image or only for a single group has it which the serve (eg drug addicts.	1	.5	.5	77.1
Haven't had many opportunities.	1	.5	.5	77.6
I am involved.	1	.5	.5	78.1
I am straight, white and all the material I have seen are about black gay men.	1	.5	.5	78.6
I didn't know where to go or who to talk to about community activities.	1	.5	.5	79.0
I do not know where to go to be involved in community activities about HIV.	1	.5	.5	79.5
I got lots a things goin' on. AND I live in Alabama - what's the point?	1	.5	.5	80.0
I just want to live my life. The Best of my Abilitys.	1	.5	.5	80.5
I should be. No reason.	1	.5	.5	81.0
I try to avoid it because of the stigma	1	.5	.5	81.4
I try to stay by myself and limit activities to family. I interact in community things but not socially.	1	.5	.5	81.9
I try to stay involved.	1	.5	.5	82.4
I work.	1	.5	.5	82.9
I'm not aware of any activities but would like to know more to become an active member.	1	.5	.5	83.3
I'm not totally comfortable with it yet.	1	.5	.5	83.8
I'm very involved.	1	.5	.5	84.3
If I was sick.	1	.5	.5	84.8
Ignorant to the community activities.	1	.5	.5	85.2

Appendix B. (continued)

What are the reasons that you are not involved in community activities about HIV?

	Frequency	Percent	Valid Percent	Cumulative Percent
Inability to find transportation	1	.5	.5	85.7
Just have not known about some activities. Just not knowing how to reach out.	1	.5	.5	86.2
Just have not made up my mind that I have HIV.	1	.5	.5	86.7
Just wasn't ready just learning I have learned to deal with it	1	.5	.5	87.1
Lack of schooling and language barriers.	1	.5	.5	87.6
lack of schooling, language barriers, speaks little english	1	.5	.5	88.1
Neutral!	1	.5	.5	88.6
No interest. Don't want people to find out about me.	1	.5	.5	89.0
No outlet or information on such programs geared toward this for me.	1	.5	.5	89.5
No reason.	1	.5	.5	90.0
No reason. Would like to be more involved.	1	.5	.5	90.5
None.	1	.5	.5	91.0
not able. age and health	1	.5	.5	91.4
Not aware of events.	1	.5	.5	91.9
not aware of these activities	1	.5	.5	92.4
Not comfortable with some people's reaction's to the virus.	1	.5	.5	92.9
not enough money for transportation to appear, or the stigma attached to it.	1	.5	.5	93.3

Appendix B. (continued)

What are the reasons that you are not involved in community activities about HIV?

	Frequency	Percent	Valid Percent	Cumulative Percent
Not involved right now because I do not need myself or my family exposed to public cause I have a illness. I do not wish to make it public at this time in my life.	1	.5	.5	93.8
Not sure of all the possible org and groups to join	1	.5	.5	94.3
Rather keep to myself.	1	.5	.5	94.8
Schedule too busy	1	.5	.5	95.2
selective involvement	1	.5	.5	95.7
Shame.	1	.5	.5	96.2
Stay busy no time.	1	.5	.5	96.7
time constraints	1	.5	.5	97.1
Time or scheduling (work).	1	.5	.5	97.6
To know the facts about HIV.	1	.5	.5	98.1
Usually health problems which I have that won't allow me to be involved 100 percent.	1	.5	.5	98.6
Wished I was more involved.	1	.5	.5	99.0
work	1	.5	.5	99.5
work, education, language.	1	.5	.5	100.0
Total	210	100.0	100.0	

Appendix C. IRB Certification

Office for Research
Institutional Review Board for the
Protection of Human Subjects



December 19, 2013

Billy Kirkpatrick
College of Commerce and Business Admin.
The University of Alabama
Box 870223

Re: IRB # 13-OR-390, "The Effects of Perceived and Internalized HIV Stigma on HIV-Related Civic Engagement"

Dear Mr. Kirkpatrick:

The University of Alabama Institutional Review Board has granted approval for your proposed research.

Your application has been given expedited approval according to 45 CFR part 46. You have also been granted the requested waiver of written documentation of informed consent. Approval has been given under expedited review category 7 as outlined below:

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your application will expire on December 17, 2014. If your research will continue beyond this date, please complete the relevant portions of the IRB Renewal Application. If you wish to modify the application, please complete the Modification of an Approved Protocol form. Changes in this study cannot be initiated without IRB approval, except when necessary to eliminate apparent immediate hazards to participants. When the study closes, please complete the Request for Study Closure form.

Please use reproductions of the IRB approved stamped consent forms to obtain consent from your participants.

Should you need to submit any further correspondence regarding this proposal, please include the above application number.

Good luck with your research.

Sincerely,



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