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Stigmatizing Attitudes of the Helping Professions toward HIV/AIDS and the Detrimental Effects of Stigma on Individuals Living with HIV/AIDS

Lorrie Johnson
The College at Brockport, lorriejohn1@gmail.com

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Stigmatizing Attitudes of the Helping Professions toward HIV/AIDS and the Detrimental Effects
of Stigma on Individuals Living with HIV/AIDS

A Senior Undergraduate Honors Thesis 12/01/2015

Submitted in Partial Fulfillment of Requirements for Graduation in the Honors College

By
Lorrie Johnson
Psychology & Social Work Major

The College at Brockport
December 1, 2015

Thesis Director: Dr. Nicole Cesnales, Associate Professor, Department of Social Work

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example of an Honors senior thesis project*

This paper reviews the literature on HIV stigma categorizing and conceptualizing stigma and identifying what makes it different from other forms of stigma. It discusses the effects that stigma has on the people living with HIV and the barriers it creates to care and prevention. It reviews the attitudes of students and professionals in the helping field primarily nurses and social workers. The literature discussed in this thesis suggests factors that contribute to stigma, as well as interventions that may be successful in diminishing stigmatizing attitudes among students and helping professionals; further addressing gaps in present research about HIV stigma.

Table of Contents

ACKNOWLEDGMENTS

In the United States, 1.2 million people are living with the HIV/AIDS virus (Center for

Disease Control and Prevention, CDC, 2014). Thirty-five years ago HIV became a part of all

our lives and because little was known about this deadly virus, fear formed in many. The faces

of those impacted have continued to change throughout the years along with the long-term

prognosis, knowledge of viral replication, methods of transmission, and potential vaccines that

promise to eliminate the future of HIV. Advancements in treatment, pre-exposure prophylaxis

(PrEP), and antiretroviral therapy have decreased the mortality rate, transforming HIV/AIDS

from an acute deadly virus to a chronic illness, but despite advancements in prevention and

treatment, alleviating HIV stigma has been limited (Okella, et al. 2015).   Since its onset,

negative stereotypes, fear of contraction, intravenous drug use (IDU), and sexual behaviors, more

specifically, men having sex with men (MSM) have resulted in HIV stigma. Stigma is

debilitating and stifling, promoting discrimination, seclusion, and segregation and is frequently a

consequence of ignorance.

This paper will conceptualize stigma, including pre-existing and overlapping layers

affiliated with HIV/AIDS. It will review the recent and historical literature on stigmatizing

attitudes faced by people living with HIV/AIDS (PLHA) within the general population, and more

specifically within the helping professions. The helping professions, for the purpose of this

paper, will primarily refer to professionals and students in the nursing and social work

field. Helping professionals provide counseling services, medical services, and case

management services to PLHA, and often provide substantial psychological, social and

emotional support; therefore, identifying and reducing stigma within the helping profession can

have a significant impact on increasing the bio-psycho-social welfare of PLHA. Because the

support and services of helping professionals are so critical in HIV care, stigmatizing attitudes of

helping professionals can have a detrimental effect on the health and psychological wellbeing of

PLHA (Chambers, et al. 2015). Diminishing Negative attitudes of helping professionals towards

PLHA may create psychological barriers to services such as HIV testing, antiretroviral therapies

(ART), and a continuum of care that is instrumental to the overall health and wellbeing of PLHA

(Valdiserri, 2002). Helping professionals and students of the helping professions (i.e. social

workers and nurses) play a significant role in providing services and social support, as well as

promoting health care and psychological wellbeing to those affected by HIV/AIDS. Therefore,

as a result of the services the helping professions provides for PLHA, lack of extensive education

specific to the needs of PLHA could contribute to higher levels of stigma and negatively impact

the care PLHA receive.

HIV defined

Human immunodeficiency virus (HIV) emerged in the early 1980's initially affecting

homosexual men. HIV can potentially develop into symptomatic HIV when symptoms begin to

appear such as fatigue and night sweats; left untreated CD4 T-cells will drop below 200, the viral

load will increase, and HIV then progresses to acquired immunodeficiency syndrome (AIDS)

(Gallant, 2012). HIV/AIDS invades and suppresses the immune system, leaving its host

susceptible to various infections such as pneumocystis pneumonia, and cancers like Kaposi's

Sarcoma (CDC, 2011). HIV is transmitted through bodily fluids that contain white blood cells

such as semen, breast milk, blood, rectal, and vaginal fluids (CDC, 2011) HIV can also be

transmitted through oral and anal sex, as well as through intravenous drug use, primarily through

the sharing of needles. HIV/AIDS is not transmitted through saliva or casual contact (CDC,

2011).

HIV timeline

Early in the 1980's unusual outbreaks of Pneumocystis Carinii Pneumonia (PCP) and

Kaposi's sarcoma were reported to the CDC. The five reported cases of PCP were otherwise

healthy homosexual men (Granfors & Stalstrom, 1987).   The first reports were published in the

CDC's Morbidity and Mortality Weekly Report, linking HIV with homosexuality and termed it a

Gay Related Immune Deficiency Syndrome "GRID" (Fee & Perry, 2008). Although the term

GRID changed to Human Immunodeficiency Virus (HIV), homosexual stigma remained linked

to the virus. The privileged and the powerful, even Ronald Reagan, the President at the time,

would not speak of, or publicly address the virus that threatened to consume a

population. President Reagan vetoed the prospect of research funding, so for eighteen months,

all that was done was to continue to count bodies (Granfors & Stalstrom, 1987).

By the end of 1981, 270 cases of HIV/AIDS had been reported among gay men, and of

these reported cases 120 individuals were already deceased (Granfors & Stalstrom, 1987). It was

not until 1982 that legislation allotted $5 million for surveillance to the CDC, and $10 million to

the National Institute of Health (NIH) for AIDS research (CDC, 2011).   In this same year, the

term AIDS emerged, along with the term came the defining statement that the disease causes

intracellular immunity deficits (CDC, 2011). At the close of 1982, the CDC estimated that tens

of thousands had become infected, and the first infant and heterosexual cases were beginning to

emerge (CDC, 2011). Some people in the religious sectors originally stigmatized PLHA by

referring to HIV/AIDS as "God's wrath", claiming that HIV/AIDS was the punishment for the

sin of homosexuality (Fee & Perry, 2008). The same religious sectors continued to stigmatize

HIV/AIDS infections within the heterosexual community by inferring it as punishment for the

acceptance of homosexual sin (Fee & Perry, 2008). The infiltration of heterosexual infections

continued to offer stigma and blame a result of risk behaviors such as intravenous drug use

(IDU) and needle sharing, as well as sexual relations with multiple partners, and commercial sex

work (CSW). Risk behaviors attributed to contracting HIV/AIDS were believed to be of choice

and perceived avoidable (Appleby, Colon & Hamilton 2013). HIV/AIDS at this point had

become a potential pandemic to all individuals, not just the gay community and the stigma began

to overlap (Fee & Perry, 2008).

By 1995, the second decade of HIV/AIDS, 500,000 cases of HIV/AIDS had been

reported and by the year 2000, HIV/AIDS had become the fourth largest killer in the world, and

notably the number one killer in Africa (CDC, 2011). The World Health Organization (WHO),

claimed 33 million people were living with HIV/AIDS worldwide, and 14 million had died as a

result of the virus (CDC, 2011). In 2003, the Center for Disease Control estimated that 40,000

new infections occur in the US annually (CDC, 2011).

Ignorance about HIV was profound. There was speculation as to what the HIV virus was,

how it developed, and how the virus was contracted. The public feared contracting HIV and was

afraid of a mere touch due to the lack of information coupled with the fact that individuals who

had contracted the virus were here one day and dead the next. This virulence initiated fear not

only among the gay community but the general population, contributing to prejudice and

discrimination toward individuals with HIV (Fee & Perry, 2008). Misguided media attention

and ignorance surrounding HIV/AIDS and the transmission of HIV further ignited panic and

fear.

From its onset, fear, prejudice, stereotyping, and discrimination have led to HIV stigma,

isolation, and a lack of basic human rights for PLHA. Healthcare coverage was inaccessible;

private insurance companies historically refused coverage; Medicaid and Medicare limited

services, offering assistance only after symptomatic AIDS had developed, at which point death

was imminent (Curran, & Jaffee, 2011). Housing was limited for those infected with HIV, jobs

were lost, and access to public education was denied, as exemplified by the life of a young boy

named Ryan White (Curran, & Jaffee, 2011). Stigma and the high cost of HIV/AIDS treatment

were barriers to accessing HIV care, which facilitated the increase of HIV, related

deaths.   While HIV is no longer a death sentence, and much more is now known about HIV

contraction, stigma experienced by PLHA remains unchanged and continues to be a large part of

the lives of PLHA today.

Present Statistics and Populations Affected

Presently, HIV/AIDS affects men, women, and children of all races and ages. HIV/AIDS

does not discriminate between heterosexual and LGBTQ communities; HIV/AIDS is an equal

opportunist, with a prevalence that varies according to risk behaviors, geographical areas,

socioeconomic status (SES), gender and race (CDC, 2011). The CDC (2011) asserts that in the

US, HIV/AIDS is most prevalent among men having sex with men (MSM) and that incidence

variations continue according to race, gender, and risk behaviors, i.e., injection drug use (IDU),

MSM, and CSW (Kaiser Family Foundation, KFF, 2015).   Geographical areas also show

variance in occurrences of HIV infection; for example, the South accounts for 54% of new

HIV/AIDS cases across the fifty states including the District of Columbia. The Northeast

follows at 24%; the West at 19%, and the Midwest at 3% (CDC, 2011). This variation can

impact the services PLHA receive, and can also influence stigmatizing attitudes toward

PLHA. The more populated with HIV a geographical area is, the greater the access to service

delivery, and the lower the instances of stigmatizing attitudes, with the exception of the outlying

rural areas (KFF, 2015).

Prevalence according to race also varies, with African-Americans having the highest

number of HIV/AIDS infections. There is one exception found in the western states where HIV

is more prevalent among Hispanics (CDC, 2011).

The mode of HIV/AIDS transmission (*e.g.* MSM, IDU, CSW) also influences the number

of HIV/AIDS infections. The most prevalent method of contracting HIV/AIDS in the U.S. is

through sexual contact, primarily men having sex with men (MSM) followed by intravenous

drug use (IDU) (CDC, 2011). MSM make up 52% of the overall population of HIV/AIDS cases

and 63% of all new cases of HIV/AIDS in the U.S. (CDC, 2013). Although African American

men represent the highest prevalence of HIV/AIDS across all categories, Caucasian men

represent the largest number of HIV/AIDS cases in the MSM group (CDC, 2013).

Presently the number of HIV/AIDS cases according to population continues to vary,

offering a heavy personal, physical and financial burden resulting from the side effects of

extensive medications, the cost of antiretroviral treatment (ART), and lack of available services

to all (Walensky, Paltiel, & Freedberg, 2002). As the number of people living with HIV/AIDS

continues to rise, the mortality rate declines; the number of new cases remains between 40,000

and 50,000 annually (CDC, 2011). It is, however, notable to remark those individuals who are

unaware of their HIV/AIDS status may skew the statistical information on HIV/AIDS that

contributes to the number of new HIV/AIDS cases (CDC, 2013). Current and historical research

continues to display the impact stigma has on creating barriers to testing and status

disclosure. To fully comprehend the physical, psychological and social standpoint of stigma, one

must first understand the construct of stigma and its effects on PLHA.

Stigma Defined

Goffman (1963) was the first to pioneer stigma and characterized it as a disgraced

identity. Goffman's attributes of stigma included a tarnishing of character and physical

deformities (Goffman, 1963). Goffman provided a basis that remains foundational in

conceptualizing stigma (Rutledge, Whyte, Abell, Brown, & Cesnales, 2011); however,

HIV/AIDS stigma has been conceptualized as a process of devaluation, which contributes to

blame, prejudice, discrimination and shaming (Emlet, 2005). HIV/AIDS stigma leads to further

segregation, division, and loss of social status as a result of the virus (Mahajan et al., 2008).

Stigma exists as a result of power imbalances, labeling, and stereotyping (Mahajan et al.,

2008), and is often used to legitimize inequality and to develop and maintain power and control

(Parker & Aggleton, 2003). It segregates individuals because of an attribute that is atypical, and

in some instances fear evoking. Stigma discredits a person, discounting their feelings and

affliction; HIV stigma can often afford blame to PLHA (Nyblade, 2006). Although HIV stigma

initially developed as a result of fear of contagion, behaviors associated with HIV/AIDS

infection are viewed as voluntary, contrary to Judeo Christian values, and subsequently devalue

and blame individuals with HIV/AIDS (Lee et al., 2002).

HIV/AIDS stigma is a more complicated form of stigma since it predominantly affects groups such as MSM, IDU, and CSW that experience stigma independent of the virus (Schuster et al., 2004). HIV/AIDS stigma has developed layers, stigma within stigma; these overlapping layers range from viral stigma to stigmatized populations of gay men, individuals of low socioeconomic status (SES), intravenous drug users (IDU), and (CSW) (Mahajan, et al., 2008).

Groups experiencing stigma in the absence of the virus are compounded with prime factors of the early decades of HIV. These prime factors include lack of accurate information, knowledge, and absence of education coalesced with misrepresentation of the virus in the media; homophobia and ignorance have continued to layer HIV stigma (Carney, Werth, Emanuelson, 1994). Layering and overlapping of stigma have led to an increase in negative attitudes toward PLHA and has infiltrated and impacted families, PLHA, healthcare settings, generalized public and society as a whole.

Types of Stigma

HIV stigma is categorized as instrumental, structural, and perceptual, which can result in the individual with HIV perceiving and internalizing stigma (Kinsler, et al. 2007). Instrumental stigma is the action and attitudes of the general population toward PLHA (Nyblade, 2006). The negative attitudes of the general public, families, and friends, and can also be attributed to fear, and the behaviors associated with HIV/AIDS such as MSM, IDU and CSW (Kinsler et al., 2006). Instrumental stigma infiltrates the workplace, educational, and healthcare institutions, and may result in adverse treatment and attitudes toward PLHA (Schuster et al., 2005). Avoidance, segregation, judgment, shaming, and discriminatory behavior is often experienced by

PLHA, and may have succeeding effects on other types of stigma, specifically institutional, perceived and internalized stigma (Earnshaw, Smith, Chaudoir, Amico, Copenhaver, 2013).

Institutionalized stigma is displayed implicitly (indirectly) and explicitly (directly) through the actions and attitudes of the helping profession. Institutionalized stigma manifests in settings such as clinics, hospitals, and medical centers (Kinsler, et al., 2007). Institutional stigma may become internalized by PLHA as a result of diminished care, shaming, discriminatory actions, and outward attitudes of both the public and of helping professions (Kinsler, et al., 2007). Institutionalized stigma is intended discrimination based on fear of contagion and the attitudes of society toward PLHA (Decon, 2005). Research indicates that institutional stigma is found among nursing students and the helping professions, resulting in part from providing direct care to PLHA, and the effects of societal attitudes (Rutledge et al., 2011). Individuals with HIV/AIDS who experienced stigmatizing treatment, begin to fear rejection and discrimination as a result of their HIV status. Fear of rejection, discrimination, combined with anticipated judgment provides a barrier to testing while deterring those who are aware of their HIV status from disclosing their status and seeking medical care (Schuster, et al., 2005). Fear and anticipation of rejection are referred to as perceived stigma (Kinsler, et al. 2007).

Perceived stigma further isolates PLHA for fear of judgment, leading to a lack of social support that is an essential part of wellness in HIV/AIDS. Perceived stigma creates barriers to wellness by decreasing the willingness to be tested, decreasing the desire to disclose HIV status, decreasing the prevalence of early and ongoing medical treatment, and by reducing participation in support groups (Schuster et al., 2005). In one study, perceived, anticipated, and imagined stigma was associated with a lower CD4 count as a result of avoiding medical care (Earnshaw,

Smith, Chaudoir, Amico & Copenhaver, 2013). Perceived stigma combined with societal stigma may lead to an individual internalizing the attitudes of society and healthcare providers. Internalized attitudes surrounding acquisition of the virus, or the attitudes associated with HIV, may result in shame, withdrawal, and self-blame that can significantly impact the physical and mental wellbeing of PLHA (Okello, et al. 2015).

Individuals with HIV may internalize stigmatizing attitudes of people living without HIV/AIDS in addition to their implicit beliefs about the virus and how they acquired it (Earnshaw, et al. 2013). PLHA may begin to view themselves more negatively, which increases sensitivity and vulnerability to actual, anticipated, and perceived stigma. Studies have shown that higher levels of physical symptoms can result from internalized stigma as well as a more rapid progression from HIV to AIDS (Lee et al., 2002). One longitudinal study demonstrated an accelerated progression from HIV to AIDS in homosexual men who internalized and anticipated stigmatizing attitudes towards them; finding that over time men who reported feeling more stigma also experienced more psychological distress and presented with a more rapid progression to AIDS (Cole, Kerneny, & Taylor, 1997). Internalized stigma and helplessness, as well as a decreased acceptance of the virus, are correlated with gaps in medical care and a reduction in compliance with (ART) (Lee et al., 2002). People who are experiencing internalized stigma avoid social support and are less likely to disclose their status to partners, family, friends and medical providers as a result of shame and embarrassment (Lee et al., 2002).

Internalized stigma can develop as a result of adverse treatment and attitudes expressed toward PLHA by society, family, friends, and members of the helping professionals. Helping professionals may demonstrate stigmatizing attitudes both overtly (openly), and covertly

(subconsciously). Overtly displayed attitudes may manifest as a refusal of care, derogatory

statements, or neglect, where covertly expressed stigma are attitudes held without awareness and

may present with avoidance of the individual, minimized care, and decreased emotional support

and blame (Schuster et al., 2004). Stigmatizing attitudes among helping professionals both

covertly and overtly are detrimental to the physical and psychological outcome of treatment of

HIV/AIDS (Nyblade, Stangl, Weiss, & Ashburn, 2009). Helping professionals should provide a

safe, nonjudgmental, confidential, and comfortable environment for PLHA to advance physical

and psychological wellness (Nyblade, et al. 2009). Many different factors can negatively impact

the attitudes of helping professionals, such as fear of contagion, societal stigma, and

discriminating attitudes toward risk behaviors. Attitudes can also be directed toward the

caregiver of the PLHA, this type of stigma is termed courtesy stigma (Rutledge, et al. 2011).

Courtesy stigma is directed toward anyone associated with HIV/AIDS and is especially

applicable to family members, partners, and helping professionals (Rutledge, et al.

2011). Individuals who associate with, or are caring for someone with HIV may experience

courtesy stigma. Courtesy stigma can impact the individual without HIV in much the same way

as it does PLHA; they may experience, anticipate, or perceive stigma due to an association with

HIV (Hongjie, Yongtang, Yehun, & Levent, 2014). Individuals suffering from courtesy stigma

often mirror the same feelings of social isolation, shame, and fear of others knowing their

affiliation with HIV (Hongjie et al., 2014). In a family system, courtesy stigma can generate a

breakdown in communication, a decline in social support, and create a distancing and silence

surrounding a relative's status for fear of family discrimination (Hongjie, et al., 2014).

Stigma infiltrates families, individuals, and the helping profession, which further deters PLHA from seeking treatment, and increasing the number of HIV/AIDS cases (Mahajan, et al., 2008).   Stigma also results in accelerated advancement from HIV to AIDS, subsequently reducing the quality of life for PLHA (Mahajan, et al., 2008). All forms of stigma interconnect with one another and substantially impact PLHA, resulting in diminished care, a reluctance to seek treatment and testing, and a fear of judgment. All stigmas negatively influences attitudes encompassing society, professionals, and students; adversely affecting the physical and psychological wellbeing of individuals living with HIV/AIDS.

The Physical, Psychological and Social Impact of HIV Fear and Stigma

Stigma and fear correlate with undetected HIV/AIDS and as shown in more recent studies, fear of judgment dissuades individuals from seeking HIV testing (Earnshaw, et al. 2013). PLHA and individuals who may suspect they have contracted HIV continue to fear stigma and discrimination delivered by health care providers and as a result may choose not to get tested. If a person feels they may have contracted HIV, or are at risk of contracting HIV, they may choose not to get tested to avoid experiencing stigma. This behavior demonstrates that fear of judgment can prove to be a psychological barrier to testing. Additionally, it discourages individuals who are aware of their HIV status from obtaining early, as well as ongoing, antiretroviral treatment and highly active antiretroviral treatment (HAART), which is instrumental in decreasing replication of the virus (Rutledge, Whyte, Abell, Brown, & Cesnales, 2011).

Research supports that early HIV testing contributes to prophylactic measures that provide life-saving health benefits such as HAART. Early administration of HAART can substantially halt HIV replication by blocking receptors and increasing CD4 counts resulting in

increased longevity and an improved quality of life (Kinsler, et al., 2007). Of the 1.2 million

people infected with HIV/AIDS today, statistics tells us that 12.8 % are unaware of their HIV

status, which equates to 1 in 8 people (CDC, 2013). Research supports that HIV stigma creates

barriers to discovering and disclosing HIV status, and research further supports that stigma has a

detrimental impact on the psychological and overall health and wellbeing of PLHA. In fact, the

literature indicates that higher levels of stigma correlate with a reluctance to seek medical

attention, a decrease in compliance with antiretroviral therapy, and an increase in psychological

distress such as anxiety, depression, and hopelessness (Varni, Miller, McCuin, & Solomon,

2012). Individuals who do not seek care as a result of fear, shaming, and judgmental attitudes

are at the most risk and are exemplary of the detrimental effects of stigma, such as HIV

progression to AIDS (Valdiserri, 2002).

In contrast, PLHA who feel less threatened and who receive non-judgmental,

compassionate care that responds to their physical, social, psychological, and emotional needs

are more willing to disclose their status. By reducing the fear of disclosing their HIV status,

PLHA are more willing to reach out for social support, obtain testing, seek, receive, and adhere

to ongoing antiretroviral care (Valdiserri, 2002). Willingness to disclose status and obtain care,

in turn, can have a positive impact on decreasing the prevalence of new cases and increasing the

overall health of PLHA. In contrast, negative attitudes toward PLHA, professionals in the

helping field may provide barriers to care if stigmatizing attitudes are held implicitly and

expressed explicitly. PLHA may rely on helping professionals as their only means of physical

and psychological support; therefore, identifying stigma within the helping profession is

instrumental to the services provided to PLHA.

Stigma and the Helping Profession

Helping professionals are influenced by the prevalent attitudes of a society including the stigmatizing attitudes connected to risk behaviors (i.e. MSM, IDU, CSW). Educators in the helping professions have historically found this a challenge in preparing nursing students to care adequately for PLHA (Bowmen, Brown, & Eason, 1994). Helping professionals may also contribute to courtesy stigma, perceived, and internalized stigma as a result of their implicit attitudes toward PLHA. One study of baccalaureate nursing students showed that nursing students viewed individuals who had contracted HIV through IDU as more deserving of the virus, less worthy of care, and less respected overall (West, Leasure, Allen, & Lagrow, 1996). In the same study students viewed individuals who contracted HIV through sexual transmission as less deserving of the virus than those whose contracted HIV through IDU, but more deserving than those who had contracted HIV through maternal transmission or blood transfusion (West, et al. 1996). This study did not consider previous knowledge of HIV, familiarity or personal experience with PLHA.

In another study conducted among nursing students, individuals infected with HIV through needle sharing and multiple sex partners experienced more stigmatizing attitudes than monogamous partners that had contracted HIV/AIDS through sexual transmission; these attitudes directly connect HIV stigma to modes of transmission (West, Leisure, Allen, Lagrow, 1996). In the same study, homosexual men and MSM were also viewed more negatively among the nursing students than heterosexual men (West, et al., 1996). Kelly, Lawrence, Smith & Hood (1987) found similar results when measuring the attitudes of medical students. In this early study participants received four identical vignettes; the only exception was that the patient

presented with either leukemia or HIV and identified as homosexual or heterosexual. The results

of this study indicated that the medical students held stigmatizing attitudes toward homosexuals

and HIV/AIDS patients. It further showed that regardless of the illness, leukemia or HIV,

homosexual patients were viewed as more responsible for their illness (Kelly, Lawrence, Smith,

Hood, & Cook, 1987).

Presently, stigma toward same-sex partners continues, with research showing preexisting

stigma correlated with HIV/AIDS can increase negative attitudes toward PLHA (Rutledge et al.,

2011). Also, Bowman et al. (1994) found that personally knowing someone with HIV impacts

the student's attitude toward HIV. Familiarity with HIV combined with increased clinical hours

spent working with PLHA may be critical to educating students of the helping professions.

Eason et al. (1994) also found that knowing someone with HIV/AIDS and familiarity

with the virus decreased stigmatizing attitudes. In fact, more recent research concurs, finding

that despite previous studies showing that African Americans experience higher levels of HIV

stigma (Loutfy et al., 2012), higher levels of self-reported HIV stigma were found among other

races (Levi-Minzi, and Surratt 2014). Levi-Minzi and Surratt's (2014) finding may reflect the

historically disproportionately high prevalence of HIV among African Americans in

communities such as South Florida (Tsoa, Dobalian, & Naliboff, 2004). Communities with a

dense population of HIV have historically led to greater outreach services and a larger

availability of services (Levi-Minzi & Surratt. 2014). It could be speculated that communities

with a higher prevalence of HIV/AIDS have less stigmatizing attitudes, suggesting that the more

familiar one is with HIV/AIDS and the greater the resources such as education, outreach, and

services, the lower the stigmatizing attitudes (Levi-Minzi & Surratt, 2014).

Contrary to the research, stigma continues to be ingrained and prevalent in some impoverished rural regions of the Deep South, which has a high prevalence of HIV (Medha, 2015). Because these impoverished areas are rural, they are less likely to provide resources, outreach, and education. Therefore, there is an increased prevalence of stigmatizing attitudes, supporting the hypothesis that advanced education and familiarity with HIV may decrease HIV stigma (Reif, Geonnotti, Whetten, K, 2006). Levi-Minzi and Sarratt's (2014) study supports an association with HIV community outreach and increased education to lowering instances of stigma, increasing comfort levels, and attitudes toward PLHA. This finding speaks to the impact of education on students; reducing stigma should begin with factual, extensive knowledge of HIV/AIDS, but should also include increasing familiarity through clinical experiences with HIV clients and working within the HIV community. The greater the comfort level, the more empathetic the attitudes of the helping profession, the less stigma PLHA will experience and the more willing the work with HIV (Reif, Geonnotti, Whetten, K, 2006).

Research among social work students, showed a correlation with higher levels of education and knowledge of HIV/AIDS, to greater comfort levels of the students working with PLHA and the lower the prevalence of stigma (Weirner, & Seigal, 1990). If comfort levels in students are high, then students may be more willing to work with PLHA and may choose to become more involved with HIV care, which will further impact a decrease in stigmatizing attitudes. Studies have shown a negative correlation with the length of time care providers work with PLHA and stigma (Levi-Minzi & Surratt, 2014). Research indicates that education, comfort levels, and knowledge have both a positive impact on reducing HIV stigma while increasing compassionate care.

The Roles of the Helping Professions

The role of the helping professional is significant in decreasing stigmatizing attitudes and increasing comfort and care levels of PLHA, suggesting that increasing HIV education and opportunities for clinical experiences would promote the willingness and desire of students and professionals to work with PLHA. Helping professionals receive extensive classroom and clinical instruction before entering the field, as a result of this training, educators are instrumental in diminishing stigmatizing attitudes among future helping professionals. Educators may be able to identify and reduce stigmatizing attitudes before the individuals enter the helping field. Both the field of nursing and the field of social work are caring professions, which involve empathy for, and a connection to people in need. Educating students on and modeling empathy and caring are a curriculum challenge (Farenwald, Basset, Tschetter, Carson, White, Winterboer, 2005). Nursing embodies five core values essential to the inclusion of human dignity, altruism, social justice, integrity, and autonomy (Farenwald, et al., 2005). The helping professional integrates these values into clinical practice, and social work mirrors these values in its code of ethics that uphold the dignity and worth of the person (NASW, 2008).   Social workers adhere to the treatment of people in a kind, and respectful way to promote dignity; encourage and uphold self-determination, human rights and the importance of human relationships (NASW, 2008). The role of the helping professional is to engage individuals in the helping process, to restore, maintain, and promote the wellbeing of persons, families, groups, organizations, and communities. Social workers' are further trained to bring forth change focusing on social issues relating to poverty, discrimination, and other forms of social injustice. The focus should be on oppression and sensitivity to the people facing HIV/AIDS. It is essential that helping

professionals meet the needs of their client by providing access to services and resources to ensure equality (NASW, 2008). Therefore, the helping professional must be free of stigmatizing attitudes in order to be sensitive to the needs of PLHA, and to address the injustices afforded them. However, despite the instrumental role the helping professions have in HIV/AIDS and the lives of PLHA, there remains a significant lack of current research that monitors the condition of stigmatizing attitudes of professionals and students in these helping fields.

With more people living with HIV, it is essential to advance HIV care and decrease HIV stigma through research that identifies stigmatizing attitudes in the helping professions as well as research in the educational training they receive. Education, prevention, treatment, along with diminishing stigmatizing attitudes among helping professionals is fundamental to the wellbeing of PLHA in this decade and the future. With advancements in medicine, prophylactics, antiretroviral therapy and treatment, the largest barrier to longevity PLHA face is stigma.

This review of the literature finds that HIV stigma impacts the future of PLHA and the barriers it creates. Research suggests that diminishing stigmatizing attitudes begins within the foundation of education. Education combined with increased clinical experience, internships, or practicums which require students to work with PLHA will advance comfort levels in students and provide a foundational knowledge base. Working with PLHA provides a familiarity that may enhance a student's desire to work with HIV clients and seek positions working with PLHA beyond their education. Students who choose to work within the HIV community will empower PLHA by decreasing institutionalized stigma, and will contribute to diminishing perceived, and internalized stigma within the HIV population. The subsequent effect of reduced, perceived and internalized stigma for PLHA is early and ongoing treatment, psychological and social support,

and an increase in the health and overall wellbeing of those living with HIV. Decreasing

stigmatizing attitudes toward PLHA will encourage individuals who are at risk of contracting

HIV, to adhere to early testing and subsequent treatment. One other positive effect of decreasing

stigma among helping professionals is the modeled behavior and shared knowledge afforded

other colleagues and practitioners in the field, as well as the public, families, and friends of

PLHA, resulting in an increase in the support systems available to PLHA.

In conclusion, the literature shows the detrimental impact stigma has on PLHA; it shows

that the helping professions, specifically nursing and social work, are essential to ongoing

compassionate care and early intervention. However, much of the research is outdated and

despite the fact that stigma has remained a constant barrier to HIV/AIDS bio-psycho-social

wellness, the present research is lacking. Many studies relied on self-reported data, which is

subject to accuracy and subjective recall. Social desirability bias is also a consideration;

participants may offer socially acceptable responses that do not accurately represent the facts.

Another consideration is the impact of research design and sampling, as well as an

individual's perception of stigma (Engel & Schutt, 2013). Many of the studies used non-random

sampling, limiting generalizability. Cross-sectional designs limit conclusions about

causality. Longitudinal studies in past research were disrupted due to morbidity, but presently

PLHA live longer healthier lives so, longitudinal studies would prove more effective as a

repeated measure. Reliable measures that are high in validity designed to identify implicit

attitudes are essential to determining stigmatizing attitudes and prejudice toward PLHA.

In 2001, the CDC asserted that "Stigma hampers prevention" and will continue to provide

barriers until it can be diminished (CDC, 2011, pg. 1). Despite advancement in treatment, care,

knowledge, and education, stigma remains a problematic part of HIV/AIDS (Chambers, et al.,

2015).   The education level and experiences of students are foundational to decreasing

stigmatizing attitudes. As the research shows, training and working in settings that provide

direct care of PLHA increases comfort levels, which subsequently increases the willingness of

helping professionals and students to work in clinical HIV care (Levi-Minzi & Sarratt,

2014). Comfort in working in HIV care will further decrease stigmatizing attitudes, which will

decrease perceived and internalized stigma.   A reduction in perceived and internalized stigma

may result in higher numbers of PLHA seeking care and will increase the continuum of care

without judgment. The overall result will be an increase in the health and longevity of PLHA as

well as a reduction of new HIV cases (Reif, Geonnotti, Whetten, K, 2006).

In addition to educating students, diminishing HIV/AIDS stigma requires continued and

ongoing research. It is imperative to direct future research at monitoring, measuring, and

identifying stigmatizing attitudes among helping professionals and students, as well as

examining effective measures of diminishing stigmatizing attitudes of professionals and students

in helping professions.   Historical literature indicates the negative impact that attitudes of the

helping profession can have on the overall wellbeing of PLHA, yet there is little recent research

presently to identify and measure attitudes both explicitly and implicitly of the professionals and

students of the helping profession. This present gap in research impedes efforts to diminish

stigma and decrease the prevalence of future HIV/AIDS infections, which is essential to

empowering individuals living with HIV/AIDS (Valdiserri, 2002).

References

Appleby, G.A., Colon, E., & Hamilton, J. (2013). *Diversity, oppression, and social functioning.*

Boston, MA: Pierson Ed Inc.

Bowman, J. M., Brown, S.T., & Eason, F. R. (1994). Attitudes of baccalaureate nursing students

in one school toward acquired immune deficiency syndrome. *AIDS Education and*

Prevention, 6, 535-541.

Carney, J., Werth, J. L., & Emanuelson, G. (1994). The Relationship Between Attitudes Toward

Persons Who Are Gay and Persons With AIDS, and HIV and AIDS Knowledge. *Journal*

of Counseling & Development, 72, 646–650. doi:10.1002/j.1556-6676.1994.tb01696.x

Center for Disease Control and Prevention. (2014, Nov 20*). Living with HIV*. Retrieved from

http://www.cdc.gov/hiv/living/index.html

Chambers, L. A., Rueda, S., Baker, D. N., Wilson, M. G., Deutsch, R., Raeifar, E., & Rourke, S.

B. (2015). Stigma, HIV and health: A qualitative synthesis. *BMC Public Health 15*:848.

Doi:10.1186/s12889-015-2197-0.

Cole, S.W., Kemeny, M.E., & Taylor, S.E., (1997). Social identity and physical

health: Accelerated HIV progression in rejection-sensitive gay men*. Journal of*

Personality and Social Psychology, 72, 320-335.

Curran, J.W., & Jaffee, H.W. (2011). *AIDS: The early years and the CDC response.* Retrieved

from http://www.cdc.gov/mmwr/preview/mmwrhtml/su6004a11.htm

Deacon, H. (2006). Towards a sustainable theory of health-related stigma: lessons from the

HIV/AIDS literature. *Journal of Applied Social Psychology, 16*, 418-425.

Earnshaw, V.A., Smith, L.R., Chaudoir, S.R., Amico, K.R., & Copenhaver, M.M. (2013). HIV

stigma mechanisms and well-being among PLWH: A test of the HIV stigma framework.

AIDS Behavior, 17, 1785-1795. Doi: 10.1007/s10461-013-0437-9.

Engel R.J., & Schutt, R.K. (2013). *The practice of research in social work*. Thousand Oaks, CA:

Sage Publications Ltd.

Farenwald, N.L, Basset, S.D., Tschetter, L., Carson, P.P., White, L., & Winterboer, V.S. (2005).

Teaching core nursing values. *Journal of Professional Nursing, 21*, 46-51.

Fee, E., & Perry, M. (2008). Johnathan Mann, HIV/AIDS, and human rights. *Journal of Public

Health Policy 29,* 54-71.

Froman, R.D., & Owen, S.V. (1997). Further validation of the AIDS attitude scale. *Research in

Nursing & Health, 20*,161-167.

Gallant, J. (2012). *100 Questions and Answers about HIV and AIDS.* Burlington, MA: Jones and

Bartlett.

Goffman, E. (1963). *Stigma: Notes of the management of spoiled identity.* Englewood Cliffs,

NJ: Prentice- Hall.

Gronsfors, M., & Stalstrom, O. (1987). Power, prestige, and profit: aids and the oppression of

homosexual people. *Acta Sociologica 30*, 53-66.

Honjie, H., Yongfang, X., Yehuan, S., & Levent D (2014). Measuring HIV Stigma at the Family

Level: Psychometric Assessment of the Chinese Courtesy Stigma Scales (CCSSs). *PLoS

ONE 9*: e92855. doi:10.1371/journal.pone.0092855

Health Resources & Service Administration. (n.d). *Who was Ryan White?* Retrieved from

http://hab.hrsa.gov/abouthab/ryanwhite.html

Kaiser Family Foundation, (2015). *HIV/AIDS.* Retrieved from http://kff.org/hivaids/

Kelly, J.A., Lawrence, J.S., Smith, S. Jr., Hood H.V., & Cook, D.J. (1987). Medical students

  attitude toward AIDS and homosexual patients. *Journal of Medical Education, 62,* 549-

  556.

Kinsler, J.J., Wong, M., Sayles, J.N., Davis, & C., Cunningham, W.E. (2007). The effect of

  perceived stigma from a health care provider on access to care among a low-income HIV-

  positive population. *AIDS Patient Care and STDs, 21,* 584-592.

  doi:10.1089/apc.2006.0202.

Lee, R.S., Kochman, A., & Sikkema, K.J. (2002). Internalized stigma among people living with

  HIV-AIDS. *AIDS and Behavior, 6*, 309-319.

Lepoire, B .A., Giles, H., & Prescott, M. (2009). Stigma by association: The role of symbolic and

  instrumental attitudes. *Communication Research Reports, 21*, 105-118. doi:

  10.108010801088240904093599773.

Levi-Minzi, M.A., & Surratt, H.L. (2014). HIV stigma among substance abusing people living

  with HIV/AIDS: Implications for HIV treatment. *AIDS Patient Care and STDs, 28,* 442-

  451. doi: 10.1089/apc.2014.0076.

Loutfy M.R., Logie C.H., Zhang Y., Blitz S.L., Margolese S.L., Tharao W.E., …Raboud, J.M.

  (2012). Gender and Ethnicity Differences in HIV-related Stigma Experienced by People

  Living with HIV in Ontario, Canada. *PLoS ONE 7* e48168.

  doi:10.1371/journal.pone.0048168

Mahajan, A.P., Sayles, J.N., Patel, V.A., Remien, R.H., Sawires, S.R., Ortiz, D.J., … Coates, T.J.

    (2008). Stigma in the HIV/AIDS epidemic: a review of the literature and

    recommendations for the way forward. *AIDS, 22,* S67-S79.

Medha, I, (2015). Understanding health care needs of persons living with HIV/AIDS in rural

    communities. Retrieved from http://www.apa.org/pi/aids/resources

    /exchange/2015/01/health-hiv-aids.aspx

NASW (2008) Code of Ethics Retrieved from:

    http://www.naswdc.org/pubs/code/code.asp.

Nyblade, L.C. (2006). Measuring HIV stigma: Existing knowledge and gaps. *Psychology, Health*

    and Medicine, 11, 335-345.

Nyblade, L., Stangl, A., Weiss, E., & Ashburn, K. (2009). Combating HIV stigma in health care

    settings: What works? *Journal of International AIDS Society, 12*, doi: 10. 1186/1758-

    2652-12-15.

Okello, E.S., Wagner, G.J., Ghosh-Dastidar, B., Garnett, J., Akena, D., Nakasujja, N., &

    Seggane, M. (2015). Depression internalized HIV stigma and HIV disclosure. *World*

    Journal of AIDS, 5, 30-40. doi: 10.4236/wja.2015.51004.

Parker, R., & Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination: A

    conceptual framework and implications for action. *Social Science and Medicine, 57,* 13-

    24.

Reif, S., Geonnotti, K.L., & Whetten, K. (2006). HIV infection and AIDS in the Deep South.

    American Journal of Public Health, 96, 970-973.

Rutledge, S.E., Whyte, J., Abell, N., Brown, K.M., & Cesnales, N. I. (2011). Measuring stigma

among health care and social service providers: The HIV/AIDS provider stigma

inventory. *AIDS Patient Care and STDs, 25*, 673-682. doi: 1089/apc.2011.0008.

Sears, B., Cooper, C., Younai, F.S., & Donohue, T. (2012). HIV discrimination in dental care:

Results of a testing study in Los Angles County. *Loyola Los Angles Law Review, 45,*

909.

Shrum, J., Turner, N., & Bruce, K. (1998). Development of an instrument to measure attitudes

towards AIDS. *AIDS Education and Prevention, 1,* 222-230.

Shuster, M.A., Collins, R., Cunningham, W.E., Morton, S.E., Zierler, S., Wong, M., Tu, W., &

Kanouse, D.E. (2005). Perceived discrimination in clinical care in a nationally

representative sample of HIV-infected adults receiving health care. *Journal of General

Internal Medicine, 20*, 807-813.

Tsao, J.C.I., Dobalian, A., & Naliboff, B.D. (2004). Panic disorder and pain in a national sample

of persons living with HIV. *Pain, 109*, 172-180. doi.org/10.1016/j.pain.2004.02.001

Valdeserri, R.O. (2002). HIV/AIDS stigma: An impediment to public health. *American Journal

of Public Health, 92,* 341-342. Retrieved from:

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447072/

Varni, S.E., Miller, C.T., McCuin, T., & Solomon, S. (2012). Disengagement and engagement,

coping with HIV/AIDS stigma and psychological well being of people with

HIV/AIDS. *Journal of social, clinical psychology, 31*, 123-150.

doi:10.10521/jscp2012.31.2123.

Walensky, R.P., Paltiel, A.D., & Freedberg, K.A. (2002). Aids drug assistance programs: Highlighting inequities in human immunodeficiency virus-infection health care in the United States. *Clinical Infectious Diseases, 35,* 606-610.

West A.M., Leasure, R., Allen, P., & Lagrow, P. (1996). Attitudes of baccalaureate nursing students toward persons with acquired immunodeficiency syndrome according to the mode of human immunodeficiency virus transmission. *Journal of Professional Nursing, 12,* 225-232.

Wiener, L.S., & Siegel, K. (1990). Social workers' comfort in providing services to AIDS patients. *National Association of Social Workers*, *35,* 18-25. doi: 10.1093/sw/35.1.18