# AN EXPLORATION OF THE VARIANCE IN FORGIVENESS IN HIV+ ADULTS THROUGH STIGMA AND SOCIAL SUPPORT

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Forgiveness is a cognitive, emotional, and behavioral response to interpersonal conflict and is essential in maintaining social harmony (Lawler et al., 2005). More importantly, forgiveness has been associated with improvements in health issues such as quality of life, depression and stress in people living with HIV (PLH; Scherbarth & Vosvick, 2006; Volpone & Vosvick, 2007; Doi, Vosvick, & Chng, 2007). Identifying correlates of forgiveness that may be clinically manipulated to improve forgiveness responses may contribute to improved health in HIV+ adults. Two potential factors that may contribute to an individual's ability to forgive include stigma and social support.

Stigma can manifest itself in many ways. For example, when seropositive individuals disclose their HIV status, some people may distance themselves. This rejection may, in turn, encourage withdrawal from social interactions, resentment and feelings of anger towards the stigmatizer, and rumination on the experience. Such responses are unlikely to contribute to a forgiving attitude in PLH. We hypothesize individuals who report higher levels of stigmatization will also report lower levels of forgiveness.

Research has also shown an association between social support and mental health. Social support can enhance emotional well-being and defend against HIV-related psychological distress and physical symptoms (Lam, Naar-King, & Wright, 2007). Additionally, social support has the potential to create a state of mind conducive to forgiveness. Of the various types of social support, emotional support may be the most relevant to forgiving behaviors because forgiveness requires a reflection on interpersonal conflict that involves emotional responses. We hypothesize that as emotional support increases in HIV+ adults they will also report increases in forgiveness.

This study used a cross-sectional correlational design to examine the relationship between two stigma subscales (disclosure concerns and negative self-image), emotional support and forgiveness in a sample of HIV+ people in Dallas/Fort Worth, Texas.

Two-hundred eighty eight participants (48.8% male, 49.5% female, 1.7% transgendered; 54.4% African-American, 29.6 European-American, 16% Latino, American Indian, or Middle Eastern; average age = 41.66 (SD = 8.39)) completed the HIV Stigma Scale (Berger et al., 2001; alpha = .95), the UCLA Social Support Scale (Dunkel-Schetter, Feinstein, & Call, 1986; alpha = .89), and the Heartland Forgiveness Scale (Yamhure, Snyder, Hoffman, & Rasmussen, 2002; alpha =

.92). When reevaluating the HIV Stigma Scale, Bunn and colleagues (2007) noted the overlapping of items between the four-factor structure within the scale and suggested an adjustment (the elimination of items that occur on more than one subscale) to create more explicit boundaries between the types of stigma. For this study, we refined the HIV Stigma Scale based on this recent finding to achieve the most accurate report of stigma for this model.

A hierarchical linear regression analysis was used to examine a model that used demographics, two stigma subscales (disclosure concerns and negative self-image) and emotional support received from family and partners as independent variables to explain the variance in our dependent variable - forgiveness. Our model was able to explain 22% of the variance in forgiveness (adjusted $R^2$=.22, $F(7, 287)$, $p$<.001) and depicts a complex relationship between stigma, social support and forgiveness. Although our findings suggest that individuals who reported less stigma related to negative self-image ($\beta$=-.39, $t$=-5.89, $p$ <.001) and who received more emotional support from a relative ($\beta$=.23, $t$=3.41, $p$ <.01) also reported higher levels of forgiveness (as we had hypothesized), we also found that individuals who reported higher levels of stigma associated with disclosure of their status ($\beta$=.21, $t$=3.21, $p$ <.01) and who received less emotional support from their partners ($\beta$=-.16, $t$=-2.74, $p$ <.01) also reported higher levels of forgiveness. Incidentally our findings also suggest that older HIV+ adults ($\beta$=.12, $t$=2.30, $p$ <.05) and those with higher incomes ($\beta$=.15, $t$=2.75, $p$ <.01) tended to be more forgiving.

These complex findings suggest that the relationship between stigma, social support and forgiveness are not as straightforward as we had assumed. Although our hypotheses are partially supported by our findings, some of our results seem counterintuitive. Perhaps PLH who are concerned with disclosure due to possible stigmatization are more likely to be forgiving since they have experienced what it feels like to be stigmatized or not forgiven because of their HIV. We speculate that they may be more willing to be understanding of others and their concerns in the hopes that their forgiving behaviors may beget less stigmatizing behaviors. Another unexpected finding was the negative relationship between emotional support from a partner and forgiveness. One explanation for this relationship may be rooted in recent findings that social support is not always positive. Researchers have found that as HIV symptoms increase and health decreases, social support from friends declines and becomes less useful (Bor et al., 1993; Turner et al.,1993; Zich & Temoshok, 1987). Perhaps something similar occurs between PLH and their partners. Additionally, the emotional support provided by the partner might be overbearing or smothering, contributing to a less forgiving attitude in the PLH.

Our findings provide a strong rationale for additional research to deconstruct the stereotypical interpretations of constructs such as stigma and social support into more basic components to better understand the phenomena that we observed in our sample. Better measures that identify different and potentially contradictory dimensions of stigma and social support may be helpful in disentangling their relationship with forgiveness and could lead to significant contributions to clinical practice with an HIV+ population.

Although this study's correlational design limits our ability to infer causality, the use of self-report data introduces the possibility of respondent bias, and our recruitment of participants only from AIDS service organizations limits generalizability, our study is important because it is the

first to attempt to identify correlates of forgiveness that may be clinically manipulated. The degree of complexity discovered between our variables also may redirect future research in a productive vein. In summary, based on our findings, clinical interventions may be developed that focus on increasing forgiveness attitudes and behaviors in HIV+ adults by focusing on specific aspects of stigma and social support.