

Perceptions of HIV-related Stigma: Locus of Control and Trait Anxiety  
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The introduction of highly active antiretroviral therapy (HAART) in 1996 has led to significant decreases in the morbidity and mortality of persons living with HIV or AIDS (PLH). HAART has also helped to improve the quality of life of persons infected with the disease. While advancements in treatment have made HIV a much more manageable disease, other variables that can affect the health of persons infected with HIV have surfaced. HIV-related stigma, considered by some researchers to be a “second epidemic”, is one such variable. Stigma is a social label that assigns undesirable attributes and traits to a person. An assumption that an HIV+ female is a sex worker or is somehow behaviorally responsible for her HIV status are examples of HIV-related stigma. The assumptions lead to a devalued identity and assign an unwarranted mark of shame, both psychosocial factors associated with poor health outcomes in PLH. Thus, it has become increasingly important to identify the mechanisms through which PLH report experiences of stigmatization.

While it is intuitively understood that the experience of living with HIV is different for men and women, more research is needed that delineates the quantitative variables within living with HIV that are unique to men and women. HIV-related stigma is no exception. For this study, we focused on variables that affect how women infected with HIV may report stigmatization, particularly trait anxiety and having an internal locus of control. Although it is supported that anxiety is positively associated with increased HIV-related stigma (Lee, 2002), the research is severely limited. Internal locus of control and its association to HIV stigma represents an even greater dearth in research. However, having an internal locus of control involves taking more responsibility for one’s own health; therefore, it seems reasonable to believe that having an internal locus of control would result in reduced stigma and better management of HIV. We hypothesized that increased trait anxiety augmented experiences of HIV stigma. We also hypothesized that having a more internal, rather than external, locus of control would decrease perceptions of stigmatization.

Female participants (n = 35) were recruited from various AIDS service organizations in the Dallas-Forth Worth Metroplex. Our participants ranged in age from 24 to 66 years, with an average age of 47.43 (SD = 8.93). The majority (n = 30, 85.7%) of our participants were African/African-American. Of our participants, 13 (37.1%) lived alone, 24 (68.6%) were not employed, and 13 (37.1%) were diagnosed with AIDS.

Several measures were used to collect demographic, medical, and psychological data. Stigma was measured using the HIV Stigma Scale (HSS; Berger, Ferrans, Lashley, 1996;  $\alpha = .96$ ); trait anxiety was measured using the State-Trait Anxiety Inventory (STAI; Spielberger, 1983;  $\alpha =$

.85); locus of control was measured using the Multidimensional Health Locus of Control Scales (MHLC; Wallston, Wallston, & DeVellis, 1978,  $\alpha = .60-.75$ )

Among our variables of interest, HIV-related stigma was significantly positively correlated with both trait anxiety ( $r = .44, p < .01$ ) and having a more internal locus of control ( $r = .42, p < .05$ ). Multicollinearity amongst the variables was assessed and was not found to be relevant. The relationships between our variables were also examined using a multiple regression model. Within our model, trait anxiety ( $\beta = .40, t = 2.73, p < .01$ ) and having a more internal locus of control ( $\beta = .37, t = 2.57, p < .05$ ) accounted for 29% of the variance in HIV-related stigma (adjusted  $R^2 = 0.29, R^2 = .33, F(2, 32) = 7.99, p < .01$ ).

The results support our first hypothesis that trait anxiety in women living with HIV or AIDS is a significant contributor to HIV-related stigma; essentially, the more prevalent anxiety was, the more stigma women living with HIV or AIDS reported. Surprisingly, having a more internal locus of control was found to be associated with more perceived HIV stigma. One possible explanation could be that WLH who have an internal locus of control blame themselves more for becoming infected with HIV and likely believe that others view them as being at fault as well. Another possibility is that HIV+ women who utilize an internal locus of control rely less on others and do not seek social support as often; because these women do not utilize social support as a coping strategy, they may perceive themselves as more stigmatized.

The cross-sectional correlational design of our study limits causal inferences and our sample is from only one geographic location and mostly consists of African/African-American women, which limits generalizability. However, the implications of this study remain important to counseling psychologists. In order to decrease the negative effects of HIV-related stigma, clinicians must work to reduce enduring traits of anxiety and encourage WLH to allow their support system to help alleviate the burdens that come with managing a chronic illness. Furthermore, additional studies are needed to deconstruct the complexities of stigma and investigate other factors that contribute to its development. We hope to expand on our study by looking at the effects of state, or more situational, anxiety and other loci of control as well. Men living with HIV or AIDS also need to be incorporated into studies in order to gain a fuller understanding of the many facets of this “second epidemic” and its effect on the resiliency of PLH.