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## Understanding Internalized HIV/AIDS-Related Stigmas in the Dominican Republic: A Short Report

**Christine Tagliaferri Rael** and

HIV Center for Clinical and Behavioral Studies at the New York State Psychiatric Institute and Columbia University, 1051 Riverside Dr., New York, NY 10032, T: 646-774-6967, F: 646-774-6955

**Karen Hampanda**

University of Colorado-Denver, Department of Health and Behavioral Sciences, Campus Box 188, PO Box 173364, Denver, CO 80217-3364, 303-556-4300 303-556-8501

Christine Tagliaferri Rael: cr2857@cumc.columbia.edu; Karen Hampanda: Karen.Hampanda@ucdenver.edu

### Abstract

HIV/AIDS-related stigmas can become internalized, resulting in declines in physical and mental health. Pathways to internalized HIV-related stigma (IS), characterized by persistently negative, self-abasing thoughts, are not well established among women living with HIV/AIDS (WLWHA) in the Dominican Republic (DR). Identifying factors involved in self-directed shaming and blaming is important, given the high HIV prevalence in the DR's most vulnerable populations. The present study sheds light on factors involved in negative and self-abasing thoughts in WLWHA in the DR by examining the relationship between depression, perceived HIV-related stigma from the community (PSC), perceived HIV-related stigma from family (PSF) and IS. The Internalized AIDS-Related Stigma Scale (IA-RSS), the Center for Epidemiologic Studies Short Depression Scale (CES-D 10), and an instrument designed to measure perceived HIV-related stigma from the community and family was administered to 233 WLWHA in Puerto Plata, DR. Data were analyzed using descriptive statistics and ordered multiple logistic regression. Results showed that depression (OR=1.60;  $p<0.05$ ), PSC (OR=3.68;  $p<0.001$ ), and PSF (OR=1.60;  $p<0.01$ ) were positively associated with IS. These findings indicate that IS-reducing interventions should address HIV-related depression. Additionally, HIV-related treatment and care services should work with WLWHA to adopt healthier attitudes about how community members view people living with HIV/AIDS in the Dominican Republic.

### Keywords

Internalized stigma; perceived stigma; HIV/AIDS; depression; Dominican Republic

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Correspondence to: Christine Tagliaferri Rael, cr2857@cumc.columbia.edu.

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## Introduction

Stigma is a key barrier to HIV-related health services (Dowson, et. al, 2012; Polinni, et. al., 2011; Steward et. al., 2013; Sayles, et. al., 2009) and contributes to secondary social (Audet, et. al., 2013; Nachega, et. al., 2012; Parker & Aggleton, 2003) and psychological (Hatzenbuehler, et. al., 2011; Tanner, Naar-King, & MacDonnel, 2012; Varni, et. al., 2012) morbidities for people living with HIV/AIDS (PLWHA). In the Dominican Republic (DR), HIV prevalence ranges from 1–12% among the country’s most vulnerable groups, including female sex workers and Haitians (Calleja, et. al., 2002; Kerrigan, Barrington, & Montalvo, 2008; Rojas, et. al., 2011; UNAIDS, 2008). Scholars note that experiences of HIV-related stigma vary widely across cultural contexts (Parker & Aggleton, 2003; Yo & Mak, 2013) and can impede efforts to address HIV/AIDS (Grossman & Stangl, 2013). Therefore, examining stigma within the appropriate socio-cultural setting is a necessary first step towards formulating effective HIV prevention, testing, and treatment interventions (Kalichman, et. al., 2009).

Stigma is “an attribute that is deeply discrediting” (Goffman, 1963, p3), and can be perceived, enacted, or internalized. Perceived stigmas are felt or imagined devaluations from individuals and/or institutions and can be examined from two distinct domains: community and family (Liu, et. al., 2011). Enacted stigmas are actual occurrences of discrimination (Steward, et. al., 2008) and internalized stigmas are self-shaming/blaming narratives that are adopted by stigmatized individuals (Scambler & Paoli, 2008). Additionally, stigmas can be layered when new stigmas are compounded on top of pre-existing ones (Nyblade, 2006). This paper focuses on internalized HIV-related stigmas (IS) due to their damaging effect on physical and mental health (Kalichman, et. al., 2009).

Multiple social and mental health factors influence HIV-related stigma in the DR. For instance, a new constitutional amendment in the DR mandates all persons of Haitian descent to seek Haitian passports or register as foreign migrants (Constitución de la República Dominicana, 2010), or face deportation to Haiti (Leclerc, 2014). Thus, we expect that being of Haitian nationality and not possessing a government-issued Dominican identification card or Haitian passport to increase IS. Additionally, there are an estimated 100,000 female sex workers (FSW) in the DR (Kerrigan, Ellen, & Moreno, 2003) who are at high risk of acquiring HIV (Baral, et. al., 2012; UNAIDS, 2002). FSW in the DR report perceived stigma related to their occupation from their home communities and families (Rael, 2015). Therefore, sex work may increase IS in WLWHA due to the stigma associated with their profession (Kennedy, et. al., 2013; Brennan, 2004; Rael, 2015) and their HIV status. We also expect that WLWHA who report worse depression will have higher IS. PLWHA are vulnerable to self-hatred (Lewis, 1998), self-abasing thoughts (Simbayi, et. al., 2007), and social isolation (Crandall & Coleman, 1992), which may worsen depression. Therefore, we expect to see a positive association between depression and IS.

The current study builds on existing research by shedding light on factors that help construct negative and self-abasing thoughts (e.g., internalized stigma) using the Internalized AIDS-Related Stigma Scale (IA-RSS; Kalichman, et. al., 2009) and considering the role of several covariates in WLWHA in the DR.

## Methods

### Participants and procedures

This study is a subset of a larger study about motherhood, the health of stigmatized women, and their children. The present paper uses data from 233 WLWHA who were receiving outpatient HIV/AIDS care from one of two affiliated treatment programs the DR. HIV/AIDS programs included: (1) El Centro de Promoción y Solidaridad Humana (CEPROSH; N=120), and (2) a CEPROSH-affiliated HIV clinic at a local public hospital (N=113).

To be eligible for this study, respondents had to be HIV-positive, at least 18 years old, not pregnant, and have at least one biological or adopted child age 15 years old or younger. Per the human subjects agreement to protect participant confidentiality, respondents were recruited from CEPROSH or the CEPROSH-affiliated outpatient clinic waiting rooms. Recruitment took place from May-September 2014. Tablet-based questionnaires were verbally administered in Spanish by trained interviewers. Interviews were conducted privately to ensure participant confidentiality. The Colorado Multiple Institutional Review Board (COMIRB), Consejo Nacional de Biética en Salud (CONABIOS) and CEPROSH granted ethical approval for this study. Participation was voluntary and informed written consent was obtained from all participants.

### Measures

IS was measured by the IA-RSS (Kalichman, et. al., 2009; e.g., “I hide my HIV status from others”; Cronbach’s Alpha = 0.76). To increase scale sensitivity, response choices were converted from dichotomous options (agree/disagree) to a 4-point scale (e.g., “no, rarely, sometimes, yes”), during a pilot study (N=50) that occurred from December 2011–January 2012. IS was ascertained by calculating mean IA-RSS scores. Higher mean IA-RSS ratings indicated more IS.

Several covariates were included in the analysis. For instance, perceived HIV-related stigma (PHS) was measured by the 9-item HIV-Related Stigma Index (HRSS), which was adapted from the Sex Worker Stigma Index (SWS; Liu, et. al., 2011). The HRSS was used in lieu of existing PHS instruments (Berger, et. al., 2001; DeMasi, et. al., 2001; Holzemer, et. al., 2007; Kinsler, et. al., 2007; Li, et. al., 2009; Sowell, et. al., 1997; Steward, et. al., 2008) because the HRSS is the only scale to measure PHS along two distinct domains, relative to this study: perceived stigma by the home community (PSC; e.g., “I feel that if I disclosed having HIV to some people, they would think I was immoral”; Cronbach’s Alpha = 0.70), and perceived stigma by family (PSF; e.g., “I feel that if I disclosed having HIV to my family, they would treat me differently”; Cronbach’s Alpha = 0.78). Response options for the HRSS were based on a locally contextualized 4-point scale (e.g., “no, I doubt it, it’s possible, yes”). PSC and PSF scales contained 5 and 4 items, respectively. Scales were scored separately by calculating means for each domain. Higher means for either domain indicated more perceived stigma.

Depression was measured using the 10-item Center for Epidemiologic Studies Short Depression Scale (CES-D 10; Zhang, et. al., 2012). With the CES-D 10, participants reported the number of times they experienced depression symptoms in the last week using a

4-point scale (e.g., “I felt that everything I did was an effort”; rarely or none of the time, some or a little of the time, occasionally or a moderate amount of the time, all of the time; Cronbach’s Alpha = 0.87). Mean scores were calculated for the CES-D 10 where higher scores meant worse depression.

Whether respondents were FSW was ascertained from the WHO World Health Survey Individual Questionnaire by asking, “What is your current job?” and noting FSW. Having a government-issued Dominican identification card or Haitian passport, was based on a question developed during the pilot study, (e.g., “Do you have a government-issued Dominican identification card or Haitian passport?”; yes/no). Finally, the model controlled for age (years), education (last grade completed), nationality (“What is your nationality?”), and partnership (“which of the following best describes your relationship type?”; partnered/unpartnered).

### Data analysis

Statistical analyses were completed in Stata 13.1. Descriptive analyses summarized participant characteristics. Means and medians were used for continuous variables and frequencies were used for categorical variables. Multivariate ordered logistic regression tested for associations between IS and covariates. Non-normality and multicollinearity did not influence study results. Listwise deletion was used in the final analysis, since missing data was <1%.

## Results

### Participants

Table 1 shows the demographic, depression, and PHS characteristics of respondents.

### Regression analysis

Table 2 shows that each 1-unit increase in depression level corresponded to a 60% ( $p<0.05$ ) increase in IS. Additionally, 1-unit increases in PSC and PSF resulted in 368% ( $p<0.001$ ) and 60% ( $p<0.01$ ) increases in IS, respectively.

## Discussion

This study is the first to shed light on factors that help construct negative and self-abasing thoughts in WLWHA in the DR. Specific variables, such as depression, were positively associated with IS in this study. This finding is consistent with previous research (Lee, Kochman, & Sikkema, 2002; Li, et. al., 2009; Radcliffe, et. al., 2015; Simbayi, et. al., 2007) and reconfirms the need to incorporate strategies to address depression in HIV-related mental health care.

PSC and PSF were positively associated with IS. However, PSC exerted more influence over IS than PSF. These results have important implications in light of existing evidence. Research in South Africa showed that PLWHA internalized HIV-related stigmas to a greater extent than those beliefs are held in the general population (Kalichman, et. al., 2005). Since PSC and IS are strongly associated with one another in this study, findings may mean that

WLWHA inflate internalized stigmas by unknowingly and falsely exaggerating perceived community-held HIV-related stigmas. This indicates a need for HIV-related treatment and care services to implement strategies that help WLWHA adopt healthier, more realistic attitudes about how others see them. In addition, community sensitization regarding PLWHA should be prioritized to reduce prevailing actual family and community stigmas.

Lacking a government-issued Dominican identification card or Haitian passport was not associated with higher levels of IS. This may be because few Haitians (10.2%) possessed this paperwork, subsequently reducing IS. Additionally, sex work was not associated with higher levels of IS, which contradicts some existing research (Logie, et. al., 2011). Associations may not have been detected between sex work and IS because of the low number of FSW (N=21) in this sample.

This study had limitations. First, because of participants' involvement with CEPROSH, all WLWHA in this study had received at least one HIV/AIDS-related psychiatric counseling session. Exposure to counseling may have resulted in lower depression and perceived and/or internalized stigma scores. Also, enacted HIV-related stigma was not measured, which may have increased or decreased perceived and internalized stigma measures, or depression. Data were collected using self-reports, which is vulnerable to social desirability bias. Lastly, the cross-sectional study design cannot establish causality; however, compelling associations between IS, depression, PSC and PSF were identified.

## Conclusions

This study sheds light on the factors that help construct internalized HIV-related stigma in WLWHA in the DR. Depression, PSC, and PSF are strongly positively associated with IS. This suggests that HIV-related interventions and mental health care should focus on minimizing depression in WLWHA. Additionally, interventions designed to reduce IS should promote healthier and more realistic attitudes about how the broader community sees WLWHA.

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**Table 1**

Demographic, depression, and perceived HIV-related stigma characteristics of participants (N=233)

	N (%)	Median	Std. dev.
<b>Demographic Characteristics of Participants</b>			
Age (mean)	32.1	31.0	7.5
Years of education (mean)	6.8	8.0	4.3
Partnership status			
Partnered	136 (58.4%)		
Un-partnered	97 (41.6%)		
Nationality			
Dominican	154 (66.4%)		
Haitian	78 (33.6%)		
Has a government-issued Dominican identification card or Haitian passport			
Yes	160 (68.7%)		
No	73 (31.3%)		
Currently works as a sex worker			
Yes	21 (9.0%)		
No	212 (91.0%)		
<b>Mental Health Characteristics of Participants</b>			
Depression level (mean)	1.7	1.8	0.7
<b>Participants' Perceived HIV-Related Stigma</b>			
Perceived HIV-related stigma by the community (mean)	3.0	3.2	0.7
Perceived HIV-related stigma by family (mean)	2.2	2.0	1.0

**Table 2**

Regression analysis among the Internalized AIDS-Related Stigma Scale and perceived community stigma, perceived family stigma, and depression (N=231)

<b>Independent characteristics</b>	<b>OR [95% CI]</b>
<b>Demographic Indicators</b>	
Age (years)	0.96* [0.93, 1.00]
Years of education (years)	1.01 [0.95, 1.08]
Partnership status (partnered)	0.87 [0.53, 1.42]
Nationality (Dominican)	0.75 [0.24, 2.33]
Has a government-issued Dominican identification card or Haitian passport (yes)	0.40 [0.12, 1.29]
Currently works as a sex worker (yes)	0.93 [0.40, 2.14]
<b>Mental Health Indicators</b>	
Depression level	1.60* [1.07, 2.38]
<b>Perceived Stigma Indicators</b>	
Perceived HIV-related stigma by the community	3.68*** [2.29, 5.93]
Perceived HIV-related stigma by family	1.60** [1.15, 2.22]

\* p 0.05

\*\* p 0.01

\*\*\* p 0.001

Chi-square = 157.8; p>0.001