



8-2017

## **A Case Study of a Mature Appalachian HIV Negative Homosexual Man on HIV Positive Homosexual Men**

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### **Recommended Citation**

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To the Graduate Council:

I am submitting herewith a thesis written by Jacob Lee Nelson entitled "A Case Study of a Mature Appalachian HIV Negative Homosexual Man on HIV Positive Homosexual Men." I have examined the final electronic copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science, with a major in Agricultural Leadership, Education and Communications.

Carrie Stephens, Major Professor

We have read this thesis and recommend its acceptance:

Joseph Donaldson, Laura Miller

Accepted for the Council:

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Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

**A Case Study of a Mature Appalachian HIV Negative  
Homosexual Man on HIV Positive Homosexual Men**

A Thesis Presented for the  
Master of Science  
Degree  
The University of Tennessee, Knoxville

Jacob Lee Nelson  
August 2017

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## ACKNOWLEDGEMENTS

I would like to thank the chairperson of my thesis advisory committee, Dr. Carrie Ann Stephens. Dr. Stephens made a concerted effort to be incredibly affable this semester, making sure to not only give constructive critique, but also uplifting encouragement. I thank Dr. Joseph Donaldson and Dr. Laura Miller, both thesis advisory committee people. Dr. Donaldson's remarkable dedication to students was certainly exemplified in our many interactions completing this work. And, having Dr. Miller as a former communication studies professor is the reason for much personal interest in how humans interact and how lives in marginalized communities can be improved.

I want to express sincerest gratitude to my parents, sister, and brother-in-law, whose unconditional support, passion for education, and dearest hopes for my success have been the basis for each great endeavor of my life. Their devotion could never be properly acknowledged.

I, too, thank David McIntosh and Dr. Gary Bates of the University of Tennessee Beef and Forage Center. Aside from being given the opportunity to work for the organization, their flexibility and support truly is outstanding.

I thank the gay networking organization that assisted my recruitment, not only for their help in attaining a subject, but also an unwavering commitment improving gay lives and those aligned with the community.

Finally, I thank the subject for his candid and genial participation in this study. Without him, none of this could have been accomplished. This thesis is dedicated to all

those living with HIV/AIDS, anyone ever made to feel lesser in being gay, and all those who fight for subjugated voices to be heard and heeded.

## **ABSTRACT**

Because of the lack of study, little is known about how members of the gay community immersed in rural areas relate to one another especially relative to the AIDS Crisis and those gay men living with HIV (Eldridge, Mack, & Swank, 2008). The purpose of this study was to investigate features of attitude (fears, threats, preconceived notions, and convictions) of a mature HIV negative homosexual man from rural Appalachia on HIV positive homosexual men (Thurstone, 1928). The central research question asked was, “How do you relate to HIV positive gay men as a HIV negative gay man having been raised in rural Appalachia and lived through the AIDS Crisis?” The criteria for selecting a subject for this study was an HIV negative homosexual male, 52-60 years of age, and being raised from birth in rural Appalachia. This thesis was a case study of one subject through a series of four interviews elucidating attitudes on psychological, social, and health implication of the subject’s interactions with people living with HIV (Halkitis, Wolitski, and Millet, 2013). The researcher transcribed these with general results narrowed into specific conclusions by identifying each time the subject re-counted an experience having to do with a gay HIV positive man. Three significant conclusions were drawn: The subject held (a) accepting, (b) concerned, and (c) empathetic attitudes toward gay men living with HIV.

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## **CHAPTER ONE**

### **INTRODUCTION AND GENERAL INFORMATION**

In this chapter, the researcher introduces the subject of this study, the social repercussions of human immunodeficiency virus (HIV) within the gay community as defined by an HIV negative homosexual man raised in rural Appalachia, and having lived through the Acquired Immune Deficiency Syndrome (AIDS) Crisis as an adult. Here also, the researcher states the problem and how this study's purpose will contribute toward a solution. The significance of the study, through the interest of those who could potentially be affected, are explicated. Additionally, limitations, assumptions and operational definitions are addressed.

#### **Introduction**

HIV is a disease that attacks the immune system's T cells (United States Department of Health and Human Services, 2015). With no treatment, the person battling the disease will not be able to properly fight illness, and currently, there is no known cure (United States Department of Health and Human Services, 2015). The disease was first discovered in the early 1980s among homosexual men, and since, this group has been the most at risk in America (Andriote, 2012).

Eldridge, Mack, and Swank (2008) asserted homophobic feelings are more commonplace in rural areas, especially in the Appalachian region. Largely, the group is relegated by inherent societal prejudice as homosexuality was characterized as a disease only 42 years ago (Eldridge, Mack, & Swank, 2008). Likewise, Appalachian residents are more likely to find homosexuality dissolute and exert sexual prejudice perpetuating a

view that this sexuality is not a rightful lifestyle (Eldridge, Mack, & Swank, 2008; Herek, 2002). To overcompensate for being homosexual, gay men are more likely to separate themselves from matters affecting their community, including HIV (Eldridge, Mack, & Swank, 2008). In overtly heterosexist societies, this set is more likely to cope with internalized homophobia (Mclaren, 2015). Therefore, uneasiness toward self-identity may create disconnectedness (Mclaren, 2015).

Most research, homosexuality focuses on urban respondents; so, there is a gap in more rural perspective of gay issues (Eldridge, Mack, & Swank, 2008). The *rural gay* was once thought to be an anthropological legend (Fisher, Irwin, & Coleman, 2014). Moreover, Fisher, Irwin, and Coleman (2014) found gay men have particularly uncommon experiences being immersed in rural regions. Therefore, these uncommon experiences may cause differentiated attitudes amongst a community.

According to Thurstone (1928), variables of attitude include a person's "preconceived notions, . . . fears, threats, and convictions" relating to a matter (p. 535). Men who are 52–60 were young adults when the HIV epidemic first occurred (Andriote, 2012). So, this study seeks to measure the aforementioned facets of attitude in an HIV negative homosexual man ranging in this age bracket in Appalachia as he relates to HIV positive gay men. Although existing research on rural homosexual life indicates that, in Appalachia, it should be harder, the problem remains that there is limited research on how this would affect an HIV negative gay men's attitudes toward those that fight the disease in the region (Fisher, Irwin, & Coleman, 2014).

## **Statement of the Problem**

In scientific research, Appalachian homosexual males as they relate to the HIV experience, is a vaguely studied subject (Eldridge, Mack, & Swank, 2008). However, this group has a distinctive perspective, especially due to increased discrimination and higher value on masculinity (Eldridge, Mack, & Swank, 2008). They are more likely to struggle with the distress of their situation, and older males who witnessed the entirety of the human immunodeficiency virus (HIV) epidemic may have a unique viewpoint (Halkitis, Wolitski, & Millett, 2013). These factors could influence mature HIV negative homosexual men's attitudes toward HIV positive gay men; however, there is inadequate knowledge, now, to draw a knowledgeable perspective (Eldridge, Mack, & Swank, 2008).

## **Purpose**

The purpose of this study is to investigate features of attitude (fears, threats, preconceived notions, and convictions) of a mature HIV negative homosexual man from rural Appalachia on HIV positive homosexual men. The central research question asked was, "How do you relate to HIV positive gay men as a HIV negative gay man having been raised in rural Appalachia and lived through the AIDS Crisis?"

## **Significance and Stakeholders**

Those that may be affected by this study are defined as people with negative attitudes against HIV positive individuals, people with HIV in rural areas, people at risk of acquiring HIV, philanthropists, activists, and prevention specialists. Young, Koch, and Preston (1989) associated homophobia with human immunodeficiency virus (HIV) and

studied the connection of treating the disease in rural locales. Although in non-urban areas the disease is more stigmatized, it has been shown that attitudes change with education (Young, Koch, & Preston, 1989). This is promising as those holding negative stereotypes about the condition, especially HIV negative gay men who are willing to accept scientific explanations, could alter their opinion about HIV (Young, Koch, & Preston, 1989). Likewise, if personal or experience based emotional opinions are elucidated, facts are more likely to be accepted (Ryffel, Wirz, Kühne, & Wirth, 2014). Hence, HIV negative men with disapproving, confused opinions of HIV could eventually be more perceptive about HIV.

In more rural areas, for those who fight HIV, there is increased shame and isolation (Hubach et al., 2015). Sexual activity, for this group, is a coping strategy (Hubach et al., 2015). Hubach et al. (2015) highlighted only about half of the HIV positive men who had sex with other men used a condom with their last sexual partner. By understanding societal dynamics that motivated these men to partake in such risky behavior would be advantageous for the rural homosexual community; since, the group is at a higher risk for HIV (Hubach et al., 2015).

Additionally, younger gay males, Mustanski and Newcomb (2013) postulated, could be more at risk for HIV if they have intercourse with older partners. Hurt et al. (2009), in a survey done in North Carolina, found the young men who had sex with men they studied had a higher rate of acquiring the disease if their partner was older. The perspective of older homosexual men, although they are HIV negative, could lead to

more research on the sexual practices of their positive counterparts and how that relates to the younger men with which they are sexually affiliated.

Cohen (2008) purported anytime philanthropists' aims are linked with a larger cause of helping the individual, it creates increased job satisfaction and purpose. This can be recognized in personal narratives of groups in crisis (Cohen, 2008). With this, job satisfaction, in turn, causes better quality work and increased fundraising efforts (Cohen, 2008). Although the participant will be HIV negative, his interviews will distinguish a segment of time so alarming it may have complicated the way they identify with the ill of their community (Halkitis, Wolitski, & Millett, 2013). Having these accounts will give historic perspective to current HIV fundraising efforts making the cause more meaningful (Cohen, 2008).

Similarly, activism could be increased with a diverse range of narratives that map community (Obenchain, Abernathy, & Lock, 2003). By distinguishing a set, homosexuals in this case, it compels HIV negative men and all people who identify with the orientation to feel more familiar (Obenchain, Abernathy, & Lock, 2003). A common thread encourages group identity building, and this can be translated to any relegated group with factions (Obenchain, Abernathy, & Lock, 2003). A more positive view of community as self could encourage any minority to work towards parity (Wiley, Srinivasan, Finke, Firnhaber, & Shilinsky, 2012).

Backus et al. (2010) showed established programs dealing with HIV can be usefully applied to different affected populations and intervening care institutions. This might benefit other groups dealing with HIV in more remote areas or places with similar

ideals on masculinity (Elmore, 2006). More broadly, any stigmatized disease could be better understood with explanations of how to care for the sick while battling sensitive societal issue (Elmore, 2006).

## **Limitations and Assumptions**

### ***Limitations***

The results of this study will be subject to the following limitations:

1. The knowledge gathered will be limited by perspective and questions and attitudinal features chosen by the interviewer.
2. As the study will seek to explain societal strains, the participant's responses could have been skewed toward a largely culturally favorable answer.

### ***Assumptions***

The following assumptions will be made in conducting this study:

2. The participant in this study will respond truthfully.
3. The attitude of this homosexual HIV negative Appalachian man ages 52-60 towards his positive counterparts will be examined fairly.

## **Operational Definitions**

1. The homosexual/gay, beyond a man who has sex with other men, is a man who identifies as exclusively having sexual attraction toward other men (Merriam Webster's Online Dictionary, 2011).
2. Appalachia is a United States' region encompassed by the Appalachian mountain range without large metropolitan areas (Merriam Webster's Online Dictionary, 2011). In this study, it is termed a locale where masculine culture is more valued

due to isolation and, historically, more brutal requirements for living (Eldridge, Mack, & Swank, 2008). The county in which the participant grew up must have received at a 3.155 or over, the median Tennessee rurality rating, on the most current index of relative rurality measurement (Tennessee Advisory Commission on Intergovernmental Relations, 2016).

3. Preconceived notions are knowledge created before an experience. In this study, they are ideas formed relating to HIV in negative gay men before being interviewed for this study (Thurstone, 1928).
4. Fear is the act of being afraid (Merriam Webster's Online Dictionary, 2011). In this study, fears are the levels of repulsiveness in HIV negative gay men created by the dangers of the disease (Thurstone, 1928).
5. Threats are potentially harmful events (Merriam Webster's Online Dictionary, 2011). In this study, they are the levels of anticipated hostility an HIV negative gay man might incur from an HIV positive gay man (Thurstone, 1928).
6. Convictions are strong opinions (Merriam Webster's Online Dictionary, 2011). In this study, they are powerfully held beliefs an HIV negative gay man has on HIV positive gay men in general (Thurstone, 1928).



## **CHAPTER TWO**

### **LITERATURE REVIEW**

In this chapter, the researcher gives a review of literature centering on the study's ontological basis, symbolic interactionism, and how the homosexual community dynamic, the AIDS Crisis, current AIDS issues, and Appalachian culture could affect the subject within that framework. Factors of attitude, the study's basis of exploration, is also thoroughly discussed especially as it relates to the methods of investigation.

#### **Symbolic Interactionism**

In George Herbert Mead's *Mind, Self, and Society*, thought, identity, and wider culture was explicated as being originated in symbolic interaction or, more basically, conversations using language and signals that occurred socially where one response, external or internal, influenced another's response (Griffin, 2012; Mead, 2015). Mead, a University of Chicago philosophy professor at the beginning of the twentieth century mainly credited with symbolic interactionism (SI) theory, believed in applicability, and as Griffin (2012) described, "If it did not work in practice, forget it!" (p. 54). Born in the mid-nineteenth century to a religious, educated New England family, Mead struggled with a Christian vocational calling before he became a European taught social pragmatist and worked as a psychological researcher, a career that allowed Mead to "pursue critical inquiry without fear of 'anathema and excommunication' from the 'all-potent Evangelicalism' of American Protestantism" (Huebner, 2015, p. 832). Studying with leading German psychological scholars of the age, Mead applied his experiences to larger contexts and argued for an interpretive look at the human experience. *Mind, Self, and*

*Society* was, in fact, the companion of Mead's much taken Chicago social psychology courses (Huebner, 2015).

In Mead's professional work, investigating a genesis for psycho-moral behavior was foundational, and beyond that, the nature of human consciousness was constantly explored (Carreira da Silva, 2010). Carreira da Silva (2010) sought to explain the connection between Mead's functional research perspective and the larger political causes with which he was involved. Mead was an active supporter of Women's Suffrage, improving the quality of life for the urban poor, using labor unions to collectivize employees and advance turn of the century working conditions, research promoting understanding of children with disabilities, and, generally, democratic ideas where individual voices held weight (Carreira da Silva, 2010; Griffin, 2012; Huebner, 2015). While understanding the importance of separable thought, Mead radically wrote, "the problems . . . of the day are not those of the inner life of the individuals but of social reconstruction" (Carreira da Silva, 2010, p. 131). Sociology as a discipline was in nascent development, and the dynamic nature of Mead's time gave great opportunity for new ideas to be practiced (Côté, 2015). Fundamentally, Mead (1919) worked to create a basis for a new, more humanistic scientific approach to social research where the communities' whole well-being outweighed other, superficial features such as power. In creating reform, society as an operable concept was more clearly defined and manipulated to derive the larger theory of social interactionism (Côté, 2015). Herbert Blumer was a student of Mead's at Chicago and wrote the book *Social Interactionism* organizing

Mead's body of work into a clear outline through his own essays while coining the term *social interactionism* (Williams, 2008).

Though their methodologies may have somewhat differed, Blumer and Mead both believed in an objective reality from which a truth, albeit adjustable to individual experiences, by deductive reasoning or sensory capabilities could be derived- a pragmatist ontology (Blumer, 1980; Williams, 2008). Williams (2008) explains social interactionism's version of reality as "out there," but also "what people make of it" (p. 850). Primarily, all things with which humans associate were given meaning influencing an interaction and vice versa; so, meaning constructed distinctive views (Griffin, 2012). Viewpoints were not measured as best to worst, but rather as positions by which one person can understand the beliefs and actions of another (Griffin, 2012). And, it was the relationship between beliefs, actions and a stimulus that defined social interactionism where humans were exposed to a stimulus, this was interpreted or assigned meaning, and a response was elicited (Griffin, 2012). Experience was principally an empirical act where better understanding an external reality was the goal (Hookway, 2016). Consequently, knowledge here was termed progressive as accruing it through reasoning cannot be separated from the reasoner's combined experiences and what meaning has already been individually defined as real (Williams, 2008). Moreover, personal realities could align and create certainties that were collectively perceived as existent (Hookway, 2016). Blumer used three concepts relative to two others to discuss a resulting framework-language, meaning, and thinking-and how these created human self and society (Griffin, 2012).

The leading premise of social interactionism was the presence of meaning and its creation and negotiation through interaction and namely language, a “complex system of symbols” (Williams, 2008, p. 850). Acceptance of meaning could be understood, here, as selected best information serving the individual set in a larger context (Griffin, 2012). Symbols, such as words, not only gave differentiating names but also connote implication- a theory was a theory, but could also be arduous (Griffin, 2012). Inherently, social interactionism was not arduous, but certainly could be interpreted as that by students of socio-psychology. On the procedure of language usage, the Karl Weick’s quote was raised, “How can I know what I think till I see what I say?” (Weick, 1979, p. 133). Here, how humans organized thought to speech or, at least, encode abstract notions was emphasized (Cossette, 1998). What humans believe to be conceptually real arose in forms of communication by having gained the evolutionary function of mutually deciphering symbols for advancement, and although social interactionism emphasized language, nonverbal acts were just as significant (Cossette, 1998; Griffin, 2012). Symbols were as varied from a blink to brightly colored clothes; because again, all material and nonmaterial human encounters emanated meaning (Williams, 2008). More deeply, meaning is not intrinsic. An arduous theory was considered that; because, the representation has been socially created, negotiated, and accepted (Griffin, 2012). Additionally, the adjective has been acknowledged as an appropriate expression through the user’s thought processes (Griffin, 2012). And that, Mead argued, was what defined human communication. Not only was encryption possible, but also thinking occurred, defined as the “ability to see oneself as an object of communication [giving] rise to the

mind, which is . . . processual and social in nature” (Williams, 2008, p. 850). After meaning was assigned, Blumer posited actions were based on the aforementioned interpretive method (Griffin, 2012).

Gabrielle Tarde suggested that all humans engage in some level of imitation, which was fundamental to being a social animal (Lane, 1984). Social interactionism defined three actions that occurred during thought: minding [an internal conversation deciding best behavior], taking the role of the other [minding while taking the role of another’s thought process], and utilizing the looking-glass self [the image one adopts while taking the role of another]. Likewise, these activities worked in constructing and managing meaning on which a person will act (Griffin, 2012). These psychological processes occurred within the mind, divided by the I and the self, and emphasized a social trait (Griffin, 2012). To reiterate the ontological stance of social interactionism in relation to thinking, Lane (1984) explained William James interpretation of social interactionism as a “dualism, separate subjective and objective worlds by envisioning the self-as-knower and the self-as-known and, therefore, as part of the objective world” (p. 271). The I, knower of all that has not been socially defined, existed freely without implication, but the self was how identity came to be known through the environment (Griffin, 2012; Lane, 1984). Accumulated meaning from personal and social judgements created a generalized other in the human psyche that functions as an extra-evaluator. Consequently, as explained by SI, meaning as best derived from an almost indiscernible process between the self and society using symbols, created and negotiated self-concept, human behavior and larger perceptions that guided humanity (Griffin, 2012; Williams,

2008). It could be assumed that interaction in the gay society is requisite to its existence, and symbols have been found to perpetuate community (Avineri, 2012).

### **Homosexual Community Dynamic**

Defining community was a problematic issue. With rural homosexual literature being limited and urban homosexual populations being studied infrequently on the subject, not much was definitively known (Fraser, 2008). Particularly for those gay men who have been rejected by their birth communities, seeking to promote activism by networking, or, for any reason, seeking social support, gay neighborhoods served as resources (Kelly, Carpiano, Easterbrook, & Parsons, 2013). Modern homosexual community was a visible marker that gives power to the individual as a platform to live out daily life as an expression of the free self (Freitas, Kaiser, & Hammidi, 1996). Geographic implications could be compared to sociological ones. Some view a decline in gay community, and possibly collective identity, as progress in that, modernly, homosexuality was generally viewed as more normal, and those who were can assimilate into the popular culture better (Kelly, Carpiano, Easterbrook, & Parsons, 2013).

Identity has usually been constructed, in times where gay opposition was commonplace, as articulating the differences in straight and gay culture; however, doing oppositely in a post-gay age [where homosexuality became more normalized], in searching out similarity, it was apparent that homosexual issues were concerned with being a part of the status-quo as Americans knew it (Ghaziani, 2011). Originally, gay culture was created as a deviation from straight culture as the ruling definition to postulate a different set of expected behaviors, mainly men being able to engage in

intimate relationships of any sort with other men (Ghaziani, 2011). Basically, a group develops a collective identity by defining in and out groups through formulating what unites them (Ghaziani, 2011). Historically, “especially from 1950s homophile organizing onward, the gay imagination has routinely oscillated between, on one side, a narrow, single-interest vision, rooted in conventional identity politics, that sought an end to discrimination against gays, and on the other, an expansive, multi-issue, coalition view that was grounded in a political philosophy of intersectionality and social justice” (Ghaziani, 2011, p. 103). Gay men who survived the AIDS crisis have collectively experienced this spectrum in varying degrees.

Acceptance in the gay community, however, was sometimes based on being societally close to prominent or widely accepted cultural norms (Valocchi, 1999). Similarly, there were aspects related to homosexuality that were given higher esteem in certain circles making specific homosexual men more validated by the mainstream (Valocchi, 1999). Therefore, integrating into popular culture, there becomes new in and out groups [ones that better fit with new cultural ideas and those that remained as outliers] (Valocchi, 1999). Dissimilarly, Lewis et al. (2015) underscores that community could be changed by advancement, such as technologically mediated communication, homosexual gathering venues, such as gay bars, still held cultural prominence going against existent prejudices (Lewis et al., 2015; Weston, 1991). Furthermore, Lewis et al. (2015) postulated how gay communities were treated in social research as non-diverse and unaffected by historical happenings. Also, the AIDS crisis was integral in understanding why homosexual community forming is so complex (Forstein, 2012).

## **The AIDS Crisis**

To first understand the impacts of human immunodeficiency virus (HIV) and it leading to the AIDS crisis, one must understand that sexual promiscuity in the gay community, circa twenty years before the epidemic, was comprehended as a celebration of liberation from hiding and stifling (Bartle, 2014). Additionally, one must concede that, although it was foremost affected, AIDS was a disease that reached far beyond homosexual men, which some contemporarily have had difficulty realizing (Forstein, 2012). It was that abiding ignorance which emphasized the complex sociological effects of the disease (Greene & Banerjee, 2006). There were many in the homosexual community who witnessed generational counterparts die traumatically from an undefined cause making them untouchable; simultaneously, certain politicians and Americans still denounced a termed “lifestyle” and the plague it brought, creating a continuum of dissimilar historical memories (Forstein, 2012; Greene & Banerjee, 2006).

Specifically, for homosexual men, movements in the pre-HIV years encouraged a time of discourse and freedom among progressive circles of homosexual men while riling disagreement in more conservative ones: The Civil Rights Act, feminism becoming a movement, rebellion in the larger gay communities, and removal of homosexuality from the scientific lexicon as a disease (Bartle, 2014). Still, this era was not comparable to the freedom modern homosexual men enjoy; because, young gay men 40-50 years ago still had an experiential memory of damaging pseudo-scientific, religious, and popular beliefs on their sexuality (Forstein, 2012). Many used these as a basis for activism, but



experiencing injury on the sexual psyche hardly could have been escaped (Forstein, 2012).

When AIDS was discovered, the link from HIV was not yet associated, and AIDS was considered a gay cancer or, more precisely but still biased, Gay Related Immune Deficiency (GRID) (Greene & Banerjee, 2006). In medicine, even views of homosexual healthcare providers were skewed towards discrimination, and the entire country was ever fearful of the frightening rise of those contracting this undetermined killer (Forstein, 2012). Backlash was not entirely sympathetic or scientific with certain critics calling for homosexuals to be ghettoed with assertions of uncleanness and deviant sexual practices and living (Forstein, 2012).

Remedy began with a governmental prescription for safer sexual practices, which was not completely received in homosexual circles (Forstein, 2012). It seemed an attack on the sexual freedom that had so long defined pride in being gay (Forstein, 2012). Finally, it was somewhat conceded by the scientific community that the disease could not just be conveyed as a virus, but that, because of human behavior being the most likely avenue of exposure, the “underlying social, psychological, and political underpinnings of sexual behavior, substance abuse, and marginalization” (Forstein, 2012, p. 46) must be considered. Concession of these exacerbating factors, however, was still not entirely common, and certainly did not make them conventional knowledge (Forstein, 2012).

Those who had contracted HIV or AIDS did not only feel contaminated, but, because of social factors, those battling the diseases were shamed (Greene & Banerjee, 2006). Fears were affirmed, particularly for homosexuals with close personal relations

warning of consequences that may befall those who live as gay men, that they were somehow living an immoral life (Forstein, 1984). While most, no matter what their background, had at least some anxiety of getting HIV/AIDS (Forstein, 1984). But, importantly, the early AIDS crisis underscored mortality and the mass death in a generation compared to its recent exuberance and youth in the light of relationships, more intimate or familial ones, that left many feeling guilty, scared, or alone (Forstein, 2012). Moreover, that in defining this mortality, most significantly, again a community of homosexual men emerged forever changed and maybe more united and sympathetic than ever (Forstein, 2012). From the beginnings of the crisis until now, varied issues have arisen and some have become more apparent.

### **HIV Today**

Per the Center for Disease Control (CDC) (2014), men who have sex with other men (MSM) counted for the majority of reported new HIV infections in the United States. Men who have sex with other men, youth and young adults 13-24, were the most affected male section in their age range standing as 92% of this demographic (CDC, 2014). MSM communities of color were more impacted as the number of reported new HIV infection rose 13% among African Americans and Latinos; while, this decreased 6% in whites (CDC, 2014). Over half a million MSM were now living with HIV in the United States with a relatively large category, 15%, were unaware of their positive status (CDC 2014). Fortunately, most newly diagnosed who do receive medical care (CDC, 2014). The CDC maintains that HIV predominately touched MSM groups, as

homophobia, stigma, discrimination and access to healthcare were the main challenges to preventing the spread of HIV (2014).

One of the most promising and medically advocated form of prevention was pre-exposure prophylaxis (PrEP), an antiretroviral oral medication, that when taken daily could reduce HIV communication over 99% (Sharma & Tan, 2014). As assuring as the medication seemed, its implementation still required concern: the problems of getting those at risk to regularly take the treatment and it not protecting against other sexually transmitted diseases were foremost apprehensions (Sharma & Tan, 2014). While the most common health risk for PrEP was nausea, researchers were vigilant that HIV could become more resistant with its use (Sharma & Tan, 2014). After HIV was developed, modern treatment could reduce viral loads to undetectable amounts which was vital to reducing transmission (Prevention Access Campaign, 2017). Immunity, as a concern for prescribers, has yet been fully measured, but contemporary studies on the subject were incredibly valuable toward a cure (AIDS Weekly, 2015; Bershteyn & Eckhoff, 2013). For best treatment to occur, early detection was essential- later diagnosis correlated to higher mortality; so, encouraging frequent testing was a key matter (May, 2016). It was, nevertheless, simple condom use that was still an anxiety for medical professionals, but could be complicated by complex psychological issues of users and choosing different prevention techniques better suited to varied situations (Rosenberg et al., 2012). It was encouraging that people living with HIV (PLWH) have longer life expectancies, and treatment for this aging population was an emerging concern for researchers (CDC, 2014). An innovative and most effective way of preventing HIV was considering

individuals' behaviors leading to possible infection in a subjective way still being careful not to blame positive people for their disease (Halkitis, Wolitski, & Millet, 2013). Social inequality was shown to directly influence intervention strategies showing that more subjugated groups were the most at risk and prevention methods should have been tailored to their individual experience as other (Halkitis, Wolitski, & Millet, 2013). Living through the AIDS crisis and battling it's resulting issues could be affected by Appalachian culture (Eldridge, Mack, & Swank, 2008).

### **Rural Southern Appalachian Culture**

The South was usually thought of as those states that seceded during the Civil War that embody a cultural mindset and memory setting them apart from even the buffer states that joined the confederacy later or were not incredibly sided during the Civil War- Alabama, Arkansas, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia (Southern United States, 2015). Of these, the Appalachian Mountains were present in the entirety of West Virginia, eastern Virginia and Tennessee, western Kentucky, North, and South Carolina and the northern parts of Mississippi, Alabama, and Georgia (Office of Inspector General, 2016). More specifically on Waldorf's continuum (2006), a classification of a modern rural area had fewer people there living, particularly more spread out, longer distances to metropolitan centers, and regions that had resisted becoming urbanized.

Once in American history, the Appalachian range was an unsettled barrier to expansion established by the quick coming of homesteaders pushed out by eastern population growth, but it was not only the physical landscape that shaped the culture

(Weller, 2013). Economic opportunity, notably farming, mining, and forestry, required spirited workers to sacrifice for the industries (Office of Inspector General, 2016; Scott, 2010). Many settlers, being independent enough to forge lives in an unfamiliar place, relished that there was a lack of hierarchy and a platform to create a living environment without unwanted influence, but, in this search for autonomy, there was a certain marginalization that affected gender typing (Scott, 2010; Weller, 2013). Communities became coterries, at least to American popular culture writers, for certain ideologies to advance a culture of “wild, inaccessible wilderness, a region of people left behind by modernity, distant in time and space from the everyday world” (Scott, 2010, p. 33).

Many ways in which Appalachian culture has long faced living conditions were synonymous with masculinity: the man as provider, an emphasis on male strength to accomplish work tasks, and expert nature skills (Scott, 2010). Scott (2010) recognized three types of men in the Appalachian coal mining industry which emphasized their heteronormativeness and ways these classifications could be widely applied to Appalachian culture. The family related masculine identity to being employed and material consumption as a father and husband (Scott, 2010). The *tough guy* took pride in or at least acknowledged the nature of rough working conditions that proved masculinity (Scott, 2010). The modern man accessed technology and made rougher tasks easier foregoing more femininely senseless ways of accomplishing work goals (Scott, 2010). These constructs were constantly and cyclically supported through the hegemony that facilitated complicated social relationships relating a woman’s role as wife, mother, and employee—the basic structure on which an identity was based (Scott, 2010).

Christian, Wolfram, and Dube (1988) explained that “although the geographical isolation of the past has been overcome to a large extent with modern transportation, evidence of this historical isolation remains” (p.74). Montgomery (2000) postulated that isolation was an elusive concept, but still had repercussions thwarting the advancement Appalachians. This culture was not completely separated from the world at large as many traveled and held professions in an ever more intercontinental setting, but, strangely, there were parts, modernly, that were staunchly, albeit implicitly, unincorporated into society decisively linking sense of place, and the societal implications of this (Christian, Wolfram, & Dube, 1988).

## **Attitude**

Even though attitude did not always connote stance, first being heavily used in figurative art where subjects would strike an attitude or pose, social scientists may have become intrigued by the word’s anthropological implications (Fleck, 2015). Charles Darwin and leading socio-psychologists took the term and those similar in the coming decades to suggest a plethora of concepts relating to emotion, introspection, and behavior (Fleck, 2015). However, in his acclaimed 1928 *Attitudes Can be Measured*, Lewis Leon Thurstone, a University of Chicago educated academic and former assistant to Thomas Edison, after becoming convinced the social sciences could not advance without a proper scale of measurement, devised an explanation for understanding attitude (Encyclopedia Britannica, 2017). Thurstone rationalized attitude as “the sum total of a man's inclinations and feelings, prejudice or bias, preconceived notions, ideas, fears, threats, and convictions about any specified topic . . . admittedly a subjective and personal affair”

(Thurstone, 1928, p. 531). While Thurstone researched ways to quantify opinion, this study utilized his delineation of attitude as an operational guide specifically looking at preconceived notions, fears, threats, and convictions per the researcher's interest. Later in the 1933 *Motion Pictures and the Social Attitudes of Children*, Thurstone simplified his goal highlighting the purpose of defining attitude- when presented with stimuli, what people preferred and why. Underneath attitude is, of course, the most natural human feelings, the gut instinct (Kahneman, 2011).

### ***Inclinations and Feelings***

Inclinations and feelings, or acting from the gut, Kahneman (2011) suggested, have more influence over our decision-making than many would consider. Gachter (2012) emphasized Rand, Greene, and Nowak's (2012) research that long deliberations gave humans chance for self-involvement; while, intuitive behavior was fundamentally motivated by the wellness of others. Haidt (2012) indicated that foundations of complex human morality were based in a natural cooperative state. Fischbacher, Gachter, & Quercia (2012) conceived, also however, that there are parasitic human behaviors, such as pilfering, that promote self-interest. Bias, through the cognizance of certain preferences, can be created (Tobena, Marks, & Dar, 1999). Put simply, the human psyche is a complicated amalgamation of inclinations that serve us and those around us while feelings toward our self and others negotiate these to create our behavior (Tobena, Marks, & Dar, 1999).

## *Prejudice and Bias*

Prejudice is “a preconceived judgment or opinion or an adverse opinion or leaning formed without just grounds or before sufficient knowledge,” and bias is the preference created from that (Merriam-Webster, 2017). As social phenomena, prejudice and bias are not simple concepts. These forces can occur within seemingly homogenous groups, usually create and in and out spectrum of membership, are related to “social identity, optimal distinctiveness, uncertainty reduction, social dominance, terror management,” identity, and power, and ranged in being obvious to extremely nuanced (Hewstone, Rubin, & Willis, 2002; p. 575). Knowing that prejudice and bias existed did mean that their uses were unchangeable, but, by gaining comprehension of the cognitive and social aspects of the problem, improvements could have been better made (Jussim, Nelson, Manis, & Soffin, 1995; Tobena, Marks, & Dar, 1999). Darwin (1993) noted the problem of bias—constant skepticism was not productive in creating beliefs, but too often believing without consideration of disagreements or to further what is already deemed real, even if it is incorrect, occurred. Biologically, prejudice and bias was deeply embedded into the neural processes of the brain to promote adaptive behaviors (Tobena, Marks, & Dar, 1999). Since humans showed an inclination to ignore rival positions, even when a reality was exposed, being contrary to opinion, unsound logic was conjured to explain the dissonance instead of accepting the truth (Tobena, Marks, & Dar, 1999). Through evolution, humans were better able to categorize information intake and solve problems when they could easily organize situations by creating schema defined by making prejudicial assumptions (Tobena, Marks, & Dar, 1999). However, the brain did



not immediately cogitate other's emotions, and this development was also applied to human qualities, which was responsible for the subjugation of certain groups defined as other (Jussim, Nelson, Manis, & Soffin, 1995). Prejudice and bias are sometimes created through holding incorrect preconceived notions (Zaretsky, 2016).

### ***Preconceived Notions***

The term preconceived notion insinuated a point in time where all prior knowledge on a subject is encoded and organized in the psyche and a related provocation that either fit or confronted this knowledge (Merriam-Webster, 2017). They are influenced by perception (Sullivan, 2009). Sullivan (2009) explained with his definition of opinion, "personal ideas that cannot be proved or disproved, as they vary according to individual perceptions" (p. 360). So, a notion, here, does not have to be based on objective agreement, but is more connected to the casual information gathering (Sullivan, 2009; Zaretsky, 2016). Zaretsky (2016) wrote that having negative preconceived notions could have been based on wrong or insufficient information holding. Also, what was believed can occur through an individual's own experiential pretext where information was not plainly incorrect, but rather not seen from the position of other (Zaretsky, 2016). Fundamentally, preconceived notions are an amalgam of ideas (Cossette, 1998; Sullivan, 2009).

### ***Ideas***

Idea, or articulated knowledge, was certainly an ethereal concept dealing with abstract thinking and the encoding of this through symbols others can understand (Cossette, 1998; Merriam-Webster, 2017). Li, Shaw, and Olson (2012) saw ideas as

pragmatic, commoditized and a natural part of human cognitive development; but still, little was known about idea value creation. Zambelli (2004) related knowledge creation when discussing ideas where all prior knowledge was arranged to create infinite combinations of new possibilities while other stimuli were being encountered. Romer (1993) explained ideas, when coming to cognizance, as useful and useless, and if useless, these usually are not given much more attention by the brain. This emphasizes that knowledge formation occurs different for every human; because, through their own experiences, different information incited individual reactions (Zambelli, 2004). Likewise, certain information could define stimuli as threatening (Jamieson, Harkins, & Williams, 2010).

### ***Threats***

Jamieson, Harkins, and Williams (2010) defined threat as stimulations with potential to take away human needs or something seen as constructive, such as self-esteem giving humans empowerment. When individuals felt threatened, they were more motivated to move away from the inauspicious situation and realign themselves to entities that created safer environments in relation to the initial danger (Sparks, Mishra, & Barclay, 2013). As a group, Sparks, Mishra, and Barclay (2013) emphasized, humans use power dynamics to create protective forces, but this was an adaptive gamble, as some played on perceived dangers to gain influence without considering the defense of supporters. It was suggested that sources of support be greatly considered for this reason (Sparks, Mishra, & Barclay, 2013). Nash, McGregor, and Prentice (2011) simplified threat as an obstruction to a goal; so, here, more psychologically, humans reacted with

anxiety. Identifying the source of anxiety was integral in creating a reaction as those who attributed their fear to something else or defined a threat with no alternative were less likely to respond (Nash McGregor, & Prentice, 2011). Saran (2011) put threat in a more continuous context where taking a chance or being involved in a risky behavior going against the status quo was cause to incite specific behavior especially related to protest and fighting back. Essentially, a threat caused fear (Bartels & Herman, 2012).

### *Fear*

Fear has been found to be innately human, and is the instinct that directs one from a hazard and into securer conditions (Bartels & Herman, 2012). Rachman (1977) postulated that fear development occurred three ways- “direct learning through classical conditioning and indirect learning through observation and verbally transmitted information” (p. 286). Essentially, Bartels and Herman (2012) explicated that avoidance was the opposite of “motivational inclinations that lead toward success” (p. 2)—it was an evolutionary practice where supposed failure could be escaped. More biologically, emotion played an important part in constructing fearful stimuli; as a survival mechanism, when more attention was payed to an environmental change, it indicated that the provocation be either avoided or gone toward according respectively to how negative or positive the experience (Ahs, 2012). Fear, here too, was an inescapable subconscious reaction influencing behavior and as far as the antithesis of professed beliefs (Bartels & Herman, 2012). Furthermore, reoccurring fear could lead to the formation of convictions (Berger and Alwitt, 1996; Holland, Verplanken, and Knippenberg, 2003).

## *Convictions*

Conviction was a lesser studied aspect of attitude, but was linked to belief to which one is deeply committed to holding (Tversky & Khaneman, 1973). Holland, Verplanken, and Knippenberg (2003) proposed that just as confidence in correctness corresponds to better information accessibility, attitudes that carried deeper conviction were more readily expressed. Furthermore, an attitude did not immediately gain this significance, but through a constant procedure of measuring attitudinal outcomes, humans developed a paradigm to perform behaviors, create stability, resist change, and process information (Holland, Verplanken, and Knippenberg, 2003, p. 595; Kraus, 1995; Krosnick & Abelson, 1992; Petty & Krosnick, 1995). Attitudes that persistently best serve sustained the deepest conviction (Holland, Verplanken, and Knippenberg, 2003). Moreover, as Berger and Alwitt (1996) defined, attitude was multidimensional, ranging both from negative to positive and dismissively to deeply convicted with previously held beliefs influencing each measurement, creating a dynamic view of conviction forming (Petty & Krosnick, 1995; Raden, 1985). Berger and Alwitt (1996) and Holland, Verplanken, and Knippenberg (2003) both highlighted that personal reflection in whatever form and influenced by whatever stimuli was essential to this process; while, Abelson (1988) originally constructed the idea of conviction as a feeling of ownership that influenced behavior and thought.

## **Features of Attitude on HIV Studied in the Homosexual Community**

In wider American culture, negative attitudes toward homosexuals, and more specifically those living with HIV, perpetuated in and out groups relating to accepted social normality (Foucault, 1973). Liamputtong (2013) used Goffman's (1963) model of stigmatization to explain that discrimination arose when ranks are given in a culture, namely, when healthier people and those closer to a status quo were more desirable. Moreover, in the United States, HIV had associations with drug use and the deviant sexual behavior of gay men, making attitudes toward it especially complicated (Scrambler, 2013). Within the homosexual community, though, there was limited study of dynamics concerning HIV and stigma. Still, the topic was of incredible significance; because, insight could explain the more adverse experiences being gay in America (Courtenay-Quirk, Wolitski, Parsons, & Gomez, 2006). "Anxiety, loneliness, depressive symptoms, engaging in avoidant coping strategies, and history of suicidal ideation" (p. 56) in homosexual men, particularly HIV positive ones, could be better understood if this topic was completely considered (Courtenay-Quirk, Wolitski, Parsons, & Gomez, 2006). The researcher has chosen to study four features of attitude on HIV in the homosexual community in this study: fear, convictions, threats, and preconceived notions.

### ***Preconceived Notions***

It was progressive of Pattison, Hauerwas, and Patton to highlight in 1976 that homosexual individuals, instead of requiring conversion, should be seen as targets- the problem is that whenever we have a persecuted group which is labeled as deviant, the person who is a member of that group becomes a social victim of

prejudicial stereotyping. The deviant is not a flesh-and-blood person but is only a thing, an It” (p. 232).

It was poignant to underline the late 1970s and early 1980s, the first days of the AIDS crisis when the disease was exclusively and negatively associated with homosexual men and their perceived deviant and overly active sexual lifestyles and intravenous drugs, socially held preconceived notions that led to stigma and homophobia (Lokko & Stone, 2016).

In the mid 1990s when the medical community were largely giving the AIDS Crisis heed, there were still those workers who held preconceived notions making patient experiences awkward (Japsen, 1994). To increase understanding and, consequently, compassion, Seth Ellis, then Vice President of Long Beach’s St. Mary Medical Center, believed “if you just . . . begin educating people, you will be off to a good start” (Japsen, 1994, p. 81). This model of knowledge building was commonly productive, but could ignore the nuanced and multifaceted nature of prejudice (Callender, 2015). By analyzing negative preconceived notions with a framework from both perspectives of the subjugated and biased, going deeply into reason why prejudice occurs obviously and implicitly, better didactic systems could have been constructed (Callender, 2015).

Then stereotyping happened, and although the cultural position of homosexuals has improved, Ware, Wyatt, and Tugenberg (2005) showed that treatment, medically and societally, was still influenced by the preconceived notions held about PLWH (Whitely, 2001). Here was seen that deleterious beliefs assumed before contact with a PLWH can damagingly affect the ensuing interaction (Ware, Wyatt, and Tugenberg, 2005).

Abdul-Malik (2004) posed that attitudes related to those first disapproving attitudes toward homosexual PLWH still existed in “high-profile members of society” (p. 80) which suggested that even seemingly outdated perspectives from decades ago did have resonance. When analyzed, there were many that still derive meaning from anti-homosexual religions, gender role norms, politics, and mass media outlets (Callender, 2015). Callender (2015) argued “there is evidence that gay and lesbian people continue to face significant stereotyping, prejudice, and discrimination across numerous functional domains of life, including employment, health care, public accommodations, civil rights, housing, and day-to-day interpersonal interactions” (p. 782). So, when social standards held support for subordinated groups, there were more tacit methods of a significant minority that showed anti-homosexual sentiment. Here were multiple and even seemingly unrelated beliefs with complex sources which contributed to one larger negative preconceived notion (Callender, 2015; Dovidio, Kawakami, & Gaertner, 2002; Dovidio & Gaertner, 2000; McConahay & Hough, 1976). These negative ideas create fears that distance one from another (Skitka, Bauman, & Sargis, 2005)

### ***Fear***

Houtsonen, Kylma, Korhonen, Valimaki, and Suominen (2014) cited fear as being a problematic force in communities where HIV was common. Not only did anxiety of the disease lead to avoidance of those in need of medical care and basic interaction, but also created a devalued social status, or stigmatization, for people living with HIV (PLWH) (Houtsonen, Kylma, Korhonen, Valimaki, & Suominen, 2014; Major & O’Brian, 2005). PLWH were sometimes predominantly associated with their disease which created

objectification; put simply, how others perceived HIV directly influenced how the person living with it was considered (Houtsonen, Kylma, Korhonen, Valimaki, & Suominen, 2014; Persson, 2005). Ultimately, aside from the fundamental fear of contraction, there was attached social nuances in being connected to a PLWH, and this could most detrimentally affect HIV positive persons. When fear especially related to stigma exists, subordinated groups were more likely to suffer from “poor mental health, physical illness, academic underachievement, . . . low social status, poverty and reduced access to housing, education, and jobs.” (Allison, 1998; Braddock and McPartland, 1987; Clark, Anderson, Clark, & Williams, 1999; Major & O’Brian, 2005, p. 394; Yinger, 1994). Externally, rejective views of PLWH were not remedied with information, and were associated to homophobia. (Herek & Capitanio, 1999; Summers, 1991; Zagumny & Deckbar, 1995). Fear of self could influence internal homophobia, and create certain convictions (Allport, 1954).

Generally, since its discovery almost 40 years ago, attitudes toward HIV have been frequently studied and shown to improve; however, specifically relating to fear and stemming stigmatization, two lesser reviewed components, negative feelings remained established (Herek, Capitanio, & Widaman, 2002). Although stigma was superficially a social issue, when internalized through interactions where PLWH were relegated, fear of lessening one’s own standing was perpetuated (Brent, 2016). Within the homosexual community, fear was extremely injurious considering being correlated with not being tested for HIV (Herek, Capitanio, & Widaman, 2003). Moreover, Myers and Dean (1998) defined internalized homophobia (IH) as a gay man’s application of an anti-homosexual



outlook on himself, and tendencies of mental illness and committing suicide were shown to increase by identifying as homosexual (Fergusson, Horwood, & Beautrais, 1999; Newcomb & Mustanski, 2010). Furthermore, IH was shown to cause difficulty identifying as gay especially in divulging orientation, not wanting to associate with other homosexual or adjacent individuals, having sexual troubles, and highly lessened self-view (Newcomb & Mustanski, 2010; Meyer & Dean, 1998). Allport (1954) postured that developments such as IH were reactions to negative features of attitude such as fear perpetuated by threat (Newcomb & Mustanski, 2010).

### ***Threats***

Joseph, Adib, Joseph, and Tal (1991) explicated that threat was linked to the prevalence of the HIV- with less risk of contraction, threat decreased. However, when faced a high threat of acquiring HIV, Joseph, Adib, Joseph, and Tal (1991) found that homosexual men were still practicing risky sexual behaviors possibly perpetuating the epidemic. Identity, here, was meaningful, and defined as variable, “there is no such thing as a single homosexual identity. Rather, its nature may vary from person to person, from situation to situation and from period to period” (Joseph, Adib, Joseph, & Tal, 1991, p. 288). By contemplating how those facing HIV saw themselves, especially in a social context, the threat HIV posed and its implications might have been better understood (Joseph, Adib, Joseph, & Tal, 1991).

The experience of threat from HIV was conceptualized as fear of contracting it and what ramifications that might incur and how vulnerable an individual was in addition to what changes one could encounter in the varied contexts of life (Rimal, Bose, Brown,

Mkandawire, & Folda, 2009; Witte, 1994; Zhang, Zhang, & Chock, 2017). Perception was certainty, and how developing HIV was comprehended through held beliefs was termed perceived threats (Zhang, Zhang, & Chock 2017). By emphasizing the threat of vulnerability while remaining compassionate toward PLWH, communicating HIV could have been reduced (Zhang, Zhang, & Chock, 2017).

Nonetheless, beyond the personal, The United Nations, in 2002, declared AIDS a threat to international peace and security upon the fear and need HIV generates.

Threats to the security of individuals underlie the larger political and economic ramifications of this disease. When children, workers, and government elites alike are affected by HIV/AIDS, the financial and administrative security of countries consequently come into doubt, and the disease turns into a politicized issue (Luo, 2002, p. 1649).

Therefore, Governments were motivated to fight the disease with scientific means realizing their international standing was at risk (Luo, 2002). The threat of being other lead to the creation of misled convictions (Skitka, Bauman, & Sargis, 2005).

### ***Convictions***

Skitka, Bauman, and Sargis (2005) linked conviction and moral mandates and found that attitudes concerning issues with moral elements influenced behavior in a regular way. The more opposite moral convictions, the more social distance was preferred with basic intolerance being shown for other opinions (Skitka, Bauman, & Sargis, 2005). Here, compliance, good-will, and building communication strategies confronting differences were less likely to occur (Skitka, Bauman, & Sargis, 2005). The

emphasizing of morality was imperative; since, those holding moral stances saw them as no less than factually absolute- a just-the-way-it-is mentality prevailed (Prinz, 2008).

Furthermore, HIV and homosexuality happened and was evaluated within social contexts. Keogh (2008) carefully described the lesser studied inner-male-homosexual-dynamic of morality and convictions concerning HIV/AIDS finding that gay men who were less exposed to HIV positive social counterparts were more likely to rely on systems of morality to manage a sexual partner's status disclosure and consequent risk. Most men with more reliance on moral judgements expected partners to automatically disclose HIV status, but, counterintuitively, voiced viewpoints that discourages this in their positive partners (Keogh, 2008). Conversely, homosexual men who were more in contact with HIV positive counterparts were less reliant on status disclosure seeing HIV as ordinary and dealing with its risks pragmatically (Keogh, 2008). If negative convictions about HIV could exist within the homosexual community, members internalized stigma. Hodgson (2007) saw this as moral decay instead of moralizing where any structure of belief that perpetuates suffering of an already afflicted group was considered at least partly dangerous (Hodgson, 2007). For eliminating prejudice, Hodgson (2007) and Keogh (2008) both prescribed compassionate and scientific consideration of PLWH.

## **Summary**

Starting with symbolic interactionism, the researcher sought to elucidate the ontology of this study where, through the subjectivity of human experience, individuals create and negotiate the meaning of their existences through the exchange of symbolic information in a dynamic environment and point of time (Griffin, 2012). For the subject,

the researcher defined the homosexual community, the presence of HIV/AIDS, and life in rural southern Appalachia as a condition where the subject derived meaning about HIV positive gay men through his unique interactions. To explore these exchanges and the connotations at which the subject arrived, certain features of his attitude, as defined by Thurstone (1928) were investigated [preconceived notions, fears, threats, and convictions] especially as they relate to other gay men living with HIV.

## **CHAPTER THREE**

### **METHODS/PROCEDURES**

In this chapter, the researcher expounds his research design, information about the subject and how he was chosen, how data was collected and analyzed for the results and conclusions sections of this study, and what strategies were used to increase confidence in this work. It should be especially noted that the single subject case study was used to protect those being recruited from the historically subjugated gay community (Callender, 2015; Merriam and Tisdell, 2016). Additionally, the recruitment specifications were designed to find the unique perspective within the gay community relating to HIV, rurality, and unique experiences of a certain age. Furthermore, the methods of multiple interviews and their analysis sought to show the perspective of the subject as a distinctive voice while simultaneously showing as much integrity to the scientific process as possible.

#### **Research Design**

This study utilized a qualitative research approach and follows a phenomenological method, as this type of investigation was suited for finding out the unique perspectives of an interviewee (Waters, 2015). Constructivism is a strategy humans use dissecting world-view and examines the truth of an individual experience (Easton, 2008). Open-ended interviews that allow for personal narrative attained this, and, although they usually study a smaller population, this type of research must not be relegated as unimportant. The complexity of the human life cannot be completely expressed in numbers (Easton, 2008). The case study method was chosen to decrease risk

in the recruitment process- only one participant from the too often marginalized LGBT+ community was needed (Callender, 2015; Merriam and Tisdell, 2016). Merriam and Tisdell (2016) described qualitative case study research as “richly descriptive” (p. 37) studies that are useful when a phenomenon and those affected by it are difficult to separate, such are human immunodeficiency virus and gay men (Forstein, 2012). The essential nature of the case study and best reason for it being employed is to profoundly investigate one thing that is expressly defined (Merriam & Tisdell, 2016). [For example, how HIV negative gay men, having been raised in rural Appalachia and lived through the AIDS crisis as an adult form attitudes toward HIV positive men. The specificity lends itself to this case studies (Merriam and Tisdell, 2016).] Just as this study did, Merriam and Tisdell (2016) explicated that case studies provide a platform to use scientific methods procuring biographical narratives, especially in the context of a historical event [AIDS Crisis]. Moreover, as recruiting from this invisible population was difficult without referral, a case study more safely gave the researcher an opportunity to take an in depth look at a hardly examined perspective which gave exhaustive information that can later be incorporated into larger studies (Easton, 2008). This study was approved by the University of Tennessee Institutional Review Board (study no. UTK IRB-16-03297-FB, see Appendix D).

## **Subject**

The target population for this study was HIV negative homosexual men 52-60 years of age having been born and lived until adulthood in rural Appalachia, a county with a most current relative rurality rating of 3.155, Tennessee’s median rurality, or

above (Tennessee Advisory Commission on Intergovernmental Relations, 2016). To attain the subject of this case study, the researcher worked with the founder of a local gay networking organization. This founder signed an agreement to send e-mails to their most appropriate members, chosen as his discretion, [See Appendix B: Recruiting Agreement] detailing the requirements of participation in this study and what would be expected of a volunteer. The founder was widely connected in this subgroup and willing to discreetly send e-mails to members and possible subjects until a participant was found. The e-mail sent was labelled as sensitive, and no recruitment materials were shown upon opening it. A recruitment flyer was attached to be seen at the potential subject's leisure. The researcher's phone number and e-mail address was also provided.

The first response via phone fit the researcher's criteria to be a subject. Although all interviews were completed, this subject later contacted the researcher to delete certain statements from the record, and the researcher thought it would be best practice to change participants as enthusiastic consent was sought. The gay networking organization associate again sent out a round of recruitment e-mails. The next phone response fit the criteria, and all other responses were politely declined.

As sexual orientation is a sensitive topic, although asked to refrain from this, could include names and descriptions of others, total confidentiality was assured. No names, cities or other specific identifiers was or will ever be associated with transcripts or publications resulting from the study, including the thesis. Any identifiers spoken about were assigned a pseudonym. This was described in the recruitment procedure along with potential subject being the sole contributor to this study.

## **Data Collection**

The researcher guided a set of four hour long conversations with this participant in a private setting. Each interview section lead narratives relating to dimensions of attitude (conveyed as preconceived notions, fears, threats, and convictions) on HIV positive men. These interviews were recorded using a digital voice recorder. The researcher then transcribed the interviews, which were kept in a password protected cloud storage website during this process, and the original digital recording files were deleted. Here, the researcher used an iterative process (Garner, Wagner, & Kawulich, 2009). The following interview questions guided the researcher:

### ***1st Interview (Preconceived Notions)***

1. Describe the experience and process first learning what HIV was.
2. How has your knowledge of HIV changed since then? What events lead to this?
3. What were your initial feelings about homosexual men with the disease?
4. Up till now, have these feelings changed, and if so, why?
5. More largely, how do you think attitudes have changed societally about homosexual men living with HIV?

### ***2nd Interview (Fears)***

1. When you consider HIV as a physical disease, do you have fears for yourself? For others? If so, what are they, and why?
2. When you consider homosexual men carrying the disease, do you have fears related to them? If so, what are they, and why?



3. When you consider the societal views of HIV, as a health and social issue, as you perceive them, do you have fears? If so, what are they, and why?
4. If any fears are explicated, what measures do you use to relieve yourself of them?

***3rd Interview (Threats)***

1. Do you find those homosexual men who live with HIV threatening at all? If so, why?
2. Do you find the disease itself threatening at all? If so, why?
3. Are there certain societal entities that threaten those living with HIV? If so, what are they and how do you relate to them?
4. If any threats are explicated, what measures do you use to protect yourself from them?

***4th Interview (Convictions)***

1. Considering HIV as health issue, are there any convictions that arise when considering how it affects homosexual men living with HIV? If so, what are they, and why?
2. As a social cause, do you hold any convictions on homosexual men living with HIV? If so, what are they, and why?
3. If convictions are present, In the past, have these motivated you to modify thinking or behavior about homosexual men living with HIV? If so, what was/were the modification(s) and why?

The topics of the interviews were chosen from Thurstone's (1928) definition of attitude: "the sum total of a man's inclinations and feelings, prejudice or bias,

preconceived notions, ideas, fears, threats, and convictions about any specified topic” (p. 531) and narrowed by the researcher’s preference to preconceived notions, fears, threats, and convictions. The nature of the questions sought to understand the psychological, social, and health implications of the subject’s interactions with people living with HIV per Halkitis, Wolitski, and Millet’s (2013) more holistic approach to research concerning the disease.

### **Data Analysis**

Yin (2003) detailed two general data analysis tools relevant for this case study: developing a case description and relying on theoretical propositions. Since this thesis is descriptive in nature, the only conclusions drawn were those explicated by the subject analyzed through the ontology of symbolic interactionism. So, the interview data was organized by introduction, preconceived notions, fears, threats, and convictions. Each section had a psychological, health, and sociological component. The results were written as a representation and deep analysis of every topic the subject discussed; however, the conclusions section took experiences the subject expounded relating to HIV positive people, and categorized all of those into themed categories relating to types of attitude. So, symbolic interactionism was employed specifically as the subject’s personal experience creating subjectivity in accruing knowledge about people living with HIV (PLWH), and how symbols were negotiated to create meaning through this process (Williams, 2008). As the symbolic interactionist model of attitude building is complex, this became the logic model which assessed the use of experiential information isolating certain experiences of the respondent relating to PLWH (Williams, 2008; Yin, 2003).

Here, simple pattern matching was used to decipher any reoccurring ways the participant may have described creating connotation (Yin, 2003). Also, this study had a chronological feature where certain events were assumed to have led to the attitudes expounded by the respondent (Yin, 2003).

### **Research Confidence**

Putting restrictions on a process designed to surpass the rigidity of numbers seems antithetical; however, taking steps to ensure confidence in this case study was an obligation of the researcher (Thomas & Magilvy, 2011). Rigor, defined by Thomas and Magilvy (2011), is the established trust of a qualitative study. While Gibbert and Ruigrok (2010) related it to the *what* and *how* of the methodology, this study deepened rigor by perceptibly detailing the population, recruitment procedure, epistemology by which the results were analyzed, and recording verbatim a series of interviews included in Appendix C.

Various researchers relate credibility to trust, but in more complex means than rigor (Cope, 2014; Polit & Beck, 2012). Case study credibility is the familiarity a person similar to the study subject may feel when reading its conclusions (Cope, 2014). This was difficult to establish as this case study investigated a hyper-specific population of one; however, the researcher relied on the authenticity of the interview by asking non-leading questions accompanied by follow ups making certain the subject was well understood, and immediately recording these verbatim using the literature to support results (Hays & Singh, 2012). Triangulation, or the use of multiple sources of data and multiple investigators to confirm study results, was employed by the researcher to increase

credibility (Merriam & Tisdell, 2016). Not only were interviews used, but also in the transcription document, notations were made observing the subject's nonverbal cues which were later incorporated into the actual transcriptions, results, and conclusions. Also, a series of academic advisors to the researcher analyzed results to increase critical thought in drawing conclusions, a skill better developed in more learned qualitative researchers (Yin, 2003).

Thurstone (1928) was a celebrated researcher, and popularized the study of attitude. The interview questions were created with his widely-used definition investigating common features of the human experience, namely preconceived notions, fears, threats, and convictions. By approaching a unique experience with more common inclinations, it added reliability, or the facility to use results in generalized manner (Yin, 2003). The researcher elucidated major problems occurring in the homosexual community relating to outlooks of HIV, and these were incorporated into the results and conclusions making this research pragmatic, even extending to other communities battling issues with similar social phenomena (Young, Koch, & Preston, 1989).

Making sure that another investigator could follow the procedures of a study was termed dependability (Yin, 2003). Thomas and Magilvy (2010) described creating an audit trail as a systemized way of ensuring this is possible. Firstly, the researcher described the purpose of the study in simplistic but recognizable terms, relating units of it to other parts of the research (Thomas & Magilvy, 2010). The most fundamental part of this study was the group from which the respondent was chosen, and the researcher extensively explored this in review of literature (Thomas & Magilvy, 2010). The means

of data collection are repeatedly discussed throughout this study (Thomas & Magilvy, 2010). Moreover, the researcher thoroughly explains the ontology of the theory used to analyze the research (Thomas & Magilvy, 2010).

### **Researcher Bias**

The researcher thoroughly reflected on inherent bias in relation to the population and experiences being studied. He is a member of the homosexual community having been raised his entire life in Appalachia; so, in many ways he identified with the respondent. However, not witnessing the overwhelming devastation during the nascent AIDS crisis afforded him privileges studying the effects of HIV. The disease, to him, was not completely associated with being gay. Although fighting HIV was a cause close to the researcher, the threat of contraction was incredibly removed compared to those who were young homosexual men in the 1980s. Although antigay legislation in the researcher's local and state government combined with a largely conservative background and community created specific trauma, his experience never compared with those living as gay in previous generations. All of this has combined, still to create a very empathetic view of the homosexual community, people living with HIV/AIDS, and those aligned with these groups.

### **Summary**

While this study is incredibly specific, many factors studied were rarely researched, and could expand almost nonexistent literature on the subject (Eldridge, Mack, & Swank, 2008). To forge this new area of inquiry, the researcher endeavored to thoroughly describe the research design, subject, means of data collection and analysis.

The case study method protected those involved in recruitment and worked well with the distinctiveness and narrative approach of the research topic (Merriam & Tisdell, 2016). In choosing the subject and through the subsequent interviews and analysis, the researcher hoped to elucidate the experiences of an HIV negative gay man, having been raised in rural Appalachia and living through the AIDS Crisis, relating to HIV positive gay men. Moreover, the researcher sought to employ strategies to increase confidence in the final results and conclusions drawn.

## CHAPTER FOUR

### RESULTS

In this chapter, the researcher relates interview results deeply identifying each theme discussed during the investigations. They are separated as the pre-interview, preconceived notions, fears, threats, and convictions.

#### Results

Using four features of Thurstone's (1928) definition of attitude, the researcher divided interview results into the following sections: preconceived notions, fears, threats, and convictions. Here, the psychological, social, and health implications of the subject's interactions with people living with HIV were sought (Halkitis, Wolitski, and Millet, 2013). How the subject gleaned meaning from these interactions and their own related experiences were used as an analytical framework (Griffin, 2012; Yin, 2013).

#### *Pre-Interview*

To make certain the subject was an appropriate participant, the researcher received the following answers: the subject was HIV negative, identified as a male and homosexual, was 54 years old, and was born and raised in County A, a county with a relative rurality of higher than 3.155, the median rurality for counties in the state of Tennessee (Tennessee Advisory Commission on Intergovernmental Relations, 2016). The subject cited a 30-minute commute to the next largest town. This town provided work for rural residents if they were not farmers themselves. The subject spoke of crops he remembered growing in County A: "tobacco fields, corn fields, and tomato fields." The subject associated rurality with being secluded and equaled that with ignorance and conservatism, but said his family was different.

Both sets of the subject's grandparents were German, "European" as he styled them. The subject automatically likened being European to "freethinking" and "more liberal" than Americans. About religiosity, the subject said his parents were practicing Methodists with pause that denoted a lack of evangelical zeal. Instead, the subject emphasized a familial philosophy. "We were raised to let people live. Their life was their business. Their circumstances were their business." The subject contrasted this to others that lived in the area. "There, it was a lot of church and Jesus."

### ***Preconceived Notions***

The subject described the general feeling of the gay population during the onset of the AIDS Crisis. "Everyone was scared to death." The subject emphatically and seriously described HIV/AIDS as a "death sentence" in the early 1980s. The subject detailed that, if the disease did not kill you itself, the drugs "burned the guys up from the inside trying to kill the virus." The hysteria was highlighted by the subject remembering,

You had people who had unprotected sex, and go home, and mix Clorox and water, and drink it thinking that that would kill [AIDS]. Because at the time, it was a big thing that Clorox would kill the active virus if it was on a surface.

Sexual practices and indulgent behaviors of the homosexual community during this time were emphasized. "It was still the age of gloryholes, bathhouses, anonymous sex, and unprotected sex. That was not underground. That was known. [Gay men] were not buying condoms at that time." Regardless of intense fear, the subject underlined that, generally, homosexual men did not change their sexual behaviors despite assuming HIV was a sexually transmitted disease. Also, the subject repeatedly spoke about the prevalent use of



drugs, especially syringe injected cocaine, at homosexual gathering spots. “They were shooting up; passing needles around.”

And, at that time, the subject was leading a double life. When asked if he was living as completely gay in the early 1980s, the subject responded, “It depended on what state I was in.” The subject had moved out of his birth city to attend school in a metropolitan area, still Southern but not Appalachian and certainly not rural. Here, he lived mainly as a gay man. However, the subjects explicated, “I was 28 when I got married [to a woman]. I was actively dating women and men at the time.” The subject again brought up his family’s approach to letting be. “And, we were really, as I said before, raised with the attitude that what you did with your life was your business.” His reason for dating women, although it was against his natural sexual inclinations, was societal, “I knew my family would love me regardless.”

Having described his personal experience and the environment in which he was immersed before and during the onset of the AIDS Crisis, the subject explained the process of him discovering HIV existing and how the disease was communicated. “There were so many different theories. You had the one about men having relations with monkeys, and that is how it all got started. That it could only be a homosexual disease.” Although, as previously discussed, sexual transfer of HIV was assumed, the subject said, “there were so many misconceptions in other ways that it could be transmitted too: by shaking hands, eating from utensils and plates that other people had eaten off of; casual contact.” The media, the subject related, created bewilderment. “In the early ages, there was not much out there. And, what was out there, one article would totally contradict the

other one; so, there was so much misleading information . . . you really did not know what to believe. You were in a constant state of confusion.”

News entities were the source of the subject’s cognizance of HIV and it being linked to being homosexual. “When the stories first started coming out, that is all they associated with it. So, you knew from day one that [HIV] was [affecting the gay community]. That is how I found out about it, media. And, the media was so ignorant about it at that time, there was so much misleading information.” The subject was active in research, though, which ultimately affected how he interacted with people living with HIV. “Gratefully, I was intelligent enough to sort through the bad information and realize that social contact, casual contact, you were not going to get it. So, I have never shunned away from someone who is positive. That has not changed. I have always been accepting.” The subject explained his ongoing education about HIV. “Even today, you have to educate yourself on it. But, the internet has been freely available, there are books that I read, the media got much better; just researching it. I took that upon myself even in the early days.”

The subject described how experiences has changed for those living with HIV. “You know, I went to school with a kid who had [HIV], and his parents would not even let him back in the house when he went to visit.” The subject became emotional about what he had seen in City A, where he attended college.

To have been in a gay world like City A was in the early 80s, to know what the guys went through was very, very hard. They were treated as lepers even in their

own community, the community that should have embraced them and supported them.

The subject continued, “A lot of the guys . . . chose suicide. It was bad.” The subject detailed the following timeline: “I went to City A, I went to school there, and finished in 1985. I stayed for 2 years. So, by the end of 1987, a lot of the guys who were diagnosed with AIDS, they knew there was no hope.” The subjects view on the changing nature of tackling HIV was hopeful.

I think they know what they are doing now. I do not know if they have a handle on the spread, but I think they have had a great deal of success with the disease. From everything I read, the medications are wonderful. I do know people who are positive. There are still side effects. They do damage to other parts of your body to where you have to take secondary medications to take care of that. But, it is not a death sentence like it was.

While the subject seemed encouraged, he elucidated a widespread problem.

The subject repeatedly expressed that people do not think HIV will ever touch them, especially those in the homosexual community. “I mean, how many guys do you know who intentionally do not use condoms? And if you are sexually passive, the risk is so much greater. That attitude is still so prevalent.” This also related to social acceptance of those living with HIV.

You have the people it just totally does not affect. They do not even know anyone gay, or they would not associate with anyone gay, and certainly not anyone HIV positive. Therefore, it is not a subject they care anything to know anything about.

If they do encounter it, they still go back to the old beliefs, the old stereotypes.

That is just how their brains organize the information.

Similarly, the subject spoke about Appalachia. “It has changed a great deal, but I think a lot, especially in this area, the ignorance is abundant.” Religious identity again surfaced. “Then you have the whole too much Jesus and too much church theory: HIV is a plague sent from God, which is probably the most ignorant.” These attitudes, according to the subject, were intentionally oblivious. “The majority people around here just do not think it affects them; so, why worry? Why try to get the information? Because, the information is out there, but it is not readily available. You have to look for it.” On Appalachia’s drug crisis and its residents being removed from HIV, the subject conveyed,

In the county where the I live, statistically more people with HIV, it is drug related. And, there are a lot of them. It is still hidden and buried. Most of the people, I would say their families do not know. Their contacts, their friends, they do not know. I do not know if they think that it cannot happen to them and that it is still a gay disease. I do not know.

The isolated nature of his city of residence had other affects.

The subject empathized for people living with HIV relating a personal anecdote. “I have heard my husband and I referred to as the ‘gay boys.’ Honestly, it does not bother me; because, people do not mean anything by it. But, we are made token. . . We are accepted like that.” There was a certain distrust with acquaintances. “But, you wonder if one of us was HIV/AIDS positive. How would those people feel then? So, it is alright to

be gay, but if you are HIV positive, I do not think some would be accepting. I know we lost friends when gay marriage passed. Because, then, it became an issue.

### *Fears*

On how HIV could affect his physical health, the subject expressed he had not fully considered the associated fear. “Gosh, I do not know. I had never really thought about that actually. I am in a relationship. We are both clean. And, if there were to be extra-play, there is a lot of research that goes into that person.” The participant and his partner do infrequently engage in open sexual behavior, and the danger of acquiring HIV persists.

The fear has decreased over the years, but there is still caution. If I was not in a relationship, I do not know. But, there is definitely fear there. At my age, it is still there. It is something I would not want to deal with now in my life, just the side effects of the medication and the fact that I am a diabetic. There is a lot of protected sex.

The subject also expressed fears outside of himself and partner. “The friends we do have that are gay are much younger. They could be my children. So, I am very open to them. I encourage them to use protection, get tested, or get on medication.” On medication, pre-exposure prophylaxis [PREP], the subject described his hesitation and optimism. “A lot of people are betting their lives on [PREP]; so, I hope it is as good as what I have read. I think it is a great step forward.”

Socially, the subject again highlighted his openness and the power of being educated about HIV. “My mind never goes to that place. I have no fear of the person

[living with HIV]. I respect the disease.” Here, caretaking was brought up. “If you were HIV positive, I would have no fear of taking care of you or anyone else. I mean, we know how you get it and we know how you do not get it.” And, again, the subject eluded to prevalent attitudes toward HIV in Appalachia. “I realize I am not the norm for this area.”

Specifically, the subject feared for those who could not afford treatment and how the American healthcare system seemingly forgetting about those living with HIV. “The medication is around \$10,000 a month. If the person makes a certain amount of money, they qualify for nothing.” Similarly, preventative measures relating to the fear of acquiring HIV was expressed.

I do not think people get tested enough. If I was living in the ‘80s at the age I am now, I would be at the clinic every week, and asking if they made sure to draw enough blood to get a good test. The fears not as bad as it is now; because, I know there are options out there. I know you do not have to go home and drink Clorox and water.

The subject communicated how his fear was derived and how he avoids witlessness.

“Living through what I lived through in the 80s in the area that I lived . . . once you had the facts, it is like a loaded gun versus an unloaded gun. One can kill you and the other cannot hurt you.”

The subject again related the homosexual party scene in the early 1980s when riotous episodes were common for him.

There was a lot going out back then, a lot of sex in bars, and a lot of the bars had cocaine rooms. It was nothing to go home with someone whose name you did not

know until the next morning, or two or three people for that matter. The leather scene was wonderful back then. The 80s were, for gays, what the sixties were for the hippies.

Drugs were again conveyed as part of the culture. “And, I think sometimes people use drugs to escape. But they were recreation then, too. They were something you did on the weekend. Cocaine was used during sexual encounters. Your sense is heightened on it.” The celebratory atmosphere was rooted in a sort of dark triumph, an acceptance of the AIDS Crisis and an overcoming of fear.

I think a lot of people thought they were going to die. So, they wanted to live while they were here. The gays were still outcasts at that time. . . . It was a death sentence either way; because, there were so many misconceptions about you how you did get it.

### ***Threat***

As a disease, the respondent still found HIV threatening. “You know, there are still cases of HIV sweeping through the blood supply at hospitals. I do not know if I could get a blood transfusion. There are still cases where it slips through.” The subject showed a sort of distrust.

Unprotected sex for anyone, homosexual or heterosexual, there is still risk there; so, you have to respect the disease. Unless you are with your partner 24 hours a day, 7 days a week, you do not know what they could be doing; so, it is your responsibility to take care of your life. Period.

This suspicion was a continuous theme.

The subject, when asked about social entities threatening people living with HIV, underscored business practices to convey negative bias. “I think there is still discrimination across the board. Businesses have just gotten smarter about how they do it.” Although the subject said it would be harder now, he still supposed HIV positive people could be easily fired.

If you went into your employer tomorrow, and told them that you were HIV positive, if they wanted to get rid of you, they would try to do it legally. They would find every little infraction on your record to use it against you. In the 1980s, they did not care if it was discrimination. Goodbye. We do not need you. A lot of that is still there.

Moreover, this misgiving about others’ perceptions of HIV was applied to familial relationships. “You never truly know who you are dealing with, even in your own family. Until the hammer hits the nail on the head, you do not know. Period.”

When confronting threats, the subject used his own behavior and experience to describe how he protects himself.

[Field of Work] is open to homosexuals, but it also may be that I was good at what I did. They called me, I did not call them. Sexually, I am very safe, which I have mentioned. And, socially, I really do not see it as a threat with other people that are positive.

### ***Convictions***

When considering convictions about HIV, the subject brought up his belief in a conspiracy theory. The subject could not accept that HIV was contacted from bestiality;



which, he described as the only prevalent explanation given in the beginning of the AIDS Crisis. “I think HIV was invented in a lab and [intended for] germ warfare.” His explanation was based in numbers.

When this first came out, the mainstay explanation the media and medical profession gave was that HIV started in Africa. Men were copulating with monkeys. But how many could have been doing that? Take from the time it started to the spread of it, ask yourself, how could this have happened so quickly. How many men who acquired this disease from monkeys were also having sex with men from other countries?

The subject cited how ardent the media, government, and medical profession was about this explanation. “We heard [African monkey epidemiology explanation] everyday. We heard that for years and years and years. It is the mathematics of it.” The subject also was cognizant that this belief was indecorous. “Being an educated man, I know how stupid that sounds. . . . Anyone who knows me will tell you I am not quick to judge. I am usually a deliberator. I am a thinker. It was the only theory they had.”

As a social phenomenon, the subject once more related his approach to life, but with a certain concern. “Your mind, your body; your sexual life, you do what you want to do. I am not going to judge you unless it hurts someone else. Do what you wish. I am still passionate about people not getting the disease, though.” Here, although the subject had previously cited encouraging younger friends to have safer sexual behavior, he shrugged off the title *mentor*.

I would not want anyone getting the disease. No one. Even if it is not a death sentence now, it is still life changing. I mean I do not mean to mentor anyone. I do not want to warp anyone, but I encourage people to educate themselves.

When asked about convictions influencing behavior, the subject answered with a progression through time. “In the early 1980s, I continued the same behavior, sexually, that I had. When I got married, yes. I was lots more cautious. And, now, still, but in a different way; because, I have different information about HIV.” The subject described his search for personal truth.

I have the belief system that you are born this way. You are not conditioned to be this way. . . . But, if I would not have been unhappy sexually in my first marriage to a woman, I would probably still be married, in the closet and having affairs with men. That is generational, that is societal. But, also, I think there are a lot of young gay men, through the indoctrination of the church and their family, they would do the same now. But, then it was still a different time.

Here, the subject reflected on the historicity of the gay movement. “So, you go back to the 1960s, to the 1970s, and in the 1980s we were coming out in rebellion. But before that it was a hidden life. It was very sad, very sad.” He also highlighted how being gay was something he had cognizance of growing up having a family member that silently identified as homosexual.

I had an uncle that was gay. It was never discussed. I knew he was gay. Everyone did. He never told me that. He was a bachelor his entire life. It was just a different time. My family did not love him any less. They did not talk about it. My mother

had a wonderful “flamer” as a friend when I was growing up. He was very accepted by my family. I have two cousins that are gay.

The subject considered his uncle’s experience further. “Horrible. Sad. What do you do when you live 30 minutes from civilization on a farm, and there may have been others around. But, I do not know.” Additionally, the subject related historicity to his own *closeting*. “It was my inner shame. . . . We were all [considered] big sissies if you gay back then. They just knew every one of us had a party dress and high heels somewhere in our closet. Now, I think it is about being open and who you are.”

Being able to be open about sexuality was attributed to a wider acceptance of people living with HIV. And, the subject emphasized empowering feelings toward being open about one’s own sexuality.

I mean I have known that I am gay since I was thirteen. I always knew though.

That was the first time that was acted on. It felt natural. . . . When I hit forty, I had very successful business, my daughters were graduating, but I had inner loneliness. I think I made a conscious decision that I was not going to care what anyone else thought anymore. I was 40, and I did not know if I would see 80. But if I did, the last 40 were going to be on my terms.

## **Summary**

The researcher endeavored to represent each topic the subject discussed and express the view attached to them. In the pre-interview, the subject explained not only his qualifying characteristics to participate in this study, but also espoused his experience growing up in Appalachia. In the preconceived notions section, the subject spoke about

what it was like in the nascent stages of the AIDS Crisis, how he related to HIV positive people then and now, and the importance of education when considering the disease. In the fears section, the subject reflected on the danger of HIV physically and socially for himself and others; while, he spoke about healthcare and other barriers to prevention. In the threats section, the subject expressed perceived hazards such as economic and health impediments for HIV positive people. In the convictions section, the subject elucidated his deeply held beliefs about the start of HIV and other topics on homosexuality.

## **CHAPTER FIVE**

### **CONCLUSIONS AND RECCOMENDATIONS**

In this chapter, the researcher espouses conclusions drawn from the interview process. Also, implications for this study relating to researchers, activists, medical professionals, and those working in diversity initiatives. Lastly, three recommendations for future research are given based on the researcher's conclusions.

#### **Conclusions**

In this case study, one HIV negative subject was interviewed, having been raised in rural Appalachia and lived as an adult thorough the AIDS Crisis. The subject expounded features of attitude toward HIV positive gay men as defined by Thurstone (1928) and narrowed by the researcher's interests: preconceived notions, fears, threats, and convictions. The researcher designed a semi-structured protocol to examine psychological, social, and health implications of the subject's interactions with people living with HIV per Halkitis, Wolitski, and Millet's (2013) more holistic approach considering the disease.

It could be reasoned that because of the specific nature of this study, all findings have an inherently novel quality. Dynamics within the gay community relating to HIV are seldom studied making the subject's opinions beneficial (Fraser, 2008). Moreover, with the subject being considered a *rural gay*, or a homosexual research respondent having deep personal connections to a non-urban area, his views are especially desirable (Fisher, Irwin, & Coleman, 2014). Most studies undertaking homosexual issues only present metropolites' perspectives (Eldridge, Mack, & Swank, 2008).

The ontology of this study was based in Mead's symbolic interactionism postulating the subject's derivation of meaning would lie in socially negotiated experiences (Griffin, 2012). By elucidating all topics discussed by the subject in the results section, the researcher narrowed these to experiences relating to HIV positive gay men, and refuted or supported these narratives with peer reviewed literature. By examining espoused narratives through this model, the researcher drew the following conclusions: the subject held (a) accepting, (b) concerned, and (c) empathetic attitudes toward gay men living with HIV.

### ***Accepting Attitude***

"I have always been accepting," the subject expressly stated his most obvious attitude about gay men living with HIV. However, according to Eldridge, Mack, and Swank (2008), showing such ease relating to this group might be unlikely. The subject deviated from the hypothesis that his experience may create difficulty concerning those farther from the status quo and especially HIV positive gay individuals (Liamputtong, 2013). While having lived a portion of his life as a heterosexual, one may assume that the subject had a certain amount of internal homophobia which makes acceptance of other gay men problematic (Newcomb & Mustanski, 2013). Still yet, the subject persistently explicated showing a broadmindedness toward his own homosexuality. Nevertheless, the subject's narrative aligned with other research findings, and, in this section, his views on education and social exposure to HIV positive gay men, misinformation about HIV, and knowledge garnering are revealed.

According to Young, Koch, & Preston (1989), better HIV education is directly linked to more tolerant attitudes. The subject recurrently cited being accepting of gay men living with HIV. “I took [education] upon myself even in the early days [of the AIDS Crisis].” Through much misinformation, the subject informed himself by seeking out reliable resources, connecting knowing how the disease spread to feeling less reproach for gay men living with HIV. “Gratefully, I was intelligent enough to sort through the bad information, and realize that with social contact and casual contact, you were not going to get it. So, I have never shunned away from someone who is positive.” The subject was frequently exposed to HIV positive gay men from the worst of the AIDS Crisis, being able to test his progressive stances. “I have no fear of the person [living with HIV]. I respect the disease. . . . I mean, we know how you get it, and we know how you do not get it.” Ryffel, Wirz, Kühne, & Wirth (2014) went further suggesting that being exposed to an emotional involvement would better influence attitudes constructively toward gay men living with HIV.

“In the early 1980s, to know what the guys went through was very, very hard.” Prati et al. (2015) discovered that knowing someone living with HIV correlated with lower chances of negative opinions against positive people. Furthermore, if a person became positive and had been in contact with another positive person prior to this, their chances of having destructive views toward themselves lessened (Prati et al., 2015). The subject not only knew gay men that were HIV positive during the beginning of the AIDS crisis, he witnessed their appalling circumstances. “With no drugs at the time, and the drugs they did have at the time being so toxic, [medications] burned the guys up from the

inside trying to kill the virus.” The subject explained the extremity of the early 1980s, “it was such a cruel, pitiful; lonely death, [positive gay men] chose suicide.” According to Greene and Banerjee (2006), the AIDS Crisis was so affecting for gay men that a dissimilar cultural memory was created. Thence, the homosexual community was left with a unique and influencing ordeal (Greene & Banerjee, 2006).

Price and Hsu (1992) explained that although, just as the subject reported, it was known that HIV could be communicated through sharing of sexual fluids and blood products, many were still reluctant about casual contact, or the disease being communicated through saliva, tears, touch, public toilets, air; etc. “There were so many misconceptions in other ways that [HIV] could be transmitted, too: by shaking hands, eating from utensils and plates that other people had eaten off of, casual contact. . . . [The early 1980s was a] scary and confusing time.” Moreover, Price and Hsu (1992) directly linked more discriminatory practices to distortion about how HIV is acquired.

The subject said his main source of knowledge about HIV/AIDS was the media. Stipp and Kerr (1989) postulated that receptivity to knowledge garnering from news outlets could be influenced by viewer held anti-homosexual sentiment. The subject, although closeted in some areas in his life, never held high levels of self-loathing relating to his true sexuality. “I never hated myself for being [gay]. I never felt shame.” So, he was more able to adjust his opinion about HIV based on scientific fact (Stipp & Kerr, 1989).

This is me, you take it or leave it. But, this coming out of the closet movement is why people are able, now, to be as accepting as they are. You go back 40 years



ago and into the 80s, if people did not think they knew anyone gay, they definitely did not think they knew anyone with HIV.

The subject continued to speak movingly about cognizance.

### ***Concerned Attitude***

The subject, through a plethora topics, related his concern for HIV positive gay men by expounding his experiences relating to them. In this section, distrust is emphasized in religious, family and governmental units. Also, apprehension for how HIV positive were treated in relation to economic opportunity and healthcare issues were revealed by the subject.

The subject showed a protective suspicion of religious organizations. The subject was concerned that gay men living with HIV would be deleteriously affected by Christian views that HIV/AIDS was a higher power's punishment for practicing homosexuality. "Then you have the whole too much Jesus and too much church theory: HIV is a plague sent from God, which is probably the most ignorant." Halpin et al. (2016) advanced that although a belief in deity aided coping living with HIV, certain religious groups perpetuated stigma and discrimination toward HIV positive peoples. Although HIV positive people might be drawn to the premise of a nurturing God, they were unlikely to easily divulge their positive status for fear of being cast out of their religious community (Halpin et al., 2016).

The subject showed distrust for the family unit. "You never truly know who you are dealing with, even in your own family. Until the hammer hits the nail on the head, you do not know. Period." The subject told of a young man he knew in the early 1980s

that became positive and was dramatically shunned by his parents. “You know, I went to school with a kid who had HIV, and his parents would not even let him back in the house when he went to visit.” The subject repeatedly eluded to not being sure about how family would react to an HIV positive status. During the advent of AIDS, it was common for gay men to disclose having the disease and their sexuality to their family at the same time causing higher chances of upheaval (Kadushin, 1996). If the family did know their son’s sexuality, a positive diagnosis could greatly complicate dealing with these pieces of information simultaneously (Kadushin, 1996).

Laughingly the subject joked, “You want me to sound crazy, do you not?” on his belief about the cause of HIV/AIDS. “The only conspiracy theory that I believe is that I think HIV was invented in a lab and meant as germ warfare. It was tested on undesirables, the homosexuals, and it got out of control. That is my personal belief,” the subject said after acknowledging his stance was indecorous. Ford, Wallace, Newman, Lee, and Cunningham (2013) showed that a distrust of government for older gay men was common with about a third being taken by conspiracy theories having to do with HIV/AIDS. And, this should be taken as a serious matter. Those gay men that exemplify this suspicion were less likely to get tested for HIV and participate in certain prevention strategies (Ford, Wallace, Newman, Lee, and Cunningham, 2013).

The subject spoke about economic discrimination faced by gay men living with HIV.

I think there is still discrimination across the board. Businesses have just gotten smarter about how they do it. If you went into your employer tomorrow, and told

them that you were HIV positive, if they wanted to get rid of you, they would try to do it legally.

Gordon (2015) explained that HIV positive are extensively protected under the Americans with Disabilities Amendments Act of 2008; however, the bill is undermined by those states that have no legal misgivings about dismissing someone for their sexuality. Subsequently, it is substantiated that gay men living with HIV are at an especial risk (Gordon, 2015).

Similarly, the subject cited the cost of HIV/AIDS treatment and his concern that healthcare was not doing enough for a chronic disease that is staggeringly expensive to treat. “Our country’s healthcare system is so messed up . . . when it comes to a life-threatening disease like [HIV], and I am not just talking about gay people, I am talking about anyone who has [HIV].” In fact, the Center for Disease Control (CDC) estimated that annual medical treatment for gay men living with HIV was over \$20,000 (CDC, 2017). While almost unaffordable without assistance the treatments, as the subject explicated, are usually deleterious to the person’s living with HIV health (Park-Wyllie, Strike, Antoniou, & Bayoumi, 2007).

Additionally, the subject explicated his concern for those taking HIV medications with a careful optimism.

From everything I read, the medications are wonderful. I do know people who are positive. There are still side effects. They do damage to other parts of your body to where you must take secondary medications to take care of that. But, it is not a death sentence like it was.

Dibonaventura, Gupta, Cho, and Mrus (2012) explained that there are side effects from antiretroviral medications commonly prescribed to treat HIV/AIDS. It was also suggested there has been little research done to measure how these affect those taking these treatments in their daily lives; however, it is widely accepted that the medications restorative properties outweigh their caustic ones (Dibonaventura, Gupta, Cho, & Mrus, 2012). “Fatigue, diarrhea, insomnia, dizziness, neuropathy, joint pain, nausea, and abdominal pain” (Dibonaventura, Gupta, Cho, & Mrus, 2012, p. 744) were the most common reported.

### ***Empathetic Attitude***

The subject showed a poignant empathy toward gay men living with HIV. In this section, the researcher relates how the historicity of the subject’s experience inspired a compassionate outlook for gay men living with HIV. It was through the exceptional experiences of the subject during the AIDS Crisis that led the researcher to the third conclusion.

The subject recounted the nascent stages of the AIDS crisis and spoke vulnerably about how he related to those who were affected. “Everyone was scared to death. . . . A lot of the guys who were diagnosed with AIDS, they knew there was no hope.” The subject spoke openly about the riotous gay scene in the 1980s where intravenously injected cocaine and uninhibited sex was commonplace. This was simultaneously remembered with a fondness and as reasons for the spread of HIV.

There was a lot going out back then, a lot of sex in bars and a lot of the bars had cocaine rooms. It was nothing to go home with someone whose name you did not

know until the next morning, or two or three people for that matter. The leather scene was wonderful back then. The 80s were, for gays, what the sixties were for the hippies.

Stonewall is synonymous with gay liberation, and was the first popular memory marking the gay rights movement (Forstein, 2012). In many metropolitan areas where rebellion was common, there came together bands of gay men who unabashedly enjoyed their sexuality physically and the culture created around it (Forstein, 2012). This was the environment in which the subject was immersed.

The researcher noted that the subject simultaneously laughed and later became emotional recalling his experiences in the early 1980s gay scene. Stories varied from mischievously relating the dynamics of group sex to how, after having an unprotected encounter, gay men would consume bleach and water to kill potential HIV.

You had people who had unprotected sex, and go home, and mix Clorox and water, and drink it thinking that that would kill [the virus]. Because at the time, it was a big thing that Clorox would kill the active virus if it was on a surface or something. So, they were dosing themselves with Clorox and water, drinking it. The subject had beheld it all and was of an era where suicide was a seemingly less painful death than early noxious anti-HIV/AIDS treatments. Diedrich (2004) defined this experience of witnessing as crisis where the onlooker is shaped to not only survive himself, but identifying with others affected, take on others' suffering as their own.

## **Implications**

By intimating the experience of one HIV negative homosexual man, having been raised in rural Appalachia and living through the AIDS Crisis as an adult, and his attitude toward HIV positive gay men, much has been considered. The possibility of using the subject's viewpoints pragmatically is great. Implications for researchers, activists, medical professionals, and those working in diversity initiatives, in this section, are described.

As the gay community lacks understanding of many of its dynamics, the outlooks expressed in this study could give ideas to researchers, deepening almost nonexistent data on rural respondents and how HIV negative homosexual study subjects relate to positive ones. The conclusions drawn from these studies could be incorporated into formal initiatives of gay organizations in non-urban areas to bring together people of opposite HIV statuses. For example, the subject combined education and exposure to HIV positive peoples as tools for creating a learned and positive attitude toward those living with the disease. An informative and entertaining lecture series could be given by HIV positive people in venues where gay men frequent. By having scientific research to promote a group dynamic, legitimizing opinions destigmatizing HIV to strengthen the gay community as whole, a more united mentality might be created battling disease.

HIV and gay advocates can use this study to better discern strategies for recruiting and retaining men of the subject's time in the movements. The subject's narrative could be useful in creating fundraiser campaigns for organizations relating to issues for which the subject expressed passion. For example, since the subject expressed profound

emotions surrounding the AIDS Crisis, a group might incorporate a brief portion of an event remembering the historicity of HIV. This would honor many donors' personal memories deepening the relationship between them and the organization.

Also, while designing HIV prevention strategies, the subject's insight could prove valuable to how similar individuals relate to sex. By knowing what behavior might be expected of individuals like the subject, interventions could be improved by medical professionals designing tactics to combat the spread of the disease. For example, the subject emphasized condom use. Making sure this type of prophylactic is available to people like the subject would be significant. Likewise, observing the experience of HIV positive individuals through the standpoint of the subject, interactions between similar parties and what meaning is negotiated within them can be better understood. As treatment is becoming more holistic, analyzing positive people's experiences deeply, seeing how and why others, such as the subject, treat them could inform professional development for psychologists.

More largely, for those working in diversity studies, by discerning how the subject chose tolerance instead of bigotry could be beneficial in creating social justice initiatives for subjugated groups with a complicated interworking. The subject was given a commonality between him and HIV positive people-both, in this study, were gay. Asking a gay man to speak on other gay men emphasized relatability. By finding subjects that unite groups could prove integral in uniting them against discrimination.

By using a case study method, the researcher sought to promote and legitimize this method of research as way of identifying and exploring unique lives and voices for

the field of qualitative research. By seeing this study, it is the researcher's hope that others will be interested in methods that investigate specific phenomenon. As writing personal narrative is important to the researcher, he wishes to promote research that emphasizes the commonality of the human experience through distinctive experiences.

## **Recommendations**

While the study is based on the distinctive perspective of one person, comparing a group of similar individuals would prove beneficial increasing confidence. As this study is based on the subject being raised in a non-urban area, the concept of rurality was emphasized. However, the subject did not seem to intensely identify with being an Appalachian. Further studies might seek to understand identity in relation to place and sexuality. Thurstone's (1928) definition of attitude was used to create methods of research for this study, however, different means could be explored on how to qualitatively delineate features of attitude. The following research questions could address these concerns:

1. What comparisons and contrasts can be drawn between a group of ten mature HIV negative non-urban homosexual gay men when analyzing their attitudes on HIV positive gay men?
2. How does a non-urban gay man describe living in a rural area related to his homosexuality?
3. Through ethnographic engagement, what do behaviors of a mature HIV negative non-urban gay man delineate about his views of HIV positive gay men?



## REFERENCES

- Abdul-Malik, O. (2004). Overcoming preconceived notions. *Clinician Reviews*, 14(8), 80.
- Abelson, R. (1988). Conviction. *American Psychologist*, 43(4), 267-275. doi: 10.1037/0003-066X.43.4.267
- Ahs, F. (2012). Amygdala and fear memories In A. Gervaise (Eds.), *Psychology of Fear: New Research* (95-112). Hauppauge, NY: Nova Science Publishers.
- AIDS Weekly. (2015). *PrEP data links anti-HIV immune response to reduce chance of infection*. [Press Release].  
[http://go.galegroup.com.proxy.lib.utk.edu:90/ps/i.do?&id=GALE%7CA420528360&v=2.1&u=tel\\_a\\_utl&it=r&p=AONE&sw=w&authCount=1](http://go.galegroup.com.proxy.lib.utk.edu:90/ps/i.do?&id=GALE%7CA420528360&v=2.1&u=tel_a_utl&it=r&p=AONE&sw=w&authCount=1)
- Allison, K. (1998). Stress and oppressed category membership In J.K. Swim & C. Stangor (Eds.), *Prejudice: The Target's Perspective* (145-70). San Diego, CA: Academic.
- Allport, G. (1954) *The nature of prejudice*. Reading, MA: Addison-Wesley.
- Andriote, J. (2012). Reclaiming HIV as a 'gay' disease. *The Gay & Lesbian Review Worldwide*, 19(5), 28-33.
- Appalachia [Def. 1]. (n.d.). *Merriam-Webster Online*. In Merriam-Webster. Retrieved November 17, 2015, from <http://www.merriam-webster.com/dictionary>
- Avineri, N. R. (2012). Heritage language socialization practices in secular Yiddish educational contexts: The creation of a metalinguistic community. (Doctoral dissertation). eScholarship.

- Backus, L., Boothroyd, D., Phillips, B., Belperio, P., Halloran, J., Valdiserri, R., & Mole, L. (2010). National quality forum performance measures for HIV/AIDS care: The Department of Veterans Affairs' experience. *Archives of Internal Medicine*, 170(14), 1239-1248.
- Bartels, J., & Herman, W. (2012). The failure threatened personality: A theoretical and empirical synthesis of fear of failure research In A. Gervaise (Eds.), *Psychology of Fear: New Research* (1-29). Hauppauge, NY: Nova Science Publishers.
- Bartle, C. (2014). Gay/queer dynamics and the question of sexual history and identity. *Journal of Homosexuality*, 62(4), 531-569. doi: 10.1080/00918369.2014.983395
- Berger, I., & Alwitt, L. (1996). Attitude conviction: A self-reflective measure of attitude strength. *Journal of Social Behavior and Personality*, 11(3), 555-72.
- Bershteyn, A., & Eckhoff, P. (2013). A model of HIV drug resistance driven by heterogeneities in host immunity and adherence patterns. *BMC Systems Biology*, 7(11), 2-26. Doi: 10.1186/1752-0509-7-11
- Billings, D., Norman, G., & Ledford, K. (1999). Back talk from Appalachia: Confronting stereotypes. Lexington, KY: University Press of Kentucky.
- Blumer, H. (1980). Mead and Blumer: The convergent methodological perspectives of social behaviorism and symbolic interactionism. *American Sociological Review*, 45(3), 409-19.
- Braddock, J., & McPartland, J., (1987). How minorities continue to be excluded from equal employment opportunities: Research on labor market and institutional

- barriers. *Journal of Social Issues*, 43, 5-39. doi: 10.1111/j.1540-4560.1987.tb02329.x
- Brent, R. (2016). The value of reducing HIV stigma. *Social Science & Medicine*, 151, 233-40. doi: <http://dx.doi.org/10.1016/j.socscimed.2016.01.014>
- Callender, K. (2015). Understanding antigay bias from a cognitive-affective-behavioral perspective. *Journal of Homosexuality*, 62(6), 782-803. doi: 10.1080/00918369.2014.998965
- Carreira da Silva, F. (2010). *Mead and modernity: Science, selfhood, and democratic politics*. Lanham, MD: Lexington Books.
- Center for Disease Control. (2014). *HIV among gay and bisexual men*. [Data file]. <https://www.cdc.gov/hiv/group/msm/>
- Center for Disease Control. (2014). *HIV among people aged 50 and over*. [Data file]. <https://www.cdc.gov/hiv/group/age/olderamericans/index.html>
- Center for Disease Control. (2017). *HIV cost-effectiveness*. [Data file]. <https://www.cdc.gov/hiv/programresources/guidance/costeffectiveness/index.html>
- Christian, D., Wolfram, W., & Dube, N. (1988). *Variation and change in geographically isolated communities: Appalachian English and Ozark English*. Tuscaloosa, AL: University of Alabama Press.
- Clark, R., Anderson, N., Clark, V., & Williams, D. (1999). Racism is a stressor for African-Americans: A biopsychosocial model. *American Psychology*, 54(10), 805-16.

- Conviction [Def. 1]. (n.d.). *Merriam-Webster Online*. In Merriam-Webster. Retrieved November 17, 2015, from <http://www.merriam-webster.com/dictionary>
- Cope, D. (2014). Methods and meanings: credibility and trustworthiness of qualitative research. *Oncology Nursing Forum*, 41, 89-91. doi: 10.1188/14.ONF.89-91
- Cohen, G. (2008). Connecting with the larger purpose of our work. *Journal of Pharmaceutical Sciences*, 97(3), 1041-1046. doi: 10.1002/jps.21248
- Cossette, P. (1998). The study of language in organizations: A symbolic interactionist stance. *Human Relations*, 51(11), 1355-77. doi: 10.1023/A:1016998316635
- Courtenay-Quirk, C., Wolitski, R., Parsons, J., & Gomez., C. (2006). *Is HIV/AIDS stigma dividing the gay community? Perceptions of HIV-positive men who have sex with men*. *AIDS Education and Prevention*, 18, 56-67. doi: 10.1521/aeap.2006.18.1.56
- Côté, J. (2015). *George Herbert Mead's concept of society*. Abingdon, UK: Taylor and Francis.
- Darwin, C. (1993). *The autobiography of Charles Darwin*. New York, NY: W. W. Norton & Company Inc.
- DiBonaventura, M., Gupta, S., Cho, M., & Mrus, J. (2012). The association of HIV/AIDS treatment side effects with health status, work productivity, and resource use. *AIDS Care*, 24(6), 744-55. doi: 10.1080/09540121.2011.630363
- Diedrich, L. (2004). 'Without-us-all-told': Paul Monette's vigilant witnessing to the AIDS crisis. *Literature and Medicine*, 23, 112-27.
- Dovidio, J., & Gaertner, S. (2000). Aversive racism and selection decisions: 1989 and 1999. *Psychological Science*, 11(4), 315–319. doi: 10.1111/1467-9280.00262

- Dovidio, J., Kawakami, K., & Gaertner, S. (2002). Implicit and explicit prejudice and interracial interaction. *Journal of Personality and Social Psychology*, 82, 62–68. doi: 10.1037//0022-3514.82
- Easton, G. (2008). Critical realism in case study research. *Industrial Marketing Management*, 39, 118-128. doi: <http://dx.doi.org.proxy.lib.utk.edu/90/10.1016/j.indmarman.2008.06.004>
- Eldridge, V., Mack, L., & Swank, E. (2008). Explaining comfort with homosexuality in rural America. *Journal of Homosexuality*, 51(2), 39-56. doi: 10.1300/J082v51n02\_03
- Elmore, K. (2006). Southern discomfort: AIDS stigmatization in Wilmington, North Carolina. *Southeastern Geographer*, 46(2), 215-230.
- Fear [Def. 1]. (n.d.). *Merriam-Webster Online*. In Merriam-Webster. Retrieved November 17, 2015, from <http://www.merriam-webster.com/dictionary>
- Fergusson, D., Horwood, J., & Beautrais A. (1999). Is sexual orientation related to mental health problems and suicidality in young people? *Archives of General Psychiatry*, 56(10), 876-80.
- Fischbacher, U., Gächter, S., & Quercia, S. (2012). The behavioral validity of the strategy method in public good experiments. *Journal of Economic Psychology*, 33(4), 897-913. Doi: 10.1016/j.joep.2012.04.002
- Fisher, C., Irwin, J., & Coleman, J. (2014). LGBT health in the midlands: A rural/urban comparison of basic health indicators. *Journal of Homosexuality*, 61(8), 1057-1061. doi: 10.1080/00918369.2014.872486

- Fleck, C. (2015). Attitude: History of concept. In *International Encyclopedia of the Social & Behavioral Sciences*. (Vol. 2, pp. 175-77). Amsterdam, Netherlands: Elsevier.
- Ford, C., Wallace, S., Newman, P., Lee, S., & Cunningham, W. (2013). Belief in AIDS-related conspiracy theories and mistrust in the government: Relationship with HIV testing among at-risk older adults. *The Gerontologist*, 53(6), 973-984. doi: 10.1093/geront/gns192
- Forstein, M. (1984, March). The psychosocial impact of the acquired immunodeficiency syndrome. In *Seminars in oncology* (Vol. 11, No. 1, pp. 77-82). Elsevier.
- Forstein, M. (2012). AIDS: A history. *Journal of Gay and Lesbian Mental Health*, 17, 40-63. doi: 10.1080/19359705.2013.740212
- Fraser, S. (2008). Getting out in the “real world”: Young men, queer and theories of gay community. *Journal of Homosexuality*, 55(2), 245-264. doi: 10.1080/00918360802129519
- Foucault, M. (1973). *The birth of the clinic*. London: Tavistock.
- Freitas, A., Kaiser, S., & Hammidi, T. (1996). Communities, commodities, cultural space, and style. *Journal of Homosexuality*, 31(1-2), 83-107. doi: 10.1300/J082v31n01\_06
- Garner, M., Wagner, C., & Kawulich, B. (Ed. 1). (2009). *Teaching Research Methods in the Social Sciences*. Abingdon, UK: Routledge.
- Ghaziani, A. (2011). Post-gay collective identity construction. *Social Problems*, 58, 99-125.

- Gibbert, M., & Ruigrok, W. (2010). The “what” and “how” of case study rigor: Three strategies based on published work. *Organizational Research Methods, 13*(4), 710-737. doi: 10.1177/1094428109351319
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs: Prentice Hall.
- Gordon, A. (2015). End around: HIV discrimination in the post-Amendments Act workplace. *Berkeley Journal of Employment & Labor Law, 36*, 215-60.
- Greene, K., & Banerjee, S. (2006). Disease-related stigma. *Journal of Homosexuality, 50*(4), 185-209. doi: 10.1300/J082v50n04\_08
- Griffin, E. (2012). *A first look at communication theory*. New York, NY: McGraw-Hill.
- Haidt, J. (2012). *The righteous mind : Why good people are divided by politics and religion*. New York, NY: Pantheon Books.
- Halkitis, P., Wolitski, R., & Millet, G. (2013). A holistic approach to addressing HIV infection disparities in gay, bisexual, and other men who have sex with men. *American Psychologist, 68*(4), 261-273. doi: 10.1037/a0032746
- Halpin, S., Rimland, D., Cooper, H., Johnson, T., McInnes, K., Ohl, M., & Perkins, M. (2016). Religion, gender, and HIV: Seeking support and circumventing stigma in the church. *The Gerontologist, 56*(3), 81. doi: 10.1093/geront/gnw162.319
- Hays, D., & Singh, A. (2012). *Qualitative inquiry in clinical and educational settings*. New York, NY: The Guilford Press.
- Herek, G. (2002). Heterosexuals’ attitudes toward bisexual men and women in the



- United States. *Journal of Sex Research*, 39 (4), 264-274. doi:  
10.1080/00224490209552150
- Herek, G., & Capitanio, J. (1999). AIDS stigma and sexual prejudice. *American Behavioral Scientist*, 42, 1126–1143.
- Herek, G., Capitanio, J., & Widaman, K. (2002). HIV-related stigma and knowledge in the United States: Prevalence and trends, 1991–1999. *American Journal of Public Health*, 92(3), 371–377.
- Herek, G., Capitanio, J., & Widaman, K. (2003). Stigma, social risk, and health policy: Public attitudes toward HIV surveillance policies and the social construction of illness. *Health Psychology*, 22(5), 533-40. doi: 10.1037/0278-6133.22.5.533
- Hewstone, M., Rubin, M., & Willis, H. (2002). *Intergroup bias. Annual Review of Psychology*, 53, 575-604. doi: 10.1146/annurev.psych.53.100901.135109
- Hodgson, I. (2007). HIV stigma: A question of morality? *HIV Nursing*, 7(3), 4-6.
- Holland, R., Verplanken, B., Knippenberg, A. (2003). From repetition to conviction: Attitude accessibility as a determinant of attitude certainty. *Journal of Experimental Social Psychology*, 39(6), 594-601. doi: 10.1016/S0022-1031(03)00038-6.
- Homosexuality [Def. 1]. (n.d.). *Merriam-Webster Online*. In Merriam-Webster. Retrieved November 17, 2015, from <http://www.merriam-webster.com/dictionary>
- Hookway, C. (21 June 2016). In Stanford Encyclopedia of Philosophy.  
<https://plato.stanford.edu/cgi-bin/encyclopedia/archinfo.cgi?entry=pragmatism>

- Houtsonen, J., Kylma, J., Korhonen, T., Valimaki, M., & Suominen, T. (2014). University students' perception of people living with HIV/AIDS: discomfort, fear, knowledge and a willingness to care. *College Student Journal*, 48(3), 534. doi: 10.1017/S0021932012000338
- Hubach, R., Dodge, B., Li, M., Schick, V., Herbenick, D., Ramos, W., Cola, T., & Reece, M. (2015). Loneliness, HIV-related stigma, and condom use among a predominately rural sample of HIV-positive men who have sex with men (MSM). *AIDS Education and Prevention*, 27(1), 72-83. doi: 10.1521/aeap.2015.27.1.72
- Huebner, D. (2015). George Herbert Mead. In *International Encyclopedia of the Social & Behavioral Sciences*. (Vol. 14, pp. 831-836). Amsterdam, Netherlands: Elsevier Ltd.
- Hurt, C., Matthews, D., Calabria, M., Green, K., Adimora, A., Golin, C., & Hightow-Weidman, L. (2009). Sex with older partners is associated with primary HIV infection among men who have sex with men in North Carolina. *Journal of Acquired Immune Deficiency Syndromes*, 54 (2), 185-190. doi: 10.1097/QAI.0b013e3181c99114
- Idea. [Def. 4]. (n.d.). Merriam-Webster Online. In Merriam-Webster. Retrieved November 17, 2015, from <http://www.merriam-webster.com/dictionary>.
- Jamieson, J., Harkins, S., & Williams, K. (2010). Need threat can motivate performance after ostracism. *Personality and Social Psychology Bulletin*, 36(5), 690-702. doi: 10.1177/0146167209358882
- Japsen, B. (1994). Better ways to care. *Modern Healthcare*, 24(40), 80-85.

- Joseph, K., Adib, S., Joseph, J., & Tal, M. (1991). Gay identity and risky sexual behavior related to the AIDS threat. *Journal of Community Health, 16*(6), 287-97. doi: 10.1007/BF01324514
- Jussim, L., Nelson, T., Manis, M., & Soffin, S. (1995). Prejudice, stereotypes, and labelling effects: Sources of bias in person perception. *Journal of Personality and Social Psychology, 68*(2), 228-246. doi: 10.1037/0022-3514.68.2.228
- Kadushin, G. (1996). Gay men with AIDS and their families of origin: an analysis of social support. *Health & Social Work, 21*(2), 141-9.
- Kahneman, D. (2011). *Thinking fast and slow*. New York, NY: Farrar, Straus and Giroux.
- Kelly, C., & Lindsay, D. (1993). Remembering mistaken for knowing: Ease of retrieval as a basis for confidence in answers to general knowledge questions. *Journal of Memory and Language, 32* (1993), 1-24. doi: 10.1006/jmla.1993.1001
- Kelly, B., Carpiano, R., Easterbrook, A., Parsons, J. (2013). The personal experience of community among urban gay men, lesbians, and bisexuals: Melting pot or mosaic. *Social Science Quarterly, 95*(3), 682-700. doi: 10.1111/ssqu.12064
- Keogh, P. (2008). Morality, responsibility and risk: Negative gay men's perceived proximity to HIV. *AIDS Care, 20*(5), 576-581. doi: 10.1080/09540120701867123
- Kraus, S. (1995). Attitudes and the prediction of behavior: A meta-analysis of the empirical literature. *Personality and Social Psychology Bulletin, 21*, 58–75.
- Krosnick, J., & Abelson, R. (1992). The case for measuring attitude strength in surveys In J. Tanur (Ed.), *Questions About Questions: Inquiries into the Cognitive Basis of Surveys* (177–195). New York, NY: Russel Sage Foundation.

- L. L. Thurstone. (2017). In Encyclopedia Britannica. Retrieved from  
<http://academic.eb.com.proxy.lib.utk.edu:90/levels/collegiate/article/L-L-Thurstone/72350>
- Lane, H. (1984). Self-differentiation in symbolic interactionism and psychoanalysis. *Social Work* 29(3), 270-74.
- Lewis, N., Bauer, G., Coleman, T., Blot, S., Pugh, D., Fraser, M., Powell, L. (2015). Community cleavages: Gay and bisexual men's perceptions of gay and mainstream community acceptance in the post-AIDS, post-rights era. *Journal of Homosexuality*, 62(9), 1-27. doi: 10.1080/00918369.2015.1037120
- Li, V., Shaw, A., & Olson, K. (2012). Ideas versus labor: What do children value in artistic creation? *Cognition*, 127, 38-45. doi: 10.1016/j.cognition.2012.11.001
- Liamputtong, P. (2013). *Stigma, discrimination and living with HIV/AIDS: A cross-cultural perspective*. Dordrecht, Netherlands: Springer.
- LoBue, V., & Rakison, D. (2013). What we fear most: A developmental advantage for threat-relevant stimuli. *Developmental Review*, 33(4), 285-303. doi:  
<http://dx.doi.org/10.1016/j.dr.2013.07.005>
- Lokko, H., & Stone, V. (2016). Stigma and prejudice in patients with HIV/AIDS In R. Parekh and E. Childs (Eds.), *Stigma and Prejudice: Touchstones in Understanding Diversity in Healthcare* (167-82). New York, NY: Humana Press.
- Luo, R. Understanding the threat of HIV/AIDS. *JAMA*, 288(13), 1649. doi:  
[10.1001/jama.288.13.1649-JMS1002-3-1](http://dx.doi.org/10.1001/jama.288.13.1649-JMS1002-3-1)

- Major, B., and O'Brian, L. (2005). The social psychology of stigma. *Annual Review of Psychology* 56, 393-421. doi: 10.1146/annurev.psych.56.091103.070137
- May, M. (2016). Better to know: The importance of early HIV diagnosis. *The Lancet*, 2, e6-e7. Doi: 10.1016/S2468-2667(16)30038-X
- McConahay, J., & Hough, J. (1976). Symbolic racism. *Journal of Social Issues*, 32(2), 23–45. doi: 0.1111/j.1540-4560.1976.tb02493.x
- McLaren, S. (2015). Gender, age, and place of residence as moderators of the internalized homophobia-depressive symptoms relation among Australian gay men and lesbians. *Journal of Homosexuality*, 62(4), 463-480. doi: 10.1080/00918369.2014.983376
- McNeil, W. (1995). *Appalachian Images in folk and popular culture*. Knoxville, TN: University of Tennessee Press.
- Mead, G. (2015). *Mind, Self, and Society*. Chicago, IL: The University of Chicago Press.
- Merriam, S., & Tisdell, E. (2016). *Qualitative research: A guide to design and implementation*. (4<sup>th</sup> ed.). San Francisco: Jossey-Bass.
- Montgomery, M. (2000). The idea of Appalachian isolation. *Appalachian Heritage*, 28(2), 20-31.
- Mustanski, B., & Newcomb, M. (2013). Older sexual partners may contribute to racial disparities in HIV among young men who have sex with men. *Journal of Adolescent Health*, 52(6), 666-667.

- Meyers, I., & Dean, L. (1998). Internalized homophobia, intimacy and sexual behaviour among gay and bisexual men In G. Herek (Ed.), *Stigma and Sexual Orientation* (160-86). One Thousand Oaks, CA: Sage.
- Nash, K., McGregor, I., & Prentice, K. (2011). Threat and defense as goal regulation: From implicit goal conflict to anxious uncertainty, reactive approach motivation, and ideological extremism. *Journal of Personality and Social Psychology*, 101(6), 1291-1301. doi: 10.1037/a0025944
- Newcomb, M., & Mustanski, B. (2010). Internalized homophobia and internalizing mental health problems: A meta-analytic review. *Clinical Psychology Review*, 30(8), 1019-29. doi: 10.1016/j.cpr.2010.07.003
- Notion [Def. 1]. (n.d.). *Merriam-Webster Online*. In Merriam-Webster. Retrieved November 17, 2015, from <http://www.merriam-webster.com/dictionary>
- Obenchain, K., Abernathy, T., & Lock, R. (2003). 20 ways to build community and empower students. *Intervention in School and Clinic*, 39(1), p.55-60.
- Office of Inspector General. (2016). Counties in Appalachia. Retrieved from <http://www.arc.gov/counties>
- Park-Wyllie, L., Strike, C., Antoniou, T., & Bayoumi, A. (2007). Adverse quality of life consequences of antiretroviral medications. *AIDS Care*, 19(2), 252-7. doi: 10.1080/09540120600774180
- Pattison, E., Hauerwas, S., & Patton, J. (1976). Understanding homosexuality: A symposium. *Pastoral Psychology*, 24(3), 231-44. doi: 10.1007/BF02211714

- Persson, A. (2005) Facing HIV: Body shape change and the (in)visibility of illness. *Medical Anthropology*, 24(3), 237-264. doi: 10.1080/01459740500182683
- Petty, R., & Krosnick, J. (Eds.). (1995). *Attitude strength: Antecedents and consequences*. Hillsdale, NJ: Erlbaum.
- Polit, D., & Beck, C. (2012). *Nursing research: Generating and assessing evidence for nursing practice*. Philadelphia, PA: Lippincott, Williams, and Wilkins.
- Prati, G., Zani, B., Pietrantonio, L., Scudiero, D., Perone, P., Cosmaro, L., Cerioli, A., & Oldrini, M. (2015). The role of knowing someone living with HIV/AIDS and HIV disclosure in the HIV stigma framework: A Bayesian mediation analysis. *Quality & Quantity*, 50(2), 637-51. doi: 10.1007/s11135-015-0168-2
- Preconceived [Def. 1]. (n.d.). *Merriam-Webster Online*. In Merriam-Webster. Retrieved November 17, 2015, from <http://www.merriam-webster.com/dictionary>
- Prejudice. [Def. 2]. (n.d.). *Merriam-Webster Online*. In Merriam-Webster. Retrieved November 17, 2015, from <http://www.merriam-webster.com/dictionary>
- Prevention Access Campaign. (2017). *Risk of sexual transmission of HIV from a person living with HIV who has an undetectable viral load*. [Consensus Statement]. <https://www.preventionaccess.org/consensus>
- Price, V., & Hsu, M. (1992). Public opinion about aids policies the role of misinformation and attitudes toward homosexuals. *Public Opinion Quarterly*, 56, 29-52. doi: 10.1086/269294
- Prinz, J. (2008) *The emotional construction of morals*. Oxford, UK: Oxford University Press.

- Rachman, S. (1977). The conditioning theory of fear acquisition: A critical examination. *Behaviour Research and Therapy*, 15(5), 375-87. doi: 10.1016/0005-7967(77)90041-9
- Raden, D. (1985). Strength related attitude dimensions. *Social Psychology Quarterly*, 48(4), 312-30. doi: 10.1037/0022-3514.69.3.408
- Rand, G., Greene, D., Nowak, A. (2012). Spontaneous giving and calculated greed. *Nature*, 489(7416), 427-30. doi: 10.1038/nature11467
- Rimal, R., Bose, K., Brown, J., Mkandawire, G., Folda, L. (2009). Extending the purview of the risk perception attitude framework: Findings from HIV/AIDS prevention research in Malawi. *Health Communication*, 24(3), 210-218. doi: 10.1080/10410230902804109
- Romer, P. (1993). Idea gaps and objective gaps in economic development. *Journal of Monetary Economics*, 32(3), 543-73. doi: 10.1016/0304-3932(93)90029-F
- Rosenberg, J., Reece, M., Schick, V., Herbenick, D., Novak, D., Van Der Pol, B., & Fortenberry, J. (2012). Condom use during most recent anal intercourse event among a U.S. sample of men who have sex with men. *Journal of Sexual Medicine*, 9(4), 1037-47. doi: 10.1111/j.1743-6109.2012.02650.x
- Rural [Def. 1]. (n.d.). *Merriam-Webster Online*. In Merriam-Webster. Retrieved November 17, 2015, from <http://www.merriam-webster.com/dictionary>
- Ryffel, F., Wirz, D., Kühne, R., & Wirth, W. (2014). How emotional media reports influence attitude formation and change: The interplay of attitude base, attitude



- certainty, and persuasion. *Media Psychology*, 17(4), 397-419. doi:  
10.1080/15213269.2014.933850
- Sadler, G., Lee, H., Lim, R., & Fullerton, J. (2010). Recruiting hard-to-reach united states population sub-groups via adaptations of snowball sampling strategy. *Nurse Health Science*, 12(3), 369-374. doi: 10.1111/j.1442-2018.2010.00541.x
- Sánchez, J., Blas-Lopez, F., Martínez-Patiño, M., and Vilain E. (2015). Masculine consciousness and anti-effeminacy among Latino and white gay men. *Psychology of Men & Masculinity*, 15, 1-10.
- Saran, G. (2011). *Threat perceptions: The policing of dangers from eugenics to the war on terrorism*. Lanham, MD: Lexington Books.
- Schutt, R. (2012). *Investigating the social world: The process and practice of research*. London: Sage Publications.
- Scott, R. (2010). *Removing mountains: Extracting nature and identity in the Appalachian coalfields*. Minneapolis, MN: University of Minnesota Press.
- Scambler, G. (2003). Deviance, sick role and stigma. In G. Scambler (Ed.), *Sociology as applied to medicine* (pp. 192–202). Edinburgh: Saunders.
- Sharma, M., & Tan, D. (2014). HIV pre-exposure prophylaxis. *Canadian Medical Association Journal*, 186(15), E588.
- Shdeki, A. (2004). Narrative survey: A methodology for studying multiple populations. *Narrative Inquiry*, 14(1), 87-111.

- Skitka, L., Bauman, C., & Sargis, E. Moral conviction: Another contributor to attitude strength or something more? *Journal of personality and social psychology*, 88(6), 895-917.
- Southern United States. (2016). In *Encyclopedia Britannica*. Retrieved from <http://www.britannica.com/place/the-South-region>
- Sparks, A., Mishra, S., & Barclay, P. (2013). Fundamental freedoms and the psychology of threat, bargaining, and inequality. *The Behavioral and Brain Sciences*, 36(5), 500-1. doi: 10.1017/S0140525X13000228
- Stipp, H., & Kerr, D. (1989). Determinants of public opinion about AIDS. *Public Opinion Quarterly*, 53, 98-106.
- Sullivan, L. E. (2009). Opinion. In *The SAGE Glossary of the Social and Behavioral Sciences*. (Vol. 3, pp. 360-360). Thousand Oaks, CA: SAGE Publications Ltd. doi: 10.4135/9781412972024.n1771
- Summers, R. L. (1991). Determinants of the acceptance of co-workers with AIDS. *Journal of Social Psychology*, 131(4), 577-578. doi: 10.1080/00224545.1991.9713888
- Tennessee Advisory Commission on Intergovernmental Relations. (2016). Just how rural or urban are Tennessee's 95 counties?: Finding a measure for policy makers. (TACIR no publication no.). Nashville, TN. <https://www.tn.gov/assets/entities/tacir/attachments/2016JustHowRuralOrUrban.pdf>

- Thomas, E., & Magilvy, J. (2011). Qualitative rigor or research validity in qualitative research. *Journal of for Specialists in Pediatric Nursing*, 16(2), 151-5. doi: 10.1177/1094428109351319
- Threat [Def. 1]. (n.d.). *Merriam-Webster Online*. In Merriam-Webster. Retrieved November 17, 2015, from <http://www.merriam-webster.com/dictionary>
- Thurstone, L. (1928). Attitudes can be measured. *American Journal of Sociology*, 33(4), 529-554.
- Thurstone, L. (1933). *Motion pictures and the social attitudes of children*. New York: The MacMillan Company.
- Tobena, A., Marks, I., & Dar, R. (1999). Advantages of bias and prejudice: An exploration of their neurocognitive templates. *Neuroscience and Biobehavioral Reviews*, 23(7), 1047-58. doi: 10.1016/S0149-7634(99)00036-6
- Trauma [Def. 1]. (n.d.). *Merriam-Webster Online*. In Merriam-Webster. Retrieved November 17, 2015, from <http://www.merriam-webster.com/dictionary>
- Tversky, A., & Kahneman, D. (1973). Availability: A heuristic for judging frequency and probability. *Cognitive Psychology*, 5(2), 207-32. doi: 10.1016/0010-0285(73)90033-9
- U.S. Department of Health and Human Services. (2015). What is HIV/AIDS? Retrieved Oct. 13, 2015 from [www.aids.gov](http://www.aids.gov).
- Valocchi, S. (1999). The class-inflected nature of gay identity. *Social Problems*, 46(2), 207-224.

- Waldorf, B. (2006). A continuous Multi-Dimensional Measure of Rurality: Moving Beyond Threshold Measures, presented at American Agricultural Economics Association, Long Beach, 2006, AgEcon Search: Minneapolis, MN.
- Ware, N., Wyatt, M., Tugenberg, T. (2005). Adherence, stereotyping and unequal HIV treatment for active users of illegal drugs. *Social Science & Medicine*, 61(3), 565-76. doi: 10.1016/j.socscimed.2004.12.015
- Waters, J. (2015). Phenomenological research guidelines. Retrieved Oct. 13, 2015 from [www.capilanou.ca](http://www.capilanou.ca).
- Weick, K. (1979). *The social psychology of organizing*. Reading, MA: Addison-Wesley.
- Weller, J. (2013). *Yesterday's people: Life in contemporary Appalachia*. Lexington, KY: The University Press of Kentucky.
- Weston, K. (1991). *Families we choose: Lesbians, gays, kinship*. New York, NY: Columbia University Press.
- Whitley Jr., B., & Kite, M. (1995). Sex differences in attitudes toward homosexuality: A comment on Oliver and Hyde. *Psychological Bulletin*, 117, 146-54.
- Wiley, S., Srinivasan, R., Finke, E., Firnhaber, J., & Shilinsky, A. Positive portrayals of feminist men increase men's solidarity with feminists and collective action intentions. *Psychology of Women Quarterly*, 37(1), 61-71. doi: 10.1177/0361684312464575
- Williams, J. (2008). Symbolic Interactionism. In *The SAGE Encyclopedia of Qualitative Research Methods*. (Vol. 2, pp. 848-53). Thousand Oaks, CA: SAGE.

- Witte, K. (1994). Fear control and danger control: A test of the extended parallel process model (EPPM). *Communication Monographs*, 61(2), 113-134. doi: 10.1080/03637759409376328
- Yin, R. (2003). *Case study research: Design and methods*. (3<sup>rd</sup> ed.). Thousand Oaks, CA: SAGE Publications.
- Yinger, J. (1994). *Ethnicity: Source of strength? Source of conflict?* Albany, NY: State University NY Press.
- Young, E., Koch, P., & Preston, D. (1989). AIDS and homosexuality: A longitudinal study of knowledge and attitude change among rural nurses. *Public Health Nursing*, 6(4), 189-196. doi: 10.1111/j.1525-1446.1989.tb00596.x
- Zagumny, M., & Deckbar, R. (1995). Willingness to work with and sympathy for HIV-positive co-workers: An experimental examination of mode of transmission, concern, and knowledge. *Psychological Reports*, 77(2), 571-576.
- Zambelli, S. (2004). Production of ideas by means of ideas: A Turing machine metaphor. *Metroeconomic*, 55(2-3), 155-79. doi: 10.1111/j.0026-1386.2004.00188.x
- Zaretsky, J. (2016). Escaping preconceived notions: One educator's teaching experience in West Africa. *Adult Learning*, 27(2), 84-6. doi: 10.1177/1045159515594182
- Zhang, J., Zhang, D., & Chock, T. (2014). Effects of HIV/AIDS public service announcements on attitude and behavior: Interplay of perceived threat and self-efficacy. *Social Behavior and Personality: An International Journal*, 42(5), 799-810. doi: 10.2224/sbp.2014.42.5.799

## APPENDICES

# Appendix A: Informed Consent

## Informed Consent Statement

Case Study in Attitude: An HIV Negative Mature Homosexual Appalachian Man on HIV Positive Homosexual Men

### Introduction

You are invited to voluntarily participate in an interview based research study that will further almost non-existent research involving homosexuality, rural Appalachia and HIV. The researcher hopes to uncover the dynamics between HIV positive and negative gay men in rural areas, especially those members having lived through the intense period of the AIDS Crisis. The researcher hopes that better understanding these relationships will delineate ways to make the LGBT+ community more united.

### Information about Participants Involvement in the Study

An interview will be set by your convenience at specified location (Hodges Library on the University of Tennessee campus) asking questions concerning preconceived notions, fears, threats and convictions of HIV as a disease and social issue on a personal and social level and how you adjust to these matters. Prior to this, a short prescreening interview will be conducted to ensure that you meet the study selection criteria. To qualify to participate in this study, you must be:

- \* HIV Negative
- \* Identify as male and homosexual
- \* Between the ages of 52-60
- \* Raised in a southern Appalachian, rural area

If you agree, there will be four one hour interviews scheduled at your convenience within a one-month period to which you must provide transportation. A parking pass will be provided at arrival each time.

This interview will be digitally recorded, then transcribed and analyzed for themes. During this process, you will be known as a pseudonym. This pseudonym will be the only identifying information attached to your answers.

It may be your inclination to cite specific persons living with HIV. Be aware that this is strictly unneeded and unwanted information. The questions being asked relate to a general attitude of HIV positive people. When talking about experiences, please do not explicitly cite acquaintances.

IRB NUMBER: UTK IRB-16-03297-FB  
IRB APPROVAL DATE: 02/06/2017  
IRB EXPIRATION DATE: 01/18/2018

## **Risks**

With a face-to-face interview procedure, there is always a risk of breach of confidentiality. Maintaining the confidentiality of your identity is of the utmost importance to the researcher and advising professor. To ensure your confidentiality, the answers you provide in this study will never be attached to your name or any other potentially identifiable information.

There is the risk that through talking about experiences on the aforementioned subjects, triggers will be set. If this occurs, the researcher or anyone associated with the study, especially the University of Tennessee, are not liable for any mental distress or behavior associated with it.

## **Benefits**

There will be no direct benefits for you as a participant.

## **Confidentiality**

The nature of this project being a case study, you will be the only contributor and basis of research.

Your answers will be recorded on a digital recording device. This audio will later be transcribed. Any private information, especially names, cities or any other possible identifiers, will be given a pseudonym that will in no way link yourself or anyone else to this study. The recording will then be destroyed.

One advising professor that will later confer the researcher's thesis, for which this study is being done, is the only person that will have access to the pseudonym-protected transcriptions.

Any violation of this agreement of anonymity would constitute a serious breach of ethical standards, and, with my advisors many combined years of principled research standards, we pledge not to do so.

The final thesis, to which your participation will contribute, will be shared with All Out Knoxville.

## **Contact**

If you have questions at any time about the study or the procedures, (or you experience adverse effects as a result of participating in this study) you may contact the researcher,

IRB NUMBER: UTK IRB-16-03297-FB  
IRB APPROVAL DATE: 02/06/2017  
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## Appendix B: Recruitment Agreement



21 December, 2016

University of Tennessee Institutional Review Board  
1534 White Ave  
Knoxville, TN 37996-1529

Dear Ms. Gilrane and Members of the Institutional Review Board:

Please note that I have agreed to distribute the following e-mail titled "SENSITIVE Info: Research Participant Needed" exactly as it is written to possible qualifying members of [REDACTED] for Jacob Nelson, Masters of Agricultural Leadership, Education and Communication candidate, for Mr. Nelson's thesis titled *Case Study in Attitude: An HIV Negative Mature Homosexual Appalachian Man on HIV Positive Homosexual Men* upon the approval of your board. Mr. Nelson will not in any way have access to a contact list or know, unless they themselves express interest through the given contact for Mr. Nelson, to whom this e-mail is distributed.

Mr. Nelson has also agreed to provide to my office a copy of the University of Tennessee approved IRB-approved, stamped consent document before he begins this research, and he will also provide a copy of the final thesis.

If there are any questions, please contact my office.

The recruitment e-mail will read as follows:

A University of Tennessee master's student is searching for a participant to complete a study. The research or researcher is in no way affiliated with [REDACTED] You may qualify to assist. Attached is an informational flyer.

Attachment:

Potential Research Participant,

Thank you for taking the time to read this e-mail. I write to you in hopes that you will contribute to a study that will further almost non-existent research involving homosexuality, rural Appalachia and HIV titled Case Study in Attitude: An HIV Negative Mature Homosexual Appalachian Man on HIV Positive Homosexual Men.

Four one hour interviews within a month will be set by your convenience at Hodges Library on the University of Tennessee campus (parking is provided; you will be responsible for transportation) asking questions concerning preconceived notions, fears, threats and convictions of HIV as a disease and social issue on a personal and social level. Prior to this, a short prescreening interview will be conducted to ensure that you meet the study selection criteria. To qualify as a participant, you must be:

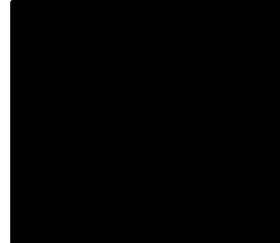
- \* HIV Negative
- \* Identify as male and homosexual
- \* Between the ages of 52-60
- \* Raised in a Southern Appalachian, rural area

This interview will be digitally recorded, then transcribed and analyzed for themes. During this process, you will be known as a pseudonym. This pseudonym will be the only identifying information attached to your answers.

It may be your inclination to cite specific persons living with HIV. Be aware that this is strictly unneeded and unwanted information. The questions being asked relate to a general attitude of HIV positive people. When talking about experiences, please do not explicitly cite acquaintances.

I give many thanks for your considering an invaluable contribution.

Jake L. Nelson  
Master's candidate  
Agricultural Leadership, Education and Communication



\*Certain sensitive information has been redacted to protect the researcher and the recruiting organization

## Appendix C: Interview Transcripts

### *Interview I: Pre-Interview and Preconceived Notions*

*Firstly, I want to make sure that you are HIV negative.*

Yes.

*That you identify as male and homosexual.*

Yes.

*And, that you are between the ages of 52 and 60.*

54

*Alright, what county were you raised in?*

County A

*How many years did you live there from birth?*

19 years

*Would you consider this a rural or suburban area?*

Rural, certainly the part that I lived in. We were 30 minutes from anything, lots of farms, everyone travelled for work if they were not farmers; lots of tobacco fields, corn fields, and tomato fields. Being secluded like that gave way to a lot of ignorance. The area I lived in was very conservative. But, I was raised with a very liberal family.

*May I ask what your family did for a living?*

We had a huge farm. We had tobacco, cattle; dairy.

*You said your family was liberal. Will you discuss that statement further?*

Both sets of grandparents were European. They came from Germany; so, they were more liberal. The Europeans are more free thinkers than Americans. That is true today.

(laughter) We were raised to let people live. Their life was their business. Their circumstances were their business. Just, raised differently than most (pause) in the area.

There, it was a lot of church and Jesus (pause and laughter) for the other families in the area.

*May I ask if your family was religious?*

(long pause) Uh, practicing Methodists. And, you know, the practicing Methodists are like the practicing, (pause) yeah. But, no one said I was comfortable with the first part of my life. I was married [to a woman] and in the closet for almost 20 years.

*Let's move on to preconceived notions. Will you describe the moment and/or process surrounding first learning what HIV was?*

Everyone was scared to death; because, there were so many different theories. You had the one about men having relations with monkeys, and that is how it all got started. That it could only be a homosexual disease. It was a death sentence, no question about that at that time. (serious look and thud like tone) It. Was. A. Death. Sentence. The drugs killed you, not the disease. At the height of it, I was in City A in school. It was almost like everyone thought it cannot happen to me, even though everyone was scared to death of it. It was still the age of gloryholes, bathhouses, anonymous sex, and unprotected sex. That was not underground. That was known. The gays were not buying condoms at that time. That was probably more associated with preventing pregnancy. Even though the fear was there, they were not going to let it change their lifestyle. That was the 80s and the early 80s.

*Did homosexual people assume HIV/AIDS was sexually transmitted?*

(emphatic tone) Yes. But, there were so many misconceptions in other ways that it could be transmitted too: by shaking hands, eating from utensils and plates that other people had eaten off of, casual contact. You know, I went to school with a kid who had it, and his parents would not even let him back in the house when he went to visit. (long pause) scary and confusing time.

*Do you remember a moment when you first had cognizance of the disease, especially as it affected the gay community?*

Well, when the stories first started coming out, that is all they associated with it. So, you knew from day one that it was. That is how I found out about it, media. And, the media was so ignorant about it at that time, there was so much misleading information. And, of course with no drugs at the time, and the drugs they did have at the time being so toxic. They burned the guys up from the inside trying to kill the virus. You had people who had unprotected sex, and go home, and mix Clorox and water (emphatic tone), and drink it thinking that that would kill [the virus]. Because at the time, it was a big thing that Clorox would kill the active virus if it was on a surface or something. So, they were dosing themselves with Clorox and water, drinking it. And, you know, cocaine was a big thing then too. So, they were shooting up; passing needles around.

*In the early 80s, may I ask if you were living as homosexual?*

It depended on what state I was in. (laughter) The two lives never clashed. It was two people living in one body. And, it was probably, being raised the way I was raised, it was probably more inner shame than it was of the family and external. It was more societal. I knew my family would love me regardless. And, we were really, as I said before, raised with the attitude that what you did with your life was your business. I was 28 when I got married. I was actively dating women and men at the time.

*Obviously, your knowledge about HIV has changed a lot since first learning what the disease was. What events lead to this knowledge gathering?*

Well, even today, you have to educate yourself on it. But, the internet has been freely available, there are books that I read, the media got much better; just researching it. I took that upon myself even in the early days. Just in the early ages, there was not much out there. And, what was out there, one article would totally contradict the other one; so, there was so much misleading information out there, you really did not know what to believe. You were in a constant state of confusion. And, I really think up until the past 15 years, that has been the state that most people have been in about the subject. There has been so much contradictory information. I think they know what they are doing now. I do not know if they have a handle on the spread, but I think they have had a great deal of success with the disease. From everything I read, the medications are wonderful. I do know people who are positive. There are still side effects. They do damage to other parts of your body to where you have to take secondary medications to take care of that. But, it



is not a death sentence like it was. To have been in a gay world like City A was, in the early 80s, (pause with tears seemingly appearing) to know what the guys went through was (emphatic tone) very, very hard. They were treated as lepers (pause) even in their own community, the community that should have embraced them and supported them. Probably about the time that I was finishing school, the fall of '81, I went to City A, I went to school there, and finished in '85. I stayed for 2 years. So, by the end of '87, a lot of the guys who were diagnosed with AIDS, they knew there was no hope, that it was such a cruel, pitiful; lonely death. They chose suicide. It was bad.

*How did you react to people when you knew they were HIV positive back then?*

Gratefully, I was intelligent enough to sort through the bad information, and realize that social contact, casual contact, you were not going to get it. So, I have never shunned away from someone who is positive. That has not changed. I have always been accepting.

Will you talk about if social perceptions of the disease have changed? And, if so, how?

It has changed a great deal, but I think a lot, especially in this area, the ignorance is abundant. In this area, I think you can divide it into categories. You have the people it just totally does not affect. They do not even know anyone gay, or they would not associate with anyone gay, and certainly not anyone HIV positive. Therefore, it is not a subject they care anything to know anything about. If they do encounter it, they still go

back to the old beliefs, the old stereotypes. That is just how their brains organize the information. Then you have the whole too much Jesus and too much church theory: HIV is a plague sent from God which is probably the most ignorant. But, the majority people around here just do not think it affects them; so, why worry? Why try to get the information? Because, the information is out there, but it is not readily available. You have to look for it. We are not buried in the closet anymore. It is still a stigma in places in this country to be gay, in the rural areas. I have heard my husband and I referred to as the “gay boys.” Honestly, it does not bother me (laughter); because, people do not mean anything by it. But we are made token. But, we are accepted like that. But, you wonder if one of us was HIV/AIDS positive, how would those people feel then? So, it is alright to be gay, but if you are HIV positive, I do not think some would be accepting. I know we lost friends when gay marriage passed. Because, then, it became an issue. But, I am sort of like that with everything: this is me, you take it or leave it. But, this coming out of the closet movement is why people are able, now, to be as accepting as they are. You go back 40 years ago and into the 80s, if people did not think they knew anyone gay, they definitely did not think they knew anyone with HIV. But, in County B, statistically more people with HIV, it is drug related. And, there are a lot of them. It is still hidden and buried. Most of the people, I would say their families do not know. Their contacts, their friends, they do not know. I do not know if they think that it cannot happen to them and that it is still a gay disease. I do not know.

*I have heard you say over and over that people just do not think HIV will happen to them.*

I mean, how many guys do you know that intentionally do not use condoms. And if you are sexually passive, the risk is so much greater. That attitude is still so prevalent, though.

***Interview II: Fears***

*When you think about HIV as a physical disease, what fears do you feel for yourself?*

The fear has decreased over the years, but there is still caution. If I was not in a relationship, I do not know. But, there is definitely fear there. At my age, it is still there. It is something I would not want to deal with now in my life, just the side effects of the medication and the fact that I am a diabetic. There is a lot of protected sex. Gosh, I do not know. I had never really thought about that actually. I am in a relationship. We are both clean. And, if there were to be extra-play, there is a lot of research that goes into that person.

*What about your fear for others?*

Our country's healthcare system is so messed up. When it comes to a life-threatening disease like this, and I am not just talking about gay people, I am talking about anyone who has it, still the medication is around \$10,000 a month. If the person makes a certain amount of money, they qualify for nothing. There are great programs out there like the Program A that helps people with HIV, providing medical care and medications. That is

still income based. Then you go back to the people who do not think it can happen to them. I do not think people get tested enough. If I was living in the '80s at the age I am now, I would be at the clinic every week, and asking if they made sure to draw enough blood to get a good test. The fears not as bad as it is now; because, I know there are options out there. I know you do not have to go home and drink Clorox and water.

*Do you communicate these concerns to friends?*

We do not have many gay friends. There are a lot of things in the gay world that I do not abide. The friends we do have that are gay are much younger. They could be my children. So, I am very open to them. I encourage them to use protection, get tested, or get on medication.

*How do you feel about the pre-exposure prophylaxis?*

A lot of people are betting their lives on it; so, I hope it is as good as what I have read. I think it is a great step forward.

*Socially, you said you have always been open toward people, even if they were positive.*

*What fears do you experience, if any, being around people who live with the disease?*

My mind never goes to that place. I have no fear of the person. I respect the disease.

(long pause) If you were HIV positive, I would have no fear of taking care of you or anyone else. I mean, we know how you get it and we know how you do not get it. But, I realize I am not the norm for this area.

*In the last section, you said that your family and doing research helped you learning about the disease. Are there any other factors that led you away from being fearful toward people living with HIV?*

Living through what I lived through in the 80s in the area that I lived, But, once you had the facts, it is like a loaded gun versus an unloaded gun. One can kill you and the other cannot hurt you. There was a lot going out back then, a lot of sex in bars and a lot of the bars had cocaine rooms. It was nothing to go home with someone whose name you did not know until the next morning, or two or three people for that matter. The leather scene was wonderful back then. The 80s were, for gays, what the sixties were for the hippies. I think a lot of people thought they were going to die. So, they wanted to live while they were here. The gays were still outcasts at that time. I honestly think the majority of homosexual people, especially in a metropolitan place like City A, it was a death sentence either way; because, there were so many misconceptions about you how you did get it. And, I think sometimes people use drugs to escape. But they were recreation then, too. They were something you did on the weekend. Cocaine was used during sexual encounters. Your sense is heightened on it.

### ***Interview III: Threat***

*In the last interview, you said you respected the disease. What threatens you about it?*

You know, there are still cases of HIV sweeping through the blood supply at hospitals. I do not know if I could get a blood transfusion. There are still cases where it slips through. Unprotected sex for anyone, homosexual or heterosexual, there is still risk there; so, you have to respect the disease. Unless you are with your partner 24 hours a day, 7 days a week, you do not know what they could be doing; so, it is your responsibility to take care of your life. Period.

*Are there entities that threaten people living with HIV?*

I think there is still discrimination across the board. Businesses have just gotten smarter about how they do it. If you went into your employer tomorrow, and told them that you were HIV positive, if they wanted to get rid of you, they would try to do it legally. They would find every little infraction on your record to use it against you. In the 80s, they did not care if it was discrimination. Goodbye. We do not need you. A lot of that is still there. They just cover themselves before they do it. You never truly know who you are dealing with, even in your own family. Until the hammer hits the nail on the head, you do not know. Period.

*How do you protect yourself from perceived threats to do with HIV?*

Professionally, I have been self-employed since I was 23. I honestly do not think I have been discriminated against in business. [Field of work] is open to homosexuals, but it also may be that I was good at what I did. They called me, I did not call them. Sexually, I am very safe, which I have mentioned. And, socially, I really do not see it as a threat with other people that are positive.

***Interview IV: Convictions***

*When you consider HIV as a health issue, what beliefs do you hold deeply?*

You want me to sound crazy, do you not? (laughter) The only conspiracy theory that I believe is that I think HIV was invented in lab and meant as germ warfare. It was tested on undesirables, the homosexuals, and it got out of control. That is my personal belief. Now, being an educated man, I know how stupid that sounds. But, this spread really fast all over the world. When this first came out, the mainstay explanation the media and medical profession gave was that HIV started in Africa. Men were copulating with monkeys. But how many could have been doing that? Take from the time it started to the spread of it, ask yourself, how could this have happened so quickly. How many men who acquired this disease from monkeys were also having sex with men from other countries. It does not click. And that was the only explanation they were giving.

*What lead you to believe this?*

Anyone that knows me will tell you I am not quick to judge. I am usually a deliberator. I am a thinker. It was the only theory they had. We heard it every day. We heard that for years and years and years. It is the mathematics of it.

*What convictions do you have toward the disease as a social phenomenon?*

Your mind, your body; your sexual life, you do what you want to do. I am not going to judge you unless it hurts someone else. Do what you wish. I am still passionate about people not getting the disease, though. I would not want anyone getting the disease. (emphatic tone) No one. Even if it is not a death sentence now, it is still life changing. I mean I do not mean to mentor anyone. I do not want to warp anyone (laughter), but I encourage people to educate themselves.

*Have your convictions concerning HIV ever caused you to modify your behavior?*

In the early 80s, I continued the same behavior, sexually, that I had. When I got married, yes. I was lots more cautious. And, now, still, but in a different way; because, I have different information about HIV. I have the belief system that you are born this way. You are not conditioned to be this way. Therefore, a dog is a dog. But, if I would not have been unhappy sexually in my first marriage to a woman, I would probably still be



married, in the closet and having affairs with men. That is generational, that is societal. But, also, I think there are a lot of young gay men, through the indoctrination of the church and their family, they would do the same now. But, then it was still a different time. We were all big sissies if you gay back then. They just knew every one of us had a party dress and high heels somewhere in our closet. Now, I think it is about being open and who you are. I felt validated when gay marriage passes, free. Had a little attitude. I totally believe in the separation of church and state. I do not believe that anyone's personal beliefs or religions should dictate who I love and want to make a life with. It is no one's business. We were sitting at home on the sofa watching the evening news when we found out. I mean I have known that I am gay since I was thirteen. I always knew though. That was the first time that was acted on. It felt natural. And, I had an uncle that was gay. It was never discussed. I knew he was gay. Everyone did. He never told me that. He was a bachelor his entire life. It was just a different time. My family did not love him any less. They did not talk about it. My mother had a wonderful "flamer" as a friend when I was growing up. To use the phrase, "queer as a two-dollar gold piece." You knew it the minute his feet hit the floor. He was very accepted by my family. I have two cousins that are gay. It was my inner shame.

*What do you think your uncle's experience was like?*

Horrible. Sad. What do you do when you live 30 minutes from civilization on a farm, and there may have been others around. But, I do not know. But, we have a friend that is

married now. I cannot imagine in my lifetime going back and not being who I am. So, you go back to the 60s, to the 70s, and in the 80s we were coming out in rebellion. But before that it was a hidden life. It was very sad, very sad. In some areas, you still have to hide who you are. Our friend is 22, and married to a woman. I feel sorry for him. I have not figured out how his wife doesn't know. But, I never hated myself for being this way. I never felt shame. But, I felt duty. I am the only male grandchild. I did not have son though. I have daughters. I felt it was expected. Now, I would not change it; because, I have two wonderful daughters. But, when I look back, if there is anything I do not like, I do not resent anyone. I have no one to blame, but myself. When I hit forty, I had very successful business, my daughters were graduating, but I had inner loneliness. I think I made a conscious decision that I was not going to care what anyone else thought anymore. I was 40, and I did not know if I would see 80. But if I did, the last 40 were going to be on my terms.

## Appendix D: Acceptance Letter

THE UNIVERSITY of TENNESSEE   
KNOXVILLE

Office of Research & Engagement  
INSTITUTIONAL REVIEW BOARD (IRB)

1534 White Ave.  
Knoxville, TN 37996-1529  
865-974-7697  
fax 865-974-7400

February 06, 2017

Jacob Lee Nelson,  
UTK - College of Communication and Inf - College of Communication and Information

**Re: UTK IRB-16-03297-FB**

**Study Title:** Copy of Whispering Hills: Attitudes of Mature Rural Appalachian HIV Negative Homosexual Men on Their Positive Counterparts

Dear Jacob Nelson:

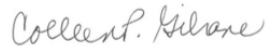
The IRB has received your written acceptance of and/or response to the provisos outlined in our previous correspondence concerning the application for the above referenced project, reviewed by the IRB at its 1/19/2017 meeting. The IRB has reviewed these materials and determined that they comply with proper consideration for the rights and welfare of human subjects and the regulatory requirements for the protection of human subjects.

Therefore, this letter constitutes full approval by the IRB of your application (version 1.1) and the accompanying Flyer v 2.0, and Case Study in Attitude Informed Consent v 1.0, dated and stamped IRB approved. Approval of this study will be valid from 02/06/2017 to 01/18/2018.

In the event that subjects are to be recruited using solicitation materials, such as brochures, posters, web-based advertisements, etc., these materials must receive prior approval of the IRB. Any revisions in the approved application must also be submitted to and approved by the IRB prior to implementation. In addition, you are responsible for reporting any unanticipated serious adverse events or other problems involving risks to subjects or others in the manner required by the local IRB policy.

Finally, **re-approval** of your project is required by the IRB in accord with the conditions specified above. You may not continue the research study beyond the time or other limits specified unless you obtain prior written approval of the IRB.

Sincerely,



**Colleen P. Gilrane, Ph.D.**  
Chair

## VITA

Jacob L. Nelson was raised in La Follette, Tennessee by his parents, Ernie and Janie Nelson. He has one sister and brother-in-law, Tiffany and Lynn Gwin. Nelson is a proud graduate of Campbell County, Tennessee public schools. In 2014, Nelson graduated from the University of Tennessee, Knoxville with a Bachelors of Communications Studies and the distinctions Summa Cum Laude, Lambda Pi Eta, Sigma Alpha Lambda, and as a National Collegiate Scholar. His senior capstone project investigated, through rhetorical feminist theory, how Southern women derived power. Nelson immediately entered graduate school at the University of Tennessee, Knoxville, and chose the Agriculture Leadership, Education, and Communication major in 2015. Nelson graduated with a Master of Science in this with a concentration on Leadership and focus on Public Relations. Nelson plans spending his career supporting historically marginalized groups and all individuals promoting, though creativity, the power of self.