Social Workers' Perceptions of Working with People who have HIV/AIDS

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Abstract

This article presents the results of a cross-sectional online survey sent to a national sample of licensed social workers to examine their attitudes toward individuals living with HIV/AIDS. The survey included the AIDS Attitude Scale (Froman, Owen & Daisy, 1992), the HIV Knowledge Questionnaire-18 (Carey & Schroder, 2002), and the Modern Homonegativity Scale (Morrison & Morrison, 2002). Factors related to education, training, and other personal characteristics are explored. In this sample, 45% of the social workers indicated that more education and training would be beneficial to them in their current position, and greater HIV knowledge was associated with more positive attitudes toward people living with HIV/AIDS. Additionally, 57% of those surveyed indicated knowing someone personally who has HIV/AIDS, and demonstrated overall higher scores on empathy, and lower scores on avoidance. Those social workers who had higher avoidance of people living with HIV/AIDS were also found to be higher in homonegativity. The findings of this study add to the body of knowledge regarding social work attitudes, and provide further insight into an area with little existing data. The authors propose further research to identify causes of attitudes, potential gender and cultural differences, and the impact of the National Association of Social Workers Code of Ethics on social workers' attitudes.

Keywords: attitudes, licensed social workers, HIV and AIDS

Introduction

Social work, founded on a set of core values, requires that all practitioners abide by the National Association of Social Workers (NASW) *Code of Ethics* in their practice. This document guides professionals regarding service, social justice, dignity and worth of the individual, human relationships, and integrity (NASW, 2008). Social workers must be aware of their own attitudes related to their clients (Heydt & Sherman, 2005), as social worker behavior, if influenced by negative attitudes, can have detrimental effects. This is important when working with stigmatized and marginalized populations, such as individuals living with human immunodeficiency virus/ acquired immune deficiency syndrome (HIV/AIDS). These individuals may feel less empowered to self-advocate and thus may rely more on social workers. Research has identified better outcomes when provider attitudes are positive (Oles, Black & Cramer, 1999), while service provision can be inadequate if affected by biases and negative attitudes held by social work professionals (Chaiklin, 2011; Hayes & Erkis, 2000; Oles, Black & Cramer, 1999; Swank & Raiz, 2007).

Review of Literature

The Centers for Disease Control and Prevention (CDC) first identified HIV/AIDS in the United States in the early 1980's (CDC, 2013). Originally referred to as Gay-Related Immune Deficiency (GRID) or the "gay plague," the disease was linked solely to the gay community for

nearly a decade (Fee & Krieger, 1993; Kitzinger & Peel, 2005). This name was later discarded when cases of HIV/AIDS appeared in hemophiliacs, intravenous (IV) drug users, and other individuals who did not identify as homosexual (Institute of Medicine Staff, 1986). Despite the recognition that HIV/AIDS does not solely affect homosexuals, and as recently as 2013, gay and bisexual men represented just slightly over half of the individuals diagnosed with HIV/AIDS in the United States (55%) (CDC, 2015), a link between bias against LGBT individuals and individuals living with HIV/AIDS still exists (Kitzinger & Peel, 2005). While there has been a decrease in media attention since the late 1980's (Brodie, Hamel, Brady, Kates, & Altman, 2004; Stevens & Hull, 2013), HIV/AIDS continues to be a health care concern throughout the United States. The CDC (2013) report that, in 2012, approximately 1,194,039 people were living with HIV/AIDS in the United States. New infections continue at a rate of approximately 50,000 individuals per year (CDC, 2013). As medical advances are made, especially in antiretroviral therapies, the lifespan of individuals living with HIV/AIDS has increased (Cahill & Valadez, 2013; CDC, 2013; Emlet, 2007) and the number of individuals with HIV/AIDS is growing. This increase will lead to more social workers encountering individuals with HIV/AIDS in various professional settings. Individuals with HIV/AIDS continue to experience stigma and many are fearful that helping professionals will be biased against them (Emlet, 2007; Kinsler, Wong, Sayles, Davis, & Cunnigham, 2007). The NASW *Code of Ethics* mandates that all social workers must advocate on behalf of oppressed individuals, such as individuals with HIV/AIDS, in order to make information, services, and resources readily available (NASW, 2008). If social workers' personal beliefs interfere with their ability to adhere to the *Code of Ethics*, service provision is impacted (DiFranks, 2008).

Research indicates that social workers' negative attitudes regarding providing care to a person with HIV/AIDS may be related to lack of education regarding the disease (Riley & Greene, 1993; Shi et al., 1993) and how the client became infected with the HIV virus (Dooley, 1995; Hayes & Erkis, 2000; Olivier & Dykeman, 2003; Owens, 1995). Dooley (1995) reports that if a person contracted the disease through what is considered no fault of their own, such as a blood transfusion or other medical procedure, that person received higher levels of empathy than a person who contracted the disease engaging in high-risk behaviors such as IV-drug use or sexual encounters. Hayes and Erkis (2000) report similar results specific to social workers. They find that if an individual contracted HIV/AIDS as a result of high risk behaviors, social workers respond with less empathy than if the client obtained the disease as a result of a medical procedure. Overall, individuals within the helping professions are found to display lower levels of empathy, and higher levels of blame on individuals who are homosexual and contracted HIV/AIDS as a result of high risk sexual behavior (Hayes & Erkis, 2000; Seacat, Hirschman, & Mickelson, 2007).

The goals of this study are to (1) survey social workers regarding their attitudes towards working with people with HIV/AIDS, and to (2) explore the personal, professional, and educational factors that may contribute to those attitudes.

Method

Study Design and Procedure

This study uses a cross-sectional research design to examine the attitudes of licensed social workers toward people with HIV/AIDS. The study was IRB approved as exempt. A random national sample of 2,054 licensed social workers was sent an email invitation and a link to an online survey through Survey Monkey, with a follow-up email and link two weeks later. Sample selection and email administration were performed by RediData, a company that provides email lists and transmission services to connect consumers to a desired audience. Out of the 2,054 potential respondents, RediData reports that there were 885 (502 first email, 383 follow-up) unique opens of the emails and that the link embedded in the email experienced 194 (139 first email, 55 follow-up) unique clicks between the two requests. Responses were received from 166 licensed social workers (8.08%). Participants who self-reported retirement or non-direct practice are excluded, resulting in an analysis sample of 119.

Measures

AIDS Attitude Scale (AAS). This 21 item measure consists of two subscales- the avoidance subscale (14 item) and the empathy subscale (7 item) and utilizes a Likert-type scale (possible item score range= 1-6). The scores for each subscale are determined by calculating a mean score of items on each subscale. A high score on the avoidance subscale (possible score range= 14-84) indicates a high level of avoidance of individuals living with HIV/AIDS. A high score on the empathy subscale (possible score range= 7-42) indicates a high level of empathy for individuals living with HIV/AIDS (Froman, Owen, & Daisy, 1992; Froman & Owen, 1997).

The AAS has been used with professional samples and is reported as valid and reliable (Froman, Owen, & Daisy, 1992; Rondahl, Innala, & Carlsson, 2003). Internal consistency reliability estimates are reported as .80-.83 for empathy and .78-.87 for avoidance (Froman & Owen, 1997;Rondahl, Innala, & Carlsson, 2003).

HIV Knowledge Questionnaire (HIV-KQ-18). On this measure there are three possible answers for each of the 18 items- True, False, and I Don't Know. A high score on the HIV-KQ-18 indicates a higher level of knowledge about HIV/AIDS than a low score (range= 0-18) (Carey & Schroder, 2002). Internal consistency of the HIV-KQ-45, the measure that the HIV-KQ-18 has been adapted from, is .91 and the measure is stable over one, two, and twelve weeks (Carey & Schroder, 2002). The HIV-KQ-18 is sensitive to change, and shows test-retest correlation at three weeks (r= .86 to .93) and twelve weeks (r= .76 to .94) (Carey et al., 1997; Carey et al., 2000; Carey & Schroder, 2002). Internal consistency ranges from α= .75 to α= .89 (Carey & Schroder, 2002). This is an older measure, however it is the most psychometrically sound measure of HIV knowledge currently available (Hughes & Admiraal, 2012).

Modern Homonegativity Scale (MHS-G and MHS-L). This scale includes 22 Likert-type items, 10 focusing on homonegativity towards gay men (MHS-G), 10 focusing on homonegativity towards lesbians (MHS-L), and 2 shared items (Morrison & Morrison, 2002). On the MHS-G and the MHS-L, the possible range of scores is 12 to 72, with a higher score indicating a higher level of homonegativity toward gay men (MHS-G) and/or lesbians (MHS-L), respectively. Morrison, Morrison, & Franklin (2009) report internal consistency reliability coefficients between .85 and .91 for the MHS-G and MHS-L. Stigma surrounding HIV/AIDS and homophobic attitudes have been linked since the emergence of HIV/AIDS in the United States in the 1980's (Fee & Krieger, 1993; Kitzinger & Peel, 2005), and remain associated due to

the prevalence of new infections in the homosexual community (CDC, 2015). This scale was included to examine whether a social worker's attitudes people living with HIV/AIDS is associated with their attitudes toward gays and lesbians.

Short Form of the Marlowe-Crowne Social Desirability Scale (MCSDS). This scale consists of 10 items on a Likert-type scale. A high score on this measure indicates a high level of interest in giving answers that are socially desirable (Strahan & Gerbasi, 1972). This measure has been tested for reliability with internal consistency reliability coefficients at .70, .66, .61, and .59 when tested on college and university students (Strahan & Gerbasi, 1972). When used as a part of an internet survey, the MCSDS had internal consistency reliability coefficients between .59 and .75 (Vesteinsdottir, Reips, Joinson, & Thorsdottir, 2015).

Analysis

SPSS 22 was used to generate descriptive statistics and frequencies to describe the sample and the results of the analysis. Correlations were used to assess associations between continuous variables, such as scores on the AAS, the HIVKQ 18, and the MHS. Independent t-tests were used to assess for associations between dichotomous variables, such as if respondent had training in related areas, a personal relationship with an individual with HIV/AIDS, or identified need for more HIV/AIDS education, and continuous variables, such as the scale scores. One-way independent ANOVAs were used to assess for associations between categorical variables, such as education level, region, and clinical specialty, and continuous variables, such as the scale scores. In this study, outliers are defined as scores that were three or more standard deviations above or below the mean (Howell, 1998). Correlations between scale scores and the MCSDS were calculated to examine social desirability bias.

Results

Demographics. The respondents (N= 119) are predominantly white, married, heterosexual, females with master's degrees. See Table 1 for a summary of demographic information. Respondents range in age from 28-75 (*M*=48.81), with professional experience ranging from 4-50 years (*M*=19.17). The most common specialties of practice are Health/Medical (24.2%), Serious Mental Illness (22.5%), and Advanced Generalist (18.3%). Respondents' geographic location is divided using the United States Census Bureau (2010) regions. The largest number of respondents are from the Midwest (37.3%), followed by the South (30.4%) and West (28.4%), with the smallest group from the Northeast region (4.0%) of the United States. There were no significant relationships between demographic categories and scale scores. See Table 2 for a summary of scale scores.

Attitudes toward Caring for People with HIV/AIDS. Participants score low (*M*= 1.33, *SD*= .44) on the avoidance subscale and high (*M*= 5.52 *SD*= .6) on the empathy subscale. Despite these positive outcomes, there are a few outliers among the group of licensed social workers that score higher on the avoidance subscale and lower on the empathy subscale than anticipated. There are two outliers (scores of 2.86 and 3.29) on the avoidance scale (identified as scores above 2.65). There is one outlier (score of 3) on the empathy scale (identified as scores below 3.72). Knowledge about HIV/AIDS is a statistically significant predictor of a decreased

Table 1

Summary of Demographic Information of Survey Respondents (N=119)

Variable	N	Percentage	Valid Percentage
Gender			
Female	85	51.2	81.7
Male	19	11.4	18.3
Race*			
Caucasian	94	56.6	89.5
Black/African American	9	5.4	8.6
Multiracial	2	1.2	1.9
Sexual Orientation			
Heterosexual or straight	91	54.8	87.5
Gay or lesbian	9	5.4	8.7
Bisexual	3	1.8	2.9
Other	1	.6	1.0
Relationship Status			
Married	62	37.3	59.0
Single	16	9.6	15.2
Long-term committed/Partnered	12	7.2	11.4
Divorced	10	10	9.5
Separated	4	2.4	3.8
Widowed	1	.6	1.0
Highest Degree Achieved			
Master's	107	64.5	89.9
Bachelor's	10	6.0	8.4
Doctoral	2	1.2	1.7
Religion*			
Christian	42	25.3	40.0
Spiritual	23	13.9	21.9
Roman Catholic	12	7.2	11.4
Atheist	7	4.2	6.7
Agnostic	6	3.6	5.7
Jewish	5	3.0	4.8
Other	4	2.4	3.8
Buddhist	3	1.8	2.9
Don't give religious things much thought	3	1.8	2.9
Political Affiliation			
Democratic Party	74	44.6	73.3
Republican Party	13	7.8	12.9
Other	4	8.4	13.9

*Categories within variables that are not represented by sample are not shown in table.

score on the avoidance subscale of the AAS (r = -.208, p = .05). Those social workers who are more knowledgeable about HIV/AIDS are less likely to have negative attitudes toward people living with HIV/AIDS.

There are statistically significant positive associations between the avoidance subscale of the AAS and the MHS-L (r = .451, p = <.001) and the MHS-G (r = .440, p = <.001). Individuals who scored higher on the AAS avoidance subscale (high avoidance) were more likely to have higher scores on the MHS-L and the MHS-G (high homonegativity). There is not a statistically significant relationship between the empathy subscale of the AAS and the MHS.

Having a personal relationship with someone who has HIV/AIDS was not associated with attitudes. The analysis indicated no significant correlation between the MCSDS and either AAS subscale (avoidance r=-.03, p=.756, empathy r=.165, p=.089), and no significant correlation between the MCSDS and any MHS subscale (MHS-G r=.078, p=.434, MHS-L r=.048, p=.635).

HIV/AIDS Knowledge, Training, and Education. The licensed social workers generally score high on the HIV-KQ-18 (*M*=15.34, SD=2.22). Respondents' scores ranged between a low score of 8 and high scores of 18, the maximum possible on the measure. Despite these high knowledge scores, 45% of the respondents indicate that more education about HIV/AIDS would be helpful in their current professional role, more than half (52.1%) had not attended a HIV/AIDS training in the last three years, and more than half (54.6%) did not have any formal curriculum on HIV/AIDS during their post-secondary education. Over half (57.5%) of the group report knowing someone personally who has HIV/AIDS. The analysis indicated no significant correlation between the MCSDS and HIV-KQ (r=-0.124,p=.208).

Table 2

Summary of Scale Scores

Scale		n	M	SD	Min.	Max.
AIDS Attitude Scale- Avoidance	AAS-Avoidance	111	1.33	.44	1.00	3.29
AIDS Attitude Scale- Empathy	AAS- Empathy	109	5.52	.6	3.00	6.00
HIV Knowledge Scale	HIV-KQ-18	107	15.34	2.22	8	18
Modern Homonegativity Scale- Gay Men	MHS-G	103	22.45	8.15	13	55
Modern Homonegativity Scale- Lesbian	MHS-L	101	21.75	8.45	12	56

Discussion

This study surveys a national sample of social workers' regarding their attitudes towards working with people with HIV/AIDS and evaluates personal, professional, and educational factors that may contribute to reported attitudes. More than half of the respondents report that they had not received any formal training in the area of HIV/AIDS education, while 45% indicate that they would benefit from obtaining more education on HIV/AIDS. As the number of new HIV/AIDS diagnoses continues to rise, and individuals with HIV/AIDS are living longer, social work, as a profession, must increase its knowledge base in order to provide the most competent and well-informed care for these clients. Schools of social work should incorporate curriculum involving individuals with HIV/AIDS throughout courses in a way similar to working with diverse populations is addressed.

This research finds that as knowledge of HIV/AIDS increases, avoidance of individuals with HIV/AIDS decreases, similar to previous studies (Riley & Greene, 1993; Shi et al., 1993). From this information, we can theorize that as more education is provided to social workers, those social workers will be less avoidant of treating clients with HIV/AIDS, and perhaps decrease the stigma associated with the disease. Despite the overall positive outcomes regarding attitudes towards individuals with HIV/AIDS, there were still outliers among this group of licensed social workers who either scored high on the avoidance subscale or lower on the empathy subscale, indicating that some social workers, despite an obligation to adhere to ethical guidelines, may avoid working with individuals with HIV/AIDS, or be less empathic to those individuals. Given the rise in both the number of individual living with HIV/AIDS in the United States, and the increased lifespan of these individuals, social workers are likely to encounter more of this population beyond just a medical setting. It is essential that all social workers routinely demonstrate understanding and empathy, and serve these individuals free from personal bias.

We also found that negative or avoidant attitudes toward people living with HIV/AIDS are associated with homophobic attitudes in some social workers. Additionally, scores of homonegativity were slightly higher towards gay men than lesbians. These two results, although not directly correlated in this study, have historical links, and further highlight the ongoing stigma associated with HIV/AIDS, homosexuality and the intersection of the two populations. Previous studies have found some individuals feel sex between two men is more of a violation of the norm than sex between two women, and that sex between two men is more highly associated with a deviant lifestyle resulting in transmission of sexual diseases such as HIV/AIDS (Herek, 1988; Ratcliff, Lassiter, Marksman, & Snyder, 2006). These beliefs and attitudes may be further compounded due to gay and bisexual men comprising just over half of the new infections of HIV/AIDS in 2013 in the United States (CDC, 2015).

Valimaki, Suominen, and Peate (1998) indicate that negative attitudes towards working with individual with HIV/AIDS can be related to fear and misconceptions about contracting the disease and corresponding stereotypes. While the overall reported attitudes of social workers were positive, there were outliers whose responses indicate higher avoidance or lower empathy. Given that the NASW *Code of Ethics* is intended to guide the practice of these social workers, it is alarming that even just a handful of those sampled demonstrated bias against either of these

groups.Having a personal relationship with someone who has HIV/AIDS is another factor that has previously been associated with positive attitudes towards working with individuals with HIV/AIDS and increased empathy toward those individuals (Roebuck, Jackson, Hilzinger, & Dwyer, 2005; Valinksi, Suominen, & Peate, 1998). While overall attitudes toward people living with HIV/AIDS are positive, in this sample a statistically significant association was not found between attitudes and knowing someone with HIV/AIDS. It may be that for this group of social workers personal relationships are not as powerful in forming attitudes as was found in previous research. Although not significantly related statistically, over half of the survey respondents report personally knowing someone with HIV/AIDS.

Limitations

Several limitations need to be considered when discussing the results of the current study. First, the response rate (8.08%) limits the generalizability of study findings. Previous research indicates that web-based surveys generate lower response rates than mail surveys (Fricker & Schonlau, 2002; Kaplowitz, Hadlock, & Levine, 2004; McDonald & Adam, 2003), as do response rates of groups of professionals that include social workers (Cook, Dickinson, & Eccles, 2009) and mental health care providers (Hawley, Cook, & Jensen-Doss, 2009). Of the 2054 email invitations that were sent out, 1,169 were never opened. This may be as a result of the email invitation being filtered to junk or spam mailboxes or may be due to social workers not recognizing the sender's address as legitimate.

Of the individuals that did reply to the survey, the demographics are skewed towards white women with Master's degrees. This was somewhat anticipated due to the existing data regarding the field of social work. In 1974, 65% of MSW graduates were women. This number rose to 85% in 2001, while the percentage of Caucasian graduates has remained relatively unchanged, varying between 78% and 74% during those years (Schilling, Morrish, & Liu, 2008). Despite the similarity between the demographics of survey respondents and the demographics of the social work profession, this survey does not represent the voices of men or individuals from diverse cultures or racial identities within the social work profession. It is quite possible that those with different cultures, racial identities, sexual identities, and gender expression would react quite differently to the survey topics than our sample.

Another potential limitation is that only social workers with an interest in the topic of HIV/AIDS or had experience working with this population, opened and completed the survey. Results indicate that 885 email invitations were opened, but only 166 completed the survey. It is possible that the social workers who opened the email invitation but did not respond had strong negative feelings about the topic, and therefor chose not to participate further. Had those individual completed the survey, the results might have demonstrated a clearer understanding of how attitudes impact working with this population. Additionally, those who were less familiar with the topic might have chosen not to answer, further skewing results towards those more knowledgeable and experienced. Had these unrepresented individuals participated, results may have been different.

Conclusion

Further research is needed that evaluates attitudes towards individuals with HIV/AIDS, and the link to homophobia, specifically within the profession of social work. This research should be conducted to identify the causes of the attitudes, differences in gender of the social worker, geographic location, and possible cultural differences. Additionally, the research should evaluate the impact of the NASW Code of Ethics on the social workers' attitudes to working with this population of clients.

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