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HIV prevention interventions to reduce sexual risk for African Americans: The influence of community-level stigma and psychological processes

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ABSTRACT

Interventions to improve public health may benefit from consideration of how environmental contexts can facilitate or hinder their success. We examined the extent to which efficacy of interventions to improve African Americans' condom use practices was moderated by two indicators of structural stigma—Whites' attitudes toward African Americans and residential segregation in the communities where interventions occurred. A previously published meta-analytic database was re-analyzed to examine the interplay of community-level stigma with the psychological processes implied by intervention content in influencing intervention efficacy. All studies were conducted in the United States and included samples that were at least 50% African American. Whites' attitudes were drawn from the American National Election Studies, which collects data from nationally representative samples. Residential segregation was drawn from published reports. Results showed independent effects of Whites' attitudes and residential segregation on condom use effect sizes. Interventions were most successful when Whites' attitudes were more positive or when residential segregation was low. These two structural factors interacted: Interventions improved condom use only when communities had both relatively positive attitudes toward African Americans and lower levels of segregation. The effect of Whites' attitudes was more pronounced at longer follow-up intervals and for younger samples and those samples with more African Americans. Tailoring content to participants' values and needs, which may reduce African Americans' mistrust of intervention providers, buffered against the negative influence of Whites' attitudes on condom use. The structural factors uniquely accounted for variance in condom use effect sizes over and above intervention-level features and community-level education and poverty. Results highlight the interplay of social identity and environment in perpetuating intergroup disparities. Potential mechanisms for these effects are discussed along with public health implications.

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Introduction

People who perceive greater bias against them because of their group membership – including being an ethnic minority, sexual minority, or mentally ill – experience poorer mental and physical health, utilize healthcare less, and suffer higher rates of mortality than those who perceive less bias (Bird & Bogart, 2001; Pascoe & Smart Richman, 2009; Williams & Mohammed, 2009). While perceptions of discrimination are not synonymous with actual discrimination because people may either underestimate or overestimate discrimination (Dumont, Seron, Yzerbyt, & Postmes, 2006; Vorauer, 2006), converging evidence of the health effects of discrimination is provided by indications of stigma at the structural level. For example, greater residential segregation is associated with poorer physical health among African Americans, not only because it differentially exposes African Americans to environmental toxins and limits access to healthy foods and quality health care (Smedley, Stith, & Nelson, 2003; Williams & Collins, 2001) but also because of the impact of segregation on psychological factors, including stress and social exclusion (Kramer & Hogue, 2009; MacDonald & Leary, 2005).

The present research is novel in its focus on bridging work on structural influences on health with psychological influences in the context of HIV prevention interventions. Although previous research suggests the importance of considering how structural

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factors may operate through and interact with individual-level factors, little empirical research has examined these influences jointly (Kramer & Hogue, 2009; White & Borrell, 2011). Moreover, previous work in this area has focused primarily on African Americans' *perceptions* of discrimination rather than directly on Whites' biases toward African Americans. We investigated how the efficacy of interventions designed to limit transmission of HIV by increasing condom use may be influenced by structural stigma – specifically, Whites' attitudes toward African Americans and residential segregation in the communities where intervention trials occurred – and explored the moderating role of psychological factors.

Despite recent medical advances in its treatment, HIV remains a major health issue in the United States and worldwide. There are approximately 48,000 new HIV infections annually in the U.S., with 44% of new infections occurring among African Americans (Centers for Disease Control, 2011). As the White House Office of National AIDS Policy (2010) noted, "HIV disproportionately affects the most vulnerable in our society—those Americans who have less access to prevention and treatment services" (p. ix). Transmission of HIV can be prevented through safer sex practices, including consistent and correct condom use (Weller & Davis-Beaty, 2002). Numerous trials have investigated behavioral interventions that deliver content interpersonally and address deficits as a strategy for increasing protective behaviors among African Americans.

The current research reports a secondary analysis of a meta-analysis of HIV prevention interventions targeted toward African Americans (Johnson et al., 2009). Meta-analysis, which provides an estimate of the magnitude of behavior change following interventions, is ideal for considering how geographic differences in stigma might shape intervention efficacy. Because intervention trials have been conducted throughout the U.S., meta-analysis allows for examination of whether Whites' attitudes and level of residential segregation in these different locations relate to intervention efficacy. Previous meta-analyses support that interventions targeting African Americans have generally increased condom use (Darbes et al., 2008). Johnson et al. found that interventions were efficacious up to three years later and were most successful when they included particular features, such as multiple intensive sessions and interpersonal skills training. Although previous meta-analyses have examined overall efficacy of interventions and have identified intervention features that are linked to greater success, they have not considered whether structural features of intervention communities may play a role in intervention efficacy. Indeed, Johnson et al. observed that, even after accounting for significant intervention-level moderators, condom use effect sizes lacked homogeneity, suggesting that other moderators may explain some of the heterogeneity in effect sizes. Thus, the present analysis considered not only whether structural factors influenced intervention efficacy, but also whether inclusion of structural factors altered Johnson et al.'s conclusions regarding which intervention-level features were associated with greater efficacy.

Whites' community-level attitudes and residential segregation are structural environmental pressures that intervention participants face before they enter and when they leave interventions. These structural factors are likely to influence intervention efficacy because they affect both the targeted behavior—condom use—and the extent to which participants are engaged in the interventions. Consistent with a growing body of research, Whites' attitudes and residential segregation are likely to be associated with both increased engagement in sexual risk behavior and increased risk for acquiring a sexually transmitted disease, implying lack of condom use (Biello et al., 2012; Roberts et al., 2012; Rosenthal et al., 2013; Stock, Gibbons, Peterson, & Gerrard, 2013). To the extent that coping with discrimination is stressful and depleting (Inzlicht, McKay, & Aronson, 2006), structural stigma is also likely to affect condom use via its influence on decreased levels of self-control and self-regulatory resources (Gibbons et al., 2012). Discrimination and stigma are also associated with mistrust of majority group members (Bergsieker, Shelton, & Richeson, 2010; Dovidio et al., 2008); this mistrust is likely to translate into decreased engagement in and acceptance of intervention messages (Wyatt, 2009). When interventions fail to address these influences of structural stigma on condom use and on the intervention itself, efficacy for improving condom use would be expected to suffer (Johnson et al., 2010; Wyatt, 2009).

Whites' community-level attitudes toward African Americans and residential segregation may both affect intervention efficacy. Because African Americans are vigilant for cues of bias (Dovidio et al., 2008; Vorauer, 2006), either negative community attitudes or high levels of residential segregation may be sufficient to undermine intervention effectiveness. Research on intergroup contact demonstrates that intergroup orientations (e.g., intergroup anxiety and empathy) are the consequence of both the frequency of contact and the quality of contact, that is, whether contact is experienced positively or negatively (see Tausch & Hewstone, 2010, for a review). In general, the valence of contact is more influential for intergroup orientations than frequency of contact. However, intergroup orientations are most favorable when contact is *both* positive and frequent (Towles-Schwen & Fazio, 2001), suggesting that community attitudes and segregation may interact such that positive community attitudes and low levels of residential segregation may combine to produce an environment highly conducive to intervention efficacy. Given the importance of the valence of intergroup contact and the paucity of research on Whites' community-level attitudes, our examination of additional moderators of structural stigma focused on Whites' attitudes.

In addition to our central focus on the influences of residential segregation and Whites' attitudes toward African Americans on intervention efficacy, we examined factors that may exacerbate or buffer against the impact of structural stigma. Our inclusion criteria, described in detail in the Method section, permitted analysis of studies in which at least 50% of the sample identified as African American ($M = 81\%$). As Whites' attitudes toward African Americans would be expected to influence African Americans specifically, we expected a stronger effect of Whites' attitudes for samples with higher proportions of African Americans. Late childhood to early adolescence has been suggested as a critical period during which experiences with discrimination may be especially detrimental, because identity is still developing and external evaluations of the self are being integrated into the self-concept (Gibbons et al., 2007). To this point, the impact of stigma tends to lead to riskier behavior, and increased sexual risk in particular, among younger African Americans (Roberts et al., 2012; Stevens-Watkins, Brown-Wright, & Tyler, 2011). Accordingly, more negative attitudes among Whites were expected to adversely influence intervention efficacy when samples were, on average, younger.

Conversely, due to the effects of stigma on self-regulation and mistrust (Bergsieker et al., 2010; Dovidio et al., 2008; Gibbons et al., 2012; Inzlicht et al., 2006), an effect of Whites' attitudes may be weakened by intervention features that potentially improved participants' self-regulation or communicated racial sensitivity and respect. Interventions that seek to improve self-control, potentially by teaching interpersonal skills for negotiating condom use with sexual partners, may buffer against an effect of Whites' attitudes. Similarly, tailoring content to participants' values and needs, which may communicate respect for participants' cultural values, may limit the effect of Whites' attitudes.

To summarize, we sought to investigate the interplay of structural and psychological factors related to stigma in influencing the

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