Verifying Quantitative Stigma and Medication Adherence Scales Using Qualitative Methods among Thai Youth Living with HIV/AIDS

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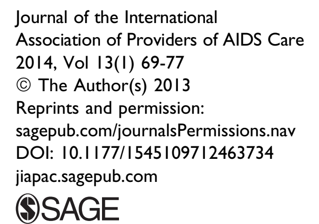

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Abstract

HIV/AIDS-related stigma has been linked to poor adherence resulting in drug resistance and the failure to control HIV. This study used both quantitative and qualitative methods to examine stigma and its relationship to adherence in 30 HIV-infected Thai youth aged 14 to 21 years. Stigma was measured using the HIV stigma scale and its 4 subscales, and adherence was measured using a visual analog scale. Stigma and adherence were also examined by in-depth interviews. The interviews were to determine whether verbal responses would match the scale's results. The mean score of stigma perception from the overall scale and its 4 subscales ranged from 2.14 to 2.45 on a scale of 1 to 4, indicating moderate levels of stigma. The mean adherence score was .74. The stigma scale and its subscales did not correlate with the adherence. Totally, 17 of the respondents were interviewed. Contrary to the quantitative results, the interviewees reported that the stigma led to poor adherence because the fear of disclosure often caused them to miss medication doses. The differences between the quantitative and the qualitative results highlight the importance of validating psychometric scales when they are translated and used in other cultures.

Keywords

stigma, medication adherence, youth living with HIV/AIDS, Thailand, qualitative methods

Introduction

Stigma was classically defined by Goffman as "the process by which the reaction of others spoils normal identity."[1] Perhaps the most stigmatized disease in modern times is HIV/AIDS. It is stigmatized by both the means by which it is acquired and the morbidity and mortality with which it is associated. The HIV/AIDS-related stigma has been found throughout the world. It has been reported in Lesotho, Malawi, South Africa, Swaziland and Tanzania,[2] the United States,[3] India,[4] Botswana,[5] and Ukraine.[6] A 12-country study from the 5 continents found that HIV/AIDS stigma was a global phenomenon.[7] Stigma has been found to be a barrier to individuals seeking HIV testing.[8-10] Stigma has also been linked to poor adherence to antiretroviral (ARV) medication regimens in 5 African countries,[11] the United States,[12] India,[13] Brazil,[14] and elsewhere.[15]

Alonzo and Reynolds suggested that HIV/AIDS stigma was unique because the stigma was associated with undesirable behaviors as well as with the actual disease. They also state that learning of one's infection creates an internalized stigma that is derived from the group norms even though the individual has not been recognized by the community as being stigmatized.[16] Because HIV/AIDS-related stigma operates at both an internalized and an external level, it is difficult to study. The actual fact of the community's stigmatization of the disease is not as important as the HIV-infected person's beliefs about that stigma. Internalized stigma and an infected person's perception of community stigma can only be discovered by direct contact with HIV-infected persons.

It has long been known that a particularly difficult group to access and study are HIV-infected youth. They are difficult to

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