2009

Predictors of Engagement in the Community Affected by HIV and AIDS

Benjamin J. Marcus
Claremont Graduate University

DOI: 10.5642/cguetd/6

Running head: PREDICTORS OF ENGAGEMENT IN THE COMMUNITY

Predictors of Engagement in the Community Affected by HIV and AIDS

Benjamin J. Marcus

Claremont Graduate University

Abstract

The goal of this study was to explore factors that lead to engagement in the community affected by HIV and AIDS (CAHA). An additional goal of this study was to better understand the relationships between *psychological sense of community* (PSOC) and *social identification* (SI), and their connections to two classes of motivations: *community concern motivations* (CCM) and *esteem enhancement motivations* (EEM). These constructs predicted two types of engagement in CAHA: AIDS activism and intentions for future participation in community related activity. Analyses were conducted on existing data (Omoto, 2005). The results indicate that PSOC and SI should be considered as independent constructs that uniquely explain community engagement. CCM were found to mediate these relationships, potentially explaining their links.

Predictors of Engagement in the Community Affected by HIV and AIDS

The community affected by HIV and AIDS (CAHA) most prominently exists as a source of social, emotional, and practical support for persons with HIV or AIDS. CAHA also includes persons using community outreach services (like friends and family of persons with HIV or AIDS), philanthropists, activists, and persons who work or volunteer in the community, such as at an AIDS Service Organization. With so many people involved, the community presumably acts as a force in promoting understanding and awareness of the AIDS pandemic, and positive social action such as volunteering for HIV and AIDS related causes. This study considers engagement, or active awareness and participation, in CAHA (cf. Omoto & Malsch, 2005; Snyder & Omoto, 2007). It focuses on psychological motivations for engagement in the community as consequences of two constructs, psychological sense of community and social identification. In general, psychological sense of community and social identification describe hypothetical psychological processes of how individuals perceive and interact with their social environment (Brewer & Brown, 1998; McMillan & Chavis, 1986; Omoto & Malsch; Tajfel & Turner, 1986).

The benefits of community engagement

Community engagement can have powerful personal and social impacts, and is often viewed as a source of personal wellness and a general indicator of societal health (e.g., Omoto & Malsch, 2005; Putnam, 2000). It is typically associated with positive outcomes that benefit all members of a community on personal and social levels. Among other benefits, these positive outcomes include an improved sense of well-being, a greater sense of social support and satisfaction, an ability to better cope with stress, increased availability of human resources such as volunteers, and more civic participation like voting and attending town-hall meetings

(Bachrach & Zautra, 1985; Obst & White, 2005; Zaff & Devlin, 1998).

Engagement in CAHA, specifically, is beneficial because it potentially improves individuals' awareness of and access to HIV and AIDS related services, increases the extent of services offered, increases the number of volunteers and paid support staff, provides more opportunities to interact with persons in support roles, and generally enhances the community's outreach ability (e.g., offering HIV and AIDS prevention programs). In short, more engagement in CAHA improves the resources available to the individuals who interact with it, and makes it easier to manage a serious public health issue.

Functional approaches to motivation

This study draws on an assumption that some of the psychological factors that can promote engagement in CAHA can be generalized from psychological factors that have been found to promote volunteerism in CAHA. That is, since volunteerism is basically a form of community engagement, it seems reasonable that some of the processes motivating it may overlap with the processes that motivate other types of community engagement, like seeking HIV and AIDS related services, participating in politics related to HIV and AIDS, or even maintaining employment in the community. Volunteerism for the community affected by HIV and AIDS has been studied from the perspective of a functional approach to motivation (Omoto & Snyder, 1995). Functional approaches to motivation assert that individuals engage in similar behaviors for different psychological reasons. In volunteerism, for example, these reasons include making social contacts, earning professional experience, learning about social issues, and other reasons (Clary et al., 1998; Houle, Sagarin, & Kaplan, 2005). Two categories of motivations have been identified as important to stimulating HIV and AIDS volunteerism: *community concern motivations* (CCM) and *esteem enhancement motivations* (EEMs, Omoto &

Snyder). CCM refer to motivations to act because of feelings of connection, responsibility, or commitment to the community. EEM refer to motivations to act based on a desire to feel better about the self. These motivations were specifically selected for this study because their basic features, a desire to help the community or a desire to help the self, seem to overlap with some of the core tenets of psychological sense of community and social identification, respectively.

Psychological sense of community

Psychological sense of community (PSOC) generally refers to a multifaceted construct that helps individuals to make sense of their social environment (i.e., community). It is primarily a set of perceptual and affective processes including a conception or awareness of a given community, feelings of belonging to the community and a connection to the issues that support it (e.g., the AIDS pandemic), a perception that this belongingness holds some mutual value to fellow community members, and a belief that all members' needs will be met through commitment and involvement (McMillan & Chavis, 1986; Omoto & Malsch, 2005). PSOC is often positively associated with some of the aforementioned outcomes of community engagement, such as greater perceptions of social support, and certain measures of subjective well-being, particularly happiness (Davidson & Cotter, 1991; Hill, 1996). One survey study reported, for example, that PSOC helped recent South African immigrants to Australia stay connected with other South African immigrants sharing a similar experience, and this enhanced sense of social support made their cultural transition easier (Sonn, 2002). PSOC can also indicate how well individuals can cope with a given situation. In another survey report, for instance, PSOC was described as a protective factor from the negative aspects of residing in low-income urban neighborhoods (Brodsky, O'Campo, & Aronson, 1999).

PSOC lends itself very well to a consideration as a motivating factor of engagement in

CAHA. If individuals perceive their connection and involvement with CAHA to benefit the community, a concern for CAHA should be a primary motivation for engagement. Thus, CCM hypothetically should result from PSOC, and subsequently lead to actual engagement in the community.

Social Identification

Social identification (SI) may also be considered a perceptual process that helps individuals make sense of their social environment. SI is primarily focused on explaining human motivation as a result of organizing one's world into social categories (Reicher, 2004). Individuals define their self-image based on their membership in various groups, forming their *social identity* (Tajfel & Turner, 1986). Groups are conceptualized through perceptions of membership in the same social category as a collection of other individuals. SI often results in group-based social hierarchies as individuals weigh the value of their affiliations in comparison to non-members and members of other groups (Brewer & Brown, 1998; Stets & Burke, 2000). For example, members of a group might consider themselves as "us," and non-members of the group as "them," and determine their social status by contrasting themselves to individuals in other groups. Individuals' perception of status not only affects their basic definition of self, then, but probably has implications for their sense of self-worth. Therefore, the "us versus them" mentality suggested by SI presumably impacts individuals' self-esteem, and consequently their motivation to protect or improve their self-esteem (viz. EEM, Brewer, 2007; Snyder & Omoto, 1992).

There are a variety of reasons to expect EEM to produce community engagement. Individuals do not always retain the ability or the desire to simply change their status (e.g., by moving to a "better" group or community). Persons with HIV or AIDS, for example, require

services that they can only find in CAHA. Such individuals may participate in community-activities to maintain their sense of self-worth, especially when this participation allows them to feel a sense of solidarity with other members, a sense of accomplishment at the their achievements, or other positive sensations. In further example, it has been reported that HIV and AIDS volunteers often feel negative social pressures of the stigma surrounding the AIDS pandemic (Snyder, Omoto, & Crain, 1999). Even while doing what they believe to be good works, the esteem they garner from their experiences is threatened based on the perceptions of others. Their participation in volunteerism, then, becomes a vehicle to reinforce or enhance their sense of self-worth by focusing on the positive and rewarding features of their engagement, rather than the perceptions of non-members. In other words, SI processes for individuals associated with CAHA leads to EEM, and subsequently lead to actual engagement in the community, at least hypothetically.

The relationship between the constructs

Although PSOC and SI are theoretically distinct variables, they do have some conceptual overlap. For example, both PSOC and SI potentially require similar cognitions as individuals acknowledge the community and classify themselves and others as part of it. There has been some debate about the relationship between these constructs, particularly whether PSOC should be considered an independent phenomenon, or as a derivative or consequence of SI. The process of connecting with an issue in PSOC, for example, in many ways reflects an identification process. Some psychologists have suggested that this identification process, one that ultimately affects one's self-definition, reflects the core components of SI. Using survey data, researchers conducted several analyses to investigate this assumption in a population of college students (Obst & White, 2005). The study used three separate measures to represent components of SI

(roughly a measure of perceptions of solidarity with the community, a measure of affective perceptions of the community, and a measure of connection to the community). Further, they collected data asking the students to conceptualize community in three different ways, as their local neighborhood, as their student community, or as a special interest group of their choosing (e.g., a hobby club). All three SI measures correlated with PSOC reasonably well in all three community-groups (*r range* = .46 to .79). Further, the researchers showed that all three measures of SI predicted PSOC for all three conceptualizations of community (*ß range* = .21 to .53, all $p <$ .001). Based on these correlational results, the researchers theorized that SI could indeed be an antecedent to PSOC.

Despite these results, it does not seem apparent that SI need be considered an antecedent to PSOC. Their three operationalizations of SI strongly overlapped with conceptions of PSOC, and thus it was unclear whether they were truly tapping unique components of SI or simply tapping those parts of PSOC and SI that were most similar. Other research has used secondary data to examine PSOC and SI in the context of HIV and AIDS volunteerism (Omoto & Malsch, 2005). The results of this study showed that PSOC and SI were not correlated at any statistically significant level (r = .04, ns). Such data is clearly inconsistent with assumptions that PSOC and SI are related at all.

Difficulty in measurement is common in research comparing PSOC and SI, and may explain why the results of such research are inconclusive (cf. Hill, 1996). This is especially true since both constructs often lead to similar outcomes, such as HIV or AIDS volunteerism (e.g., Omoto & Malsch, 2005). Additionally, based on the conceptual descriptions outlined here, PSOC and SI should be independent constructs despite any limitations in measurement. This study will test the hypothesis that PSOC and SI are independent constructs that uniquely

contribute to engagement in CAHA. Further, it will seek to explore hypotheses that PSOC leads to CCM that drive engagement, and that SI leads to EEM that drive engagement. Making these connections will not only shed light on the nature of all the constructs in question, but may also expand the options for measuring PSOC and SI using motivations as indicators of their presence.

The Current Research

This study used an existing data set. The data were collected as part of a research program examining the effects of psychological sense of community (PSOC) in a workshop-style intervention designed to enhance recruitment of new volunteers and promote the functioning of volunteers, persons with HIV or AIDS, and AIDS service organization staff (Omoto & Snyder, 2005). The current research used baseline survey data from this study.

Specific hypotheses, as outlined above, were tested using a set of regression and mediation analyses. To restate these hypotheses in terms of these analyses: 1) PSOC and social identification (SI) should independently predict engagement in CAHA while controlling for one another, 2) Community concern motivations (CCM) should mediate the relationship between PSOC engagement in CAHA, and 3) esteem enhancement motivations (EEM) should mediate the relationship between SI and engagement in CAHA. Additional expectations included that if EEM also mediated PSOC and engagement, the effect would be weaker than the CCM mediation, and that if CCM mediated SI and engagement, the effect would be weaker than the EEM mediation. This last expectation was not specifically testable, but observations were made about the strengths of the indirect effects in the mediation analyses.

Community Engagement

Community engagement is a broad behavioral class that can manifest in a variety of actions. Thus, for depth and thoroughness in this study, all predictions are tested using two

different sets of outcomes that reflect engagement in CAHA. The first is AIDS activism behaviors, or intentional efforts to participate in or benefit HIV and AIDS related social issues. Following research suggesting that intentions are among the best predictors of actual action (Ajzen & Fishbein, 1977), the second operationalization of community engagement is intentions for future participation in CAHA. Both operationalizations of community engagement should yield similar patterns of results based on the hypotheses.

Methods

Participants

Participants were recruited from one or more AIDS service organizations in metropolitan Los Angeles or metropolitan Minneapolis. Recruitment material, including posters and flyers, directed potential participants to contact the research team's Los Angeles or Minneapolis office if they had an interest in participating. All participants were required to be English speaking, at least 18 years of age, able to complete a questionnaire independently, and be available to participate in a set of workshops. If they met these criteria, they were scheduled for an initial survey session, the source of data for this study.

The final sample included responses from 465 participants, after removing responses from 165 individuals who did not have a score on one or more of the theoretically relevant measures. Four additional cases with extremely low responses were also removed to ensure normality in the PSOC distribution.

Procedures

The surveys were administered in easily accessible public places. The Los Angeles survey sessions were held at a local public library. The Minneapolis survey sessions were held on the University of Minnesota campus. Once informed consent procedures were completed for

the Los Angeles participants, they were provided a copy of the survey and a pen. The participants were allowed to find any spot on the premises where they felt comfortable working and to return the survey to the researcher when finished. Following informed consent procedures in Minneapolis, participants were directed to one of four laptop computers that automatically administered the survey. Participants were provided compensation of $25 for their time. No specific debriefing measures were completed because this was only the first part of a multi-component study. However, participants retained the ability to withdraw from future participation at any time.

Measures

The baseline measures that participants completed included an intensive survey. The content of the survey was identical for both Minneapolis and Los Angeles, excepting some minor wording changes to identify the region where the questionnaire was administered. A variety of items were selected to describe the sample. These included demographic items relating to age, socioeconomic status, gender, sexuality, race, religious beliefs, political beliefs, and HIV status. A checklist assessed the experience participants had with twelve actions in the community affected by HIV and AIDS (e.g., "I am involved in HIV/AIDS activism"). Participants indicated if they had *never* been involved, *previously* been involved, or were *currently* involved with these activities. For the current study, these items were recoded to "no" (*never done this*) and "yes" (*previously or currently done this*).

In addition, five separate measures from the survey were used in the current analyses. These measures were constructed as means of selected item scores. Scores were computed using a "three-quarters rule." That is, each participant needed to have responded to at least three-quarters of the items in a given measure for a total score to be computed. A respondent

completing an index composed of twelve items, for example, must have completed at least nine of the items for a score to be computed. Otherwise the scale score was considered "missing." Copies of items for each measure appear in Appendix A, and are described below.

Psychological Sense of Community. PSOC was tapped using 18-items rated on a 7-point, Likert-type scale ranging from *1, Strongly disagree* to *7, Strongly agree* (Omoto & Snyder, 2005). These items included, "I feel a sense of attachment and belonging to the community affected by HIV/AIDS," and, "The community affected by HIV/AIDS becomes stronger when members share their knowledge of resources with one another."

Social Identification. Six items were designed to tap respondents' sense of identity with the community affected by HIV/AIDS (Omoto & Snyder, 2005). Items were measured using a 7-point Likert-type scale ranging from *1, strongly disagree* to *7, strongly agree*. Items in this measure include statements such as, "Being associated with the community affected by HIV/AIDS brings meaning to my life," and, "Being associated with the community affected by HIV/AIDS is an important part of who I am."

Community Concern Motivations. This five-item measure was a subscale of a larger index of functional motivations for volunteerism (Omoto & Snyder, 1995). The items were adapted in this questionnaire so respondents were directed to consider their most important role at the ASO they affiliate with most in CAHA (e.g., a volunteer, an employee, a philanthropist). Each motivation was rated using a 7-point Likert-type scale from *1, Not at all important* to *7, Extremely important.* The *community concern* subscale assessed the individual's motivations for involvement in terms of a desire to benefit CAHA. An example of an item included in this measure was, "Because I consider myself an advocate for communities affected by HIV/AIDS and HIV/AIDS related issues."

Esteem Enhancement Motivations. Five additional items from the larger motivation index (Omoto & Snyder, 1995) comprised a second subscale of EEM. The items tapped the extent to which persons engaged themselves in the community to feel good or better about their self. Items in this measure included, "To feel needed," and, "To feel less lonely."

AIDS activism. A scale of general activism contained a subscale of five items relating specifically to AIDS related activism. These items asked people to report their level of activism in the 3 months prior to completing the questionnaire (e.g., "*In the past 3 months*, how often have you worked on or helped plan fundraisers, special events, or other activities for an AIDS service organization?"). These items were measured with a 7-point Likert-type scale anchored ranging from *1, Not at all* to *7, Very frequently*.

Intent to participate. This eleven-item measure assessed respondents' intentions to participate in future CAHA related activity. It includes items such as, "How strongly do you wish to become involved in HIV/AIDS activism?" and "How strongly do you wish to become involved in making HIV/AIDS policy?"[1] Respondents rated each item using a 7-point Likert-type scale ranging from *1, Not at all* to *7, Extremely.*

All measures except for SI had reliability coefficients ranging from *Cronbach's alpha* = .80 to .88 (Table 1). SI showed a relatively low reliability of *Cronbach's alpha* = .65. Because of this low reliability for the SI measure, results using this variable should be interpreted with caution. Means and standard deviations for each scale are also shown in Table 1. Note that participants reported fairly low levels of AIDS related activism ($M = 2.18$, $SD = 1.45$). PSOC levels, on the other hand, were fairly high relative to the other scales ($M = 5.72$, $SD = .93$).

[1] An argument can be made that these items better reflect *desires* for community engagement rather than actual intentions to participate. Because the items were originally intended to tap intentions based on the corresponding documentation, they are interpreted as such in the current research. However, the reader should interpret them with this limitation in mind.

Results

Descriptive characteristics of the sample are shown in Table 2. Notably, the sample was composed predominantly of males. Most participants in the sample earned less than $20,000 per year. Finally, more than three-quarters of the sample reported that they were HIV+.

Participants had a diverse array of involvement in the community affected by HIV and AIDS (Table 3). Most reported that they received services from an AIDS service organization. However, many participants also reported various other types of involvement in the community affected by HIV and AIDS such as participating in AIDS service organization special events and being involved in making HIV and AIDS policy. Participants often had multiple roles in the community affected by HIV and AIDS. The total number of roles held for each participant ranged from 0 to 11. The mean number of roles was 4.15 (SD = 2.29) and the mode was 4 (n = 86).

HIV status as a control variable

Preliminary analyses comparing HIV+ participants to all other participants suggested differences between these groups on some of the key measures. For example, HIV+ respondents showed significantly higher mean levels of EEM than other respondents (M = 4.76, SD = 1.48 and M = 3.27, SD = 1.68, respectively; t = -.83, $p < .001$). To minimize the effects of these group differences, HIV status was used as a control in all analyses.

Correlations

The upper portion of Table 1 shows partial correlations between the measures in this study controlling for HIV status. The correlations ranged from *partial* r = .07 to r = .53. All correlations were positive. The only correlation that was not statistically significant was between EEM and AIDS activism. PSOC and SI were relatively highly correlated (*partial* r = .47, $p <$

.001), as were EEM and CCM (*partial r* = .45, $p < .001$). Two assumptions suggested by the hypotheses of this study are that CCM should better relate to PSOC than to SI, and that EEM should better relate to SI than to PSOC. The partial correlation between CCM and PSOC (*partial r* = .44, $p < .001$) was greater than the partial correlation between CCM and SI (*partial r* = .37, $p < .001$), though the difference between these correlations was not statistically significant based on Fisher's r-to-z tests ($z = 1.53$, ns). The partial correlation of EEM with PSOC (*partial r* = .17, $p < .001$) was slightly stronger than the EEM – SI correlation (*partial r* = .16, $p < .01$), the obverse of what was expected. Again, however, the difference between these correlations was not statistically significant ($z = .084$, ns). These results did not support assumptions about the relationships between PSOC, SI, and motivational constructs. Regression analyses were used to gain a clearer picture of the relationship between these variables and their connections to engagement in CAHA.

Analyses of AIDS Activism

The first step in the analyses was to determine if PSOC and SI would both predict AIDS activism while controlling for one another. This was achieved using hierarchical linear regression. HIV status was included as a control variable by entering it into the first step of the model. PSOC and SI were entered at the second step. Results of the model with all variables are shown in the upper-left portion of Table 4. The cumulative R^2 of the model was significant at .08, $F(3, 445) = 12.64$, $p < .001$, with the bulk of the variance explained by PSOC and SI, $\Delta R^2 =$ .08, $F(2, 446) = 18.64$, $p < .001$. SI ($\beta = .21$. $p < .001$) did account for more variance in AIDS activism than PSOC, ($\beta = .11$, $p < .05$). However, these results showed that both PSOC and SI simultaneously and independently contribute to predicting AIDS activism.

A parallel hierarchical linear regression analysis was conducted to determine whether CCM and EEM would both predict AIDS activism while controlling for one another. Again, HIV status was entered on the first step as a control variable. Results for the model containing all the variables are shown in the lower-left portion of Table 4. The cumulative R^2 of the model was .13, $F(3, 445) = 21.46$, $p < .001$. The bulk of the explained variance in the model resulted from adding the motivations, $\Delta R^2 = .13$, $F(2, 446) = 31.87$, $p < .001$. In the final model, CCM accounted for more variance in AIDS activism ($\beta = .39$, $p < .001$) than EEM ($\beta = -.11$, $p < .05$). These results show that when controlling for CCM, EEM actually become negative predictors of AIDS activism. This is a surprising result. First, the hypotheses of this study imply that EEM and SI should be positively related, if at all. Second, because EEM should flow from SI, and since SI was shown to positively predict AIDS activism, EEM also should have positively predicted AIDS activism. The implications of this result will be revisited in the discussion section. For the moment, note that the results showed that CCM and EEM simultaneously and independently predicted AIDS activism.

Hierarchical regression analyses were used to explore the ability of the motivations to mediate the relationship between PSOC or SI and AIDS activism, following procedures adapted from Baron and Kenny (1986). Specifically, four separate mediation models predicting AIDS activism were tested beginning with the relationship of PSOC and AIDS activism as mediated by CCM, followed by PSOC and AIDS activism as mediated by EEM, the relationship of SI and AIDS activism as mediated by CCM, and finally the relationship of SI and AIDS activism as mediated by EEM.

Results for each mediation analysis are shown in Figure 1. If the indirect paths of the models (i.e., the path of mediation) were significant, Sobel tests were used to confirm mediation.

Partial mediation was shown if the direct effects remained significant after the confirmation of the Sobel test. Full mediation was shown if the direct effects were not significant after the Sobel test. To clarify these analytic procedures, the first mediation analysis will be described with some detail.

PSOC and AIDS activism mediated by CCM. Each mediation analysis consisted of two hierarchical regression equations. In this case, the first equation used PSOC to predict CCM (including HIV status as a control variable). PSOC accounted for a significant portion of the variance in CCM, $\Delta R^2 = .19$, $F(1, 447) = 107.38$, $p < .001$, *cumulative* $R^2 = .20$, $F(2, 446) = 56.09$, $p < .001$. This represents a component of the indirect path in the model. Its significance suggests that there is possible mediation.

The second regression equation, after controlling for HIV status in step one, showed the total effects of PSOC predicting AIDS activism in step two. CCM were added on a third step. Allowing PSOC and CCM to control for one another on the third step showed the weight of PSOC's direct effects on AIDS activism, and CCM's effects on AIDS activism (i.e., the second indirect path of the model). The overall model was significant at $R^2 = .12$, $F(3, 445) = 20.64$, $p < .001$. At step 2, PSOC explained a portion of this variance, $\Delta R^2 = .04$, $F(1, 447) = 20.63$, $p < .001$. Adding CCM at step 3 also explained additional variance, $\Delta R^2 = .08$, $F(1, 447) = 38.89$, $p < .001$. However, PSOC's predictive power in the final model was not significant, but CCM retained significant predictive power ($B = .27$, $SE = .04$, $p < .001$). These results suggested that the CCM did indeed mediate the relationship between PSOC and AIDS activism. A Sobel test confirmed this, $z = 5.33$, $p < .001$. Because the direct effects of PSOC on AIDS activism (i.e., the effects of PSOC while controlling for CCM) were not significant, the results showed that CCM

fully mediated the relationship between PSOC and AIDS activism. In this case, then, the influence of PSOC on AIDS activism was accounted for by CCM.

PSOC and AIDS activism mediated by EEM. As shown in Figure 1, PSOC significantly predicted EEM and AIDS activism (all $p < .001$). However, EEM did not predict AIDS activism when controlling for PSOC. That is, no significant indirect effect of EEM emerged. EEM did not mediate the relationship between PSOC and AIDS activism.

SI and AIDS activism mediated by CCM. The first hierarchical regression of HIV status and SI predicting CCM was significant, with SI explaining additional variance in CCM, $\Delta R^2 = .14$, $F(1, 447) = 75.54$, $p < .001$, *cumulative* $R^2 = .38$, $F(2, 446) = 38.52$, $p < .001$. The second hierarchical regression equation in this analysis used HIV status, SI, and CCM to predict AIDS activism. SI explained some variance in AIDS activism ($\Delta R^2 = .06$, $F(1, 447) = 32.26$, $p < .001$, $B = .29$, $SE = .05$), and adding CCM to the model explained additional variance $\Delta R^2 = .07$, $F(1, 447) = 35.77$, $p < .001$, $B = .246$, $SE = .04$, *cumulative* $R^2 = .14$, $F(3, 445) = 23.74$, $p < .001$. Weights for the indirect paths in the analysis were significant, and mediation of SI and AIDS activism by CCM was confirmed using a Sobel test ($z = 4.88$, $p < .01$). Given the significance of the direct effects of SI in this model ($B = .17$, $SE = .05$), it was concluded that CCM partially mediated the relationship between SI and AIDS activism. That is, the influence of SI on AIDS activism was partially accounted for by CCM.

SI and AIDS activism mediated by EEM. SI predicted both AIDS activism and EEM, as shown in Figure 1 (all $p < .001$). However, EEM did not predict AIDS activism when controlling for SI. In other words, the indirect effects of the model were not significant, showing that EEM did not mediate SI and AIDS activism. EEM did not contribute to explaining the relationship between these variables.

Summary. The regression results confirmed that of PSOC and SI were independent predictors of AIDS activism. They also showed that CCM and EEM were independent predictors of AIDS activism, with the caveat that EEM do so in a manner opposite of what was predicted. Thus, results for CCM support predictions that they derive from PSOC in driving AIDS activism. The results for EEM, however, do not support hypotheses that they derive from SI. In summary, it was found that CCM mediated links to AIDS activism for both PSOC and SI, whereas EEM did not mediate these links. Again, these results do not wholly conform to predictions. Specifically, it was expected that the EEM would mediate SI and AIDS activism, and that this effect would be stronger than any mediation of SI and AIDS activism by CCM. However, the opposite results were found.

Analyses of Intent to Participate in the Community Affected by HIV and AIDS

The remaining analyses focus on the second operationalization of engagement in CAHA, intentions for future participation. As shown in the upper-right portion of Table 4, results of a hierarchical regression show that both PSOC and SI significantly predicted intentions, *cumulative* $R^2 = .13$, $F(3, 445) = 21.46$, $p < .001$. PSOC and SI explained most of this variance, $\Delta R^2 = .13$, $F(2, 446) = 31.87$, $p < .001$. PSOC accounted for more variance in intent in the final model ($\beta = .33$. $p < .001$) than did SI ($\beta = .11$, $p < .05$). Again, however, the main point is that the variables simultaneously and independently predicted intent.

Results of a hierarchical regression (lower-right portion of Table 4) showed CCM, and EEM to account for portions of variance in intentions, *cumulative* $R^2 = .29$, $F(3, 445) = 60.35$, $p < .001$. In the final model ($\Delta R^2 = .29$, $F(2, 446) = 89.61$, $p < .001$), CCM better predicted intentions ($\beta = .45$, $p < .001$) than did EEM ($\beta = .08$, ns). As with the results for AIDS activism, the results provided by EEM were unexpected. Given that EEM are expected to derive from SI,

that SI's ability to predict intent was small compared to PSOC, and that SI was relatively less reliable than the other measures, the fact that EEM's predictive ability was mitigated is perhaps not surprising. At the very least, EEM's weight on intent in this case is positive, something that is consistent with expectations.

Procedures of the mediation analyses for the relationships between PSOC or SI and intentions for community involvement mirrored those for the relationships between PSOC or SI and AIDS activism. The first regression models in these analyses (i.e., PSOC or SI predicting CCM or EEM) duplicate those reported earlier, and are not repeated. Results for these mediation analyses are shown in Figure 2.

PSOC and intent to participate mediated by CCM. HIV status, PSOC, and CCM explained a portion of the variance in intent in hierarchical regression, with PSOC significantly predicting intent, $\Delta R^2 = .14$, $F(1, 447) = 73.70$, $p < .001$, *cumulative* $R^2 = .31$, $F(3, 445) = 66.54$, $p < .001$. CCM explained additional variance in the final model ($\Delta R^2 = .17$, $F(1, 447) = 105.57$, $p < .001$, $B = .40$, $SE = .04$), showing that it predicted intent to participate while controlling for PSOC. Because both indirect paths of the model were significant, a Sobel test confirmed mediation ($z = 7.31$, $p < .001$). The direct effects of PSOC on intent ($B = .28$, $SE = .07$, $p < .001$) indicated that the model was partially mediated by CCM. In summary, CCM appears to explain a portion of PSOC's effects on intentions to participate in CAHA.

PSOC and intent to participate mediated by EEM. A hierarchical regression model containing HIV status, PSOC, and EEM predicted intent to participate in CAHA. In the final model, EEM significantly predicted intent, $\Delta R^2 = .06$, $F(1, 447) = 31.95$, $p < .001$, *cumulative* $R^2 = .20$, $F(3, 445) = 31.46$, $p < .001$. Both indirect paths of the model were significant, and a Sobel test confirmed that EEM mediated PSOC and intent ($z = 3.01$, $p < .01$). The model was

considered partially mediated because the effects of PSOC in the final model were significant even after controlling for EEM. In this case, EEM seems to partially explain the relationship between PSOC and intentions to participate in CAHA.

SI and intent to participate mediated by CCM. HIV status, SI, and CCM predicted intent to participate using a hierarchical regression equation. SI predicted intent in step 2 of the model, $\Delta R^2 = .07$, $F(1, 447) = 33.19$, $p < .001$, $B = .30$, $SE = .05$, $p < .001$. Adding CCM to the final model explained much additional variance in intentions for community involvement, $\Delta R^2 = .22$, $F(1, 447) = 136.11$, $p < .001$, *cumulative* $R^2 = .29$, $F(3, 445) = 60.40$, $p < .001$. Both indirect paths of the model significantly predicted intentions, and a Sobel test confirmed that CCM mediated the model ($z = 6.9$, $p < .001$). Because the direct effects in the model were not significant, the relationship was considered fully mediated. That is, the effects of SI on intentions to participate in CAHA were apparently accounted for by CCM.

SI and intent to participate mediated by EEM. HIV status, SI, and EEM explained a portion of variance in intent, with EEM significantly predicted intent in the final model, $\Delta R^2 = .07$, $F(1, 447) = 34.83$, $p < .001$, *cumulative* $R^2 = .14$, $F(3, 445) = 24.02$, $p < .001$. Because both indirect paths of the model were significant, a Sobel test confirmed mediation ($z = 2.98$, $p < .01$). Because the effects of SI on intentions to participate in CAHA remained significant after controlling for EEM, the relationship was considered partially mediated. EEM, then, partially explained the effects of SI on intentions for engagement.

Summary. Results again showed that while controlling for one another, PSOC and SI uniquely predicted intent to participate in CAHA. This is consistent with hypotheses. However, the remaining results did not confirm predictions about the relationships between PSOC and SI, motivations, and intentions. The results of the mediation analyses also do not wholly conform to

the rationale of this study. More specifically, note that the standardized indirect effects (i.e., the results of the Sobel test) are smaller for EEM's mediation of SI and intentions than CCM's mediation of SI and intentions. This suggests that CCM was a stronger mediator of SI and intentions than EEM. In other words, CCM apparently explained more of the effects of SI on intentions than EEM. Following assumptions that EEM should be more related to SI than to CCM, these results are in opposition to expectations that the mediation of SI and intent should have been stronger by EEM than by CCM.

The results for the analyses of intentions for engagement in CAHA, then, yielded similar patterns shown for the analyses of AIDS activism. Overall, CCM appear to be more related to both PSOC and SI than EEM. Further, they seem to explain more of the effects of PSOC and SI on both operationalizations of engagement in CAHA than do EEM.

Discussion

The results of this investigation show that when controlling for one another, PSOC and SI explained unique portions of variance in both AIDS activism and in intentions to participate in CAHA. This is a simple, but important finding, showing that PSOC and SI can be considered as independent constructs because they simultaneously affect the behaviors assessed in this study. Further, these results occurred across two operationalizations of community engagement, suggesting, potentially, that the effects are stable across different types of engagement in CAHA. These results, then, add credence to the idea that PSOC is an independent psychological phenomenon from SI.

The remaining results did not confirm the hypothesized relationships between PSOC and SI, and CCM and EEM. CCM did mediate the relationship between PSOC and both types of community engagement, and based on observations of the strengths of the indirect effects in

these mediations, apparently more strongly than EEM. However, EEM did not appear to mediate the relationship between SI and community engagement more strongly than CCM. Rather, the opposite pattern was found such that CCM was a better mediator of SI and community engagement than EEM. In fact, CCM were so strong in some analyses that they fully mediated the ability of PSOC or SI to predict community engagement. In summary CCM, compared to EEM, better explained the links between engagement in CAHA, and both PSOC and SI.

It is worth noting some of the circumstances in which the discrepancy between the expected and actual patterns of results occurred. More specifically, it was particularly unexpected that EEM were not significant predictors of AIDS activism when analyzed alone or in the mediation analyses. In fact, when controlling for CCM in a regression model, they actually became negative predictors of AIDS activism, the opposite of what was expected given that SI was a positive predictor of AIDS activism. One possible explanation for these results lies in the nature of the community affected by HIV and AIDS. For example, the stigmatizing nature of HIV and AIDS activism, such that self-esteem may actually be damaged by engaging in HIV and AIDS activism, that are negatively viewed in participants' various social environments (Snyder et al., 1999). Individuals who choose to participate in HIV and AIDS volunteerism presumably do so to fulfill some other psychological needs (i.e., have different functional motivations) than feeling good about themselves, such as a concern about the community (Omoto & Snyder, 1995). It is possible that CCM act as protective factors to the negative feelings associated with AIDS activism, offsetting the negative EEM. Indeed, follow up mediation analyses using EEM as a mediator of CCM and AIDS activism showed that CCM actually better explained the variance in AIDS activism when mediated by EEM (total effects $B = .30$, $SE = .038$, $p < .001$; direct effects $B = .34$, $SE = .043$, $p < .001$; Sobel test $z = -2.11$, $p < .05$). Although this pattern

needs to be explored more thoroughly, it can be tentatively interpreted such that CCM did indeed offset the negative effects of EEM.

Interpreted in plainer language, these results indicate, potentially, that members of CAHA are motivated by their concerns for a "greater good," and that they will act upon these motivations even in the face of a personal sacrifice (e.g., loss of self esteem). This unexpected finding raises questions about the nature of functional motivations, and should be addressed in future research exploring how motivations and internal psychological states interact and influence each other. Some questions, for example, involve whether CCM will consistently supersede EEM in community settings outside of CAHA, or whether the relationships of functional motivations to PSOC and SI change in other community settings. It is important, that is, to explore *when* one might expect certain motivations to be more important than others. Doing so could serve to enhance researchers' abilities to make behavioral and attitudinal predictions using these constructs. These predictions could be used to improve theoretical knowledge about functional motivations. Further, on a somewhat more practical level, improved knowledge about these constructs could help researchers design better studies and interventions designed to improve engagement in CAHA, or serve a variety of other applications.

While these results may lead to several interesting questions about the nature of functional motivations, overall they results do much less to clarify the nature of PSOC and SI than originally expected. It was shown that PSOC and SI should be considered independently, however, the ways the constructs are differentiated and related remain unclear. The fact that CCM were better mediators of community engagement than EEM for both PSOC and SI, for example, suggests that they would be useful constructs to differentiate PSOC and SI, at least not in CAHA. Initially, future research should first seek to establish whether PSOC and SI should be

considered as independent constructs outside of CAHA. Beyond this, more research is needed to understand how and why both PSOC and SI work, including a more in-depth analysis of the components that comprise these constructs, which of these components are common or uncommon to one another, and how these components might be used to improve measurement of the constructs. Additionally, research should continue to explore PSOC's and SI's relationships to other psychological phenomenon as an alternative route to differentiating them. In general, more theoretical knowledge about PSOC and SI is needed to understand how and when they work.

Although the main questions of this study, then, remain unanswered, the links between both PSOC and SI and CCM in CAHA is a pattern that can be interpreted positively, and may have direct utility to the community. At times, in fact, CCM accounted for the entire effects of PSOC or SI on community engagement. Workshops or other interventions designed to improve or increase engagement in the community affected by HIV and AIDS can be designed such that they capitalize on this knowledge by crafting messages that directly appeal to individuals' concerns for the community itself (as opposed to appealing to individuals' self esteem, for example). If levels of CCM do positively correspond to levels of PSOC and SI, as shown in this study, then hypothetically increasing CCM should lead to increased levels of some of the critical components of PSOC and SI (e.g., knowledge and understanding of the community and of the issues that form it, feelings of connection to the community, etc.). In other words, connecting PSOC and SI to CCM offers a level of flexibility that may be useful in improving the quality of engagement in CAHA, as well as the quantity.

Though informative, the findings of this study should be considered in relation to a few limitations. First, as already discussed, CAHA has highly specific needs, goals, and customs. The

psychological feelings and attitudes participants hold relevant to this community may not generalize to other communities with different needs, goals, and customs. Additionally, the data used here came from an existing research program, and were not specifically tailored to the needs of the current research. Future research should work to replicate these findings in community settings outside of CAHA, and ideally should use methods specifically tailored to the research questions.

Conclusion

This study was conducted with to better understand PSOC and SI, and the classes of functional motivations, CCM and EEM. Although the predicted patterns of relationships between these variables were not obtained, they did show that PSOC and SI can be considered as unique and independent constructs, and that CCM may be important in understanding their links to community engagement. On a theoretical level, these results are important because they may lead to future research on the nature of PSOC, SI, and functional motivations. On a more applied level, the results obtained here might be most useful in applications relating to CAHA. For example, understanding individuals' motivations, like CCM, for engagement in this community may contribute to retaining a thriving and diverse community membership, and ultimately may afford many resources to PWH/As or anyone else affected by the crisis. These resources include a volunteer corps to staff ASOs, fiscal sponsorship, a social support network, and a powerful voice to further promote knowledge and understanding of the devastating effects of HIV and AIDS.

References

Ajzen, I., & Fishbein, M. (1977). Attitude-behavior relations: A theoretical analysis and review of empirical research. *Psychological Bulletin, 84*(5), 888-918.

Bachrach, K. M., & Zautra, A. J. (1985). Coping with a community stressor: The threat of a hazardous waste facility. *Journal of Health and Social Behavior, 26*(2), 127-141.

Baron, R. M., & Kenny, D. A. (1986). The moderator-mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology, 51*(6), 1173-1182.

Brewer, M. B. (2007). The social psychology of intergroup relations. In A. W. Kruglanski & E. T. Higgins (Eds.), *Social Psychology: Handbook of basic principles* (2nd ed., pp. 695-715). New York: The Guilford Press.

Brewer, M. B., & Brown, R. J. (1998). Intergroup relations. In D. T. Gilbert, S. T. Fiske & G. Lindzey (Eds.), *The handbook of social psychology* (4th ed., Vol. 2, pp. 554-594). New York: McGraw-Hill.

Brodsky, A. E., O'Campo, P. J., & Aronson, R. E. (1999). PSOC in community context: Multi-level correlates of a measure of psychological sense of community in low-income, urban neighborhoods. *Journal of Community Psychology, 27*(6), 659-679.

Clary, E., Snyder, M., Ridge, R. D., Copeland, J., Stukas, A. A., Haugen, J., et al. (1998). Understanding and assessing the motivations of volunteers: A functional approach. *Journal of Personality and Social Psychology, 74*(6), 1516-1530.

Davidson, W. B., & Cotter, P. R. (1991). The relationship between sense of community and subjective well-being: A first look. *Journal of Community Psychology, 19*(3), 246-253.

Hill, J. L. (1996). Psychological sense of community: Suggestions for future research. *Journal of Community Psychology, 24*(4), 431-438.

Houle, B. J., Sagarin, B. J., & Kaplan, M. F. (2005). A functional approach to volunteerism: Do volunteer motives predict task preference? *Basic and Applied Social Psychology, 27*(4), 337-344.

McMillan, D. W., & Chavis, D. M. (1986). Sense of community: A definition and theory. *Journal of Community Psychology: Psychological Sense of Community, I: Theory and Concepts, 14*(1), 6-23.

Obst, P. L., & White, K. M. (2005). An Exploration of the Interplay between Psychological Sense of Community, Social Identification and Salience. *Journal of Community & Applied Social Psychology, 15*(2), 127-135.

Omoto, A. M., & Malsch, A. M. (2005). Psychological sense of community: Conceptual issues and connections to volunteerism-related activism. In A. M. Omoto (Ed.), *Processes of community change and social action* (pp. 83-103). Mahwah, NJ: Lawrence Erlbaum Associates.

Omoto, A. M., & Snyder, M. (1995). Sustained helping without obligation: motivation, longevity of service, and perceived attitude change among AIDS volunteers. *Journal of Personality and Social Psychology, 68*(4), 671-686.

Omoto, A. M., & Snyder, M. (2005). [Psychological sense of community intervention in AIDS service organizations]. Unpublished raw data. Unpublished Unpublished raw data.

Putnam, R. D. (2000). *Bowling alone: The collapse and revival of American community*. New York: Touchstone Books/Simon & Schuster, Inc.

Reicher, S. (2004). The Context of Social Identity: Domination, Resistance, and Change. *Political Psychology, 25*(6), 921-945.

Snyder, M., & Omoto, A. M. (1992). Who helps and why? The psychology of AIDS Volunteerism. In S. Spacapan & S. Oskamp (Eds.), *Helping and being helped: Naturalistic studies*. Newbury Park, CA: Sage Publications.

Snyder, M., & Omoto, A. M. (2007). Social action. In A. W. Kruglanski & E. T. Higgins (Eds.), *Social psychology: A handbook of basic principles* (2nd ed.). New York: Guilford Publications, Inc.

Snyder, M., Omoto, A. M., & Crain, A. (1999). Punished for their good deeds: Stigmatization of AIDS volunteers. *American Behavioral Scientist, 42*(7), 1175-1192.

Sonn, C. C. (2002). Immigrant adaptation: Understanding the process through sense of community. In A. T. Fisher, C. C. Sonn & B. J. Bishop (Eds.), *Psychological Sense of Community: Research, Applications, and Implications* (pp. 205-222). New York: Kluwer Academic/Plenum Publishers.

Stets, J. E., & Burke, P. J. (2000). Identity theory and social identity theory. *Social Psychology Quarterly, 63*(3), 224-237.

Tajfel, H., & Turner, J. C. (1986). The social identity theory of intergroup behavior. In S. Worchel & W. G. Austin (Eds.), *Psychology of Intergroup Relations* (2nd ed., pp. 7-24). Chicago: Nelson-Hall.

Zaff, J., & Devlin, A. S. (1998). Sense of community in housing for the elderly. *Journal of Community Psychology, 26*(4), 381-397.

Appendix B: Scale Items

Psychological Sense of Community

1. There is such a thing as a "community affected by HIV/AIDS."
2. If someone asked, I could define "community affected by HIV/AIDS."
3. All people—regardless of HIV status—are members of the community affected by HIV/AIDS.
4. The community affected by HIV/AIDS is made up of people with different backgrounds, values, and opinions.
5. The bonds that connect members of the community affected by HIV/AIDS are more important than whether or not people have HIV disease.
6. I identify with the community affected by HIV/AIDS.
7. I feel a sense of community with people affected by HIV/AIDS.
8. I feel a sense of attachment and belonging to the community affected by HIV/AIDS.
9. I am similar to members of the community affected by HIV/AIDS.
10. I feel strong ties to the community affected by HIV/AIDS.
11. If someone I did not know within the community affected by HIV/AIDS had an emergency, I would be willing to help.
12. Members of the community affected by HIV/AIDS can have a positive affect on the future of their community.
13. The community affected by HIV/AIDS should work together to create a better future for its members.
14. The actions of today's community affected by HIV/AIDS will have an impact on future community members.
15. The community affected by HIV/AIDS becomes stronger when members share their knowledge of resources with one another.
16. All members of the community affected by HIV/AIDS – even HIV- individuals – face similar challenges.
17. Members of the community affected by HIV/AIDS have an obligation to work together to help other members.
18. The success of the community affected by HIV/AIDS depends on members working together.

Social Identification

1. Being associated with the community affected by HIV/AIDS brings meaning to my life.
2. I have difficulty thinking of myself not being a member of the community affected by HIV/AIDS.
3. Being a part of the community affected by HIV/AIDS is something I rarely think about. (REVERSED)
4. I have no clear feelings about being a part of the community affected by HIV/AIDS. (REVERSED)
5. Being associated with the community affected by HIV/AIDS is an important part of who I am.
6. I see little similarity between myself and other people in the community affected by HIV/AIDS. (REVERSED)

Community Concern Motivations

1. Because of my sense of obligation to communities affected by HIV/AIDS.
2. Because I consider myself an advocate for communities affected by HIV/AIDS and HIV/AIDS related issues.
3. Because of my concern and worry about communities affected by HIV/AIDS.
4. To get to know people in communities affected by HIV/AIDS.
5. To help members of communities affected by HIV/AIDS.

Esteem Enhancement Motivations

1. To make my life more stable.
2. To escape other pressures and stress in my life (e.g., from work, from home).
3. To feel less lonely.
4. To feel needed.
5. To feel better about myself.

AIDS Activism

1. *In the past 3 months*, how often have you made donations of money or other material goods to groups and organizations engaged in charitable activities that are related to HIV/AIDS?
2. *In the past 3 months*, how often have you worked on or helped plan fund-raisers, special events, or other activities for an AIDS organization?
3. *In the past 3 months*, how often have you attended HIV/AIDS fund-raisers, special events, or other activities for an AIDS organization?
4. *In the past 3 months*, how often have you involved yourself in HIV/AIDS activism activities (e.g., writing to legislators, involvement in public awareness activities)?
5. *In the past 3 months*, how often have you worked on policies and issues related to HIV/AIDS?

Intent to Participate in the Community Affected by HIV and AIDS[2]

1. How strongly do you wish to volunteer at your PRIMARY ASO or another AIDS service organization?
2. How strongly do you wish to become a paid employee at your PRIMARY ASO or another AIDS service organization?
3. How strongly do you wish to receive services from your PRIMARY ASO or another AIDS service organization?
4. How strongly do you wish to participate in prevention or education programs at your PRIMARY ASO or another AIDS service organization?
5. How strongly do you wish to do an internship at your PRIMARY ASO or another AIDS service organization?
6. How strongly do you wish to serve on the Board of Directors at your PRIMARY ASO or another AIDS service organization?
7. How strongly do you wish to donate money to your PRIMARY ASO or another AIDS service organization?
8. How strongly do you wish to participate in special events at your PRIMARY ASO or another AIDS service organization?
9. How strongly do you wish to become involved in HIV/AIDS activism?
10. How strongly do you wish to become involved in making HIV/AIDS policy?
11. How strongly do you wish to acquire a paid position that involves providing services to those with HIV/AIDS?

[2] "ASO" refers to AIDS Service Organization

Table 1. Descriptive Statistics and Correlations for Community Engagement

	1	2	3	4	5	6	Alpha
1. Psychological Sense of Community	-	*.473***	*.440***	*.167***	*.210***	*.377***	.870
2. Social Identification	.485***	-	*.374***	*.163***	*.260***	*.263***	.648
3. Community Concern Motivations	.414***	.358***	-	*.448***	*.341***	*.531***	.845
4. Esteem Enhancement Motivations	.216***	.195***	.390***	-	*.070*	*.299***	.804
5. AIDS Activism	.216***	.269***	.332***	.080	-	*.291***	.851
6. Intentions for future ASO involvement	.383***	.282***	.520***	.305***	.302***	-	.880
Mean (*SD*)	5.72 (*.93*)	4.66 (*1.28*)	4.85 (*1.64*)	4.46 (*1.64*)	2.18 (*1.45*)	4.22 (*1.46*)	

Note: * $p < .05$. ** $p < .01$. ***$p < .001$. Zero-order correlations are shown in the lower portion of the matrix. Partial correlations (controlling for HIV status) are shown in the upper portion.

Table 2. Sample Characteristics

Education and Employment		*Race/Ethnicity*	
High school education	25.6%	Hispanic heritage	15.3%
Greater than high school education	66.8%	Black/African American	45.6%
Full or part time employed	20.9%	Hispanic/Latino	14.0%
Unemployed	23.0%	Native American/Indian	7.1%
On disability	44.9%	White/Caucasian/Euro-American	35.5%
Earning less than $20,000 per year	78.3%	Other race/ethnicity	5.3%
Gender and Sexual Orientation		*HIV Status*	
Male	72.3%	HIV+	77.2%
Female	24.3%	Length as HIV+ range in years	.08 to 24.75
Transgender	1.3%	Mean years as HIV+ (*SD*)	10.02 (*6.18*)
Heterosexual	34.0%	*Age*	
Gay or lesbian	49.9%	Age range	19 to 77
Bisexual	12.5%	Mean age (*SD*)	43.14 (*8.54*)
Political Orientation			
Democrat	63.3%		
No political party affiliation	24.1%		

Note: Total $n = 465$.

Table 3. Roles Held in the Community

ASO Volunteer	50.75%
In ASO Education Programs	58.92%
Receive ASO Services	81.08%
ASO Intern	10.75%
ASO Employee	8.17%
Donate Money to ASO	33.55%
ASO Board of Directors	7.74%
In ASO Special Events	70.75%
Involved in HIV/AIDS activism	49.46%
Involved in HIV/AIDS policy	22.37%
HIV/AIDS Service Provider	14.19%
Other	6.02%

Note: Percentages will sum to more than 100% because many participants held multiple roles in the community. Total n = 465

Table 4. Regression Analyses Predicting AIDS Activism and Intentions to Participate in the Community Affected by HIV/AIDS

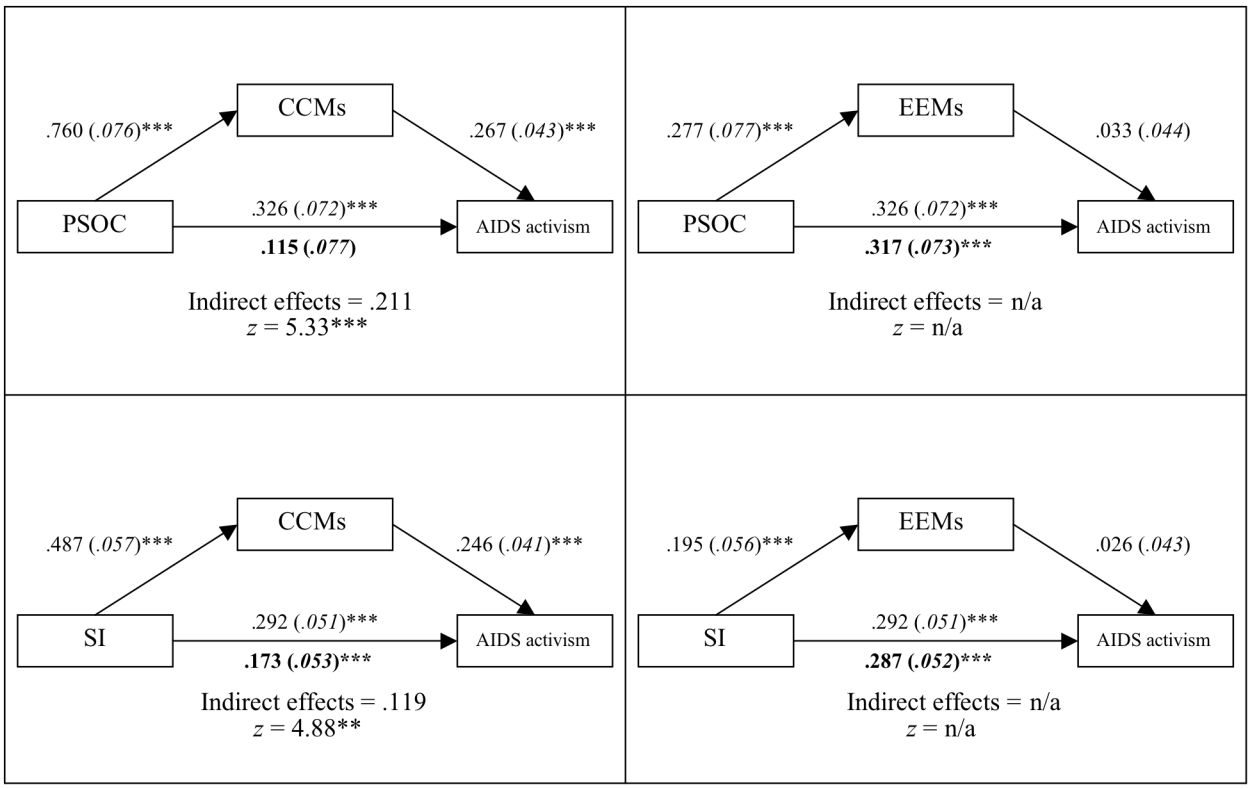
	AIDS Activism						*Intent to Participate*					
	Block 1			*Block 2*			*Block 1*			*Block 2*		
Predictor/ Statistic	*B*	*SE*	*β*	*B*	*SE*	*β*	*B*	*SE*	*β*	*B*	*SE*	*β*
Constant	2.079	.150	-	.119	.410	-	4.059	.154	-	.725	.403	-
HIV Status (Control)	.128	.168	.036	-.026	.164	-.007	.198	.172	.054	-.064	.162	-.018
Psychological Sense of Community	-	-	-	.175	.080	.114*	-	-	-	.516	.079	.330***
Social Identification	-	-	-	.232	.058	.208***	-	-	-	.126	.057	.110*
Δdf	1, 447	-	-	2, 446	-	-	1, 447	-	-	2, 446	-	-
ΔR^2	-	-	-	.077	-	-	-	-	-	.151	-	-
ΔF	-	-	-	18.64***	-	-	-	-	-	39.62***	-	-
R^2	.001	-	-	.079	-	-	.003	-	-	.154	-	-
F	.58	-	-	12.64***	-	-	1.32	-	-	26.93***	-	-
Constant	2.079	.150	-	.666	.248	-	4.059	.154	-	1.546	.230	-
HIV Status (Control)	.128	.168	.036	.402	.176	.113*	.198	.172	.251	.257	.163	.070
Community Concern Motivations	-	-	-	.336	.043	.390***	-	-	-	.441	.040	.449***
Esteem Enhancement Motivations	-	-	-	-.098	.046	-.112*	-	-	-	.073	.043	.082
Δdf	1, 447	-	-	2, 446	-	-	1, 447	-	-	2, 446	-	-
ΔR^2	-	-	-	.125	-	-	-	-	-	.286	-	-
ΔF	-	-	-	31.86***	-	-	-	-	-	89.61***	-	-
R^2	.001	-	-	.126	-	-	.003	-	-	.289	-	-
F	.58	-	-	21.46***	-	-	1.32	-	-	60.35***	-	-

$p < .05$. ** $p < .01$. ***$p < .001$. Final df in all models = 3, 445. Total $n = 446$.

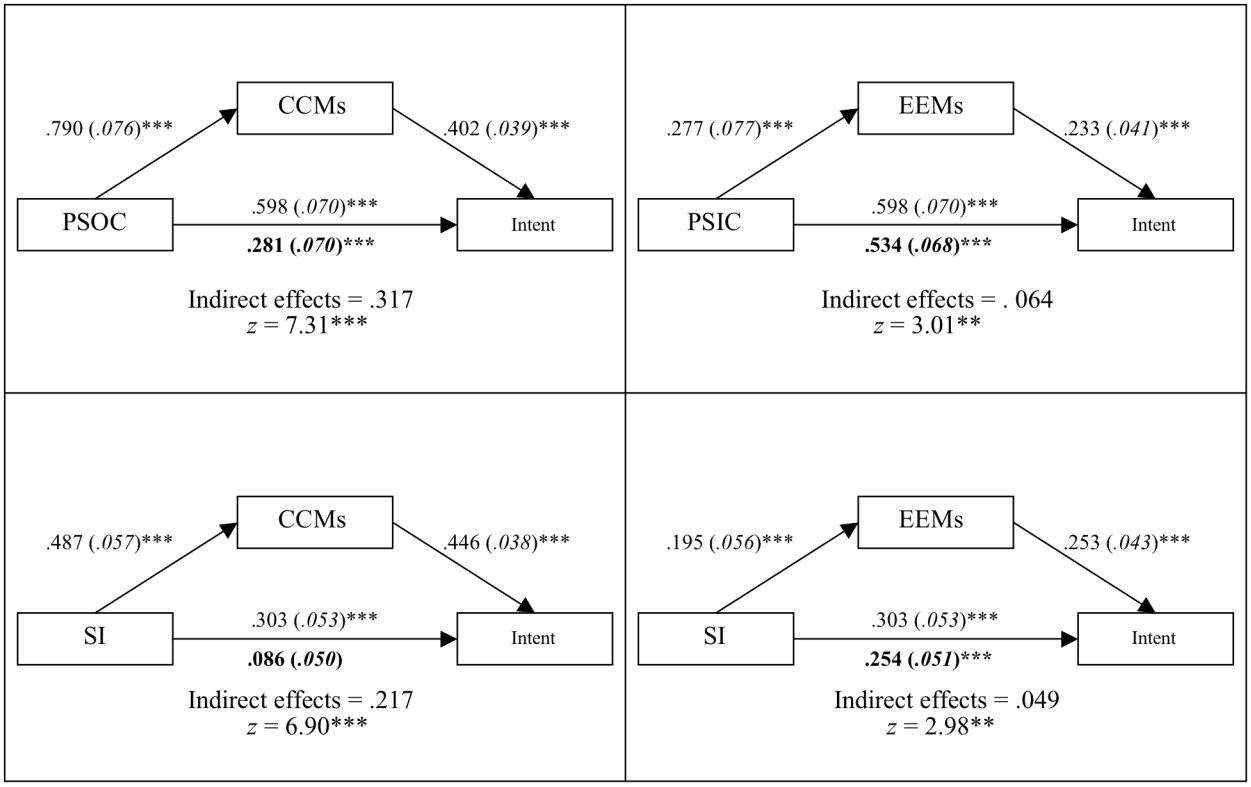
Figure Captions

Figure 1. Mediation models predicting AIDS activism

Figure 2. Mediation models predicting intent to participate in CAHA



Note: *$p < .05$, **$p < .01$, ***$p < .001$. *B* regression coefficients are shown, with standard errors of *B* in parentheses. Direct effects of each model are shown in bold. Indirect effects are calculated as the difference between the total and direct effects.



Note: *$p < .05$, **$p < .01$, ***$p < .001$. *B* regression coefficients are shown, with standard errors of *B* in parentheses. Direct effects of each model are shown in bold. Indirect effects are calculated as the difference between the total and direct effects.