The Problem of "Us" Versus "Them" and AIDS Stigma

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This article has two goals. The first is to consider what the social-psychological literature on social identity, ingroup-outgroup perception, and prejudice contributes to the understanding of AIDS-related stigma. The second is to address ways to make the world more comfortable and compassionate for people with AIDS (PWAs). At the core of AIDS-related stigma is the perception that PWAs are members of an outgroup threatening one’s social identity as a member of the nondeviant ingroup. A variety of psychological principles operate to heighten this perception and to make the boundaries between “us” and “them” seemingly impenetrable. Furthermore, reactions to PWAs are strongly affective and often involve multiple and conflicting emotional experiences. Models that consider the multifaceted, symbolic aspects of AIDS-related stigma may inform strategies for reducing the stigma. However, because many people may be resistant to direct attitude change tactics, the authors suggest an additional strategy that seeks to change attitudes indirectly by first changing behaviors.

AIDS. The acronym itself has the power to elicit multifaceted feelings including fear, revulsion, anger, contempt, self-righteousness, sympathy, pity, and shame. Furthermore, these feelings are not limited to the disease but are also conferred on those with whom the AIDS label has come to be most closely associated. The AIDS label is stigmatizing. This pattern of prejudice can take the form of negative attitudes and stereotypes about the epidemic and those who are victims of the illness, as well as hostile and avoidant behaviors directed toward people with AIDS (PWAs). Thus, beyond coping with a life-threatening disease, PWAs have fallen victim to profound patterns of discrimination: They have been fired from jobs, driven from their homes, and socially isolated (Herek & Cogan, 1995; Herek & Glunt, 1988; Hunter, 1990).

Several theorists have noted that negative reactions could be expected toward any epidemic of a lethal disease (Herek, 1990; McNeill, 1976; Pryor, Reeder, & McManus, 1991; Rosenberg, 1987). However, the nature of reactions and stigma associated with AIDS extends beyond realistic fears about risk for
infection and reflects instead the nature of AIDS-related stigma as a social phenomenon. AIDS stigma is socially constructed. In different regions of the world, AIDS stigmatization varies according to the groups in which the disease is most prevalent. In Africa and much of Asia, for example, AIDS is most prevalent among heterosexuals. In the United States, AIDS has been most prevalent among marginalized groups including homosexual and bisexual men, injecting drug users, Haitian immigrants, Blacks, and Hispanics. The specific nature of AIDS stigma in the United States appears to derive in large part from the prevalence of AIDS in these groups (Herek & Cogan, 1995). Thus, AIDS stigma is both a personal phenomenon, reflecting a potential threat to physical well-being (i.e., to one's identity as a healthy person), and a social phenomenon, reflecting a threat to core social values involving sexual behavior, morality, and religion. Indeed, rarely has any stigma had the capacity to simultaneously threaten so many core social identities.

The goals of this article are twofold. First, we consider what the social-psychological literatures on social identity, ingroup-outgroup perception, and prejudice can contribute to understanding AIDS stigma. Second, we address ways to make the world more comfortable and compassionate for PWAs. One of our basic contentions is that at the core of AIDS stigma is the strong perception that those who are HIV positive or who have AIDS are perceived by the uninfected as members of an outgroup. This perception is coupled with the need of uninfected persons to protect their social identity as a member of the nondeviant ingroup. A variety of psychological principles operate to heighten the perception among the uninfected of a difference between the ingroup ("us," or uninfected, nondeviant people) and the outgroup ("them," or infected, deviant people) and to make the boundaries between us and them rigid and seemingly impenetrable.

A second premise of this article is that traditional models of prejudice lack the ability to address the complex and multifaceted components of AIDS stigma. AIDS stigma is by no means a simple attitudinal phenomenon. It involves a potential threat not only to uninfected people's physical well-being but also to their valued social identities. Reactions by the uninfected to PWAs are strongly affective and often involve multiple and conflicting emotional experiences (Pryor & Reeder, 1993; Weiner, 1993a, 1993b). One of the current themes in AIDS stigma work is that the uninfected's attitudes toward PWAs are strongly related to heterosexuals' attitudes toward homosexuality (Conrad, 1986; Herek & Capitania, 1999 [this issue]; Herek & Glunt, 1988, 1993; Pryor et al., 1991; Pryor, Reeder, Vinacco, & Kott, 1989), and that expressing negative attitudes toward PWAs has become a convenient means of expressing hostility and intolerance of homosexuals and what they are believed to symbolize. We argue that models considering the multifaceted and symbolic aspects of AIDS stigma have the potential to inform strategies for reducing the stigma. However, because many uninfected people may be highly resistant to direct attitude
change, we suggest an additional strategy that seeks to change attitudes indirectly by first changing behaviors.

**SOCIAL IDENTITY THEORY AND AIDS STIGMA: THE MOTIVATION TO VIEW “US” AS DIFFERENT FROM “THEM”**

Because a social identity conception serves as our central theoretical focus, we first outline the essential elements of this theory that was developed by Tajfel (1981) and Tajfel and Turner (1986) to explain the nature of intergroup relations and the psychology of group processes. The theory's starting premise is that salient or important group memberships constitute a fundamental part of people's identities or self-concepts (see also Turner, 1987). Its second premise is that people are motivated to establish and maintain their self-esteem, and that various group memberships have positive esteem implications. Social identity theory holds that several psychological processes operating in the service of promoting self-esteem result from the act of categorizing oneself and others into groups. For example, group categorization leads to an accentuation of differences between one's own group and other groups (e.g., Abrams & Hogg, 1990).

In addition, group categorization leads to a series of social comparison processes. Tajfel and Turner (1986) argued that positive self-esteem is achieved and maintained through intergroup comparisons along characteristics that favor the ingroup. That is, when group boundaries are made salient, people search for intercategory differences that favor the group to which they belong or with which they identify. This competitive orientation leads to perceptual biases and discriminatory behavioral strategies, which function as attempts to differentiate between the ingroup and outgroup in a manner favoring the ingroup. As a result, differences favoring the ingroup are exaggerated, whereas differences favoring the outgroup are minimized or ignored. Tajfel and Turner (1986) further suggested that these categorization processes produce affective and motivational outcomes. That is, when social identities are salient, people can be expected to experience positive affect on behalf of the ingroup and be moved to act toward ingroup goals. Similarly, negative emotions can be directed toward the outgroup. Such emotions, experienced in response to group-based outcomes, can be considered social, as opposed to personal emotions (Smith, 1993).

We believe that AIDS stigma is inextricably intertwined with social identities and the motivation to maintain positive social identities. We contend that a great deal of negativity toward PWAs arises out of uninfected people's need to protect their identity as healthy and nondeviant. Interactions with PWAs simultaneously make salient and threaten social identities that, for some, involve personally important moral and religious core values. As the history of the epidemic makes clear, a variety of factors conspired to facilitate the perception of those who fell prey to HIV in the early stages of the epidemic as different and deviant. In what
follows, we place this history in the context of social identity theory and the motivation to perceive the ingroup ("us") as different from and better than the stigmatized outgroup ("them").

**US VERSUS THEM: LINGUISTIC CONTAINMENT OF THE DISEASE**

Categorization of people into groups simplifies the complexity of the social world (Allport, 1954; Hamilton & Sherman, 1994; Hamilton & Trolier, 1986). However adaptive such categorization processes are for social perception, it is well documented that even the mere categorization of people into ingroups and outgroups leads social perceivers to differentiate between ingroup and outgroup members in ways that most often favor the ingroup (see Devine, 1995, for a recent review). In a provocative line of research, Dovidio, Gaertner, and their colleagues suggested that even the linguistic labels used to connote ingroup status (us, our, we) compared to outgroup status (them, they, theirs) conspire to create and perpetuate intergroup biases (Dovidio & Gaertner, 1993; Perdue, Dovidio, Gurtman, & Tyler, 1990). A brief consideration of the history of AIDS in the United States reveals how language, especially when combined with ingroup members' motivations to distance themselves from outgroups, can manufacture group boundaries to perpetuate and exaggerate the perceptions of difference.

**THE GENERAL PUBLIC VERSUS RISK GROUPS AS US VERSUS THEM IN THE HISTORY OF AIDS**

AIDS was first identified in the United States in 1981 among homosexual men. The assumption that their homosexuality made PWAs vulnerable to the then-mysterious disease generally convinced uninfected Americans that the disease was safely contained among a subgroup of the population. This assumption was, however, ultimately abandoned when the illness was discovered among injecting drug users and Haitian immigrants. As it became clear that the disease was no longer exclusive to the gay community, questions immediately arose as to exactly who was at risk and how the disease was spread. As scientists worked to understand the modes of transmission of what was becoming known as a deadly disease, fear in the general public escalated. In an effort to quell these fears, the Centers for Disease Control (CDC) used the notion of risk groups to differentiate between those who were initially the most common victims of the disease and everyone else.¹ The use of risk group labels encouraged collective rather than individualized perceptions of PWAs. Thus, from the inception of the epidemic, the public was encouraged to think about AIDS in terms of social groups and not individual persons (Herek, 1990). According to social identity theory (Tajfel, 1981; Tajfel & Turner, 1986; Turner, 1987), this
categorization would inevitably lead uninfected people to accentuate differences between themselves and PWAs and to make intergroup comparisons that would exaggerate their own favorable characteristics.

Early on, AIDS became associated with the populations it most often affected: homosexual and bisexual men, injecting drug users, and Haitian immigrants. A factor in AIDS stigmatization that cannot be overlooked in examining these historical facts is that each of these groups was already stigmatized in the United States (Herek, 1990). For the uninfected, the course of the disease easily gave rise to perceptions of those infected with HIV and those with AIDS as "them" (Sontag, 1988). Because of the close association between AIDS and the risk groups, members of the latter are multiply stigmatized whether or not they are infected with HIV. Consequently, many homosexual and bisexual men and injecting drug users suffer from AIDS stigma, even when not infected.

The literature on ingroup-outgroup tensions documents an obvious preference for members of one's ingroup (see Devine, 1995, for a review). In the case of AIDS stigma, not only is this preference evident, but outgroup members can be perceived as a threat to ingroup social identities. Such threats can elicit social emotions from ingroup members that range from dislike and contempt for the outgroup to callousness and disregard (Blendon & Donelan, 1988; Herek & Cogan, 1995). Terms like immoral, disgusting, and dirty are part of AIDS stigma (e.g., Pryor et al., 1989). It is no coincidence that AIDS-related media coverage and research increased as AIDS was discovered to be "creeping outside well-defined epidemiological confines" (Newsweek, 1983, p. 74). The linguistic boundaries between us and them were effectively being challenged. When it became clear that the disease did not respect the linguistic socially defined boundaries, a newly felt need for protective action arose among the uninfected. Thus, concern derived not from worry about the well-being of those already stricken with the disease (who were generally perceived as dirty, immoral, and them), but rather from fear of the disease's potential to affect the general public (cast as clean, acceptable, moral, and us). As such, the disease endangered both the health and the social identities of the so-called general public. The outgroup now was not only different, but threatening.

As will become apparent, the public's focus on risk groups may be the single most destructive social component of the AIDS epidemic. Even AIDS education materials have promoted a rather prevalent us versus them theme (Croteau & Morgan, 1989). Uninfected people are often presented as innocents, threatened not by their own risk behaviors but by guilty, blameworthy others. Members of the risk groups and PWAs had become a menace to the health and social identities of the general public. The ultimate impact of these social barriers in the form of risk group labels served to further marginalize and stigmatize those who fell prey to the disease.
AIDS AS ACQUIRED:
THE MORAL CULPABILITY OF THEM

As we have indicated, to observe AIDS stigma in the United States is to confront a pluralistic phenomenon. The multiple stigmatization of PWAs may arise out of the multiple attributions uninfected people make about PWAs when thinking about AIDS and how one contracts it. As its name indicates, AIDS is an acquired disease, and among those who are fortunate enough not to have HIV, the knowledge that someone has been diagnosed HIV positive elicits interest in and concerns over how the virus was caught. Whether driven by a desire to learn how to avoid the illness, a need to judge others or distance oneself from the infected, or simple curiosity, HIV-negative individuals often speculate, on finding out that a person is HIV positive, about the means by which he or she acquired the virus (Weiner, 1993a, 1993b). Unfortunately, the salience of this particular attribution facilitates what may be the most insidious of all aspects of AIDS stigma: blame.

A common theme in the stigmatization of PWAs is that they are morally suspect and therefore ultimately to blame for their circumstances. In most cases, one must actively acquire HIV through blood-to-blood contact, which occurs most efficiently through needle sharing and unprotected homosexual or heterosexual sex, activities that are greatly frowned upon in a heterocentric, puritanical society such as the United States. In short, the stereotype holds that the typical person with AIDS did something bad to get it. When AIDS is contracted through heterosexual sex, the most common attribution by the uninfected is blame—in this case, for promiscuous behavior—which further serves to protect the uninfected person’s ingroup status as a nonpromiscuous heterosexual. In this manner, former ingroup members are functionally (and conveniently) placed outside the boundary of “good” heterosexuals. For many of the uninfected, the promiscuous other has become representative of yet another finite group of people from whom it is easy to distance oneself. This notion of blame and responsibility is also implied in the use of the label innocent victims (Albert, 1986) to refer to those who did nothing voluntary to contract the disease (e.g., hemophiliacs, babies born to HIV-infected mothers).

Blame helps to make what is incomprehensible somehow explicable and potentially controllable. In premodern times, disease was explained by the wrath of God or divine intervention. According to Cadwell (1991), in the case of AIDS, attributing blame “is an attempt to make the locus of risk outside oneself in ‘the other’ ” (p. 240). Only when outcomes are controllable can blame be attributed, and with blame comes responsibility. Indeed, a substantial minority of Americans see AIDS as deserved punishment for offensive and immoral behavior and these beliefs are on the rise (Blendon & Donelan, 1988; Herek & Capitanio, 1998). This minority of individuals is part of a larger group that
subscribes to the "just world" hypothesis (Lerner & Miller, 1978). Embodied in popular adages like "what goes around comes around," the just world hypothesis holds that events happen to people for a reason. Specifically, good things happen to people who have been good, and bad things happen to people who have been bad. Despite its suggestion of a watchful God, the just world hypothesis is endorsed by religious and nonreligious people alike. At its root is the desire to impose some predictability onto the world in the form of cosmic balance. Unfortunately, the hypothesis is usually used fallaciously as a post hoc justification for others’ misfortunes. In the case of AIDS stigma, endorsement of the just world hypothesis by the uninfected is generally associated with the belief that PWAs acquired HIV because the watchful eye of a greater cosmic force has given them what they deserve. It thus serves to justify assessments of PWAs' moral culpability for AIDS, and to widen the gap between us and them.

Perceived responsibility for being in a stigmatized condition is an important factor not only in determining how uninfected people think about PWAs, but also in determining how they react to individuals with this stigma. Weiner (1993a, 1993b) has explored extensively the dichotomy of sin and sickness as attributions made about disadvantaged others. He argues that AIDS is considered by many to be a sin in addition to a sickness because of the attributions made about personal responsibility of PWAs for their illness. Weiner’s theory arises out of his own observations that the U.S. legal system is dedicated to determining people’s moral culpability for their actions. The extent of punishment or lack thereof is a positive function of the degree to which individuals are perceived to be in control of their reprehensible actions or stigmatized status. Weiner asserted that with perceived controllability come attributions of responsibility and blame, and that these attributions determine the type of affect directed toward the person or group being evaluated. Affect is proposed to be the necessary antecedent of attitudes and behaviors directed toward stigmatized others.

Weiner (1993a, 1993b) and Weiner and Kukla (1970) propose a model to account for attitudes toward others who have been stigmatized by failures. According to this model, failure due to lack of effort evokes more punishment and intolerance than failure due to lack of ability. This model can be represented as a flow chart beginning with perceptions of controllable causality for another's stigmatized condition or "failure" (see Figure 1). The model can be applied to AIDS stigma by defining failure as the contraction of HIV. When PWAs are perceived as having control over the means by which they contracted HIV (e.g., homosexual sex, drug use), they are held responsible for their condition. Perceived responsibility elicits anger from the uninfected and thereby leads to neglect and rejection. On the other hand, when PWAs are perceived as not having control over the means by which they contracted HIV (e.g., blood transfusion), they are not held responsible for their condition. Perceived lack of
Figure 1: Model for Reactions to Other’s Stigmatized Condition or Failure

Responsibility elicits sympathy from uninfected others and thereby leads to helping behavior.

Zucker and Weiner (1993) tested a path model that included the terms described above, with interest in giving help as the outcome variable. They found that responsibility was negatively related to sympathy and positively related to anger. In addition, sympathy positively predicted help giving and anger negatively predicted help giving. Weiner (1993b) proposed that the same basic pattern holds for aggression toward target persons after they acquire a negative condition.

In a timely study of AIDS and responsibility, Weiner and his colleagues (Graham, Weiner, Giuliano, & Williams, 1993) examined HIV-negative people’s reactions to Earvin “Magic” Johnson, a distinguished professional basketball player who publicly announced that he was HIV positive. Before Johnson had publicly announced how he had contracted HIV, participants speculated on how he had acquired HIV and reported their feelings of anger and sympathy toward him. When participants imagined that he had acquired HIV through a blood transfusion, they blamed Johnson less than when they guessed that he had acquired HIV from drug use or homosexual sex. As blame increased, attributions of responsibility and feelings of anger rose whereas feelings of sympathy declined, in a clear interaction pattern.

Weiner (1993a) proposed that there are cognitive connections to the perceived causes of AIDS that result in different affective reactions. AIDS and its most commonly perceived sources—homosexuality and drug use—are regarded by many as controllable, deviant, morally repugnant, dangerous, and deadly. When encountering a PWA, any of these cognitive connections may be activated. Each leads to specific and different affective consequences. For example, the idea that AIDS is contagious elicits fear and anger whereas the conception that homosexuality, a perceived source of HIV infection, is morally wrong elicits feelings of disgust (Weiner, 1993a). These different affective reactions are likely to lead to different behavioral tendencies ranging from altruistic help to neglect or even aggression (see also Smith, 1993).
ADDRESSING SYMBOLIC REACTIONS:  
CHANGING THE FACE OF HOMOPHOBIA  
AND OTHER CONCEPTIONS OF THEM

The best-known AIDS risk group in the United States is homosexual men. It appears that since the beginning of the AIDS epidemic in this country, there has been a general inability among heterosexuals to separate the disease from gay men. Uninfected people's attitudes about AIDS are often intertwined with their attitudes toward homosexuals (e.g., Herak & Capitanio, 1999; Herak & Cogan, 1995; Herak & Glunt, 1988, 1993; Pryor et al., 1989). Because homosexuality and AIDS are so closely linked in the collective mind, prejudice toward homosexuals can kindle hatred toward PWAs, and vice versa. Homophobic people may come to stigmatize AIDS victims, whereas those afraid of the disease may transfer their fear to homosexuals. This vicious cycle of fear and hatred can lead to a comfortable cycle of rationalization and justification for negativity expressed toward both homosexuals and PWAs. Returning to our argument that AIDS stigma is tied to the motivation to maintain positive social identities, we contend that homosexuals are just one example of a risk group that threatens heterosexuals' social identities involving personally important moral and religious core values. Indeed, the threat to important social identities, combined with the desire to see oneself as safe from the disease, may together underlie a tendency among the uninfected to see PWAs as responsible for their disease.

The symbolic threat that AIDS poses to multiple social identities makes AIDS prejudice a stigma that will not easily be eradicated. If the majority of uninfected people's negative attitudes toward PWAs are rooted in homophobia, then it seems clear that the latter attitudes need to be changed. Indeed, Herak and others have argued that an underlying problem in AIDS stigma in the United States is homophobic attitudes, because heterosexuals' negative attitudes toward homosexuals are so closely related to their negative attitudes toward PWAs (Herak & Capitanio, 1999). Homophobic attitudes clearly are a serious problem, but social psychology's traditional approaches to attitudes may not capture the complexities of people's reactions to PWAs (Smith, 1993). We believe that the issues are more complex than simply changing heterosexuals' negative attitudes toward homosexuals. A broader conception in terms of social identities and the nature of the threat to social identities created by AIDS may ultimately prove more productive in reducing the ill effects of AIDS stigma. The conception we recommend here is a link between appraisals, affect, and action tendencies (Smith, 1993; Weiner, 1993a, 1993b; Weiner & Kukla, 1970; Zucker & Weiner, 1993).

Smith (1993) argued that the traditional social-psychological conceptions of stereotypes, prejudice, and discrimination as beliefs, attitudes, and attitude-driven behavior may be inadequate to explain the complex nature of reactions to outgroup members. Specifically, Smith contends that prejudice-as-attitude
models focus too narrowly on the evaluative (like vs. dislike) nature of stereotypes and attitudes. The prejudice-as-attitude conception cannot effectively explain the variety of qualitatively distinct emotional reactions to outgroups such as hatred, fear, contempt, and disgust. Smith additionally contended that, despite advances made in the prejudice-as-attitude tradition, it cannot effectively account for situational specificity in ingroup members’ reactions to outgroup members (i.e., the fact that people respond to members of an outgroup differently in different situations).

To address these complexities, Smith (1993) offered an alternative conceptualization in terms of appraisals, emotions, and action tendencies, based on perceivers' social identities. He proposed that when people are in intergroup interactions, their social identities become salient and appraisals are made of outgroup members in the context of these social identities. Smith's model, which is conceptually quite similar to Weiner's analysis reviewed above, contends that people's cognitions or appraisals regarding stigmatized others lead to the particular emotional reaction that they experience in response to these others. This emotional reaction in turn determines the type of behavior ultimately exhibited toward the stigmatized others. Whereas Weiner's (1993a, 1993b) model is constructed in terms of a dichotomy of emotional reactions (anger vs. sympathy), Smith's model allows for greater complexity in emotional reactions, depending on the appraisals made and the specific social identities threatened. Given our contention that AIDS stigma is multifaceted because AIDS and PWAs can threaten so many different social identities, Smith's analysis may provide a particularly useful explanatory framework. HIV-negative people may make dramatically different appraisals of PWAs based on whatever social identity has been made salient, and their emotional reactions to PWAs can in turn include not only sympathy and anger, but fear, disgust, contempt, and a host of other emotional reactions. Table 1 provides a diverse sampling of threatened social identities and appraisals that may be made regarding PWAs, and the emotions and action tendencies that may be expected to be associated with each.

Traditional approaches to prejudice are not equipped conceptually to address such complexities in reactions to PWAs. It is not enough to talk about the positivity or negativity of an uninfected individual's reaction to PWAs. It is also necessary to know which cherished value, rule, or norm has been violated. For example, a PWA may be viewed as a threat to one's social identity as a conservative and religious heterosexual. The PWA, particularly if homosexual, will be viewed as morally weak and irreverent to religious codes of behavior. This appraisal may result in feelings of disgust and anger, which in turn lead to active avoidance and rejection of the PWA. Disgust and anger, however, are only two of the possible emotions that may be experienced as a result of different appraisals regarding PWAs, and it is important to note that the appraisals are not mutually exclusive. That is, a person can be viewed as violating more than one cherished value (e.g., a homosexual may be viewed as violating religious values, as
TABLE 1: Examples of Threatened Identities, Appraisals, Emotions, and Action Tendencies of Uninfected Heterosexuals Toward PWAs

<table>
<thead>
<tr>
<th>Threatened Identity</th>
<th>Appraisal</th>
<th>Emotion</th>
<th>Action Tendencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instrumental</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self as a healthy person</td>
<td>PWA is contagious</td>
<td></td>
<td>Active avoidance or nonaltruistic help</td>
</tr>
<tr>
<td>Symbolic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self as a moral heterosexual</td>
<td>PWA violates moral values (e.g., homosexual)</td>
<td></td>
<td>Neglect or active discrimination</td>
</tr>
<tr>
<td>Self as virtuous and conscientious</td>
<td>PWA is morally weak (e.g., drug user)</td>
<td></td>
<td>Neglect or active discrimination</td>
</tr>
<tr>
<td>Self as careful and avoiding danger</td>
<td>PWA has acquired a controllable illness</td>
<td></td>
<td>Active discrimination</td>
</tr>
</tbody>
</table>

NOTE: PWA = person with AIDS.
promiscuous, and as reckless). In such cases, we expect the emotional reactions elicited in response to that person to be similarly multifaceted. Recognizing the complex nature of people’s emotional reactions may help us to understand the breadth of their negative action tendencies and may be related to the tenacious resistance of their negativity to change (Smith, 1993; Zuwerink & Devine, 1996).

It is our contention that the pattern of attribution, affect, and action serves to protect HIV-negative people’s social identities as healthy, moral, and safe. By making attributions of blame, uninfected individuals can decrease their sense that the disease is capricious and increase their sense of control. Establishing this control creates the sense of invulnerability. To improve uninfected people’s attitudes toward PWAs, it will be vital to tailor persuasive appeals to fit their appraisal and emotional reaction. Trying to decrease fear in reaction to AIDS, as is often done with educational materials (see Pryor et al., 1991), does nothing to reduce the anger and disgust resulting from feeling that one’s moral codes of behavior have been violated. We resonate strongly to Smith’s (1993) admonition that traditional strategies for reducing negative attitudes, rooted for example in the contact hypothesis or in changing the valence of negative attitudes, are likely to fail in reducing prejudice toward homosexuals or PWAs because these strategies oversimplify what is involved in changing attitudes related to cherished social identities.

COMBATING AIDS STIGMA:
A BATTLE ON TWO FRONTS

In the final section of this article, we propose a two-pronged strategy for reducing AIDS stigma that combines a direct attitude change approach with an indirect approach of changing attitudes by first changing behaviors. We advocate this strategy as a means of helping to make PWAs’ social environment less conducive to the expression of prejudice, yet rich with information that should help facilitate attitude change among those who stigmatize PWAs.

CHANGING ATTITUDES DIRECTLY

The first part of our strategy involves implementing attitude change directly through what Devine and Hirt (1989) call message-based persuasion, wherein communications are constructed to convey positive information about the attitude object with the expectation that this information creates positive attitudes, which in turn will lead to positive behavior toward the attitude object. Perhaps the most important component of reducing AIDS stigma is to challenge the uninfected person’s notion that AIDS is a disease of “them” by eradicating ingroup-outgroup boundaries. This goal could be achieved with public education information campaigns that address risky behaviors without attributing
these behaviors to a specific group. Such an approach should help to break down the conception of us versus them and create the impression of one group, all people, who are threatened by the disease.

The symbolic threat of AIDS to multiple social identities makes AIDS-related prejudice a stigma that will not be eradicated by simple informational campaigns alone. More elaborate communications should be developed that explicitly target the various threats to social identities and emotional reactions that uninfected people feel toward PWAs (see Table 1). Although addressing the risk behaviors may help to quell the fears of those whose sense of themselves as healthy individuals is threatened, it would not reduce negative feelings among those who feel disgust toward PWAs because of the disease’s connection to perceived immoral activities (e.g., homosexuality). For the latter group, a more effective strategy may be to diminish the connection between the disease and these groups as well as to attack their homophobic attitudes. By eliminating the threat to their identity as a moral heterosexual, the basis for the attitudes is eliminated. A series of communications that address the threats to various social identities may be an effective strategy for reducing prejudice among those with symbolic reactions to PWAs.

Changing such group-based reactions is likely to be difficult. Indeed, the perennial challenge faced by prejudice theorists is to change negative attitudes. Attitudes rooted in core values, such as those associated with AIDS stigma, are notoriously difficult to change (Eagly & Chaiken, 1993; Rokeach, 1973; Zuwerink & Devine, 1996). Indeed, heterosexuals with highly homophobic attitudes are strongly resistant to direct attitude change efforts (Herek & Glunt, 1988; Pryor et al., 1989). People’s core values are likely to be related to important social identities. However, the emphasis on cherished social identities suggests a possibly effective strategy to initiate change. Rokeach (1973) developed a technique that encouraged people to view their prejudiced racial attitudes in the context of their more important values of being egalitarian. To the extent that there was an inconsistency between their values and their more specific attitudes, people became dissatisfied with their prejudiced attitudes and prejudice reduction was initiated. It is possible that heterosexuals’ prejudices toward homosexuals or PWAs could be inconsistent with other cherished social identities, such as perceiving oneself as a caring and compassionate person. Making such inconsistencies salient (e.g., confronting the person with the incompatibility of prejudice and compassion) may similarly produce self-dissatisfaction and help to initiate change (Rokeach, 1973). More recent work suggests that such self-dissatisfaction is indeed motivating and facilitates prejudice reduction efforts (Devine & Monteith, 1993; Monteith, 1993). However, given the complex and tenacious nature of prejudice and AIDS stigmatization, we propose a second approach to reducing AIDS stigma that may facilitate change if used in tandem with the direct change efforts.
CHANGING ATTITUDES INDIRECTLY
BY CHANGING BEHAVIORS FIRST

Perhaps equally important to direct attempts to change attitudes are indirect efforts focused on first changing behavior as a means of producing attitude change. Devine and Hirt (1989) called this strategy behavioral-based persuasion. A wealth of social-psychological research points to the effectiveness of inducing behavioral change as a precursor to attitude change. Research on the well-documented cognitive dissonance effect (Festinger, 1957) demonstrates that, when induced to behave in a manner inconsistent with their initial attitudes, people will change their attitudes to conform to their behavior. Despite its effectiveness, the problem with efforts to change social stigmatization of a particular group in this way is figuring out how to induce behavioral change in the first place. In his chapter on the values, rationales, and impact of social marketing campaigns, Salmon (1989) pointed out that one of the most effective ways to implement behavioral change is to involve powerful organizations in the social marketing process: “Without question, this power (to control the framing or defining of an issue) resides disproportionately with government, corporations, and other institutions possessing legitimacy, social power and resources and access to the mass media” (p. 25). Thus, it seems that there are two ways that government and other powerful institutions can invoke behavioral change in mass populations: first, by legislating change, and second, by campaigning for change.

The first strategy, legislation, was accomplished by the inclusion of PWAs and HIV-positive people under the Americans with Disabilities Act. However, despite the protection of PWAs under the law, AIDS stigma persists. Although legislation may help to minimize some of the most overt kinds of prejudice against PWAs, its power to eliminate some of the more subtle types of discrimination is tenuous (see Burris, 1999 [this issue]). Legislative action need not be the only route toward behavioral change, however. When combined with other strategies, mandating change may facilitate the speed with which behavioral change becomes attitudinal change. For example, information campaigns could be developed to support behavioral change through appeals to audience members’ existing identities (e.g., law-abiding citizens) or the identities that they want to have (e.g., fair and open-minded humanitarians).

Perhaps the most basic identity to appeal to is audience members’ identity as possessing the majority opinion (Cialdini, 1988). If informational campaigns are created in which tolerance for PWAs is portrayed as part of a positive social identity that is held by the majority (e.g., being a humanitarian), behavioral change should be facilitated in both the short- and long-term. Given that most people already hold the belief (whether they practice it or not) that prejudice is wrong, such campaigns should work to induce HIV-negative people to act in accordance with this belief. The ultimate goal of the behavior-first campaigns
that we are advocating is to create a social environment in which tolerance toward PWAs is seen as the norm and extreme anti-PWA views cannot flourish.

The benefits of the current legislation are that it creates a certain amount of behavioral change instantly, and the likelihood that behavior-consistent attitudes will follow is increased by the fact that most people already hold positive attitudes toward obeying the law. Deference to authority is the behavioral default for many (Cialdini, 1988). Thus, changing social norms may be sufficient to produce behavior change. Following such behavior change, powerful psychological principles rooted in dissonance theory are pulled into play that may contribute to positive change. When behavior contradicts attitudes, people experience discomfort, which they are motivated to reduce (Festinger, 1957). When the behavior change is inevitable, people need to develop rationalizations to support their behaviors. As a result, people may begin to minimize the negative aspects of their attitudes and maximize the positive aspects of their changed behavior. In addition, they may come to view themselves as the type of people who do not discriminate against others and who are fair-minded and tolerant (Cialdini, 1988).

We advocate using message-based and behavioral-based persuasion strategies in concert to create the most comprehensive and effective attack possible on AIDS stigma. In addition, we advocate constructing the messages in terms of risky behaviors rather than risk groups to avoid exacerbating the problem of AIDS stigma. The combination of attitude-change campaigns, behavior-change campaigns, and legislation is a powerful antidote to the problem of AIDS stigmatization. Although such a project may seem like an enormous undertaking, we believe that with time and the continued spread of AIDS, it will become more and more evident to the worldwide risk group that we all have a stake in altering the current environment of prejudice that keeps PWAs from living in a comfortable and compassionate world.

NOTE

1. We do not wish to suggest that the Centers for Disease Control (CDC) had any negative motivations in using the risk group terminology. Indeed, given the ambiguity surrounding the disease at that time, we suspect that the CDC was doing its best to communicate with the American public about the disease. Furthermore, the use of this terminology is not uncommon practice. However, we believe that the concept of risk groups has contributed greatly to the sense that those vulnerable to the disease are outgroup members and simultaneously confers on those who are not members of the so-called risk groups a sense of invulnerability to the disease.

REFERENCES


