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**Some psychological factors underlying the request for social isolation of
Aids victims**

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Introduction

In recent years the question of isolating aids patients has been the focus of energetic debate. On the one hand, in order to control the epidemic, there is the call for measures which include mandatory registration, isolation, and exclusion from the work place of individuals who carry the AIDS virus. On the other hand, there is concern that such measures threaten basic human and constitutional rights.

Psychologically, the call for isolation of AIDS virus carriers can be understood as an expression of fear of the disease due to the increasing risk of infection. But fear is not the only possible reason behind the demand for isolation. AIDS can be considered to be a sexually transmitted disease, primarily spread by homo- and bisexual males as well as by drug users and prostitutes. In either case, socially related prejudices and animosities directed towards these minorities may be an additional motivating factor stimulating the call for isolation of AIDS virus carriers.

Research Questions

The central research question guiding the present study was: Is the tendency to isolate AIDS virus carriers motivated primarily by the fear of getting infected with the AIDS virus, or are other motivational factors involved? In addition to the fear of getting infected with the disease, two other probable motivations were tested: (a) belief in a just world (LERNER 1970, 1980) and (b) prejudices held against the primary AIDS at-risk groups: homosexuals, prostitutes, and heroin addicts (fixers).

The threat of being infected with the AIDS virus presents not only a danger to physical health, but also poses a threat to the security providing conviction that the world is just. How does a belief that the world is just, as a general perspective, relate to tendencies to want to isolate AIDS virus carriers? One's belief in a just world might be threatened if a person can be accidentally infected with the AIDS virus. However if infection with the AIDS virus is seen as caused by the individual himself, and, therefore avoidable, the belief that the world is just is not affected. Accordingly, attribution of blame to the victims for having caused their fate themselves is expected by those individuals who believe in a just world (LERNER 1980; MONTADA 1983). Such attributions of blame have their effects. They interfere with prosocial feelings and behavior while, at the same time, making antisocial feelings and behaviors easier as e.g. the request for isolation of AIDS virus carriers.

Evidence for this is available from everyday observations (RYAN 1971), field experiments (PILIAVIN, RODIN & PILIAVIN 1969) and studies (MONTADA, SCHNEIDER & REICHLER 1988). Rejection is frequent when personal responsibility is assumed for an emergency situation. Accordingly, in the case of AIDS patients who are accused of being responsible for their situation, the path is clear to take actions which will separate them, for example, exclusion from the work place and isolation. The harshness of these approaches is justified not only because of their preventive effects, but also because they serve as penalties for self-induced risks and the endangerment of others.

Isolation tendencies can be explained more directly by prejudices against at-risk groups. Prejudices lay the basis for the request to exclude these groups. This applies to the needy as well as to the victims of misfortune (MONTADA, SCHMITT & DALBERT 1986; MAES & MONTADA 1988), especially when the victim himself poses a threat, such as in the case of AIDS. The tendency to isolate AIDS patients can be explained with this hypothesis, assuming that

the greater majority of AIDS victims come from social groups against which there is a good deal of prejudice.

The empirical question to be clarified was whether social prejudices lead directly to tendencies to isolate AIDS virus carriers or whether intervening factors are involved. Concerning mediating factors one hypothesis was that the risks due to contacts with AIDS victims could be exaggerated. For example, those who overestimate the risks from non sexual bodily contact or shared use of toilets and swimming facilities will be more likely to support or approve isolation of AIDS virus carriers if the latter come from groups against which there is prejudice.

A further empirical question was addressed in this study: How do members of the at-risk groups, e.g., homosexuals, differentiate themselves from members of the "normal" population in regard to tendencies to isolate AIDS virus carriers. Do they support or do they reject separation because they identify socially with the AIDS virus carriers or because they see themselves as potential AIDS victims? Possibly through this anticipation they can represent the position of AIDS victims, namely, the rejection of isolation from the larger society.

In order to answer the questions raised above, scales were developed which were designed to measure attitudes toward the isolation of AIDS patients and to assess the validity of a few selected predictors. All the scales used in the investigation, with the exception of the "belief in the just world"-scale, were newly developed.

Methods

1. Definition of the variables

The variables used in the study were defined by items requiring the subject

to respond to a series of statements. With the exception of estimates of the risk of infection from the AIDS virus, personal evaluation of the statements was made on a six-point scale (1 = I completely disagree; 6 = I agree fully). The dimensionality of the scales was ascertained by subjecting the items to principal component analysis with varimax rotation employing criteria such as factor loadings, item consistency and discriminability. In all subsequent analyses only those scales and items were used which met or expanded the traditional psychometric criteria.

Tendencies for social isolation of AIDS virus carriers

There are several forms of isolation: Disallowing participation in certain professions or occupations, firing from the job, exclusion from social groups, assignment to isolation wards, barring from use of public toilets and bathing facilities, etc. In order for isolation to be effective, public health officials must be able to apply, by force if necessary, diagnostic controls and preventive procedures. Exemplary items to assess this are: "Protection of the population justifies steps which involve reduction of the basic rights of the virus carrier." "Virus carriers whose occupation requires intensive contact with people should not be allowed to continue their occupations." "AIDS patients should not be allowed to use any public bathing facilities." A 14 item scale measuring attitudes concerning the isolation of AIDS virus carriers was established. It had high internal consistency ($\alpha = .91$).

Belief in a just world

RUBIN and PEPLAU (1975) were the first to operationalize and apply Lerner's construct by developing a scale assessing individual differences in the strength of belief in a just world. A reliable and valid German version of the scale was developed by DALBERT, MONTADA, and SCHMITT (1985, 1988). The

German version contains both a general scale and area specific subscales. In the present study, items from the general scale were used to measure subjects' generalized belief in a just world. Example items are: "In my view, the world is generally just." "I am certain that justice in the world will prevail." A four item scale measuring "belief in a just world" was shown to be sufficiently reliable ($\alpha = .73$).

Blaming AIDS victims for self-infliction of the disease

In order to assess the tendency of the subjects to directly blame or to reproach the AIDS victims for their own responsibility for the disease, statements specifically addressing AIDS transmitters were formulated. Examples of the items are: "Many AIDS virus carriers have themselves to blame through their deviant sexual behavior." "There is something true about the statement that many AIDS infections are a punishment for an immoral lifestyle." The resulting seven-item scale was reliable ($\alpha = .74$).

Opinions on the risk of contact with AIDS virus carriers

Opinions on the risk of infection with the AIDS virus were assessed through questions involving different aspects of everyday life, work in the medical professions, and sexual activity. According to present knowledge, the risk of getting infected with the AIDS virus through everyday, casual contact is minimal. It was expected that the appraisal of the risk of getting infected through everyday, casual contact would be a direct or indirect predictor of the tendency to socially isolate AIDS virus carriers. Factor analysis of the data revealed two factors: "Everyday (casual) contacts and working in medical professions" (Factor 1) and "sexual contacts" (Factor 2). As shown in the subsequent analyses only items marking the first factor were used, informations given are on these only. Examples of items are: Use of public saunas, shaking hands with an AIDS virus carrier, and caring for AIDS

patients under standard hygienic conditions.

The risks inherent in these contacts were assessed on a six-point scale (1 = not at all dangerous; 6 = very dangerous). The internal consistency estimate for the items marking Factor 1 was $\alpha = .87$.

General and AIDS-specific fear of becoming ill

In order to assess the fear of becoming ill, six general and four AIDS-specific items were employed. Factor analysis of these data resulted in a two-factor solution, with each factor being marked by four items. The first factor, "general fear of becoming ill", was marked by items such as "Although I have no specific complaints, it gives me comfort to be regularly examined by a doctor." The second factor, "AIDS-specific fear of becoming ill", was marked by items such as "Ever since symptoms of AIDS have become known, I frequently observe myself for typical signs of symptoms of AIDS". The internal consistencies of the scales were $\alpha = .78$ and $.68$, respectively.

Attitudes towards the at-risk groups

Scales were developed to assess potentially prejudicial attitudes toward the three at-risk groups: homosexuals, prostitutes, and heroin addicts. Not only negatively formulated items were used but also those with liberal, accepting and understanding viewpoints were given. Factor analysis of the data resulted in factors reflecting the positive or negative orientations expressed in the items. For further analyses, only the negatively stated items were used. For the scales assessing attitudes towards homosexuals and prostitutes, the internal consistencies were high ($\alpha = .81$ and $.78$, respectively). The scale assessing attitudes towards heroin addicts was defined by only two items thereby not allowing calculation of internal consistency estimates.

Further analyses of the data involving attitudes to the three at-risk groups were carried out using an aggregate score summed across the negative items of all three at-risk groups.

Samples

Two subsamples were included with a total of 107 subjects, 44 women and 62 men aged between 17 and 54 years, the mean age being 26. Sampling was done (a) in the general student population (N = 97) and (b) in a local group of homosexuals (N = 11). The sexual orientation was one of the informations asked for in the questionnaires. Six students reporting to have homo- or bisexual orientations were added to the group of homosexuals, raising the number in this subsample to N = 17. Since five subjects did not inform about their sexual orientation they were excluded. The heterosexual student sample comprised 85 subjects. 61 subjects in the sample reported to have had or to still have contact to homosexuals (14 of them frequently), 30 to drug addicts and 16 reported experiences with prostitutes.

Data analyses and results

Data analyses were performed by product-moment correlations, multiple regression analyses and path analyses were employed in order to describe the relationships among the variables mentioned above.

Results

- (1) Prediction of the tendency to call for isolation using bivariate correlational and multivariate regression analyses

The product-moment correlations between the predictor variables and the variable assessing the "Tendency to isolate AIDS victims socially" are presented in Table 1. As can be seen from inspection of Table 1, all the

predictor variables are correlated in the expected direction with the criterion variable. The highest correlation between the criterion variable and predictor variables is for "Perceived risk of infection due to casual contact". This is followed by the variables "Social prejudice against AIDS at-risk groups" and "Blaming AIDS victims to be responsible for their own infection".

The predictors are moderately correlated among themselves (Table 1). In order to estimate their independent contribution in predicting the criterion variable, the tendency to isolate AIDS victims socially, multiple regression analyses were performed. The results, which can be seen in Table 2, show that two predictor variables make significant ($p < .05$) independent contributions. They are: "Perceived risks of casual contact" and "Blaming AIDS victims for their own plight". The total variance explained in the regression model is a relatively impressive 54%. As can be seen from the results of the regression analyses, general fear of sickness does not make a significant, independent contribution to the criterion variable, and, surprisingly, neither did negative social attitudes or prejudice toward the at-risk groups. However, the question of whether these variables are significant or not was examined by employing path analyses. The path model used was based on the theoretical considerations and the empirical results already presented.

(2) A path model to predict-the-tendency to isolate AIDS victims socially

Theoretically, there are several alternatives where the variable "Risk from casual contact" should be placed in the path model. The location of one variable in a path model was a problem. This was "Perceived risk of casual contacts with AIDS-virus carriers". This variable can be seen as antecedent or as consequent to the fear of getting infected with AIDS. Fear may lead to an overestimation of the risk of contact and, vice versa, the perceived

risk can contribute to the development of fear. It can also be regarded as antecedent to social prejudices against at-risk groups as posing a threat to the health of the general population, or it can be viewed as a result of social prejudices to the extent that they are justified by the dangers presented by the at-risk groups.

This latter hypothesis forms the basis of the path model selected. In the model it was assumed that social prejudices do not directly result in requesting isolation; rather, they are mediated through the justification that direct or indirect (non sexual) contact with AIDS virus carriers is a risk. The empirical data support this hypothesis very neatly.

As proximal predictors the following variables were viewed (Figure 1): "Fear of getting AIDS-infected", "Perceived risk of casual contact with AIDS-virus carriers" and "Blaming the AIDS victims for having caused their own infection". These three variables focus directly on AIDS while the distant predictors do not. The distant predictors are: "General fear of sickness", "Prejudice against AIDS at-risk groups", "General belief in a just world".

This path-model was supported by the empirical results. (a) The percentage of variance of the proximal predictors explained by the distal predictors is substantial. (b) There was no direct path of the distal predictors to the criterion. (c) The percentage of explained variance of the criterion through the proximal predictors is relatively high. As was to be expected from the results of the regression analyses (cf. Table 2), the variable "Fear of getting AIDS-infected" did not make a significant, independent contribution to the prediction of the criterion variable. "Perceived risk of casual contact with AIDS-virus carriers" and "Blaming AIDS-victims for having caused their own infection" did significantly contribute to the prediction of the "Tendency to isolate AIDS victims socially". The

variables reflecting "Social prejudice against at-risk groups" and "general belief in a just world" were found to be significant background variables.

To test whether or not the predictive power of "Fear of getting AIDS-infected" is included in the variable "Perceived risk of casual contact with AIDS-virus carriers" this latter predictor was excluded from the analysis. By doing this, the "Fear"-variable should become a significant predictor if it were represented by the "Risk"-variable. In fact, by this procedure, "Social prejudice against at-risk groups" becomes a significant predictor (see Table 3), whereas, "Fear of getting AIDS-infected" does not, although the regression coefficient approximates significance ($\beta = .20$, $p = .06$), indicating that some of the variance of the criterion is predicted by both the "Fear" variable and the "Risk" variable.

Sexual orientation as a moderator of the interrelationships

In addition to the "heterosexual" sample used in the study, a group of homo- and bisexual persons ($N = 17$) was included in the study. The expectation was that this sample would yield results different from the general population in terms of mean values of the variables assessed as well as in the interrelations among the variables, e.g., between the predictor and criterion variables. As can be seen from inspection of Table 1, these expectations were partly confirmed. Not only are there significant differences between the sub-samples with respect to the criterion variable "Tendency to isolate AIDS-virus carriers" (2.49 vs. 1.85, $p < .05$), "Social prejudice against AIDS at-risk groups" (2.18 vs. 1.63, $p < .05$), and tendencies to blame the victims (1.93 vs. 1.51, $p < .05$), but also the bivariate correlations between some predictor variables and the dependent variable are smaller and, generally, statistically insignificant.

This is not likely to be a methodological artifact as variances of the variables are similar in both samples. Rather, it more likely relates to differential validity of these predictors in both samples. There is one surprising exception, however. In both samples "Perceived risk of casual contact with AIDS-virus carriers" is highly correlated with "Tendency to isolate AIDS-virus carriers", inspite of the fact that the mean of the criterion variable is significantly lower for the at-risk sample. It seems, that the correlation is due to very few subjects, whereas the majority of the at-risk groups is rejecting both variables, and because of this, they do not contribute to the correlation at all. As the predictor set for the variable "Perceived risk of casual contact with AIDS-virus carriers" is roughly the same in both samples, it might be concluded that there are some subjects in the "at-risk"-sample whose attitudinal dynamics resemble those of the heterosexual sample.

Discussion

The results of this study suggest that the tendency to socially isolate AIDS victims is not motivated by a personal "Fear of getting AIDS-infected". This generalization may appear to be questionable in as much as the single variable found to be most salient for predicting the tendency to isolate AIDS victims was "Perceived risk of casual contact with AIDS-virus carriers". The meaning of this predictor seems to be somewhat equivocal. Certainly, perceived risk does not imply fear. Caution or a competent and responsible handling of risks may prevent fear. The meaning of the variable needs to be clarified by using the relationships to the other variables employed in the study.

Comparing the bivariate correlations between "Perceived risk of casual contact with AIDS-virus carriers" and other variables in the study, it becomes apparent that the shared variance with the "Fear"-variable is substantially less than with the variable "Social prejudice against AIDS at-risk groups". This supports the following interpretation of the path

model: The tendency to isolate AIDS victims socially is based on the perspective that casual contact is not completely without danger. But this latter variable functions to a great deal as a mediator of a background variable, namely "Social prejudices against AIDS at-risk groups". Such prejudices do not, apparently, lead directly (that means without 'rational' arguments) to isolation tendencies; rather, they are mediated by the danger perceived from casual contact.

Social prejudices also increase the tendency to blame AIDS victims for having caused their own infection and, thereby, indirectly increase the tendency to call for social isolation of AIDS patients. The sum of the indirect effects of social prejudice is considerable.

The belief in a just world is the second background variable which has an indirect effect on "Blaming AIDS-victims for having caused their own infection" as well as an almost statistically significant effect on the "Perceived risk of casual contact with AIDS-virus carriers". Blaming the AIDS victims for their own plight interferes with perceiving them as victims of injustice. They do not deserve compassion, rather punishment, especially if they affect or endanger others.

To support the study further exploratory assessments with a homo- and bisexual sample was conducted. We expected that individuals who belong to an at-risk population differentiate themselves not only in their responses to the items but also in the interrelationships between predictor and criterion variables. Our expectancies were partially confirmed, yet all results have to be considered a proviso because of the small size of the sample. This can be interpreted in the light of the fact that the members of at-risk groups most likely see themselves as potential AIDS victims and identify with AIDS-infected people, and their views and justifications for

these views are different from those of the majority population.

The next group of results concerns the prediction of the "Tendency to isolate AIDS-virus carriers". Most predictors have lower bivariate relationships to this criterion or none at all, what might be considered a case of differential validity of these predictors. However, the variable "Perceived risk of casual contact with AIDS-virus carriers" has about the same impact on the variable "Tendency to isolate AIDS-virus carriers" as is the case for the heterosexual sample. The "Perceived risk"-variable is predicted by "Social prejudice against AIDS at-risk groups". The basic attitudinal dynamics seem to be the same in both samples. However, since in the homo- and bisexual sample there are some subjects who do not contribute to the covariance because of a perfect rejection of both "isolation"- and "prejudice"-items, the empirical relationships were based only on a part of the sample.

Several practical applications can be drawn from the results of the present study. They are, however, probably best left to the reader to make. Nonetheless, it should be pointed out that subjectively experienced fear of becoming infected is not adequate to explain the tendency to socially isolate AIDS-victims. Arguments against the call for isolation have to consider the social attitudes against at-risk groups and, as an example of general world views, the belief in justice.

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Table 1a: Prediction of "tendency to socially isolate AIDS patients" on the basis of bivariate correlations by various predictors for heterosexual students (80 = N = 85); means (M) and standard deviations (s) of the variables given in the diagonal

Variable	1	2	3	4	5	6	7
1 Tendency to isolate AIDS-virus carriers	M = 2.49 s = .97						
2 Fear of getting AIDS-infected	.41	M = 1.98 s = .76					
3 General fear of sickness	.33	.50	M = 3.27 s = 1.26				
4 Perceived risk of casual contact with AIDS-virus carriers	.74	.36	.22*	M = 2.18 s = .89			
5 Social prejudice against AIDS at-risk groups	.56	.39	.36	.61	M = 1.98 s = .67		
6 General belief in a just world	.32	.25*	.27	.35	.51	M = 1.96 s = .72	
7 Blaming AIDS-victims for having caused their own infection	.53	.38	.20*	.53	.64	.50	M = 1.93 s = .69

* = $p > .01$

Table 1b: Prediction of "Tendency to socially isolate AIDS patients" on the basis of bivariate correlations by various predictors for homo- and bisexuals (17 = N = 16); means (M) and standard deviations (s) of the variables given in the diagonal

Variable	1	2	3	4	5	6	7
1 Tendency to isolate AIDS-virus carriers M = 1.85 s = .91							
2 Fear of getting AIDS-infected M = 2.18 s = 1.06	.04*						
3 General fear of sickness M = 2.96 s = 1.13	.09*	.21*					
4 Perceived risk of casual contact with AIDS-virus carriers M = 1.63 s = .58	.78	.27*	.16*				
5 Social prejudice against AIDS at-risk groups M = 1.70 s = .62	.32*	.53	-.18*	.47			
6 General belief in a just world M = 1.92 s = .84	.02*	.09*	-.22*	.23*	.48		
7 Blaming AIDS-victims for having caused their own infection M = 1.51 s = .64	.18*	.45	.44	.58	.10*	.50	

* = $p > .05$

Table 2: Multiple regression from tendency to socially isolate AIDS-victims on all path-model-predictors (heterosexual subjects, N = 75)

Predictor	r	beta	b	F _b	P _{F_{tot}}	R	R ²	R ² _{ch}
Perceived risk of casual nonsexual contacts with AIDS-virus carriers	.71	.60	.66	41.98		.709	.502	.502
Blaming AIDS-virus carriers for having caused their infection themselves	.52	.22	.31	5.44*	< .01	.733	.537	.035
(intercept)			.44					

* = .01 < P_{F_b} < .05

Table 3: Multiple regression from tendency to socially isolate AIDS-patients on all predictors except for risks in everyday contacts and attributions of self-blame (heterosexual subjects; N = 76)

Predictor	r	beta	b	F _b	P _{F_{tot}}	R	R ²	R ² _{ch}
Social prejudice against AIDS at-risk groups	.55	.55	.77	31.72	.01	.55	.30	.30
(intercept)			.98					

Note: Not included in the equation were:

- General belief in a just world
- General fear of sickness
- Specific fear of contacting the AIDS disease

Pathmodel for the prediction of the tendency to socially isolate AIDS-patients

