



Published in final edited form as:

Psychol Sci. 2011 May ; 22(5): 579–583. doi:10.1177/0956797611404898.

Community Norms about Suppression of HIV/AIDS Prejudice and Perceptions of Stigma by People with HIV/AIDS

Carol T. Miller, Kristin W. Grover, Janice Yanushka Bunn, and Sondra E. Solomon
University of Vermont

Abstract

We investigated the relationship between reports by 203 people with HIV/AIDS in New England communities about their experiences with stigma and reports by 2,444 randomly selected residents of those same communities about their motivation to control HIV/AIDS prejudice. Multi-level regression analyses revealed that the disclosure concerns of participants with HIV/AIDS were lower in communities in which residents were motivated by personal values to control HIV/AIDS prejudice, and were higher in communities in which residents were motivated by social pressure to control HIV/AIDS prejudice. Reported experiences with discrimination and exclusion were unrelated to these community motivations. These results suggest that the realities of the communities in which stigmatized people live shape their perceptions of stigmatization.

Keywords

Stigma; Prejudice/Stereotyping; Social Interaction; Social Perception; Motivation; Personal Values

How does the experience of being stigmatized arise? One seemingly straightforward answer is that people experience stigma when other people stigmatize them. However, personal standards and social norms about the acceptability of prejudice can lead people to try to suppress expressions of prejudice (e.g., Devine & Monteith, 1993; Crandall & Eschleman, 2003), which are important contributors to the experiences stigmatized people have with prejudice. Being stigmatized involves two main types of experiences (Scambler, 1998): (1) the anticipation or fear of being stigmatized (*felt stigma*) and (2) being the target of discriminatory behavior (*enacted stigma*). Suppression of prejudice by community members may have different relationships with different types of stigma. The present study examined the association between community-level motivation to control prejudice and the perception of felt and enacted stigmatization by members of a stigmatized group (people with HIV/AIDS) living within these communities.

The only prior research on this issue is an innovative study which demonstrated that among college students with concealable stigmas (e.g., mental illness, sexual and physical victimization), concerns about disclosure (a component of felt stigma for people with concealable stigmas) were related to cultural stigma, as assessed by asking an independent sample of college students to rate how people with each of the concealable stigmas are viewed by others (Quinn & Chaudoir, 2009). The present study goes beyond this method by asking randomly selected residents of communities in which people with a concealable stigma live to report their *own* motivations to control prejudice rather than to report their

(possibly inaccurate) perceptions about the community at large. It also examined not only the disclosure concerns of stigmatized people, but also their perceptions about enacted stigma (e.g., being excluded, losing friends). Thus, this study is unique in that it assessed both felt and enacted stigma among stigmatized people who live within particular communities and the motivations of people living in *those same* communities regarding the expression of prejudice.

Motivation to Control Prejudice

The social and personal acceptability of prejudice plays a central role in the expression of prejudice (e.g., Devine & Monteith, 1993; Crandall & Eschleman, 2003). People who are high in internal motivation to control prejudice are motivated by personal standards of tolerance not to be prejudiced. Such individuals avoid stereotyping (e.g., of Blacks; Plant & Devine, 1998), and are relatively willing to interact with stigmatized individuals (e.g., someone with HIV/AIDS; Grover, Miller, Solomon, Webster, & Saucier, in press). Accordingly, we hypothesized that people with HIV/AIDS should feel less stigmatized in communities where there is relatively high internal motivation to control prejudice (Hypothesis 1).

External motivation to control prejudice arises when individuals perceive that prejudice is not socially acceptable. Social pressure sometimes can result in decreased prejudice expression. For example, among high prejudice participants, learning that others did not share their views reduced the expression of anti-Black attitudes (Blanchard, Crandall, Brigham, & Vaughn, 1994) and the physical distance they kept from a Black confederate (Secrist & Stangor, 2001).

However, social pressure to suppress prejudice may not always reduce the expression of prejudice. People who perceive social pressure to suppress prejudice tend to be prejudiced (Devine, Plant, Amodio, Harmon-Jones, & Vance, 2002). Also, as is implied by the term *political correctness*, individuals who perceive social pressure may experience psychological reactance (Brehm, 1966), which may motivate them to counteract a perceived threat to freedom by acting in opposition to the social pressure. For example, external motivation to control prejudice toward people with HIV/AIDS is correlated with wanting to avoid contact with an HIV+ individual (Grover et al., in press).

We hypothesized that if social pressure to suppress prejudice trumps the relatively high levels of prejudice characteristic of people high in external motivation to control prejudice, individuals with HIV/AIDS living in communities with high levels of external motivation to control prejudice should experience relatively low levels of expressed prejudice and therefore should perceive themselves as relatively unstigmatized (Hypothesis 2a). However, if social pressure to suppress HIV/AIDS prejudice results in psychological reactance, people with HIV/AIDS should perceive themselves as *more* stigmatized in communities in which there is relatively high external motivation to control prejudice (Hypothesis 2b).

Felt and Enacted Stigma

An important distinction between stigmatizing experiences involves the anticipation of stigmatization (felt stigma) versus the perception that one has been subjected to actual instances of discrimination and mistreatment (enacted stigma; Scambler, 1998). Because community members frequently are motivated to suppress prejudice, stigmatized people may have few experiences with blatant expressions of prejudice that can easily be identified as enacted stigma. Prejudice nonetheless may “leak out”, making stigmatized people fearful of disclosing their stigma (an important form of felt stigma) without being able to recall instances in which they experienced actual discriminatory treatment. Furthermore, in

communities in which motivation to control prejudice is not sufficiently strong to discourage overt expressions of prejudice, stigmatized people living in those communities may avoid discrimination by concealing their stigma. However, in such communities stigmatized people may continue to be especially fearful about disclosing their stigma. In other words, in such communities felt stigma, as exemplified by disclosure concerns, remains high even in the absence of experiences with overt discrimination. This reasoning suggests a third hypothesis. That is, the relationships we previously hypothesized between perceived stigma and internal motivation to control prejudice (Hypothesis 1) and between perceived stigma and external motivation to control prejudice (Hypotheses 2a and 2b) would be stronger, or perhaps would even be limited to, felt stigma (i.e., disclosure concerns).

Method

Participants with HIV/AIDS

Adults living with HIV/AIDS (N = 203) were recruited through medical clinics, AIDS service organizations, and newspaper advertisements. Participants lived in Vermont (73.5%), New Hampshire (19.5%), Massachusetts (6%), and northern New York (1%). They were predominantly male (72.5%), White (80.5%), and exclusively homosexual (41.5%) or bisexual (14.5%). On average they were 43.2 years old and had been living with HIV/AIDS for 11 years. Based on self-reports about AIDS-related diseases, most (69%) met the criteria for CDC's (1993) severest HIV/AIDS clinical disease category.

Procedure—Participants could participate at our laboratory or at their recruitment site. Procedures were the same, except that we used laptop rather than desktop computers when participation occurred off-site. Participants privately completed computer-administered measures (MediaLab; Jarvis, 1997) with assistance available as needed. Participants were monetarily compensated for time and travel expenses.

Measures—The measure of perceived HIV/AIDS stigma was Bunn, Solomon, Miller, and Forehand's (2007) revision of the HIV/AIDS Stigma Scale (Berger, Ferrans & Lashley; 2001). The subscales¹ included from this measure were *enacted stigma* (11 items, e.g., "I have lost friends by telling them that I have HIV/AIDS") and *disclosure concerns* (8 items; e.g., "I worry that people who know will tell others"). Responses were made on 4-point scales (1 = strongly disagree, 4 = strongly agree), and were averaged to compute subscale scores (Cronbach's alphas, 0.82 – 0.95), with higher scores indicating greater stigma.

Community Participants

Within 8 weeks after the participation of a participant with HIV/AIDS, we recruited 11 to 13 community members from the town in which the participant with HIV/AIDS resided. When more than one participant with HIV/AIDS lived in a community, we recruited an independent sample of community respondents from that community for each participant with HIV/AIDS. The 2,444 community participants ranged in age from 18 to 75 (M = 49.0), 64.5% were female and 95% were White.

Procedure—Random digit dialing was used to select community members within the three-digit telephone exchange of the participant's telephone number or town of residence. If there was no response after a given number was called 10 times, it was replaced by another randomly selected number. People younger than 18 or who did not reside at the residence

¹This measure includes two additional subscales. We excluded the *negative self-image* subscale because it assesses self-perceptions, and we excluded the *concern with public attitudes* subscale because it focuses on public attitudes toward people with HIV/AIDS in general, rather than on the individual's own experiences.

we called were not interviewed. Interviews were conducted with the CI-3 Computer Aided Telephone Interviewing system. We obtained interviews from 68% of the numbers called. There was no compensation (other than a thank-you) for participation.

Measures—In order to avoid threatening the privacy of people with HIV/AIDS in these communities, the community motivation measures were embedded in a 30-minute interview about diverse topics (e.g., perceptions about community quality of life). Consequently, we used slightly abbreviated versions of motivation to control HIV/AIDS prejudice scales (Pryor, Reeder, & Landau, 1999), which themselves were adaptations of Plant and Devine's (1998) motivation to control racial prejudice scales. We used three (of four) items from the internal motivation to control prejudice scale (e.g. "I attempt to act in non-prejudiced ways towards people with HIV/AIDS because it is personally important to me.") and the three (of four) items from the external motivation to control prejudice scale (e.g. "Because of today's politically correct standards, I try to appear non-prejudiced towards people with HIV/AIDS."). Scores were averaged across items (1 = strongly disagree and 4 = strongly agree; Chronbach's alphas = 0.82 and 0.74 for the internal and external scales, respectively).

Results

Table 1 shows that participants with HIV/AIDS reported relatively few experiences with enacted stigma, with the mean falling significantly below the scale midpoint of 2.5 [$t(195) = -2.72, p = 0.007$], but nonetheless had relatively high levels of disclosure concerns, with the mean falling above the scale midpoint [$t(195) = 6.91, p < 0.0001$].

Because participants with HIV/AIDS and community members were linked by living in the same communities, we analyzed these data with multi-level regression analyses. We clustered smaller communities geographically so that each community cluster was home to at least three participants with HIV/AIDS (and their associated community members). Data from four communities that did not meet this criterion were removed from the analysis, resulting in 33 different community clusters.

In the first level of the multi-level analysis of each of the perceived stigma scores, we entered the age, gender, and the clinical disease stage of the participants with HIV/AIDS, and in the second level we entered the average (see Table 1) for each community for internal and external motivations to control prejudice.

Table 2 shows that the disclosure concerns of people with HIV/AIDS were negatively related to community internal motivation to control HIV/AIDS prejudice, and were positively related to community external motivation to control HIV/AIDS prejudice. In other words, participants with HIV/AIDS experienced the most concerns about disclosure in communities in which internal motivation to control prejudice was relatively low and external motivation to control prejudice was relatively high.

Consistent with Hypothesis 3, both internal and external community motivation to control prejudice were unrelated to enacted stigma. Repeating the analysis while controlling for community population size and density produced the same results. Repeating the analysis with the interaction term between internal and external motivation to control prejudice entered as a Level 2 variable revealed no interaction for either enacted stigma [$F(1,29) = 0.38, p = 0.54$] or disclosure concerns [$F(1,29) = 0.33, p = 0.57$].

Discussion

The present study is the first to our knowledge that assessed both sides of the prejudice equation within the same communities. Our findings suggest that community reactions to people with HIV/AIDS are related to disclosure concerns of people with HIV/AIDS living in *those* communities. These findings suggest that the experience of stigmatization may be based on the realities of the communities in which stigmatized people live.

Although this conclusion may appear to be so obviously true that demonstrating the relationship is superfluous, there is in fact considerable disagreement about whether the experience of stigmatization is grounded on actual expressions of prejudice toward members of the stigmatized group. Prior research has shown that stigmatized people differ in how vigilant they are to expressions of prejudice (Kaiser, Vick, & Major, 2006; Pinel, 1999), and how they interpret ambiguous events that may (or may not) be expressions of prejudice (Major, Quinton, & Schmader, 2003). Moreover, although it is often assumed that strong positive relationships between psychological distress (e.g., depression) and perceived stigma constitute evidence that prejudice undermines psychological well-being (Branscombe, Schmitt, & Harvey, 1999), psychological distress could also affect the interpretation of events as expressions of prejudice (Major et al., 2003). Because distress may be a cause of perceived prejudice, the effects of community expressions of prejudice on the experience of stigmatization cannot be assessed simply by asking stigmatized people how much prejudice they experience – hence the need for studies such as the current study.

Consistent with Hypothesis 1, our finding that disclosure concerns of participants with HIV/AIDS were relatively low in communities in which community members' internal motivation to control prejudice was relatively high suggests that community members who are personally motivated to control prejudice may provide an environment in which people with HIV/AIDS feel relatively safe about disclosing their HIV/AIDS status. In contrast, our finding for external motivation to suppress HIV/AIDS prejudice suggests that social pressure to avoid prejudice may be associated with greater perceived stigmatization (as we predicted in Hypothesis 2b). This hypothesis was based on past research (Devine et al., 2002; Grover et al., in press) suggesting that people who perceive high levels of social pressure to inhibit prejudice tend to be prejudiced and/or may experience psychological reactance to the pressure they feel not to be prejudiced.

Consistent with Hypothesis 3, internal and external community motivations to control HIV/AIDS prejudice were related to disclosure concerns, but not to perceptions of enacted stigma. Participants reported relatively few instances of enacted stigma, suggesting that prejudice suppression pressures may prevent community residents from expressing blatant prejudice. However, this alone does not explain why enacted stigma was unrelated to community motivations.

One possibility is that even when people try to suppress the expression of prejudice, it may “leak out” in ways that can make stigmatized people experience some degree of discrimination and exclusion, thereby weakening the association of community motivation to control prejudice and enacted stigma. In addition, our findings for disclosure concerns indicate that the communities in which residents might be most inclined to discriminate toward people with HIV/AIDS may also be the communities in which people with HIV/AIDS provide residents with relatively few opportunities for discrimination and exclusion (by concealing their stigmatized status). This also would tend to weaken the association of community motivation to control prejudice and the perception of enacted stigma by people with HIV/AIDS living in those communities.

This possibility reminds us that these data are correlational and thus cannot establish a causal relationship between community motivation and disclosure concerns of stigmatized people living in the community. It also highlights that the experience of stigmatization is an interchange between the stigmatized and the stigmatizers. Community members' motivation to suppress prejudice may affect how safe stigmatized people feel about disclosing their stigmatized status, but stigmatized people's own actions (e.g., hiding their stigmatized condition) may also affect the likelihood that community members will express prejudice.

Finally, prejudice reduction interventions typically attempt to change people's hearts and minds. If such efforts succeed in reaching personal values that govern the expression of prejudice, they may have the desired effect of improving the lot of stigmatized people. However, if efforts to reduce stigma succeed only in ramping up perceived social pressure to avoid being prejudiced, they could inadvertently increase the experience of stigmatization among its targets.

Acknowledgments

Funding

This research was supported by a National Institute of Mental Health grant (RO1 MH 066848) authored by Sondra E. Solomon and Carol T. Miller.

References

- Berger B, Ferrans CE, Lashley FR. Measuring stigma in people with HIV: Psychometric assessment of the HIV stigma scale. *Research in Nursing and Health*. 2001; 24:518–529. [PubMed: 11746080]
- Brehm, JW. *A theory of psychological reactance*. Oxford, England: Academic Press; 1966.
- Blanchard FA, Crandall CS, Brigham JC, Vaughn LA. Condemning and condoning racism: A social context approach to interracial settings. *Journal of Applied Psychology*. 1994; 79:993–997.
- Branscombe NR, Schmitt MT, Harvey RD. Perceiving pervasive discrimination among African-Americans: Implications for group identification and well-being. *Journal of Personality and Social Psychology*. 1999; 77:135–149.
- Bunn JY, Solomon SE, Miller CT, Forehand R. Measurement of stigma in people with HIV: A re-examination of the HIV Stigma Scale. *AIDS Education and Prevention*. 2007; 19:198–208. [PubMed: 17563274]
- Bunn JY, Solomon SE, Varni SE, Miller CT, Forehand RL, Ashikaga T. Urban-Rural differences in motivation to control prejudice toward people with HIV/AIDS: The impact of perceived identifiability in the community. *Journal of Rural Health*. 2008; 24:285–291. [PubMed: 18643806]
- Branscombe NR, Schmitt MT, Harvey RD. Perceiving pervasive discrimination among African-Americans: Implications for group identification and well-being. *Journal of Personality and Social Psychology*. 1999; 77:135–149.
- Centers for Disease Control and Prevention. Revised classification system for HIV infection and expanded surveillance case definition for AIDS among adolescents and adults. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 1993.
- Crandall CS, Eshleman A. A justification-suppression model of the expression and experience of prejudice. *Psychological Bulletin*. 2003; 129:414–446. [PubMed: 12784937]
- Devine, PG.; Monteith, MJ. The role of discrepancy-associated affect in prejudice reduction. In: Mackie, DM.; Hamilton, DL., editors. *Affect, cognition, and stereotyping: Interactive processes in intergroup perception*. Orlando, FL: Academic Press; 1993. p. 317-344.
- Devine PG, Plant EA, Amodio DM, Harmon-Jones E, Vance SL. The regulation of explicit and implicit race bias: The role of motivations to respond without prejudice. *Journal of Personality and Social Psychology*. 2002; 82:835–848. [PubMed: 12003481]

- Dovidio, JF.; Gaertner, SL. On the nature of contemporary prejudice: The causes, consequences, and challenges of aversive racism. In: Eberhardt, J.; Fiske, ST., editors. *Confronting racism: The problem and the response*. Newbury Park, CA: Sage; 1998. p. 3-32.
- Dunton BC, Fazio RH. An individual difference measure of motivation to control prejudiced reactions. *Personality & Social Psychology Bulletin*. 1997; 23:316–326.
- Gonzalez A, Miller CT, Solomon SE, Bunn JY, Cassidy DG. Size matters: Community size, HIV stigma, and gender differences. *AIDS and Behavior*. 2009; 13:1205–1212. [PubMed: 18815878]
- Gonzalez A, Grover KW, Miller CT, Solomon SE. A Preliminary Examination of Sexual Orientation as a Social Vulnerability for Experiencing HIV/AIDS-related Stigma. To appear in *Journal of Applied Social Psychology*. 2010
- Grover KW, Miller CT, Solomon S, Webster RJ, Saucier DA. Mortality salience and perceptions of people with AIDS: Understanding the role of prejudice. *Basic and Applied Social Psychology*. in press.
- Jarvis, BG. MediaLab (computer software; Version v2004). New York, NY: Empirisoft;
- Kaiser CR, Vick SB, Major B. Prejudice expectations moderate preconscious attention to cues that are threatening to social identity. *Psychological Science*. 2006; 17:332–338. [PubMed: 16623691]
- Major B, Quinton WJ, Schmader T. Attributions to discrimination and self esteem: Impact of group identification and situational ambiguity. *Journal of Experimental Social Psychology*. 2003; 39:220–231.
- Monteith MJ, Deneen NE, Tooman GD. The effect of social norm activation on the expression of opinions concerning gay men and blacks. *Basic and Applied Social Psychology*. 1996; 18:267–288.
- Pinel EC. Stigma consciousness: The psychological legacy of social stereotypes. *Journal of Personality and Social Psychology*. 1999; 76:114–128. [PubMed: 9972557]
- Plant EA, Devine PG. Internal and external motivation to respond without prejudice. *Journal of Personality and Social Psychology*. 1998; 75:811–832.
- Pryor JB, Reeder GD, Landau S. A social-psychological analysis of HIV-related stigma: A two-factor theory. *American Behavioral Scientist*. 1999; 42:1193–1211.
- Pryor JB, Reeder GD, Vinacco R, Kott TL. The instrumental and symbolic functions of attitudes toward persons with HIV/AIDS. *Journal of Applied Social Psychology*. 1989; 19:377–404.
- Quinn DM, Chaudoir SR. Living with a concealable stigmatized identity: the impact of anticipated stigma, centrality, salience, and cultural stigma on psychological distress and health. *Journal of Personality and Social Psychology*. 2009; 97:634–51. [PubMed: 19785483]
- Scambler G. Stigma and disease: Changing paradigms. *Lancet*. 1998; 352:1054–1055. [PubMed: 9759769]
- Sechrist GB, Stangor C. Perceived consensus influences intergroup behavior and stereotype accessibility. *Journal of Personality and Social Psychology*. 2001; 80:645–654. [PubMed: 11316227]

Table 1

Means, Standard Deviations, and Intercorrelations for Perceived Stigma (Participants with HIV/AIDS) and Motivation to Control Prejudice (Community Residents)

Perceived Stigma^I	M	SD	Correlation (<i>df</i> = 192)
Disclosure Concerns	2.85	(0.72)	.27 (<i>p</i> < .01)
Enacted Stigma	2.35	(0.76)	
Motivation to Control Prejudice	M	SD	Correlation (<i>df</i> = 31)
Internal Motivation	3.18	(0.07)	.16 (<i>p</i> = .36)
External Motivation	2.60	(0.09)	

^IDescriptive statistics for these measures also appear in papers on the psychometrics of the scale (Bunn et al., 2007), and on the role of community size (Gonzalez, Miller, Solomon, & Bunn & Cassidy, 2009) and participant sexual orientation (Gonzalez, Grover, Miller, & Solomon, 2010) in the perception of stigma. The statistics reported here differ slightly from these reports due to patterns of missing data.

Table 2

Associations of Community Internal and External Motivation to Control Prejudice (Level 2 Variables) with Perceived Stigma by Participants with HIV/AIDS

	Parameter Estimates (SE)	<i>F</i>	<i>p</i>
Disclosure Concerns (Level 1 Variables)			
Age	-0.011 (0.006)	3.55	0.06
Disease Stage	0.291 (0.108)	7.32	<0.01
Sex	-0.038 (0.114)	0.12	0.73
Disclosure Concerns (Level 2 Variables)			
Internal Motivation	-1.512 (0.739)	4.19	0.05
External Motivation	1.691 (0.607)	7.75	0.01
Enacted Stigma (Level 1 Variables)			
Age	0.000 (0.008)	0.00	0.99
Disease Stage	-0.209 (0.124)	2.86	0.09
Sex	-0.043 (0.125)	0.12	0.73
Enacted Stigma (Level 2 Variables)			
Internal Motivation	0.643 (0.714)	0.56	0.46
External Motivation	0.639 (0.856)	0.80	0.38

Note: SE is the standard error of the parameter estimate. For Level 1 variables, $df = (1, 156)$, based on the n for participants with HIV/AIDS. For Level 2 variables, $df = (1, 30)$ based on the n for community clusters. Disease stage and gender were dummy coded with clinical category C and males coded as +1, and clinical category A/B and females coded as 0.