

**DO YOU HAVE A FRIEND?: THE IMPACT OF PERSONAL KNOWLEDGE OF
SOMEONE WITH AIDS ON ATTITUDES TOWARDS AIDS**

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ABSTRACT

The study of attitudes towards those with AIDS is relatively recent. Most studies have examined attitudes concerning health and medical concerns. Little research has focused on attitudes toward social and behavior concerns. The few that have focused on such attitudes have employed relatively small samples collected primarily out of convenience. The studies that have used national samples have primarily addressed public policy issues. Using national data from the 1988 General Social Survey, this paper examines the effects of personal knowledge about the AIDS virus and other attitudinal variables on four dimensions of social and behavioral concern for those with AIDS in American society. Sociodemographic variables, which prior studies have demonstrated as important predictors of attitudes toward AIDS, are included as controls in this research that presents findings from a multivariate analysis. Results suggests that the impact of personal knowledge of someone with AIDS does not strongly lead to more supportive attitudes regarding the rights of people with AIDS, except when the economic costs of AIDS care is concerned. Directions for future research are presented and discussed.

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INTRODUCTION

The AIDS virus continues to wreak devastation of pandemic proportions across the world. In spite of noble and immense efforts to educate people about the virus and ways of avoiding infection, the number of persons afflicted with the HIV virus continues to escalate. As of 2001, the Center for Disease Control and Prevention reports that 42 million people are living with HIV throughout the world. In addition, 14 million people have died worldwide from AIDS related illnesses (CDC 2001). It is apparent that AIDS has become an indiscriminate scourge that has left no nations unscathed.

The United States, considered by many as one of the most resourceful countries in the world, has endured overwhelming impediments in its attempts to combat AIDS. Since 1981, when the first known emergence of the HIV infection in the United States was discovered in flight attendant Gaetan Dugas, the number of people infected with HIV has exploded (Shilts 1987). In 2001, it was reported that 850,000 to 950,000 people were living with the HIV virus in the United States. AIDS induced illnesses have resulted in the deaths of 467,910 Americans. Approximately 40,000 Americans were newly diagnosed as HIV-positive in 2001 (CDC 2001). Perhaps equally grievous is the fact that the breadth of these findings fails to include people who are not aware of their HIV status.

It is clear that the extent of the social upheaval attributed to the AIDS epidemic continues to be magnified by uncertainty in the larger society as to the means of HIV infection. In spite of AIDS education programs implemented during the middle and late 1980's, the notion that same-sex oriented males are responsible for the spread of the AIDS virus refuses to be completely rejected (Carney, Werth, and Emanuelson 1994; Elwood 2002; Fish and Rye 1991). Indeed,

research into attitudes of people concerning AIDS among samples of the larger population reflects little change despite nearly 20 years of AIDS education efforts. The morbidity of an HIV-positive diagnosis, misunderstandings concerning the means of HIV transmission, and the AIDS infirmity's association with politically oppressed groups warrants the need for further research into attitudes about AIDS, knowledge of AIDS, and the implications for public policy (Schneider, Snyder-Joy, and Hopper 1993).

This study is an attempt to extend the existing literature regarding attitudes towards AIDS in studies of national samples. First, I will review the existing literature concerning knowledge and attitudes about AIDS. Secondly, I will conduct an analysis of demographic variables and their associations with knowledge about AIDS and attitudes towards AIDS. The data source for the analysis is the 1988 General Social Survey. It is duly acknowledged that a more recent data set would comprise a more accurate reflection of current attitudes towards AIDS and elicit more convincing findings. However, this was not feasible due to the scarcity of available national survey data with a focus on attitudes towards AIDS. Due to these shortcomings, the study will draw conclusions regarding knowledge and attitudes concerning AIDS with a keen awareness of the unique nature of the data. In the analysis, I seek to address these questions. Are age, gender, income, religious affiliation, political ideology, and educational attainment correlated with attitudes towards AIDS? Is race a significant influence regarding attitudes towards AIDS? Are attitudes towards AIDS influenced by one's attitudes towards homosexuality? I will follow the analysis with a presentation of the findings regarding attitudes towards AIDS during the late 1980's and conclude with a discussion of the findings.

REVIEW OF THE LITERATURE

Previous studies of attitudes towards AIDS have employed diverse approaches. LePoire and colleagues (1990) analyzed Proposition 64, a bill proposed by the California legislature in 1986. If enacted, this legislation would have declared AIDS a contagious disease, and AIDS patients would have become subject to isolation laws. Though research was available confirming that HIV/AIDS was not a contagious disease, interest remained favoring the quarantine of AIDS patients. However, the proposition was defeated. Findings suggest that educated, higher income earning, non-Christian liberals were less likely to approve of isolation than others. It is also asserted that those who voted to isolate AIDS patients did so due to the association of AIDS with homosexuality and not due to public health concerns (LePoire et al. 1990; Stipp and Kerr 1989). The pronounced relationship between AIDS and homosexuality is suggested to have been depicted through the media, a notable contributor to public attitudes about AIDS isolation laws throughout the middle and late 1980's (Hertog and Fan 1995; Stipp and Kerr 1989). It is concluded that liberals were against isolation, being more inclined to accept alternatives to traditional family values and favoring greater support of democratic principles. LePoire and colleagues (1990) also found that born-again Christians were in favor of isolation and showed definite prejudice against AIDS patients.

Greeley (1991) also touches on the issue of religiosity and attitudes towards AIDS. He reports that Protestants are more strongly in favor of enforced use of identification tags than Catholics. It is suggested that perhaps the disproportionately southern population of Protestants may explain their display of more traditional beliefs. However, it is also noted that a Protestant tradition of reaffiliation during adolescence may serve to reinforce ties to fundamentalist doctrine

and refute notions of affirming AIDS patients. The more AIDS-tolerant attitudes of Catholics were found among the more educated and politically liberal people who have maintained their ties to Catholicism while refusing to be swayed by their more orthodox parishioners (Begue and Morin 1998). The research regarding religion and attitudes towards AIDS concludes that attitude changes concerning AIDS policies are more likely to occur among groups with less restrictive religious doctrines and more benevolent definitions of God (Greeley 1991).

Witt (1989) conducted a survey of undergraduate students concerning authoritarianism and attitudes toward those with HIV. The author suggested that those students who reported more authoritarian values would also have a higher degree of prejudice towards AIDS patients. The findings suggest a weak association between authoritarianism and attitudes towards AIDS. In addition, knowledge of HIV transmission was not associated with a greater degree of acceptance or tolerance towards AIDS patients. It is concluded that authoritarianism may be an antecedent variable for those persons who have knowledge about AIDS but remain prejudiced toward those afflicted with the AIDS virus. Authoritarian persons may simply see AIDS patients as members of an out-group and, therefore, deserving of prejudice (Carney, Werth, and Emanuelson 1994; Preston, Koch, and Young 1991; Witt 1989).

Other researchers have taken different approaches to the study of attitudes towards AIDS. In their study, Schneider and colleagues (1993) proposed that people make decisions about public policy regarding AIDS through the employment of either symbolic or instrumental frameworks. Symbolic frameworks suggest that people make decisions about policy based on core values, rather than the political issues at hand. For instance, someone who hates homosexuals and associates AIDS with homosexuality may reject policies designed to create support for people who have AIDS based solely on this core value. Instrumental frameworks

suggest that people make decisions about policy based on the policy issue and their knowledge of the issue, e.g., someone who fears HIV infection via casual contact is more likely to vote for policy suggesting that people with AIDS wear identification bracelets (Jelen and Wilcox 1992; Schneider, Snyder-Joy, and Hopper 1993). The researchers concluded that there is evidence that people make decisions based on both symbolic and instrumental models, noting that those who feared contagion by casual contact were also homophobic (Pryor et al. 1989; Schneider, Snyder-Joy, and Hopper 1993).

Other studies have supported the association between homonegativity and opprobrious attitudes towards people with AIDS. Research by Price and Hsu (1992) suggests that people who deride homosexuals do so in part to reassert the solidarity of their reference group in opposition to homosexuals and then project this attitude onto other groups, such as people with AIDS (Durkheim 1964; Herek and Capitanio 1997). Others suggest that people may develop negative attitudes towards homosexuals and AIDS patients, then seek out disparaging information that can be applied to both groups, e.g., homosexuals are unethical, therefore people with AIDS are unethical (Schulte 2002; Schneider, Snyder-Joy, and Hopper 1993). It has been argued that those who hold these views resist scientific evidence regarding AIDS and its transmission because new evidence may be incompatible with their religious convictions and attitudes about sexuality. Also, incorporating more current information on AIDS may trigger fears concerning their own potential for infection, thus strengthening the stigma portrayed on the homosexual population (Price and Hsu 1992; Schulte 2002). Research findings suggest that people with higher educational attainments and an identification with liberal political agendas disprove of restrictions to civil rights, including the rights of homosexuals and people with AIDS (Price and Hsu 1992).

Other researchers suggest that core beliefs denouncing homosexuality may not be predictors of policy favoring a greater understanding and contribution towards supporting AIDS patients (Jelen and Wilcox 1992; O'Donnell et al. 1987; Pryor et al. 1989). Jelen and Wilcox (1992) used the data from the 1988 General Social Survey to uncover information on attitudes about AIDS. It is asserted that a disinclination for governmental activism in response to the HIV epidemic is not due to discrimination against those infected with HIV, but rather a politically conservative bent against government spending. However, attitudes of conservatism were also associated with intolerance of homosexuality and fears of persons with AIDS, while higher levels of educational attainment were positively correlated with tolerance towards homosexuals and people with AIDS (Jelen and Wilcox 1992; Price and Hsu 1992). Jelen and Wilcox also looked at the impact of race on homosexuality and attitudes about AIDS. Their findings suggest that although African-Americans seem to adhere to more homonegative opinions than whites, African-Americans are less likely than Whites to agree with limitations on the civil rights of any group. The authors conclude by suggesting the need to weigh the effects of instrumental and symbolic values in order to better understand people's attitudes about AIDS (Jelen and Wilcox 1992).

Pryor and colleagues also explored the instrumental and symbolic bases for negative attitudes towards persons with HIV. The researchers note that symbolic values are not based on scientific evidence, e.g., cancer may be a metaphor for destruction and symbolically taint persons interacting with those who have cancer, but empirically there is no possibility of contagion (Pryor et al. 1989; Sontag 1978). Their research suggests that those with negative attitudes towards homosexuality held negative attitudes about HIV-positive persons who are not homosexual (Pryor et al. 1989; Kraft and Rise 1995). The researchers refer to Goffman's

(1963) notion that the stigma associated with a group may be transferred to others the observer defines as connected with the stigmatized group. It is suggested then that the stigma of HIV infection apparently travels a convoluted pathway to those who are seemingly only arbitrarily linked to the marked group (Goffman 1963; Pryor et al. 1989). A conclusion borne out of the research is that those prejudiced against homosexuals will show a symbolic aversion against persons with HIV and greater concern for contracting HIV through casual interaction (Pryor et al. 1989). Also, those displaying a fear of homosexuals may associate homosexuality with other worrisome possibilities, such as the fear of receiving an HIV-positive diagnosis. The authors also suggest that those who stigmatize people with AIDS and homosexuals may group these constructs and make decisions based on this grouping (Pryor et al. 1989).

Other research suggests that people's knowledge of modes of AIDS transmission may have little to do with their attitudes and behaviors regarding AIDS (Johnson 1995; Kraft and Rise 1995; Sheehan et al. 1990). Johnson (1995) shows that social traditionalism and conservative political ideologies are strongly associated with intolerance towards homosexuals and discrimination against persons with AIDS regardless of one's knowledge of AIDS transmission (Johnson 1995; LePoire et al. 1990; Preston, Koch, and Young 1991). In another vein, Sheehan and colleagues (1990) surveyed college students at a Western university and looked at the effects of increased AIDS education through the media and educational resources. They found that increased information improved AIDS knowledge among the students, but there were no significant changes in attitudes or beliefs about people who were HIV-positive (Carney, Werth, and Emanuelson 1994; Hayward and Weissfeld 1993; Sheehan et al. 1995). Men appeared to be markedly more homonegative and fearful of contracting the AIDS virus than women. Interestingly, college students' AIDS related risk behaviors showed little change, even among

men in the sample (Sheehan et al. 1995). Kraft and Rise (1995) echo the notion that knowledge of AIDS transmission did not result in attitudinal change among adults in Norway. Their research suggests that negative attitudes towards people with AIDS are indicative of more broad ranging negative attitudes regarding deviant or unpopular groups and ideologies. They concluded that the general attitude of prejudice towards minority groups must be targeted by educators, e.g., a person holding a prejudice against homosexuals but who has learned the factual modes of transmission will continue to remain homophobic unless steps are taken to target the homophobia (Kraft and Rise 1995; Stipp and Kerr 1989).

Perhaps nowhere is the knowledge of AIDS transmission and an attitude of tolerance more important than among the medical care personnel providing relief to AIDS patients. As in the larger society, among medical professionals the fear of AIDS has been associated with homonegativity (Bliwise et al. 1991; Gershon et al. 1994; O'Donnell et al. 1987; Preston, Koch, and Young 1991; Royce and Birge 1987; Schulte 2002). Studies of medical professionals suggest that their attitudes towards those with HIV have undergone some favorable changes since the mid-1980's, however, these changes do not appear to be far-reaching (Valimaki et al. 1998). In a study of rural nurses published in 1991, only forty-two percent had professional contact with a person living with AIDS, and almost twenty percent stated that they would refuse to treat persons with AIDS. This research also found that many nurses reported that they did not want their children to attend school with a student who has AIDS. Several of the nurses were angered at what they perceived as an increased risk of AIDS imposed on health care workers and the heterosexual community by homosexuals. Still others reported that they considered people with AIDS to be undeserving of health care privileges that the HIV-negative population has learned to expect. Homophobia and misconceptions about transmission were suggested to be the primary

reasons for the nurses' fear of AIDS (Preston, Koch, and Young 1991). Even among graduate nursing students and medical students in San Francisco, the origin of the efforts to procure national attention to the problems of AIDS, the research reveals homophobia and fears of AIDS (Bliwise et al. 1991; Shilts 1987). This certainly suggests that health care providers are not immune to popular beliefs and attitudes associated with AIDS.

Other research looks at knowledge of AIDS in terms of having a relationship with someone afflicted with AIDS rather than knowing the modes of AIDS transmission. It is suggested that prolonged experience with AIDS patients may impact the attitudes of medical personnel. In their study of a major AIDS care facility in Massachusetts, O'Donnell and colleagues (1987) found that regular, intimate contact with AIDS patients reduced health care providers' fear of AIDS and increased their tolerance for AIDS patients (Hayward and Weissfeld 1993; Royse and Birge 1987; Schulte 2002; Valimaki 1998). The researchers attribute the initial intolerance towards AIDS patients to the stigma associated with homosexuals and IV-drug users. However, despite efforts to educate health care workers about AIDS transmission, the lethality of an HIV-positive diagnosis coupled with the inexistence of curative treatment appear to foster continued distrust and ambivalence of the HIV-positive population (O'Donnell et al. 1987). Hayward and Weissfeld (1993) reported similar findings regarding negative beliefs about AIDS in their study of physicians in U.S. residency programs. Residents who believed their efforts to provide treatment to AIDS patients were hopeless appeared more disinclined to provide health care, as were those who expressed discomfort providing care for homosexuals and intravenous drug users. However, residents who had ambulatory experience with AIDS patients reported future intentions of providing AIDS care regardless of their attitudes about AIDS. It is asserted

that the residents' commitment to fulfilling their professional responsibilities as physicians outweighed any prejudicial feelings towards AIDS patients (Hayward and Weissfeld 1993).

Medical personnel at Johns Hopkins University performed one study that took a unique approach concerning knowledge and attitudes towards AIDS in the medical field. The researchers compared attitudes regarding AIDS between clinical and nonclinical staff. It was hypothesized that AIDS knowledge, perceived risk of infection, and the extent of fear of infection are important variables in determining one's tolerance towards persons with AIDS. Interestingly, both the nonclinical and clinical population of hospital workers overestimated risk of infection for viable means of HIV transmission, e.g., being pricked with a contaminated needle. Also, the nonclinical population was strikingly more concerned about AIDS and workplace safety than the clinical staff. The findings also suggest that nonclinical workers were more intolerant than clinical workers. In addition, there appeared to be no association between attitudes towards AIDS and previous knowledge obtained through AIDS-related training. However, personally knowing someone with AIDS did seem to have an impact. There was an association between personally knowing someone with AIDS (for nonclinicians) or regularly caring for someone with AIDS (for clinicians) and tolerance towards persons with AIDS. The researchers concluded by arguing for a greater degree of interaction among AIDS patients and all hospital employees in order to create an atmosphere of tolerance within the clinic (Gershon et al. 1994).

Studies of counseling students have also yielded interesting findings regarding attitudes towards AIDS. Despite rigorous measures taken to impart knowledge about AIDS and dispel myths concerning AIDS, the research suggests that some students continue to maintain prejudicial beliefs regarding AIDS patients. As reflected in the larger population, counseling

students who are homophobic are also likely to harbor fears of AIDS patients (Carney, Werth, and Emanuel 1994; Dupras, Samson, and Tessier 1989). As reported in the research on health care professions, a personal relationship with someone who has AIDS is suggested to increase acceptance of AIDS patients among counselors (Carney, Werth, and Emanuelson 1994). Carney and colleagues (1994) also found that personal knowledge of someone who is homosexual may also contribute to more accepting attitudes towards people with AIDS (Schollay, Doucett, and Margeaux 1992). Interestingly, some studies discovered the existence of homophobia among counseling students, which may suggest further investigation into associations between these attitudes and AIDS patients (Carney, Werth, and Emanuelson 1994; Glenn and Russell 1986). A final unique finding among counseling students was the positive correlation between attitudes towards AIDS, experience working in AIDS care, and behaviors towards AIDS patients (Carney, Werth, and Emanuelson 1994; Schollay, Doucett, and Margeaux 1992).

Another noteworthy element of the research regarding attitudes towards AIDS is the impact of Magic Johnson's public announcement of his HIV-positive status. In November of 1991, Earvin "Magic" Johnson's announcement that he was HIV-positive coupled with his stark assertions and demeanor that bespoke an aura of unblemished heterosexuality are purported to have impacted public opinion concerning the modes of HIV transmission (Bruce, Pilgrim, and Spivy 1994; King 1993; Pollock 1994). Perhaps for the first time the American public was inspired to question their lasting notions about AIDS and the homosexual populations imbued with the stigma of AIDS. Pollock argues that public values and attitudes can be quickly and decisively changed when value-loaded symbols are supplied to the public at the optimal time (1994). He posits that Magic Johnson's fame and easily recognized countenance can be considered value-loaded symbols. It is noted that Magic's size, health, charisma, and

heterosexuality caused even the least attentive citizen to question their assumptions about people with AIDS. This “value shift hypothesis” is suggested to have shaken previous values and beliefs concerning attitudes towards AIDS policy and created a lasting image of HIV as an illness transgressing the homosexual population (Pollock 1994: 430). Pollock concludes that people typically ignore statistics and look to cultural symbols to make sense of their worlds (1994).

However, despite research that suggests Johnson’s announcement may have had short-term effects on attitudes towards HIV, much of the research argues that there were no significant long-term changes in attitudes regarding HIV and AIDS (Brown and Baranowski 1996; Siegal 1993; Sumner 1992). Sumser investigates the attitudes of college students towards AIDS before and after Johnson’s announcement. It is hypothesized that the announcement may be able to potentially educate and alert students about HIV and give a “face” to AIDS (Sumser 1992). The results did suggest that immediately following Johnson’s announcement there was an attitude change concerning attitudes about AIDS. However, researchers found no significant change in attitudes before and some duration after Johnson’s disclosure (Brown and Baranowski 1996; Siegal 1993; Sumner 1992). The author concludes that celebrities may not have the long-term impact on attitudes and behaviors to the extent that is often anticipated and hoped (Siegal 1994; Sumser 1992). However, Sumser notes the need for such research targeting young urban African-Americans who may be more likely to identify with Johnson and the potential for long-term changes with respect to attitudes towards people with AIDS (Sumser 1992; Quadagno et al. 1997). The research on Johnson also suggests that personally knowing someone infected with the AIDS virus could impact one’s attitudes and behaviors concerning AIDS (Gerbert, Sumser,

and Maguire 1991; Sumser 1992). Perhaps it would be interesting to ask if Johnson's announcement impacted the attitudes towards AIDS of those who knew him personally.

The present study seeks to address some of the under-explored factors potentially associated with personal knowledge of someone with AIDS and public attitudes towards AIDS. As previously researched by Jelen and Wilcox (1992), it will examine the attitudes regarding AIDS and knowledge of AIDS based on data obtained from a national sample. This study will then compare the findings of the convenience samples found in the literature with the findings of national samples. It will inquire into the demographic and socioeconomic variables associated with personal knowledge of someone with AIDS and attitudes towards AIDS. It will also address suspected associations between personal knowledge of someone with AIDS, attitudes towards homosexuality, and attitudes towards AIDS. However, unlike much of the previous research, this study will also address issues regarding personally knowing someone with AIDS and attitudes towards AIDS from a national probability sample. Upon completion of the analysis I will note the findings, discuss them, and make concluding remarks regarding this study and its place within the current literature on attitudes towards AIDS.

METHODOLOGY

Data

The data for this analysis are provided by the 1988 General Social Survey (GSS). The GSS is a national survey that is currently conducted biannually by the National Opinion Research Center (NORC). Respondents are chosen from a probability sample of non-institutionalized adults living in the United States. The interviews were conducted in the respondent's homes by representatives from NORC. The survey was administered after 3:00 P.M. and limited to one respondent per household. The average length of the interviews is about ninety minutes. The survey instrument is used to obtain information from the sample regarding their attitudes, beliefs, and values concerning a broad array of issues. The interviews are then coded and reported cumulatively in the GSS codebook. In 1988, representatives from the NORC completed 1,481 interviews for the GSS (General Social Survey, 2002).

It is restated here that this study is an attempt to ascertain attitudes about AIDS from a national probability sample. The questions concerning attitudes towards AIDS were first posed for the 1988 GSS and have yet to reappear in the GSS. The author was unsuccessful in locating other surveys of national probability samples with a focus on attitudes regarding AIDS, necessitating the use of the 1988 GSS. Hence, the findings of this study pertain to attitudes towards AIDS during the late 1980's with no intent to deduce current attitudes about AIDS. However, the forthcoming findings could potentially contribute to hypothesis development with regard to future research on attitudes towards AIDS.

Dependent Variables

The dependent variables in the analysis are operational indicators measuring the respondents' attitudes concerning AIDS. Because this study will employ logistic regression to analyze attitudes about AIDS, the upcoming description of the dependent variables will include the steps taken to create dichotomous dependent variables. Responses affirming AIDS patients' rights to privacy, health care, and assembly were recoded (1). Disaffirming responses were recoded (0).

One dependent variable measures respondents' opinions regarding the exclusion of people with AIDS from certain freedoms experienced by the general population. The General Social Survey (GSS) poses the following question (AIDSSCH): "Do you support or oppose prohibiting students with the AIDS virus from attending public school?" There are four possible responses: Support (1), Oppose (2), No opinion (8), No answer (9). For the analysis using logistic regression, Support (1) was recoded (0). Then, Oppose (2) was recoded (1). No opinion (8) and No answer (9) were recoded system missing (SYSMIS).

A second dependent variable taps the respondents' attitudes regarding the government's responsibility to intervene by providing free health care to people with AIDS. The GSS question states (AIDSHLTH): "Do you support or oppose having the government pay all of the health care costs of AIDS patients?" There are four possible responses: Support (1), Oppose (2), No opinion (8), No answer (9). A dichotomous variable was created first by recoding Oppose (2) into (0). Support remains coded (1), while No opinion (8) and No answer (9) was recoded system missing (SYSMIS).

A third dependent variable taps into the respondents' views of people with AIDS as deserving or undeserving of disability benefits from their employer. The GSS question reads

(AIDSFARE): “Do you support or oppose making victims of AIDS eligible for disability benefits?” There are four possible choices: Support (1), Oppose (2), No opinion (8), No answer (9). A dichotomous variable was created by recoding Oppose (2) into (0). Support remains coded (1), while No opinion (8) and No answer (9) were recoded (SYSMIS).

A fourth dependent variable refers to the respondents’ views about making it mandatory for people with AIDS to wear tags denoting their status as AIDS patients. The GSS question states (AIDSIDS): “Do you support or oppose requiring people with the AIDS virus to wear identification tags that look like those carried by people with allergies or diabetes?” There are four possible choices: Support (1), Oppose (2), No opinion (8), No answer (9). A dichotomous variable was created by recoding Support (1) into (0). Oppose (2) was recoded (1), while No opinion (8) and no answer (9) were recoded (SYSMIS).

Independent Variable

The independent variable in this study refers to knowledge about AIDS based on one’s personal relationship with someone who has AIDS or has died of AIDS-related illnesses. Previous research suggests that among hospital employees, personally knowing someone with AIDS is strongly associated with tolerance towards people with AIDS (Gershon et al. 1994). It is expected that personally knowing someone with AIDS will be positively associated with tolerance towards people with AIDS in the larger society as well. Personally knowing someone with AIDS is operationalized in the General Social Survey (GSS) by asking the following question (AIDSKNOW): “How many people have you known personally, either living or dead, who came down with the disease called AIDS?” Answers are reported based on the actual number of persons known to have AIDS by the respondent, i.e., (0) if the respondent has never

personally known someone with AIDS, (1) if the respondent knows or has known one person with AIDS, (2) if the respondent knows or has known two people with AIDS, and continuing in this pattern through knowledge of six people with AIDS. If a respondent has known seven or more persons with AIDS, the response was coded (7). If there was no answer, the response was coded (9).

For this analysis, a dummy variable was created from the variable (AIDSKNOW). Responses denoting that one has never personally known someone with AIDS remain coded (0). Responses indicating that one has personally known one or more people with AIDS will be recoded (1). If there was no answer, the response (9) was recoded system missing (SYSMIS).

Control Variables

A goal of the study is to decipher the effects of personally knowing someone with AIDS on attitudes toward AIDS. The inclusion of control variables in the model will help to facilitate this objective. Control variables will be used in an attempt to isolate the effects of the independent variable, personal knowledge of AIDS, on the dependent variables, attitudes towards AIDS. The control variables include a host of sociodemographic variables and variables measuring one's tolerance and acceptance of homosexuality.

Sociodemographic Variables

The sociodemographic factors used in the analysis include: age, gender, marital status, race, family income, years of education, region of the country, urban or rural residence, political ideology, frequency of religious service attendance, and religious affiliation.

It is suspected that age would have some impact on one's attitudes towards AIDS. The respondent's age (AGE) is measured in the 1988 General Social Survey in actual years: eighteen year olds were coded (18), nineteen year olds were coded (19), twenty year olds were coded (20), and so on.

It is suggested that women may be more empathic than men (De Beauvoir 1989). As asserted by Jelen and Wilcox (1992), it is projected that women will have more accepting attitudes towards AIDS than men. The respondent's sex (SEX) is coded (1) for males and (2) for females in the GSS. A dummy variable was created for the variable (SEX) so that the arbitrarily assigned values for male and female could be interpreted in the regression analysis. Females were recoded (1) and males were recoded (0).

This study will also examine the relationship between marital status (MARITAL) and attitudes towards people who have contracted AIDS. The GSS codes marital status as follows: married (1), widowed (2), divorced (3), separated (4), never married (5). It is suggested that people who are married or widowed may tend to hold similar attitudes about life, while people who are divorced or separated may be inclined to hold similar attitudes about life. Also, people who have never been married may maintain attitudes differing from those of people who have been married. Therefore, three dummy variables were created. Married (1) and widowed (2) respondents will be combined, creating the dummy variable (MARRIED). Divorced (3) and separated (4) respondents will be combined, creating the dummy variable (DIVORCED). A dummy variable (SINGLE) was created for people who responded that they have never married (5).

In addition, I will also examine the extent to which race may influence variations in attitudes towards people with AIDS. It is suggested that although African-Americans may be

more disapproving of certain behaviors than Whites, e.g., homosexuality, they may also be more approving of the rights of all minority groups e.g., homosexuals and people with AIDS (Jelen and Wilcox 1992). Race (RACE) is currently coded (1) for white, (2) for black, (3) for other races in the GSS. These will be recoded using the dummy variable (0) for white, and (1) for black. People who identified with other racial groups were recoded system missing (SYSMIS). This will allow for a better understanding of what African-Americans think about AIDS compared to Whites.

It may be considered that as family income increases, attitudes of acceptance may also increase. Level of family income (INCOME86) is coded using the 20 point scale as assigned by the GSS:

Family incomes under \$1,000 are coded (01), family incomes between \$1,000 and \$2,999 are coded (02), family incomes between \$3,000 and \$3,999 are coded (03), family incomes between \$4,000 and \$4,999 are coded (04), family incomes between \$5,000 and \$5,999 are coded (05), family incomes between \$6,000 and \$6,999 are coded (06), family incomes between \$7,000 and \$7,999 are coded (7), family incomes between \$8,000 and \$9,999 are coded (08), family incomes between \$10,000 and 12,499 are coded (09), family incomes between \$12,500 and 14,999 are coded (10), family incomes between \$15,000 and 17, 499 are coded (11), family incomes between \$17,500 and 19,999 are coded (12), family incomes between \$20,000 and 22,499 are coded (13), family incomes between \$22,500 and \$24,999 are coded (14), family incomes between \$25,000 and 29,999 are coded (15), family incomes between \$30,000 and \$34,999 are coded (16), family incomes between \$35,000 and 39,999 are coded (17), family incomes between \$40,000 and 49,999 are coded (18), family incomes between \$50,000 and

\$50,999 are coded (19), family incomes from \$60,000 and over are coded (20), and refusals are recoded system missing (SYSMIS).

It is also expected that as a respondent's years of education increase, one's attitude towards AIDS may also become more tolerant. Level of educational attainment (EDUC) is coded using the 20 point scale as assigned by the GSS. Answers are coded based on the actual number of years of formal schooling: no formal school is coded (0), completion of 1st grade is coded (1), completion of 2nd grade is coded (2), and continuing this pattern through seven years of college (19). Eight or more years of college are coded (20).

The part of the country one inhabits may also play a role in persons' attitudes towards AIDS. It is posited that people dwelling in the Southern states may be less tolerant of minority groups, such as people with AIDS, than people in more Northern states. The GSS uses the variable (REGION) to refer to the region of the country inhabited by the respondent. New England is coded (1), Middle Atlantic states are coded (2), Eastern North Central states are coded (3), Western North Central states coded (4), Southern Atlantic states coded (5), East South Central states coded (6), West South Central states coded (7), Mountain states coded (8), and Pacific states coded (9). To get a better understanding concerning the notion of regional effects on attitudes pertaining to AIDS, this analysis will compare northern and southern states. Therefore, the Southern Atlantic states (4), the East South Central States (5), and the West South Central states (6) will be recoded (1) and defined as (SOUTH). All other regions will be recoded (0).

It is anticipated that people with a more liberal political ideology may be more tolerant of minority groups than those with a more conservative political disposition. This study will control for political ideology, especially due to the findings of Jelen and Wilcox (1992), which

suggest that the conservative political inclinations of some respondents may be due to a stance opposing government intervention rather than discrimination against minority groups. The GSS refers to political ideology with the variable (POLVIEWS) and codes it as follows: extremely liberal (1), liberal (2), slightly liberal (3), moderate (4), slightly conservative (5), conservative (6), extremely conservative (7). In order to allow for a more understandable interpretation of the logistic regression analysis, the choices will be recoded as follows: extremely conservative (1), conservative (2), slightly conservative (3), moderate (4), slightly liberal (5), liberal (6), extremely liberal (7).

This study will also control for religious service attendance. It may be suggested that those who attend religious services frequently may also be likely to have less accepting attitudes about minority groups such as people with AIDS. Frequency of religious service attendance (ATTEND) is coded in the GSS as follows: never (0), less than once a year (1), about once or twice a year (2), several times a year (3), about once a month (4), 2-3 times a month (5), nearly every week (6), every week (7), several times a week (8), and don't know or no answer (9) are recoded as system missing (SYSMIS).

People in more rural locations may be less tolerant with respect to attitudes about AIDS than people in more urban areas. In the GSS, the population density of the geographic location is identified by the variable (SRCBELT). It is coded as follows: central city of one of the 12 largest SMSA's is coded (1), central city of the remainder of the 100 largest SMSA's coded (2), suburbs of the 12 largest SMSA's coded (3), suburbs of the remaining 100 largest SMSA's (4), other Urban (counties having towns of 10,000 are more) coded (5), other Rural (counties having no towns of 10,000 are more) coded (6). For the purposes of this study, (SRCBELT) will be recoded as follows: central city of one of the 12 largest SMSA's (6), central city of the remainder

of the 100 largest SMSA's (5), suburbs of the 12 largest SMSA's (4), suburbs of the remaining 100 largest SMSA's (3), other Urban (counties having towns of 10,000 are more) (2), other Rural (counties having no towns of 10,000 are more) (1). This now pairs the more tolerant responses with the more urbanized areas.

It is projected that religious affiliation may also impact attitudes regarding AIDS. For this study, the effects of being affiliated with Catholicism and Conservative Protestantism are being considered. The GSS asks "What is your religious preference?" A dummy variable was created to isolate the effects of identifying oneself as Catholic. Then, a dummy variable was created to control for the effects of those who identify themselves as Conservative Protestants. Conservative Protestants included the following religious groups as categorized in the GSS: Southern Baptist, Baptist, Evangelical Congregational, Assembly of God, Brethren Church, Brethren, Plymouth, United Brethren, United Brethren in Christ, Christian Disciples, Christ in Christian Union, Christ Church Unity, Christ Adelprians Church of Christ (Evangelical), Church of Christ, Churches of God, Church of God in Christ, Church of God in Christ Holiness, Church of Holiness, Pilgrim Holiness, Nazarene, Pentecostal Assembly of God, Pentecostal, Church of God, Pentecostal Holiness, 7th Day Adventist, Sanctified, Sanctification, United Holiness, and assorted smaller evangelical and fundamentalist groups.

Attitudes Towards Homosexuality

Much of the research suggests that attitudes towards homosexuality are associated with attitudes towards AIDS (Bliwise et al. 1991; Gershon et al. 1994; O'Donnell et al. 1987; Preston, Koch, and Young 1991; Royce and Birge 1987; Schulte 2002). However, it warrants repeating that homonegativity may not be related to attitudes towards AIDS in cases where one may be

averse to government intervention (Jelen and Wilcox 1992). General acceptance of homosexuality (HOMOSEX) will be coded using a four-point scale as reported in the GSS. The question states: “What about sexual relations between two adults of the same sex—do you think it is always wrong, almost always wrong, wrong only sometimes, or not wrong at all?” Possibly responses include always wrong coded (1), almost always wrong coded (2), wrong only sometimes coded (3), not wrong at all (4), and Other coded (8) and No answer (9). Other and No answer were recoded (SYSMIS) in order to analyze the impact of attitudes of those respondents who expressed definite opinions about homosexuality. This variable is analyzed in an effort to control for the possibility that attitudes towards homosexuality are associated with attitudes towards AIDS.

It is suggested that tolerance of homosexuality may be positively associated with an affirmation of the rights of people with AIDS. Therefore, a tolerance towards homosexuality scale was created for this study. The scale includes three indicators of tolerance, with more tolerant attitudes coded (1) and less tolerant and indifferent responses coded (0). Then, the scores on the three variables are summed under the new variable name (HOMOTOL). A score of (3) would indicate that the respondent appears to be quite tolerant of homosexuality. A score of (0) indicates that the respondent refuted all three notions of tolerance towards homosexuality. Below is a detailed description of the scale.

A first question on the scale refers to a homosexual person’s right to public expression. The item reads (SPKHOMO): Suppose this admitted homosexual wanted to make a speech in your community. Should he be allowed to speak, or not? Possible responses include the following: yes, allowed to speak (1), not allowed to speak (2), don’t know (8). In order to more easily interpret the findings of the analysis using logistic regression, responses disproving of (2)

or indifferent to (8) the right to speak were recoded (0). The affirming response (1) remains coded as assigned in the GSS.

The second question refers to a homosexual person's right to hold particular jobs. The question reads (COLHOMO): Should such a person be allowed to teach in a college or university, or not? Possible responses include: yes allowed to teach (1), not allowed to teach (2), don't know (8). The affirming response to being allowed to teach (1) remains unchanged. Responses refuting the right to teach (2) or indifferent (8) were recoded (0).

The third question refers to the respondent's views on censoring books written supporting homosexuality. The GSS question reads (LIBHOMO): If some people in your community suggested that a book he wrote in favor of homosexuality should be taken out of our public library, would you favor removing this book, or not? Possible responses include: favoring book removal (1), not favoring removal (2), don't know (8). Responses favoring book removal (1) or uncertainty regarding this issue (8) were recoded (0). Responses against censoring the book (2) were recoded (1).

Analytic Strategy

Logistic regression will be used to analyze attitudes towards AIDS based on one's personal knowledge of someone with AIDS. Logistic regression is used when one seeks to regress dichotomous dependent variables on continuous or dichotomous independent variables. Dummy variables are created for each dependent variable. In this type of regression, the coefficient corresponding to the dependent variable is called the logit, or log of the odds ratio (Knoke, Bohrnstedt, and Mee 2002). In this study, the logit enables the researcher to predict the probability or likelihood that a respondent will have a particular attitude about AIDS.

ANALYSIS AND RESULTS

Table 1 (page 29) includes the descriptive statistics reported as means and standard deviations for the variables used in this study. For the dependent variable addressing public attitudes concerning the rights of children with AIDS to attend public school, 74 percent of respondents supported the right of children with AIDS to pursue public education. Thirty-three percent of those questioned believed that the government should pay all of the health care costs of AIDS patients, while 37 percent of respondents were opposed to mandating that people with AIDS wear identification tags. For the fourth dependent variable measuring public sentiment concerning the legitimacy of people with AIDS to claim disability benefits, 60 percent of the respondents favored the inclusion of people with AIDS for this right.

For the independent variable in this study, personal knowledge of someone with AIDS, nine percent of respondents knew of at least one person who had AIDS (mean = .09). Sixty-four percent of respondents were either married or widowed, and 13 percent were African-Americans. The mean for total family income was (12.97), which is equivalent to an annual family income of between \$20,000 and \$22,499. Thirty-three percent of respondents lived in the South, and most of the respondents reside in the suburbs of large cities (mean = 2.99). With regards to religious affiliation, 26 percent of respondents were Catholics and 16 percent identified themselves as conservative Protestants. The measure for one's general acceptance of homosexuality had a mean of (1.54), signifying that among most respondents homosexuality was either always wrong or almost always wrong. However, respondents appeared to show a degree of tolerance toward homosexuality (mean = 1.95). The mean reveals that the public supports tolerant attitudes towards homosexuality for two out of the three indicators in this study.

Table 1: Descriptive Statistics for the Dependent, Independent, and Control Variables

VARIABLES	MEAN	STANDARD DEVIATION
Keep Children with AIDS Out of school	.74	.44
I.D. Tags for People with AIDS	.37	.48
Government Pays for AIDS Care	.33	.47
Disability Benefits for AIDS Patients	.60	.49
Personal Knowledge of AIDS Patients	.09	.29
Age	45.37	18.32
Female	.57	.50
Married	.64	.48
Black	.13	.34
Total Family Income	12.97	4.93
Years of School Completed	12.54	3.11
Southern Residence	.34	.47
Urban Residence	2.99	1.45
Political Ideology	3.89	1.36
Religious Service Attendance	3.84	2.69
Catholics	.26	.44
Conservative Protestants	.16	.37
Acceptance of Homosexual Relations	1.54	1.06
Tolerance of Homosexuality	1.95	1.24

Table 2 (page 34) displays the logistic regression results for the effects of personal knowledge of someone with AIDS on four indicators of attitudes towards AIDS with controls for sociodemographic variables and attitudes towards homosexuality. Model I reflects the results of the impact of personal knowledge of someone with AIDS on attitudes towards public school attendance for children with AIDS. As shown in Model A, the effect of personal knowledge of someone with AIDS alone does not seem to impact one's attitudes towards AIDS in this model (odds ratio = 1.720). Model B displays the effects of personal knowledge of someone with AIDS on attitudes towards AIDS with controls for sociodemographic variables. Controls for race, gender, income, religious affiliation, and all other sociodemographic variables are not significantly associated with attitudes towards AIDS with regard to school attendance. However, the results do suggest that a general acceptance of homosexuality was significantly associated with a belief in the rights of children with AIDS to attend public schools (odds ratio = 1.577). This finding supports previous research suggesting that people who reveal an acceptance of homosexuality are also likely to support the civil rights of people with AIDS (Pryor et al. 1989; Schneider, Snyder-Joy, and Hopper 1993). The chi-square for Model I is (34.185).

Model II of Table 2 displays the findings addressing the research hypothesis that personal knowledge of someone with AIDS is related to one's attitude concerning the government's role in paying for AIDS care. In Model A, results were significant in the bivariate regression analysis of personal knowledge of AIDS and attitudes towards government responsibility for AIDS treatment (odds ratio = 1.784). However, it is reported in Model B that personal knowledge is not associated with a belief in the government's responsibility to pay for the health care of AIDS patients when control variables are left in the analysis (odds ratio = 3.621). Age and Catholic

religious affiliation are positively correlated with a belief in government intervention in the AIDS crisis, with odds ratios of (1.019) and (2.004), respectively. Also, the findings suggest that high income earning families are opposed to government subsidies for AIDS care (odds ratio = .918, $p < .01$). The negative correlation between acceptance of homosexuality and support for government intervention in the AIDS crisis (odds ratio = .703) reflects the findings of Jelen and Wilcox (1992). Perhaps the strongest finding in Model II concerns race. Blacks were almost 2.5 times more likely than whites to support government intervention in AIDS care, with an odds ratio of (2.433). Politically liberal respondents showed strong affirmation concerning government responsibility for AIDS care, with an odds ratio of (1.436). The finding regarding politically liberal respondents confirms previous research suggesting that liberals are more likely than conservatives to advocate for the support of minority groups such as AIDS patients (LePoire et al. 1990; Stipp and Kerr 1989). The chi-square for Model II is (65.557).

Model III of Table 2 (page 35) exhibits the findings regarding the allocation of disability benefits for people with AIDS. In the absence of control variables (Model A), personal knowledge of AIDS was significantly associated with attitudes towards the access to disability benefits. A respondent who personally knew someone with AIDS was twice as likely as other respondents to believe that AIDS patients should be eligible for disability benefits (odds ratio = 1.946). However, when accounting for the effects of the control variables (Model B), personal knowledge of AIDS was not associated with attitudes towards disability benefits for AIDS patients (odds ratio = 1.785). Also illustrated in Model B, results suggest that lower family incomes, political liberalism, and an acceptance of homosexual relations were positively correlated with the notion that AIDS patients should receive disability benefits, with odds ratios of (.934), (1.257), and (1.688, $p < .01$), respectively. In addition, black respondents were almost

three times more likely than white respondents to approve of disability benefits, with an odds ratio of (2.878). This finding lends support to the Jelen and Wilcox (1992) argument that although blacks report less acceptance of homosexuality than whites, blacks appear more solidly aligned with preserving and expanding the rights of minority groups than whites. The chi-square for Model III is (73.853).

Model IV of Table 2 illustrates the research findings regarding personal knowledge of someone with AIDS and the belief that identification tags should be worn by people with AIDS. The bivariate regression results reported in Model A suggest that there is no significant relationship between personal knowledge of AIDS and attitudes towards mandatory identification tags for people with AIDS (odds ratio = 1.502). In addition, personal knowledge of AIDS was not associated with attitudes towards identification tags with controls for sociodemographic variables in place (Model B). Also in Model B, results suggest that respondents who were defined as tolerant of homosexuality were strongly opposed to mandatory identification tags for people with AIDS (odds ratio = 1.612, sig. = .000). Race, gender, and income were not significantly associated with attitudes concerning identification tags for people with AIDS. Contrary to previous research that suggests higher levels of educational attainment, political liberalism, and Catholic religious affiliation are associated with an objection to mandatory identification tags for AIDS patients, this study did not find these variables to be significant. The chi-square for Model IV is (56.606).

In sum, gender, marital status, level of educational attainment, region of residence, population density of residence, religious service attendance, and conservative Protestant affiliation were not statistically significant in any of the four models measuring attitudes towards AIDS. One's tolerance of homosexuality, age, and Catholic affiliation were each significant in

one of the four models. Race, total family income, and political ideology each showed significance in two of the four models regarding attitudes towards AIDS. Lastly, acceptance of homosexuality proved significant in three of the four regression models.

Table 2: Logistic Regression Results: The Impact of Personal Knowledge of Someone with AIDS on Attitudes Towards AIDS

	MODEL I Keep Children with AIDS Out of School		MODEL II Government Pays for AIDS Care	
	A	B	A	B
Personal Knowledge of AIDS Patient	.542/1.720 (.320)	.176/1.193 (.471)	.579/1.784 (.267)*	1.287/3.621 (.400)
Age		-.002/.998 (.008)		.018/1.019 (.008)*
Female		-.247/.781 (.274)		-.300/.741 (.271)
Married		-.211/.810 (.323)		-.123/.884 (.313)
Black		-.213/.808 (.397)		.889/2.433 (.391)*
Total Family Income		-.012/1.013 (.030)		-.086/.918 (.031)**
Years of School Completed		.071/1.073 (.053)		-.026/.975 (.052)
Southern Residence		-.080/.924 (.301)		-.275/.759 (.305)
Urban Residence		-.050/.951 (.095)		.027/1.027 (.094)
Political Ideology		.050/1.051 (.100)		.362/1.436 (.102)**
Religious Service Attendance		.037/1.038 (.053)		-.101/.904 (.053)
Catholics		-.234/.791 (.327)		.695/2.004 (.311)*
Conservative Protestants		-.162/.851 (.401)		-.011/.989 (.447)
Acceptance of Homosexual Relations		.455/1.577 (.178)*		-.352/.703 (.144)*
Tolerance of Homosexuality		.199/1.22 (.115)		.141/1.151 (.124)
Constant		-.742/.476 (.981)		-1.169/.311 (.951)
Chi-square		34.185		65.557
N=		355		349

Note: cell entries are given as logistic regression coefficient/ odds ratio, with the standard error given in parentheses.

*p<.05

**p<.01

	MODEL III Disability Benefits for AIDS Patients		MODEL IV I.D Tags for People with AIDS	
	A	B	A	B
Personal Knowledge Of AIDS Patient	.666/1.946 (.295)*	.579/1.785 (.457)	.407/1.502 (.266)	-.107/.899 (.405)
Age		-.006/.994 (.008)		.010/1.010 (.008)
Female		.174/1.191 (.244)		-.318/.728 (.242)
Married		.156/1.169 (.290)		.102/1.107 (.287)
Black		1.057/2.878 (.460)*		-.673/.510 (.434)
Total Family Income		-.068/.934 (.030)*		-.054/.947 (.029)
Years of School Completed		-.022/.979 (.049)		.074/1.077 (.048)
Southern Residence		-.055/.946 (.264)		.054/1.056 (.271)
Urban Residence		-.080/1.083 (.088)		.122/1.130 (.090)
Political Ideology		.229/1.257 (.092)*		-.035/.966 (.089)
Religious Service Attendance		.032/1.033 (.047)		-.049/1.050 (.046)
Catholics		-.021/.979 (.290)		.442/1.555 (.278)
Conservative Protestants		-.393/.675 (.338)		-.655/.520 (.384)
Acceptance of Homosexual Relations		.524/1.688 (.149)**		.211/1.235 (.118)
Tolerance of Homosexuality		.184/1.202 (.110)		.478/1.612 (.122)**
Constant		-.814/.443 (.934)		-2.899/.055 (.881)*
Chi-square		73.853		56.606
N=		378		386

Note: cell entries are given as logistic regression coefficient/ odds ratio, with the standard error given in parentheses.

*p<.05

**p<.01

DISCUSSION AND CONCLUSIONS

This study attempts to augment previous explorations into the impact of personal knowledge of someone with AIDS and attitudes towards people with AIDS. In order to better understand the effects of personal knowledge of AIDS, several demographic variables were included in the analysis. These variables include the respondent's gender, marital status, race, total family income, level of educational attainment, region of residence, population density of residence, political ideology, and religious affiliation. Another purpose of the study is to probe what previous research has suggested is the correlation between attitudes regarding homosexuality and attitudes towards people with AIDS. Opinions about homosexuality were measured based on one's level of general acceptance of homosexuality and one's degree of tolerance regarding a homosexual person's rights to express himself or herself through public speaking, teaching, and writing.

Several research hypotheses were rejected in this study. Though it was anticipated that women would be more supportive of people with AIDS, gender was not significantly associated with attitudes towards people with AIDS for any of the models. It may be suggested that future research targeting personal knowledge of AIDS and gender explore intervening factors that could potential lead to a greater understanding of sex differences (or similarities) in attitudes about AIDS. It was also hypothesized that married and widowed respondents would hold different attitudes about AIDS than people who are divorced or separated. However, the regression analysis suggests no differences in attitudes towards AIDS bases on personal knowledge of someone with AIDS and marital status.

It was also projected that one's level of educational attainment would impact one's attitude towards AIDS. In short, personal knowledge of someone with AIDS and the accumulation of more years of schooling were predicted to increase one's tolerance towards people with AIDS. However, it seems that personal knowledge of AIDS and higher levels of education did not appear to significantly impact attitudes towards AIDS. Also, it was expected that respondents living in the South would be more rejecting of notions of tolerance towards people with AIDS than people in other regions. This assumption was made based on the South's history of discrimination against minority groups. People who live in the South and report personal knowledge of someone with AIDS do not appear to be more intolerant of AIDS patients than people living in other parts of the United States. Another geographic variable, population density of one's area of inhabitation, was anticipated to impact attitudes towards AIDS. Though it was expected that urban dwellers with personal knowledge of AIDS would be more accepting of people with AIDS than their rural counterparts, the analysis suggests that no relationship exists between personal knowledge of someone with AIDS, the population density, and attitudes towards AIDS.

Still other sociodemographic variables showed no relationship to attitudes towards people with AIDS. One's frequency of attending religious services was anticipated to impact attitudes towards AIDS. Though it was expected that frequent religious service attendance would be associated with less accepting attitudes towards people with AIDS, this study revealed no support for this hypothesis in all four models. It was also expected that one's affiliation with conservative Protestantism would suggest an unsupportive view of people with AIDS, as Greeley (1991) found such a relationship among Protestants in his study of attitudes towards AIDS. In

this study, of conservative Protestantism and personal knowledge of AIDS were not significantly correlated with attitudes about AIDS.

Other sociodemographic measures did appear to impact attitudes about AIDS. For instance, it was suggested that personal knowledge of AIDS and age may impact attitudes about AIDS. According to this study, as people who know someone with AIDS get older, they tend to support government efforts to pay for the health care of AIDS patients. Though unresearched in this study, it may be speculated that such support could be related to an aging respondent's identification with AIDS patients through what they may foresee as their own potential need of government support later in life. Age was not associated with attitudes towards keeping student with AIDS out of schools, isolating people with AIDS, or a belief that AIDS patients should be eligible for disability benefits.

A second variable dealing with religion, religious affiliation, is suggested to have some effect on attitudes towards people with AIDS. Reflected in previous research by Greeley (1991) and Begue and Morin (1998), this study suggests that Catholic affiliation is positively associated with supportive attitudes towards people with AIDS. More concretely, Catholics with personal knowledge of AIDS are significantly in favor of assigning the responsibility to pay for the health care of AIDS patients to the government. This study did not seek to determine the characteristics of Catholicism or the characteristics of the sampled Catholics, e.g., their political views and level of education. Future research into the specific attributes within denominations effecting attitudes towards AIDS would be undoubtedly illuminating.

Total family income also appeared to significantly affect one's attitudes about AIDS. This study suggests that higher income earners are not approving of government funding to pay for the health care costs of AIDS patients, nor are they encouraging of disability benefits for

people with AIDS. This finding contradicts this study's surmise that higher income earners will have more accepting attitudes about AIDS. Other research does evidence a more individualistic approach to social problems taken by the wealthy, who may define the poor and other minority groups, such as AIDS patients, as worthy of blame for their unfortunate circumstances and undeserving of assistance from the government and employers (MacNair 1995). Interestingly, for the two attitudinal variables that suggest little or no economic cost, keeping children with AIDS out of public school and enforcing people with AIDS to wear identification tags, income was not significantly related to support or opposition. This suggests a heavy reliance on instrumental values in making decisions about attitudes towards AIDS.

Personal knowledge and attitudes towards AIDS also appears associated with political ideology (LePoire et al. 1990). As with higher total family income levels, people who were more politically conservative were more likely to oppose measures suggesting that the government pay for AIDS care and also oppose the rights of people with AIDS to disability benefits. This parallels the research of Jelen and Wilcox (1992), which suggests that politically conservative people may opt against supportive steps to care for people with AIDS due to their opposition to government spending of any kind rather than direct discrimination against people with AIDS. This finding supports the idea suggesting that people make decisions based on instrumental values despite one's personal knowledge of someone with AIDS.

Another variable related to attitudes towards the cost of paying for the health care of someone with AIDS is race. In perhaps one of the stronger findings in the study, blacks who personal knowledge of someone with AIDS were overwhelmingly more supportive of governmental intervention in the care for people with AIDS and the rights of AIDS patients to disability benefits than whites. There were no significant racial differences concerning beliefs

about allowing children with AIDS to attend public schools and opinions about mandatory identification tags for people with AIDS. This reflects the findings of Jelen and Wilcox (1992) regarding Blacks' unequivocal support of civil rights of minority groups outweighs any feeling of intolerance they may have towards another group.

The link between tolerance of homosexuality of the respondents who personally know someone with AIDS and attitudes towards AIDS warrants further interpretation. First, one's personal knowledge of AIDS and tolerance of homosexuality, though expected to be associated with all four models, was significant for one of the models. Homosexuality tolerance was strongly associated ($p < .01$) with opposition to mandatory identification tags for people with AIDS. This finding appears reasonable, considering that the tolerance variable included three questions concerning a homosexual person's having as much right participate in public life as any other person, i.e., to give a speech, teach at a university, or avoid censure due to a publication's homosexual-positive content. It seems fitting that one who affirms the majority of these freedoms would also promote the inclusion of AIDS patients' rights to participate in public life unfettered by the stigma of identification tags.

Another measure of beliefs about homosexuality, one's general tolerance of homosexuality, suggests mixed messages from this research. As expected, a general acceptance of homosexuality predicted an affirmative response to the rights of people with AIDS (Bliwise et al. 1991; Gershon et al. 1994; O'Donnell et al. 1987; Preston, Koch, and Young 1991; Royce and Birge 1987; Schulte 2002). In this study, a general acceptance of homosexuality was correlated with a belief in the rights of people with AIDS to disability benefits ($p < .01$) and a belief that children with AIDS should be allowed to attend public schools. This is the sole finding of the study that includes both an economic support and a social support for people with AIDS.

However, this analysis also suggests that those with personal knowledge of AIDS and who accept homosexuality appear to be opposed to the government financing health care for people with AIDS. It seems that this group may support the rights of people with AIDS, but object to personal financial contributions to this cause.

As part of the logistic regression analysis, this study was able to observe the impact of personal knowledge of someone with AIDS on attitudes towards AIDS without the constraints of the control variables. This study suggests that personal knowledge alone significantly impacts the variable related to the economic support for AIDS patients, i.e. people support governmental responsibility for covering the entire cost of AIDS health care and the right of AIDS patients to disability benefits. However, personal knowledge alone was not associated with support or opposition to children with AIDS' attendance at public schools or opinions regarding compulsory identification tags for people with AIDS. This discovery runs counter to the assumption that personal knowledge of AIDS patients would encourage support for any efforts to promote the well-being and rights of people with AIDS. It does not seem that to intimately know of the struggles experienced by people with AIDS is to know the extent to which the resources and rights needed to promote health and social justice are lacking.

There are perhaps a few additional scenarios that need to be investigated. It is suggested by the research that disclosure to friends and family that one has AIDS may lead to estrangement from key members of one's social networks (Kalichman et al. 2003; Serovich 1993; Serovich et al. 2001). Shame and hatred of the illness may be displaced to the people afflicted with the virus, potentially impacting attitudes towards people with the illness (Sontag 1978). Also, one with personal knowledge of someone with AIDS may not define people they know with AIDS and people they do not know with AIDS similarly. For example, one who has friend with AIDS

may view the friend as an innocent victim, while others with AIDS may be seen as immoral opportunists seeking to spread the virus.

It is posited that personal knowledge may not beget support for people with AIDS. One may know someone who has AIDS who has also caused great distress. Support for this person with AIDS could possibly extend life and extend distress; death could signal the end of an arduous relationship. Also, those who have personally cared for a family member with AIDS may love the AIDS patient and yet find relief from suffering through the death of the beloved (Brabant 1996). In these cases, monies from the government and disability funds granted to pay for the health care of people with AIDS may be unwelcomed.

This project makes no projection about current attitudes towards AIDS. A major limitation of this study is due to unsuccessful attempts to obtain data from a national probability sample beyond 1988. It would be shortsighted to suggest that attitudes about AIDS have not changed since that time. Therefore, this study has provided no current and definitive answers concerning the impact of personal knowledge of AIDS on attitudes towards AIDS, but it has raised several questions. This study suggests no significant opposition to school attendance for children with AIDS nor significant support for mandatory identification tags for people with AIDS. However, economic support for people with AIDS appears to be a contentious issue. Future research targeting the interacting effects of race, total family income, and political ideology on attitudes towards economic support of AIDS is needed. Also, potential links between the acceptance of homosexuality, tolerance of homosexuality, and economic support for AIDS care may help to answer questions about these issues. In addition, future studies discerning what it means to personal know someone with AIDS, how one defines the personal

with AIDS and his/her health situation, and the one's role in the life of the AIDS patient may lend further incites into peoples' attitudes towards AIDS.

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